

**Perceptions and practices related to home based and facility
based birth.**

A qualitative study from Agemssa, Ethiopia

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Picture 1:

Made by Tegegne Yirdaw, a local painter in Lalibela, Ethiopia.

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List of abbreviations

AAAQ framework	-	Availability, Accessibility, Acceptability and Quality
ANC	-	Antenatal care
TBA	-	Traditional birth attendant
SBA	-	Skilled birth attendant
WHO	-	World Health Organization
EmOC	-	Emergency obstetric care
MoH	-	Ministry of Health
IDI	-	In-depth interview
FGD	-	Focus group discussion
NSD	-	Norwegian Social Science Data Service
MDG	-	Millennium development goal
MMR	-	Maternal mortality ratio
HEP	-	Health extension program
HEW	-	Health extension workers

Summary

Introduction

Despite the indications of sharp declines in maternal mortality rate the past few years, maternal mortality still remains unacceptably high, and many countries are not on track to achieve the aims of the millennium developments goal 5. Ethiopia has one of the highest numbers of maternal deaths in the world, around 20 000 deaths annually. Less than six% of the births in Ethiopia are attended by a skilled birth attendant, a very low figure also in an East African context. In order to enhance our understanding of the very high numbers of home births in Ethiopia, the present study set out to explore perceptions and practices that can help explain the apparent emphasis of home birth and the experienced barriers to birth giving at health facilities. The study draws up the Availability, accessibility, acceptability and quality framework (AAAQ) in the discussion of the findings.

Methods

To gain in depth get understanding of the study topic a qualitative design was chosen including one community based setting and one health facility based setting.

Qualitative data triangulation was applied to collect the data. A total of 31 in-depth interviews, 2 focus group discussions and one observation of a homebirth that ended at a health facility were carried out. The data was transcribed and translated from Afaan Oromo to English. The analysis of the collected data is based on Malterud's "Systematic Text Condensation".

Results

Home birth was perceived to be the normal place to give birth and was highly valued as signifying health among the informants. There was a general scepticism- related to giving birth at health facility that was seen as an option in cases of emergencies only. Regarding the decision-making process it was the husband, who ultimately decided where his wife was going to give birth, but the results of the study revealed that the mother, elderly female family members and neighbours also strongly influenced this decision.

Conclusion

Homebirths were culturally elaborated and emerged as highly valued as meaningful events and as signs of health and wellbeing. There was a simultaneous scepticism to birth taking place at health facilities indicating a strong emphasis on the ‘acceptability’ dimension of the AAAQ framework. There was substantial openness for facility based delivery in cases of emergency, and a call for available emergency obstetric services. A stark difference hence emerged between what was experienced as delays in the care seeking in cases of what was perceived to be “normal” deliveries and in cases of more obvious emergency situations where ‘accessibility’ and ‘availability’ limitations emerged strongly.

Key words: Perceptions, practices, homebirth, health facility birth, decision-making

Introduction

In the developing world today it is not a matter of course that women have access to obstetric care services. Every day 1000 women die from complications related to childbirth or pregnancy. Most of these deaths are avoidable and 99% are happening in low-income countries, which illustrate the huge inequities regarding access to health care (WHO, 2010a). Hogan, et.al (2010) found that over 50% of the maternal deaths were occurring in only six countries, Ethiopia being one of them (Ibid, p.1609).

Ethiopia has one of the highest maternal mortality figures in the world with 720 deaths per 100,000 live births (WHO, et.al., 2007, p.24). The Ethiopian Ministry of Health (MoH) estimates that complications during pregnancy, delivery or during the postpartum period, lead to 20.000 maternal deaths and in addition will 400.000 more suffer from pregnancy and birth related disabilities every year in the country (Ministry of Health, 2009).

Maternal health is put at the core of the global health agenda, focused through one of the main development goals, MDG 5, which aims to reduce the maternal mortality ratio by three quarters between 1990 and 2015, and achieve universal access to reproductive health by the year 2015 (WHO, 2010b). Until recently the annual number of maternal deaths has been estimated to be over 500.000. A recent study done by Hogen, et.al (2010), states however that these numbers in 2008 had dropped to 350.000. The numbers are however still unacceptably high, and most of the countries are not on track to achieve MDG 5 (Hogan, et.al; 2010, p.1609).

A mother's death is not only a personal tragedy, but it can have huge social, economic as well as health consequences (Seifu et.al, 2011, p.126) and will commonly have severe consequences for her children as well; a child who has lost his/ her mother is three to ten times more likely to die at a young age (Save the children, 2008, p.11). In the "State of the world's mother's report 2008" the well being of mothers and children are compared in 146 countries. In the report the Nordic countries are among the top 10 regarding the well being of mothers and children, while sub-Saharan countries, including Ethiopia, are dominating the bottom 10 (Save the children, 2008, p.37).

Around 50% of women in the world today give birth alone or with the help of an untrained birth attendant (WHO, 2008, p.2). If we compare Ethiopia with Tanzania and Kenya, which all are located in eastern Africa, we find huge differences when it comes to the utilisation of health facilities and skilled birth attendants (SBA). In Ethiopia it has been found that only 5,8% gave birth with a SBA (WHO, 2008, p.3), while the figure was 41,6% in Kenya (Ibid, p:2) and 46,3% in Tanzania (Ibid, p.2). A difference was also found between urban and rural areas in the usage of a SBA. In Tanzania the use of SBA was 80,9% in urban- versus 38% in rural areas (Ibid, p.2), in Kenya the numbers are 72% urban- versus 34,5% rural areas (Ibid, p.2) and in Ethiopia 44,8% urban versus 2,7% rural (Ibid, p.3).

Analytical approach

The AAAQ framework

United Nations for Human Rights and WHO, states in their report that “human rights are central to the achievement of the Millennium Development Goals” (2008, p.1). The International Covenant on Economic, Social and Cultural Rights (ICESCR) states in Article 12 that “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standards of physical and mental health” (OHCHR, 2007, p.4). “To clarify and operationalize the provision of article 12 the UN committee on Economic, Social and Cultural Rights adopted General Comment 14” (OHCHR and WHO, 2008, p.8), which states four criteria to evaluate the right to health: *Availability* (“in sufficient quantity”), *Accessibility* (affordable, non-discrimination, physical), *Acceptability* (ethically, culturally, confidentiality) and *Quality* (scientifically and medically) (Ibid, p.9-10).

This framework is included and will be used in this context to illustrate the different factors affecting and influencing the decisions on where to give birth and to indicate where the main barriers to give birth at health facilities may lie.

Background information and literature review

In the world today many people live in extreme poverty, struggling with illiteracy, ill health, low life expectancy and social exclusion (Pogge, 2005, p.1). In the 1960's Johan Galtung (1969) argued that violence is more than personal violence; "violence is here defined as the cause of the difference between the potential and the actual, between what could have been and what is" (Ibid, p.168). When a person dies from something that is avoidable, violence is present (Ibid, p.169). Galtung further specified that in structural or indirect violence, are the violence "built into the structure and shows up as unequal power and consequently as unequal life chances" (Galtung, 1969, p.171). Social arrangements "are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people" (Farmer, et.al. 2006, p.1686), the violence is "exerted systematically" (Farmer, 2004, p.307). Galtung (1969) further specified how structural violence could be aggravated further if a person has lack of power, lack of education and lack of health (Ibid, p.171).

