A mother's journey:
The meaning of having a baby born too soon
for postnatal women in Malawi

A thesis presented to Trinity College Dublin, the University of Dublin,
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Doctor of Philosophy in Nursing and Midwifery

by
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DECLARATION

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Signed: Jennifer M. J. Trainor

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DEDICATION

To the late Shirley Brown, my guardian angel: I'll be seeing you in Galway Bay.

To the late Leslie Johnson: Il y a longtemps que je t'aime, jamais je ne t'oublierai.

And to L.J. and E.T.: For your enduring love and support, and for encouraging me to "go as far as you can go in nursing." I am forever grateful. (After this, no more school!).

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ABSTRACT

Background

Preterm birth remains a critical global health challenge, particularly in resource-constrained settings such as Malawi, where maternal and neonatal healthcare resources are often limited. While it is undeniably crucial to understand the epidemiological landscape of preterm birth, the incidence, causes and possible control of perceived risk factors showcase one aspect of a complex issue. Birth statistics do not account for a woman's personal meaning or experience of preterm birth. As such, this study aimed to explore mothers' lived experiences of having a preterm baby and to illuminate the meaning of their preterm birth experience in Malawi.

Methods

Sixteen postnatal mothers, from the Blantyre district in southern Malawi, who believed to have given birth too soon, were purposively selected as participants for the study. In-depth, unstructured interviews were utilised to capture their experiences of giving birth to a preterm birth baby. The research process embraced the principles of Gadamerian hermeneutics, emphasising a collaborative and dialogical approach to data interpretation and analysis.

Findings

The study uncovered a central theme defining the preterm birth experience as *the unexpected journey*. This overarching narrative was further delineated by four themes: *something is wrong*, *the unforeseen birth*, *walking through the unknown*, and *stepping into the clearing*. The findings highlighted the profound impact of preterm birth on the lives of mothers in Malawi.

Conclusion

The experience of preterm birth unveiled a complex journey that was marked by a range of sentiments, including anxiety, hope, and resilience, profoundly impacting the well-being of both the infant and the mother throughout each challenging phase. By recognising the complexities surrounding preterm birth, this study demonstrated the necessity for further women-centred research and the development of culturally tailored interventions to improve the outcomes and experiences of those affected by this phenomenon.

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LIST OF ABBREVIATIONS

CH: Health Centre

CHAM: Christian Health Association of Malawi

COVID-19: Coronavirus SARS-CoV-2 (declared pandemic between 2020 and 2023)

C/S: Caesarean section

MLW: Malawi-Liverpool Wellcome Trust

PAHO: Pan American Health Organisation

PTB: Preterm baby

SBA: Skilled birth attendant

SMI: Safe Motherhood Initiative

TA: Traditional Authority

TBA: Traditional birthing attendant

UN: United Nations

UNDP: United Nations Development Programme

UNPF: United Nations Population Fund

VB: Vaginal birth

WHO: World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Planting the seed of research

During my first summer as a neonatal nurse, I encountered a mother who had recently arrived in Canada from sub-Saharan Africa. I remember the evening of our first encounter quite vividly: she was quietly sitting next to her child's incubator, her hands lightly pressed up against the incubator doors. Her child's 550-gram body, born prematurely at approximately 25 weeks, was overwhelmed by an abundance of life-sustaining tubes and wires. I noticed an empty seat beside her and asked if I could sit down. She consented, and we began speaking about the child who lay before us and about her family back home. I enquired about her family, and whether she had had the opportunity to provide them with regular updates on her child. There was a moment of silence. She lowered her head, and a tear rolled down her cheek. Speaking softly, the mother confided that she could not admit to her family that she had given birth to a preterm infant. "I am ashamed", she divulged. She stated that it was not something she could reveal to her family. Her family would simply not understand.

At the time, I was perplexed as to the reason why a mother would not wish to share the news of her birth. Attempting to gain a better understanding, I reflected upon our interaction that night. She had given birth prematurely, but her child was nevertheless improving with each passing day. I considered the milestones this child had attained. He was beginning to take milk orally, requiring less of a dependence on the intravenous infusion. Furthermore, he was breathing better, requiring less support from the ventilator. Was this not good news? Why would the mother not wish to share her child's progress? Why did she feel ashamed? These questions remained with me. The answers, however, were not as simple as I had once thought.

1.2 Introduction

This chapter provides an overview of this hermeneutic phenomenological study about the meaning and experiences of preterm birth for mothers in Malawi. I will first share a brief background of how I became interested in this topic, followed by an introduction to the context of birth. I will then discuss the research purpose, the study's rationale, and research design. I will conclude with an overview of how each chapter of this thesis will be structured.

1.3 Background: The birthing space

When considering the experience of pregnancy and childbirth in research, contemporary discussions often emphasise the technological process of birth (Davis-Floyd & Sargent, 1997; Kitzinger, 2005, 2006; Thomson, 2010) and are predominantly concerned with issues of risk and safety (Kay et al., 2017). Historically, the practice, and the 'knowing' of pregnancy and childbirth, were primarily attended to by and in the domain of women (Davison, 2020). However, the rise of modern sciences brought a desire for scholars to discover 'objective truths' about the world in which we live, including within the realm of pregnancy and birth. Consequently, a positivist epistemology began to dominate the healthcare landscape, increasing the obstetric presence in the birthing space (Crowther, 2020; Davison, 2020).

While viewing and understanding childbirth from a biomedical process may be one lens of analysis, a feminist lens would argue that birth is a complex, yet normal experience. It is uniquely understood by each woman, extending beyond the boundary of medicine or science (Crowther, 2020; Jordan, 1993). The seminal works of feminist and academic writers, such as Rich (1976), Oakley (1979, 1980, 2000), hooks (1984), Davis-Floyd (1992), Jordan (1993), Kitzinger (2005, 2006), and Hill (2019), have challenged the biomedical narrative of childbirth. They have explored its impact on women's experiences

and have advocated for the centring of women's voices during childbirth. However, upon further investigation into preterm birth literature, I noted that there was a dearth of research focusing on the voices and lived experiences of mothers of preterm babies in developing countries. This point encouraged me to reflect upon and ask further questions about preterm birth on a global scale.

1.4 Research purpose

The purpose of this work was to explore the meaning and experience of preterm birth for mothers in Malawi. The aim was to illuminate the perceptions and ways of understanding of preterm birth through a feminist lens, focusing on the unique perspectives, experiences, and stories of each mother. The intention was to uncover the rich meaning embedded within each mother's story, to further the knowledge and research base of preterm birth.

1.5 Rationale of the study

Addressing the worldwide impact of preterm birth holds paramount importance in the pursuit of the United Nations' third Sustainable Development Goal (SDG), which seeks to ensure healthy lives and promote well-being across all age groups (United Nations [UN], 2022). Specifically, indicator 3.2.2 aims to bring neonatal mortality down to 12 or fewer neonatal deaths per 100 live births in all countries (UN, 2022). While it is undeniably crucial to understand the epidemiological landscape of preterm birth (Ohuma et al., 2023), incidence, causes and possible control of perceived risk factors show one aspect of a complex issue. Birth statistics do not account for a woman's personal meaning or experience of preterm birth, and there is an absence of published research in this area. Malawi drew special attention because, at the time this project was initiated in 2017, the country had the highest preterm birth rates, estimated at 18.1 per 100 live births (Blencowe et al. 2013a; Purisch & Gyamfi-Bannerman, 2017). Particularly, I had not been able to find any studies

occurring in Malawi which sought to illuminate the meaning, experience, and perception of preterm birth from the mother's perspective only. Levison et al. (2014) stated that successful implementation of prevention strategies and interventions for preterm birth may be hampered unless women's perception of preterm birth and birth culture are understood. A better understanding of this aspect of preterm birth may contribute to a knowledge base to build and underpin the development of policy, with a view to preventing preterm birth and implementing health and well-being strategies for women pre and during pregnancy.

1.6 Research design

The research's aim was to explore and illuminate the meaning and experience of preterm

birth for postnatal mothers in Malawi.

The specific research objectives were as followed:

1. To explore and illuminate a foundation of knowledge on the meaning, experience, and perception of preterm birth in Malawi, based on the lived experience of the participating mothers.
2. To explore, understand, and provide an interpretation of women's experiences of giving birth to a preterm infant
3. To illuminate the personal and cultural context of the preterm birth experience for mothers in Malawi
4. To explore how mothers of preterm infants understand their preterm birth experience after the birth

The research questions were as followed:

1. What is the meaning of preterm birth for postnatal mothers in Malawi?
2. How do mothers experience and perceive preterm birth?

This study was informed by the philosophy of hermeneutic phenomenology, guided by the approach developed by Gadamer (1975). While hermeneutics is often associated with the interpretation of texts, it has been applied to a wide range of fields, including literature, art, history, and the social sciences. Gadamer's philosophy offers an appropriate philosophical foundation for exploring the meaning and experiences of preterm birth, with a central commitment to centring women's voices. This seems crucial given the medical and technical focus that has been considered authoritative knowledge on pregnancy and childbirth (Jordan, 1997) denying and devaluing women's knowledge (de Kok et al., 2020). Gadamer's hermeneutics, as articulated in "Truth and Method" (1975), fundamentally challenges the notion of fixed and universal truths. It champions the idea that understanding is an ongoing, dialogical process, aligning with the research's goal of exploring the multifaceted meanings of preterm birth. By embracing this framework, I acknowledge that experiences and interpretations are dynamic, inviting an in-depth exploration of the layers of significance within women's experiences. Furthermore, the feminist perspective, as outlined in "Feminist Theory: From Margin to Center" by bell hooks (1984), reinforces the importance of prioritising women's voices. It emphasises the need to amplify marginalised voices and recognise the complexities of women's experiences, particularly in settings like Malawi. Gadamer's hermeneutics complements this perspective by providing a methodological approach that values participants' voices and encourages a collaborative and empathetic research environment (Gadamer, 1975).

The contextual sensitivity inherent in Gadamer's hermeneutics aligns with the necessity of understanding the sociocultural factors shaping women's experiences. Smith et al. (2009) highlighted the significance of considering the cultural background in qualitative research. In the case of preterm birth in Malawi, this includes cultural nuances, traditions, local beliefs, and one's historicity which may profoundly influence women's

experiences. Gadamer's hermeneutics guides researchers to immerse themselves in this setting, ensuring a more nuanced and culturally sensitive understanding. As such, this approach recognises the dynamic nature of interpretation, values women's voices, and appreciates the importance of contextual understanding, making it a compelling choice for researching women's experiences of preterm birth in Malawi. A further critical discussion of hermeneutics will be presented in Chapter Four.

1.7 Navigating this thesis

The following summary outlines the structure of this thesis and the content of each chapter.

Chapter One introduces the study background and provides the purpose and overall aim of the research exploring the meaning and experience of preterm birth for mothers in Malawi.

Chapter Two provides a background to the geo-political, social, and economic landscape in Malawi related to women's health.

Chapter Three introduces the topic of preterm birth and presents a review of existing literature from a hermeneutic perspective.

Chapter Four is divided into two sections. Section one explores my positionality relevant to this research. Section two presents the chosen research methodology, based on Gadamer's hermeneutic phenomenology. It provides the historical context of hermeneutics to clarify the philosophical foundations upon which Gadamer's work is based.

Chapter Five offers an account of the research methods and data analysis approach employed for this study. Furthermore, the project's rigour, trustworthiness, and ethical considerations are discussed.

Chapter Six reports the findings using 'the mother's journey' analogy. The overarching theme, and four sub-themes, are each individually explored through the mothers' narratives.

Chapter Seven offers an in-depth discussion of the findings and provides concluding

remarks about the research study and offers recommendations and implications for clinical practice, policy development, education, and further research.

1.8 Conclusion

This introductory chapter has provided insight into how the concept for this study came to fruition. It has presented a brief overview of birth, leading to the project's purpose and rationale. The research design was also introduced. The upcoming chapter will offer further insight into the social, political, and economic context of Malawi.

CHAPTER TWO

INTRODUCTION TO MALAWI

2.1 Introduction

This chapter introduces the Malawian context. The study used hermeneutics as its methodology, which considers the importance of context in understanding the human experience. As such, the objective is to offer a thorough understanding of the various socio-cultural, healthcare, economic, and policy factors which provide the backdrop to the experiences of mothers and families in Malawi.

2.2 Geographic and demographic overview

The Republic of Malawi is a landlocked country located in southeast Africa. It shares its borders with Tanzania, Mozambique, and Zambia. As of 2024, the total population of Malawi is approximately 21.5 million individuals (United Nations Population Fund [UNPF], 2024). The population remains mostly rural (84%); however, urbanisation levels are expected to rise by 2030 (McBride & Moucheraud, 2022; National Statistics Office [NSO], 2019). The official language is English, with Chichewa being a major language spoken by most inhabitants of the country. There are 10 primary cultural groups, including Chewa (34.3%), Lomwe (18.8%), Yao (13.2%), Ngoni (10.4%), Tumbuka (9.2%), Sena (3.8%), Mang'anja (3.2%), Tonga (1.8%), Nyanja (1.8%), and Nkhonde (1%) (Central Intelligence Agency, 2023). Faith is an important part of everyday life, with most citizens identifying as Christian (77%) or Muslim (13%) (NSO, 2019). Cultural beliefs often play a central role in shaping women's perceptions, decision-making processes, and healthcare-seeking behaviours, particularly concerning pregnancy, childbirth, and postnatal care (Roberts et al., 2016). In a country where religious and spiritual beliefs hold considerable influence, understanding the interplay between faith and maternal health

experiences is important to consider. This point will be explored later in Chapter Three.

Malawi is divided into three main regions: Northern, Central, and Southern regions. Blantyre, where the research took place, is in the Southern Region of the country. Malawi is further broken down into 28 districts. Six districts are in the Northern Region, nine are in the Central Region, and the remaining 13 districts are situated in the Southern Region. The following figure (Figure 1) situates the country in further detail, illustrating the three regions and 28 districts.

Figure 1

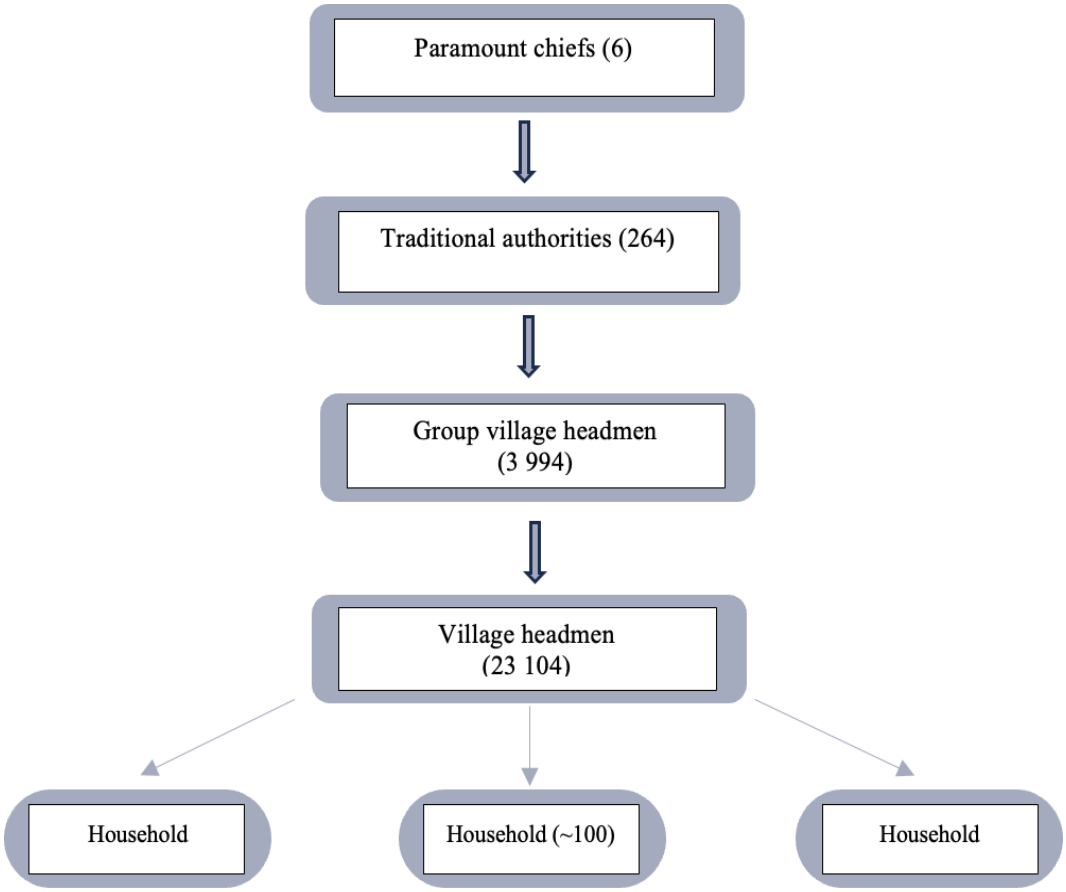
Map of Malawi

On a local political level, a dual governance system is in place, where democratically elected local government officials work alongside a traditional chieftaincy hierarchy. From a political perspective, districts in Malawi are subdivided into constituencies, each of which is represented by members of parliament in the National Assembly. These constituencies are then divided into smaller units known as wards, which have local councillors representing them in district councils (Government of Malawi, 2017).

The traditional chieftaincy hierarchy, contrarily, is structured into four distinct ranks: the Paramount Chief, Traditional Authority (TA), Group Village Headman (GVH), and the Village Headman, who is also commonly referred to as a village chief (Basurto et al., 2020; Carlson & Seim, 2020). Traditionally, village heads have held positions of authority and leadership, particularly concerning local governance and conflict resolution. The following figure (Figure 2) provides a visual overview of the traditional hierarchy in Malawi.

Figure 2

Traditional Hierarchy in Malawi



Note. This figure demonstrates the hierarchy of traditional leaders in Malawi. Specific numbers are approximate and were informed by the data from Carlson, E., & Seim, B. (2020). Honor among chiefs: An experiment on monitoring and diversion among traditional leaders in Malawi. *The Journal of Development Studies*, *56*(8), 1541–1557.

The authority of traditional leaders can extend to traditional healing practices and healthcare beliefs, which can impact community attitudes and practices related to pregnancy, childbirth, and healthcare access. For example, traditional leaders hold an instrumental role in encouraging communities to support safe motherhood initiatives[1] and

[1] The Safe Motherhood Initiative is a global programme focused on reducing maternal mortality and improving the overall health of mothers and newborns through various interventions and strategies, emphasising access to quality maternal healthcare services, skilled birth attendance, and postpartum care. This is further discussed in Chapter Three.

in actively supporting women to give birth at local health facilities (Godlonton & Okeke, 2016). Walsh et al. (2018) found that while the village chief's role in promoting maternal, newborn, and child health services was generally positive, there were instances where this encouragement took on a coercive nature. Instead of empowering women to opt for a health facility-based birth, local bylaws were implemented as punitive measures against women who did not choose this option, imposing fines as a form of punishment. As such, this point underscores the significant influence wielded by traditional leaders at the local level, having a potential impact on the experiences of childbearing women in Malawi.

2.3 Healthcare infrastructure

2.3.1 Biomedical healthcare

The biomedical health system in Malawi is structured across different tiers[2], including the community and primary level, secondary, and tertiary levels (Government of Malawi, 2017; Mchenga et al., 2022). Ideally, they are each connected by a referral system. In practice, a significant proportion of services provided at the tertiary level are intended for conditions that ideally fall within the scope of primary care or district hospitals. This situation is, in part, attributed to inadequate gatekeeping measures at the lower tiers of the healthcare system (Government of Malawi, 2017; Makwero, 2018). The majority of healthcare services (63%) are provided through government facilities, which, despite certain service constraints, are accessible free of charge. Additionally, the Christian Health Association of Malawi (CHAM) delivers healthcare services (26%) for a nominal user fee, while a smaller proportion of services are provided by private for-profit and non-governmental organisations (11%). The health system relies significantly on external donor support (Masefield et al., 2020).

[2] Literature discussing the healthcare structure in Malawi often integrates the community level with the primary care tier. For simplicity, I have decided to use the term 'primary healthcare' to describe both community and primary tiers, as they are both generally the first point of contact for an individual's healthcare needs.

Primary healthcare, including community services, includes health posts[3], dispensaries, village clinics, maternity clinics, health centres, and community and rural hospitals (Government of Malawi, 2017). At this level, a range of inpatient and outpatient services are provided, primarily overseen by midwives, nurses, and health surveillance assistants (HSAs). Primary healthcare has been provided without charge at the point of access since 1964. The entitlement of the population to essential services without user fees, including maternal healthcare, was established through the implementation of the Essential Health Package (EHP) in 2004 (McGuire et al., 2021). To further improve the accessibility of maternal and child health services, CHAM facilities, within catchment areas where government facilities are not available, have offered the EHP without imposing user fees under the Service Level Agreement (SLA) since 2006 (Manthalu, 2019; McGuire et al., 2021).

Secondary healthcare consists of both district and CHAM-run hospitals (CHAM, 2023; Government of Malawi, 2017). Inpatient and outpatient services are provided to the surrounding catchment population, acting as referral centres for primary healthcare facilities. Nurses, midwives, and general practitioners primarily provide care at this level. Finally, the tertiary level includes four central hospitals, located across the country, each offering specialised healthcare services.

According to the Government of Malawi (2017), the national access policy aims to guarantee that all households reside within a five-kilometre radius of a healthcare facility, representing a reduction from the previous target of eight kilometres. During the 2011-2016 period, the construction of 12 new health facilities was undertaken. However, despite these efforts, the percentage of the population living within an eight-kilometre radius of a health facility decreased from 81% to 76 % during the same timeframe (Government of Malawi,

[3] Health posts in Malawi are basic healthcare facilities located in local communities, often providing essential medical services and health education.

2017; McGuire et al., 2021). Shedding light on this point is crucial when comprehending the challenges and obstacles pregnant women might face throughout their maternal journey. The geographical barriers and long distances to healthcare facilities can significantly impact their birthing experiences, particularly when looking at an unexpected preterm birth.[4]

2.3.2 Traditional healthcare

Traditional and religious healthcare in sub-Saharan Africa constitutes an integral aspect of many countries' cultural and healthcare frameworks. It represents a blend of age-old customs, spiritual beliefs, and indigenous healing practices (WHO, 2023c). While approximately 90% of mothers give birth in healthcare facilities, traditional healers remain a vital component of healthcare in Malawi, retaining a significant influence on the community's well-being (Lampiao et al., 2019). Expectant mothers in Malawi often seek the guidance and care of traditional birth attendants[5] (TBA), healers, community elders, and spiritual leaders. They play a significant role in providing prenatal support, addressing pregnancy-related concerns, and assisting during childbirth (Roberts et al., 2017). Rooted in a deep understanding of local traditions and cultural norms, traditional healthcare for pregnant women embodies a holistic approach that acknowledges the interconnectedness of physical, emotional, and spiritual aspects of maternal well-being.

Ryan et al. (2015) discovered that expectant mothers often opt to seek the services of a TBA over biomedical practitioners. These reasons included the absence of support from their spouse, geographical distance to the nearest health facility, financial constraints limiting transportation options, embarrassment for not obtaining necessary items for birth at the hospital[6], the desire for physical contact and emotional support during labour and birth, and unexpected or sudden onset of labour. These findings were supported by studies

[4] Further discussion on preterm birth is covered in Chapter Three.

[5] *Azamba* in Chichewa

[6] Many women are expected to bring certain items with them to the hospital, in preparation of birth.

conducted in other sub-Saharan African countries. Pregnant women in Tanzania favoured a TBA for childbirth, as it provided them with the opportunity to birth in a private setting, with the support of someone from their own community in whom they had confidence (Pfeiffer & Mwaipopo, 2013). In Ghana, the primary motivation of women for opting for traditional birth attendant-assisted birth was the perception of superior care. Traditional birth attendants were favoured due to their perceived experience, respect for traditional birthing positions, and their ability to address the emotional needs of women during childbirth, which was seen as lacking in younger midwives. Furthermore, challenges related to the conduct of midwives, potential mistreatment, and aversion to caesarean sections were identified as obstacles to birthing in a health facility. Societal norms established a connection between womanhood and vaginal delivery, leading to differential treatment for those undergoing caesarean sections (Tabong & Segtub., 2021). Highlighting why expectant mothers often choose to consult a TBA over biomedical practitioners in Malawi underscores the significance of their role according to cultural and social beliefs.

Religious and cultural beliefs have shown to influence pregnant women's health-seeking behaviours when faced with pregnancy-related questions or concerns. Makombe et al. (2023) found that the use of herbal medicines was prevalent among pregnant women in Malawi. The participants utilised herbal remedies to hasten the labour process, hoping to avoid undergoing a caesarean birth. Many participants shared their concerns that medical practitioners were quick to recommend surgical intervention, without allowing sufficient time for a natural labour experience. This point can be linked back to previously mentioned studies (Pfeiffer & Mwaipopo, 2013; Ryan et al., 2015). It appears that there is a strong desire among pregnant women in Malawi for a more holistic, women-centred approach. A study by Roberts et al. (2017) highlighted the women's beliefs in accessing antenatal care in Malawi. The authors found that strong religious beliefs influence

healthcare-seeking behaviours. Some women avoided seeking hospital care due to religious convictions, choosing instead to pray or seek help from religious leaders. Many churches organise support groups for pregnant women, offering counselling and educational sessions. Furthermore, the authors highlighted the influence of advice by women's own mothers, community elders, friends, and pastors, when providing information about pregnancy and birth. These influential individuals contribute to a pregnant woman's decision to seek antenatal care, possibly overruling medical recommendations.

Exploring the intricacies and presence of traditional healthcare in the context of pregnancy is crucial for comprehending the multifaceted nature of maternal care in Malawi, beyond a biomedical model. These have been demonstrated to influence a woman's pregnancy journey and decision-making processes.

2.4 Impact of COVID-19 on women in Malawi

The COVID-19 pandemic has left an indelible imprint on the lives of women in Malawi, particularly affecting their experiences surrounding childbirth and maternal healthcare. The far-reaching implications of the global health crisis have transcended mere health concerns, deeply impacting socio-economic dynamics and exacerbating existing gender disparities in the country. While I did not explicitly set out to explore the meaning of mothers' experiences of preterm birth within a specific COVID-19 context, it was an important setting to consider and highlight as being a mitigating factor within their experience.

The pandemic led to substantial disruptions in routine maternal healthcare services, severely challenging pregnant women and new mothers to access vital healthcare. Access to antenatal care, skilled birth attendants, and postnatal support in Malawi was significantly curtailed, hindering the continuum of essential maternal healthcare services (Blair et al., 2023). There were public transport restrictions, a lack of personal protective equipment

(PPE) for both mothers and personnel, hospital strikes, and refusal of those seeking care, including pregnant mothers, at major healthcare facilities. According to the World Health Organization [WHO] (2020), the disruptions in health services caused by the pandemic resulted in a notable reduction in the utilisation of maternal and newborn healthcare services, potentially leading to adverse maternal and neonatal health outcomes.

Blair et al. (2023) found that foetal distress reports tripled during the first nine months of the COVID-19 pandemic (April to December 2020), along with increased reports of neonatal asphyxia. The use of anticonvulsants was also significantly increased during this period. The authors hypothesised that the increase in neonatal asphyxia and distress may have been caused by a lack of attendance by healthcare personnel. Furthermore, the authors thought that the increased usage of anticonvulsant medication was due to untreated malaria or undiagnosed or uncontrolled preeclampsia[7]. Both conditions are recognised for their potential to induce seizures (Fox et al., 2019; Schantz-Dunn & Nour, 2009) and may possibly be worsened by limitations imposed during the COVID-19 pandemic, such as the interruption of prenatal care, avoidance of healthcare facilities due to apprehension, temporary closures of healthcare centres, and inadequate transportation services. Consequently, mothers who did not attend or have access to prenatal care appointments faced an increased likelihood of a missed or mismanaged diagnosis (Blair et al., 2023).

The restrictions placed during the COVID-19 pandemic also significantly impacted the presence of birth companions in Malawi, altering the birthing experiences of many labouring mothers. The presence of a birth companion is culturally important in various sub-Saharan countries, a feature in respectful maternity care[8] (Wanyenze et al., 2022). The WHO (2020) strongly advocated for the presence and facilitation of a selected labour

[7] Preeclampsia is a pregnancy complication characterised by high blood pressure and signs of damage to another organ system, often the liver or kidneys. It usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal. Eclampsia is a severe complication of pregnancy, characterised by the onset of seizures (convulsions) in a woman with preeclampsia.

[8] Respectful maternity care is further discussed in Chapter Three.

companion at birth, even during the pandemic. Almeida et al. (2023) stressed the significance of social support in mitigating the impact of the pandemic on women's mental well-being, highlighting its role as a mediator in alleviating the adverse effects of COVID-19. Hughes et al. (2022) found that approximately 49% of Malawian women reported that they were denied the opportunity to have a birth companion during labour, while 60% indicated that they were not permitted to have a companion during birth in March 2020. However, it was unclear whether women were denied or not offered companions during labour and birth due to COVID-19 restrictions or whether there were other logistical reasons within the healthcare facilities. With that, it was plausible that mothers in my study would have experienced a similar pattern, potentially affecting the meaning of their birth.

The pandemic has further amplified the existing gender inequality, with women bearing a disproportionate burden of this crisis. The closure of schools and childcare facilities, coupled with heightened caregiving responsibilities, has added significant economic and familial pressure on women (Almeida et al., 2023). The United Nations Development Programme [UNDP] highlighted that the pandemic has increased women's vulnerability to gender-based violence, hindering their access to essential maternal healthcare services and contributing to challenging birthing experiences (UNDP, 2020). The pandemic-induced economic downturn, coupled with widespread job losses and reduced household incomes, intensified financial constraints, making it increasingly difficult for women to access quality maternal health services. Further, an analysis of the socio-economic impact of the pandemic in Malawi drew attention to a significant decline in household incomes, particularly among vulnerable communities, further deepening disparities in healthcare access and utilisation (UNDP, 2020). While antenatal care costs are covered under primary healthcare, transport costs to the health facility and personal protective equipment (PPE), which was mandatory for those seeking healthcare in many

facilities, increased the financial burden on many families (Senkyire et al., 2023; UNICEF, 2020). Consequently, many mothers had to make difficult choices, at times foregoing the necessary prenatal medical care.

There were certain notable points related to preterm birth in Malawi. Blair et al. (2023) noted that the incidence of premature birth notably rose during the first nine months of the COVID-19 period (April to December 2020) in Blantyre, Malawi. This observation contrasts with evolving data from higher-income nations. Several studies indicated an overall decrease in preterm births following COVID-19-related lockdowns; however, a rise was noted in preterm births among women who contracted the virus (Dench et al., 2022; Karasek et al., 2021; Wood et al., 2021). Blair et al. (2023) linked the heightened prevalence of preterm labour during the COVID-19 period to the plausible stress and fear experienced by mothers at the onset of the pandemic, as well as the potential maternal contraction of the virus. As such, it is important to consider not only the potential stress and fear of having a baby, but the added impact of the COVID-19 context.

The pandemic significantly influenced the healthcare system, social dynamics, and economic conditions, all of which contributed to the overall experience of birth for many mothers in the country. The challenges brought about by COVID-19, such as disruptions in healthcare services, economic hardships, and increased stress levels, can potentially exacerbate the risks and difficulties associated with birth, impacting the emotional and physical well-being of both mothers and infants. The unique hardships faced by pregnant women and the supportive quantitative research in Malawi underscores the urgent need to prioritise women’s voices and to hear the voices behind the numbers.

2.5 Conclusion

This chapter has provided insight into Malawi's social, political, and economic landscape. Furthermore, the COVID-19 pandemic and its impact on women in Malawi was explored, to situate the study further. The following chapter will introduce preterm birth in more detail and present a hermeneutic review of relevant literature.

CHAPTER THREE

REVIEW OF THE LITERATURE WITHIN HERMENEUTICS

3.1 Introduction

The study aims to explore and illuminate the meaning of preterm birth for mothers in Malawi. In Malawi, the complex interplay of cultural beliefs, healthcare practices, and socioeconomic factors emphasises the importance of comprehending the diverse meanings associated with preterm birth for postnatal mothers. This chapter opens by reflecting upon the initial approach of a scoping review and how it lacked authenticity in relation to the nature of the work. Subsequently, the hermeneutic literature review is presented, with further discussion focusing on its alignment with the aims, objectives, and research question of the study. Later in this chapter, an overview of preterm birth will be introduced, highlighting its global significance to provide contextual understanding. Following this, the chapter will examine relevant literature, exploring key themes identified during the hermeneutic literature review process. Grounded in Gadamerian hermeneutics, this review seeks to move beyond the surface-level accounts and statistical data and explore the intricacies and contextual nuances that define the subjective experiences of postnatal mothers in the wake of preterm birth. By exploring various academic and empirical works, this study aims to provide a comprehensive and culturally sensitive understanding of the physical, emotional, and sociocultural dimensions that shape and contextualise motherhood and preterm birth for women in the Malawian and global context.

3.2 Initial literature search

I embarked on a preliminary scoping review using electronic databases, such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, Maternity and Infant Care Database, Internurse, Intermid, Cochrane Library, Applied Social

Science Index and Abstracts, EMBASE, and EBSCO E-Book Nursing Collection. Keywords included: perception* (OR) attitude* (OR) knowledge (OR) experience* (OR) meaning (OR) understanding (OR) belief* (OR) attitude (AND) mother* (OR) maternal (OR) pregnant (OR) pregnancy (OR) women (AND) preterm (OR) premature (OR) prematurity (AND) birth (OR) delivery (OR) labor (OR) labour (OR) infant* (OR) babies (OR) baby (OR) neonate* (AND) Malawi* (OR) Africa (OR) sub-Sahara*. Only studies published in English were included. To set practical boundaries, I reviewed studies from the year 2000. The following table (Table 1) details the review's initial inclusion and exclusion criteria.

Table 1

Inclusion and Exclusion Criteria in Literature Search

Inclusion criteria	**Exclusion criteria**
Sources: • Research articles from electronic databases • Literature from non-governmental organisations Dates: • Literature from 2000-2023 Language: • Studies published in English Population: • Mothers of preterm infants Content: • Studies that relate to the meaning, perception, beliefs, or experiences of mothers of preterm birth in Malawi.	Sources: • No general exclusion criteria for source types Dates: • Prior to 2000 Language: • Studies not published in English Population: • Studies which did not include mothers in their study population. Content: • Studies unrelated to the meaning, perception, beliefs, or experiences of preterm birth. • Studies not conducted in Malawi.

Engaging in a scoping literature review originally appeared practical for a thorough examination of existing research, especially to gain insights into preterm birth within the context of Malawi. However, despite conducting a comprehensive search of the literature, the findings proved to be rather limited. Only seven research articles were identified that specifically included mothers in their study population, focusing on their perceptions, knowledge, or experiences related to preterm birth in Malawi. These articles will be revisited further below (section 3.6). Nevertheless, upon deeper reflection, I found myself grappling with a pivotal question: was that all? Was there not a plethora of additional literature awaiting exploration that could potentially enrich my knowledge and understanding of birth and maternal health? My background as a nurse, having primarily approached birth from a biomedical standpoint, compelled me to re-evaluate my approach to this research. I had been immersing myself in hermeneutics and sought a method for reviewing literature that aligned with this philosophical approach to explore concepts of birth in a more holistic manner. This shift prompted me to recognise and acknowledge my own biases and preconceived notions of birth and how that might have influenced my selection and interpretation of the literature.

3.3 Literature review framework and the hermeneutic study

Crafting a comprehensive literature review can pose challenges, especially when undertaking research guided by hermeneutics. Proponents of systematic reviews argue that employing a methodical approach to literature searches results in impartial, extensive, and replicable reviews (Kitchenham & Charters, 2007). The absence of a standardised protocol or universally accepted criteria for evaluating the quality of hermeneutic literature reviews further complicates this process (Webber et al., 2023). Conversely, Boell and Cecez-Kecmanovic (2010) challenged the assertion that a structured literature selection process can always result in an "unbiased, complete, and reproducible" review (p. 130). The authors

contend that, in many instances, achieving a comprehensive review of relevant literature cannot be attained through a structured approach. Further, they assert that adhering to a methodical process requires establishing the research question beforehand, potentially impeding scholars from exploring additional literature if it deviates from the predetermined review parameters (Boell & Cecez-Kecmanovic, 2010). As such, many academics advocate for an approach that aligns with the specific methodological and philosophical underpinnings of the study at hand, to create a meaningful synthesis of literature within intricate contexts of a particular study (Greenhalgh et al., 2017; Greenhalgh et al., 2018; Smythe & Spence, 2012). Reviewing literature with a hermeneutic lens would encourage the idea that interpretation is never final but an ongoing reinterpretation (Boell & Cecez-Kecmanovic, 2010). This was a point which particularly resonated with me.

