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The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi

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Abstract

Traditional leaders play a prominent role at the community level in Malawi, yet limited research has been undertaken on their role in relation to policy implementation. This article seeks to analyse the role of traditional leaders in implementing national maternal, newborn and child health (MNCH) policy and programmes at the community level. We consider whether the role of the chief embodies a top-down (utilitarian) or bottom-up (empowerment) approach to MNCH policy implementation. Primary data were collected in 2014/15, through 85 in-depth interviews and 20 focus group discussions in two districts in Malawi. We discovered that traditional leaders play a pivotal role in supporting MNCH service utilization, through mobilization for MNCH campaigns, and encouraging women to give birth at the health facility rather than at home or in the community setting. Women and their families responded to bylaws to deliver in the facility out of respect for the traditional leader, which is ingrained in Malawian culture. Fines were imposed on women for delivering at home, in the form of goats, chickens and money. Fear and coercion were often used by traditional leaders to ensure that women delivered at the health facility. Chiefs who failed to enforce these bylaws were also fined. Although the role of the traditional leader was often positive and encouraging in relation to MNCH service utilization, this was sometimes carried out in a coercive manner. Results show evidence of a utilitarian top-down model of policy implementation, where the goal of health service utilization justified the means, through encouragement, fear, punishment or coercion. Although the bottom-up approach would be associated with a more empowerment approach, it is unlikely that this would have been successful in Malawi, given the hierarchical nature of society. Further research on policy implementation in the context of community participation is needed.

Keywords: Malawi, traditional leader, maternal, newborn and child health, community health, top-down policy, utilitarian, empowerment, community participation

Introduction

Despite decades of global recognition (WHO 1978) and empirical studies recognizing the importance of the community in improving their own health and accessing health services (McCoy *et al.* 2012; Molyneux *et al.* 2012; Walsh *et al.* 2012; Rifkin 2014; George *et al.* 2015) and in particular in accessing maternal and child health services (Coutinho *et al.* 2005; Rosato *et al.* 2008; Kumar *et al.* 2012; Marston *et al.* 2013; Prost *et al.* 2013; Kumar and Agrawal 2016),

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Key Messages

- Traditional leaders played a pivotal role in implementing maternal, newborn and child health (MNCH) policy in Malawi, through mobilization of the community for MNCH campaigns, and encouraging women to deliver at the health facility rather than with Traditional Birth Attendents (TBA).
- Fines were imposed on women for delivering at home, in the form of goats, chickens and financial fines. Fear and coercion were often used by traditional leaders to ensure that women delivered at the health facility. Chiefs who fail to enforce these bylaws were also fined.
- Results from our study show evidence of a primarily utilitarian approach to community health, through top-down implementation of MNCH policy, where the end—health service utilization—justifies the means, be that through encouragement, fear, punishment or coercion. Although policy was being implemented at the community level involving chiefs, this is primarily through the utilitarian approach handed down from the national level.
- Although the bottom-up approach would be associated with a more empowerment approach, it is unlikely that this would have been successful in Malawi, given the hierarchical nature of society. Further research on policy implementation in the context of community participation is needed.

most studies have assessed individual factors that affect women and their families' decisions, such as the Three Delays Model (Thaddeus and Maine 1994; Gabrysch and Campbell 2009; Lohela *et al.* 2012).

However, there is growing recognition amongst policy makers, health-care and development practitioners and researchers, of the importance of health and community systems in reducing maternal, newborn and child mortality and improving health (Ergo *et al.* 2011; Rodriguez-Garcia *et al.* 2013; GFATM 2014). For example, the Integrated Management of Childhood Illness strategy includes a community component that acknowledges the importance of informal community-based systems to addressing child health (CORE Group 2010). Furthermore, a number of community systems frameworks explore and unpack the components of a community system such as the Global Fund to Fight AIDS, TB and Malaria (GFATM 2014); and frameworks on how to strengthen these components (Rodriguez-Garcia *et al.* 2013). Aubel (1999) specifically looks at how to strengthen partnerships between formal and informal systems.

Traditional leaders and maternal, newborn and child health

The focus of leadership within health systems to date, in respect of maternal, newborn and child health (MNCH), has been on leadership in the formal sector (Roncarolo *et al.* 2017) with a lack of attention to the role of traditional leadership in in the community. Likewise, the role of leadership in health policy implementation primarily focuses on the formal sector (Gilson and Raphaely 2008). Although a small number of studies recognized the importance of traditional leaders in promoting MNCH (Kululanga *et al.* 2012; Greeson *et al.* 2016), we did not locate empirical studies that analysed in detail their role in promoting MNCH. The absence of analysis of the role of traditional leaders in promoting health service utilization in the published literature is surprising, given the recognition of their role within the community system (Kululanga *et al.* 2012; Greeson *et al.* 2016). Marston *et al.*'s (2013) systematic review on the effectiveness of community participation interventions in maternal and newborn health, argues for the need for better studies, in particular qualitative studies in the area.