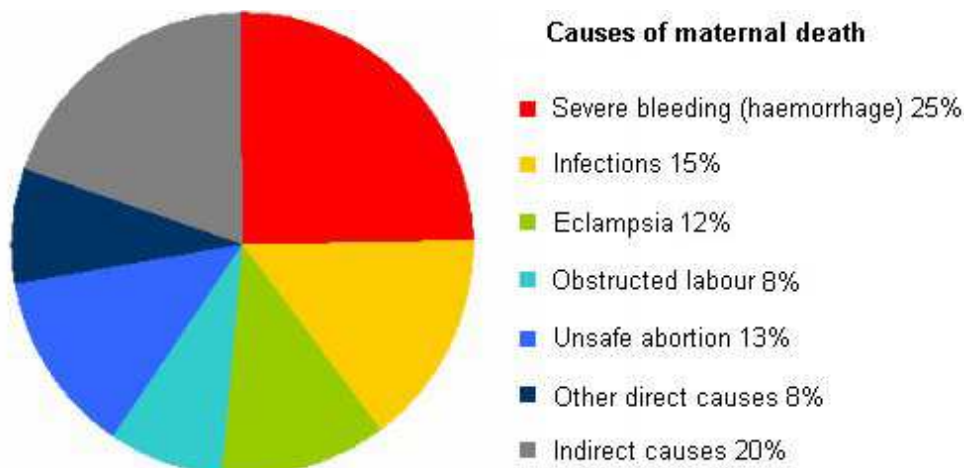
Maternal health indicators are known to be the indicators with the largest inequalities between and within countries (Zere, et. al.; 2011, p.2). Health services for women in childbirth are extremely inequitably distributed between and within countries. There are different underlying social determinants affecting maternal health; like inequity, poverty, gender discrimination and women's empowerment (WHO and UNICEF, 2010). To be able to achieve equitable and good health, access to- and utilization of health care services are vital (CSDH, 2008).

There are complex reasons why the majority of women in Ethiopia give birth at home. This study intends to explore perceptions that underlie the high number of home births in Ethiopia. Factors and barriers that can influence the decision to seek health care in the view of the Availability, Accessibility, Acceptability and Quality (AAAQ) framework will be explored to illustrate different dimensions that might make them choose to deliver outside a health facility or delay women in reaching a health facility.

Causes of maternal mortality and morbidity

There are both ‘direct’ and ‘indirect’ causes of maternal mortality and morbidity.

There are different biomedical *direct* causes of maternal deaths related to pregnancy, childbirth and the postpartum period, with four major “maternal killers”, namely: eclampsia (pregnancy-induced hypertension), obstructed labour, postpartum haemorrhage (severe bleeding) and septicaemia (mostly after delivery) (Lindstrand, et al., 2006, p.239).



Source: *The World Health Report 2005. Make every mother and child count.* Geneva, World Health Organization, 2005.

The *indirect* causes of maternal deaths and disabilities are already existing diseases, or new diseases that is not a direct obstetric cause, e.g. malaria, heart diseases, anaemia and hiv/aids (Seifu, et.al; 2011, p.129-130). Non-medical factors that can cause maternal deaths and disabilities are related to lack of available and accessible good quality health services, poverty, cultural factors and women’s lack of education and their position in the society (Seifu, et.al; 2011, p.130-131), leading us back to Galtung (1969) and Farmers (2006) focus of structural barriers. These are thus complex factors and some of these central factors and reasons will be elaborated on in the coming sections.

Most importantly the complications and leading causes of maternal deaths mentioned above can be averted if necessary treatment is given. To be able to confront these complications and hence to reduce the maternal deaths, the availability, accessibility, acceptability and quality of lifesaving services, commonly known as emergency obstetric care, must be improved (WHO, et.al. 2009, p.vii). The health facilities in

many African settings are equipped with poor resources and do not provide full maternity services. Maternity services equipped for emergency obstetric care are commonly not available or accessible for women in childbirth. What is more, increasing the availability of health services doesn't necessarily lead to increase in the utility (Thaddeus and Main, 1994:1093, Das, et.al, 2010, Mushi, et al., 2010).

Social and cultural dimensions of pregnancy and childbirth

The biological processes of pregnancy and childbirth are universal, but there is enormous diversity when it comes to the socio-cultural elaboration of pregnancy and childbirth in different societies around the world (Knutsson; 2004, p.26-27).

Childbirth is an emotional, personal and intimate experience that is marked by culture; and is in itself a socio-cultural event (Anderson & Staugård, 1986). To understand the conditions that shape knowledge, decision-making and practice in relation to pregnancy and delivery, one needs to grasp the most basic aspects of the social and cultural context of pregnancy and childbirth argues Knutsson (2004, p.27).

Jordan (1993) states in her classical study that birth is “consensually shaped and socially patterned”: childbirth is both a physiological and a cultural event (Ibid, p. xii.). Jordan further writes that births: “consists of a set of internally consistent and mutually dependent practices that make sense from the inside out, though not necessarily from the outside in” (1993, p.xii). Chalmers (1990) write that childbirth “reflects the social organization, beliefs, and priorities of the society in which the birth occurs” (1990, p.xiii). There are many culturally embedded practises connected to pregnancy and childbirth, a time when both mother and child are vulnerable and are perceived to be in danger. “In order to deal with this danger and the existential uncertainty associated with birth, people tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context”, Jordan writes (1993, p.4).

Potential factors influencing women's decision- and possible delays regarding place of delivery

Thaddeus and Maine (1994) launched the concept “stages of delay” in an attempt to explain and identify some reasons why and where the delays are occurring regarding the decision on where to give birth as well as their potential to receive obstetric care. The *first* stage is the delay in deciding to seek care due to e.g. fear of high financial cost, cultural beliefs or traditions. The individual, the family, neighbours, husband, or a combination of all, can be involved in the decision-making process about seeking obstetric care. Previous experience or perceptions about the quality of care can be an additional factor. The *second* stage is the delay in arriving at a health care facility, due to e.g. poor distributions of health facilities, lack of transportation and poor infrastructure. The *third* stage of delay is related to receiving needed care after arriving at the health facility. These different stages of delay may all lead the woman to maternal death or to other obstetric complications like obstetric fistula (Thaddeus and Maine, 1994, p.1091-1092). These ‘stages of delay’ nicely illustrates the factors influencing the decisions on where to give birth and it will in the coming sections shortly be mentioned some of these different factors.

Socio-cultural factors

Socio-cultural factors play a role in the first stage of delay (Thaddeus and Main, 1994, p.1091). Interaction between a person's beliefs, culture and values affect health-seeking behaviour together with the personal costs and benefits of doing it (Gillespie, 1995, p.106). Social- and cultural factors surrounding childbirth play a role both at individual-, household- and community level, influencing health seeking behaviour (Osubor, et.al., 2006, Montaug et.al., 2011). Rather than affecting the delay in reaching a health facility, socio-cultural factors influence the delay in the decision to seek care (delay 1) (Thaddeus and Maine, 1994. Gabrysch and Campbell, 2009). Factors like maternal age, level of formal education; marital status, religion and “traditional” beliefs are factors that can influence the decision on where the woman will give birth (Gabrysch and Campbell, 2009).

Distance and cost

Cost and long distances with poor infrastructure and lack of transportation are known barriers for seeking health care, and are associated with availability and accessibility

of the health facilities. Distance can play a role both in the decision to seek care (delay 1) as well as in reaching the health facility (delay 2). Cost can be an important factor regarding the delay in decision to seek care in the first place (*first delay*), and also a delay in reaching a health facility when first decided (*second delay*). But the importance of cost can also depend on the severity of the problem (Thaddeus and Main, 1994, p.1094-95 and Gabrysch and Campbell, 2009).