In my hermeneutic research, I encountered one approach which captured my interest. Smythe and Spence (2012) presented valuable insights into the process of reviewing the literature in the context of hermeneutic research. The authors stressed the significance of bringing fresh perspectives to the interpretation of words, meanings, and thoughts within the literature. Instead of outlining a specific step-by-step guide, Smythe and Spence (2012) underscored several key principles that reflect the application of a hermeneutic approach to literature reviews (Webber et al., 2023). These principles include engaging with a diverse array of relevant literature, recognising researchers' biases, viewing the literature as a partner in dialogue, incorporating philosophical literature, and attending to the nuanced meanings embedded within language. The following table (Table 2) outlines the framework suggested by Smythe and Spence (2012).

Table 2

Main Characteristics of a Hermeneutic Literature Review

• Consult various literature, spanning various subjects, genres, time, and culture. This includes a comprehensive range of material, including poetry.
• The researcher discloses how their own prejudices have led to the selection and a particular understanding of the literature. This may include the telling of stories to demonstrate how understanding has been formed and remains ongoing, as one pursues meaning.
• The literature acts as a shared method to incite thinking. It is more conducive to reflect upon an article than simply restating its contents.
• Consult the philosophical literature as part of the methodological process and discussion.
• There is emphasis on identifying meaning through a variety of ways of thinking, including metaphors, description, and pictures. Further understanding is developed by viewing the material from a distance and 'reading between the lines'.
• Language carries concealed meaning. As such, quotes are provided to capture a particular concept.
• Material relating to the context of the research is viewed as equally significant as literature related to the subject.

Note. Table modified from Smythe, E. & Spence, D. (2012) Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods* 11(1), p. 12-25.

Smythe and Spence's (2012) literature review framework resonated profoundly with me due to its flexibility and creativity in exploring diverse forms of literature. It advocated for openness and transparency from the researcher, encouraging reflective practice, critical analysis, and the pursuit of deeper, less apparent meanings. This framework appeared intrinsically related to the hermeneutic circle[9], a concept significant to hermeneutics, positing that the understanding of any part of a text is shaped by the whole and vice versa (Boell & Cecez-Kecmanovic, 2010). This circular process involves the interpreter continuously moving between the parts and the whole, refining and deepening their understanding, thereby challenging preconceptions and biases for a more nuanced comprehension of the text and its context (Gadamer, 1975).

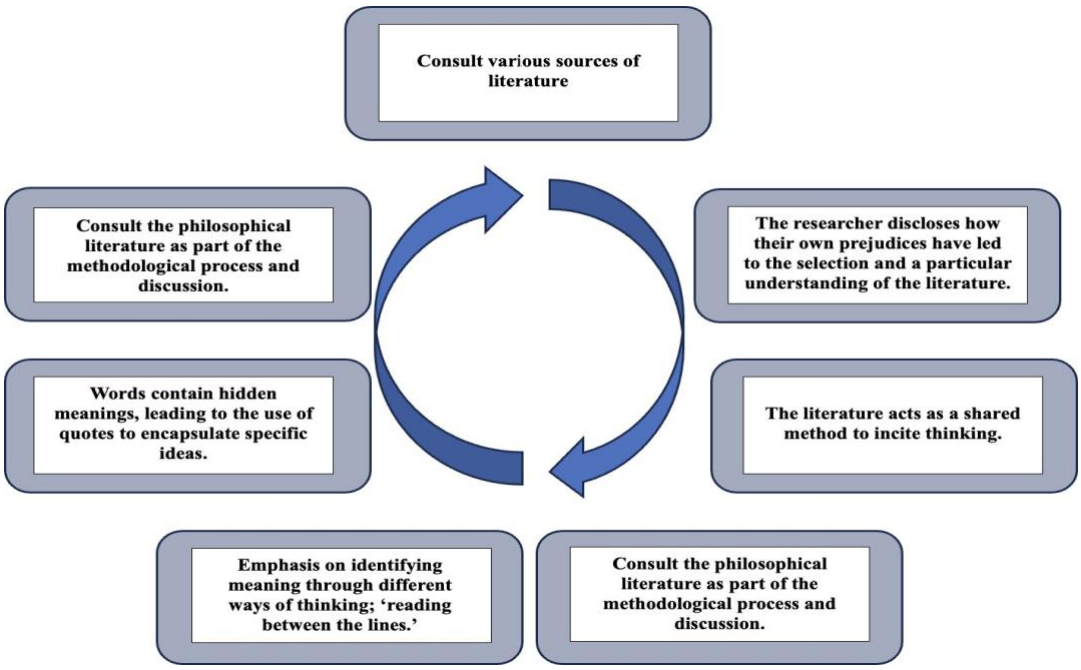
The literature review, much like the hermeneutic circle, involves an iterative and interpretive process navigating the complexities of existing research. It requires balancing the analysis of individual studies with the synthesis of their collective insights (Webber et al., 2023). Researchers engaging in a hermeneutic literature review undertake a journey that mirrors the dynamic interplay of preunderstandings and emergent themes, allowing for evolving interpretations and insights (Boell & Cecez-Kecmanovic, 2010). Smythe and Spence's (2012) principles align closely with the hermeneutic circle in several respects: engaging with diverse literature reflects the hermeneutic practice of considering multiple perspectives, recognising researchers' biases align with acknowledging the impact of preunderstandings on interpretation (Gadamer, 1975), viewing the literature as a conversational partner corresponds to the focus on dialogue and understanding (Lawn, 2006), and integrating philosophical texts enriches interpretation (Webber et al., 2023). Although various scholars have proposed hermeneutic circle literature review frameworks, I found Smythe and Spence's

[9] The hermeneutic circle is further discussed in relation to hermeneutic philosophy in Chapter Four.

(2012) approach to be more adaptable and open, aligning better with Gadamerian[10] hermeneutic philosophy. Below, in Figure 3, I have incorporated Smythe and Spence's (2012) framework into a hermeneutic circle.

Figure 3

Reviewing Literature Using the Hermeneutic Circle Framework



Note. Figure adapted from Smythe, E., & Spence, D. (2012) Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods* 11(1), p. 12-25.

3.4 Application and reflection of the adapted framework

In conducting a hermeneutic literature review on the meaning of preterm birth in Malawi, using Smythe and Spence's (2012) framework, I engaged with a comprehensive array of texts across various disciplines, genres, and cultural contexts. The initial review of scientific articles and the preliminary scoping review provided a foundation for further exploration of previously overlooked aspects of birth. By utilising the reference sections of

[10] Gadamer and his hermeneutic philosophies will be further discussed in Chapter Four.

these research articles, I employed a snowballing technique to first identify additional relevant literature. Throughout this process, I meticulously documented emerging keywords and themes, which were subsequently categorised into different sections. Emerging themes, including the intricate dynamics of motherhood, power structures, medical authority, women's knowledge, women's ways of knowing, and the complex landscape of birth politics, were beginning to surface as significant factors contributing to the nuanced experiences and meanings for mothers of preterm infants.

Organising the keywords into coherent categories facilitated a comprehensive examination of the intricate nature of preterm birth in Malawi. Medical and clinical terminologies such as "premature birth", "neonatal care", and "gestational age" introduced the healthcare and biomedical dimensions of preterm birth. Sociocultural and contextual lexicons such as "maternal experiences", "birth narratives", and "traditional birth practices" offered perspectives on the cultural and societal facets. Psychological and emotional descriptors like "maternal anxiety", "postpartum depression", and "parental stress" underscored the mental health challenges associated with preterm birth. Moreover, terms pertaining to healthcare systems and policies, including "access to healthcare" and "healthcare disparities", facilitated an examination of structural and systemic issues. References to developmental and long-term outcomes such as "infant development" and "early intervention programmes" enriched the understanding of the enduring impact on child development. Additionally, categorising terminologies associated with birth and women's health, such as "women-centred care" and "empowerment in childbirth", alongside feminist terminology like "gender equity" and "reproductive rights", enabled a deeper exploration of the intersection between healthcare, gender, and empowerment. The following table (Table 3) overviews some of the keywords noted during the literature review from a hermeneutic framework, which allowed for a more comprehensive and

holistic exploration of relevant work.

Table 3

Keywords from Hermeneutic Literature Review

Medical and Clinical: • Premature birth (baby born too soon) • Neonatal care • Gestational age • Low birth weight • Maternal healthcare • Prenatal care • Complications of preterm birth	**Healthcare Systems, Policies, and Politics:** • Access to healthcare • Healthcare disparities • Midwifery vs. obstetric care • Health policy interventions • Global health initiatives
Sociocultural, Contextual, and Historical: • Maternal experiences • Birth narratives • Cultural perceptions of birth • Traditional birth practices • Community health beliefs • Family dynamics • Socioeconomic factors • Colonial history • Decolonisation • Postcolonial era • Imperialism • Colonial legacy • Power, oppression, and resistance	**Ethical and Philosophical:** • Ethical considerations in neonatal care • Rights of the child • Reproductive rights/justice • Philosophies of care • Patient autonomy and informed consent • Hermeneutics • Gadamer and Heidegger • Hermeneutic circle • Fusion of horizons • Language and interpretation • Meaning making • Preunderstanding/preconception
Psychological and Emotional: • Maternal anxiety • Postpartum depression • Bonding and attachment • Parental stress • Coping mechanisms	**Developmental and Long-term Outcomes:** • Infant development • Long-term health outcomes • Early intervention programmes • Paediatric/neonatal care/follow-up care • Education and cognitive development
Birth and Women's Health: • Birth experiences (traumatic birth, a "good birth") • Models of birth • Maternal autonomy • Obstetric interventions • Maternal mortality	**Feminism:** • Gender equity • Reproductive rights • Feminist health care • Women's empowerment • Intersectionality • Patriarchy

• Birthing practices • Women-centred care • Empowerment in childbirth • Respectful maternity care • Holistic care • Emotional support • Shared decision-making	• Gender-based violence • Social justice • Feminist post-colonialism • Women's ways of knowing

Recording key terms acted as a catalyst for exploration, reflection, and intellectual inquiry, prompting me to scrutinise and be scrutinised in my perspective and approach. Throughout this process, I wrestled with emerging themes, leading me to interrogate the foundational assumptions of medicine, nursing, and my own professional practice. Reflecting on these themes compelled me to critically assess the theories and practices within healthcare, an area that, despite my professional background, posed unfamiliar challenges. This enquiry extended to the nuanced language employed in nursing and medicine concerning birth, including terms like "failure to progress", "incompetent cervix", and "stirrups", which carry implicit judgements and can dehumanise the birthing experience. The term "preterm birth" itself, rooted in biomedical discourse, highlighted its potentially limited applicability across different cultures and languages. This recognition emphasised the importance of acknowledging that such terms might not resonate universally and underscored the need for a more inclusive and culturally sensitive vocabulary. Furthermore, incorporating a feminist lens into this hermeneutic approach was pivotal in foregrounding issues of gender, power, and agency. Engaging with feminist theories enabled me to spotlight the intersectional dimensions of preterm birth, including how gender inequities, cultural practices, and socio-economic conditions influence women's birthing experiences. This feminist hermeneutic lens stressed the significance of amplifying women's voices and narratives, thereby challenging dominant biomedical discourses that often marginalise or overlook these perspectives.

This methodological shift facilitated a more holistic investigation of the literature, encompassing various aspects such as maternal mental health, traditional birth practices, and healthcare disparities. It facilitated a deeper exploration of the sociocultural and psychological dimensions of preterm birth, resulting in a more comprehensive understanding of the phenomenon. The integration of hermeneutic and feminist frameworks also underscored the ethical imperative of acknowledging and addressing the broader socio-political contexts within which health issues are situated.

3.5 Preterm birth: Beyond the incubator

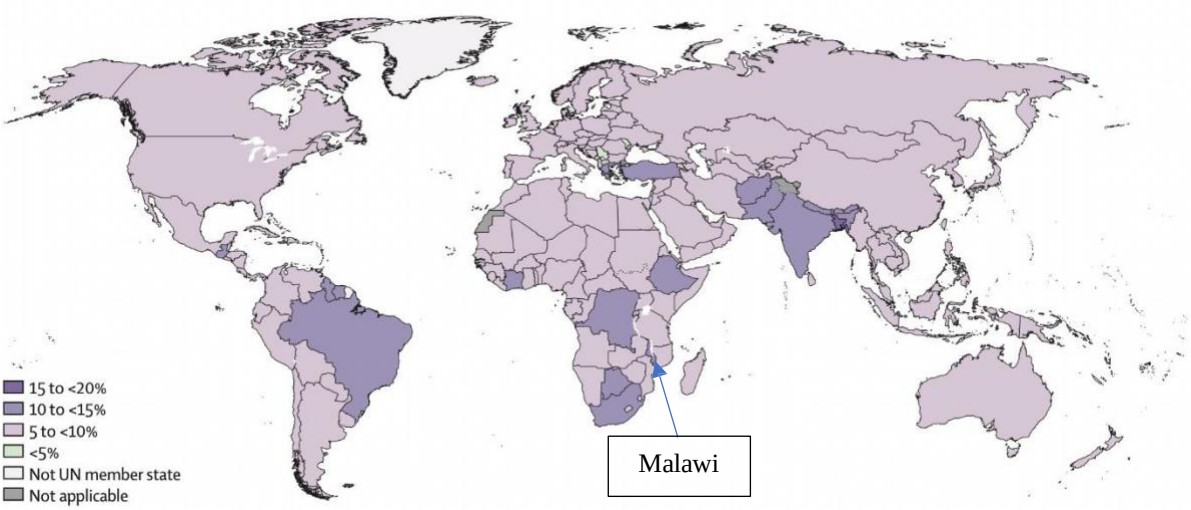
Preterm birth, a significant global health issue, refers to the birth of babies before completing 37 weeks of pregnancy[11] (WHO, 2023a). The WHO (2023a) further classifies preterm birth into distinct sub-categories, including extremely preterm (less than 28 weeks), very preterm (28 to less than 32 weeks), and moderate to late preterm (32 to 37 weeks). Statistics indicate a staggering 13.4 million babies were born prematurely in 2020, surpassing 1 in 10 births worldwide (PAHO, 2023). Tragically, around 900,000 infants succumbed to complications associated with preterm birth in 2019 (Perin et al., 2022), with survivors often facing enduring challenges such as learning disabilities, visual and hearing impairments, and other lifelong disabilities (Ohuma et al., 2023). Notably, prematurity remains the leading cause of mortality in children under 5 years of age globally, with stark disparities in survival rates across various regions (Perin et al., 2022). Most preterm births occur in southern Asia and sub-Saharan Africa, highlighting notable variations in the occurrence of preterm birth across different regions (WHO, 2023a). Malawi currently has a preterm birth rate of 14.5 per 100 live births (WHO, 2023b). Disparities in the survival rates of premature infants are starkly evident depending on the geographical location of birth. For instance, in low-income countries, over 90% of extremely preterm

[11] An average pregnancy is 40 weeks in length.

babies born before 28 weeks do not survive beyond the initial days of life, in contrast to less than 10% in high-income regions (WHO, 2023a). The following figure (Figure 4) shows the estimated national preterm birth rates in 2020.

Figure 4

Estimated Global Preterm Birth Rates for 2020



Note. Figure derived from Ohuma, E., Moller, A-B., Bradley, E., et al. (2023). National, regional, and worldwide estimates of preterm birth in 2020, with trends from 2010: A systematic analysis. *The Lancet*, 402(10409), p. 1266. Malawi has been highlighted on the map.

Statistics on preterm birth provide a thorough understanding of the prevalence and impact of this global issue. However, through my hermeneutic review of the literature, I found that this picture fails to capture the lived experiences and perspectives of women directly affected by preterm birth, resulting in a gap where women's voices and narratives remain unheard. Furthermore, mothers in Malawi may not commonly use the term 'preterm birth' to describe their experiences or the birth of their babies. This underscores the importance of exploring their narratives and understanding their cultural and contextual ways of framing and discussing childbirth and related experiences. By doing so, we, as researchers, may bridge the gap between a biomedical lens and a women-centred, feminist

approach to understanding birth in Malawi.

3.6 Reviewed preterm birth literature in Malawi

Research carried out in Malawi on preterm birth has predominantly focused on the cultural language, perceptions, and understanding of the causes of preterm birth (Levison et al., 2014; Tolhurst et al., 2008). Among the seven articles, four centred on community-based contexts, while the remaining three specifically addressed the experiences within a hospital setting. In the forthcoming section, I will provide descriptions of these studies and critically identify any existing gaps in the literature.

Within a community setting, Tolhurst et al. (2008) shed light on community perspectives, including mothers of preterm infants, fathers, TBAs, and healthcare providers, regarding strategies to prevent preterm births, encompassing measures such as prevention and treatment for sexually transmitted infections, avoidance of witchcraft, reduction of manual labour, and prevention of violence. In a similar study, Gondwe et al. (2014) investigated community perspectives on the causes of preterm birth and their caregiving practices for premature infants. The study revealed various perceptions of preterm birth, including factors such as maternal age, heredity, sexual conduct, and maternal illnesses during pregnancy. The provision of warmth emerged as the primary element of care for preterm newborns. The participants also highlighted challenges related to caring for premature infants, including limited knowledge about proper care, economic constraints, and the time-intensive nature of caregiving, which often led to neglect of household, farming, and business responsibilities. Women were primarily responsible for the care of preterm babies.

Levison et al. (2014) sought to assess the knowledge and perceptions of preterm birth and oral health in at-risk environments in Malawi. The authors found that participants expressed openness to exploring innovative preventions and interventions for preterm birth,

including considerations of oral health impacts. Meanwhile, Lydon et al. (2018) attempted to provide a deeper understanding of the perspectives, attitudes, beliefs, and practices of both the community and healthcare workers regarding preterm and low birth weight babies, as well as kangaroo mother care (KMC) in Malawi. Mothers and fathers learned about KMC post-birth, with men often excluded from discussions due to gender norms. Health facilities were the main source of KMC information, while community and religious leaders provided support and advocacy. Initial negative views on preterm births and KMC transform through counselling and positive experiences.

Focusing on mothers and babies in hospital, Chisenga et al. (2015) conducted a study in two hospitals in Malawi to assess the experiences of mothers with preterm or low birth weight infants staying in the Kangaroo Mother Care (KMC) ward. The authors identified that factors such as awareness, counselling, and support contributed to increased KMC adoption, while prolonged hospital stay, limited decision-making authority, inadequate support, physical discomfort, and a preference for incubator care served as barriers to its uptake.

Gondwe et al. (2022a) illuminated the challenges faced by mothers during their infants' hospitalisation. Mothers of both preterm and term babies were included. These challenges included financial constraints, disrupted household responsibilities, and negative experiences within the hospital environment, including unsupportive staff behaviour and delays in provided care. Mothers of preterm infants specifically expressed certain apprehensions, including concerns about kangaroo mother care. For example, the absence of a support person for these mothers amplified their fear of neonatal hypothermia when KMC was disrupted. Furthermore, fear of the child's prognosis, issues of delayed breastfeeding and infant feeding struggles, separation anxiety and the loss of the parental role were also prominent. To assess the needs of mothers in hospital with a preterm baby,

Gondwe et al. (2022b) further explored the necessary support for Malawian women with preterm infants during their hospitalisation. The findings indicated that women preferred female members from their maternal families as their guardians during hospitalisation. Their identified support needs included physical, financial, emotional, and spiritual assistance. However, barriers such as financial constraints and a lack of accommodation for guardians often left the participants without physical support from their chosen individuals.

These studies are undoubtedly valuable and provide crucial insight into the lives and views of mothers of preterm infants. Notably, however, the existing literature on preterm birth in Malawi exhibits several discernible gaps, particularly concerning the lack of exclusive focus on women's voices. For example, both Tolhurst et al. (2008) and Gondwe et al. (2014) explored community perceptions of preterm birth. However, the participants included mothers of preterm infants, fathers, nurses, midwives, traditional birth attendants, grandparents, and other community members. Recognising the significance of various viewpoints, feminist and women-centred research emphasises the central role of women's voices. Acknowledging this gap and examining the research from a feminist perspective, I specifically highlighted the perspectives and experiences of women in this study.

Similarly, upon examining the research by Gondwe et al. (2022a) and Gondwe et al. (2022b), it became apparent that these studies did not exclusively prioritise the experiences of mothers with preterm infants. Additionally, the narratives of women primarily revolved around the hospital environment. Although I did not exclude the experiences of mothers who gave birth in the hospital or presently had a hospitalised child, my aim was to explore the diverse experiences of mothers from different backgrounds, including women who might not have had any hospital-related experiences at all. Indeed, I intentionally refrained from setting specific criteria based on hospitalisation or birth

location, in response to the literature gap. This approach aimed to foster a more dynamic and diverse range of voices.

To ensure a broad spectrum of perspectives, I adopted an inclusive approach by allowing a one-year timeframe for participant inclusion, which was not commonly found in the existing literature. This strategy aimed to incorporate the experiences of mothers within a wide range of postpartum durations, presenting a unique temporal dimension not commonly highlighted in previous studies.

An inclusive understanding of the intricate facets of preterm birth demands a broad exploration of women's multifaceted experiences, underscoring their personal experiences and the profound significance attached to their individual paths. Integrating these insights into the literature is crucial for adopting a more comprehensive and empathetic strategy in addressing the complexities surrounding preterm birth in Malawi. The themes which emerged from the initial exploration of the literature will be further explored below.

3.7 Safe Motherhood Initiative

The Safe Motherhood Initiative (SMI) in Malawi has been an essential programme dedicated to improving maternal health and reducing maternal mortality rates (Ministry of Health, 2024). Established in 1987 at The Safe Motherhood Conference in Nairobi, Kenya, this event marked the genesis of the widespread use of the term 'safe motherhood' (SM) within the global discourse (Ohaja, 2012). This initiative was introduced in Malawi in 1996 in recognition of the critical challenges faced by pregnant women and new mothers and has focused on enhancing access to quality reproductive and maternal healthcare services across the country (Pindani et al., 2021). Its approach has encompassed various strategies, including increasing access to prenatal and postnatal care, promoting skilled birth attendance, advocating for family planning services, and facilitating community-based education on maternal health and nutrition (Mahler, 1987). Through the implementation of

these varied interventions, the Safe Motherhood Initiative has (ideally) played a pivotal role in empowering women, protecting their reproductive rights, and fostering better maternal and child health outcomes in Malawi (Manda-Taylor et al., 2017; Pindani et al., 2021). However, this *one-size-fits-all* approach may not necessarily benefit all women in all contexts.

3.7.1 What is the meaning of 'safe motherhood'? What constitutes a 'safe birth'?

Safe motherhood refers to the collective efforts aimed at guaranteeing all women have access to the necessary care required to ensure their safety and well-being during pregnancy and childbirth (Rana, 2020). Often, the emphasis tends to neglect the social and cultural significance embedded within the childbirth process, consequently downplaying the profound impact of societal frameworks on birthing experiences (Jordan, 1993; Ohaja, 2012). Facilitating childbirth under the supervision of a skilled birth attendant is considered a pillar to ensuring a safe birth (Ohaja et al., 2020). This practice also serves as a fundamental benchmark for monitoring global progress in reducing maternal mortality rates (AbouZahr & Wardlaw, 2000). Discussions in high-income countries centre on promoting women's autonomy in choosing their preferred birthing methods (Galková et al., 2022). Conversely, women in low-income nations are strongly encouraged to give birth in healthcare facilities (Gamah et al., 2022), with traditional authorities often influencing this narrative (Walsh et al., 2018). Such endeavours are frequently accompanied by a critical examination of the role of traditional birth attendants within communities (Nyirenda & Maliwichi, 2016).

Biomedical knowledge has taken precedence as the primary authoritative source of information in the field of childbirth (Uny et al., 2019). Women who comply with medical recommendations and protocols may be perceived as exercising 'autonomy' to the extent that they consent to their treatment (Newnham & Kirkham, 2019). However, it becomes

evident that the notion of ‘autonomy’ is at best superficial when women choose to reject suggested medical interventions (Newnham & Kirkham, 2019). One potential rationale for the escalating medicalisation of birth is its alignment with dominant power and knowledge structures that endorse a specific interpretation of rationality and ‘truth’ (Newnham, 2014). Consequently, the concept of a ‘normal’ birth has increasingly come to signify a medically supervised hospital birth in numerous nations, encompassing the full scope of medical procedures and practices (Newnham, 2014).

In such cases, the comprehensive extent of medical authority is readily apparent through various ways, including persuasion, coercion, threats, and the withholding of care (Newnham & Kirkham, 2019). This dominance is further accentuated by a prevailing discourse of the inherent ‘risk’ of birth, which can accentuate the potential for complications in pregnancy and childbirth (Davis-Floyd, 1994; Lothlian, 2009). Consequently, there is a reinforced belief that women can only be assured of their safety when medical technology and diagnostic tests are available, typically administered by skilled birth attendants (SBAs)[12] (Uny et al., 2019). Traditional birth attendants, conversely, do not conform to the ‘skilled’ designation, primarily because they lack formal medical training and operate within an alternative knowledge system of childbirth (Uny et al., 2019). It is this distinction that has led to their exclusion from global safe motherhood strategies.

Policymakers and programme developers often prioritise medical interventions while neglecting the socioeconomic, cultural, and political influences of a particular context, including the effects of colonialism and post-colonialism, religious dynamics, international policies, and globalisation (Ohaja, 2012). As a result, certain Western medical

[12] A skilled birth attendant is an accredited health professional, including midwives and nurses, who has undergone formal education and training to attain proficiency in managing uncomplicated pregnancies, childbirth, and the immediate postnatal phase.

practices within pregnancy and childbirth may contradict local values and belief systems (Ohaja, 2012). For example, Ng'oma et al. (2019) conducted research on the perceptions surrounding perinatal depression and the treatment needs in Malawi, aiming to facilitate the creation of a culturally sensitive intervention. The findings revealed the widespread recognition of perinatal depression as a prevalent mental health issue impacting the self-care activities and overall functioning of women during the perinatal phase. Most perinatal women expressed a preference for individual counselling, indicating psychological interventions as the recommended and suitable primary treatment for perinatal depression. Notably, the study revealed that most women were hesitant to consider medication as a treatment option, as they perceived their symptoms more as social difficulties rather than an illness warranting medicinal treatment (Ng'oma et al., 2019). As such, understanding the cultural context and the broader social implications of medical practices is essential for developing effective and culturally sensitive maternal healthcare interventions.

3.8 Barriers to women seeking care

3.8.1 Mistreatment of women

Bohren et al. (2015) offered a comprehensive analysis that sheds light on the prevalence and diverse forms of mistreatment experienced by women during childbirth in healthcare facilities worldwide. Employing a mixed-methods systematic review, the authors examined various studies, highlighting the range of mistreatment encountered by women, including physical and verbal abuse, neglect, stigma, discrimination, and violations of privacy and dignity.

The review accentuated the significant impact of mistreatment on women's experiences of childbirth, highlighting its detrimental effects on maternal health outcomes, psychological well-being, and the overall quality of care. By synthesising data from different geographical regions and healthcare settings, the review revealed the systemic and

structural factors contributing to the mistreatment of women during childbirth, such as power differentials, inadequate resources, and cultural norms within health institutions (Bohren et al., 2015). It further called attention to the urgent need for comprehensive and rights-based approaches to maternal healthcare, advocating for the implementation of policies and interventions that centre respectful and compassionate maternity care. It demonstrates the importance of empowering women, promoting their decision-making autonomy, and fostering an environment of dignity, respect, and equity within healthcare settings globally (Bohren et al., 2015).

3.8.2 Barriers in Malawi

For a more comprehensive, contextual understanding of the Safe Motherhood Initiative, it is imperative to consider the specific socio-economic and cultural backdrop within which a mother is situated. Findings from the studies researched by Kambala et al. (2011), Kumbani et al. (2013), and Manda-Taylor et al. (2017) collectively underscore the significant challenges faced by mothers in accessing maternal health services in Malawi. A predominant theme that emerged was the arduous journey to healthcare facilities, exacerbated by long distances, the physical strain of labour, and unpredictable weather patterns. Spousal support was identified as a crucial factor influencing women's ability to seek timely medical assistance, with the lack of such support leading to further impediments in accessing care. Additionally, the studies highlighted the critical role of traditional birth attendants in communities, with some mothers turning to TBAs due to their accessibility, compassion, and understanding nature. The experiences shared by mothers revealed instances of mistreatment, disrespect, and even denial of care at healthcare facilities, indicating systemic challenges within the healthcare system itself.

The fear of social stigma associated with giving birth in a hospital, particularly for young, unmarried women, was found to contribute to delays in seeking appropriate care.

The influence of religious groups advocating alternative forms of maternal healthcare further complicated the decision-making process for mothers, adding another layer to the multifaceted challenges faced in accessing maternal health services. These findings collectively stress the need for a comprehensive approach that addresses not only the logistical barriers but also the social and cultural complexities influencing maternal healthcare access in Malawi.

3.9 Respectful maternity care: The need for women-centred care

"Fish can't see water: the need to humanize birth", by Wagner (2001), is a poignant metaphor that encapsulates the essence of the humanisation of childbirth. The phrase implies that individuals often fail to recognise the significance of their immediate environment, especially when it becomes an intrinsic part of their existence. In the context of childbirth, it symbolises the pervasive normalisation of medicalised birthing practices to the extent that the fundamental human aspects of the birthing experience are overlooked or disregarded.

My research review suggests that the Safe Motherhood Initiative is not inherently detrimental. However, it does underscore a significant emphasis on the implementation of biomedical frameworks that may not always align with culturally appropriate practices. This raises the question of how mothers perceive and navigate these aspects within the context of their preterm birth experiences. Specifically, it prompts an exploration into whether mothers predominantly adhere to a medical model of birth or whether traditional values continue to play a significant role in shaping their birthing experiences.

Understanding mothers' experiences in this context requires a nuanced exploration of the complex interplay between biomedical interventions and traditional cultural values. By studying how mothers interpret and respond to the medicalisation of childbirth and whether they prioritise traditional practices or beliefs, a more comprehensive understanding

of the intricate dynamics shaping their preterm birth experiences can be attained. This knowledge is crucial for informing the development of culturally sensitive and holistic maternal healthcare approaches that respect and integrate both biomedical and traditional perspectives, ultimately fostering more inclusive and effective maternal care.

3.10 Conclusion

The literature reviewed on preterm birth in Malawi has shed light on certain experiences and perceptions of mothers with preterm infants. A gap was identified to further justify this study. The Safe Motherhood Initiative and a critique of its implementation were further explored, highlighting the barriers mothers encounter when accessing healthcare services. Coupled with the intricate dynamics of humanised birth practices, the complexities inherent in the provision of maternal healthcare in resource-limited settings were revealed. The interplay between knowledge and power emerged as a critical determinant in shaping the discourse surrounding preterm birth and maternal well-being. The following chapter will present the methodology, underpinned by Gadamer's hermeneutics.

CHAPTER FOUR

PHILOSOPHICAL FRAMEWORK AND METHODOLOGY

4.1 Introduction

This methodology chapter first situates and discusses my positionality within the research. As philosophical assumptions guide research decisions (Lopez & Willis, 2004; Creswell & Poth, 2018), personal epistemological and ontological positions, and their associated philosophical beliefs will further be explored. Furthermore, it demonstrates how those beliefs informed the paradigm of qualitative research and the selection of hermeneutic (interpretive) phenomenology as its methodology. This chapter proceeds to explicate the foundation and development of interpretive phenomenology and its key philosophers. By exploring earlier thinkers, it becomes possible to trace the evolution of ideas and identify the key contributions that laid the groundwork for Gadamer's philosophical concepts. Finally, this chapter concludes with a discussion on the theoretical lens and hermeneutic concepts of Hans-Georg Gadamer, which provide the philosophical foundation of this study.

4.2 Understanding birth through a changing lens: A women-centred approach

My journey as a neonatal and obstetrics nurse, educator, and white woman has been shaped significantly by my initial immersion in the clinical intricacies of Western, medical practices. Trained within the parameters of a predominantly biomedical model, my understanding of childbirth was confined to empirical evidence and standardised protocols. I was guided by the premise that medical interventions and technological advancements were essential for ensuring optimal maternal and neonatal outcomes. This lens, rooted in the authoritative knowledge of medicine, fostered a perception of childbirth as a consistent, clinically managed process, largely detached from the subjective nuances of individual

experiences and cultural contexts. This largely shaped my previous perception of a 'successful' and 'safe' childbirth. However, my interactions with feminist and midwifery literature, women-centred novels, and further visits to Malawi illuminated the limitations of my previous medical lens, urging me to transcend the confines of a biomedical perspective and explore the rich tapestry of subjective birthing experiences that exist within this cultural milieu. I have come to appreciate and align with the interconnectedness of childbirth within broader social dynamics, including family structures, spiritual beliefs, and collective rituals, all of which significantly influence women's perceptions of pregnancy, childbirth, and postpartum care. The notion of 'safety' during childbirth has acquired a multifaceted meaning, encompassing emotional well-being, cultural dignity, and community solidarity within the Malawian context.

Ely et al. (1991) underscored the significance of qualitative researchers situating themselves within the research context, stressing the necessity for self-reflection and awareness of their own biases and values. As an outsider to the Malawian context, I have grappled with the complexities of insider-outsider knowledge dynamics (Dwyer & Buckle, 2009), cognisant of the colonial legacies that continue to shape power differentials (Memmi, 1974) and knowledge hierarchies within healthcare systems (Newnham & Kirkham, 2019.) The historical impact of colonialism on the construction of authoritative knowledge, coupled with the legacy of Western-centric ideologies, has perpetuated a systemic marginalisation of indigenous birthing knowledge and epistemologies, relegating them to the peripheries of mainstream healthcare discourse (Smith, 1999). Being 'part of the group' being studied offers the advantage of acceptance, as one's membership can provide access to groups that might otherwise be closed to 'outsiders' (Dwyer & Buckle, 2009). Furthermore, Dwyer and Buckle (2009) posited that participants are often more inclined to share their experiences due to the presumed understanding and shared

distinctiveness, creating a sense of unity. “You are one of us, and it is us versus them (those on the outside who don’t understand)” (Dwyer & Buckle, 2009, p. 58). While the authors have expressed the benefits of being an insider within research, Dwyer and Buckle (2009) did suggest that the crucial factor is not whether one is an insider or an outsider, but rather the ability to remain open, authentic, honest and deeply engaged with the experiences of one’s research participants, as well as committed to accurately and comprehensively representing their experiences.

As I navigated the intricacies of the birthing space and experiences in Malawi, reflexivity and critical introspection remained central to the dynamics of the entire research process. Being an outsider to the communities I was studying, it was crucial for me to approach this research with humility and respectful engagement. I acknowledged that my insights, interpretations, and analyses were inherently shaped by my own perspective and experiences and influenced my understanding of preterm birth in a Malawian context. Given this philosophy, I selected Gadamer’s hermeneutics to illuminate the embedded meaning of the lived experience of birth in Malawi (Gadamer, 1975). By acknowledging the influence of my own background and experience, combined with the mothers’ preterm birth experiences in Malawi, I sought to bridge the gap between my perspective and the participants’ unique understanding, aiming to unveil the diverse layers of meaning embedded within their birthing experiences. I endeavoured to conduct culturally sensitive research that honours the intricacies and richness of mothers’ stories. Gender plays a pivotal role in shaping how we perceive the world, construct knowledge, and establish social structures, influencing the distribution of power and privilege (Guy & Arthur, 2022). The core of feminist research aims to elevate women’s voices and experiences, particularly those from marginalised communities (Guy & Arthur, 2022). I entered the research space with the focus of amplifying the voices and experiences of

Malawian mothers, ensuring that their narratives took centre stage and that their voices were accurately represented. With collaborative research methodology, I established a platform for meaningful dialogue and co-creation of knowledge, fostering an environment that respects the rich cultural diversity and complexity of birthing practices in Malawi.

Aligned with the principles of hermeneutics and the feminist perspective, I adopted a deliberate and gradual integration and introduction to the community members, women's groups, local health networks, and traditional leaders. My intention was not merely to conduct brief visits; rather, I dedicated approximately 14 months to my work in Malawi. During this time, I actively immersed myself in the local culture, taking the initiative to learn Chichewa, the native language. This linguistic effort significantly contributed to building a strong rapport with members of the community. Additionally, the presence of my research assistant, although not from the local community but being Malawian herself, appeared to enhance my approachability within the community. Although I may not have shared the exact background as those within the community, I actively positioned myself as a woman with a similar desire for children, allowing me to establish a rapport with Malawian mothers during the research process.