Traditional leaders play a prominent role at the community level in Malawi (Chinsinga 2006; Logan 2013), exercising governance, power and authority. Malawi has six levels of chieftaincy: paramount chiefs, senior chiefs, chiefs; sub-chiefs, group village head (GVH); and village head (Chinsinga 2006). Limited research has been undertaken on traditional leaders and health in Malawi. Kululanga *et al.* (2012) studied male involvement in MNCH in Malawi and found chiefs to be greatly respected community leaders, who were knowledgeable about maternal health problems in the district. Manda-Taylor *et al.* (2017) found that chiefs played an active role in supporting MNCH attendance. A study of community health workers (CHWs) in Ethiopia, Kenya, Malawi and Mozambique, found that the traditional leaders fostered CHW relationships with the community, through enhanced community respect and credibility towards these CHWs (Kok *et al.* 2016). The purpose and means by which community leaders engage in community health is still open to debate.

Utilitarian and empowerment models in community health

Discussions around different models in community-based health programmes have centred on the dichotomy between utilitarian and empowerment models (Rifkin 1996, 2014; Morgan 2001; Perez *et al.* 2009). The utilitarian approach quantifies changes in health outcomes as a result of community participation (Rifkin 1996). Participation is seen as a means to achieving outcomes, and not as a value or worthwhile objective of itself. Such an approach is less interested in the context and processes that are involved in the health of communities than in how they contribute to achieving health goals.

The empowerment model sees community participation itself as an objective, aiming to enable communities to access health services and control their health, through promoting their capacity to mobilize as a community (Perez *et al.* 2009; Draper *et al.* 2010). According to this framework, indicators of success of an intervention or programme lie not only in the service coverage or impact, but also in its effects on, and the responses of, the community; and the increase in its social capital (Putman 2000; Welshman 2006). It sees the process and outcome as equally important.

Community participation is interpreted as a way to distribute power more evenly within and between communities, healthcare professionals, and the state, while also developing individuals' and groups' own abilities to participate in the process of change (Marston *et al.* 2013).

Linked to this debate are the models of policy implementation. Analysis of policy frequently focuses on top-down or bottom-up approaches to policy implementation (Sabatier 1986; Erasmus and

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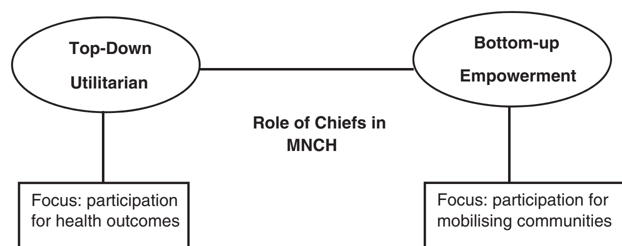

Figure 1. MNCH policy implementation at the community level

Gilson 2008; Erasmus *et al*. 2014; Gilson and Raphaely 2008). The top-down model, mirroring the utilitarian model in community health, focuses on the premise that policy, once developed at the centre,

> *is handed in to the administrative system for execution, and successively refined and translated into operating instructions as it moves down the hierarchy to operatives at the 'bottom' of the pyramid* (Barrett 2004).

Policy is controlled through hierarchy and authority (Barrett 2004) and 'implementers are simply tasked with executing plans to achieve them' (Erasmus and Gilson 2008). A bottom-up-approach, paralleling the empowerment model in community health, such as street-level bureaucracy (Cooper *et al*. 2015) emphasizes the importance of community-participation in sustainable policy implementation. However, a systematic search of literature on health policy analysis between 1994 and 2007, found only a small number of studies that focussed on community participation (Gilson and Raphaely 2008).

This article seeks to analyse the role of one central component of the community system—traditional leaders—in MNCH service utilization in Malawi, in particular the role of village chiefs[1] in implementing national MNCH policy and programmes at the community level. In order to do this we consider whether the role of the chief embodies a top-down (utilitarian) or bottom-up (empowerment) approach to MNCH policy implementation. We analyse their role along the utilitarian/empowerment continuum, described earlier, and illustrated in Figure 1, specifically in terms of the extent to which the traditional leader embodies a top-down utilitarian, or bottom-up empowerment approach to implementation of MNCH policy at the community level. From the perspective of policy implementation analysis, it is also interesting to examine the extent to which implementers (in this case the chiefs) use discretionary power to change the policy as it moves to implementation stage within the community system.