Quality of care, and perceived benefit of care at the health facility

How the woman perceives the benefit of delivering at a health facility, as well as how quality of care are perceived primarily depends on their health knowledge and own- or others experiences. These can be important factors influencing their health seeking behaviour, whereas the outcome depends on positive or negative perceptions and/or experiences (Thaddeus and Main, 1994, p.1094-95 and Gabrysch and Campbell, 2009). How factors like the conduct of the health staff, their procedures, and their ability to keep privacy, traditions and age of health workers are perceived can affect decisions to seek care (Moland, 1992, p.85-88, 96; Thaddeus and Main, 1994, p.1094-95; Gabrysch and Campbell, 2009). How the actual quality of care is at the health facilities can also influence the third stage of delay, delay in receiving needed care after arriving at the health facility (Thaddeus and Main, 1994, p.1092)

Giving birth at home versus giving birth at a health facility

‘Western’ biomedicine is spread all over the world, but in many parts of the world it still provides only a small part of the health care that is given (Helman, 2007, p.82-96). People have different views about ill health, the cause of it, and how to treat it. Kleinman (1980) mentions three sectors of health care that has its own ways of explaining and treating ill health. The three sectors are overlapping and are interconnected to each other: The *popular health sector* is the largest sphere of the three health sectors; it is here the illness first is defined and different initiatives are suggested to heal the illness. It is a lay arena, which holds the individual, family, community beliefs and activities and social network. It is here the health seeking behaviour starts. In the *folk sector* healers who are not part of the official medical system are found. Within the folk sector different components are found, some close to the professional sector, while the majority is related to the popular sector. The third

sector is the *professional health sector* where mainly the scientific medicine is found (Kleinman, 1980, p.50-60). Kleinman's model of the three different health sectors illustrates and highlights the different "arenas" the women use during time of delivery.

Anderson and Staugård (1986) describe in their early, but still relevant study some typical aspects of "traditional"- and "modern" approaches to childbirth. In the "traditional" approach there are minimal resources for interventions and fewer possibilities to handle complications during birth, the childbirth is seen as an event that takes place in a familiar atmosphere, where the assistants are older, experienced and have local cultural knowledge. In a "modern" approach childbirth is emphasised as a biological event where medical/technical interventions are available, and where it is possible to handle most complications. Within the modern health services birth is commonly taking place in a "foreign" environment, and the birth attendants are often young and may have no self-experience in giving birth. It has been documented that if local pregnancy and birth related practices, beliefs and rituals conflict with what is provided within the "modern" services, the "modern" service will be underutilized (Anderson & Staugård; 1986, p.16-19). At the health facility birth is a medical event, with technology and standardized procedures as dominant factors (Moland, 2002, p.216). Chalmers (1990) comments on the changes that have occurred in childbirth: "By moving into Western society, better physical care of mother and baby has been achieved but less mental, emotional and spiritual preparation for birth and parenthood is occurring" (1990, p.28).

The different views and wishes related to where to deliver differ from country to country, between ethnic groups within the country and from urban to rural areas. A study carried out among the Datoga of Tanzania, revealed that many disliked hospitals because people didn't speak their language, the health facility didn't allow relatives to join the labouring woman, and their dresses and decorations were removed (Blystad, 2000, p.116-117). On the other side there are people who prefer giving birth at a health facility; e.g. the Chagga people, in the Kilimanjaro region, Tanzania, where women perceive lay birth care and home delivery as back-ward, unsafe and only an alternative for emergency (Moland, 2002, p.50-51).

The professional health sector

Most of the maternal complications cannot be predicted or prevented, Campbell et.al (2006) argue that factors like distance to health care and who is attending the delivery are therefore crucial factors when determining interventions that are needed to be able to reduce the maternal deaths (Ibid, p.1291). For example if a woman suffers from postpartum haemorrhage, it is estimated that the woman on average will die within two hours. Two hours is a very short time if the one who assists doesn't understand the severity of the situation, and if there are no interventions at the community level and long distances to a facility that offers emergency obstetric care services (Abdella, 2010, p.120).

WHO's strategy to achieve MDG 5 is to make every woman deliver at a first level facility by a skilled birth attendant (World health report, 2005). With Ethiopia's high population, and low number of health workers (0,03 doctors per 1000, 0,21 nurses per 1000 and 0,01 midwives per 1000 (2003)) (WHO, 2006) it is a challenge to achieve WHO's goal that every childbirth should be attended by a SBA. To achieve the MDG 5 and to be able to reach the remote part of the country, the Ethiopian government has started a Health Extension Program (HEP). The Health Extension Workers (HEW) is females who are found in every kebele of the country and are given their salary from the government. They will be trained for one year; where maternal and child health, health education and communication are some of the fields they are being trained in. They are given training to attend normal deliveries and to be able to detect women at risk and to refer them to health facilities when needed (Wilder, 2008 p.2-3; Moh. Ethiopia, 2009; Karim, et al. 2010, p.92).

The World Health Organization's strategy further includes that there should be a possibility of back up if complications should occur during delivery. The "back-up" needed to save the lives of women with obstetric complications that can occur during pregnancy or childbirth is defined as Emergency Obstetric Care (EmOC) (World health report, 2005, p.71-72), and is perceived as critical to reduce the maternal mortality. If obstetric emergency occurs, the ability to refer the woman to EmOC services may be vital to safe the life of the woman (Paxton, et al., 2005, p.182). The problem in many developing countries is the lack of health workers that can provide EmOC services, and the distances to the life saving services, which may become too

long for many women. To make EmOC services more available for the majority of the rural women in Ethiopia, non-physicians have recently been trained to perform surgical interventions, in a project named '*Reducing Maternal Mortality*', in southwest Ethiopia (Lindtjorn.no). A similar intervention has been successfully implemented in Mozambique for about 20 years, where research shows that trained non-physicians carried out the majority of the emergency obstetric surgery. An added dimension of value was that it was more likely that non-physicians remained in the rural area compared to the physicians, thus ensuring a continuity and retaining of the lifesaving skills for the women living there (Pereira, et.al, 2007 p.1531,1533).

Antenatal care (ANC) sessions are meant to follow up the pregnant woman as well as detect, predict and inform about possible complications, and are also intended to introduce the health facility to the women with the intention that the woman will seek assistance more readily from the health facility during childbirth (Magoma, et.al; 2010, p.1-2). One of United Nations Population Fund's (UNFPA) strategic recommendations against maternal mortality and morbidity is to "raise awareness on sexual and reproductive health and reproductive rights" (Jones, 2007, p.29). They further specify that "it is critical that messages demystify the root cause of delivery complications, describe the signs of obstructed labour and underscore the consequences of delay in seeking medical care when complications arise" (Ibid, p.29). This message should not only reach women, but also husbands, elders- and religious leaders in the community (Ibid, p.29). Lewis and de Bernis (2006) highlight the importance that the pregnant woman, her family and the community have knowledge about risk factors in pregnancy and childbirth, as well as awareness about the need to seek antenatal care, and the importance of skilled care during childbirth (Ibid, p.19). Others also highlight how knowledge and awareness about risks and symptoms on complications could increase the health seeking behaviour when it comes to both preventive and emergency care-seeking (Gabrysch and Campbell, 2009, p.8). Muleta (2004) state in her study from Ethiopia that the awareness of complications was very limited, and that "community education about problems following teenage pregnancy, signs and symptoms of obstetric labour and the advantage of institutional delivery might reduce the rate of obstetric fistula" (Muleta, 2004, p.9), and that lack of knowledge could be one possible factor for not seeking medical care (Muleta, et al. 2008, p.49). In addition are the different views and wishes related to where to deliver

largely linked to exposure of formal education. In Ethiopia women with secondary or higher education are 52% more likely to give birth at a health facility compared to women with no education (2%) (CSA, 2006, p.116).

The popular- and folk health-sector

In Ethiopia, as in many other poor countries, it is common that relatives or traditional birth attendants assist during childbirth (Campbell and Graham, 2006, p.1293). The strong emphasis on the so-called popular- and folk sector regarding assistance during delivery, is revealed by figures from the Ethiopian Demographic Health Survey (EDHS), showing that more than 60% of the births are assisted by family members or others, less than 30% are attended by TBAs, and as mentioned above, only 5,8% are attended by a SBA (CSA, 2006, p.117).