4.3 Epistemology and theoretical perspectives: Situating constructionism

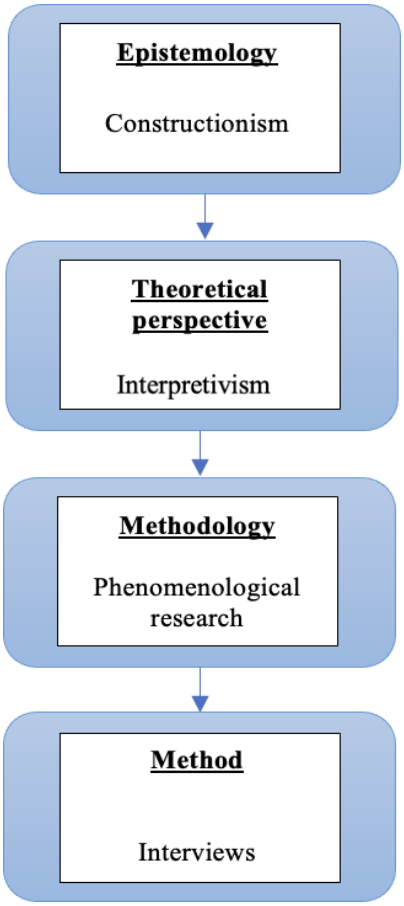
Prior to the commencement of this research, a comprehensive analysis of my personal worldview was undertaken to appropriately guide the research process. I questioned my personal views on the nature of reality (ontology) and what it means to know (epistemology) (Creswell & Poth, 2018). Through my interaction with the literature, I adopted a perspective that acknowledges the existence of multiple ways of understanding and interpreting reality. I rejected the idea that research findings are objective facts or established truths (Crotty, 1998). Furthermore, I recognised my strong conviction in the understanding that knowledge is subject to interpretation and can be shaped through lived

experiences, jointly created through shared language and dialogue, and influenced by its context (Gadamer, 1975). Upon consulting the literature, I noted that I embraced a social constructionist perspective as my epistemological framework. Crotty (1998) explained that constructionism suggests that meaning is not discovered but constructed through our engagement with the world. As such, various individuals may construct meaning in different ways, even when considering the same phenomena. As Crotty (1998) suggested: "There is no meaning without a mind" (p.8-9).

Social constructionism is an epistemology which encompasses an interpretive theoretical perspective in the context of research. To further illustrate this point, the following figure (Figure 5) maps the relationship between epistemology, the theoretical perspective, methodology, and methods, according to Crotty (1998).

Figure 5

Connection between Epistemology, Theoretical Perspective, Methodology, and Methods



Note. This figure was adapted from Crotty, M. (1998). *The foundations of social research,* (p. 4). Allen & Unwin.

4.3.1 Differing theoretical perspectives: Positivism/postpositivism and interpretivism

Positivism is an empirical approach that perceives the world as an objective reality, aiming to gather tangible evidence and derive values from observable elements (Ryan, 2018). It rests on the principle that all individuals perceive a comparable reality and possess the capacity to understand society through observation and measurement (Junjie & Yingxin, 2022). In contrast, postpositivism is an epistemological position that acknowledges the conjectural nature of knowledge, understanding that absolute truth is unattainable (Creswell, 2009). It emphasises the importance of evidence, data, and rational considerations in shaping knowledge (Creswell, 2009). In research, postpositivism involves formulating and refining claims based on the available evidence, rather than proving hypotheses (Guba & Lincoln, 1994). Researchers adhere to standards of validity and reliability, striving to develop relevant, accurate statements that explain the situation or describe causal relationships (Guba & Lincoln, 1994). While recognising the presence of bias, postpositivism stresses objectivity and critical examination of methods and conclusions (Creswell, 2009).

Conversely, interpretivism, often viewed as an opposing perspective to positivism, challenges the very idea of complete objectivity in research. It asserts that objectivity is unattainable, and that human experiences and phenomena are inherently subjective and complex (Creswell, 2009). Interpretivists posit the importance of understanding the unique perspectives of individuals or small groups by exploring their experiences, beliefs, and interpretations (Schreiber & Martin, 2016). This approach prioritises qualitative analysis, focusing on detailed observations, interviews, and contextual analysis to grasp the nuanced and intricate aspects of human behaviour and society (Chowdhury, 2014; Kaplan & Maxwell, 2005). In opposition to the quantitative analysis favoured by positivism, interpretivism values the depth of insight gained from smaller, more intimate datasets.

4.3.2 What does it mean for this study?

In my study, I aim to explore the meaning of preterm birth in Malawi. It is apparent that in the field of maternity research, the focus continues to be on women's reproductive functions, often overshadowing their personal encounters. Research frequently prioritises a narrow perspective that aligns with empirical and scientific principles, as seen in studies that primarily evaluate women's care experiences through satisfaction surveys. Consequently, the intricate and diverse narratives of women are often marginalised or obscured within such research frameworks (Thomson & Crowther, 2019). The repercussions of a positivist approach, rather than a focus centred on women's experiences, have been highlighted within the literature to cause harm to women (Bohren et al., 2015; Newnham & Rothman, 2022; Thomson & Downe, 2008). Embracing a perspective that recognises diverse ways of interpreting reality and challenges the notion of research findings as absolute truths facilitates a deeper understanding of the intricacies of women's experiences. The adoption of an interpretive approach enables the research to centre women's voices and provide meaningful insights into the multifaceted experiences of mothers in Malawi.

4.3.3 Considerations of different methodological approaches

In the initial stages of planning the research methodology, I carefully examined several qualitative research designs, including ethnography, grounded theory, and descriptive phenomenology. Each approach offered unique advantages and posed certain challenges that needed to be addressed considering the research question and aim.

Ethnography, a research approach centred on understanding a community's culture and behaviours through immersion (Ormston et al., 2014), presented logistical challenges. Given my status as an outsider, both culturally and linguistically within the Malawian community, complete immersion and linguistic fluency were unattainable, making it

difficult to comprehensively grasp the community's intricate cultural dynamics. Moreover, the significant time commitment required for authentic ethnographic research was impractical within the scope of my project.

Grounded theory, known for its systematic approach to theory development (Glaser & Strauss, 1967), did not align with the primary goal of my research, which was to explore and elucidate mothers' experiences rather than to generate a new theory. It is important to note also that grounded theory did not fully align with the philosophical underpinnings of hermeneutics, which stresses the significance of interpretation, context, and the historical situatedness of human experiences. While grounded theory highlights the empirical analysis of data to derive theoretical insights (Glaser & Strauss, 1967), hermeneutics explores the interpretive and contextual dimensions of human understanding (Dibley et al., 2020).

Descriptive phenomenology, informed by the philosophy of Husserl, focuses on the rich description of lived experiences (Tassone, 2017). He had a profound fascination with how people connect and interact with each other, which he often referred to as 'intersubjectivity'. This concept encompassed experiences of being part of a community and sharing a collective world (Moran, 2013). Furthermore, in his phenomenological philosophy, Husserl advocated for the act of bracketing. This involves temporarily setting aside or suspending one's preconceived beliefs and assumptions to achieve a more direct and unbiased encounter with the phenomenon under investigation (Thomas & Sohn, 2023). Although I initially considered utilising descriptive phenomenology in my research, I ultimately decided against it. This decision was influenced by the method's reliance on bracketing, which is not supported by interpretive epistemology. I recognised that setting aside my own experiences and assumptions, which inherently influenced my approach to this research, would be challenging and, arguably, impossible. Lastly, its descriptive

approach did not encompass the necessary depth to explore the meaning of the experience, as outlined in the research question.

While ethnography, grounded theory, and descriptive phenomenology did not align with the epistemological and philosophical assumptions of the study, the interpretive phenomenological approach, or hermeneutics, provides a comprehensive methodology for deriving lived experiences of phenomena. This approach integrates both the individual's perspective and the influence of socio-cultural context on the interpretation of events. It recognises the inherent subjectivity in research and the role of the researcher in constructing meaning, aligning with a social constructionist epistemology. The following section will explore the origins of hermeneutic thinking and discuss the selection of Gadamer.

4.4. Origins of phenomenology and hermeneutics

The contributions of two German philosophers, Husserl and Heidegger, marked the emergence of two branches of phenomenological thought: descriptive phenomenology and interpretive (hermeneutic) phenomenology. Husserl's phenomenology is centred on the description of how a person situates themselves within the lived experience (van Manen, 1990). He emphasised the importance of suspending presuppositions and biases to allow for an objective analysis of subjective experiences. Conversely, hermeneutics explores how one interprets the "texts of life" (van Manen, 1990, p. 4), while practising reflexivity to be aware of one's biases (prejudices), historical and cultural context (Gadamer, 1975). Hermeneutics derives from the Greek term *hermeneuein*, defined as 'to translate' or 'to interpret' (Palmer, 1969). The term also finds its roots in Greek mythology with Hermes, the messenger of gods, who could convey deities' desires to humanity (Moules, 2002). In the seventeenth century, Protestant theologians sought to promote the dissemination of God's word (or will) to the general population by establishing a structured, methodical

approach to understanding scripture (Lawn, 2006). Consequently, hermeneutics evolved as the 'art' of interpreting biblical texts, accompanied by a formative, systematic set of guidelines to govern the process of interpretation (Grondin, 1994). However, this rigid adherence to a method of interpreting texts would be challenged by philosophers.

4.4.1 Nature of understanding: Schleiermacher

Friedrich Schleiermacher (1768-1834), a theologian and German philosopher, is central to the conceptualisation of Gadamer's work, due to his pioneering contributions to the understanding of interpretation and understanding. One of Schleiermacher's notable thoughts was to place the hermeneutic circle at the core of his interpretation and theory (Schleiermacher et al., 1978). It contested that meanings are not fixed but rather constantly reshaped in response to changing contexts, rendering circularity constructive rather than detrimental (Schleiermacher et al., 1978).

Schleiermacher's other significant contribution was his expansion beyond textual, or biblical, interpretation, embracing the idea of meaning in relation to cultural and historical contexts (Lawn, 2006). Schleiermacher theorised two main methods of interpreting our understanding: psychological and grammatical interpretation (Negru, 2007). For example, within speech, psychological interpretation would attempt to understand expressions in relation to the person, whereas grammatical interpretation would explore the expression in relation to language (Negru, 2007). His efforts attempted to lead toward the development of a comprehensive hermeneutic approach, applicable to various forms of interpretation (Schleiermacher et al., 1978).

4.4.2 Human versus natural science: Dilthey

The concepts of 'human science' and 'natural science' are frequently recognised by the work of German philosopher Wilhelm Dilthey (1833-1911) who furthered the work of Schleiermacher. Dilthey questioned the status of science, rejecting the concept that all

knowledge could be amalgamated into one category (Lawn, 2006). As reported by van Manen (2016), Dilthey sought to establish a methodological and theoretical foundation for the human sciences that differentiated from the natural sciences. He rejected the scientific model, *Naturwissenschaft*en, and proposed the model of *Geisteswissenschaften* ('the sciences of the spirit') for the human sciences (van Manen, 2016). He contended that the inquiry into the human sciences was embedded in *Verstehen* (understanding) and that the key to understanding humanness was through *Geschichtlichkeit* (historicity) and the social context of one's own existence (Crotty, 2020).

Further Dilthey asserted that the human context is *Ausdruck* (an expression) of human consciousness, termed the 'objective mind' (Palmer, 1969). Broadening to a more sociological pursuit, Dilthey expressed how *Erlebnis* (lived experience) can be embodied through language, art, religion, literature, and law, that is, in all cultural structures (Crotty, 2020). In essence, he provided a version of the hermeneutic circle, supposing that understanding our world is linked to our cultural and historical past (Lawn, 2006). That is, to fully understand context, the intricacies of the past are key to hermeneutic understanding.

4.4.3 Modern hermeneutics: Heidegger

Martin Heidegger (1889-1976) is often distinguished for his work in challenging the Husserlian phenomenological ideals, which revolved around their descriptive nature. He advocated for a deeper, more interpretative understanding of the human experience (Horrigan-Kelly et al., 2016; Palmer, 1969). As such, he expanded the scope of hermeneutics through his focus on the study of 'being in the world', or *Dasein,* rather than solely focusing on 'knowing the world' (Heidegger, 2019). Coming from the German word *da-sein,* or simply, 'being-there', *Dasein* relates to the concept of what essence exists within our 'existence', existing in our current state, as whatever it is that defines us (Zuckerman, 2015). Sheehan (2001) further offered another potential meaning of the word, having

translated *Dasein* to mean “always being open” or simply “openness” (p.194). Heidegger (1962) stressed the significance of exploring the ordinary aspects of our lives, suggesting that individuals often speak about their everyday experiences in terms of ‘being’, even if they may not be consciously aware of it.

Although critiqued for being complex in nature (Dreyfus & Wrathall, 2007), Heidegger’s work has been influential in the shaping of hermeneutics (Benner, 1994; Diekelmnn & Ironside, 1998). I have chosen not to further explore or discuss the philosophical concepts of Heidegger alone. Rather, as Gadamer built upon the philosophical thoughts of Heidegger, I did not wish to repeat certain hermeneutic concepts which have informed both philosophers. As such, I will explore key Gadamerian philosophical concepts in the following section, which informed this hermeneutic study, with the acknowledgement that Heidegger’s philosophy heavily influenced Gadamerian thought.

4.4.4 Gadamer

Hans-Georg Gadamer (1900-2002) is known for his contribution and advancement of hermeneutics. His work is centred around the idea of understanding, which is primarily achieved through language and text. According to Gadamer (1975), language is the primary tool for communicating and interpreting human experiences. He argued that language does not simply serve as a means of conveying information but also shapes our experiences and understanding of the world. Furthermore, Gadamer stressed the central importance of texts in interpretation. Texts, according to Gadamer (1975), are not simply words on a page, but they are living and dynamic and continue to be interpreted in new ways across time. The meaning of a text, therefore, is never static but is continually evolving and shifting.

One key concept in Gadamer’s hermeneutics is the fusion of horizons, which is closely linked to the hermeneutic circle. The hermeneutic circle refers to the recursive

process of interpretation, where the understanding of the whole is informed by the understanding of its parts, and vice versa (Gadamer, 1975). The fusion of horizons, on the other hand, refers to the process of understanding that takes place when the interpreter and the text come together (Gadamer, 1975). In this process, the interpreter brings his or her own horizons or biases to the text, which then fuses with the horizons of the text to create a new understanding that encompasses both.

Historicity is another central component of Gadamer's hermeneutics. He highlighted that understanding cannot be divorced from the historicity of the interpreter and the text being interpreted. The context in which interpretation takes place is shaped by a specific historical moment, which must be considered in the interpretation process (Gadamer, 1975).

Gadamer's hermeneutics also considers the concept of *Verstehen* (for-understanding). This refers to the idea that interpretation should aim to achieve a full or holistic understanding of a phenomenon. According to Gadamer (1975), interpretation should strive to uncover the implicit meanings and intentions of a text or individual's experiences, which can only be achieved through a hermeneutic exploration of the context in which they occur.

4.5 Critiques of Gadamer hermeneutics

4.5.1 Habermas and Gadamer

While I have come to appreciate the philosophy and language utilised in Gadamerian hermeneutics, the theoretical framework has not been without its critics. Gadamer proposed that a more profound way of understanding human objectivity and Dasein could be achieved by acknowledging the essential roles of historicity and prejudice (Regan, 2012). However, Habermas, in his critique, questioned this notion, arguing that the hermeneutic circle might not fully uncover all pre-existing prejudices influencing new

interpretations (Regan, 2012). He believed that inquiry should not be constrained by the authoritative influence of human tradition, as perspectives are shaped by a multitude of interests and fundamental conditions governing the continuation and self-formation of the community (Habermas, 1971; Regan, 2012). For Habermas, the inquiry process involves unravelling ideological misconceptions perpetuated through the concept of tradition or historicity, ultimately limiting the potential for critical analysis (Regan, 2012). He asserted that the legitimacy of prejudice, endorsed by tradition, hinders the capacity for reflection, as the authority of traditions and knowledge do not align (Regan, 2012).

According to Gadamer's hermeneutics, language serves as the vital bridge for transmitting history, allowing the connection of ideas across time (Gadamer, 1975, 2004). It enables us to both grasp and exchange with the past due to our shared linguistic framework. Additionally, beyond its role in tradition, language is intrinsic to the process of understanding it (Negru, 2007). Gadamer asserts that language acts as the universal medium through which understanding is achieved, with interpretation serving as its vehicle (Gadamer, 1975, 2004). This implies that all understanding fundamentally involves interpretation, occurring within a linguistic context that enables the expression of objects while remaining closely tied to the interpreter's own language (Negru, 2007). Habermas, on the other hand, challenges the notion of the universality of hermeneutics as grounded in the universality of language (Negru, 2007). Habermas disputed Gadamer's idea of language as the foundation for the universality of hermeneutics, arguing that Gadamer fails to acknowledge language's dual role (Negru, 2007). According to Habermas, language serves as both a tool for social power and domination and is influenced by subconscious factors that lead to its systemic distortion (Habermas, 1971).

4.5.2 Feminist critique of Gadamer

During my initial review of the literature, I pondered Gadamer's work and raised the question of whether it could be considered feminist or if his concepts could be applied to feminist scholarship. Initially, my interpretation leaned towards an affirmative perspective. Notably, feminism and hermeneutic phenomenology exhibit several critical epistemological and ontological themes in common (Code, 2003). Both movements strive to significantly root knowledge within lived human experience, and both seek to scrutinise claims of scientific knowledge, underlining the importance of critiquing knowledge and objectivity. Furthermore, both movements argue that interpretations are inevitably influenced by personal biases, historical contexts, and societal structures, stressing the role of subjectivity and social context in shaping interpretations and understanding (Code, 2003). While I still maintain the stance that Gadamer's work can be applied to feminist scholarship, there are a few points within the literature that argue against this perspective.

Fleming (2003) staunchly contended that Gadamer's perspectives exhibit an anti-feminist stance. The author asserts that it is a significant error to consider Gadamer as an ally to feminist thought, arguing that Gadamer's concept of interpretive understanding is inherently antagonistic to feminist principles. The core of her critique is that Gadamer's approach to the "other" in dialogue is instrumental rather than genuinely inclusive or respectful. Fleming claims that Gadamer's insistence on achieving unity and assimilation within the hermeneutic process effectively reduces the "other" to a mere tool for achieving this unity. This relegation of the other to the role of a useful provocation rather than an equal participant, she believes, undermines the feminist emphasis on valuing and respecting the distinctiveness and autonomy of marginalised voices (Fleming, 2003). Thus, Fleming maintains that Gadamer's hermeneutics does not adequately address, nor supports, feminist

aims, making Gadamer's philosophical framework deeply hostile to feminist values.

Further supporting Fleming's (2003) views, Fiumara (2003) questioned the central role that Gadamer assigns to the concept of questioning in hermeneutics. Fiumara asserts that Gadamer's importance on questioning perpetuates a tradition of logocentrism (Dostal, 2003; Fiumara 2003). She introduces the notion of "epistemophily", which advocates for both listening and questioning, criticising Gadamer for overlooking the former (Fiumara, 2003, p. 137). The author argues that Gadamer's framework fails to accommodate the type of questioning inherent in women's experiences and perspectives. While Gadamer does recognise the importance of openness and listening in human relationships, Fiumara regards this acknowledgment as incidental rather than integral to his philosophy. She interprets Gadamer's recognition of this as an unintended admission that the inclusive and receptive nature of epistemophily occasionally emerges within the predominantly unwelcoming landscape of Gadamer's hermeneutics (Dostal, 2003; Fiumara 2003). In turn, Fiumara implies that Gadamer's philosophical approach fundamentally diverges from feminist principles.

While some scholars criticise Gadamer's hermeneutic philosophy for its insufficient account of the unique challenges and perspectives of women in the interpretive process, others note his relative silence on gender-related issues and women's specific experiences (Code, 2003). Gadamer highlights the importance of acknowledging our historical, cultural, and contextual backgrounds, recognising that, as researchers, we are never detached from our own historical situatedness (Gadamer, 1975). Notably, Gadamer lived through pivotal social and political movements, including the women's suffrage movement, the rise of Nazism, second wave feminism, and other social-political movements. Despite these historical influences, Gadamer has remained mute on gender-political issues while his work does not explicitly engage with gender-related issues

(Schott, 2003). Even in his own memoirs[13], he describes his father in detail but fails to mention his mother – or any other woman for that matter. The brief mention of his wife, though not by name, was in reference to her reading one of his dissertations (Schott, 2003). As such, it leaves one to wonder whether Gadamer 'practices what he preaches' or ignores them if they are not of great interest to him (Schott, 2003).

While this section highlights some of the criticisms of Gadamer's philosophy, I will explain in the following section why I believe his philosophy is valuable and relevant for this study. Additionally, I will discuss how Gadamer's philosophy can be interpreted through an intersectional and feminist lens.

4.6 Intersectionality and feminist lenses: Gadamer and this study

In selecting Gadamer as the philosophical focal point of my research, I was motivated by the assumptions underpinning his hermeneutical approach. Gadamer's rich philosophical framework, I believe, offers a multifaceted lens through which to examine the complexities of interpretation, understanding, and meaning of experiences that come with birth. While there are critiques of Gadamer's philosophies, I argue that, through intersectional and feminist lenses, Gadamer offers the best approach to holistically explore the meaning of preterm birth for postnatal mothers in Malawi.

The fundamental premise of intersectionality asserts that dominant power structures are embedded within policies and practices. These structures systematically marginalise individuals or groups based on their identities and social contexts, excluding them from certain privileges (Haghiri-Vijeh & McDonald, 2022). Intersectionality serves as an analytical framework for addressing and understanding complex issues, working on challenging issues related to relationality, power, social inequality, social context, and social justice (Collins, 2019; Haghiri-Vijeh & McDonald, 2022). This paradigm aims to

[13] Philosophical Apprenticeships (1977)

reveal the intricate factors affecting human lives. As part of an evolving critical theoretical paradigm, intersectionality is grounded in the scholarship of Black, post-colonial, Indigenous, queer, and other marginalised groups (Collins, 2019; Haghiri-Vijeh & McDonald, 2022). The varied experiences of oppressed individuals are influenced by their unique contextual situations. Intersectionality acts as an analytical tool to expose the dynamics of power (Collins & Bilge, 2016). However, researchers who apply intersectionality may base their work on different underlying assumptions.

In a similar vein, feminist research is rooted in a dedication to equality and social justice, with an awareness of the gendered, historical, and political processes that shape the production of knowledge (Wilson, 2023). This approach not only addresses structural inequalities but also seeks to bring to light the diverse experiences of women and other marginalized groups, thereby fostering awareness of how social hierarchies influence and perpetuate oppression (Brown et al., 2013). Furthermore, feminist scholars contend that there are various and diverse pathways to generating scientific knowledge, much like there are numerous perspectives on truth (Beckman, 2014). Central to this perspective is the practice of reflexivity, which involves a disciplined self-reflection by the researcher to examine how their own positionality, values, and biases may impact the research process and outcomes (Al-Hindi & Eaves, 2023). Ultimately, what defines research as feminist is the integration of feminist principles throughout the entire process, from the development of the research question and data collection and analysis to the writing up and dissemination (Wilson, 2023). This holistic application of feminist principles ensures that the research remains committed to challenging existing power structures and promoting social justice at every stage of research.

In sum, integrating Gadamer's hermeneutical approach with intersectional and feminist lenses provides a powerful framework for exploring the meaning of preterm birth

for postnatal mothers in Malawi. This synthesis enables a deeper understanding of how historical, cultural, and social contexts shape the experiences and interpretations of these mothers. By addressing the complex interplay of power dynamics, social identities, and knowledge production, this approach fosters a more inclusive and nuanced analysis. Intersectionality reveals the potential systematic marginalisation of individuals based on their unique identities, while feminist principles ensure a commitment to equality, reflexivity, and social justice throughout the research process. Together, these perspectives enrich our comprehension of the complex realities faced by postnatal mothers, offering valuable insights into the broader implications of their experiences and contributing to more equitable and informed health policies and practices.

4.7 Conclusion

In this chapter, a comprehensive analysis and justification were presented regarding the methodological perspective chosen for this research study. Following a thorough examination of the research question and objectives, an interpretive inquiry was viewed to be the most appropriate selection. Deliberation among various methodological approaches, including ethnography, grounded theory, and descriptive phenomenology, ultimately led to the adoption of a hermeneutic (interpretive) phenomenological approach, primarily for its emphasis on the interpretation of meaning. Additionally, the chapter concluded with an exploration of critiques of Gadamer's work and reasoning for selecting Gadamer's hermeneutics. The subsequent chapter will explore the methods employed in this work, rooted in the philosophy of Gadamerian hermeneutics.

CHAPTER FIVE

METHODS

5.1 Introduction

This chapter discusses the methods used to illuminate the meaning of preterm birth for postnatal mothers from Mpemba (Blantyre) in Malawi. The stages undertaken within the research process includes the various steps in obtaining ethical and research approval, the research design, recruitment techniques, the data collection, and the analysis. As reflection is naturally entwined within hermeneutics, my reasonings, choices, and challenges are reflected upon throughout this chapter and thesis. A review of the study's rigour and trustworthiness concludes this chapter.

5.2 Ethical approval

Ethical approval was obtained from the Health Policy and Management and Centre for Global Health Research Ethics Committee (HPM/CGH REC) at Trinity College Dublin in February 2019 (Appendix 1). The College of Medicine Research and Ethics Committee (COMREC) in Malawi initially approved the study in March 2020 (Appendix 5). It was subsequently reapproved for a second year, following the delays associated with COVID-19, in May 2021.

5.3 Partnerships and local approvals in Malawi

5.3.1 The Malawi Liverpool Wellcome Trust

According to the National Commission for Science and Technology of Malawi (2011), under the guidelines for research in the social sciences and humanities, international researchers are required to be affiliated with a Malawian research or government institution. This policy is to ensure the researcher's work adheres to Malawian ethical and research rules. I reflected and studied my positionality as I was entering the unique and sacred sphere

of motherhood from a non-Malawian perspective.

Appropriate steps needed to be taken for this culturally sensitive, women-centred work. I wanted to ensure that the entire research process and its results were conducted and shared with the utmost respect and sensitivity. Therefore, the first year of my doctoral studies involved travelling to Malawi on two occasions for consultation opportunities with health workers and researchers in Malawi. I was introduced to the Malawi Liverpool Wellcome Trust. After several meetings and presentations with research staff at the MLW, I was offered to be hosted by the organisation as a visiting doctoral research student (Appendix 2). I joined their maternal health and social science research groups. The leads of both research groups were assigned to the project as in-country mentors to offer research support and expertise in maternal health and qualitative research.

5.3.2 Clinical Research Support Unit

This step within the research journey was departmental approval from the Clinical Research Support Unit (CRSU) at the MLW. The CRSU oversee and monitors research projects based at or hosted by the Malawi Liverpool Wellcome Trust. I met with the individual departments of the MLW and underwent specific inductions and training related to each department. A total of 12 departments were consulted and signed off on the project:

- Grants
- Clinical Research
- Laboratory
- Finance
- Procurement (supplies)
- Data Management
- Statistics
- Field Site
- Science and Community (community engagement)
- Facilities
- Health and Safety
- Clinical Research Support Unit

An Investigator Site File Index for Non-Clinical Trials (ISF), a computer-based filing system, was meticulously established, as required, to organise and file all documents related to the study. ISF documents included study monitoring and annual reports, ethics applications, the participant information leaflet and consent form, approval letters, training logs, and meeting notes. This file had to be reviewed and accepted by the CRSU, before formal approval was granted (Appendix 6).

5.3.3 Queen's Hospital Department of Obstetrics and Gynaecology

At the suggestion of the MLW, a meeting was scheduled with the head of Obstetrics and Gynaecology at the Queen Elizabeth Central Hospital in Blantyre. It was an opportunity for the local obstetrics team to become familiarised with the research taking place within the Blantyre District. Following the introduction, the head of Obstetrics and Gynaecology approved the research study (Appendix 3).

5.3.4 District Health Office-Blantyre District

A research presentation was arranged for the head of the District Health Office of Blantyre, along with nurses, midwives, physicians, and other health professionals who worked within the Blantyre District. The health workers posed questions regarding the research design, participant recruitment, the research impact, and how the information was to be disseminated. The feedback received was that the district did not see the value in hearing the experiences of mothers regarding their preterm birth experience. It was suggested that I conduct a mixed-methods study to further add statistical significance to the area of preterm birth. Though this initial result was challenging to receive, I viewed it as an even greater motive for the project's importance. The health care department adhered to a positivist view of research, not fully understanding the significance or research contribution of qualitative research. In response, I highlighted the importance of qualitative research, the gap in the literature, and how it could impact the work of future quantitative

research. Once certain aspects of the project were clarified, the project received full research approval from the District Health Office of Blantyre (Appendix 4).

5.4 Choosing the research location: Mpemba

Several factors were considered when selecting a location in the Blantyre district. Upon consulting my in-country mentors, two main factors were identified as potential factors influencing the potential location: accessibility and research-site saturation. I was living in Blantyre and required a community within a commutable distance from the city. Furthermore, I considered the ongoing community research studies within the district, as I did not wish to overburden the local citizens (Patel et al., 2020). This phenomenon has been labelled as 'research fatigue' or participation fatigue, which emerges when an individual or a group becomes tired of involvement in research activities (Clark, 2008). Entire towns have also experienced excessive research attention, particularly when they become a symbolic focal point for researchers investigating socially diverse communities (Neal et al., 2015). The community of Mpemba, located approximately 15 kilometres southwest of Blantyre, was viewed as an ideal community for this study.

Mpemba encompasses a collection of villages within its territory. For the 2020-2021 year, the population was 23 561 inhabitants, with 5 419 women of reproductive age (NSO, 2021). There were 1 060 live births and 990 surviving infants. There were no data available regarding preterm births specifically for Mpemba. The community features a primary health centre, aptly named the Mpemba Health Centre, providing a variety of health services, including outpatient services and a full labour and birth wing. The health centre also provides medical services to more isolated villages within the Mpemba community during village outreach days. On specific days each month, staff nurses and midwives from the Mpemba Health Centre travel to a particular village, providing care and themed educational talks to community members who may have difficulty accessing

the main health centre. The following figure (Figure 6) maps out the community of Mpemba.

Figure 6

Map of Mpemba

5.5 Meeting the community

While preparing for the interviews, I, along with my research assistant, were kindly invited to Mpemba to be formally introduced to the village chiefs, elders, religious leaders, community midwives, nurses, and health workers. This occurred at the local elementary school, located adjacent to the Mpemba Health Centre. Dressed in a traditional Malawian *chitenji*, I introduced myself in Chichewa and provided a brief background about the project. I was met with smiles, nods, and the odd chuckle, likely over my stumbles and mispronunciations in Chichewa. My research assistant supplied a more in-depth overview of the research project and gave translated answers to any questions. Copies of the

participant information leaflet (Appendix 11) and the information flyer (Appendix 9) were distributed in Chichewa to those who were interested. The information package and leaflet had contact information for both me and my research assistant. Several nurses, midwives, community health workers, village elders, and chiefs took note of our contact information.

Two former traditional birth attendants and current village elders introduced themselves and invited us to sit under a tree. The traditional birth attendants reminisced about a time when they were the primary consultants for expectant mothers. One of the elders shared the following statement: "We were once the ones who were called to births. We were always there. Now, we tell them to go to hospital". The two elders smiled at one another as if they shared a secret that only they understood. This very simple statement seemed to not only represent a passing of the torch, but also appeared to underscore the nuanced and intricate relationship between tradition and modernity within maternal healthcare. I was especially interested to see if this aspect would arise during the interviews.

5.5.1 Sitting among mothers

After the introductory meeting with the community, I, along with my research assistant, were kindly invited to the Mpemba Health Clinic by the community nurses and midwives. On our first visit, I sought to simply observe the daily routine of the health centre. That day, there was a health talk and a postpartum health check taking place, for mothers who had given birth within the previous six weeks. After being introduced by the community nurses, and having no objections to our presence, we sat among the mothers during the health talk. It was such a simple, yet powerful moment: *sitting among the mothers*. I noted that the babies were sleeping on their mothers' backs, were being breastfed, or were being passed from one mother to another for a moment of rest. Though I am not yet a mother, my experience of childbirth has been that of the medical provider. I reflected in that instant and noted a passage from Kitzinger (2005) in my field diary from

that day: “Obstetric language is mechanistic; women’s is experiential” (p. 60). Here, it was to be among mothers, with mothers, to focus solely on their voices and experiences.

5.6 Recruitment

The Mpemba Health Clinic was our initial site for recruitment. The nurses and midwives at the clinic kindly agreed to act as gatekeepers after our community engagement presentation. Every day, mothers would present themselves to the clinic for a variety of reasons, such as health talks, postpartum and newborn assessments, and under-five health checks. Each mother and child are provided with a ‘health passport’, a document which contains important health information for that individual. For example, the document contains pertinent information regarding each pregnancy and birth, for the mother, and relevant newborn data for the child. Furthermore, the passport states the gestational age of the baby at birth, based on an ultrasound or last menstrual period (LMP). If a mother presented to the clinic and had given birth too soon, the nurses and midwives would ask a few simple questions during their private appointment, such as “Tell me about your baby. How old was your baby at birth?” If the mother provided any indication that she believed to have given birth too soon, the attending nurse or midwife would provide a brief introduction about the study. If the mother was interested, she was directed to our location outside the clinic, sitting under a lemon tree, approximately 25 metres from the clinic.

This location was selected for several reasons. Firstly, I did not want to put any pressure on the mothers to participate in the study. If she were interested or required further information, the mother presented herself to inquire about the study. If the mother was not interested, she simply did not approach. Secondly, the position under the lemon tree provided the privacy and quiet space required to further discuss the project. Thirdly, it allowed for physical distancing outside, as required by the COVID-19 protocol, put forth by the MLW and the WHO. The area under the lemon tree became associated with the study,

where we became colloquially known as '*the ladies under the lemon tree'*. As the project developed, through snowballing, mothers would present themselves at that location, without the assistance or direction of the nurses and midwives at the clinic.

A mother who presented herself was greeted and provided with the participant information leaflet in Chichewa (Appendix 11). The various points of the research were reviewed by my research assistant. The mothers were then invited to call if they were interested in participating. A date, time, and location which best suited the participant was arranged. One interview (n=1) was conducted outside of a mother's home. The remaining mothers (n=15) were either interviewed outside of the Mpemba Health Clinic or at a health post. Following the ethical guidelines at Trinity College Dublin, a minimum of seven days lapsed between the initial meeting and the interview.

5.7 Inclusion and exclusion criteria

Though medical identifiers were collected during the recruitment process, such as estimated gestational age at birth, the mother's sole belief of whether she gave birth too soon was used as an exclusive benchmark of inclusion. According to Smythe (2011, p. 36), "such lived-understanding is often covered over, taken for granted and/or silenced amidst theoretical/scientific discourse". This was an important aspect within the hermeneutic paradigm which was greatly considered and guarded. If a mother had presented herself with a preterm baby, according to her medical history, but did not believe to have given birth sooner than expected, then that potential participant was excluded from the study. Contrarily, if a mother had given birth to a term infant, but believed to have given birth too soon, she was invited to participate in the study. It was crucial that the participants' own understanding led their experience, and that it was not bound or stifled by the preterm birth definitions within a medical model. It was driven by the mother's understanding of her own birth experience (Belenky et al., 1997). As such, medical wordings were generally

avoided. Terms such as ‘preterm birth’ were replaced with more neutral and culturally understood terms, for example, ‘having a baby born too soon’.

5.8 Sampling process

Purposeful sampling is a method often employed within qualitative research. Creswell (2013) stated that purposefully selecting individuals for a study can enlighten and inform about a specific phenomenon. This study considered the meaning of the preterm birth experience for mothers, and thus purposeful sampling was regarded to be an appropriate sampling method within hermeneutic research. However, I carefully considered the community nature of the project. Engagement with community elders, chiefs, birth attendants, and the wider social systems embedded within the communities was a tenet of this project and could influence interest and participation. Noy (2008) stated that social knowledge, central to the snowballing method, highlights the notion that knowledge is continuous and ever-evolving, rather than a static, positivist concept. Knowledge is not simply contained or boxed, nor does it merely dwell within scholarly sources, esteemed members of society or male academics. The author stated that this ideology is built upon a positivist, patriarchal standpoint. Noy (2008) further developed the point that snowballing is fundamentally social as it appreciates and utilizes the natural social structures and networks which are presently established within communities. This sampling method can holistically develop in tandem with the various parts of the research project, to support the potential development of organic knowledge (Noy, 2008).

However, snowballing was not chosen as a ‘fall-back’ method. Rather, it was carefully reflected upon and chosen due to its alignment with hermeneutic and feminist perspectives.