This study was conducted within the Community Systems Strengthening for Equitable MNCH project[2] (COSYST–MNCH) that explored the community systems factors underpinning MNCH services in Malawi.

Maternal and child health policy in Malawi

Although many of Malawi's maternal and child health indicators have improved considerably in recent years, Malawi is progressing slowly towards global targets on maternal mortality. By 2015, Malawi had achieved 111% progress on child mortality (Kanyuka *et al*. 2016), yet only 72% progress on maternal mortality (Gov. of Malawi 2015) or similar. Table 1 summarizes progress in key MNCH indicators between 1992 and 2015.

Although Malawi adopted a number of policy approaches to manage and improve MNCH over the last number of decades (Daire and Khalil 2015) this paper focusses on those from the year 2000, see Box 1.

Table 1. Progress on key MNCH indicators between 1992 and 2017

Indicator	1992	2015/16
Under-five mortality	234/1000 live births	63/1000 live births
Infant mortality	135 live births	42 live births
Institutional deliveries	55%	91%
Home deliveries	43%	7%
Proportion of births in health facilities assisted by a skilled provider	55%	90%

Source: Ministry of Health Demographic and Health Survey (2017).

Box 1. Policy approaches to manage MNCH in Malawi

- Guidelines for Community Initiatives for Reproductive Health (MoH 2005 & 2012)
- Assessment of Future Roles of TBAs in Maternal and Neonatal Health in Malawi (MoH 2007)
- Malawi National Sexual and Reproductive Health and Rights policy (MoH 2009)
- Malawi Health Sector Strategic Plan 2011–16 (MoH 2011)
- Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity.

The use of traditional birth attendants (TBAs) in childbirth has generated much debate globally (Ana 2011). The role of TBAs was formally recognized in Malawi in the 1980s, in the provision of antenatal care (ANC), attending births, and postnatal care (Chen *et al*. 2011). The Malawian Government introduced a national policy to ban TBAs from involvement in deliveries in 2007, as part of the Safe Motherhood Initiative, with the aim of reducing the high rates of maternal and newborn mortality. The ban was reinforced in 2009 (Ministry of Health 2009). Following international pressure at the MDG summit in 2011, Malawi's President reversed the decision to ban TBAs, stating that they should be trained in safer delivery methods (Butrick *et al*. 2014).

The Presidential Initiative for Safe Motherhood was launched in 2012 under the Office of the President and Cabinet by former President of Malawi, Dr Joyce Banda. The goal was to demonstrate political will and commitment to reducing maternal and newborn deaths in Malawi. One of the pillars of this initiative was the reinstatement of the ban on TBAs, which was applied through mobilization of community members, primarily chiefs, to encourage women to seek skilled birth attendance (Butrick *et al*. 2014). The chief was tasked with leading the implementation of the ban at the community level. This created 'champions' for the policy (Butrick *et al*. 2014). As part of this process the chiefs could pass local bylaws which assert that all women in the community should deliver in a health facility and that anyone who does not will pay some fine or penalty, such as a goat or a chicken (Butrick *et al*. 2014). Similar approaches have been adopted in Zambia and Tanzania (Chimhutu *et al*. 2014; Greeson *et al*. 2016). An evaluation of the policy reported that the ban had been effective at increasing overall rates of delivery by skilled attendants (Godlonton and Okeke 2016) According to Greeson *et al*. (2016), a better understanding of the intended and unintended effects of such policies is needed, which is a gap that this article seeks to fill.

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Table 2. In-depth interviews conducted

	Mchinji							Nkhotakota						
	Mduwa		Mkanda		Mchinji District Hospital			Malengach-anzi		Mwadzama				
	M	F	M	F	M	F	Total	M	F	M	F	M	F	Total
Traditional Leaders	6		2				8	3		6				9
Religious Leaders	5		2				7	4		3				7
Government Officials					4	1	5					3	2	5
Senior NGO officials					1	7	8				1	5	2	8
Health personnel	2	1		2			5	2		1	2			5
HSAs	2		1				3	2	3	4				9
TBAs		1		2			3		2		1			3
	15	*2*	*5*	*4*	*5*	*8*	*39*	*11*	*5*	*14*	*4*	*8*	*4*	*46*

Methods

Setting

Two districts in Malawi, Mchinji and Nkhotakota, were selected as case studies (Yin 1999; Gilson 2012) and within these, two traditional authorities (TAs): Mchinji (Mduwa TA and Mkanda TA) and Nkhotakota (Mwadzama TA and Malengachanzi TA) districts. Inclusion criteria for selection of the TAs were that (i) the non-governmental organization (NGO) project partner had current/recently completed projects in the TAs; and (ii) that the NGO partner had established links with other stakeholders working in these TAs, thereby providing entry points for the research. The exclusion criterion for TA sampling was that the NGO partner was not working in these districts or TAs.