In 1978 the Alma Ata declaration declared that primary health care was to be the key for the governments to fulfil good health care for their people. The aim was to bring the health system as close as possible to the people (WHO, 1978), and “it should be designed in a way that communities could afford” (Lindstrand, et. al., 2006, p.269). This was easily applauded by all, but nonetheless found to be difficult for many of the low-income countries to live up to (Ibid, p.269). To use the available resources, there was a focus on training village health workers, including training programs for TBA’s in countries where there was lack of health professionals in order to give women skilled care during birth. This strategy was eventually modified as research found that training of TBA’s had little impact on reducing the number of maternal deaths without the support of skilled back-up services (WHO, 2006, p.3, Campbell and Graham, 2006, p.1293). Thirty years after the Alma Ata declaration the WHO has returned to the Primary Health Care strategy. The renewed strategy is also relevant for the focus on this study, where some countries train community workers to attend deliveries, like focus on health extension workers in Ethiopia.

Rationale of the study

There are many and complex factors that contribute to the unacceptably high number of maternal deaths in certain areas of the world. It is still not entirely clear why so many women choose not to come to the health facilities for birth giving also in areas where they are fairly easily accessible. This study aims to explore the context behind the high numbers of maternal mortality and morbidity, and the low number of births attended by skilled birth attendants in Ethiopia. The study does this by focusing on perceptions and practices related to birth giving both at home and at health facilities in an Ethiopian context. The material will be discussed through an assessment of the relevance of the UN committee's Availability, Accessibility, Acceptability and Quality framework (AAAQ)

Objectives

General Objective:

To explore perceptions and practices linked to childbirth, and generate knowledge that can increase our understanding of the reasoning behind high numbers of home deliveries and the experienced barriers to birth giving at health facilities.

Specific objectives:

- 1) Explore the perceptions and practices of home birth in an Ethiopian setting
- 2) Explore the perceptions and practices of birth giving at health facilities in an Ethiopian setting
- 3) Look at the reasoning behind why many women deliver at home drawing on the *availability, accessibility, acceptability* and *quality* framework (AAAQ).

Methods

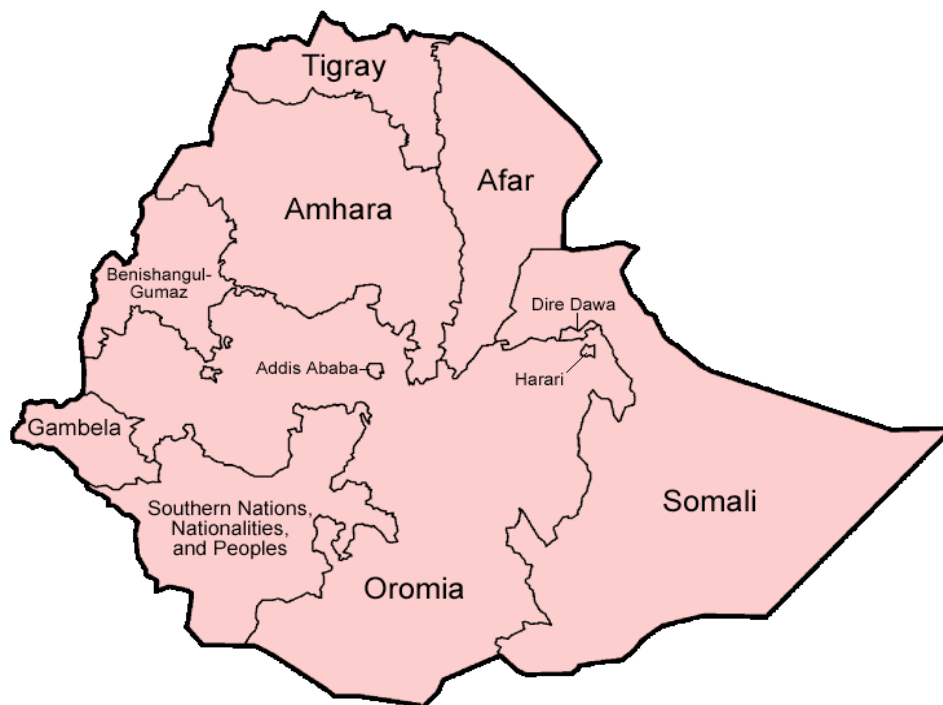
Study area

Ethiopia:

Ethiopia is located at the Horn of Africa. It is a landlocked country bordering Kenya, Sudan, Eritrea, Djibouti and Somalia and covers an area of 1.104,300 km².

Ethiopia is a multi-ethnic and multi-linguistic country with more than 80 different ethnic groups. It has a growing population with a total fertility rate of 6.02 (CIA, 2011). It reached a population of 84 million in 2010 (UNDP, 2010), which makes it the second most populated country in Africa after Nigeria. Ethiopia is one of the least urbanized countries in the world; 85% of the total population lives in the rural area (MOH Ethiopia, 2009). Agriculture accounts for 85% of the labour force and 45% of the GDP (CIA, 2011).

Life expectancy is 54 years, 46% of the population are malnourished and 57,3% are illiterate (FN-sambandet, 2009). Shortage of health workers is an enormous challenge, with coverage of 0,03 doctors per 1000, 0,21 nurses per 1000 and 0,01 midwives per 1000 (2003) (WHO, 2006).



Source: Ethiopian regions. Wikipedia.org (2011)

Local study context:

The present study was carried out in a village (kebele) named Agemssa (around 500 km west of Addis Abeba), located east in Wollega zone in the Oromia region. Oromia region covers an area of 353,632 km², and has a population of around 26,5 million (2005). Oromia region is divided into 12 different zones. Wollega zone is divided into east- and west. Agemssa is located in the eastern part of Wollega under the district (woreda) Ameru (Wikipedia, 2009). Since Agemssa is located close to the Amhara region and the Benshangul Gumuz region, a smaller number of people from these two regions are also found in the study area. However in this study the informants are Oromo, who also make up the majority population in the study area where Afaan Oromo is the first spoken language.

In Agemssa people mainly live as farmers, there is school up to 10th grade, and there is one health centre. The health centre can perform basic emergency obstetric care. It is 164 km to the nearest hospital in Nekemte where comprehensive Emoc services are available

Study design

In a qualitative study the researcher seeks in depth understanding about what and why people think and feel as they do, about beliefs, experiences and behaviours (Debus, 1986:2). Hudelson (1994) describes qualitative research as “an approach, which seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied” (Ibid, p.2). Further Hudelson writes that qualitative research approaches place “an emphasis on providing a comprehensive or “holistic” understanding of the social settings in which research is conducted” (Ibid, p.2), and that “qualitative research relies on a research strategy which is flexible and iterative” (Hudelson, 1994, p.2).

Francis and Heggenhaugen (1999) describes how a qualitative approach is the best way to get the “insider’s perspective and an accurate assessment of socio-cultural context” (1999, p.99), and to know the reasons why people are doing what they do, to explore people’s practises, beliefs and the socio-cultural context they are living in (Debus, 1986, p.2; Francis and Heggenhaugen, 1999, p.98;)

A qualitative design was used in this study because the aim of the research was to gain in-depth information about experiences, perceptions and practices related to childbirth. To gain a fairly thorough understanding, the study was conducted in one community based setting and in one health facility based setting. In-depth interviews, focus group discussion and observation were employed as study methods. The study was carried out from June 2010 until October 2010.

Study population

The study population in the community-based component consisted of women delivering their babies at home, plus elderly women, fathers and one TBA. In the health facility-based component women who gave birth at a health facility, women attending ANC sessions and health workers were interviewed. Regarding the informant group of women who delivered at a health facility all had started the delivery home, but due to complications had to move to a health facility.