5.9 Sample size within hermeneutics

The interviews were undertaken over a period of three months: from May to July of 2021. A total of 16 mothers volunteered to share their meaning and unique experience of giving birth to a baby born too soon. Within the literature, Creswell and Poth (2018) provided a large sample range for phenomenological studies, between five to 25 participants. However, hermeneutics does not seek to ascertain or refute a particular theory, nor does it attempt to provide the ultimate answer to a particular question (Dibley et al., 2020). Rather, it is the coming together of different voices, the fusion of varying horizons of understanding (Gadamer, 1975). The word 'sample' is not a hermeneutic concept (Crowther, 2014). Therefore, I was not focused on the 'number' *per se.* Rather, I was motivated to be flexible and was balancing between meeting mothers who fitted the inclusion criteria, the level of interest to participate, and the ability to achieve a level of richness within the interviews to provide an interpretation (Dibley et al., 2020). The ability to be flexible and trust that my journey would not always be comfortable was important (Crowther & Thomson, 2020).

I faced an internal struggle during my compressed timeframe in Malawi regarding having sufficient data. I persistently questioned whose stories and voices were potentially remaining silent and whether I could reach a deeper level of understanding with just one more interview. Would I have *enough?* When is *enough?* This was a challenging aspect as I did not have the literal translation of the interviews until days later. Therefore, I had to trust that this process would reveal the meaning of the phenomenon.

5.10 Gaining understanding: The data collection process

5.10.1 The pre-interview

I felt an immense duty of care toward the mothers who were sharing the intimate details of their lives. The names and contact information of two local health workers were

provided in case the mothers required any additional support after the interview. Two names were provided in the case that a mother did not feel comfortable speaking with one of the individuals. Prior to the commencement of the interviews, I consulted with female elders of the community and a local midwife to obtain feedback on who could potentially provide support to the mothers after the interview, should it be required. I initially thought that a woman from outside the health network would be most appropriate; however, this was not the case. The names of two health workers were identified: a nurse-midwife and a community nurse. The rationale provided was that these two women were well respected, local members of the Mpemba community. Although trained medical professionals, they also provided non-medical support to local mothers through the women's groups and general wellness care. These two women, who were mothers themselves, understood the traditional and cultural values of the community, and would already be one of the first individuals to be called if there was a general need in the villages. It was crucial to utilise systems of support already in place, as I was advised that previous projects had implemented support systems which were neither appropriate nor locally accessible. When approached, the two nurses gladly accepted this role and would check in throughout the research process to inquire if they could be of assistance.

At the pre-arranged meeting place, the mothers were provided with a review of the study, including its aims and objectives. I provided a brief introduction in Chichewa, while the more in-depth information was delivered by my research assistant. It was reiterated that the interview was completely voluntary and that their information, such as name and contact information, would not be shared with anyone. The benefits and risks, although unlikely, were also reviewed. The participants were invited to ask any questions. The mother's permission was sought regarding the recording of the interview, to which all mothers consented. Once queries had been addressed, the consent form was signed. Prior to starting

the interview, the mother, my research assistant, and I would have an informal 'chat'. Conversations were exchanged, and basic personal information, such as age and information on past pregnancies, was gathered to further inform the context. This was to establish a rapport with the participant (Oakley, 1981).

5.10.2 The interview: A three-way conversation

Ryan et al. (2009) described three main forms of qualitative interviews: structured, semi-structured, and unstructured interviews. Van Manen (2016) argued that the type of interview selected should be grounded in the nature of the research question. Vandermause and Fleming (2011) encouraged the use of an unstructured approach to foster trust between the researcher and the participant in hermeneutic research. As such, an open, unstructured approach was adopted, opening the conversation with an open-ended statement: "Tell me about your experiences of having a baby born too soon/sooner than expected." For consistency, all interviews began with this question. The mothers were then encouraged to elaborate or clarify their stories or experiences, using prompts such as "Could you tell me a little bit more?" or "What do you mean by that?". I approached each interview with the openness and trust required in hermeneutic phenomenology, remaining open to new knowledge and new ways of understanding—the 'play' of the conversation (Smythe et al., 2008). A total of 16 (N=16) interviews were collected between May and July of 2021, ranging from 34 minutes to one hour and 31 minutes in length, with an average duration of approximately one hour and 15 minutes.

A pilot interview was conducted to understand the dynamics of a three-way conversation involving myself, the interpreter, and the participant. Initially, I introduced myself and attempted to establish rapport with the participant in English, while my research assistant provided translation. However, I recorded in my field notes a perceived obstruction in my approach with the participant. The conversation appeared overly

funnelled, as it seemed that I was communicating through the interpreter rather than engaging in a dynamic three-way dialogue. Additionally, initiating the conversation in English appeared to hinder the potential for deeper interaction. I discussed these aspects with my research assistant to explore how we could modify this approach. Influenced by readings on colonialism and post-colonial theories, we decided that I would introduce myself in Chichewa rather than English. I hypothesised that speaking in English could act as a barrier to trust and rapport. While not fluent, I was confident I had developed a sufficient command of the language to convey simple sentences about myself, the research, and to ask questions to the participant. Gadamer (1975) argued that openness and authenticity are crucial on the path to understanding, and I took these points to heart.

In subsequent interviews, I observed that speaking the participant's language significantly fostered rapport. Participants often smiled or laughed at my attempts to speak Chichewa, which often broke the ice, and facilitated a more dynamic and engaging conversation among the three of us. My research assistant transitioned to a role that was more facilitative rather than merely translational, thereby enabling a more fluid and interactive dialogue. This shift enhanced the overall quality and depth of the data collected, contributing to a richer and deeper understanding of the participants' perspectives.

The three-way interview process significantly impacted data collection by introducing multiple perspectives and dynamics. This approach involves the interviewer, the participant, and an interpreter, which can enrich the data but also introduce complexities. The interpreter acts as a bridge, enabling the horizons of understanding to expand and even overlap each other (Brämberg & Dahlberg, 2013). The presence of an interpreter ensures that language barriers do not hinder communication, allowing the interviewee to express themselves more comfortably in their native language. However, this also means that subtle details and meanings might be lost or altered in translation,

potentially impacting the authenticity and accuracy of the collected data (further explored in section 5.11).

There was little guidance in the literature on how to conduct a three-way interview dynamically and fluidly. Therefore, my research assistant and I used the pilot interview to address any difficulties. We decided to be transparent with the participant from the beginning, stating that the interpreter might revert to English to ensure my understanding and that I might switch to English to further clarify any discussed points. This approach ensured that no one felt left in the dark or excluded, fostering a more inclusive and effective communication environment. Mothers, particularly in the first few interviews, stated that this transparency made them feel at ease and included, even if they did not understand what was being said.

Additionally, my research assistant and I decided that the optimal dynamic was to allow the participant to fully answer the question or wait for a natural pause before verbally translating any portion of the conversation. This decision was based on our experience during the pilot interview, where the interpreter attempted to quietly translate as the participant was speaking. Upon reflection, we noted that this approach could potentially make the participant feel interrupted or cut off. Given my ability to understand parts of the participant's narrative, the interpreter took notes and provided a synopsis during pauses in the conversation. A verbatim translation was then provided within 48 hours to further support our field notes. This method ensured that the participant's responses were fully heard and respected, while also maintaining the integrity and accuracy of the data during analysis.

5.10.3 Confidentiality and identity protection

Great care and consideration were taken regarding the identity protection of the mothers. The goal for each participant was complete confidentiality throughout the entire research process, that is, during the recruitment, data collection, analysis, and reporting of the findings (Kaiser, 2009). Particularly, vulnerable individuals or those with stigmatising traits could face negative consequences if their identities are revealed (Baez, 2002; Kaiser, 2009). Therefore, careful plans were put into place throughout the entire research process to protect the participants.

My research assistant and I underwent extensive training in confidentiality and the process of informed consent at the Malawi-Liverpool Wellcome Trust. My research assistant, and an independent translator, who only had access to the transcripts with identifiers removed, signed a confidentiality agreement prior to the commencement of the study. At the start of each interview, the aspect of confidentiality, and its meaning, was discussed with each participant. This aspect was crucial for the process of informed consent and to build trust and rapport with the participant (Crow et al., 2006). Although the mothers signed an informed consent form, their form was not coded or linked to any transcript or audio recording file. Age, names, occupations, specific villages, phone numbers, addresses, and any other identifiable information were redacted from all written transcripts.

I asked each participant to choose pseudonyms for identity protection within the research. I felt it was important that the participant select names which were personally and culturally meaningful. Vandermause and Fleming (2011) stated that pseudonyms could also hold symbolic significance in relation to the phenomenon of interest. When selecting their pseudonym names, the mothers often chose the names of important women or girls in their lives, such as that of their own mother, grandmother, friend, or daughter. In this study, instead of simply writing ‘Participant 1’, the name was a true reflection of the uniqueness

of each mother.

5.10.4 Data transcription and protection

Data collection was conducted in accordance with the General Data Protection Regulations (GDPR) (2018), the data protection laws of the College of Medicine Research and Ethics Committee (COMREC), and its research affiliate, the Malawi- Liverpool Wellcome Trust (MLW). The interviews (N=16) were transcribed by my research assistant verbatim from Chichewa into English, based on the audio recordings, to ensure the accurate representation of the conversations. Non-verbal cues and emotional tones, such as pauses, silences, smiles, tears, facial reactions, and tone of voice, were all noted, to add further context to the transcript (Dibley et al., 2020). Furthermore, interruptions, such as telephone calls, background noise, and noises from their babies, were also noted. A second, independently qualified translator verified the translation via the Brislin Model (1970). Transcriptions did not contain any identifiers, such as names, contact information, and villages.

Fieldnotes were taken during and immediately after the interview, annotating my different impressions of the conversation. This step was crucial in my reflection on what occurred, what I would have done differently, whether I was comfortable, and what I found challenging (Phillippi & Lauderdale, 2018). I further noted how I personally was feeling that day, whether I felt optimistic, anxious, afraid, or upset, to reflect upon whether that could have influenced the interview.

Transcribed documents were kept on a password-controlled, encrypted computer. Pseudo-anonymized transcripts were viewed by my supervisory team via the secured TCD One-Drive. Consent forms were stored at the MLW in Malawi.

5.10.5 Safety and security

Prior to the interview phase, a safety and security protocol was established, in conjunction with the MLW, to ensure the health and safety of all parties involved in the study. COVID-19 protocols were respected, including conducting interviews outside, respecting a distance of at least one metre, and the usage of medical-grade masks. My research assistant and I would report to the health and safety manager and/or my in- country mentor at the MLW, either through phone, e-mail or in person, prior to leaving for the field. They would then be notified when we had completed interviews for the day. Furthermore, my research assistant and I were always accompanied by an MLW representative in a 4x4 off-terrain vehicle when the interviews were not conducted at the Mpemba Health Clinic. The community health worker or nurse and the village chief would be notified of our presence in the community the day prior or the morning of the interview. Interviews would occur during daylight hours only.

5.11 Translation

The objective of cross-language research and translation is to attain an equivalence between two languages (Lee et al. 2008). The transcripts were translated using the Brislin Model (1970). The Brislin Model is an established translation guideline in cross-language research (Brislin, 1970; Lee et al., 2008). The Brislin Model of translation (1970) is a comprehensive approach to understanding and evaluating the process of translation. It emphasises the importance of cultural factors and context in the translation process. The model focuses on three key components: (1) forward translation, where a text is translated from one language to another (Example: Chichewa to English); (2) back translation, where the text is then translated back to the original language to assess accuracy (Example: English to Chichewa); and (3) back-translation review, which involves comparing the original and back-translated texts to identify any discrepancies or areas where the intended

meaning may have been distorted. This process may occur several times if there are any inconsistencies present (Brislin, 1970; Lee et al., 2008). Both translators agreed on the final translation. The Brislin Model is commonly used in cross- cultural research and is a tool for ensuring the accuracy and reliability of translated materials.

5.11.1 Cross-language research

Cross-language research transpires when a language barrier exists between a researcher and the participants of a research study (Squires, 2008). Squires (2008) stated that language assists participants in expressing their identity, permitting the communication associated with their cultural background, gender, ethnicity, and other elements related to their sense of self. However, translation is an intricate process as there may be different meanings between languages (Kapborg & Berterö, 2002). This barrier can be mitigated with the use of an interpreter (Squires, 2008). However, using an interpreter in research is not without issue. Twinn (1997) conducted research exploring the validity and reliability of translation in nursing research. The author studied how six Cantonese-speaking women utilized cervical screening services. Specifically, the author reported that major complexities of translating involve the various understandings from interpreters and the difficulty of translating concepts and different grammar structures into English.

Squires (2009) performed a critical literature review of research that involved cross-language qualitative research within nursing and health sciences disciplines. The author reviewed the literature and amalgamated the recommendations to assess cross-language qualitative research. The following recommendations were tested against published cross-language qualitative studies. The recommendations were a useful guide to assist with my own research and for selecting my research assistant. The following table (Table 3) shows the recommended steps when pursuing cross-language research. Each section will be explored in further detail below.

Table 3

Recommendations for Cross-Language Qualitative Research

Conceptual Equivalence
1. Offer a rationale as to why the analysis transpired in the stated language, particularly if it was different than the participants' language.
2. Establish a translation wordlist in multi-language projects to confirm conceptual equivalence.
3. Validate the translation by a trained bilingual professional, not associated with the data collection process or the preliminary translation phase.
Translator's Qualifications
4. State the translator's prior involvement with translation and qualifications.
5. Explain the researcher's language abilities.
6. Explain the identity of the translator and researcher, in comparison to the participants.
Translator's Role
7. Explain the translator's role in the study
8. Explain when interpreter/translation services are used in the research process.
9. Acknowledge the individual who conducted the analysis and state the language in which it occurred.
10. Explain why more than one translator was used when the research was conducted in one language.
Methods
11. Select a suitable qualitative method for the cross-language study.
12. Pilot test the translated interview guide prior to conducting the study.
13. Note the participants' country of origin.
14. Indicate that the use of interpreters or translators may have caused limitations to the study.

Note. Adapted from Squires A. (2009) Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies* 46(2), p. 277-287.

5.11.2 Conceptual equivalence

Researchers may avoid projects that encompass another language due to its challenging nature (Kapborg and Berterö, 2002). However, cross-language research is not an impossible task. It was established early on that the interviews would occur in Chichewa, as this is one of the official languages of the country and the dominant language spoken in the Blantyre District of Malawi. The first step involved combing the literature to identify known words related to preterm birth in Chichewa. The wordlist was validated by the head of translation at the Malawi Liverpool Wellcome Trust, who was not associated with the data collection process. This individual was both fluent in English and Chichewa. A Malawian midwife also reviewed and approved the Chichewa lexicon catalogue.

5.11.3 Translator's qualifications and role

The process of finding a suitable translator was laborious, as this individual would be a critical figure in the interpretation process of the data; however an excellent candidate was found. My research assistant was fluent in both English and Chichewa. She was part of the Chewa people, meaning Chichewa was her mother tongue. However, she attended an international English secondary school and developed an equally fluent level of English. Furthermore, she had previously participated in several research studies, having personally interviewed mothers regarding their birth experiences. As a mother herself, she was familiar with the vocabulary and traditions around pregnancy and childbirth. If my research assistant knew one of the participants, which could hinder the interview, a second female translator from the MLW was available in an emergency.

My research assistant's role was two-fold: she acted as a translator during the interviews, and subsequently translated and transcribed the interviews. Furthermore, and most importantly, she provided invaluable insight into the traditions and cultural nuances surrounding pregnancy and birth of the Chewa people. While not assisting with the

analysis, she provided a level of interpretation which would not have been achieved without her cultural knowledge and understanding.

5.11.4 Methods

Gadamer's hermeneutics, known for its emphasis on understanding and interpretation, can serve as a valuable framework for maintaining fidelity in cross-language research endeavours (Gadamer, 1975). When applied in such contexts, Gadamer's approach encourages researchers to engage in a dynamic process of interpretation that transcends linguistic barriers and cultural differences. One key aspect of Gadamer's hermeneutics is the recognition of the interpreter's preconceptions and biases, which can be particularly relevant in cross-language research. Acknowledging these preconceptions enables the researcher to approach the interpretation process with openness and humility, allowing for a deeper understanding of the complexities embedded in the linguistic and cultural nuances of the target language. This self-reflexive stance is essential in ensuring that the research remains faithful to the intricacies of the language being studied, thereby facilitating a more accurate and nuanced interpretation of the data.

Hermeneutics underscores the importance of dialogue and conversation as central components of the interpretive process (Gadamer, 1975). When applied to cross-language research, this aspect encourages researchers to actively engage with bilingual or multilingual participants, fostering meaningful exchanges that help bridge potential language gaps and facilitate a more comprehensive understanding of the research topic. By prioritising dialogue and promoting an atmosphere of mutual understanding, Gadamer's hermeneutics facilitates the development of trust and rapport, thereby enhancing the accuracy and authenticity of the research findings across different languages and cultures.

5.12 A Gadamerian framework

Interpretive research has long been recognised for its distinctive characteristic of eschewing a rigid methodology for data analysis (Fleming et al., 2003). While Gadamer (1975) has provided a profound understanding of theory for the interpretation of texts, he did not suggest a prescribed method for achieving this understanding. Nevertheless, Gadamer's stance suggests the necessity of a systematic approach for interpretation (Fleming et al., 2003). Moules et al. (2015) argued that establishing a formulaic approach for analysis in interpretive work would contradict the principles of hermeneutics. According to this view, attempting to impose a rigid analytical framework might stifle the interpretive process and hinder researchers from fully engaging with the complexities and nuances of the subject matter. Academics have further acknowledged the potential benefit of a more structured approach within descriptive and interpretive phenomenology (Colaizzi, 1978; Diekelmann, 1992; Fleming et al., 2003; Giorgi, 1989; van Manen 1990). However, not all were appropriate for this study.

For example, Giorgi (1989) offered systematic research frameworks. However, this approach is rooted in Husserl's descriptive phenomenology, which demands the suspension of preconceived notions (bracketing). I did not support the idea of bracketing because it disregards the researcher's personal and contextual perspectives, which can significantly influence the interpretation of data. Moreover, bracketing can be impractical, and arguably impossible in research, especially when working with complex and multifaceted phenomena that require a nuanced understanding. Therefore, with further review of the literature, the framework developed by Fleming et al. (2003) appeared to be the most appropriate methodological approach.

The selection of Fleming et al.'s (2003) analytical framework stemmed from its ability to effectively incorporate Gadamer's major concepts and research process, from the initial formulation of the research question to its final step of establishing trustworthiness. However, there appeared to be a critical step missing from Fleming et al.'s (2003) framework. Reflexivity was not incorporated into the approach, which I felt was a fundamental philosophical principle of Gadamer's hermeneutics. As such, I respected the Fleming et al. (2003) framework for this research, while incorporating a sixth step, a reflexivity step, which was woven throughout the framework. This reflexivity allowed for further openness to the spirit of hermeneutics (Smythe et al., 2008) while approaching the framework with flexibility, as the context dictated. The following table (Table 4) shows the selected Gadamerian framework, with the addition of a sixth step.

Table 4

The Gadamerian Framework

Step One: Selecting a research question **Step Two**: Identification of preunderstandings **Step Three**: Acquiring understanding through dialogue with participants **Step Four**: Acquiring understanding through dialogue with text The participants' texts should be reviewed to discover meaning which reflects the text as a whole. The researcher's preunderstanding will influence the first pass of the text. Individual sentences or sections should be reviewed to illuminate the meaning and understanding of the phenomenon. This step will assist in the development of themes of the subject at hand, which should elucidate detailed understanding, which may challenge and be challenged by the preunderstanding of the researcher. Individual sentences or specific passages are then connected back to the meaning of the entire text (part of the whole). Understanding through the hermeneutic circle may only be achieved if this movement of 'back to the whole' is included in the research process. The stage includes the identification of sections which may represent a shared understanding between the participants and the researcher. **Step Five**: Establishing trustworthiness **Added Step Six: Reflexivity (**Smythe et al., 2008)

Note. Adapted from Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing: Developing a Gadamerian-based research method. *Nursing Inquiry*, *10*(2), 113–120. https://doi.org/10.1046/j.1440-1800.2003.00163.x and Smythe, E., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies, 45*(9), 1389–1397.

5.12.1 Selecting a research question

The researcher is inherently immersed in their contemplation of the subject matter (Smythe et al., 2008). Crafting and delineating the research question involves a dynamic and intricate process (Dibley et al., 2020). It necessitates continual navigation between the initial study ideas, the insights gleaned from the literature review, and the essential philosophical considerations of the hermeneutic phenomenological approach (Dibley et al., 2020). This iterative approach aims to formulate a question that is both answerable and reflective of the primary aim of the study while aligning with philosophical and methodological principles (Dibley et al., 2020). As such, crafting my hermeneutic research question involved a continual oscillation between my initial concepts, the insights gained from my review of existing literature, and the fundamental philosophical tenets of hermeneutic phenomenology.

In the initial stages of framing my research question, I navigated various pivotal considerations. These included my interest in exploring the experiences associated with preterm birth and whether my focus should be directed towards labour and birth or encompass the postpartum phase. In addition, I pondered over whether I should work with parents as a whole or concentrate exclusively on the perspective of either mothers or fathers. I further deliberated on the specific aspect of the experience that piqued my interest. Was it the profound significance and meaning of the experience or a descriptive portrayal of the actual lived experience itself? These reflections and considerations coalesced into the formulation of my research question: “What is the meaning of preterm birth for postnatal mothers in Malawi?”. Although this question served as the focal point of my research, I maintained an openness to exploring new avenues of thought and inquiry throughout this study (Smythe et al., 2008).

5.12.2 Identification of preunderstanding

The concept of preunderstanding suggests that our knowledge is never built from scratch but is always reliant on some form of prior understanding, such as accumulated individual and collective knowledge, perspectives, beliefs, customs, assumptions, goals, and interests related to the phenomena being studied (Gadamer, 1975). The primary research questions that directed this study were centred on understanding the meaning and experience of preterm birth for postnatal mothers in Malawi. However, these questions and my personal perspective and philosophical presumptions continually evolved throughout the research journey, influenced by my pre-existing knowledge and shifting perceptions of preterm birth. As emphasised by Dibley et al. (2020), the development of the research question is not a linear process but rather involves navigating between the initial research idea, literature review, and hermeneutic philosophies. Different philosophical and methodological viewpoints may lead to other research inquiries. Even when I believed I had my research question, I remained open to refining it as new insights emerged.

Two methods that effectively exposed and challenged my preconceptions were maintaining a research diary and having preliminary discussions (pre-interviews) with my supervisors and colleagues (Smythe, 2011). Journaling helped identify biases within the study, while the preliminary discussions allowed for a deeper awareness of my preconceived notions that might impact interpretation (Dibley et al. 2020). I established a consistent writing routine early in my PhD programme with my reflective diary. Additionally, my supervisors and I engaged in fruitful discussions about my beliefs, experiences, and prior research concerning preterm birth.

I am a woman, Canadian, and a nurse with experience in the neonatal intensive care unit and the birthing ward. I have always considered my work to be patient-focused, emphasising holistic care over mere treatment. However, my experience in critical care

areas involved objective, quantitative measures of success. My previous research in Uganda focused on the stigma surrounding preterm infants in the special care unit (NICU) and was defined from a biomedical perspective. Participants were limited to neonates born under 37 weeks' of pregnancy admitted to the special care unit (NICU), without the flexibility to incorporate alternative forms of knowledge or involve community participants.

Upon initial discussions with my supervisors, I faced the question, 'What is preterm birth?' Although I assumed this was a straightforward query, my attempt to define preterm birth beyond a biomedical lens led to confusion and frustration. This moment prompted a period of deconstruction, confronting issues related to the history of medicine, feminism, technological control of birth, and authority over women. During the subsequent 'reconstruction' phase, I gained clarity that my prior training and biases were not detrimental but rather contributed to my understanding of the world, compelling me to adopt a new lens of comprehension. This process has been one of the most transformative experiences of my nursing career (Gadamer, 1975).

5.12.3 Acquiring understanding through dialogue with participants

In a Gadamerian context, the process of 'gaining understanding' takes precedence over the conventional notions of 'gathering information' or 'collecting data' (Fleming et al., 2003). This emphasis underscores the significance of engaging in dialogue, both with research participants and the texts derived from their narratives (Gadamer, 1975). Gadamer (1975) advocated for an open and receptive stance in these dialogues, accentuating the role of language as the medium through which understanding is cultivated. It is within this framework that I, as the researcher, became attuned to the multifaceted layers of meaning embedded within the research context, fostering a deeper comprehension of the lived experiences and perspectives of the participants (Fleming et al., 2003; Gadamer, 1975).

It is worth noting that Gadamer (1975) underlined the significance of engaging in multiple conversations with participants, considering that understanding is shaped by the context at hand. He referred to this evolution of understanding as the hermeneutic circle[113], the iterative process through which both the participants' and the researcher's understanding of the phenomena evolve over time (Gadamer, 1975). As such, Fleming et al. (2003) suggested meeting the participant over several visits. Given the challenges posed by the remoteness of some areas, time constraints, and the importance of encouraging participation, I decided to schedule one interview initially, with the possibility of further discussions if a mother desired to further explore her experiences. This approach enhanced the feasibility of the study for both me and the participants. Indeed, maintaining this flexibility in the research process to accommodate the needs and circumstances of the participants is crucial for ensuring successful engagement and valuable contributions to the study.

Gadamer's notion of fusion of horizons[14] clarifies the process through which understanding is achieved, highlighting the dynamic interplay between the perspectives of the participant and the researcher (Fleming et al., 2003). This concept underscores the ever-evolving nature of the present horizon, stressing the continuous integration of diverse perspectives into a new and evolving understanding. It becomes imperative for the researcher to recognise the influence of personal feelings and experiences on the research process and incorporate this awareness into the study. However, it is crucial to acknowledge that achieving a complete understanding of the other remains an ongoing and evolving endeavour (Gadamer, 1975). Navigating the threshold of sufficient interpretation posed a challenge for me. Relying on Gadamer's philosophies and having faith in the interpretive

[13] Please see Chapter Four for further detail on the hermeneutic circle.

[14] Further discussion on fusion of horizons may be found in Chapter Four.

process offered reassurance that the depth of meaning would eventually become apparent (Smythe, 2011).

5.12.4 Acquiring understanding through dialogue with text

Gadamer consistently emphasised the significance of spoken dialogue, but in most research, interviews need to be transcribed (Fleming et al. 2003). When analysing these transcripts, researchers must avoid overreliance on the written text. Instead, they should read the transcripts while listening to the recorded conversations, as these two aspects work in tandem to establish shared understanding (Gadamer, 2004). The 'text' not only encompasses the written transcripts but also includes the spoken words on tape, written notes about the interview context, and the researcher's observations. Non-verbal cues are also crucial in shaping understanding and should be considered as part of the 'text' (Fleming et al., 2003).

The interview transcripts were transcribed verbatim by my research assistant into English and were thoroughly reviewed to capture the essence of the entire text. Understanding the text-as-a-whole was vital in laying the groundwork for the subsequent analysis, as it significantly influenced the interpretation of each part. I used reflexivity to consistently be in touch with my prejudices and to remain open to the possibility of new understanding. The transcripts were extensively annotated, identifying key features and narratives that shed light on the nuances of the phenomenon. I paid close attention to the transcripts, aiming to identify moments that indicated a transformation in my understanding. Throughout the process of uncovering meaning, the central focus remained on the project's aim of understanding the meaning of preterm birth for mothers in Malawi.

In the subsequent phase, each section was thoroughly explored to further illuminate its meaning, facilitating a deeper understanding of the phenomenon of preterm birth. Initial themes were identified and subsequently scrutinised considering my pre-existing

understanding and perspectives. As each sentence and section were linked to the overall meaning of the text (part-of-the-whole), the comprehension of the text-as-a-whole was broadened, enriching my interpretive lens of preterm birth.

This phase entailed pinpointing excerpts that appeared to represent the shared understandings between the researcher and the participants. These selected passages, which will be further illuminated in Chapter 6, will offer readers insight into the fusion of horizons between the participants and me, as the researcher.

5.13 Establishing trustworthiness

Establishing trustworthiness often involves consideration of several key criteria. However, Crowther and Thomson (2023) warn that qualitative research cannot follow the same rigour and control as quantitative or positivist methodologies. After a thorough examination of the available literature, it became evident that Lincoln and Guba's (1985) framework for establishing trustworthiness was preferred among qualitative researchers, chosen for its ability to encompass and address key elements within qualitative research methodologies (Thomson & Crowther, 2023; Dibley et al., 2020; Nowell et al., 2017). These four elements are credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). I will explore each point in further detail and how they each relate to my work.

5.13.1 Credibility

Credibility refers to the extent to which the findings accurately represent the viewpoints of the participants (Lincoln & Guba, 1985). To bolster the credibility of my hermeneutic study, I diligently documented and transparently portrayed the data collection and analysis procedures, providing a clear account of my research journey. I also integrated direct quotes from participants, allowing their voices to underscore the authenticity of the findings. In addition, I maintained an audit trail, meticulously recording all aspects of my

research process, including supervision, analysis meetings, and key decision-making moments, thereby showcasing the rigour and trustworthiness of my study.

5.13.2 Dependability

Dependability pertains to the consistency and stability of the research process and findings over time (Lincoln & Guba, 1985). I was uncertain whether dependability could be fully ascribed to a study grounded in Gadamer's philosophy, given the dynamic nature of both my horizons and those of the participants. Consequently, a final interpretation is not attainable, and the interpretation of data will likely evolve over time. However, an explicit audit trail demonstrating the decision-making process and the reasoning behind any adjustments to the study procedures, along with the provision of samples from the results, can contribute to establishing credibility (Dibley et al., 2020). I ensured dependability in the study, to the best of my ability, by maintaining a clear audit trail that documented the decision-making process and any modifications to the research procedures. Additionally, providing samples of the raw data allowed for transparency and a comprehensive understanding of the research process.

5.13.3 Confirmability

Confirmability involves the objectivity of the research, ensuring that interpretations remain faithful to the participants' voices (Lincoln & Guba, 1985). To maintain confirmability in my research, I ensured that my interpretations were clearly linked to the data, thereby establishing a coherent and logical connection between the findings and the participants' experiences. Additionally, I maintained a detailed audit trail that documented the decision-making processes and any adjustments made during the course of the study, providing transparency and accountability for the analysis and conclusions drawn.

5.13.4 Transferability

Transferability focuses on the applicability of the findings to other contexts or settings beyond the immediate research environment (Lincoln & Guba, 1985). The transferability of findings from this study to other settings or groups is limited due to the hermeneutic nature of the research. Rather than seeking generalisability, this study focused on offering a profound comprehension of the significance of preterm birth for postnatal mothers, specifically in the context of Malawi. To enhance the transferability of my research, I provided a detailed account of the research context and setting, clearly outlined the characteristics and backgrounds of the participants, and meticulously documented the data collection and analysis procedures. Additionally, I thoroughly connected my findings to the existing body of literature to showcase the relationships and implications of my research within the broader scholarly landscape (Dibley et al., 2020).

5.13.5 Reflexivity

Reflection and reflexivity are distinct concepts in qualitative research (Dibley et al., 2020). Reflection pertains to looking back on a past event for the purpose of learning from it (Mortari, 2015). On the other hand, reflexivity involves an ongoing process of active self-awareness that occurs while an event is unfolding (Dowling, 2006). The researcher practising reflexivity constantly adapts their influence, minimizing negative impacts and enhancing positive ones, to benefit the study consistently (Dibley et al., 2020). I remained reflexive through each step of the research process and followed the steps recommended by Dibley et al. (2020). I documented my thoughts on these questions in my fieldnotes diary, which served as a valuable starting point in my thoughts and helped me maintain a hermeneutic stance. In my case, it has required me to continually reassess how my own background and experiences might shape the research and its findings. This ongoing examination has been crucial in maintaining a balanced

perspective and allowing for a more nuanced interpretation of the data. The following table (Table 5) demonstrates the research process and example questions which I asked myself for reflexivity purposes.

Table 5

Reflexivity Questions in the Research Process

The Research Process	**Reflexivity Questions**
The research idea	*What drives my interest in this topic? Who stands to gain from this research?* *Are there alternative methods to explore this subject?*
Literature search and research question	*Does this research article contribute to answering my question?* *Am I selecting it solely because it aligns with my initial perspective?* *Am I remaining receptive to the potential for diverse perspectives and exploring alternative viewpoints?*
Recruiting participants	*What aspects of who I am are likely to motivate people to participate, and what factors might potentially dissuade them from doing so?*
Data collection	*What information am I receiving from the participant, and is it influenced by my existing assumptions?* *How can I communicate this matter to the participant in a manner that avoids introducing prejudice?* *Have I embraced the phenomenological approach that allows me to remain open to the potential of alternative perspectives?*
Data analysis	*Am I interpreting the data to fit my expectations?* *Am I interpreting the data to align with my preconceived notions?* *Am I maintaining an openness to alternative interpretations and explanations within these data?*

Note. This table was adapted from Dibley, L., Dickerson, S., Duffy, M., & Vandermause, R. (2020). *Doing hermeneutic phenomenological research: A practical guide*. SAGE Publications Ltd.

The practice of reflexivity has played a vital role in shaping the trajectory of my research. By maintaining an active awareness of my own biases and preconceptions, I have been able to navigate the complexities of the research process more effectively. This has enabled me to approach the data with a more open and nuanced perspective, fostering a deeper understanding of the participants' experiences. Reflexivity has not only enhanced the rigour of my study but has also contributed to a more comprehensive and insightful interpretation of the research findings.

5.14 Personal challenges: COVID-19

Authenticity and transparency are integral to the hermeneutic approach, and thus, I feel I must share the hurdles I faced during my doctoral journey. In early 2020, I was all set to begin my data collection in Malawi, having dedicated the previous months securing the necessary approvals and engaging with the local community in Mpemba. However, as COVID-19 began to unfold, neighbouring countries closed their borders, and flights came to a halt, forcing me and other researchers to return home. Despite the uncertainty that loomed, my unwavering dedication to the project's aim prompted my return to Malawi in April 2021 with special dispensation from the university. After a mandatory quarantine, I swiftly resumed community engagement activities and prepared to restart the project.

The Malawi-Liverpool-Wellcome Trust introduced new legislation aimed at safeguarding both the researcher and the participants. These policies included:

- Conducting conversations outside
- Sitting at least one metre apart
- Practicing good hand hygiene
- Wearing masks for all involved in the conversation
- Monitoring our personal health for signs and symptoms of COVID-19

At the time, there was a lack of literature to guide how conversations would transpire with physical distancing and masks, and how this might impact communication. Research on mask types revealed that there was a type of clear mask adapted for persons with hearing impairment. The section around the mouth is clear, allowing for those to see mouth movements and facial expressions. Upon consultation with my supervisory team and guidance from medical staff at the MLW, it was agreed that those masks would be appropriate to use during interviews, to balance the need for personal protective equipment and maximise the communication between all involved. Each participant was provided with a clear mask, with my research assistant and I each having our own clear mask. Though cumbersome at times, particularly during longer interviews, they provided a space for connection and communication. The structure of the lower face, through smiles, pursed lips, and frowns, were all visible, further contextualising the conversation.

5.15 Conclusion

This chapter discussed the methods that formed the basis of this research, emphasising Gadamer's interpretive phenomenology. It not only justified the methodological choices, but also provided an insight into my perspective, influenced by personal beliefs and values regarding reality and truth. It concluded by evaluating the study's rigour and trustworthiness, demonstrating the thoroughness of the research methods employed. The following chapter will introduce the participants and illuminate the findings from the interviews.

CHAPTER SIX

PRESENTATION OF THE FINDINGS

6.1 Introduction

This study used a hermeneutic phenomenological approach to achieve a greater understanding of the meaning of the preterm birth experience for mothers in Malawi. Furthermore, the study aimed to illuminate the personal understanding and meaning that mothers gave to that experience. Drawing on the analytical method outlined in Chapter Five, section 5.12, this chapter presents key findings from the research study. In this chapter, the participating mothers are introduced, using a pseudonym name purposely chosen by the participants themselves. The overarching theme, *the unexpected journey*, and its four main themes, *something is wrong*, *the unforeseen birth*, *walking through the unknown*, and *stepping into the clearing*, were central to capturing the meaning of the lived experience. These themes are presented and deconstructed to reveal sub-themes and related interpretations of meaning. Passages from the mothers' lived experiences are used throughout to support the emerging themes.

6.2 The participants

Demographic information was gathered about the mothers and their children during the data collection phase of the project. Upon initially meeting the mothers, many of these aspects were shared by participants through informal conversation. These informal conversations facilitated the building of rapport and were often the 'starting point' for many of the mothers' stories. The mother's age, the weight of her baby, pregnancy history, type of birth (vaginal or caesarean section), and where the participant gave birth were elements which were discussed. While this information provided medical context, the mother's personal belief of whether she gave birth too soon determined whether she met the central

benchmark of inclusion for the study. The intention was to underscore the significance of women's perspectives, extending beyond a predetermined definition of preterm birth from a biomedical lens.