Eighty-five in-depth interviews and 20 focus group discussions (FGDs) were undertaken across both districts between August 2014 and January 2015 in this qualitative study. For individual interviews, the inclusion criteria were stakeholders who were involved in MNCH at the district and community level. Exclusion criteria were stakeholders that were not involved in MNCH at the district and community level. For the FGDs, inclusion criteria were: mothers who used formal MNCH services; mothers who did not use formal MNCH services; and their caregivers. Exclusion criteria were women who did not have children and; those who were not involved in caring for the women at the time.

Semi-structured interview guides explored community systems enablers and constraining factors contributing to MNCH service utilization. Interview guides were piloted in both districts. Participants were purposively sampled based on their characteristics, roles and experiences. Snowball sampling was also used, in order to access community networks and individuals that might otherwise not be known to the research team. Written informed consent was obtained from participants. Interviews were conducted in a private space and participants were assured that their personal details would be omitted from transcripts to ensure confidentiality. The following issues were explored with interviewees and FGD participants: factors that assist/hinder MNCH service utilization at the community level; and decision making and ownership at the community level. Eight traditional leaders were interviewed in Mchinji and nine in Nkhotakota.

Data saturation is reached when no new information is obtained (Fusch and Lawrence 2015). In this study, saturation began to emerge in the last two to three interviews for each interview category. Tables 2 and 3 show the attributes of participants. In-depth interviews and FGDs were conducted in Chichewa (the local language) by two Malawian Chichewa speaking research assistants (one male and one female), audio-recorded (with permission), transcribed in Chichewa and then translated to English. Transcripts were checked for completeness against the recorded interviews. Ethics approval for the research was granted by the University of Malawi's College of Medicine Research and Ethics Committee (COMREC No. P08/13/14430). In addition, permission to collect data in Mchinji and Nkhotakota was obtained from the Ministry of Health's Reproductive Health Unit.

An inductive–deductive approach to data analysis was undertaken (Pope *et al.* 2000) whereby themes were identified from published literature and meaning emerged inductively from the data. Data analysis was iterative, ongoing throughout the data collection process. The Malawi and Irish research teams undertook the coding separately, which was followed by a joint meeting in Malawi, where a final coding scheme for all the data collected was agreed. Interview and focus group transcripts were analysed using NVivo 10 software.

Results

The results relating to the role of traditional leadership in MNCH focussed on the following themes: (i) respect for the position of traditional leader by the community; (ii) support from traditional leaders for MNCH service utilization; (iii) links between the formal health system and the community or traditional structures; and (iv) traditional leaders as enforcers of MNCH policy.

Respect for the position of traditional leader

Many interviewees referred to chiefs as being influential, leaders of the community, with some using the term 'owner of power'. Their powers were often referred to as being 'formal' and permanent, primarily consisting of the direction of development agendas in the form of making bylaws for the village to follow. They were also seen as the source of wisdom as they let people know what needs to be done to enable development in the village. This encompassed legal issues, funerals, encouraging women to deliver at hospitals and enforcing the TBA ban (discussed below). It was widely believed that chiefs have legitimate authority, because they are chosen by the people and are trusted by government.

> *They have legitimate authority. Because he is a person chosen by members of the village, he is not chosen by the government, so we have trust in them, we know them, and they have ownership of the village or the chieftaincy* (Religious leader, M24[3]).

In most communities, the village heads are elected, often by the family of the deceased chief, including in some cases, by the clan Grandmothers. The importance of choosing someone who will preserve culture was discussed. It was stated that the formal powers of the chief come from the TA, who pass rules to the chiefs, who in

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Table 3. FGDs conducted

	Mchinji (M)					Nkhotakota (KK)				
	Mduwa		Mkanda			Malengachanzi		Mwadzama		
	M	F	M	F	Total	M	F	M	F	Total
Caregiver–Husbands	1		1		2	2		1		3
Caregiver–Grandmothers + Mother in-law		2			2		1			1
MNCH users (pregnant women + women with under-5 children)		2		2	4		1		2	3
MNCH non-users (pregnant women + women with under-5 children)		1		1	2		1		2	3
	1	*5*	*1*	*3*	*10*	*2*	*3*	*1*	*4*	*10*

turn pass them on to the community.[4] The character of the chief in many cases was mentioned as being of utmost importance.