Number of study participants for IDI's	N = 31	Number of study participants for FGD's	N = 9
Women who gave birth at home	6	Women who gave birth at home	5
Elderly women	4	Women who gave birth at a health facility	4
Husbands	5		
TBA	1		
Women who gave birth at a health facility	6		
Women attending ANC	5		
Health Workers	4		

Table 1

Except for the health workers the majority of the informants had no or little formal education and many were illiterate. The health workers were diploma and degree nurses. They were all associated with the Antenatal care (ANC) sessions and had responsibilities to assist during delivery at the health facility. No midwife or physician was employed at the health centre. The traditional birth attendant (TBA) interviewed was the only one in Agemssa; she had no formal education, nor formal training, but worked as a TBA and was particularly known for her massaging skills, not only to labouring women, but also for people with other problems.

Inclusion criteria

Women of childbearing age:

Women in childbearing age consisted of three groups;

1) Women who had given birth at home

For the first group the inclusion criteria was that the woman had delivered at home at least two times, and that it was not more than two years since their last delivery.

2) Women who had given birth at a health facility

Regarding the group of women delivering their children at a health facility the inclusion criteria was that they had given birth at least one time at a health facility, with no more than two years since their last delivery. In this group I tried to find both women who had gone to a health facility to deliver as her first choice, and women who had given birth at a health facility as their second choice, due to complications. Unfortunately I was not able to find any women who had given birth at a health facility as their first choice. All of the women interviewed in this group had started with homebirth first, and later went to health facility due to complications.

3) Women attending antenatal care sessions.

For the third informant group the inclusion criteria were that they had attended ANC sessions at least one time.

Other important stakeholders:

To get a broader perspective other informants categorized to have a role and impact regarding childbirth, were included in the study. These informants were:

4) Health workers

The inclusion criteria for health workers were that they were working in the ANC program and attended deliveries. Among the health workers who filled the inclusion criteria were there one female and three males and all volunteered to participate

5) Traditional birth attendant (TBA)

The inclusion criteria for the TBA were that she was still practising. It was only one TBA in Agemssa

6) Husbands

The inclusion criteria for the men were that they had at least one child and lived together with the mother when she gave birth. The reason for this was that if he were not in a relationship with the mother he would not commonly have any involvement or responsibility over the woman in labour. All the men being interviewed had not less than three children and lived together with the mother

7) Elderly women

The inclusion criteria for the elderly women were that they had at least participated in two deliveries. The elderly women being interviewed had all participated in many deliveries, and two of them were known in the area for their abilities regarding cutting of the cord and removal of the placenta.

Recruitment of study participants

The aim of qualitative method is not to obtain statistical representativeness in sampling, but to obtain detailed and holistic views about what is being studied (Malterud, 1993; Pope, et.al.; 2002). *Purposeful sampling* was used to find informants for this study (Hudelson, 1994, p.37). By using purposeful sampling key informants are selected to be able to get in-depth understanding about what that is “typical” within the field that is being studied (Patton, 2002, p.46, 230). Snowball sampling

was used, asking informants about other people who could possibly be relevant informants for the study (Patton, 2002, p.237). Different types of informants were used to be able to find a variety of the questions being studied (Malterud, 2003).

Before we started the interviews we discussed with the administrator of Agemssa and the director at the Health Centre and agreed with them on how to proceed.

The informant group of women who gave birth at home, women who gave birth at a health facility and elderly women and males were interviewed at home, with exception of two of the interview with the males that was conducted in the field. The informants were either recruited through informal talks, or people suggested possible “information-rich cases” that could be relevant for the study. In this case, the person suggesting an informant asked the particular person and made an appointment for us if the person was willing to participate. Using these methods in recruiting informants we tried to reduce the “pressure” that could have occurred if we had gone directly to their homes and asked them.

Women attending the ANC sessions were interviewed at the health facility. The ANC sessions were only held on Thursdays, we were present from the morning of until they closed. The nurse would inform the women present about the research, that it was voluntarily to participate and that saying no to participation would not have any say in her further sessions. The researcher and research assistant were sitting in another private room, if they wanted to participate they came to our room, and if not they went home. Everyone, except one woman who said she did not have time accepted to participate.

The interviews of the health workers took place in a private room at the health centre during their working hours when they had the possibility to take a break.

Regarding the recruitment of the TBA was it she who came and greeted us the first time, and since we lived nearby we met occasionally, and had many informal conversations, and we later got the opportunity for an in-depth interview.

Data collection methods

Semi-structured in-depth interviews

Through in-depth interviews the researcher wishes to gain an in-depth understanding of a phenomenon under study (Hudelson; 1994, p.11). Through this method the researcher can obtain detailed information about what is being studied (Pope, et.al. 2002) Weaknesses of semi-structured interviews can be the interview guide it self, if the relevant questions are not covered (Hudelson, 1994, p.12). Further the interviewer and the settings can affect the informants (Francis and Heggenhaugen, 1999, p.99). As the study included different groups of informants one semi-structured interview guide, translated to Afaan Oromo was prepared for each group with a set of open-ended questions. In the “guide” the main questions to be asked were listed, but the researcher had the opportunity to follow leads and new topics that arose during the interview (Hudelson; 1994, p.11). All of the informants accepted the use of a digital recorder during the interviews. In general the informants seemed freely, and were open and willing to share their knowledge and experiences and provided valuable knowledge to the research.

Focus group discussion

New information can be produced quickly in a focus group, and it is a good method to identify and explore attitudes, beliefs and behaviour in a population (Hudelson, 1994, p.21). The dynamic in the group can produce data that may not be found through individual interviews, “the synergy and dynamism generated within homogenous collectives often reveal unarticulated norms and normative assumptions”, and focus groups “take the interpretive process beyond the bounds of individual” (Kamberelis & Dimitriadis 2005, p.903). The interactions between the participants in a focus group may lead to new and valuable thoughts from the participants (Debus; 2007:8-9). Weaknesses of focus groups are that the results depend on the dynamics in the group; it is important that all the informants in the group participate, i.e. that the discussion is not dominated by one or two people (Debus, 1986, p.48; Hudelson, 1994, p.21). Another challenge can be if people fears to speak out their own opinions and simply go with what the others are saying (Debus, 1986, p.48).

For the two focus groups that were conducted we separated women who had given birth at home (1) and women who had given birth at a health facility (2), consisting of five and four participants in each group, respectively. Topic guides were made in advance for the two focus groups that were conducted, and a digital recorder was used during the discussion. Each discussion lasted for around one hour.

Observation- and participant observation in the field

Ethnography is a method used to gain knowledge about cultural processes where the researcher will stay and participate in a social context over time. It is important that the researcher finds a balance between participation in the society as well as an observation of the society (Heggen and Fjell, 1998). Ethnography is a time consuming method, requiring long time spent in the field.

Since the researcher had a relatively limited time in the field (4 months) and with little skills in the Oromo language, this study will not be classified as an ethnographic study, but the data collection methods used were drawing upon certain aspects of ethnography. The prime focus was on aspects around practices and perceptions related to maternal health. In the phase of collecting data, in-depth interviews, focus group discussions, observation and participation in the daily life were used, which is also common methods to use in ethnographical studies (Hardon, et.al; 1994).

Participant observation is a method used in ethnographic studies, where the researcher participates in what is being studied to get an “inner-perspective” (Malterud, 2003). Through this method the researcher gets the opportunity to observe people's activities and behaviours in the people's own environment (Polit and Beck, 2004, p.378). The participation of the researcher in this study was not solely related to maternal health, but more related to the informants' daily life. Participation in daily life activities brought the researcher closer to the society and able to grasp some of the life and context the informants lived in. Observation can also be a way of understanding and/or confirming the data being already collected (Hardon et al, 1994, p.158).

Unstructured observation was used during observation of a home delivery that ended at the health centre; with this type of observation the researcher didn't participate, the main aim was to observe the delivery in its context (Hudelson, 1994). The observation

that was done confirmed many of the descriptions that were told during the in-depth interviews. The documentation of the observation was done through field notes. Some of the informal conversations were tape recorded when something of particular interest emerged.