The following table (Table 6) provides an overview of the 16 participating mothers. Nine mothers were recruited using purposive sampling, with the remaining seven participants recruited through snowballing. All participants had given birth within one year of the interview. Mothers' ages have been categorized into the following groups to protect their identity: 18-25, 26-30, 31-35, and greater than 36 years of age. The estimated gestational age, based on the mother's health passport, and the age at which they believe to have given birth, are included. Gestational ages ranged from 28 to 36 weeks. Thirteen mothers birthed their babies in either a hospital or the local health centre. One participant gave birth at home while another gave birth en route to the local health centre. One mother gave birth unexpectedly in a neighbouring country. The mothers were all living in the Mpemba community at the time of the study. I included both the mother's perception of the baby's age at birth and the clinical age at birth to gain a comprehensive understanding of the mothers' experiences and perspectives.

Table 6

Summary of Participants from Mpemba

Name	**Mother's age** (Time of study)	**Baby's age at birth** (health passport)	**Baby's age at birth**	**Number pregnancies and living children**	**Birth weight** (kg)	**VB/CS** VB: Vaginal birth C/S: Caesarean section	**Location of birth** HC: Health Centre CH: Central Hospital HB: Home birth
Chisomo	18-25 years	32 weeks	7.5 months	2 pregnancies 2 living children	2.2 kg	VB	CH
Bridget	31-35 years	32 weeks	7 months	4pregnancies 4 living children	Unknown	VB	HB
Anna	26-30 years	28 weeks	6 months	3 pregnancies 3 living children	1.175 kg	VB	HC
Miracle	18-25 years	35 weeks	8 months	3 pregnancies 3 living children	2.1 kg	C/S	CH
Manny	18-25 years	34 weeks	8 months	3 pregnancies 3 living children	3 kg	VB	HC
Malita	18-25 years	33 weeks	8 months	1 pregnancy 1 living child	2.5 kg	VB	HC
Mary	31-35 years	35 weeks	8 months	4 pregnancies 4 living children (twins in most recent pregnancy; one baby passed at birth)	2 kg	VB	CH
Faith	Greater than 36 years	36 weeks	8 months	2 pregnancies 2 living children	1.6 kg	VB	HC
Ruth	18-25 years	36 weeks	8 months	1 pregnancy 1 living child	2.5 kg	VB	HC
Grace	26-30 years	35 weeks	8 months	3 pregnancies 3 living children	2.8 kg	VB	HC
Alinafe	26-30 years	36 weeks	8 months	2 pregnancies 2 living children	3.6 kg	VB	HC
Nelly	18-25 years	33 weeks	7 months	2 pregnancies 2 living children	2 kg	VB	CH
Sevelia	31-35 years	35 weeks	8 months	4 pregnancies 4 living children	Unknown at birth; 2.3 kg one month postpartum	VB	HB
Belita	26-30 years	34 weeks	7 months	3 pregnancies 3 living children	3.1 kg	VB	HC
Pemphero	18-25 years	36 weeks	8 months	1 pregnancy 1 living child	2.3 kg	C/S	CH
Maude	31-35 years	35 weeks	8 months	4 pregnancies 5 living children (2 sets of twins (This pregnancy: twins; one baby passed at birth)	1.5 kg	VB	Outside of home; on route to hospital

6.3 Being-in-the-world of birth

Each woman, each mother, had a distinctive narrative to recount. Their words were thoughtfully conveyed in this study, representing their truth at the moment they were shared. Despite the uniqueness of each individual's story, a common thread resonated throughout. Consequently, I aimed not to merely 'assert' my interpretation of the findings. This felt inauthentic and incongruent with hermeneutics. Crowther et al. (2016) contended that a phenomenological story can accompany a reader to experience a deeper understanding of a phenomenon. Furthermore, as meaning can evolve over time, we can never reach a 'final' interpretation of a phenomenon. As such, it was considered that the use of the journey metaphor was a meaningful and discerning way to illuminate the phenomenon in a hermeneutical manner. The 'unexpected journey' metaphor is my interpretation of the meaning of the experience of preterm birth for mothers who participated in this study. It is a fusion of horizons of both my preconceptions and the contextual variations of each birth story. The following figure (Figure 7) encapsulates the mothers' unexpected birthing journey encompassing the themes of *something is wrong*, *the unforeseen birth*, *walking through the unknown*, and *stepping into the clearing*.

Figure 7

The Mother's Journey

The mothers in the study experienced a unique journey. The women shared that birth itself was predictable; they knew it was *eventually* going to occur. However, their stories demonstrated the precariousness of the experience, the unpredictability of the expected journey. There was an innate assumption, an expectation as such, that the women would birth their babies at the time assigned by the medical staff. However, there was a moment that emerged when the mother would recognise that something was wrong. This point in time varied between mothers. As mothers experienced their unforeseen birth, mothers stepped into a unique type of unknown or unfamiliar territory. Finally, mothers emerged into a new phase of their experience, a clearing. The following table (Table 7) presents the findings, branching from the overarching theme of *the unexpected journey.*

Table 7

Comprising Themes, Sub-themes, and Categories

Themes	Sub-Themes	Categories
Theme 1: Something is wrong	"Labour can happen at any moment"/Recognition	Firm belief in due date
		Suddenness/abruptness of labour and birth
		Confident in own knowledge
		Consulting family/friends for reassurance/confirmation
		Perceived to be unrelated to pregnancy
	Fear	Inconsistent information
		Language
		Not addressing information/lack of effective communication/left in limbo
		Unsure what was going to happen/uncertainty
	Seeking help	Not being believed/not taken seriously/dismissed
		Treated for another condition
		Refusal of care
		Dehumanising treatment/loss of agency
		Personal invasion
		Good care
Theme 2: The unforeseen birth	The robbed moment	Birthed away from home
	Unprepared	Lack of resources (baby clothes, money)
Theme 3: Walking through the unknown	Feeling helpless	Lack of control
		Managing birth alone
	Feeling stigmatised	Judged by others/scepticism
	Fearful (of) (for)	Baby's health/possible death
		The future/what is to come
		Getting caught/getting into trouble
		New experience/reality
		Being mocked/potential associated stigma
		Others handling baby
	Burden of responsibility	New caring responsibilities
Theme 4: Stepping into the clearing	Acceptance	'It was my time'
		'Out of my control'
		(Giving birth) Only option/Only way out
		'Just had to happen this way'/It is what it is
	Normalisation	Past familial experiences (of PTB)
		'It happens'
		New ways of knowing
	Coping	Faith
		Support
		Baby's growth and development
	Hope	Following hospital guidelines/medical advice
		Future possibilities
		Success story
		Not treated differently/ "Like a normal baby"
	Transformation	Taking back control/taking back future

This section has introduced the participants and provided an overview of the findings which emerged from our research conversations. The subsequent section will explore the themes and sub-themes in-depth, with excerpts from the mothers' narratives.

6.4 Transcript alterations

The use of ellipses (…) within the quotes represents a continuation of thought by the participant. The mother's words were not altered. Rather, answers were integrated for clarity, to recount a series of events, or to elucidate a thought following a probing statement. Brackets within the text were added to provide further clarity or to anonymize personal details. For example, medical site names were removed, replacing their official names with either [Central Hospital] or [Health Centre]. Children's names were also replaced with [child's name].

6.5 Their stories: Theme 1: "Something is wrong"

The following theme provides a reflective context of the worldviews mothers held, leading up to the moment of recognition that "something was wrong" in their pregnancy. This period was different for each participant. Some mothers, both first-time and experienced ones, expressed confidence in their personal ways of knowing. Other mothers, who had never given birth too soon before or had never been pregnant, were unsure of what they were feeling and perceived it to be unrelated to the pregnancy. The issues to be discussed in this theme are the varying ways mothers recognised that 'something was wrong', and the factors influencing their fear, contextualised through their embodied and experiential knowing.

6.5.1 "You never know when labour can happen"

6.5.1.1 Firm belief in due date

When mothers were generally asked about their experience, many described the hours, days, and even weeks prior to the birth of their child. The women discussed their everyday lives of caring for children, tending to the home, and going to work. The vast majority expressed their assumption that they were to give birth at nine months. This expectation was often reflected by mothers' firm belief in their due date. Health workers from the local health centre would provide an estimated due date, generally expressed as a specific week within the month (for example, Bridget was expected to give birth the first week of July). Certain mothers, who may have had an ultrasound at some point in the pregnancy, were provided with a more specific date. It was noted that mothers appeared to hold those estimated due dates with great esteem, as reflected in Bridget's thoughts and actions.

I was told at the antenatal clinic that my due date would be the 4th of July and, as such, I should be prepared by the end of June. Since labour can start at any moment which you never know when that [labour] could happen, July was just an estimate. So, that's what was on my mind: that I should prepare in June and the baby would be born in July. The same week of my last visit to the clinic (in early May), I got a message that my mother had passed away in [a neighbouring country]. I started off to [the neighbouring country] to make the funeral arrangements, but I had not carried anything related to preparations for the baby. **(Bridget)**

In Bridget's case, medical professionals had estimated her due date to be July 4th. Although she recognised that "labour could start at any moment", she expected to give birth in or around the beginning of July. With the passing of her mother, Bridget was anticipating her baby to be born at a pre-established time, and, as such, left for the neighbouring country with no preparations made for the birth.

This firm belief in their due date, and the knowledge provided to them by healthcare workers, appeared to be a common theme for many mothers. Moreover, it is plausible that some mothers even disregarded signs of labour, under the assumption that they would not give birth until their due date, a specific predetermined time. For example, Sevelia retrospectively recognised that the signs she had been experiencing prior to giving birth were signs of labour. However, she did not associate her symptoms to be related to labour based on her due date. Miracle also held firm in her belief of her due date.

At first, I felt tired. That was at the beginning of the eighth month of my pregnancy. I never thought they were signs of labour. (…) I was told I was to only give birth the next month. **(Sevelia)**

My due date was the 20th of November as advised by the midwife during the antenatal clinics. I was not expecting to deliver this early in October. **(Miracle)**

However, the particular language Sevelia used in her reflection should be noted: "I was told I was only to give birth the next month". In the context of medical authority, this sentence suggests that the information Sevelia received from her doctor was considered an authority in establishing her expectations for her due date. Jordan (1993) asserted that the dominant group within healthcare holds the power to control what knowledge holds the most weight. As such, Sevelia's response of *"I was told"* suggested that she accepted the doctor's authority of his knowledge of when she was to give birth. Authoritative knowledge will be further explicated in the Discussion Chapter.

6.5.1.2 The suddenness/abruptness of labour and birth

One aspect of the mothers' stories was the description of the 'suddenness' of their labour. Several of the mothers reported their signs of labour as sudden, catching them by surprise. Both Maude and Alinafe recognised, however, that something was indeed wrong.

It started when I was asleep at home. I woke up only to find that my water had suddenly broken and I immediately told my in-laws. I was staying at my husband's home. I knew something was wrong. We immediately started off to the hospital. But before we reached the hospital, things got worse. I could no longer walk because the babies had already started coming out. We had to stop and both babies were born along the way. **(Maude)**

I started suddenly feeling sick (…) I started feeling backaches and lower abdominal pains and then I was bleeding (…) I thought it was a dangerous sign because, from what I know, a pregnant woman is not supposed to suddenly bleed during the pregnancy. **(Alinafe)**

Bridget, who had travelled to a neighbouring country to mourn the passing of her mother, explained the 'suddenness' of her journey. On the same evening of her arrival, she began to feel unwell and subsequently gave birth to her son. As an experienced mother, she recognised her own signs of labour; however, her experience rapidly intensified beyond her expectations.

When I arrived in [the neighbouring country], the same evening, I started feeling body pains. Then, I started feeling very cold and was shivering. Since it was an emergency trip, I had not carried with me clothes that would keep me warm. I informed my relatives about the situation, and they said that there were no nearby hospitals that we could go to. By 8 or 9 o'clock [the next day], I felt so cold and was unable to stand or walk. My relatives carried me into the house immediately. I started feeling labour pains. I recognised them because I had had other children. (…) My legs were swollen. I was feeling pain on my things and lower back. (…) Within a short period, I gave birth to a baby boy. (…) I had travelled together with my sister, so she was the one who assisted me [to give birth]. I progressed so quickly and ended up having a home birth. **(Bridget)**

The swift progression of Bridget's labour on the very day of her arrival appeared to have left her both shocked and concerned, prompting her to rely on her maternal instincts and past childbirth experiences. Despite her familiarity with the signs of labour, the unexpected acceleration of birth surpassed her previous experiences, emphasising the unpredictability and intensity of her childbirth experience.

6.5.1.3 Confident in her own knowledge

While not expected, a few participants recognised the sudden changes to their body as signs of labour and were confident in their knowledge of what steps needed to be taken. For Mary, after her contractions had begun, the rupturing of her waters was the confirmation she required to know she was in labour.

I started feeling pains in my abdomen. (…) I knew that they were labour pains and I that I needed to go to the hospital. My heart was beating fast and I felt very hot in my body. Whilst there [at home], my water broke out, which confirmed to me that I was in labour. **(Mary)**

6.5.1.4 Consulting friends or family for reassurance/confirmation

Conversely, other mothers were more unsure and consulted trusted women in their family or village for reassurance or confirmation. Malita, for example, was unsure of her embodied knowing, as this was her first pregnancy.

I started experiencing signs of labour on Monday, but I was not sure of what to do because it was my first time to experience that. The situation got worse on Tuesday, and then I decided to inform my [older, female] neighbour who told me that I should not be worried because my pregnancy was still in its eighth month and not the ninth month. **(Malita)**

The advice provided, while likely well-intentioned, might reflect a cultural or local belief about the timing of labour and pregnancy duration. It may even reflect the biomedical authoritative knowledge ingrained into community life that the doctor's word is unquestionably accurate.

Pregnancy enhances a woman's bodily consciousness significantly, acting as a revelatory experience that intensifies her sense of embodiment (Warren & Brewis, 2004). In this context, embodiment refers to the deep, intuitive understanding that arises from the bodily experiences of pregnancy and birth (McClean & Mitchell, 2018), also signifying a societal phenomenon that elucidates the intricate connection between an individual's body and the broader social fabric (Neiterman, 2012). It suggests that while human bodies shape society, social norms and structures also leave a lasting imprint on human bodies (McClean & Mitchell, 2018; Neiterman, 2012).

6.5.1.5 Perceived illness/unrelated to pregnancy

There were some participants who recognised changes to their bodies but did not associate it with their pregnancy. For example, Chisomo was experiencing oedema in the later part of her pregnancy. While she understood what was experiencing was abnormal, she sought help for an illness perceived to be unrelated to the pregnancy.

I was very sick before giving birth. Everybody was aware of my condition as I had become swollen. I went to the hospital and thought it had nothing to do with the baby.(…) I was only expecting to receive blood pressure treatment, not to give birth. **(Chisomo)**

The mothers' intuitive sense that something was awry was expressed through various forms of understanding. Several sought counsel from their families, relying on communal knowledge, while others relied on their own embodied experiences. Some mothers even acknowledged that they felt something was wrong, although they linked it to

other health concerns or dismissed its relevance to their pregnancies. One thread, however, that all mothers expressed in their recognition that something was wrong was the sentiment of fear. This sub- theme will be explored in the next section.

6.5.2 Fear

The sentiment of fear, and fear of the unknown, is woven throughout the birthing journey. Vulnerability was palpable in the mothers' stories. However, the fear revealed by the participants was expressed in different contexts according to her own experience. The fear associated with 'something is wrong' was generally focused on a period of time before the birth, depending on the experiences of the mother leading up to the birth. Apart from one participant, who briefly discussed her fear over the lack of resources prior to her birth, mothers focused on the uncertainty of their situation, their vulnerability, and the distress of a possible negative birth outcome. Once the baby was born, it appeared that women acquired a new array of fears, particularly that of an unknown future.

6.5.2.1 Inconsistent information and language

While hospitals and birth clinics were regarded by the women as preferred locations to give birth, there was a powerful message of fear mediated by experiences with health professionals. Grace, for example, was in a constant state of worry due to the conflicting and inconsistent information she was receiving from the attending doctor.

I was worried about what was happening because when one doctor did the examination, he said I was ready to give birth and then another doctor came and told me a different story. I was wondering what was happening to me. (...) I was asked to go and buy medication that would induce labour (...) and another doctor came in and he said the drugs are not really needed. (...) When the health care workers were about to write a referral letter for me to go to [the central hospital], that's when another doctor came in and said, "No, this one will not go to [the central hospital]. She will give birth right here." **(Grace)**

This quote reflects the complex and potentially confusing nature of receiving differing medical opinions and advice from multiple health professionals. The inconsistency in the information provided by different doctors appeared to create uncertainty and anxiety for Grace, contributing to a sense of bewilderment and a lack of clarity about her situation. The varying recommendations for induction medication further accentuated the confusion, as the expectant mother was left unsure about the most appropriate course of action for her specific circumstances. The conflicting perspectives from the healthcare workers demonstrate the challenges in providing consistent and unified care, potentially impacting the mother's trust in the medical decision-making process and creating added emotional distress during an already challenging time.

In Grace's story, it is important to note the language used by the medical staff member. A humanised birth entails acknowledging and honouring women's values, beliefs, and emotions while upholding their dignity and autonomy throughout the birthing journey (Behruzi et al., 2010). A doctor described her as "this one" and "she" when *they*, the doctor, were deciding upon Grace's birth options. Being referred to as "this one" was undeniably dehumanising and objectifying. Furthermore, it appeared Grace was not consulted or included in any discussion regarding her own birth. In fact, by using the third person, "she", it appeared the doctor speaking acted as if she were not present. Her agency and bodily autonomy were stripped from her. Coupled with the inconsistent information, Grace portrayed her fear through the language used by the doctor.

6.5.2.2 Not addressing informational needs

For Ruth, upon experiencing labour pains, she promptly sought medical attention at the health centre. However, her encounter with healthcare staff revealed a conspicuous lack of information or explanation regarding her labour, which caused immense uncertainty.

I left for the hospital straight away and was taken to an examination room to measure the cervix length which was six centimetres and I was advised to wait. I went for another examination [six hours later] where they noticed that the dilation had reduced to two centimetres. I spent a night at the hospital and the following morning at 6:00 another examination was done, of which the length was at 6 centimetres. I was advised to be doing exercises. I took a walk up and returned at noon. They did another examination which again came to six centimetres and was told to continue with the exercises. I continued with the exercise, even although I was in pain. I had another examination a few hours later and the length had reduced to four centimetres. (…) Because the dilation kept going up and down each time I had an examination, I was very afraid because I did not know what was going on. **(Ruth)**

According to Nunes et al. (2014), effective communication by maternity care staff can contribute to a positive birth experience for a woman during labour and childbirth. Ruth's account epitomised her sense of being in a state of uncertainty and feeling in limbo, exacerbated by her unmet informational needs during her preterm labour. The fluctuating measurements of her cervix, coupled with the inconsistent advice and lack of clarity provided by her healthcare professionals, left Ruth with a profound feeling of confusion and fear. The absence of a comprehensive explanation or a clear understanding of her situation prevented her from gaining control over her birthing experience, intensifying her feelings of helplessness and vulnerability.

This highlights the critical importance of effective communication and transparency in addressing the informational needs of expectant mothers, ensuring their active participation and informed decision-making during their labour and birth process.

6.5.2.3 Unsure what was going to happen/uncertainty

In keeping with the previous concept of poor communication, one mother was given an ultimatum by an attending doctor upon arriving at the health centre with signs of preterm labour. She was not left with any room for question or dialogue: give birth at the central hospital or risk your own life or that of your child. These were Pemphero's words.

[At the health clinic], they told us that if we stayed there and waited for the baby to be born, either the baby or I, the mother, would not survive. That's why we just agreed to go to [the central hospital]. It was painful for me to be in a position to pick one, so that's why I chose the option to go to [the central hospital]. **(Pemphero)**

This particular scenario is an example of intense fear experienced by expectant mothers when seeking help at the health centre. Pemphero was confronted with a life-threatening ultimatum during preterm labour, by an individual in power. This confrontation, which essentially stripped her of power and control, further intensified the already heightened sense of fear and vulnerability associated with preterm labour, emphasising the profound emotional impact and challenges faced by expectant mothers in such critical moments. Pemphero's experience is also reflected in the following theme "seeking help".

6.5.3 Seeking help

In the context of maternal healthcare in Malawi, the experiences of expectant mothers often reflect a complex narrative encompassing being disbelieved and not being taken seriously when seeking help, leading to dismissive attitudes, treatment of unrelated conditions, or refusal of essential care. This process, sometimes marked by dehumanising treatment and a loss of agency, can further manifest as a sense of personal invasion. The following sub-themes will reflect the care received when seeking healthcare.

6.5.3.1 Not being believed/not taken seriously/dismissed

Before giving birth, Manny was experiencing abdominal pain. However, on her first visit, she was not provided with any treatment and was sent back home. Subsequently, Manny returned to the hospital due to persistent pain. Here is her experience.

Just a few days before giving birth I came here at the hospital to seek treatment because I was feeling stomach pains, but I was not given any treatment so I went back home. I came again with the same stomach pains and at night labour started. The doctor told me I would have a preterm birth. ***(Manny)***

Not being believed or not being taken seriously during pregnancy can be an extremely distressing experience for women. When their concerns are dismissed, it can lead to heightened anxiety and feelings of vulnerability. A study by Merone et al., (2022) found that women experiencing chronic pain felt that their pain and suffering were disregarded in healthcare settings, leading to emotional distress. Consequently, many have developed a fear of seeking medical help due to their negative encounters with healthcare services.

6.5.3.2 Treated for another condition

Mothers in this study were also dismissed or not believed in their own embodied way of knowing. A few mothers expressed how they presented themselves to the hospital with labour pains but were subsequently ignored or dismissed and tested or treated for another condition.

It all started when I experienced water discharge. I went to the hospital, but once there, the doctor said it wasn't time for me to give birth so he conducted a malaria test on me. The results were negative. At around 12 am, the doctor did a vaginal exam. At this time, the vaginal way was not dilated but the doctor said we should wait. At around 6 in the morning, another doctor came in and after doing another vaginal exam he realised that I wasn't dilated and I did not have malaria. I was then asked to go and buy medication that would induce labour. My mother went to buy the medication at the pharmacy. At that time, I was in panic. I was having difficulties breathing, so another doctor came in and said the drugs are not really needed. **(Grace)**

Grace's ordeal at the hospital presented a distressing account of the complexities and challenges often encountered within healthcare systems. The initial focus on conducting a malaria test, while her symptoms indicated labour, illustrated the confusion

and misdirection that can arise during critical medical evaluations. The subsequent discrepancies caused by not listening to Grace's experience and signs of labour led to the unnecessary purchase of labour-inducing medication, reveal the potential for miscommunication and the resulting emotional turmoil experienced by the patient.

6.5.3.3 Refusal of care

Anna presented herself to the hospital for bleeding when she was five months pregnant. In the wake of COVID-19, she was refused healthcare because she did not have a mask. When she managed to procure one, her embodied knowing, as was highlighted with other mothers, was dismissed, and she was subsequently 'investigated' for another illness.

When my pregnancy was 5 months old, I started to lose blood. When I went to the clinic, I was sent back because I didn't have a mask and I didn't have money to buy one. I went again the next day and they prescribed Fansidar [antimalaria medication] for me and then I stopped momentarily losing blood. I started to lose more blood again after a few days and I started to lose water. I went back to the clinic, and they called an ambulance for me. **(Anna)**

Anna's experience highlights the challenges pregnant women face, especially when seeking timely and appropriate medical care. The initial setback due to the lack of a mask demonstrates the intersection of socioeconomic factors and healthcare access, indicating the barriers that individuals from underserved communities may encounter when trying to access essential services.

6.5.3.4 Dehumanising treatment/loss of agency

When Belita was giving birth, it appears she experienced dehumanising treatment by a nurse who was providing care. She was verbally abused, while also not being listened to when describing how she was feeling.

Before the baby was born, I was with my guardian. Every time I started feeling like I'm about to give birth, my guardian would call the nurse. Several times she called the nurse, the nurse would come quickly and then leave saying "I was not yet ready to give birth". At one point, she shouted at us. Later, I felt that the birth was starting. We called but it took her [the nurse] time to come. When she came, the birth had already happened. I told her that I had been calling for several times before the labour started but she didn't want to help me. The nurse simply replied by saying "you were not ready to go into labour when you were calling me." (…) At that moment, inside my heart, I was wishing if they could just send me to [the central hospital] because I wasn't really seeing the help that they were giving me. **(Belita)**

Belita's words highlighted her frustration and perceived lack of support from the nurse during her labour process. Her statements conveyed a sense of feeling neglected and misunderstood, particularly in the moments leading up to the birth. Experiences like this one can significantly impact a mother's well-being, both during and after childbirth, potentially negatively affecting future birthing experiences.

6.5.3.5 Personal invasion

Some of the mothers expressed how they were subjected to numerous vaginal examinations. This appeared to be quite a traumatic experience and a personal invasion.

The labour pains started at home. When I came here at the health centre, the doctor examined me almost five times. I was told that they could not find the way [had not dilated]. (…) Doctors were changing shifts [at the health clinic], so another doctor came in to test me for malaria and high blood pressure. The malaria test was negative but my blood pressure was high. I was therefore told to wait for some time. If it failed [continue to not dilated], then they would send me to [the central hospital]. I was then told that I was not ready to give birth because the way could not be found. But I told them that the feelings in me were labour pains and not just malaria. So, they kept me for observation. I was in so much pain. **(Faith)**

Faith's narrative vividly portrays the profound sense of personal intrusion and dehumanisation experienced during her childbirth journey. The repeated examinations conducted by various doctors highlighted the challenges faced in respecting the privacy,

dignity, and autonomy of expectant mothers. The prioritisation of testing for malaria and high blood pressure, while necessary for medical evaluation, demonstrated the clinical focus overshadowing the emotional and psychological needs of the individual. Faith's persistent description of her symptoms as labour pains, met with scepticism, highlighted the significance of validating and respecting the lived experiences and voices of women during childbirth

6.5.3.6 Good care

Mothers also discussed the 'good care' that they received when seeking healthcare. One point which stood out was Sevelia's description of the care she received when giving birth at her neighbour's home.

The situation got worse at around eleven o'clock, but I was able to stand up and asked people escort me to the hospital. After walking for a short distance, my legs went numb, and I couldn't walk any more. We asked for permission to deliver at the nearby [neighbour] house. We were warmly received, and she provided us with space. A woman at the house helped me give birth. She was so caring, and she did everything until my baby was born. She had the necessary protective materials, and she did everything well that I couldn't differentiate with giving birth at the hospital. I received almost the same care and treatment I would have got at the hospital. **(Sevelia)**

This is in stark contrast to other experiences where mothers lacked agency or were personally violated during vaginal examinations. The following theme, the unforeseen birth, will further explore mothers' 'robbed moment' of birth and the impact of feeling unprepared.

6.6 Theme 2: The unforeseen birth

This theme investigates mothers' narratives of unexpected childbirth. The mothers expressed feelings of unpreparedness and described how the experience deviated significantly from their expectations, resulting in a sense of having their anticipated moment taken from them. Additionally, they addressed the substantial financial challenges precipitated by the premature birth and its unforeseen circumstances.

6.6.1 The 'robbed moment'

6.6.1.1 Birthing away from home

Mothers were interviewed using unstructured interviews, consistent with hermeneutics, to further explore their views of having a baby too soon. While the description of their birth was briefly discussed, most mothers accounts appeared to reflect two main sub-themes: the 'robbed' moment, or the lack of joy, and being unprepared. Being a former neonatal and obstetrics nurse, I had thought there would be more focus on their physical birth experience. After all, birth is a natural, physiological experience. This was not the case, as all the participants focused on the period after the birth. Within their words of the unforeseen birth, I interpreted vulnerability. Many of the mothers were away from home, were denied a guardian[15], and were threatened with the fear of the immediate unknown. This was not the joyful moment they had planned. The following section will review previously stated sub-themes of the 'robbed' moment and being unprepared.

According to Crowther (2019), birth creates a world united by a sense of belonging and community. The birthing process is generally a communal event, grounded in the sense of connection with others. When this relationship is broken, there can be unease. The mothers in this study explored the central idea of joy and their relationship with others in

[15] A guardian is a female friend or family member who accompanies the labouring mother to hospital and assists in taking care of the mother and baby in the postpartum phase.

their birthing journeys. This concept of joy was expressed through the expectation of support from a partner or having a female companion at one's side during the birthing process. For example, Malita's husband did not wish to be at the hospital while she gave birth. She had expected her partner to be by her side, which greatly impacted the joy she felt when giving birth.

He [husband] was not cheerful, or jovial and never cerebrated the birth of the baby like most men do when their wives have given birth. (…) I was saddened by his behaviour. **(Malita)**

The presence of COVID-19 imposed certain restrictions within the clinic and hospital setting. This included a ban on most guardians and visitors. Within Malawi, a female companion is commonplace to assist during the birth and recovery process, to provide meals, and to support the mother with her baby. Mothers were stripped of their support system, gravely affecting their experience of birth. These are Miracle's words.

It was a bad experience because when one has given birth, you expect someone to be there to celebrate with you and to assist in taking care of you and the baby which was not in my case. This is why I wanted to be discharged so that I could recover from home with my family. (…) I was lacking food because they were not allowing any visitors or guardians at the hospital due to COVID-19. My younger sister would sometimes manage to give me food through the window. Although some other times she was sent back by hospital attendant before giving me the food, so a day would go by without me eating food. **(Miracle)**

For Anna, being away from home and not having a guardian or support person appeared to increase her fear and sense of vulnerability. Immediately after the birth, she was affronted with the fragility of her child's health and the fear of what was to come.

I was not allowed to have any guardian to support me in this. I was very scared because some babies who were born too soon were dying in front of us. These babies that were dying were looking to be in a better condition than my baby, so I was scared that I might lose my child. **(Anna)**

Most mothers elucidated that their birthing story was not what they expected. They expressed that there was little joy, if any, which was further magnified by a lack of community or spousal support. This lack of support appeared to create a sense of vulnerability. Furthermore, their vulnerability was escalated by a sense of being unprepared.

6.6.2 Unprepared

6.6.2.1 Lack of resources

At the moment of birth, a majority of mothers described their 'unpreparedness' in relation to material aspects; not having the expected resources, clothes, or household items prepared for the baby. However, mothers also expressed their emotional and psychological unpreparedness of their experience. Their births were sudden. Some mothers birthed very shortly after experiencing changes to their bodies. While mothers recognised that something was wrong, and sought assistance, most of the women were not anticipating to give birth before their prescribed due date. For example, Mary was only planning on gathering the baby's necessities in the weeks prior to the expected due date. To her surprise, she then discovered, as she was in labour, that she was to give birth to twins.

I was nervous as I did not expect to give birth so soon and I was not fully prepared for the arrival of the baby. (…) I was not prepared and ready to have a baby at that time as I had planned to start buying the necessary baby items the following months. I had no [baby] clothes or baby basin. (…) I was not prepared to have the baby yet but also I did not have enough resources to support two babies. **(Mary)**

Bridget, who experienced the sudden passing of her mother, had to travel to a neighbouring country to support her family. She reflected on the fact that 'there were no signs' that a birth could be imminent. The concept of 'being prepared' appeared to an important value and discussed the implications of having a baby too soon. Consequently, Bridget gave birth in another country, interfering with the plans of burying her beloved mother.

I did not anticipate this to happen to me in a foreign land as my visit was to attend my mother's funeral. I did not carry anything with me for the birth of a child. Neither did I think of buying stuff right there because there were no signs that I might give birth whilst there.(…) It is a painful experience because you plan to give birth at the normal ninth month and not earlier than that. As a result, it happens when you are not fully prepared. {…} Preparation is important for a birth just like when we are expecting a visitor. I was prepared to give birth after nine months which would have given me ample time to get organized and buy baby stuff. But instead, the baby was born too soon, which was a bit of a problem. **(Bridget)**

Maude described how she felt giving birth on the way to the healthcare facility. She was assisted by a traditional birthing attendant who lived nearby. She expressed that her "heart was not ready", while giving birth extremely quickly. It appeared Maude was illuminating how the precariousness of her experience did not allow her to fully prepare or process the birth. There were several overwhelming factors to consider in her birthing journey.

I felt very uneasy and worried. It was in June; the cold month. I was very worried that the babies might not survive in the cold. Giving birth on the road and in the cold season really worried me. The other thing was the way it happened. It happened as if I was given a labour inducing injection. That troubled me so much. My heart was not ready. **(Maude)**

Sevelia also gave birth on route to the hospital. These were her thoughts about feeling unprepared.

I planned to leave for the health clinic right away, but I had no means of transport and that was the challenge. I had no money to hire a vehicle, so I decided to start walking. (…) *I was scared because I was not fully prepared. My partner left me when I was three months pregnant. The work that I do wouldn't fully support for timely preparations for the baby. That made me more worried.* **(Sevelia)**

However, the idea of 'unpreparedness' expanded as their stories were explored and mothers transitioned into the next step of their experience: the 'unknown'.

6.7 Theme 3: Walking through the unknown

As the participants journeyed through their birthing experience, all mothers appeared to transition into a period of 'unknown'. It was characterized by feelings of helplessness, stigmatization, fear, an increased burden of responsibility, and feeling unsure. Not all participating mothers experienced or discussed these concepts. However, each story was highlighted by some form of 'unknown' after their birth. These sub-themes, and what they meant for the mothers' experiences, will be explored further.

6.7.1 Feeling helpless

6.7.1.1 Lack of control

In feeling helpless, mothers explored how they felt a lack of control while being in hospital. Several mothers had to stay in the hospital while their child was receiving medical care. They were not able to provide care for their child on their own schedule. Mothers were required to report to the special care unit at certain times, every two to four hours, as appointed by the medical staff. Mothers' intuition, women's way of knowing, was denied while they were in hospital. They were under the control of the medical authority's regime. This was Miracle's experience.

Most of the women had their babies in the Kangaroo Care ward. They had to breastfeed them every 2 to 4 hours, as instructed by the doctor. For me, that was a bad experience because we were not able to attend to the babies when they were crying outside the scheduled times. (…) Whenever babies cry, we are supposed to breastfeed them to help them stop crying. But in the Kangaroo Care, they were left to cry until the time the mothers were scheduled to go in and breastfeed them or change their diapers. (…) I got tired of being in the hospital and wanted to be discharged home. (…) During my earlier days at home, I started feeling pain in the stomach, but it was a good experience because I had a guardian who was able to take care of me and my baby whenever I was not feeling well. **(Miracle)**

In Miracle's account, it appeared her sense of control was partially regained when she returned home. This is not to say that everything was resolved upon returning home. However, Miracle stated that being at home provided a level of familiarity and opportunity to be cared for by family members. This comfort revealed to be a supporting factor in Miracle's journey through the unknown.

Malita, on the other hand, faced a distressing unknown situation after the birth of her first child. While she birthed without the support of her husband, it appeared Malita was unprepared for what was to come. Malita expressed how she was treated upon discharge from the hospital with her baby, returning to her husband's village.

I did not receive any support even during the time I was in the hospital. My husband never visited us and he did not even provide the name for the child until the day we were discharged. As a result, I had to name the child myself since it is a requirement to do so before being discharged. I was not welcomed at their home and nobody supported me because my husband was claiming that the baby was not his. He advised all his relatives to stay away from me. I continued staying there up to the point where I could not even afford laundry soap. (…) There are times I would go to sleep on an empty stomach. **(Malita)**

Contrary to Miracle's experience, it seemed Malita did not regain a sense of control once returning home. In Malita's case, she was at the mercy of her husband and the community, shunned and stigmatized by others, to the point of destitution. This sense of

insecurity was forced upon her, initially while in hospital. Her power and agency were further stripped once she returned to her husband's village. This would have caused immense emotional pain, fear, and uncertainty for Malita and that of her child.

6.7.1.2 Managing it alone

The feeling of 'helplessness' was discussed in the uncertainty of managing things alone. This was highlighted by mothers emphasising that not being in their own environment created a feeling of not being in charge of the situation. For example, Bridget expressed that the absence of her husband, who was in long term care, and the birth of her child in another country, caused her great distress.

I gave birth in a foreign land where I had no access to medical care and I was not able to buy baby stuff. This was the saddest thing was giving birth unexpectedly apart from the absence of my husband. I did not have my own baby stuff to use during her birth except the ones that were provided by well-wishers. (…) Initially, I was hoping to visit the hospital [before leaving] but my family told me that it would be difficult to visit a hospital when you have given birth at home and while being a foreigner.

She continued:

My family [in the house] advised everyone not to let people know that I had giving birth because I was not a resident of [the country]. It could have not gone well with the authorities.(…) I had to hide indoors during the few days we were there, as we did not want the chief to know about the birth of my baby. I could get into trouble with him [the chief]. **(Bridget)**

While Bridget demonstrated immense strength when speaking, there appeared to be sadness in her voice. Bridget was removed from her core support system while having to bury her mother in the neighbouring country. She lacked the majority of her own belongings, depending on the generosity of others. There was no celebration or coming together of a community. Contrarily, she was required to remain hidden, subject to being in trouble with the local chief. This appeared to leave Bridget in a precarious situation, creating immense

fear of what was to come.