> *If the chief is skilful, people obey him for instance in this community we believe in going to the hospital and people come to the hospital because of the skills of the chief* (Religious leader, KK36[5]).

> *When he talks people listen, so when something comes with the village chief the people understand it more than if someone else should say it* (HSA, KK8).

There were frequent references by all respondent categories to the chiefs' devotion to their communities. Examples were given where chiefs cultivated crops to help poorer people in the village and paid for transport to the health facility with their own money. It was reported by some interviewees that if the chief does not perform on development issues, the village development committee can question the chief and that he can be forced to step down. It was reported that people respond to the bylaws to deliver in health facility out of respect for the chief, which is ingrained in culture.

Support from traditional leaders for MNCH service utilization

All interviewees from the different categories spoke of traditional leaders playing a pivotal role in supporting MNCH service utilization. Mobilization of the community for MNCH campaigns and activities, reportedly, was primarily through traditional leaders. This support would often be through committees and group meetings. Specific MNCH committees were mentioned in some areas. Groups, consisting of chiefs and the GVH, reportedly convened to discuss MNCH issues collectively. It was frequently mentioned that the chief encouraged breastfeeding; nutrition; family planning, antenatal care (ANC) and under-fives clinic attendance, including vaccinations. Maternal health task forces were instituted at GVH level in Mchinji. It was reported that while these worked well in some parts of the district, others were constrained due to a lack of funding.

Many accounts were given where chiefs encouraged women not to deliver with TBAs, but to deliver at the hospital or health facility. In Nkhotakota, one TA chairperson established a group of chiefs to discuss the high number of infant deaths due to TBAs. Chiefs often rejected or discouraged traditional practices and beliefs, especially TBAs.

> *People don't like those traditional beliefs or maybe talking about traditional healers, maybe the chief having the mindset saying: whenever a traditional healer can come at night, I will be charged by the government, delivering from the village, the chief hates that, whenever you could be doing this, you will be like bringing the old fashioned behaviour that existed long time ago* (Senior Group Village Headman [SGVH], KK30).

This belief was reinforced by the opinion, articulated by some chiefs, that TBAs were responsible for women dying in childbirth due to TBA practices, since they believed them to be untrained and not having the necessary skills to conduct deliveries, but that this had not been as prevalent in recent years:

> *In the past we used to have a lot of pregnant women dying because of the TBAs, they used to go TBAs so most of the times the TBAs are not trained so they were just trying this so in the end the pregnant woman would die. So when we encourage women, the death of pregnant women has decreased so encouraging women is no longer a strange thing to us* (SGVH, KK37).

It was reported by a number of respondents that chiefs are embarrassed when their villages fare poorly in comparison to others, which makes them encourage women to deliver at the health facility. However, one community described how the senior chief sensitized the chiefs to promote hospital birth, which result in changed practice initially, however women returned to home births over time.

Despite the positive reports of chiefs' involvement in MNCH, some negative reports were also given. Some examples were described of chiefs blocking links with NGOs that promote MNCH, due to beliefs in cultural practices and traditional medicine. In a small number of cases in Nkhotakota, health facility staff reported that community members were influenced by chiefs not to deliver at the health facility, but instead with TBAs.

Linking the formal health system and the community

Chiefs were often described—by district and health facility staff—as partners in health service planning, with the chief representing the primary link between the hospital/health facility and the community, e.g. through calling meetings to link the formal health system and the community, specifically for ANC and delivery attendance and under-five clinics. They often monitored MNCH programmes and delivered feedback to the community. Health Surveillance Assistants[6] (HSAs) reported that they relied on chiefs for delivering services to communities and NGOs reported implementing projects only following discussion with the chiefs. Chiefs generally required that they were informed of community events relating to MNCH before they began. Many examples were cited where outreach clinics were dependent on chiefs' support.

> *As a community health worker you do inform the chief that you want to have an awareness campaign, and then uses his/her authority to inform the villagers* (HSA, KK, N11).

Although there were many reports of such involvement and support, some chiefs in both Mchinji and Nkhotakota reported that they were not considered as partners in the planning of health services even though they were eager to do so.