Situating the researcher

To be in an area with a different social and cultural context and with lack of language skills the challenges can be many. That I arrived with another cultural background, as well as being a nurse could easily be factors that would restrict the informants' valuable information. These were differences and obstacles I was highly aware of and tried to reduce. The fact that my husband is an Ethiopian, and comes from the research area, was without doubt an advantage, especially since we had a relatively short stay of four months in the area. I will further elaborate around my role as a researcher under the section of "reflection on the research methods".

Research assistance

Due to my lack of ability to perform the interviews in Afaan Oromo a research assistant was needed. The research assistant was a male and a nurse as well. The fact of him being a male could easily restrict the informants sharing valuable information since the topic is related to females. But in the absence of a suitable female assistant and experience of openness among the women towards him prior to the study, we decided to try. From the experience during the interviews and the result of the study it does not seem like the fact of him being a male restricted the informants, though we can not say this for sure. The role of the research assistant will be further elaborated under the section of "reflection on the research methods".

Data analysis

The analysis is not a separate phase in the process of qualitative research. It is intertwined with the data collection and interpretation, and is thus a continuous process taking place throughout the research process, although there are phases where a more systematic and rigorous analysis of the data takes place (Blystad, 2005, p.85-86). To be able to analyse the material rigorously, the collected data needs to be more systematically analyzed after the fieldwork. In the analysis process the researcher is naturally looking for material that can answer the research question (Malterud, 2003:77).

Data transcription and translation

During the phase of transcription the conversational interaction between two individuals taking part in the interview becomes abstract and fixed in a written form (Kvale and Brinkmann, 2009, p.177). Oral language is however different from the written language, and to write down exactly what the informants are saying, can in some cases give a wrong or different meaning than what was communicated during the interview. So when translating the text, it is important to remember that the purpose is to give as correct and valid version as possible of what that was said (Malterud, 2003, p.77-79). There are huge challenges when it comes to translation related to the impact translation and the translator might have on the study findings. It is important that decisions on translation are made consciously, and that there is a balance between language competence and cultural knowledge (Larkin et. al, 2007, p.468, 471).

It was the research assistant who transcribed and translated all the interviews. The first interviews were transcribed word by word to the language the interview was conducted in, Afaan Oromo, but due to time some of the interviews were translated in the process of transcription. The assistant had a linguistic understanding- as well as a cultural understanding of the language and the context where the interviews were conducted in. In addition he expressed that it helped him during transcription and translation that he had been present during the interviews. Before the transcription started we had discussed many terms that had been revealed during the interviews that I needed a deeper explanation on. This made the person who transcribed/translated aware of the importance of accuracy of the translation as well as to catch the cultural essence and understanding of words and terms that was used, rituals and happenings that were described.

Systematic text condensation

The data analysis of the collected data is based on Malterud's (2003) "Systematic Text Condensation", which is inspired of Giorgies phenomenological method (sited in Malterud, 2003), a useful scheme for development of descriptions and perceptions related to experiences, in this case related to child-birth. Malterud refers to four steps in the process of analysing the material:

1. *Sense in the whole*: get a total impression of the data, where the entire description is read in context in order to get a general sense of the whole statement
2. *Discrimination of meaning units*: Identifying meaning units with the focus on the phenomenon being researched
3. *Transformation and abstraction of meaning units*: Abstracting the content of each meaning unit
4. *Synthesis into a consistent statement*: Summarize the importance of the meaning units

(Malterud, 1993, p.204; Malterud, 2001, p.487; Malterud, 2003, p.100-111).

Sense in the whole:

This first step was a time-consuming, but important part of the analysis in order to get a total impression of the material. While reading themes emerged from the text, to systemize and easier get an overview over the themes they were written down on a separate paper where three columns were prepared. In the left column was the major themes, in the middle section relevant phrases that “belonged” to the theme were written down; e.g. under the theme *expression of pain* phrases like “*not culturally accepted to express pain loudly*”, “*Bite my teeth together*”, “*bad pain, like I am going to die*”, etc. were written down. The right column was made for codes. Doing this was a little bit on the side of Malteruds four steps; but this was done because the material was vast and it was an important tool to get a systematic overview over the data.

Discrimination of meaning units:

During this stage text that was relevant for the research question were sorted out. What was done in the previous stage with writing down themes, phrases and codes, helped to get a clear overview over the themes that were relevant for the question being studied. When reading the text the meaning units were coded and highlighted. The meaning units are text parts that have a connection with the relevant themes. The codes worked like a label that connected the text parts that had something in common. The coded meaning units were finally extracted by cutting and pasting under the relevant themes.

Transformation and abstraction of meaning units:

The meaning units were coded, and the meaning units with the same code belonged to one code-group, which were placed under the theme they 'belonged' to, like described above. In this part of the analysis each of these code-groups were looked at one by one. Due to a rich material, subgroups were created under each code-group (theme), e.g. under the code-group *Privacy* subgroups like *privacy at home* and *privacy at health facility* were made.

Retelling and summarizing each subgroup condensed the content. Quotes were used to illustrate what was being told in the condensed subgroup.

Synthesis into a consistent statement:

In the fourth and last step the knowledge and importance from each of the condensed code-groups and subgroups were recontextualized and summarized. Quotations were used to illustrate the main point about what was being told. Finally to be able to validate the findings the results were compared with the original transcripts to see the text in its original context.

Ethical considerations

The Norwegian Social Science Data Service (NSD) (App 1 and 2) and the Oromia Regional Health Bureau in Ethiopia (App 3) approved the proposal. In addition I got a letter of support, which I had to take to the Zonal office in Shambo (App 4), which again wrote me a letter of support to bring to the health centre and administration in Agemssa.

An informed consent sheet translated from English to Afaan Oromo was read and explained and given to the informants to sign. Even though I didn't face any difficulties regarding the signing of the informed consent, I felt it would have been more appropriate with an oral consent since the majority of the informants were illiterate.

Findings

Most of the women interviewed were aware of the signs of pregnancy, some didn't go anywhere to confirm their pregnancy, some went to the traditional birth attendant (TBA) and others went to the health centre. The study revealed that the women attending antenatal care (ANC) sessions came relatively late in their pregnancy for their first session, and often only once. It was not common to tell people about your pregnancy, and many told that they tried to hide it as long as possible, even some husbands complained that their wives didn't tell them when they got pregnant: *"Culturally we have some problems with our wives in this area i.e. the lady as general doesn't tell to anybody that she is pregnant though she knows that she is, because she feels shame to tell"*. (husband –45 yrs). Even some of the women attending the ANC sessions confirmed that they felt shy to attend the ANC; *"I know it is good, but I feel not to go. My biggest problem is shying"* (ANC attendant – 33 yrs). And some also feared what others would say if they went often to the health facility: *"I don't go so much because I fear what people will say if I redundantly go to health facility"* (ANC attendant – 35 yrs). Many of the women attending the ANC only went once to confirm that their pregnancy seemed ok: *"Today is my first day since I got pregnant though it now is in its 9th month. I came today just to check myself but I had no problem"* (ANC attendant – 33yrs).

Factors influencing the decision on where to give birth

The study revealed different factors and explanation on the decision on where to deliver. These factors also influenced the possible delay regarding decision to seek health care during delivery and also delays in reaching health care facility when first decided to seek help. Factors mentioned are here divided into 4 groups: 1) Norm in the society, 2) meaningful aspects around home birth, 3) perceptions around health facility deliveries and 4) distance and costs

1) "Norm" in the society, depending on possible complications

"Everybody is born at home, and it seems natural to keep on doing that" (elderly woman – 56 yrs).