6.7.2 Feeling stigmatised

6.7.2.1 Judged by others

There was a common sentiment among many women who asked why they had given birth too soon. In their moment of unknown, many mothers asked God why they were being placed in this situation. Others asked the question as they came to terms with their new reality. Chisomo, for example, asked this question as she was walking through her unknown journey.

It was very hard to come into terms with it [having a baby too soon]. I was wondering as to why I had to give birth too soon when my first son was born in full term. **(Chisomo)**

This type of questioning appeared to be the result of many confrontations. Mothers not only feared ridicule, which will discussed later in this chapter, but faced direct stigmatisation. This had a profound effect on their journey.

The majority of mothers explored their experience of direct stigmatisation from family and community members. They illuminated how they were judged by others or faced scepticism about their pregnancy. Mothers were faced with questions by family, friends, and medical professionals as to 'why' they had a baby too soon. There was a sense of guilt and shame for participants. Faith was questioned by her doctor and compared her to other mothers in the hospital.

When I gave birth, the child was small and looked weak. Doctors said other women were giving birth to normal children despite being [HIV] positive, so what was my problem? I told them that it had just happened. I follow all instructions. **(Faith)**

Faith emphasised how she followed all the medical directives of the hospital. In turn, it came across that Faith was questioning her sense of self through the doctors' words. Faith asked "what was my problem?" to imply she felt she had an anomaly as she had not birthed a 'normal' baby. This type of self-questioning and scepticism continued with others in their community.

Sevelia spoke about how she faced judgment from community members when returning home. When probed, Sevelia revealed how she felt ridiculed for the size of her child.

Giving birth too soon is a burden because people speak badly about women with a baby born too soon. (…) Back home, people laughed at me. My pregnancy looked bigger than eight months and I never expected to give birth to a tiny baby. So, people laughed at me and spoke a lot of bad things about my baby. **(Sevelia)**

While community members also criticized the size of her baby, it emerged that Manny's family was accepting to the fact that she gave birth too soon.

They [Manny's family] accepted it because I did not plan for it and I could not control it. However, some people were so mean. They were saying, "You have given birth to a tiny and malnourished baby". **(Manny)**

Bridget encountered community disbelief that her child would not survive. Furthermore, because the baby's health was improving, she was accused of not being truthful of when she gave birth. It was also noted that her sister provided support during this distressing time.

Some people in the community were arguing that a preterm baby cannot survive. So they were of the opinion that I was lying to them the baby and that the baby was born at nine months. Some were saying a preterm baby can survive even if born at eight months. Although people had different thoughts and views, the good thing was my sister was on my side. **(Bridget)**

Two mothers, Ruth and Malita, had their children's paternity questioned by their husbands after the birth of their children. Ruth was accused of deceiving her husband as to when she conceived their child. He did not believe that it was remotely possible to birth a child too soon. Ruth emphasised that preterm birth could occur spontaneously, or that 'it does happen'. Additionally, while the participant attempted to explain this aspect to her husband, he was only convinced a further two months later, once he was informed of another preterm birth that occurred in another district. He was only convinced once a male friend had provided a similar example to his own. He did not trust his wife's knowledge or explanation of the matter.

He [husband] was very surprised, to the extent that he questioned the possibility of being the father, after having a preterm birth. I said 'it does happen'. At first, he did not believe me. He was of the view that I lied about the pregnancy the very first time I was telling him [of the pregnancy] and that I was really two months [further along]. It took him another two months to accept that it was indeed a premature birth after being convinced with justifications from other people. (…) I went to stay with my mum after being discharged from the hospital. When he visited us, he apologized for not believing me. He said he realised that it was possible to have a preterm birth after he became aware [from a male friend] that a woman in [another district] had given birth at 7 months pregnant. **(Ruth)**

Similarly, Malita's husband refused to support his child as the baby was born before the expected due date dictated at the health clinic. He denied paternity of Malita's baby. Subsequently, due to this belief, Malita's husband influenced the village to shun and abandon her and her baby. This is further explored in 'Feeling helpless' (section 5.8.1).

My husband was not supporting the baby because he said the baby was not his as the baby was born before the due date. **(Malita)**

Anna's friend confided in her that there was a belief that Anna had attempted to terminate her pregnancy on separating from her husband. Anna's display of a strong exterior was contrary to her fear felt internally. These are her words.

My friend told me that a lot of people in the community were saying that I took medicine and that I was trying to abort the baby. They were saying I was trying to abort the baby because my husband left me. But I told her [friend] that they were just saying those things because they did not know what I was going through. The truth is I was absolutely terrified when I was going through all that. **(Anna)**

While many mothers expressed concrete examples of experiences of stigma, a major concern for mothers was the fear of potential consequences of having a baby too soon. This aspect will be discussed in the subsequent section

6.7.3 Fearful of...fearful for

Every mother experienced some type of fear after the birth of their child. However, these fears were all associated with the 'unknown' of their unexpected journey. Mothers experienced fear of their child's health while they were in hospital and once discharged home. There were constantly enveloped by personal and community doubts that the baby would not survive. This had an impact on the mothers' wellbeing. For example, Faith and Nelly both expressed fear of the uncertainty of their baby's health.

When I was discharged, people at home started saying, "Where is the child?". They said many things to the effect of "From the child's look, it is doubtful that it would survive". They said my child would die [emphasized]. So, I lived with worries and in fear that I would lose the child. The community treated me as if I was the first person to have ever given birth to a premature child. **(Faith)**

I was worried because I was not sure if my baby would develop without any problems. **(Nelly)**

Alinafe stated that her family expressed relief that she and her child had survived this experience. Evidently, there was fear of death of the mother or the child by Alinafe's family.

We were all happy that both me and the baby were alive. (…) What I mean is that based on what happened to me at the hospital and the experience I went through, they [her family] were happy that both me and the baby survived. **(Alinafe)**

Anna also described her experience in a similar fashion. However, she further alluded to the unfamiliarity of her situation. This was stressed as a new experience not only to Anna, as a mother, but to her family as well. The unknown territory was a new experience for all. It appeared that the lack of knowledge or specialized understanding for the care of a preterm infant created further fear and confusion.

I was scared because it was a new thing to me. In my family, nobody had ever gone through that before and the baby was very small and delicate. I was asking myself if the baby was ever going to grow up properly. I had a lot of unanswered questions. (…) I wasn't sure if my child was going to die or survive. **(Anna)**

Most mothers discussed the fear and the potential impact of cold on the health of their babies. All the participants emphasized the importance of keeping a preterm baby warm in the weeks following the birth. Furthermore, most women stressed the value in following medical directions. Manny, for example, linked the significance of following hospital advice and the fear of allowing other family or community members to carry her baby. She doubted the ability of others to replicate the same level of care she had been providing. Additionally, Manny displayed apprehension of freely allowing all to care for

her child due to fear of ridicule and stigmatization. These are Manny's thoughts.

We fear that the baby may feel cold and some people may say bad things to you for having a preterm birth. I was also scared of anybody carrying the baby. (…) When some people carry the child, they may not follow the advice that I was given at the hospital. Also some could see the baby and say some disrespectful things about the baby's weight. Others may laugh at you. **(Manny)**

Initially, it appeared that Chisomo was very well supported after she gave birth. However, upon further discussion, Chisomo continuously emphasized throughout her story that she was *visibly sick*, and that her preterm birth was accepted by her family and community for this reason. She further revealed that had she not had visible oedema, there was the potential for stigmatization. Chisomo alluded to the idea that hiding a pregnancy, due to infidelity, and having certain diseases could be grounds for associated stigma for having a baby too soon.

There were no negative experiences because I was visibly sick. Had it been that I was not sick, there could have been some negative experiences. For instance, people could have thought that the pregnancy was due at a later date, but that I had given birth sooner because I had been hiding the pregnancy; because it was not my husband's baby. There could have been such kind of suspicions. (…) If people were not aware of my visible health problem, they could have thought I had other kinds of diseases. **(Chisomo)**

Pemphero was a mother who did not wish to disclose to her extended family that she had given birth too soon. Apart from her mother, sparse details surrounding the birth were extended to others. Upon further probing, Pemphero illuminated the fear that she faced about having a baby born too soon.

We never told them that the baby was born too soon; we just told them that the baby was born and now we have been discharged (…) I didn't want to tell anyone. (…) I live in the village. If you tell everyone that the baby was born preterm, then witches may attack the baby. (…) People believe that babies born too soon are easy targets for witches. If the baby dies, they have a reason to say that the baby died because it was born too soon. (…) Those who practice witchcraft come and visit the baby. If they know that the baby was born too soon, they ask questions like, "Why was the baby born too soon yet your abdomen was big?" And that's when they go and do their witchcraft things. (…) They can kill the baby. **(Pemphero)**

Most mothers discussed fear of their baby's death from a medicalized view. For example, most mothers discussed these fears in terms of weight, size, and development. Contrarily, this was not the case for Pemphero. While she also experienced a fear for her child's health and wellbeing, Pemphero's fear was rooted in traditional beliefs. She feared that if it was disclosed that she had given birth too soon, her child would be sought out by witches and could potentially die because of witchcraft. As a result, Pemphero chose to keep her birth a secret.

6.7.4 Burden of responsibility

6.7.4.1 New caring responsibilities for PTB

The burden of responsibility of having a child born too soon was a central concept as mothers were discussing this segment of their journey. The babies themselves were not the burden; rather, the increased levels of care required interfered with their resumption of daily tasks. In Malawi, babies would generally accompany their mothers or would be cared for by other community members. However, this type of birth altered the expectations of mothers' postpartum plans for her resumption of everyday activities.

Many mothers compared the care of a baby born at full-term to that of a preterm infant. Keeping the baby inside, warm, and away from non-household members were main points of perceptions of care for a baby born too soon. Furthermore, a birth weight of 2.3

to 2.5 kilograms or upon reaching their gestational due date was the period of time when mothers could resume daily activities or introduce the baby to the community. Many mothers also expressed that activities could be resumed if the medical team consented.

Mary, for example, emphasised the point of requiring to keep her newborn inside at all times, due to his perceived preterm status.

When you have a preterm born, baby you need to stay indoors with the baby for a long period of time. You have to focus all your attention on caring for the baby while a baby born at full term is allowed to go outside the house after a few days. **(Mary)**

The concept of 'restriction', or being able to leave one's house, was discussed in different contexts. Manny accentuated the ability to resume the chores and daily tasks quickly with a full-term baby. Furthermore, she highlighted the perceived freedom one might have with an at term baby, compared to the limitations of a preterm baby.

I was feeling emotional pain because it is a difficult to take care of the baby born too soon to reach the health of a full-term baby. (…) It's not a good thing because it is a big burden because there is a lot to do when you give birth too soon than when you give a full-term birth. (…) It is painful because for a full-term baby, I can leave her in the house as I do other chores and activities. But as for the preterm baby, it is difficult to do other chores and other activities while the baby is on the stomach [skin-to-skin]. **(Manny)**

Maude and Pemphero both had a similar rhetoric in their own journey.

I have learned that preterm birth is a problem. It makes the mother too busy taking care of the baby. The baby is not yet mature and the mother may not be carrying out some home chores because she must pay all attention to caring for the baby. **(Maude)**

When you have given birth to a preterm baby, you can't walk around with the baby outside. You just stay indoors. The baby needs to be kept warm at all times, and you can no longer work normally. While with a full-term baby, the mother is much more free. **(Pemphero)**

Ruth emphasised that certain tasks have to be reprioritised when caring for a preterm baby. Furthermore, she expressed the increased care required for the baby while in hospital.

You do not have spare time to do household chores as the whole time is dedicated to caring for the baby. You cannot go outside with the baby until a certain period. More time is spent in hospital in the Kangaroo ward. (…) Taking care of a preterm baby takes more energy as you need to dedicate all your time to the baby. When a baby is born full- term, you could leave the baby asleep and do other things. **(Ruth)**

While mothers discussed the burden of responsibility, they were adamant in following medical advice after birth; there was no room for interpretation. For example, Faith discussed how continuously performing skin-to-skin made it difficult for her to sleep. Furthermore, she compared herself to other parents, waiting for her moment to return to community life. However, while highlighting its burden to everyday activities, Faith never wavered in following the hospital's advice.

It was a burden for me because, even when I was sleeping, I had to keep the baby on my stomach for a month and two weeks. I was always indoors and I was coming to the hospital every Thursday for check-ups and weight checks. (…) You see, for you to sleep, you must sleep on your back. So, it was difficult because you are used to sleeping on your sides. It was a strange thing that, whenever you sleep, the baby must be on your stomach. Therefore, it was a burden on me. (…) I was envious of my friends who gave birth in full- term because I kept wondering how long it would take my baby to reach the size of my friends' children. That was a burden to me too. I could not go out far. I had to be in the house most of the time. Going out was only when I was going for a bath. **(Faith)**

All mothers grappled with a level of uncertainty in their collective birth journeys. While all individually different, there were echoes of similarity between them all. The unknown, defined by the mothers as feeling helpless, stigmatised, fear, and increased burden of responsibility, resulted in the mothers gaining a new found perspective and

knowledge base. This is not to say it was the end of their journey. Their journey continues to evolve. However, it provided a level of clarity as they stepped into a form of clearing.

6.8 Theme 4: Stepping into the clearing

'Stepping into the clearing', or the process of new understanding through another lens, was shared by all mothers during their journeys. This came to be in a variety of ways. Certain mothers accepted their preterm birth and encouraged others to normalise having a baby too soon. Other participants found a new form of strength through their hope, faith, and support from others. Lastly, a few mothers experience a transformative event, one characterised by reclaiming her knowledge and autonomy. These concepts will be discussed below.

6.8.1 Acceptance and normalisation

6.8.1.1 'It was my time', 'It was out of my hands' and 'It was my only way out'

Most mothers eventually described some form of acceptance and normalisation of their preterm birth. There was a familiar stoicism among the mothers, having a very direct view on the matter. Chisomo was quite familiar with the concept of preterm birth. Her mother had given birth to three children, all born too soon, and provided care and guidance to Chisomo. As such, she was very well supported at home. Furthermore, Chisomo even hinted that it was perhaps 'her time' to experience what her mother had endured.

This was not something strange to me as my mum had given birth to 3 children too soon, so it was my time to go through the same. (…) When I say "it's my time" I mean to say that I was not sure as to when I would give birth. But what I know is that at seven months, the baby is at least fully developed. It just had to happen that way, just like how it was with my mum. **(Chisomo)**

Chisomo discussed how her family and relatives were supportive because they recognised that she was ill. Having suffered from oedema in the pregnancy, or being

'visibly sick', Chisomo stressed that giving birth too soon was her 'only way out' of her illness.

Miracle was quite neutral when describing her situation, simply stating 'it is what it is' and that there was 'no choice' in the matter of her birth. She further stated that her family was neither excited nor solemn about the occasion. Rather, they took the event as a point of fact. However, she did emphasise that she would not be abandoned for having a baby too soon.

I had no choice but to accept the situation I was in. (…) It is what it is. They (her family) accepted the situation because it was out of anybody's control. They could neither be excited nor feel bad about it but instead accept it. (…) They could not have abandoned me and the baby because of the preterm delivery. **(Miracle)**

Furthermore, it emerged that there was an inherent acceptance of preterm birth as mothers journeyed through their experience. This was reflected through notions of 'it is what it is' and that preterm birth 'just happens'. Certain mothers focused on the fact that their child was born alive and healthy. Here are a few reflections of certain participants.

I cannot tell whether I would give birth today and tomorrow. Who knows? You eventually realise it just happens. **(Bridget)**

We accepted it because I did not plan for it, and I could not control having a baby too soon. **(Manny)**

I accepted the situation that I was going to give birth too soon. I was just happy that the baby was born healthy. She was a gift. **(Nelly)**

Bridget was challenged with having an unexpected birth in another country, while having to organise the burial for her mother. However, it seemed that she did not let these events overwhelm her. In the interview, Bridget alluded to the fact that she could not let

having a baby born too soon to get in the way of all the things she had to do.

The birth happened after having buried my mum. I was going through so much. But still, things needed to continue on and get done. **(Bridget)**

It is possible that family support facilitated the participants' views of normalisation. Several mothers expressed experiencing positive or 'normal' support from their family and community.

They all received me well; they were even coming to visit me and the baby. **(Nelly)**

People welcomed me and the baby very well. My husband and other relatives helped me from the hospital to help me carry the baby home. Once home, I was well treated by everyone and the case is the same now. (…) My husband's reaction was normal; he took it as if that's how it should have happened. (…) What I mean is that I told myself not to worry about the situation because it would not be good for my condition The best was to accept the situation as a will of God.(…) I just think that's the way it was supposed to happened **(Belita)**

For Ruth, her experience with her family was not altered by her preterm birth. Her family reminded her that she was not the first woman to have given birth too soon. This was not said in an aggressive or condescending way. Rather, it was expressed as a measure of comfort, a reminder that it happens to other women as well.

Nothing changed once arriving home. We were living as we used to be without any problems. Everyone encouraged me to take good care of the baby and reminded me that I was not the first person to give birth prematurely. **(Ruth)**

This was contrary to Malita's experience, who suffered greatly at the hands of her husband and the community. He ordered the village to have no contact with Malita, to shun her, and to not provide basic necessities of life. This situation was rooted in Malita's preterm birth.

I was not welcomed at his home. He was refusing to carry the baby and he was always shouting and was abusive when speaking to me. (…) He advised all his relatives to stay away from me. **(Malita)**Sevelia stressed that giving birth too soon could happen to any woman. As such, she championed for further education in antenatal clinics. This was interpreted as a method to destigmatise, or normalise, preterm birth among the community.

It's not good to mock others because you never know the same might happen to you in future. We should be made aware at the antenatal clinic that it is possible to give birth too soon so that nobody should mock others. It should be emphasised that nobody wishes to give birth too soon. **(Sevelia)**

In this section, the participants' experiences of the normalisation and acceptance of preterm birth were explored. The following section will attempt to reveal the methods in which mothers coped in their journey and what brought them hope.

6.8.2 Coping

6.8.2.1 Faith

There were a variety of factors which influenced mothers' coping mechanisms and provided hope. Faith in God and in the health system, family support, seeing baby's health improve, success stories, and baby's future possibilities were all discussed by mothers. Each of these will be explored further.

Faith was an influencing factor in the majority of mothers' coping mechanisms. Both faith in God and the medical establishment were two systems which helped a majority of mothers to cope. In Anna's case, her belief in God was a provision of solace and comfort while her child was in hospital. She prayed, fasted, and attended church. Furthermore, Anna

attributed her experience of having a baby too soon to 'God's will' or 'God's plan'. It appeared to provide her with strength. This was Anna's reflection.

When you go through this experience, you need strength. You can always ask God for help and God can make a path where is no way. (…) Taking care of this baby has been made possible through the grace of God. Some people also give birth to a baby too soon, but the baby sometimes doesn't survive but only God knows it all. (…) God knows everything and we don't know his plans we just realise that it has happened so maybe that's how God had written it down that I will give birth too soon. **(Anna)**

In addition, Anna's faith in God further influenced her faith in the medical professionals. She was advised that God could work His miracles through the hands of doctors. This provided further comfort, assisted Anna to cope, and was a source of hope for her child.

The pastor would tell me that for the child to be healed by Christ, I needed to have faith so I indeed had faith in God. I was going for prayers day and night. When I go to pray, the baby seemed to be feeling better, but when I return home, the sickness could return. At some point in time, I almost thought of sleeping at the church with the child. (…) So, one day the pastor told me to go to the hospital. He said that sometimes God works through other people so it could happen that God could give the doctors some other wisdom to heal the child and I believe that. **(Anna)**

6.8.2.2 Support

Faith was also encouraged by her supportive family. They provided her with faith, words of affirmation, and support. Furthermore, they also provided examples of community members who also had given birth too soon, and described how their children were thriving in the community. Not only was Faith's family a source of strength, it also appeared to be the foundation of her hope for the future.

My family just encouraged me to take good care of the baby. They also said I shouldn't be taking the baby outside because the baby is very small. I shouldn't feel like it's a burden. They were telling me not to worry so much about it because the baby will survive and grow up strong. My family were even giving me examples of people who also gave birth to preterm babies but their babies survived. **(Faith)**

Anna was also inspired by the stories that were shared with her from her fellow mothers in hospital. In particular, one encounter truly resonated with her. This was her story.

I only had courage because of my friends and fellow mothers who had also given birth too soon (…) Some lady whom I met at the clinic told me that she, herself, was also born too soon. The time that I had met her was when she was 50 years old. She also said her mom told her that her weight was 900g yet my child was born at 1.2 kg. So the lady encouraged me that my baby would survive and grow up normally. She also survived the same condition as my baby. And her situation was even worse because during their time there was nothing like the medical care now, like kangaroo care, so that gave me some courage. **(Anna)**

6.8.2.3 Baby's growth and development

Mary and Grace expressed how the continued growth and development of their children provided comfort and hope in their journey.

I am encouraged with the way he is now comparing to when he was born. He is growing well and without any problems. He has made a good progress, without any complications. **(Mary)**

I'm not seeing any problems with the child so that is what is giving me hope. (…) There are no new problems or new illnesses that I have seen in the baby. I'm living with the baby normally at home. **(Grace)**

6.8.3 Hope

6.8.3.1 Following hospital guidelines/medical advice

Faith in medical advice, and adamantly following those guidelines, provided immense hope to several mothers. For example, Manny expressed great pride when stating that she followed the hospital's guidelines when caring for her baby. Additionally, she revealed the potential consequences of not following hospital directives.

What gave me hope is that I followed all the lessons that I was taught at the hospital on how to take care of the baby. Without those lessons maybe the baby could have died. **(Manny)**

Faith, the participant, also disclosed potential sequelae if hospital directions are not followed. It is possible that Faith was associating blame or stigma to those who do not adhere to the hospital guidelines and experience a neonatal death.

Some preterm babies die when they are not well taken care of. That is if the baby wasn't kept warm all the time and if hospital instructions were not properly followed. **(Faith)**

Mothers found strength through a variety of different mediums. This newly formed strength was foundational in the transformation of mothers. The following section will further explore the transformation experienced by the participants in this study.

6.8.4 Transformation

6.8.4.1 Taking back control/taking back future

Mothers in this study all experienced 'transformation'. Certain transformations were more radical, directly related to a firm action or decision. For others, their transformation was more subtle, hidden within, and only revealed itself after further discussion and reflection. The follow section will illuminate some of those transformations.

For previous reference, Malita was being stigmatised and shunned to the point of destitution while living in her husband's village. Her power had been stripped. It appeared, however, that Malita had reached a breaking point. She decided to take her future back. There was encouragement from her family to return to where belonged, where she could be surrounded by those who would support her. While certain aspects remained uncertain at that time, Malita took that step into the clearing. She gathered her strength to regain control and reclaim her power.

There are times I would go to sleep on an empty stomach. That is when I decided to go back home where I would be able to work and support myself. My relatives were shocked when I explained to them how I was being treated at my husband's home and they encouraged me to return home where they would be able to support me. (…) They were worried as to how I would be able to financially support the baby but I decided to leave as I could not cope with how I was being treated with no support from the father of my child. **(Malita)**

Malita further expressed great pride in describing her current situation. She illustrated her outlook with positivity and strength.

Life is much better here, as I am able to work. I am involved in small businesses to support myself and my baby, compared to the time I was living in my husband's village. (…) My family is always there and provide for me when I ask for something like soap and other things. They witnessed what I was going through at my husband's home and they promised to support me when I return home. **(Malita)**

While Malita has expressed the burden of responsibility for giving birth too soon, there was a positive outlook to her journey. There was an emphasis on the importance of work and its correlation to financial independence.

I was excited when I gave birth because I knew I would be able to work to support myself as opposed to the time when I was pregnant. I resumed work three months after as I had to take care of my baby during the first three months. (…) At my husband's home there were times I would go to sleep with an empty stomach. I was lacking soap and money. But now that I am living with my family, I am able work and support myself. **(Malita)**

For other mothers, their transformation was revealed in their new way of knowing and newly attained confidence.

In earlier times, I was even afraid of handling him. But that is now in the past. He is growing. I can now carry him on my back confidently. **(Faith)**

I have learned a lot of new things from the birth of this baby. For instance, I had only heard about kangaroo care, but now, I have experienced it. I have also learned how to take care of a preterm baby. I never knew that a preterm baby, especially a baby born at six months old, can have all the organs or body parts. But now I know. **(Anna)**

Grace's transformation appeared to be in her confidence in caring for a baby born too soon. Preterm birth had not been discussed at the antenatal seminars. The experience gained provided important insight into the advice she would provide to other mothers.

They never talked about preterm birth (…) Health professionals should be able to inform or advise us that it is possible to experience preterm or full-term birth. (…) I would encourage mothers to care for the child by keeping the baby in a warm environment and dress the baby in warm clothes. The mother shouldn't take the baby outside the house until the expected day that the baby would to be born so that the baby should continue feel like they are still in the mother's womb. That is what I would advise a mother that has given preterm birth. **(Grace)**

Grace's statement highlighted the importance of comprehensive education and guidance for expectant mothers, especially regarding the possibility of preterm birth. By emphasising the need for health professionals to provide information and advice on both preterm and full-term births, Grace demonstrated the significance of equipping mothers with the knowledge necessary to care for their newborns in the event of a preterm birth.

6.9 Conclusion

This chapter explored the experience and meaning of preterm birth for 16 mothers in Malawi. The ‘unexpected journey’ was highlighted as the overarching meaning of the experience. This was supported by four themes: “something is wrong”, the unforeseen birth, walking through the unknown, and stepping into the clearing. The following Discussion Chapter will further explore these concepts in depth, supported by philosophical points and relevant literature to take the ‘interpretive leap’.

CHAPTER SEVEN

DISCUSSION AND CONCLUSION

7.1 Introduction

Over the last six chapters, we have journeyed through the meaning of preterm birth for mothers. For this study, I considered it imperative that I listen to the voices of women. I wanted to explore their truths, heard and unheard, through feminist and intersectional lenses As Gadamer stated, “Hermeneutics encourages not objectification but listening to one another—for example, the listening to and belonging with someone who knows how to tell a story” (Gadamer, 1994, p.xi).

Each mother told her own story and revealed meaning in each spoken word. Through a fusion of horizons, *the unexpected journey* was revealed as a core meaning of the experience. Furthermore, four subsequent sub-meanings, or themes, *something is wrong*, *the unforeseen birth*, *walking through the unknown*, and *stepping into the clearing*, were central to capturing the worldview and meaning of the lived experience as it was shared. This chapter discusses these concepts in further detail, along with the development of a conceptual framework, supported by hermeneutic philosophy and relevant literature. To conclude, the study limitations and recommendations for clinical practice, education, and future research are presented.

7.2 Overview of aim, objectives, and research question

To review, the aim of the research was to explore and illuminate the meaning and experience of preterm birth for postnatal mothers in Malawi.

The specific research objectives were the following:

1. To explore and illuminate a foundation of knowledge on the meaning, experience, and perception of preterm birth in Malawi, based on the lived experience of the participating mothers.
2. To explore, understand, and provide an interpretation of women's experiences of giving birth to a preterm infant.
3. To illuminate the personal and cultural context of the preterm birth experience for mothers in Malawi.
4. To explore how mothers of preterm infants understand their preterm birth experience after the birth.

The research questions were the following:

1. What is the meaning of preterm birth for postnatal mothers in Malawi?
2. How do mothers experience and perceive preterm birth?

7.3 Conceptual framework

Preterm birth, as previously discussed, is medically defined as the birth of a baby before 37 weeks of a 40-week pregnancy. It remains a significant global public health concern, with relevance to the context of Malawi. It not only poses immediate risks to the health and survival of preterm infants but also has profound implications for maternal well-being (WHO, 2023a). However, the complexities surrounding preterm birth extend far beyond the medical domain, encompassing a rich tapestry of social, cultural, and gendered

experiences that require nuanced exploration.

This conceptual framework seeks to express the intricate terrain of the meaning of preterm birth in Malawi by weaving together multiple theoretical threads. It integrates a feminist lens that acknowledges the gendered nature of maternal experiences. Gadamer's hermeneutics provides a philosophical foundation for the interpretive process, emphasising the role of historicity, dialogue, understanding, and horizons in uncovering the meaning embedded within narratives. The Hero's Journey narrative can be used as a metaphorical lens for understanding the maternal experience. By embracing a feminist stance, I acknowledge the significance of gender dynamics and the interpretive nature of understanding preterm birth experiences. As we embark on this journey of exploration and empowerment, it is my hope that this framework will contribute to a deeper understanding of preterm birth in Malawi and inspire action that promotes the health, agency, and dignity of women and their babies.

7.3.1 The heroine's journey

The metaphor of 'the journey' has been used within research to explain and explore concepts within pregnancy, childbirth, and motherhood (Athan & Miller, 2005; Javadifar et al., 2016; Montgomery et al., 2023; Lothian, 2008; Werner et al., 2021). Thomson and Downe (2013) conducted a secondary analysis from an interpretive phenomenological study which looked at the narratives of mothers who had had a traumatic birth followed by a positive experience. The authors re-examined the interviews using 'the hero's journey' concept, popularised and further developed by Campbell (1993). The classic hero, or the monomyth, outlines a common structure that heroes follow as they embark on an adventure (departure), face trials (initiation), and ultimately undergo a personal transformation (return) (Campbell, 1993; Lehner, 2021; Thomson & Downe, 2013). While the Hero's Journey is typically associated with heroic quests, it can also be a metaphorical lens through

which to understand and empathise with the emotional and transformative aspects of the preterm birth experience for mothers in Malawi.

While Campbell's original hero's journey structure has 17 steps, divided between the 'departure, 'initiation', and 'return' phases, the author acknowledges that the hero (or heroine) may not journey through all 17 steps. As such, I selected the steps which closely aligned with the mothers' preterm birth journey. Furthermore, it is important to note that while the term 'hero' may assume that the protagonist is inherently male, Campbell stated the following:

"The hero, therefore, is the man or woman who has been able to battle past his personal and local historical limitations to the generally valid, normally human forms. Such a one's vision, ideas, and inspirations come pristine from the primary springs of human life and thought" (Campbell, 1993, p. 41).

I will use the term 'heroine' to associate the mothers' experiences with the hero's journey. Below, each stage of the journey is outlined and linked to preterm birth. The following section outlines the stages of adventure, linking with the preterm birth experience. A conceptual framework (Figure 8) will follow, integrating the two to present *the mother's journey*.

7.3.2 Steps of the heroine's journey relating to preterm birth

Stage one: Departure

The call to adventure: In the context of preterm birth, the call to adventure is the unexpected onset of labour or complications leading to an early birth. This sudden and unplanned event disrupts the ordinary life of the expecting parents, thrusting them into an unfamiliar and unknown challenging situation.

Refusal of the call: Initially, mothers may struggle to accept the unexpected circumstances and the uncertainties a preterm birth brings. Mothers may experience feelings of fear, anxiety, and doubt.

Crossing the threshold: The actual birth of a preterm baby represents crossing the threshold into a new and challenging world. This is represented by the 'stepping into the unknown' phase of the preterm birth experience.

Stage two: Initiation

Road of trials: Mothers are walking through the unknown, experiencing feelings of helplessness, lack of control, stigmatisation, fear [of baby's health, of the new reality, of the future] and feeling unsure in her own knowledge. Mothers may recognise the increased burden of responsibility of having a preterm baby. If the mother or baby is in hospital, medical tests, treatments, and medical professionals may be seen as challenges or adversaries.

Meeting with the goddess: Mothers may seek support from other women and mothers for guidance, support, and expertise as they navigate the complexities of preterm birth. They equip parents with the knowledge and tools necessary for this unique journey.

Apotheosis: Mothers step into a clearing of new understanding and knowledge. There is acceptance of their situation, newly developed pride, and a sense of taking back control.

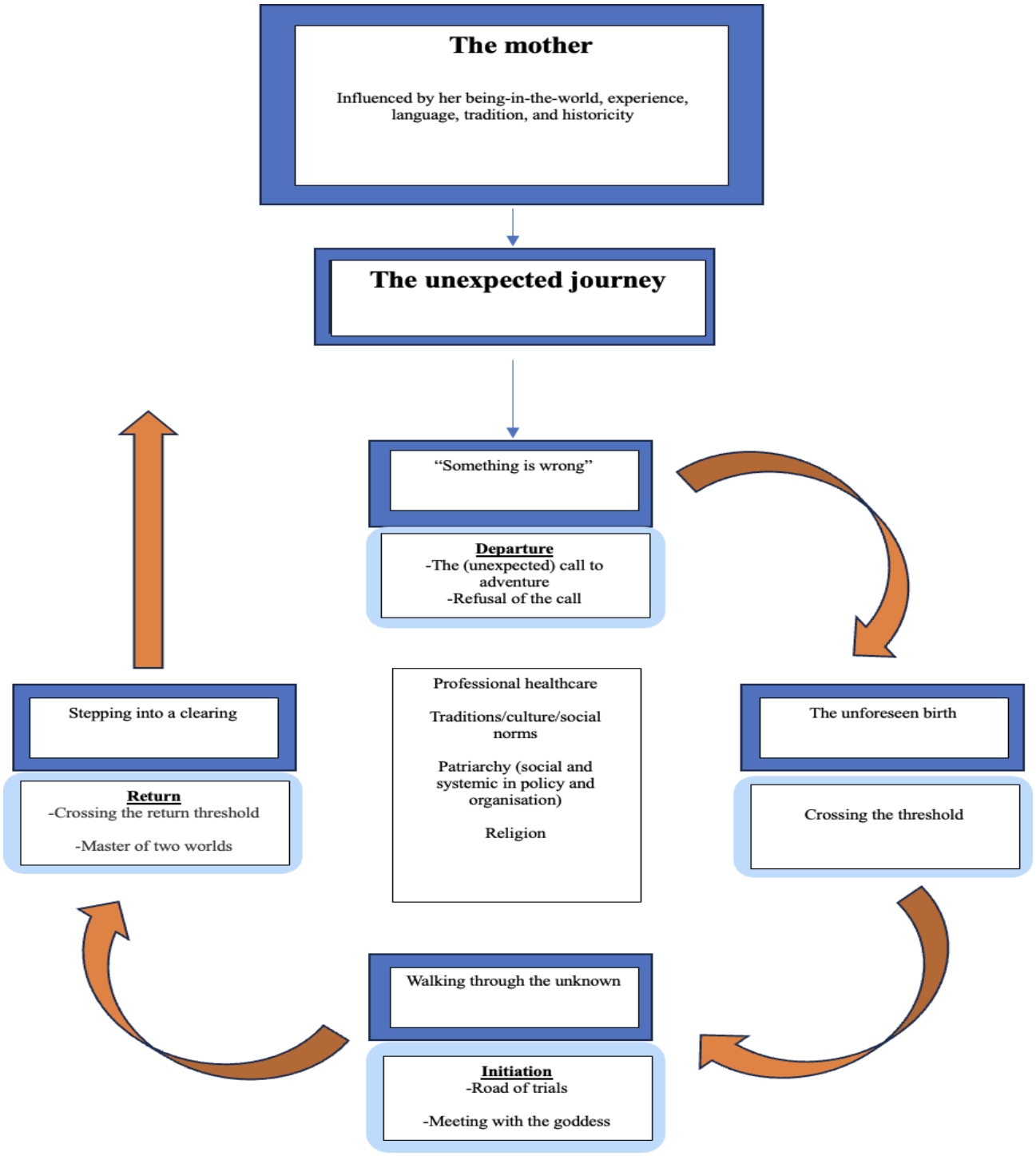
Stage three: Return

Crossing the return threshold: This step into the clearing is not the end of the journey. Challenges remain that require the mother to draw upon their strength, ways of coping, and faith.

Master of two worlds: Mothers experience a transformation within themselves and take back control of their future (new found empowerment). There is a potential for the normalisation of preterm birth, which may also extend to family and community members.

Figure 8

Conceptual Framework: The Mother's Journey



7.4 A fusion of horizons

Gadamer's concept of the fusion of horizons underscores the idea that the interpretation process is dynamic, interactive and an ongoing process where the interpreter's horizon and the horizon of the text fuse together (Gadamer, 1975). It emphasises the importance of openness, dialogue, and the recognition of the historical and cultural context in which interpretation takes place (Bartley & Brooks, 2023).