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In Mchinji district, it was described how the hospital held meetings with the chiefs to discuss MNCH issues, including numbers of women who delivered at the hospital. Links between chiefs and Village/Area Development Committees for recording births were also reported. An example was given where a chief complained to the government about treatment of women by staff at a hospital in Nkhotakota, which resulted in changed practices and improved treatment in that hospital. In another example, the GVH got together to build an under-five clinic in a community. It was reported that chiefs played a role in promoting male attendance at ANC, in requiring that women be accompanied by their husband for ANC. If they did not attend, a letter would be provided by chiefs detailing why the husband was unable to attend and requesting that the woman be seen on her own.

Traditional leader as the enforcer of MNCH policy

Local bylaws had been developed to enforce women to deliver at the hospital or health facility. These bylaws were not however legally binding. It was stated that these were developed and instituted by traditional leaders, although it was considered that central government encouraged chiefs to enforce these fines.

> *What I do is to force pregnant women to go to the hospital, for that's what they say. And if a woman gives birth at home that is an offense. It is an offense from the office of the TA and down to the village headman. It is against the bylaw if a woman gives birth at home, as such she is asked to pay a fine of a chicken or goat. And that teaches people lessons. They no longer want to give birth at home* (Village headman, M35).

Fines were imposed on women, under these bylaws, for delivering at home, in the form of goats and chickens and also financial fines ranging from 500 to 3000 Malawi Kwacha (~US$1–$5 at the time of the research). Fines were also enforced for not attending ANC or under-fives clinics.

> *There are different kinds of punishment, some could mention of a goat, just to frighten people the most, they do mention of a goat, therefore as a villager, once you happen to think of where you are going to get a goat from, it would be better to go to the hospital* (HSA, KK24).

Sometimes these fines were given to the chief, and sometimes to the Village Head, GVH or TA. There was one report of financial fines being given to the health facility.

A recurring theme was that very often, fear and coercion were used by traditional leaders to ensure that women delivered at the health facility. Terms such as ‘punishment’, ‘crime’ and ‘fear’ were common, articulated by chiefs themselves to explain why they enforced the bylaws, as well as women and their families. It was also common for the words ‘encouragement’ and ‘fines’ to be used in the one sentence. It was reported by a number of interviewees—from all stakeholder groups—that women use the health facility out of fear. There were frequent references to women being afraid of being punished for not delivering at the hospital. However, for the most part, it was not considered by most respondents that the fines were unreasonable. Examples were given as follows:

> *So I think it is because we are afraid that is why we go to the hospital* (Female users, KK, FGD3).
>
> *They should take the message that if you give birth at home you will pay 6 goats… that is the message of encouragement through the chief* (Female users, KK FGD9).

There were also accounts of chiefs being accountable for MNCH outcomes, in that they were also fined if women delivered at home. ‘Call groups’ were discussed, where pregnant women were being watched by messengers and brought to the traditional court, if they did not deliver at the facility/hospital. Watchmen were mentioned in both Nkhotakota and Mchinji, where chiefs entrusted community members to observe pregnant women in the villages in order to track if they attend the health facility:

> *We chase them not to deliver here but at the hospital; also we have put a rule that there is a punishment when they deliver in the village (Village headman, M19).*

> *Sometimes it happens that the woman accidently delivers at 8th month…we discuss with her but still she has to give an apology (Village headman, M13).*

> *So, if they knew that the time has come to give birth and she was supposed to wait at the hospital but the husband did nothing about it, that, is considered a crime (SGVH, M27).*

Discussion

The practice of community leaders imposing fines and other penalties on women who do not deliver at health facilities has been documented in other countries (Chimhutu *et al.* 2014; Greeson *et al.* 2016). Godlonton and Okeke (2016) found that the ban on TBAs in Malawi decreased the use of TBAs by ~15%. This article offers insights into one influence for this at the community level, the role of the traditional leader. Results from this study show that while the role of the chief was often positive and encouraging in relation to MNCH service utilization; this was sometimes carried out in a coercive manner. Rather than empowering women to deliver in a facility, the implementation of local bylaws effectively punished women who fail to do so with a fine. Chiefs who failed to enforce these bylaws were also fined, therefore displaying evidence of the top-down approach to policy implementation, within the informal health sector. For the most part, the chief did not alter the policy as it moved from national to community level. However where the chief did not implement the policies as intended, he in turn was penalized for not doing so.