It appeared clear from the study that home was the natural and normal place to deliver. And that giving birth at a health facility only was deemed an option in case of emergency. *“If the delivery looks normal, everybody prefers to give birth at home”* (woman, home birth – 25 yrs), also the health workers confirmed this; *“They prefer to give birth at home until they confirm that it is complicated”* (health worker – 23 yrs). But even though most of the women had a desire to deliver at home, some felt that there was an expectance of home delivery from family members and neighbors that made a pressure on them to deliver at home *“I know that all neighbors prefer that we should deliver at home and this has pressure on the person who decide to take us to seek better help.”* (woman, home birth – 25 yrs). Some also experienced the fact of being criticized if they went to health facility for minor reasons; a elderly lady confirmed this saying: *“If you just decide to take your wife to health facility for delivery without any confirmation that she is in trouble, the others will talk about you saying, “Why did they go while she could give birth at home in a natural way?” I personally prefer if people can take ladies to the health facility only when it seems difficult”* (elderly woman – 62 yrs).

2) Meaningful aspects around home birth

When a woman is to give birth the news are normally rapidly spread and family members and neighbours will come and offer their help. The woman in labour will have a leaned sitting position and in addition to her own dress will she normally be covered with a blanket for no one to see “her body”. The women helping the mother in labour will all have different tasks, *“The one who sit behind me will extend her hands and support my abdominal sides while supporting my back, one or two will hold my knees so that the pain will be reduced, and the other will have responsibility to check inserting her hands under the close but will not see with her eyes”* (woman, home birth – 40 yrs). Encouraging the woman are one important part, the elderly women are supporting her and praying for her; *“The one that is checking if the baby is coming is responsible to support me ideally as well”* (woman, home birth – 40 yrs). *“We that help the woman in labor also encourage her and pray for her”* (elderly woman – 56 yrs).

It is normally the mother or the mother in-law (depending on whom they live near by) who will cut the cord and remove the placenta. If they are not around or if they don't

feel confident in doing so, the one in the room with most experience will carry out this task. To tie the cord two different methods were employed; one was to tie the cord at two places before cutting, while the other was the “squeezing method”; *“You squeeze the end of the cord and press it and keep it for some time. Then you release it and it will not bleed. But you have to press it well”* (elderly woman – 56 yrs).

The placenta was much feared and was perceived as the “second birth”: *“After that there is the so called “obbaatii” (placenta), which keeps the baby when she is in the abdomen. That is a problem just like giving birth. If not lucky, it can even force us to go to the health facilities”* (woman, home birth – 40 yrs). The placenta should not be thrown away, but should be deeply buried in the ground so no animals can dig it out and eat it. Some used a bowled plate (*qiraacii*), which is made of clay to place the placenta on, and then covers with a similar plate before they bury it. The one who cuts the cord will also remove- and later bury the placenta. The women were highly aware that if the placenta didn’t come out it could be serious for the mother. If difficulties occurred they would massage the abdomen. If they still would not succeed they would call for the TBA or would go to the health facility, informants revealed.

The hours and days after birth are important, and it is a time where much care is given to the woman. The woman will be washed and put to bed right after the delivery; neighbors will come to visit (*gumaataa*), and give small things like money, a gift for the child, porridge, etc. The women who visit will at this time feed the new mother with the porridge one after the other in turn. The porridge is said to have a healing effect on the mother after delivery. It is said to strengthen her back, its heat cleans up clotted blood, and its softness will not disturb and will help to heal the wound that is formed in the abdomen after delivery. On the 5th day after childbirth porridge will be prepared on the three stones (*gomjii*), where St. Mary is said to sit after the delivery. The porridge is prepared on this day to show St. Mary respect and to thank her for her presence and help during the delivery. *“This fifth day porridge has a meaning. Saint Mary sit on the three stones called ”gomjii” between where the fire is. It is said that Saint. Mary will go down of the stones on the fifth day. The porridge is made in respect to her and to say good bye and thank you!”* (woman, home birth – 25 yrs)

3) Perceptions around health facility deliveries

There was a genuine skepticism among the women regarding methods used during health facility deliveries. Use of episiotomy and examination were factors that made the women concerned about giving birth at health facility. *“At home, there is no problem. But if we come to the health facility there are many things that can happen. For example, they insert their hands to our body while we will never do that at home. Of course they don’t mean it negative but we don’t like it. They also tear our skin with scissors”* (ANC–18 yrs). To be shy over how the body was exposed during delivery at health facilities was also mentioned as a factor that made the informants prefer to deliver at home; *“many fear going there because they are shy.”* (woman, home birth – 22 yrs). Also the health workers were aware of this factor; *“Some women don’t want to show “their body” to other people while they give birth, and they therefore prefer to give birth at home”* (health worker – 23 yrs)

The health workers being strangers to them, and with the absence of support they were used to from home births, made some women perceive as if the health workers didn’t care about the outcome of the deliver. Also the young age of the health workers made some lack trust to them, they concluded that their low age gave little knowledge and experience. This is reasonable thinking while they in the community is used to that the one that help them during labour have experience and is older. *“Some people complain that the health personals may not have enough knowledge because many of them are young and fresh”* (woman, facility birth – 26 yrs).

4) Distance and costs

“The dangerous thing is distance from health facility. There are many examples. There was one lady not far from here, the labor started her and stayed on her for two days. On the third day, the husband came home from his farm place and saw his wife’s situation. Then he began to ask help from area people to help him carry her to the health centre. Then, they started their journey that evening. But at the health centre they were told to go to hospital. But the woman died before they could get a car” (woman, home birth –30 yrs).

The informants in this study lived with a maximum walking distance of 30 minutes to the health centre, so in their case distance was not brought up as an issue for not

giving birth at the health centre, but if they were in need of comprehensive emergency obstetric care they had a distance of 164 km and transportation was not easily available. *“There is a huge problem when it comes to transportation, there are few cars available, and the cost is very high”* (health worker – 20 yrs).

The cost was also mentioned as a factor for not to deliver at a health facility, though not a major, thinking that why should they pay for something they could do for free at home. But in case of emergency there was a genuine agreement that being poor would not restrict them to go to hospital, even though it would lead them into debt for years; *“many people lost their land and house to take birth-giving lady to hospitals when problem occurred. But if something happen, our being poor will not protect us from going to health facility”* (woman, home birth – 25 yrs).

When and where to seek assistance outside home during delivery?

The health workers mentioned that some few women who had got advice from antenatal care sessions, health extension workers or in some way had awareness about health facility deliveries made it as their first choice. However, It came clear from the study that the main reason for a woman to deliver at a health facility was due to complications, the health workers also confirmed this. *“I go to health station only if I become seriously sick and I pray to God that this should not happen to me”* (woman, home birth – 25 yrs). *“It was not my will to go but the baby didn’t come out and finally I became unconscious. Then, my family took me to the hospital to save my life”* (woman, facility birth – 35 yrs).

But even though giving birth at a health facility was normally the second or third choice of place for the women to give birth, they were all grateful for its existence in case problems occurred during deliveries. *“I thank God for He gave wisdom to human beings and they could help each other. They could cure me when I was to die. Sometimes I don’t need to complain, because the advantage weighs much more”* (woman, facility birth – 27 yrs).

There was a general awareness about possible complications that could occur related to delivery. The most frequently complications mentioned were bleeding, but also complications like obstructed labor and retained placenta was mentioned. *“I know*

many that died because of childbirth. The main reason for it is bleeding then died. Some also died because the baby didn't come out, and others for unknown reasons” (elderly woman – 56 yrs). Depending on the problem it varied on where the women would seek help if complications occurred. Regarding obstructed labour or retained placenta most of them answered that they would try the TBA first or some person with extra massaging skills; but when it came to bleeding most of them answered that they would go directly to the health facility trying to pour cold water over the woman on the way to reduce the bleeding: *“We use our traditional system to stop the bleeding, like pouring very cold water to her body and head. This really sometimes reduces bleeding until she reaches the health facility”* (elderly woman – 62 yrs). The TBA was confident that she could manage many difficult complications, except bleeding; *“My biggest fear is the bleeding. It is so terrible and I can't manage that – the blood is coming like water with power (akkoma bishani homnan lola'a)* (TBA - 46 yrs).