As outlined in Chapter Six, my interpretation of the findings indicated that mothers passed through four unique phases in their preterm birth journey (something is wrong, the unforeseen birth, walking through the unknown, and stepping into the clearing), all underpinned by the unexpected nature of their births. These findings indicate that the meaning of mothers' lived experiences of having a baby born too soon is one of uncertainty, vulnerability, and disembodied care. Mothers' embodied knowledge of birth, birth choices, and personal power were frequently disregarded or undermined by medical professionals. These patterns were frequently evident in their received care during labour and birth and through their interactions with family and friends. Furthermore, issues around women's power, personal authority, and their knowledge base were often suppressed or disregarded entirely, depending on the context and stage of the journey. These points will be discussed in the next section.

7.4.1 A woman's voice and patriarchy as a system of authority

A feminist lens brought forth a critical view that foregrounds the influence of gender and intersectionality in shaping women's experiences during pregnancy and childbirth in Malawi. It emphasises the need to challenge existing gender inequities and biases within healthcare systems and societal norms. Concurrently, Gadamer's hermeneutics, with its philosophical underpinnings, encouraged a deeper appreciation of the historical and cultural factors that influence the interpretation of preterm birth experiences in Malawi. The

hermeneutic tradition underscores the dialogic nature of understanding, where the participant and the researcher engage in meaningful conversations to gain insights into the lived realities of preterm birth. The intersection of Hans-Georg Gadamer's hermeneutics and feminism is an area where the philosophy of interpretation and feminist theory converge. While Gadamer's hermeneutics primarily focuses on the interpretation of texts and understanding human experiences, it can be applied within feminism to address various aspects of gender, power, and knowledge production. Paulo Freire's "Pedagogy of the Oppressed" (1970) and bell hooks' seminal works, particularly "Feminist Theory: From Margin to Centre" (1984), resonated powerfully for me in this discourse.

Patriarchy is a social system where authority and power are predominantly held by men, often to the detriment of women and marginalised gender identities (hooks, 2004). It remains a form of systemic oppression that perpetuates gender-based hierarchies (see the works of Rich, 1976; Rothman, 1989; Jordan ,1993; Davis-Floyd, 1992, 1997; Davis- Floyd et al., 2010). Freire (1970) argued that oppression and social change can be applied to critique and challenge patriarchal systems. Patriarchy, like other forms of oppression, relies on maintaining authority and silencing the voices of the oppressed (Freire, 1970). Both hooks and Freire advocate for centring the voices and experiences of marginalised individuals and groups. The author hooks (1984) called for a shift of marginalised voices from the periphery to the centre, accentuating the importance of disenfranchised perspectives in discussions about feminism and broader societal issues. Freire (1970) similarly argued for the inclusion of the oppressed as active participants in their own education and liberation. The intersectionality lies in the recognition that education should empower those traditionally on the margins, enabling them to challenge and transform oppressive systems.

The importance of 'centring' the voices and experiences of marginalised women can be applied to understanding women's knowledge and experiences of preterm birth in Malawi. Many of the participants encountered the influence of both biomedical and patriarchal structures in their experiences. Mothers who felt something was different in their bodies mostly sought assistance from medical practitioners. However, as set out in chapter five, a common theme, which kept repeating, was not being believed or not being taken seriously by medical professionals. Mothers were dismissed, had their concerns completely disregarded, were treated for an entirely different condition (for example: malaria) during their 'something is wrong' and 'the unforeseen birth' phases of their journey. They were subjected to numerous vaginal examinations, at times without consent. They were provided with differing updates on their 'current status' which often left the mothers confused, anxious, and angry. The dismissal of personal knowledge experienced by the participants was a distressing reality that reflects systemic challenges within healthcare systems. When the women encountered symptoms such as contractions, abdominal pain, or vaginal bleeding, which could indicate preterm labour, their concerns were sometimes met with indifference or downplayed as routine discomfort. This dismissal not only disregarded the potential severity of their situation, but also denied women the agency to advocate for their own health. Participants had their autonomy, knowledge, and decision-making capacity disregarded as they entered the world of medicine.

"Being oppressed means the absence of choices. It is the primary point of contact between the oppressed and the oppressor…[P]atriarchy is structured so that sexism restricts women's behavior in some realms even as freedom from limitation is allowed in other spheres". (hooks, 1984, p.5)

Several studies have examined the mistreatment of women during pregnancy and childbirth (Shabot, 2016; Vedam et al., 2019; Thomson & Downe, 2008; Davis, 2019; Shabot, 2021; Hughes et al., 2022). A systematic review by Bohren et al. (2015), involving research from 34 countries, analysed the mistreatment of women during childbirth across varying income levels and geographical settings. The study identified various forms of mistreatment during childbirth. This included verbal abuse, physical abuse, non-consented care, neglect or abandonment, and discrimination These forms of mistreatment could occur at different stages of maternity care, from prenatal to postnatal care. Bohren et al. (2015) also highlighted several barriers to addressing mistreatment during childbirth. These included a lack of awareness among healthcare providers, limited accountability mechanisms, and insufficient training on respectful maternity care. Societal norms and gender inequality also played a role in perpetuating mistreatment. These results were consistent with the experiences of the mothers in this study. This was particularly demonstrated as mothers sought help when going into labour and giving birth and experiencing the 'unknown' of the postpartum experience.

The mistreatment experienced by the mothers in this study, including being dismissed, neglected, abandoned, or experiencing excessive or non-consensual examinations, added to their potential vulnerability. Drawing upon authors hooks (1984) and Freire (1970), it is evident that such oppressive practices silence women's voices, undermine their agency, and perpetuate power imbalances between patient and medical authority. Furthermore, mistreatment oppresses mothers by denying them the compassionate and respectful care they need during this critical time. In the context of bell hooks' feminist perspective, these barriers reflect how oppressive systems can resist change. Freire's critical pedagogy suggests that addressing mistreatment requires a critical awareness of these barriers and a commitment to transformative education for both

healthcare providers and women, enabling them to challenge oppressive norms and practices. The centring of the mothers' experiences in this study hopefully provided a basis of understanding to address and tackle the system of patriarchy.

Mothers did not only experience a patriarchal oppression while in the hospital. A few mothers in the study, as discussed in chapter five, experienced great difficulties with their male partners once they returned home. For example, two mothers experienced their partners not believing they were the biological fathers of their children. One father did not believe preterm birth could happen and only came to terms with the principle of preterm birth once a male friend reassured him that it could happen. Another father refused to acknowledge his child, and accused his wife of infidelity. Furthermore, he was able to have the community members of their village shun the mother, effectively making her an outcast.

Conscientization, as developed by Freire (1970), involves individuals critically examining their circumstances, identifying oppressive structures, and working towards social change through dialogue and action. In essence, both Freire and hooks champion inclusivity, empowerment, and the challenging of oppressive structures, albeit in different contexts—education and feminism—resulting in transformative and liberatory approaches. The dynamics of knowledge and authority play a pivotal role. Knowledge, traditionally held by healthcare providers, is redefined as a shared resource where the expertise of both providers and patients is valued. Conscientization encourages women and communities to actively participate in healthcare decisions, thereby challenging the existing power structures. In this new paradigm, knowledge is co-constructed through dialogue, with a focus on informed decision-making and shared authority.

7.4.2 Disembodied care: Power and control

In maternal health, a vulnerable pregnant woman is characterised by potential exposure to physical, psychological, cognitive, or social risk factors coupled with insufficient support or coping mechanisms (Scheele et al., 2020). Conversely, resilience, within literature, refers to the ability of public health and healthcare systems, communities, and individuals to avert, defend against, swiftly respond to, and recover from health emergencies, especially those whose magnitude, timing, or unpredictability could potentially overwhelm standard capabilities (Bayntun et al., 2012). Various factors influence power dynamics, social structures, and health outcomes. Institutionalised power, along with social, political, and economic advantages and disadvantages allocated to different genders, shapes power relations (Sule et al., 2022). Additionally, gender intersects with other social determinants of health, such as social class, race, and ethnicity, thereby determining the hierarchy of social structures and power dynamics, and subsequently impacting health outcomes (Creighton & Oliffe, 2010; Sule et al., 2022). These influences will be examined further in relation to power, control, and disembodied care.

In this study, power negotiation emerged as a key dimension influencing vulnerability and resilience among mothers during childbirth. Power dynamics were evident through the power roles of healthcare professionals, significantly impacting maternal autonomy and experiences. In Blantyre, women were ‘required’ to birth at medical facilities. Traditional birth attendants, who once played a crucial role in supporting women through childbirth, have been marginalised or forced into hiding due to stringent regulations and the dominance of institutionalised medical practices. The relegation of TBAs is often a consequence of policies that favour hospital births over home births, threatening fines or legal action against those who assist in non-institutional births. This suppression not only diminishes the role of TBAs, but also strips women of the choice to engage with familiar

and culturally resonant birthing practices. The forced reliance on hospital births reflects broader societal power structures where district and medical authorities dictate acceptable childbirth practices, often disregarding women's preferences and traditional knowledge systems.

This research highlighted women's limited capacity to negotiate and their lack of autonomy in making healthcare decisions. This undermined maternal agency and birth choices, as medical practitioners often imposed their own decisions without considering maternal preferences. Despite encountering substandard treatment, mothers in this study tended to comply with the provided care rather than assert themselves. This may stem from a feeling of dependence on the biomedical system or not wanting to be viewed as demanding. Some qualitative analyses suggest that patients report high satisfaction levels partly because they are reluctant to critically evaluate the care they receive, particularly those with lower social, economic, reproductive, or marital status (Béhague et al., 2008). This reluctance stems from their dependence on healthcare providers and their lack of perceived power within the biomedical setting. Consequently, patients' assessments of care quality are influenced by broader systemic power imbalances (Béhague et al., 2008). Den Hollander et al. (2018) further highlighted the limited negotiating ability and autonomy of women in healthcare decision-making in Ghana. The study revealed significant power disparities between healthcare providers and women, particularly in an authoritative context. When recruiting for healthcare studies, women were generally uninformed about basic health information, and there was a high level of therapeutic misconception. Additionally, women tended to rely more on the opinions of medical professionals rather than focusing their own needs or personal knowledge (Den Hollander et al., 2018).

In further research, within certain cultural contexts, a woman's status can impact their agency in receiving care. For example, unmarried women and young mothers face

barriers to accessing care, partly due to the strong emphasis on marriage and motherhood prevalent in many African societies (Sule et al., 2022) They are often more likely to live in poverty, report feeling socially stigmatised and mistreated by healthcare institutions and providers (Irinyenikan et al., 2022). Women frequently have limited agency and bodily autonomy during childbirth, often dependent on various influencing socio-economic factors. This can manifest in various ways, such as restricted autonomy in seeking healthcare, insufficient financial resources, or fear that assumptions about being pregnant may result in a lack of appropriate care (Bohren et al., 2014) They may experience mistreatment during childbirth, especially in settings where organisational challenges impede the provision of care or where there is a lack of woman-centred maternity care.

7.4.3 Understanding preterm birth and its impact in Malawi

The mothers in this study all expressed their 'expected' length of pregnancy of being nine months in length. Most of the participants emphasised the importance of the size of babies, associating a 'big baby' with strength and being overall healthier. Mothers also referenced weight, between 2.3-2.5 kg, as an important factor of when preterm babies were considered 'healthy' and strong enough to leave the home. The mothers associated having a baby born too soon with poor nutrition, gender-based violence, previous preterm birth, level of physical activity (being idle or working too hard), high blood pressure, anxiety, and illness (anaemia, for example). These findings were comparable to other studies looking at the understanding of preterm birth in sub-Saharan Africa (Milford et al., 2023).

The psychosocial impact of preterm birth on mothers in Malawi, as in many other parts of the world, can be profound and multifaceted. The psychosocial findings revealed how mothers experienced preterm birth and how it impacted their birthing journey expectations. The mothers in this study highly anticipated the birth of their child and all 'expected' to give birth in or around the nine-month mark. All women attended the local

health clinic for their antenatal appointments as well as the weekly antenatal health talks[16]. Most of the women were provided with specific due dates. However, most women were not informed about the risks of having a preterm baby, provided with information about preterm birth risk factors, or what to do if something did not feel quite right. This point felt important to address. When mothers unexpectedly went into labour, it shattered their expectations of how they thought their experience would be. It not only impacted them on a psychosocial level, but it impacted their ability to work, prepare their home, and financially budget for their future baby's necessities. Furthermore, it propelled them into a world of fear, varying experiences with the medical authority, and feelings of helplessness and uncertainty.

These findings were congruent with other studies, for example a Canadian qualitative study conducted by Lasiuk et al. (2013) to understand the parental traumas associated with preterm birth. The study highlighted parents' 'shattered expectations' of parenthood during the preterm labour and birth of their child, describing the sudden and unforeseen nature of the experience. These parents characterised their experience through continued feelings of uncertainty, helplessness, a lack of control, and fear over their child's health. Similarly, in the United States, Hinic (2021) also found that unexpected birth events, such as unforeseen caesarean sections, negatively impacted the woman's perception of her birth experience. Mothers used similar language such as 'not expected', 'scary', and 'distressing'.

Although participants acknowledged perceived medical causes for preterm birth, spiritual, social, and traditional beliefs were equally viewed as important. The participants' narratives prominently featured their religious beliefs or faith, which served as a foundation for their interpretation of their preterm birth experience. Specifically, preterm birth was

[16]Each week, at the Mpemba Health Centre, nurses and midwives presented on a different topic related to pregnancy and childbirth. Topics included breastfeeding techniques, what to expect in childbirth, proper postpartum hygiene, how to bathe a newborn etc.

commonly contextualized as being part of a divine plan orchestrated by God, expressed as ‘God’s will’, ‘God’s plan’ or that the situation was ‘out of their control’. Faith in the medical professionals caring for their babies also appeared to be an important coping method. This perception of events appeared to comfort the mothers because it implied a lack of personal control over the circumstances. Faith in the medical professionals caring for their babies also appeared to be an important coping method. This perception of events appeared to comfort the mothers because it implied a lack of personal control over the circumstances. Consequently, the mothers frequently expressed feelings of gratitude towards God and the medical professionals for their own survival and that of their child, despite the challenges associated with preterm birth.

Stigmatisation, discrimination, and the high burden of care were challenges faced by the mothers. The participants were questioned by community members as to why they had given birth too soon. In particular, mothers experienced ridicule and judgment over the size of the baby. There were also questions raised by husbands over the paternity of the child. Mothers also believed that witchcraft could be a cause of preterm birth or cause death to the newborn.

Spiritual and social beliefs, such as those associated with ‘God’s plan’ and witchcraft, have been found in similar studies to explain pregnancy loss in Uganda and Kenya (Ayebare et al., 2021). Milford et al. (2023) found that community members in both South Africa and Kenya had negative perceptions of preterm babies. Carers of low weight babies in Malawi also faced stigma from the community (Koenraads et al., 2017). Mothers were accused of having illnesses, such as HIV, or of not taking adequate care of herself. As such, parents felt immense shame and would avoid seeking medical care due to fear of being mocked. This presence of stigma can deter individuals from seeking timely and appropriate healthcare. As shown in Koenraads et al. (2017), fear of judgment or

discrimination can lead mothers and families to delay seeking medical attention for a preterm infant or even avoid it altogether.

7.4.4 The impact of social support and COVID-19 on mothers in Malawi

Mothers in this study experienced an unexpected shift in their birthing experience, apart from giving birth too soon. Due to public health restrictions at the time, many mothers were not permitted to have a guardian, or birthing partner accompany them in the hospital. Furthermore, certain mothers gave birth alone, due to the reduced contact of nurses and midwives. In Malawi, guardians are not only there to provide physical support, but to provide emotional support as well. Support during labour and birth has been well documented in literature related to its positive clinical outcomes and experiences of care (Bohren et al., 2019; Thomson et al., 2022). According to the WHO (2018) intrapartum guidelines, a birth companion and emotional support are recommended practices for labouring mothers in order to provide woman-centred care. Even during the COVID-19 pandemic, the World Health Organization continued to advocate for the presence of a birth companion (WHO, 2020).

A global health survey of medical workers, conducted by Asefa et al. (2022), supported these findings. The study found that infection prevention measures implemented during the COVID-19 pandemic resulted in the negative provision of respectful maternity care. Health care workers reported reduced emotional support for women through the restriction or banning of birth companions, the ban on cultural representatives, and the reduced contact of health workers with labouring mothers.

Mothers were dramatically impacted by the outbreak of COVID-19. Specifically, it effected their right to woman-centred care. The absence of a birthing companion can negatively affect maternal well-being. Mothers may experience higher levels of stress and fear, which the mothers expressed in this study, which can have implications for the

progress of labour and overall birth experience. This can be especially concerning in cases of preterm birth, where additional medical attention and emotional support may be needed.

7.5 Implication on research, policy and practice, and education

7.5.1 Research implications

This study on the meaning of preterm birth for mothers in Malawi has significantly influenced the research landscape by challenging the dominant positivist paradigm that often overlooks women's experiences. Traditionally, maternal health research in Malawi has heavily relied on quantitative methods, focusing on statistical findings. However, this work underscores the critical role of qualitative methodologies in capturing the rich, personal narratives of mothers who have experienced a baby born too soon. By integrating qualitative approaches, the research has provided a more comprehensive understanding of the emotional, cultural, and social dimensions of preterm birth, which quantitative data alone cannot fully capture.

The initial reluctance to approve this study due to its qualitative nature highlights the entrenched biases within the research community. By showcasing high-impact empirical evidence from this work, the study has engaged both quantitative and qualitative researchers in meaningful dialogue, fostering a collaborative research environment. The successful negotiation and advocacy to include women's voices and experiences in this project has potentially paved the way for future research on birth and women's health to adopt qualitative methods or incorporate a mixed-methods approach. This inclusion broadens the scope of research, enabling the development of policies and interventions that are more culturally tailored based on the experiences and narratives of mothers. The inclusion of qualitative perspectives sets a precedent, encouraging other researchers to adopt similar methodologies. The findings serve as a springboard for future research projects that prioritise women's voices, challenging the dominance of positivist paradigms

and promoting a more inclusive and holistic approach to maternal health research in Malawi and beyond.

7.5.2 Policy and practice implications

The findings from this study have significant implications for maternal health policy in Malawi, highlighting the need for reforms that incorporate women's voices and experiences. Current policies often overlook the specific needs of mothers, especially those who have experienced preterm birth, and attempt to apply policies that may not be culturally appropriate or relevant in all regions. This study advocates for integrating maternal feedback into healthcare planning and evaluation to make services more responsive and tailored to women's needs.

A key policy recommendation is the establishment of comprehensive educational initiatives targeting healthcare providers and community leaders. These initiatives should focus on increasing awareness and preparedness for preterm birth, underscoring cultural sensitivities and appropriate responses to preterm labour. Policymakers should develop frameworks that mandate the inclusion of maternal narratives in healthcare training and policy formulation. Such policies would ensure that healthcare providers are better equipped to support expectant mothers, thereby reducing anxiety and uncertainty associated with preterm birth.

Additionally, the study highlights the need for policies that promote community-based support systems. Involving traditional leaders and community health workers can foster a supportive environment for expectant mothers. This approach bridges the gap between formal healthcare services and cultural practices, providing culturally appropriate support throughout prenatal and birthing journeys. Integrating maternal experiences into policy development can lead to more compassionate and effective healthcare services, potentially improving maternal health outcomes.

Shifting maternal health policy towards a woman-centred approach that values and incorporates mothers' voices is essential. Policies can create a more empathetic and supportive healthcare environment by integrating maternal feedback and promoting comprehensive educational initiatives. Further research is necessary to continue developing and implementing culturally appropriate policies based on regional variations. This ongoing research will ensure that interventions remain relevant and effective in addressing the unique needs of different communities across Malawi. These reforms have the potential to transform maternal healthcare in Malawi, ensuring that the needs and experiences of mothers are central to healthcare planning and delivery.

7.5.3 Educational implications

The study's findings reveal a critical gap in knowledge and preparedness for preterm birth among mothers in Malawi. Mothers reported that very few health workers discussed preterm birth or what to do if preterm labour signs are recognised, highlighting the need for targeted educational programmes. Comprehensive educational curricula for healthcare providers, including nurses, midwives, and community health workers, are essential to bridge this knowledge gap. These programmes should focus on preterm birth awareness, signs of preterm labour, cultural implications, and effective communication strategies to support expectant mothers. By enhancing the knowledge and skills of healthcare providers, these educational initiatives can improve the overall quality of maternal care.

One aspect of feedback from participants was their desire to participate in training programmes for healthcare workers and to be active contributors to research and training. Mothers suggested that training programmes could incorporate guest speakers who have experienced having a baby born too soon. This would provide healthcare workers with direct insights and a deeper understanding of the emotional, physical, and social challenges

associated with preterm birth. By integrating maternal stories into training modules, healthcare workers can learn about certain lived experiences, such as obstetrical violence and dehumanised treatment, and develop strategies to prevent such occurrences. This approach can foster empathy and compassion, enabling healthcare providers to deliver more personalised and supportive care. This emphasis on empathy and cultural sensitivity is crucial for improving maternal health outcomes and enhancing the overall birthing experience for women.

Furthermore, the study advocates for the inclusion of preterm birth education in community outreach programmes. These programmes can raise awareness among expectant mothers and their families, providing essential information on recognising the signs of preterm labour and seeking timely medical assistance. Community-based educational initiatives can also engage traditional and female leaders, ensuring that cultural practices are respected and integrated into maternal healthcare. By promoting community involvement, these programmes can create a supportive network for expectant mothers, reducing anxiety and uncertainty associated with preterm birth.

The study highlights the importance of targeted educational programmes in improving maternal healthcare. By focusing on preterm birth awareness, cultural sensitivity, and empathy, these initiatives can enhance the knowledge and skills of healthcare providers and community leaders. The inclusion of maternal narratives in educational curricula can foster a more compassionate and supportive healthcare environment, ultimately improving maternal and neonatal outcomes. The study's findings expose the need for ongoing education and training to ensure that healthcare providers are equipped to support expectant mothers through the complexities of preterm birth.

7.6 Study limitations

7.6.1 Lost in translation

In academic research, recognising the constraints and potential weaknesses of a study can serve to enhance the overall transparency and integrity of the research process (Ross & Zaidi, 2019). Moreover, understanding the limitations can contribute to the development of more precise and insightful research questions. As such, it is crucial for researchers to critically evaluate and explicitly communicate the limitations of their study to foster a more comprehensive understanding of the research outcomes and their implications for future investigations and practical applications.

One of the primary limitations was the conduction of interviews in a language that was not my native tongue. While efforts were made to address this challenge, the inherent complexity of language and cultural nuances introduces a risk of information loss or misinterpretation during the translation process. This limitation may affect the subtle understanding of the participants' narratives and their lived experiences related to preterm birth, potentially leading to a loss of meaning in certain conversations. To mitigate the 'lost in translation' issue, careful steps were taken in choosing an appropriate translator with relevant experience and cultural appropriateness. A second, independent translation was also conducted by someone familiar with cultural birth terminology to ensure accuracy. The Brislin method of back-translation was employed to verify the fidelity of the translations, further minimising the risk of misinterpretation.

Moreover, the ongoing COVID-19 pandemic necessitated the use of masks during the interviews to ensure the safety and well-being of all participants and researchers involved. While this precautionary measure was crucial, it may have inadvertently limited the non-verbal communication cues and facial expressions that could provide essential context and depth to the participants' accounts. This had the possibility to diminish the comprehensive understanding of the participants' emotions, subtle nuances, and non-verbal cues, which were integral to capturing the holistic nature of their stories. To assist with these contextual limitations, extra precautions were taken during the interview process, including the use of clear masks. These masks allowed mothers to see my face and expressions, and vice versa, maintaining a level of non-verbal communication that would otherwise be lost with standard masks. While cumbersome to wear at times, clear masks provided a level of protection while still enabling the ability to read non-verbal and more subtle body language.

7.6.2 Transferability

When interpreting the findings of a hermeneutic study, it is paramount to contextualise the analysis within the broader social, political, and cultural framework in which the narratives were captured (Thomson & Crowther, 2023). While the study was dedicated to capturing the meaning of the lived experiences of mothers with preterm babies, it was also important to acknowledge that it may not fully encompass the diverse spectrum of cultural beliefs, practices, or experiences prevalent among mothers in various other regions of the country. Embracing the principles of hermeneutics, it is important to stress that the study does not purport to establish universally applicable truths. This consideration is particularly important for readers unfamiliar with hermeneutics, as it highlights the need to approach the findings with caution when attempting to compare or apply them to different contexts or settings. However, the findings can provide a sense of understanding that can

resounds with others and can be further understood when considering its own context.

7.6.3 Constraints of COVID-19 and participant limitations

The constraints imposed by COVID-19 significantly impacted the study, particularly by limiting the recruitment period to three months. This truncated timeframe may have excluded potential participants who could have contributed valuable insights and experiences, thereby enriching the study's findings. With more time, a broader and more diverse participant pool could have been achieved, potentially capturing a wider array of perspectives and enhancing the depth of the research outcomes. Additionally, the necessity to assist with participant recall led to the decision to restrict the study to individuals who had given birth within the past year. While this limitation aimed to ensure the accuracy and relevance of participants' memories, it inadvertently excluded those whose childbirth experiences might still be vivid and impactful, despite occurring more than a year ago. These individuals might have offered different or evolving perspectives, particularly on longer-term postpartum experiences and challenges.

Both limitations highlight significant constraints on the study's ability to fully capture the diverse spectrum of childbirth experiences during the pandemic. The time-bound nature of recruitment and the recall period restriction could lead to a somewhat homogeneous participant group, potentially skewing the results. This homogeneity might not fully represent the varied experiences of all new mothers, particularly during the unprecedented time of COVID-19. In future studies, extending the recruitment period and broadening the recall timeframe could help mitigate these issues. Allowing more time for recruitment would enable researchers to reach a larger and more varied population, while a longer recall period could include more diverse stories and insights, thereby providing a richer and more comprehensive understanding of the experience of having a baby born too soon.

7.6.4 Language limitations

The limitation imposed by my fluency in English and French, and the consequent reliance on literature in these languages, poses significant constraints on the comprehensiveness and depth of the study. This is particularly evident in the context of conducting research in Malawi, a country where the predominant language would not be English or French. As a guest researcher in Malawi, access to grey or academic literature in languages other than English or French was restricted, thus limiting my ability to explore a broader range of perspectives, insights, and data. This limitation is particularly salient in the Malawian context, with its own rich linguistic and cultural heritage. The dominance of English and French, as colonial languages, in academic discourse may result in the marginalisation of indigenous languages and knowledge systems. By prioritising English and French sources, the study may inadvertently perpetuate linguistic and epistemic colonialism, neglecting valuable contributions from local scholars and communities who may publish in Chichewa or other indigenous languages.

The limitation of linguistic diversity in the sources consulted may hinder the researcher's ability to fully engage with Gadamer's views on language. Gadamer (1975) stressed the significance of language as a medium through which understanding and interpretation occur, highlighting the importance of engaging with diverse linguistic contexts to enrich interpretation. By restricting the sources to English and French, the study may overlook subtleties in meaning, cultural contexts, and interpretations that could have been gleaned from literature in other languages. Furthermore, this limitation underscores broader issues of access and representation in academic research. The dominance of English and French in scholarly communication can exacerbate existing inequalities, disadvantaging scholars and communities who are not proficient in these languages. It is imperative for researchers to be cognisant of these linguistic biases and strive towards

greater inclusivity and diversity in their research practices. Efforts to address this limitation may involve collaboration with local scholars and translators, as well as advocating for greater recognition and inclusion of diverse linguistic perspectives in academic discourse.

7.6.5 Being a nurse and a guest-researcher in Malawi

Being a nurse and a guest-researcher in Malawi introduced several notable challenges and limitations to this study. Despite not being a mother myself, leveraging discussions about my nieces proved instrumental in establishing rapport and trust with the participants. However, many mothers assumed I held medical expertise and often sought advice on treatment or infant care. This prompted concerns that their responses might be influenced by a perceived expectation, rather than their genuine experiences. To mitigate this potential bias, I employed strategies to minimise my influence on their narratives, emphasising confidentiality and redirecting the focus to their individual experiences.

My professional background as an NICU nurse, coupled with my exposure to a medicalised system, could have influenced my interpretation of the data. Despite my efforts to remain transparent about my biases and preconceptions, the philosophical perspectives of Gadamer and Heidegger suggest that interpretation is inherently subjective and is shaped by the researcher's pre-existing understandings. Throughout the study, I actively reflected on and acknowledged my biases, acknowledging and reflecting upon a gradual transition from a medical lens to a feminist perspective through extensive readings and introspection. In terms of data analysis, I made concerted efforts to maintain transparency regarding my background and the potential factors that could have influenced my interpretation. Employing a systematic and self-reflective approach, I diligently described the research processes and the derivation of findings. I employed systematic methods, such as utilising Word documents and detailed written records, to uphold transparency and enable others to follow my decision-making process. Additionally, I regularly sought input from my

supervisors, engaging in discussions about my interpretative approaches and findings. Data passages were meticulously included at sufficient length to provide adequate context, allowing readers to comprehend both the findings and my interpretation. The intention behind this transparency is to facilitate other researchers in analysing the data and reaching similar conclusions. However, it is crucial to acknowledge that this interpretation reflects my perspective at this moment. In the realm of hermeneutics, interpretations are subject to evolution over time and with evolving experiences (Gadamer, 1975).

7.7 Conclusion

Throughout this heartfelt project, which has spanned a significant portion of the past six years, my interactions and profound discussions with the mothers have shed light on the intricate and multifaceted nature of their experiences. These conversations revealed a pervasive sense of uncertainty in their journey through preterm birth. This uncertainty, though varying in its intensity, emerged as a common thread woven through their narratives, highlighting the challenges and complexities they faced along their path. However, amidst the shadows of uncertainty, a powerful narrative of transformation and resilience emerged, depicting the mothers' remarkable capacity to find solace and strength despite the adversities they encountered. It became clear that their stories transcended accounts of struggle and vulnerability, embodying a narrative of redemption and empowerment, where they reclaimed a feeling of stability and purpose in the face of adversity.

Nevertheless, their stories also unravelled the profound implications of an entrenched birth culture that often disregarded the voices and experiences of these resilient mothers. The prevalent themes of dehumanised birthing experiences, misinformation, and the systemic dismissal of their concerns highlighted the urgent need for a paradigm shift in the approach to maternal healthcare, one that encourages a holistic approach to maternal

well-being throughout their childbirth journey. Considering these compelling insights, this research calls for a transformative re-evaluation of existing maternal healthcare frameworks, stressing the necessity of inclusive and women-centred approaches that prioritise the voices, experiences, and overall well-being of mothers, thus fostering a more compassionate and empowering landscape for childbirth experiences.

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APPENDICES

Appendix 1
Ethical Approval Trinity College Dublin
Health Policy and Management and
Centre for Global Health Research Ethics Committee

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Jennifer Trainor
36 Rowan House,
Sussex House
Mespil Flats,
Ballsbridge
Dublin 4
D04 CP40

28 February 2019

Re: The meaning of preterm birth for postnatal childbearing women in Malawi

Application 26/2019/01

Dear Jennifer,

Thank you for your submission of the above proposal to the HPM/CGH REC.

The REC has given ethical approval to the proposed study.

Yours sincerely,

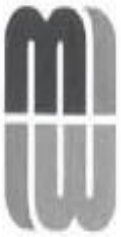
Prof Charles Normand
Chair of the HPM/CGH REC

Bainistíocht agus Beartas Sláinte
3-4 Plás Foster,
Coláiste na Tríonóide,
Baile Átha Cliath,
Ollscoil Átha Cliath,
Baile Átha Cliath 2, Éire.

Health Policy and Management
3-4 Foster Place,
Trinity College Dublin,
The University of Dublin,
Dublin 2, Ireland.

+353 1 896 2201
hsmsec@tcd.ie
www.medicine.tcd.ie/health_policy_management

Appendix 2
Malawi-Liverpool Wellcome Trust Host Approval Letter



Malawi-Liverpool-Wellcome Trust
Clinical Research Programme
P.O Box 30096, Chichiri, Blantyre 3, Malawi.
Tel. +265 1 876444 Fax +265 1 875774

6th November, 2019

Jennifer Trainor
Malawi Liverpool Wellcome Trust
P.O Box 30096
Chichiri
BLANTYRE 3

Dear Jennifer,

RE: RSG FEEDBACK LOI530 THE MEANING OF PRETERM BIRTH FOR POSTNATAL MOTHERS IN MALAWI

Thank you for submitting the above LOI.

We are pleased to inform you that your proposal has been approved and we wish you all the best as your study commences.

Yours Sincerely,

S Gordon

Stephen Gordon
MLW Programme Director

Appendix 3
Queen's Central Hospital-Department of Obstetrics and Gynaecology Approval

Principal

M. H. C. Mipando, MSc, PhD.

Our Ref.:

Your Ref.:

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 871911
01 874107
Fax: 01 874 700

November 26, 2019

Jennifer Trainor
Malawi Liverpool Wellcome Trust
P.O. Box 30096
Chichiri, Blantyre 3

Dear Jennifer,

RE: THE MEANING OF PRETERM BIRTH FOR POSTNATAL MOTHERS IN MPEMBA, BLANTYRE

Thank you for submitting the proposal for the aforementioned project.

I am pleased to inform you that your study has been approved by the Department of Obstetrics and Gynaecology at Queen Elizabeth Central Hospital. Please keep us posted if there is any need of assistance from the department.

Kindest regards,

LA Gadama

Dr. Luis Gadama
Head: Obstetrics & Gynae Department
Email: lgadama@medcol.mw

Appendix 4
District Health Office (Blantyre) Approval

Telephone: Blantye 01 875 332 /01 877 401

Fax: 01 875 430/ 01 872 551

Communication should be addressed to :
Blantyre District Council
Director of Health and Social Services
0882002533 ; gkawalazira@yahoo.co.uk

In reply please quote No. .....

MINISTRY OF HEALTH AND POPULATION

DISTRICT HEALTH OFFICE
P/BAG 66

28th February,2020

Jennifer Trainor
Malawi Livepool Wellcome Trust
BLANTYRE

Dear Sir/Madam

APPROVAL LETTER FOR PRETERM BIRTH STUDY BY JENNIFER TRAINOR

On behalf of the Blantyre DHO Research Coordination Committee, I hereby write to approve the above named study. The study aims at assessing the meaning of preterm birth for postnatal mothers in Mpemba. Mothers will be recruited at Mpemba health centre, one of our health centres in Blantyre District.

Ensure that you adhere to the approved study protocol as you collect data. If you meet any challenges feel free to consult us.

Sincerely,

Blantyre District Council Director of Health & Social Services MAR 2020 Private Bag 65 Blantyre

Dr. Gift Kawalazira
DIRECTOR OF HEALTH AND SOCIAL SERVICES (Ag.)

Appendix 5
College of Medicine Research and Ethics Committee (COMREC) Approval

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.11/19/2867 - The meaning of preterm birth for postnatal mothers in Mpemba, Blantyre by Jennifer Trainor

On 06-May-20

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study

06-May-20

Prof. E. Umar -Chairperson (COMREC) — Date

Approved by College of Medicine 06-May-2020 (COMREC) Research and Ethics Committee

Appendix 6
Clinical Research Support Unit (CRSU)
Malawi-Liverpool Wellcome Trust

Malawi-Liverpool-Wellcome Trust
Clinical Research Programme
P.O Box 30096, Chichiri, Blantyre 3, Malawi.
Tel. +265 1 876444 Fax +265 1 875774

19 May 2021

Ms. Jennifer Trainor
Malawi-Liverpool-Wellcome Trust
Clinical Research Programme
P. O. Box 30096, Chichiri
Blantyre 3
Malawi

RE: Preterm Birth: Study Initiation Approval

Dear Jennifer,

Thank you for joining Alex shabani for the CRSU study initiation visit on 12 May 2021. The purpose was for the monitor to perform a review of essential documentation, study procedures, facilities, personnel qualifications, quality systems, and laboratory management.

We are delighted to see that the study team is prepared and can now provide approval to begin recruitment for the study. Congratulations!

Please note that there are still outstanding action items. These are listed in the study initiation monitoring visit report. Please follow up to ensure these items are adequately addressed and send all resolution follow-up documents to Alex Shabani (ashabani@mlw.mw) as they are available.

Thank you so much for your work you invested in preparing this study. Please note that the CRSU team is happy to assist you at any time point during the conduct of the study.