Although many women mentioned being fearful of the policy, interestingly, none of the women or their families considered the approach or fines to be overly coercive. Women generally accepted these fines without question. However, fining of women raises issues of equity, as poorer families are less likely to be able to afford transport to get to a health facility in the first place and may also not be in a position to pay the fines for not delivering at a facility (Butrick *et al.* 2014). There are two sides to improved maternal health outcomes, that is, while reducing maternal deaths and improving delivery by skilled personnel was to be commended, the means by which it is achieved seems to be unquestioned. The Results-Based Financing for Maternal and Neonatal Health (RBF4MNH) Initiative[7] was designed to increase health service utilization for MNCH in Malawi, with Mchinji being one of the implementation districts. This included financial incentives for health provision in results based facilities and conditional cash transfers to pregnant women to recoup expenses relating to facility childbirth. Interestingly, the initiative did not seem to have an impact on the use of delivery and early neonatal health care services, according to participants. Although participants did report greater registration uptake of pregnant women, there were still considerable challenges facing women accessing services related to transport costs, and other household caring and household responsibilities. Nor did it improve ANC seeking behaviour, and it did not

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have any effect on the equitable utilization of services between women of different wealth levels. Although some participants in this study mentioned allowances for staying at maternity waiting homes[8] to cover food and firewood, this did not seem to be universally applied. The facility received the results-based financing and used this to support women in seemingly limited ways, such as the provision of basic maternity and newborn supplies.

Although national level support for TBAs has fluctuated, district and community level support for the ban has remained, and according to Butrick *et al.* (2014) it appears to be sustained over time. One reason for the central involvement of the chiefs would be that due to their positions, they are in the optimum position to ensure that women and their families adhere to the policy. This is supported by Godlonton and Okeke (2016). Our study did not observe major differences in implementation of the policy by the chiefs in the two districts or the four TAs, displaying a strong national policy and directive. Further research could investigate why there is general support for a top-down policy that women fear, that leads to punishments, and the likelihood of greater expense in spending time at health facilities.

Results from our study show evidence of a primarily utilitarian approach to community health, through top-down implementation of MNCH policy, where the end—health service utilization—justifies the means, be that through encouragement, fear, punishment or coercion. Although policy was being implemented at the community level involving chiefs, this is primarily through the utilitarian approach handed down from the national level. There was very little questioning of the policy from any of the women or families that participated in this study. Kululanga *et al.* (2012) found that community members generally do not question traditional leaders, as it shows disrespect for the position. Our study suggests adherence to an authoritarian figure, seen by community members as a legitimate authority, rather than an empowerment model. In addition, it raises the possibility that the positive view of the chief, as an authority figure, might be sufficient to encourage women to give birth in health facilities, without the need to resort to legislated punishments. In turn, the chiefs did not question the national level policy, or alter it. They did not use their discretionary power as implementers to adapt policies to their local community context (Barrett 2004) or to challenge the status quo, as would define bottom-up approaches to policy implementation (Erasmus and Gilson 2008; Sabatier 2008). Therefore, while chiefs have been empowered to a certain degree, they did not actually alter the policy in its' implementation.

This study has shown that the coercive top-down approach was not viewed negatively by the women or their families, showing that the empowerment, bottom-up approach may not work in such a hierarchical society. Puri *et al.* (2004) illustrate that the degree of participation of community members in the design, development or implementation of land degradation and water policy in India depended on the socio-economic, cultural and political situations faced in each setting, including existing power asymmetries (Puri *et al.* 2004).

It cannot be concluded however, that the approach adopted by the chiefs in these two districts is wholly utilitarian. Chiefs have an important symbolic role, as community members and leaders, and can be seen to be empowered to implement MNCH policy at the community level; and as having an empowering influence on their communities. There emerged, in the interviews and FGDs, other forms of community influence by chiefs, through their engagement with and support to CHWs and committees. Despite this, the agency role of chiefs, who are required (indeed forced) by the state to in-turn coerce women and their families means that a top-down approach to policy implementation is enforced. Although the chief as a member of the community, was empowered to participate in the promotion of MNCH service utilization and indeed supported and encouraged women and their families to utilize MNCH services, he also implemented the policy at the community level on behalf of the government, as the enforcer of MNCH policy, which does not in itself have community empowerment as an aim.

Although the chief displayed relative power, in reality he is subject to the power of the TA. This is shown by the fact that the chiefs are also fined if the policy is not enforced. The conditionally positive view of the chief in the eyes of the community is partly based on the office he holds; but partly depends on his 'skill' and the 'devotion he shows' to his community, which more than negates any negative connotations that result from his agency role. Hence, his legitimacy depends on both his office and his person.