Best regards,

Brian Ngwira
Clinical Research Support Quality Manager
Malawi-Liverpool-Wellcome Trust Clinical Research Programme

Appendix 7
Study Reapproval/COMREC Progress Report Form

COMREC PROGRESS REPORT FORM

COMREC Use Only
Type of Review: _____

The College of Medicine Research and Ethics Committee
College of Medicine, Private Bag 360, Chichiri

Progress Report

1.	Title of Study	The meaning of preterm birth for postnatal mothers in Mpemba, Blantyre
2.	COMREC #	P.11/19/2867
3.	Start Date	06 / 05 / 2020 (D D / M M / Y Y Y Y)
4.	COMREC Expiration Date	06 / 05 / 2021 (D D / M M / Y Y Y Y)
5.	Anticipated End Date	05 / 05 / 2022 (D D / M M / Y Y Y Y)
6.	Principal Investigator	Jennifer Trainor
7.	Co-Investigator(s)	Academic supervisors from Trinity College Dublin: Dr. Fintan Sheerin Dr. Vivienne Brady
8.	Student Investigator(s)	
9.	Host Department	Maternal Health Group-The Malawi-Liverpool Wellcome Trust
10.	Phone No	+353 87 366 2633
	Email	trainorj@tcd.ie

Approved by
College of Medicine
12-May-2021
(COMREC)
Research and Ethics Committee

1

11. Name of sponsor[1]	The Malawi-Liverpool Wellcome Trust
12. Name of funder[2]	Trinity College Dublin
13. Amount of funding *(please indicate the currency)*	10 159 GBP
14. Amount of CoM overhead fees CoM (10%) in the original approved budget *(please indicate the currency)*	923 GBP
15. Amount of overhead fees paid to CoM (10%) *(please indicate the currency)*	0
16. Amount of CoM overhead fees outstanding (if any) *(please indicate the currency)*	923 GBP

17. If CoM overhead fees are outstanding, provide an explanation why the fee is outstanding in the space below;

The current project, and its participation recruitment, has not yet begun. The principal investigator will be returning to Malawi in April, which is when the funds will be transferred to CoM.

[1] A Sponsor is either an individual, organization or other legal entity which takes responsibility for initiating, managing and/or financing a study.

[2] A funder is an institution, organization or company that simply provides funding, but does not take up the responsibility of initiating or managing the study.

EXECUTIVE SUMMARY OF THE PROJECT

In the space below, provide a brief summary of the progress and results obtained to date (Please explain any changes made or are being planned for approval as indicated in C4).

This past year has been overall very successful, though not without its setbacks due to COVID-19. The researcher had spent October of 2019 to March of 2020 in Malawi, securing approval from their in-country host, the Malawi-Liverpool Wellcome Trust (MLW), the Department of Obstetrics and Gynaecology (Queen's Hospital), and the District Health Office of Blantyre (DHO). Full ethical approval was authorized by COMREC on May 6, 2020. Due to the unforeseen circumstances surrounding COVID-19, and for the health and safety of the participants, data collection was not able to proceed as scheduled. A COVID-19 risk assessment has been completed for the study. The researcher is in regular communication with the MLW regarding the current COVID-19 situation in Blantyre. The plan is to commence participation recruitment in April or May of 2021.

A. Project Status: (Since last approval, check one category only.)

1. Enrollment Has Not Begun* ☒
2. Actively Enrolling Participants* ☐
3. Enrollment Completed, Contact with Participants Ongoing ☐
4. Contact with Participants Completed, Analyzing Identifiable Data Analysis Only ☐
5. Analyzing Identifiable Data (Samples or Data) Only ☐
6. Analyzing Unidentifiable Data; Data Do Not Contain Identifiers or Linkage to the Data if this is a Program Project, check here ☐
7. Complete Section E., sign the Progress Report and attach a ☐
8. Completed List of Associated Projects ☐

If enrollment has not begun or you are actively enrolling participants, attach a copy of the consent document used or to be used.

B. **Number of Participants enrolled, Records Reviewed or Samples Analyzed:**

What is the total sample size?

1. Since last renewal: N/A

# of males		# of females	
# of adults		# of children	

2. Since original approval:

# of males	N/A	# of females	0
# of adults	0	# of children	N/A

C. ***(Answer Questions 1 through 7 based on information since last review. Attach a memo explaining "Yes" answers to questions 1 through 6.)***

	Yes	No	N/A
1. Have any participants withdrawn voluntarily or been withdrawn from the study?	☐	☒	☐
2. Have any unexpected side effects, complications, or findings been noted that have not been reported to the Committee?	☐	☒	☐

D. As Investigators indicate your assessment of the progress of this study

As expected ☐

Not as expected ☐

Above expectation ☐

E. **Funding Status**: *(select one)*

Awarded ☒

Pending ☐

Project **not** funded ☐

If awarded or pending, provide the following information: Application made to the Wellcome Trust for a Research Training Fellowship has been successful

Signature of Principal Investigator

1	9	/	0	1	/	2	0	2	1
D	D		M	M		Y	Y	Y	Y

Date

*****SEE BELOW FOR INVESTIGATOR RESPONSIBILITIES*****

Investigator Responsibilities

- Changes, amendments, or addenda made to the protocol or the informed consent process must be submitted to the COMREC for review and approval prior to initiating the change. This includes changes in investigator(s), sample size, population, research site, subject compensation, etc.
- Incarcerated individuals may not be included in the study unless the study has been approved by the COMREC for inclusion of prisoners.
- The COMREC protocol number should be cited in all correspondence.
- Adverse events should be reported promptly to the COMREC.
- Significant new information that may affect the risk: benefit ratio must be submitted promptly to the COMREC.
- Only consent/assent documents with a valid approval date may be presented to the participants.
- Signed consent forms for all participants enrolled in the study must be retained on file.
- All active research projects must be reviewed and re-approved by the COMREC prior to the project's expiration date.
- The Principal Investigator is responsible for submitting progress reports by the project's current submission date.
- The Principal Investigator is responsible for keeping the Co-Investigator(s) and Student Investigator(s) informed of the status of the project.

RETURN THIS FORM AND SUPPORTING DOCUMENT(S) TO:
College of Medicine Research and Ethics Committee , Mahatma Ghandi Road

COMREC USE ONLY:

Project Re-approved for Period _____ to _____

Project Reclassified as Exempt Status; Continuing Review No Longer Required

_____ _____

Chair/Secretary, COMREC **Date and Stamp**

Approved by
College of Medicine
12-May-2021
(COMREC)
Research and Ethics Committee

Appendix 8
Approved Study Flyer (English)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Sharing your experiences of your baby arriving sooner than you expected

- *Do you believe that you gave birth too soon?*
- *Have you given birth within the last year?*
- *Are you 18 years and over?*

I invite you to share your experiences of having a baby born sooner than expected by participating in a confidential interview. I would be very interested in hearing your story.

Is this something you would be interested in sharing? Please get in touch by phoning or texting +265 (0) 993 322 502.

Chimwemwe Ligomba (Chichewa speaker)
+265 (0) 993 322 502

Jennifer Trainor
Principal Investigator
+265 (0) 995 291 970

Appendix 9:
Approved Study Flyer (Chichewa)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Kugawana ndi ena zimene mwakumanapo nazo chifukwa choti mwana wanu anabadwa mwamsanga kusiyana ndi m'mene mumayembekezera

- *Kodi mukukhulupilira kuti munabereka mwamsanga?*
- *Kodi munabereka mu chaka chatha?*
- *Kodi muli ndi zaka 18 kapena kuposerapo?*

Ndikukupemphani kuti mugawane nafe zimene munakumanapo nazo chifukwa chobereka mwana mwamsanga kusiyana ndi m'mene mumayembekezerera potenga nawo mbali mu zokambirana mwachinsinsi. Ndikhala ndi chidwi kwambiri kumva nkhani yanu.

Kodi zimenezi mukhoza kukhala osangalala kugawana ndi ife?
Chonde tilankhuleni kudzera pa foni kapena potu
+265 (0) 993 322 502.

Chimwemwe Ligomba (Wolankhula chichewa)
+265 (0) 993 322 502

Jennifer Trainor
Principal Investigator
+265 (0) 995 291 970

Appendix 10
Participant Information Leaflet (English)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

PARTICIPANT INFORMATION LEAFLET

STUDY NAME: **The meaning of preterm birth for postnatal mothers in Mpemba, Blantyre**

LOCATION: **Mpemba, Malawi**

INTRODUCTION

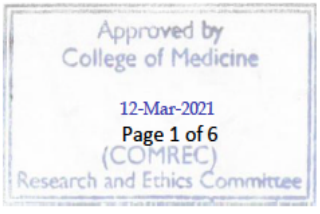
My name is Jennifer Trainor, and I am currently pursuing a doctoral degree at Trinity College, University of Dublin, in Ireland. As part of the doctoral degree requirement, I am conducting research entitled "The meaning of preterm birth for postnatal mothers in Malawi". I am working under the supervision of Dr. Fintan Sheerin and Dr. Vivienne Brady, from the School of Nursing and Midwifery, Trinity College Dublin. I would like to invite you to consider taking part in my research study. This research study has received ethical approval from the University of Dublin, Trinity College, and the College of Medicine Research and Ethics Committee (COMREC), Malawi.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore mothers' experiences of having a preterm infant/baby born too soon/sooner than expected in Malawi. The information gained from this study will help to better understand a woman's personal meaning or experience of having a baby born too soon/sooner than expected.

WHAT WILL MY PARTICIPATION IN THE STUDY INVOLVE?

In order to take part in the study, you must be over the age of 18 and have or believe to have given birth to a baby too soon within the last year. I would like to speak with you about your experiences and personal meaning of having a baby born too soon or sooner than expected. The information collected will be based on an interview, lasting around one hour, which you will lead. Our conversation will be at a time and place most convenient for you. You will have the opportunity to follow-up with a second interview, if you would like to further talk about your experiences with me. With your permission, I will record our conversation. Copies of our interview and my understanding of our conversation will be available for you to check or further explain any part of the interview. This is to make sure I have represented your experiences properly.



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

WHAT ARE THE POSSIBLE RISKS AND BENEFITS OF THE STUDY?

Though there are no direct benefits for participating in the study, some people might find it helpful to discuss their experiences. It is hoped that what I learn from our conversation will help add to a body of research on women's knowledge, by understanding your personal meaning and understanding of birth.

It is possible that you may become upset or uncomfortable talking about your experiences of giving birth too soon. A counsellor/support person is available to you at any point, if you feel you need further support. You are under no obligation to share any distressing experience with me, and I will treat everything you choose to tell with me with the utmost respect and confidentiality. Should you feel uncomfortable, the interview can be stopped or postponed to a later date. You may also withdraw your consent of participation at any time. Should you need further support, please contact Mphatso Makawa at +265 999 096 124 or Mrs. Moyenda at +265 999 354 505.

If you tell me information about nursing, midwifery, or medical malpractice, or illegal activity, I will have to break confidentiality and report this information to the local ethics board and the police, where relevant.

WHO PAYS FOR THE COSTS OF PARTICIPATING IN THIS STUDY?

You are not expected to pay for anything to participate in the project. Participants will be compensated MWK 4500 for their time in this study.

WHAT IF SOMETHING GOES WRONG?

If you were injured in this study, which is unlikely, you would be eligible for compensation either through a medical malpractice insurance or through a no-fault study participant insurance. Please contact your study team for assistance in filing a claim.

WHAT ARE MY RIGHTS?

Your participation in this study is entirely voluntary. If you agree to participate in the study, you will be asked to sign a consent form, which says that you are willing to take part in this study. Your participation is entirely voluntary. You are not forced to participate. You may stop, postpone or withdraw your consent at any point in the interview, without question.

The information collected in this study, including your identity, will be kept strictly confidential. Your identity will never appear in any published documents or reports. Documents, audio recordings, or field notes collected during our conversation will be stored in a secure place, for a maximum of five (5) years. Only the researcher will have access to the confidential material.

WHAT HAPPENS AFTER THE STUDY?

Findings from this project will be presented and published in academic journals for scientific reasons and will not be used for any other study without your permission. You will remain anonymous, and your name or personal information will never be shared.

WHO DO I CONTACT FOR MORE INFORMATION OR IF I HAVE CONCERNS?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

Jennifer Trainor
Principal Investigator
+265 (0) 995 291 970
trainorj@tcd.ie

Chimwemwe Ligomba (Chichewa speaker)
Research Assistant
+265 (0) 993 322 502

Alternatively, you may contact the chairperson of the College of Medicine Research Ethics Committee which oversees the research, by telephone on 01 871911, by email at comrec@medcol.mw or by postal address at COMREC Secretariat, College of Medicine, P/bag 360, Blantyre 3.

This study has been reviewed and approved by the College of Medicine Research and Ethics Committee (COMREC) in Blantyre. This is a committee that ensures research participants are protected from harm.

Appendix 11
Participant Information Leaflet (Chichewa)

Chikalata cha uthenga kwa wotenga nawo mbali

Ntchito: Tanthauzo la kubereka mwana mimba isanakhwime kwa amai amene abereka kumene ndikutulutsidwa mu chipatala (patatha maola 48) ku Mpemba, Blantyre

Malo: Mpemba, Malawi

Mau Oyamba

Dzina langa ndi Jennifer Trainor, ndipo ndikuchita maphunziro a udotolo a degree ku Trinity College, University of Dublin, Ireland. Ngati mbali imodzi ya zoyenereza pa degree ya udotolo, Ndikuchita kafukufuku wotchedwa "Tanthauzo la kubereka mwana mimba isanakhwime kwa amai amene abereka kumene ndikutulutsidwa mu chipatala(pakatha maola 48) ku Malawi". Ndikugwira ntchito moyang'aniridwa ndi a Dr. Fintan Sheerin komanso a Dr. Vivienne Brady, kuchokera ku ya sukulu ya anamwino ya azamba ya Trinity College ku Dublin. Ndikufuna ndikupempheni kuti mutenge nawo mbali mu kafukufuku wanga. Kafukufukuyu wapatsidwa chilolezo kuchokera ku University of Dublin, Trinity College, komanso College of Medicine Research and Ethics Committee (COMREC), Malawi.

CHOLINGA CHA KAFUKUFUKU NDI CHIYANI?

Cholinga cha kafukufukuyu ndikufufuza zimene amai amakumana nazo akabereka mwana wosakwana masiku/wobadwa msanga/wobadwa nthawi yosayembekezereka ku Malawi. Uthenga umene ungapezeke kuchokera mu kafukufukuyu udzathandizira kumvetsa bwino m'mene mai amatanthauzira tanthauzo kapena zimene amakumana nazo akabereka mwana mwamsanga/nthawi yosayembekezereka.

KODI KUTENGA NAWO MBALI KWANGA MU KAFUKUFUKUYU KUKHALA KOTANI?

Pofuna kutenga nawo mbali mukafukufukuyu, mukuyenera kukhala a zaka zoposera 18 komanso mukhale kuti munabereka kapena tikukhulupilira kuti munabereka mwana osakwana masiku mkati-kati mwa chaka chathachi. Ndikufuna ndikambirane nanu zokhudzana ndi zimene munakumanapo nazo komanso m'mene mumatanthauzira kubadwitsa mwana mwamsanga kapena nthawi yofulumirirapo ndi m'mene mumayembekezera. Uthenga umene mungatolere udzachitika kudzera mu zokambirana zimene zingadzatenge ola limodzi, zimene mutadzatsogolere ndinu. Zokambirana zathu zidzachitika pokambirana ndi munthu m'modzi pa nthawi komanso pa malo oyenerera kwa inu. Mudzakhala ndi mwayi wokhala ndi kucheza kwachiwiri pa nkhani ya kalondo-londo, ngati mungafune kucheza nane moonjezera pa zimene mwakumanapo nazo. Ndi chilolezo chanu, ndidzajambula zocheza zathu. Zolemba za kucheza kwathu komanso kumvetsa kwanga kwa kucheza kwathu zidzaperekedwa kwa inu ndicholinga choti muone kapena mufotokoze moonjezera, gawo lina lililonse la kucheza kwathu. Izi zidzachitika pokufuna kuonesetsa kuti ndalemba zinthu zimene mwakumanapo nazo moyenerera.

ZIOPSYEZO NDI PHINDU PA KAFUKUFUKUYU NDI LOTANI ?

Ngakhale kuti palibe phindu lobwera nthawi yomweyo chifukwa chotenga nawo mbali mukafukufukuyu, anthu ena akhoza kuchitenga chinthu chimenechi kukhala chothandiza kuti akambirana zimene amakumanapo nazo. Pali chikhulupiliro choti zimene ndingaphunzire kuchokera pa zokambirana zathu, zidzathandizira kuonjezera ku gulu la kafukufuku pa zimene amai amadziwa , pakumvetsa kwanu tanthauzo la kubereka komanso kumvetsa kuti kubereka ndi chani. Palibe ndalama imene idzaperekedwe kwa inu chifukwa cha kutenga nawo mbali kwanu mu kafukufukuyu.

Ndi zotheka kuti mukhoza kukwiya kapena kusowa mtendere kukamba zokhudzana ndi zimene munakumanapo nazo pobereka mwana nthawi isanakwane. Phungu wa za umoyo azikhalapo nthawi ina iliyonse,ngati mukuona kuti mukufunika thandizo loonjezera. Simukukakamizidwa mwanjira ina iliyonse kugawana nane uthenga wina uliwonse wokhumudwitsa wokhudzana ndi zimene munakumanapo nazo,ndipo ndidzakusungirani ulemu komanso chinsinsi pa china chilichonse mungasankhe kundiuza. Ngati mungasowe mtendere,zokambiran zikhoza kuimitsidwa ndi kudzachitikanso tsiku lina mtsogolo. Mukhozanso kuchotsa chilolezo chanu choti mutenge nawo mbali nthawi ina iliyonse. Mukafuna thandizo loonjezera, chonde lumikizanani ndi Mphatso Makawa pa +265 999 096 124 kapena Mrs. Moyenda pa +265 999 354 505.

Mukandipatsa uthenga wokhudzana ndi za unamwino, uzamba, kapena wogwira ntchito za chipatala amene walephera kutsatira malamulo pa ntchito yake, kapena ntchito yovomerezeka ndikuyenera kuphwanya lonjezo losunga chinsinsi ndikukadandaula za uthenga umenewu ku bungwe loyang'anira za ufulu wa anthu pa kafukufuku komanso polisi, pamene kuli koyenelera.

NDI NDANI AMENE AKULIPIRA KUTENGA NAWO MBALI M'KAFUKUFUKUYU ?

Simukuyembekezeka kulipira china chilichonse chifukwa chotenga nawo mbali m'kafukufukuyu. Otenga nawo mbali athokozedwa ndi ndalama yokwana MWK4500 chifukwa chogwiritsa ntchito nthawi yawo mu kafukufuku.

NANGA NGATI CHINA CHAKE SICHINAYENDE BWINO?

Ngati munavulala mu kafukufukuyu, zimene sizingachitike, ndinu oyenera kupepesedwa kudzera ku inshulansi yaku Chipatala kapena yak u kafukufuku ya anthu otenga nawo mbali. Chonde lumikizanani ndi ndi a m'gulu la kafukufuku kuti akuthandizeni kumalizitsa chikalata choti muthandizidwe.

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Munjira ina, mukhoza kulumikizana ndi wapamphando wa komiti yoona za ufulu wa kafukufuku la College of Medicine Research Ethics Committee limene limayang'anira kafukufuku yonse pa nambala ya foni iyi: 01 871911, pa email iyi: comrec@medcol.mw kapena pa adilesi iyi: COMREC Secretariat, College of Medicine, P/bag 360, Blantyre 3.

Kafukufukuyu waunukidwa ndi kuvomerezedwa ndi a komiti yoona za ufulu wa kafukufuku ya College of Medicine Research and Ethics Committee (COMREC) ku Blantyre. Iyi ndi komiti imene imaonetsetsa kuti anthu otenga nawo mbali m'kafukufuku ndi otetezedwa ku zinthu zimene zingawavulaze.

Approved by
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12-Mar-2021
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Appendix 12
Consent Form (English)

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Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

PARTICIPANT CONSENT FORM

The meaning of preterm birth for postnatal mothers in Mpemba, Blantyre

BACKGROUND: This purpose of this study is to explore mothers' experiences of having a preterm infant/ baby born too soon/sooner than expected in Malawi. The information gained from this study will help to better understand a woman's personal meaning or experience of having a baby born too soon/sooner than expected.

PROCEDURE:

- In order to take part in the study, you must be over the age of 18 and have or believe to have given birth to a baby too soon/sooner than expected within the last year.

- I am very interested in hear about your personal experiences of having a baby born too soon/sooner than expected. Therefore, the information collected in the study will be based on one-to-one interviews with the help of a translator. Our conversation will be at a time and a place that is convenient for you. You will lead the interview. You are welcome to talk about any part of your experience of having given birth sooner than expected. Should you wish to further talk about your experiences with me, you will have the opportunity to follow-up with a second interview. This second interview can be arranged at a time and place convenient for you.

- With your permission, our conversation will be recorded. Transcripts and my understanding of your own transcript will be available for you to check or explain any part of the interview.

CONFIDENTIALITY: Your identity will remain confidential at all times. Your name or identity will never appear in any published documents or reports. All documents will be kept in a locked computer and/or cupboard. Only I will have access to the confidential material.

VOLUNTARY PARTICIPATION: Your participation in this study is entirely voluntary. You may stop, postpone or withdraw your consent at any point in the interview, without question.

BENEFITS AND RISKS: Though there are no direct benefits for participating in the study, some people might find it helpful to discuss their experiences. It is hoped that what I learn from our conversation will help add to a body of research on women's knowledge, by understanding your personal meaning and understanding of birth. It is possible that you may become upset or uncomfortable talking about your experiences of giving birth too soon. A counsellor is available to you at any point, if you feel you need further support. You are under no obligation to share any distressing experience with me, and I will treat everything you choose to tell with me with

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The University of Dublin

the utmost respect and confidentiality. Should you feel uncomfortable, the interview can be stopped or postponed to a later date. You may also withdraw your consent of participation at any time. Should you need further support, please contact Mphatso Makawa at +265 999 096 124 or Mrs. Moyenda at +265 999 354 505.

If you tell me information about nursing, midwifery, or medical malpractice, or illegal activity, I will have to break confidentiality and report this information to the local ethics board and the police, where relevant.

Please answer the following questions by putting your initials or your thumbprint to the response that applies

1. I have read, or had read to me, the information leaflet for this project and I understand the contents. ☐
2. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. ☐
3. I understand that I may withdraw from the study at any time and I have received a copy of this agreement. ☐
4. I freely and voluntarily agree to take part in this research study, though without prejudice to my legal and ethical rights. ☐

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The University of Dublin

PARTICIPANT CONSENT FORM

The meaning of preterm birth for postnatal mothers in Mpemba, Blantyre

Name of participant	Date	Signature/thumb print for illiterate participants
Name of witness (if participant is illiterate)	Date	Signature
Name of study staff obtaining informed consent	Date	Signature

Appendix 13
Consent Form (Chichewa)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Chikalata cha chilolezo

Tanthauzo la kubereka mwana masiku asanakwanire kwa amai amene abereka kumene ndikutulutsidwa mu chipatala(patatha maola 48) ku Mpemba, Blantyre

CHIYAMBI: Cholinga cha kafukufukuyu ndikufufuza zimene mai amene wabereka mwana wosakwana masiku amakumana nazo ku Malawi. Uthenga umene ungapezeke kudzera mu kafukufukuyu udzathandizira kumvetsa bwino m'mene amai amvetsera tanthauzo la zimenezi kapena zimene anakumapo nazo pobereka mwana mwamsanga/mofulumira ndi m'mene amayembekezera.

NDONDOMEKO:

- Pofuna kutenga nawo mbali mukafukufukuyu, mukuyenera kukhala a zaka zoposera 18 komanso mukhale kuti mwaberekapo kapena tikukhulupilira kuti munaberekapo mwana osakwana masiku mkati-kati mwa chaka chathachi.

- Ndili ndi chidwi kwambiri kumva za zimene mwakumanapo nazo pobereka mwana wosakwana masiku/ mofulumirirapo ndi m'mene mumayembekezera. Choncho, uthenga umene ungatoleredwe mu kafukufukuyu udzakhala wochokera pa kucheza kwathu mothandizidwa ndi wothanthauzira mawu. Kucheza kwathu kudzachitika ndi munthu m'modzi pa nthawi komanso malo oyenerera kwa inu. Mudzatsogolera kuchezaku. Khalani omasuka kulankhula zokhudzana ndi china chilichonse chimene mwakumanapo nazo pobereka mwana osakwana masiku. Mukafuna kuti mukambirane ndi ine zokhudzana ndi zimene mwakumanapo nazo, mudzakhala ndi mwayi wokhala kucheza kwachiwiri pa nkhani ya kalondo-londo. Kucheza kwachiwiriku kukhoza kukonzedwa pa nthawi komanso malo amene ali oyeneerera kwa inu.

- Ndi chilolezo chanu, kucheza kwathu kudzajambulidwa. Mudzapatsidwa zolemba zochokera ku mawu ojambulidwa komanso kumvetsa kwanga kwa zolembedwazo kuti inu muzione kapena mufotokozerepo mbali inaa ili yonse ya kucheza kwathu.

CHINSINSI: Uthenga wofotokoza zokhudzana ndi inu udzakhala wa chinsinsi nthawi zonse. Dzina lanu kapena uthenga wofotokoza zokhudzana ndi inu siudzapezeka mu zikalata zotsindikizidwa kapena mu malipoti ena aliwonse. Zolemba zina zilizonse zidzasungidwa mu makina a kompyuta/kapena mu kabati yokhoma ndi ma kiyi.

KUTENGA NAWO MBALI MODZIPEREKA: Kutenga nawo mbali kwanu mukafukufukuyu ndikodzipereka. Mukhoza kusiya, mukhoza kusintha tsiku kapena kuletsa chilolezo chanu nthawi ina iliyonse mu mchezowu, popanda kufunsidwa chifukwa chake.

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PHINDU KOMANSO MAVUTO: Ngakhale kuti palibe phindu lobwera nthawi yomweyo chifukwa chotenga nawo mbali mukafukufukuyu, anthu ena akhoza kuchitenga chinthu chimenechi kukhala chothandiza kukambirana zimene amakumana nazo. Pali chikhulupiliro choti zimene ndingaphunzire kuchokera pa zokambirana zathu, zidzathandizira kuonjezera pa kafukufuku pa zimene amai amadziwa ,pa kamvetsedwe kanu ka tanthauzo komanso kumvetsa kuti kubereka ndi chani. Nzotheka kuti mukhoza kukwiya kapena kusowa mtendere kukamba zokhudzana ndi zokumana nazo pamene mwabereka mwana nthawi imene mimba isanakhwime. Phungu wa za umoyo azipezeka kwa inu nthawi ina iliyonse,ngati mukuona kuti mukufunika thandizo loonjezera. Simukuloredwa mwanjira ina iliyonse kugawana nane uthenga wina uliwonse, ndipo ndidzasungira ulemu komanso chinsinsi china chilichonse mungandiuze. Mukasowa mtendere; kucheza kukhoza kuimitsidwa kapena kudzachitika tsiku lina. Mukhozanso kuchotsa chilolezo chanu choti mutenge nawo mbali nthawi ina iliyonse. Mukafuna thandizo loonjezera, chonde lumikizanani ndi Mphatso Makawa pa +265 999 096 124 kapena Mrs. Moyenda pa +265 999 354 505.

Mukandiuza za uthenga wokhudzana ndi chisamaliro cha mu Chipatala, ubereki, kapena kuphwanya malamulo akagwiridwe ka ntchito mu Chipatala, ndikuyenera kuphwanya lonjezo losunga chinsinsi ndikukadandaula za uthenga umenewu ku bungwe loyang'anira za ufulu wa anthu pa kafukufuku komanso polisi, kumene kuli koyenerera.

Chonde yankhani mafunso otsairawa poika lembani zilemba zoyambilira za maina anu kapena chidindo cha chala chanu pa yankho limene mwasankha)

1. Ndawerenga, kapena anandiwerengera, chikalata cha uthenga cha kafukufukuyu, ndipo ndikumvetsa za zimene zalembedwamo. ☐
2. Ndinali ndi mwayi wofunsa mafunso komanso ndakhutitsidwa ndi mayankho a mafunso anga onse. ☐
3. Ndikumvetsa kuti ndikhoza kutuluka mu kafukufuku nthawi ina iliyonse ndipo ndalandira chikalata cha chilolezochi. ☐
4. Ndikuvomereza momasuka komanso mosakakamizidwa kutenga nawo mbali mukafukufukuyu, ngakhale kuti panalibe kuweruza ufulu wanga wovomerezeka komanso pakafukufuku. ☐

Chikalata cha chilolezo

Tanthauzo la kubereka mwana masiku asanakwanire kwa amai amene abereka kumene ndikutululutsidwa mu chipatala(patatha maola 48) ku Mpemba, Blantyre

Dzina la wotenga nawo mbali	Tsiku limene anasayinira	Siginitchala kapena chidindo cha chala kwa amene sangalembe
Dzina la mboni (ngati wotenga nawo mbali samalemba ndi kuwerenga)	Tsiku limene anasayinira	Siginitchala
Dzina la ogwira ntchito ya kafukufuku amene akutenga chilolezo	Tsiku limene anasayinira	Siginitchala

Appendix 14
Interview Guide (English)

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Interview Guide (English)

The unstructured interview will be guided by the participant. However, the following prompts may be used.

Demographics/Questions about family

- Where are you from?/Where are you living now?
- How old are you?
- Are you in school? No: How old were you when you left school?
- Are you married/have a partner?
- Do you work? What do you do?
- How many pregnancies have you had?
- How many children do you have at home?
- Were any of them born too soon/sooner than expected?
- If yes, how old were they when they were born?

Main interview: Unstructured; beginning with an open-ended question:

What does having a baby born too soon/sooner than expected mean to you? What do you think it means to others?

What is your understanding of having a baby born too soon/sooner than expected?

Tell me about your experiences of having a baby born too soon/sooner than expected.

The following prompts may be used:

- Tell me about your pregnancy/labour with your baby. How did you know your baby was born too soon? When were you expecting to give birth? Where did you give birth? Who was there to assist you? How were you feeling during the pregnancy? Did you feel that anything was different compared to your other pregnancies? How old was the baby when you gave birth? Stories, advice from family, any other babies born too soon in the family?

- How did you feel after the birth? How do you feel now? How do you feel about yourself, your partner, other children, family/friends, your community?

- Did you tell your extended family, friends or neighbours about the birth? If yes: Please describe their reaction. How did that make you feel? If no: Please explain your decision not to tell them.

- Before you gave birth, what had you heard about preterm birth/babies who are born too soon? (Who gave you that information? What did they say?) Before giving birth to your baby, did you know of other mothers who had given birth to a premature baby/baby born too soon? If yes: How did you find out about it? How did you feel?

- Explain how you think your community views premature birth/babies who are born too soon. What do you think influences their views? Stories of/from family, friends, neighbours, and community members about babies who were born too soon.

- If a mother or a woman asked you why a woman might give birth to a baby too soon/sooner than expected, what would you tell her?

- Is there a word in Chichewa (or another language spoken at home) that describes a baby born too soon/sooner than expected? What does it mean? Used in a positive, negative or neutral way?

If experiences with the hospital staff (nurses, midwives, doctors; antepartum or postpartum) is brought up

- During your antenatal appointment(s), did the midwife/nurse/doctor discuss preterm birth with you? What was discussed?

- Did the nurses/midwives/doctors provide information on premature babies and their needs? Did you feel your questions were answered?

Final thoughts

- Any final thoughts, stories, opinions? Questions? Mothers may follow-up and schedule a second interview, if desired.

Appendix 15
Interview Guide (Chichewa)

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Zotsogolera Mchezo (Chichewa)

Mafunso a muzokambirana, kweni-kweni adzatsogoleredwa ndi wotenga nawo mbali. Komabe, posafuna kutaya nthawi, mfundo zotsatirazi zikhoza kugwiritsidwa ntchito.

Mbiri ya munthu/Mafunso okhudzana ndi banja

- Mumachokera kuti?/Kodi mumakhala kuti?
- Muli ndi zaka zingati?
- Muli pa sukulu? Ayi: Kodi munali ndi zaka zingati nthawi imene mumasiya sukulu?
- Kodi muli pa banja/Kodi muli ndi chibwenzi?
- Kodi mumagwira ntchito? Mumagwira ntchito yanji?
- Mwakhalapo ndi mimba maulendo angati?
- Muli ndi ana angati pakhomo?
- Alipo amene anabadwa mwachangu /mofulumira kusiyana ndi m'mene munkayembekezera?
- Ngati inde, kodi munali ndi mimba ya miyezi ingati nthawi imene amabadwa?

Gawo lalikulu locheza: Mafunso ofunsa mopanda ndondomeko; kuyamba kufunsa limeli yankho lake litabweresenso funso lina

Kodi kukhala ndi mwana wobadwa masiku asanakwanire /mwamsanga kuposa nthawi yoyembekezereka zimatanthauza chani kwa inu? Mukuganiza kuti izi zimatanthauza chani kwa ena?

Mumamvetsa kuti ndi chani kubereka mwana masiku osakwanira/kubadwa mwamsanga kusiyana ndi nthawi yoyembekezera?

Ndiuzeni zimene mwakumanapo nazo pamene munabadwitsa mwana wosakwana masiku mwamsanga kusiyana ndi nthawi yoyembekezereka.

Mfundo zotsatirazi zikhoza kugwiritsidwa ntchito pofunsa mafunso

- Ndiuzeni zokhudzana ndi mimba yanu/pamene mumabadwitsa mwana wanu. Munadziwa bwanji kuti mwana wanu anabadwa mwamsanga? Kodi mumayembekezera kuti mukhoza kubadwitsa liti mwanayo? Kodi munaberekera kuti? Ndi ndani amene anakuthandizani? Kodi mumamva bwanji nthawi imene munali ndi mimba? Kodi mumamva kuti china chake chimachitika mosiyana ndi mimba zina? Kodi mwanayo anabadwa muli ndi mimba ya miyezi ingati ? Nkhani, malangizo kuchokera kwa achibale, panali ana ena amene anabadwa masiku osakwanira mu banja mwanu?

- Mumamva bwanji mutabereka? Mukumva bwanji pakali pano? Kodi mumadzimva bwanji nokha, mukumva bwanji zokhudzana ndi amuna anu/ chibwenzi chanu, ana ena, achibale/Anzanu, dera lanu?

- Kodi munawadziwitsa achibale anu, anzanu kapena oyandikana nanu zokhudzana ndi kubadwa kwa mwanayu? Ngati inde: chonde fotokozani kuti anachilandira bwanji. Kodi zimenezi zinakukhudzani bwanji? Ngati ayi: chonde fotokozani zokhudzana ndi chiganizo choti musawadziwitse za zimenezi.

- Musanabereke, munamva chani zokhudzana ndi kubadwitsa mwana wosakwana masiku /ana obadwa mwamsanga? (Anakupatsani uthenga umenewo ndi ndani? Anati chani?) Musanabereke mwana wanu, kodi mumadziwa za amai ena amene anabadwitsapo mwana wosakwana masiku /mwana wobadwa mwamsanga? Ngati inde: Kodi munadziwa bwanji zokhudzana ndi izi? Munamva bwanji

- Fotokozani za zimene mukuganiza kuti anthu a ku dera lanu amaonera zokhudzana ndi kubadwitsa mwana wosakwana masiku /ana obadwa mwamsanga. Kodi mukuona kuti ndi chani chimene chimabweretsa maganizo amenewa? Nkhani zokhudzana ndi /zochokera kwa abale awo, anzawo, oyandikana nawo, okhala nawo kudera zokhudzana ndi ana obadwa masiku asanakwane.

- Ngati mai a mwana kapena mai anakufunsani chifukwa chimene mai angaberekere mwana mwamsanga /angabereke mwamsanga kusiyana ndi nthawi yoyembekezereka, kodi mungawauze chani?

- Kodi pali mawu mu chichewa (kapena mu chilankhulo china chimene mumagwiritsa ntchito pakhoma) amene angathe kufotokoza za mwana obadwa mwamsanga /mwamsanga kusiyana ndi nthawi yoyembekezereka? Kodi zimatanthauza chani? Amagwiritsidwa ntchito mwaubwino, moipa kapena mongolankhula?

Ngati zokumana nazo zanu ndi ogwira ntchito ku Chipatala (anamwino, azamba, madotolo; zochitika mwana akangobadwa kapena pakadutsa nthawi atabadwa) zikambidwe

- Pa nthawi imene mumayendere ku chipatala muli ndi mimba, kodi azamba/namwino /dotolo amakambirana nanu zotani zokhudzana ndi kubadwitsa mwana osakwana masiku? Kodi munakambirana chani?

- Kodi anamwino/azamba/madotolo anapereka uthenga wotani pa zimene zimafunika kwa ana obadwa masiku osakwana? Kodi mukuona kuti mafunso anu anayankhidwa?

Maganizo omaliza

- Kodi mungafune anthu ena atadziwa chani, zokhudzana ndi kubadwitsa mwana osakwana masiku /kubadwitsa mwana mwamsanga /mwamsanga kusiyana ndi nthawi yoyembekezereka? Maganizo ena aliwonse omaliza, nkhani, maganizo? Mafunso? Amai akhoza kuchita kalondo-londo ndikukonza zokambirana kachiwiri, Ngati angafune.