The role of traditional leaders in Africa has often been demarcated between traditionalism and modernism (Kululanga *et al.* 2012; Logan 2013). Traditionalists assert that chiefs motivate their people, through community mobilization (Chinsinga 2006; Mohlala *et al.* 2011), without always capturing the more complex processes at play. Logan's study (2013) asserted that traditional leaders continue to play a significant role in many African communities, while Chigudu (2015) contended that the institution of traditional leadership adapts to the changing values of its people. In contrast, modernists view traditional leaders as 'instruments of social oppression' (Chinsinga 2006), hindering democracy (Chigudu 2015). A numbers of studies have concluded that elected governments and traditional leadership work together, with a dependence on traditional leaders to mobilize communities (de Sousa Santos 2006; Logan 2013; Bolarinwa *et al.* 2014). What emerges from our study is that the chief embodied both a traditionalist and a modernist approach, located primarily within the utilitarianism top-down model of policy implementation. Although there is some evidence of the chiefs and community being empowered, they did not actually alter the policy as it moved from national to community level. Perhaps chiefs are caught in the middle of a well-intentioned, but potentially oppressive state policy.

Conclusion

Whether the implementation of a policy is empowering or not depends on the perspective taken—for the common good given the context, that is maternal and child health outcomes, i.e. the utilitarian approach—or to empower people with the information—i.e. the empowerment approach.

A meta-synthesis (Renfrew *et al.* 2014) concluded that women place importance on having a sense of control in relation to childbirth, and in making choices regarding their care. Based on our study, we have argued that the safe motherhood initiative in Malawi is not primarily designed in this way, as the focus is on trying to improve national maternal and neonatal survival in resource limited service contexts. Where community conditions are those of extreme poverty, and related to this, where women's health status is generally poor, giving birth at facilities with skilled birth attendants has the potential to improve outcomes, especially when there are limited skilled birth attendants outside the health facilities. Juxtaposed with this is a situation where the health facilities are resource constrained. This article does not address enablers and constraining factors to utilizing health facilities for delivery, nor does it make a judgement on the importance of health facility delivery in this setting (neither quality of care nor delivery outcomes were measured); and is specifically limited to the role of traditional leaders. However, in rural Malawi, communities, families and women experience extreme poverty and the costs of using such services—which some chiefs help to alleviate—and the penalties for not using them are both relevant. However, it is notable that most

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women and their families in this study did not consider that their rights were infringed by fining women for not giving birth at health facilities. That in itself raises questions about a deeper level of disempowerment that forms part of their lives.

This study aims to open up a debate on an area of global policy that will benefit from further scrutiny. The World Health Organization maintains that women and newborns should not be mistreated or penalized due to their socio-economic status (WHO 2016). Studies have found that women who deliver at home in lower and middle income countries are poorer and/or less educated, thus potentially making penalties for this practice a regressive tax on the most vulnerable (Houweling *et al.* 2001; Gabrysch and Campbell 2009). This raises questions about this dimension of the MNCH policy in Malawi, where poor women are more likely to deliver at home and therefore are more likely to be fined. However, it does not attempt to make a conclusive judgement, in that hospital deliveries may—and hopefully do—bring comparative benefits to poor women as well as to others, through better pregnancy outcomes.

Evidence exists to show that these community approaches work (Rifkin 2014; George *et al.* 2015). Should the pendulum shift more in favour of the bottom-up empowerment approach, giving greater recognition for the positive influence of traditional leaders, contributing to women, their families and communities being enabled and empowered to utilize MNCH services? Although the bottom-up approach would be associated with a more empowerment approach, it is unlikely that this would have been successful, given the hierarchical nature of society in Malawi (Puri *et al.* 2004). Evidence shows that empowerment models are difficult to implement, and can make unrealistic expectations about the abilities of the poor to participate (Brett 2003, Michener 1998). Further research on policy implementation in the context of community participation is needed.

Notes

1. Although it is recognized that there is a hierarchy to traditional leadership in Malawi, for the purpose of this paper, we use the generic terms ‘chief’ or ‘traditional leader’ unless interviewees specified a particular type/level of traditional leader.
2. https://cosyst.wordpress.com/
3. M denotes Mchinji
4. According to the Chiefs Act (1967), while formal powers officially stem from the President, in practice the authority comes from Local Government.
5. KK denotes Nkhotakota
6. HSAs provide a wide range of preventative and curative services to a specific catchment area. Their responsibilities include MNCH, environmental health, communicable diseases and community case management (Chikaphupha, *et al.* 2016).
7. http://www.tractionproject.org/sites/default/files/PBI%20Results-Based%20Financing%20in%20Malawi_Brief%201.pdf
8. Maternity waiting home brings women within close proximity to a health facility close to due date.

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