There was a variation of explanations regarding the causes of the different complications. The causes varied from hard work, low age and height, use of contraceptives and man made mistakes to more supernatural explanations like evil or punishment from God. In addition was also the lack of emergency obstetric care mentioned as a cause to death of a woman in childbirth; *“we don't have any hospital here, the health centre we have here cant do any operations. We have a too long distance to be treated. Had we had hospitals here, many women and their children wouldn't have died”* (woman, home birth – 30 yrs).

Discussion

The world health organization's strategy to reach the MDG5 is to make every woman deliver at a first level health facility by a skilled birth attendant (SBA) and that there should be a possibility of back up if complications should occur during delivery (World health report, 2005, p.71-72). Availability and accessibility of these services are essential. But even though there has been an increase of health centres and health posts in Ethiopia, the utilization is indeed one of the lowest in the world (Seifu, et.al.; 2011, p.127). The findings from this study makes it clear that the third 'A' in the

AAAQ framework, *Acceptability*, turns out to be more decisive regarding the decision on where to deliver, then availability and accessibility.

As revealed in the results section of this study there are many practices related to childbirth, indicating that as much as childbirth is a physiological event, it is also a social-, and cultural event (Jordan, 1993). Practices related to childbirth emerged as culturally embedded among the informants and proved to be an important factor influencing the decision making process as well. The naturalness around homebirth and the view that giving birth at health facility was not necessary if no complications occurred during the delivery, were views deeply embedded among the informants and one of the major findings of this study explaining why the women preferred to deliver at home, which is supported by other studies as well (Adamu and Salihu, 2002; Magoma, et al., 2010). Some of the factors influencing the women's desire to deliver at home were different perceptions around health facility deliveries. In contrast to the home deliveries' 'safe', 'natural' and 'supportive' environment, the health facility was to the informants connected with complications and lack of support. The feeling of lack of support at health facilities was perceived as that the health workers didn't care about the mother or the unborn child, this is important to notice since trust to the health workers and health facilities in general is one of the keys to be able to increase the health seeking behaviour among the women. If the aim is to make more women deliver at a health facility it is important to take the women's experiences and perceptions about the care that are given at health facilities seriously and into consideration. The perceptions the women and society have regarding the quality of care at the health facility is one possible factor reducing the acceptability to give birth at a health facility (Kerber, et.al., 2007, p.1363) and by that also influencing the first stage of delay – to delay the decision to seek care (Thaddeus and Main, 1994, p.1019).

The results from this study illustrates how social- and cultural factors surrounding childbirth played a role both at individual-, household- and community level, influencing the decision to seek care (Osubor, et.al., 2006; Montaug et.al., 2011). Continuing Jordan's (1993) statement that birth is also a social event was illustrated by the way both family members and neighbours were involved in the delivery as well as in possible decision making processes. Though the husband turned out to be

the person with the final decision regarding when and where to seek assistance during childbirth, turned the role of the relatives and neighbours (esp. elderly women) out to be decisive in the decision making processes, similar findings has also been found in other African settings, like Tanzania and Uganda (Urassa, et.al., 2009, P.225; Kyomuhendo, 2009, p.232). The “norm” in the community to give birth at home as the optimal, signaling a healthy pregnancy and successful birth, may result in additional pressure on the woman to deliver at home. The women who gave birth at health facilities without a real problem were indeed likely to be criticized, which indicates the strength of the “norm”. One would stay at home as long as possible, and wait with the intense hope that everything eventually would turn out well.

Though many had good experience with health workers and were grateful for their presence, the health worker’s often poor attitudes was commented by some of the women and by the health workers them selves. Other studies have also mentioned how health workers attitudes can affect the woman’s decision to seek help as well as receiving help (Magoma, et.al. 2010). On questions of whether this could affect their decisions on where to seek help, some of the women answered yes if the obstacle was seen as minor, but in cases of emergency this aspect would not be considered. Other factors that were mentioned by the informants for not seeking assistance from health facility were the fear of the health workers not keeping their confidentiality and the lack of support form health workers during childbirth, which was perceived as the health workers didn’t care of the outcome of the childbirth. All these factors led to a lack of trust of the health workers.

Regarding knowledge about possible complications during delivery the informants showed general knowledge about complications like bleeding, retained placenta and obstructed labour. In contrast to bleeding and retained placenta, was obstructed labour not perceived as emergency and was not a factor hastening the decision to seek care. Some researches argue that lack of knowledge about complications can influence the decision to seek care (Muleta 2004, p.15; Gabrysch and Campbell, 2009, p.8), and figures shows that there could be a connection with the level of formal education among the women and their use of health facility as a place for deliveries as well (CSA, 2006, p.116). From the findings of this study we are not able to neither support nor reject these statements, but agreeing that it could be a possible factor at the same

time agreeing with Lewis and de Bernis that increasing knowledge is not alone enough (2006, p.19).

Though *acceptability* emerged as the strongest indicator explaining why the majority of women choose to deliver at home, the result of the study also indeed indicate that *availability and accessibility* are factors influencing the place of delivery. As the distance to health facility in this study was a maximum of 30 min walking distance, the issue of distance being a factor in delay in seeking care was not as much relevant. A study done by Montagu, et.al (2011) found that poor availability of health facilities was *not* the major reason why women chose to deliver at home (Ibid, p:6), supporting other findings that increasing availability doesn't necessarily mean increase in utilization (Kerber, 2007, p.1363; Das, et.al, 2010, Mushi, et al., 2010). But in case of e.g. the need of caesarean section, the informants were concerned about the long distance to hospital, and in addition the problem of finding transportation and high cost of car rental that could cause huge delays in reaching a health facility and in worst case result in deaths or disabilities. Cost of health service deliveries being another factor was though not mentioned as a major factor not to deliver at health facility. Another study found similar findings, supporting this, showing that "only 7% of the poorest women reported cost as a deciding reason for not going to a facility for delivery" (Montagu, et.al., 2011, p.4). But in case of covering costs for transportation in times of emergencies the informants revealed that the amount could lead them into depth for many years, and in addition could the time spent in borrowing the money influence the delay in reaching the health facility (Filippi, et.al. 2006).

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For policy makers there will always be a question about prioritizing. Should facility-based services be scaled up? Or should there be a stronger focus on scaling up the community-based services with more skilled birth attendants in the community? Or is there a either or? The findings from this study highlights how determinants like *acceptability* of health facilities and both social- and cultural factors like practices as well as the 'nourishing' of home as the optimal place to deliver, influence the first stage of delay, the delay in seeking care to health facilities in any childbirth, where home is normally considered to be their first choice while health facility is the second or even third choice. These motivations to deliver at home will not disappear easily, even though health facilities will be more available and accessible (Montagu, 2011,

p.7). On the contrary all the informants included in this study emphasised that in case of complications they eventually would consider to seek care, and that they were much concerned about the lack of comprehensive emergency obstetric care services nearby. These findings support Gabrysch and Campbell's (2009) findings that the factors influencing the care seeking for preventive purposes are necessarily not the same as the determinants influencing care-seeking in case of emergency (ibid, p.18).

To be reminded, the intention of the AAAQ framework was to clarify and evaluate the right to health that is stated in Article 12: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standards of physical and mental health" (OHCHR, 2007, p.4). In line with Galtung (1969) and Farmer et.al (2006) are most of the maternal deaths a result of structural violence, knowing that most of the maternal deaths are avoidable if necessary care is accessible (Abdella, 2010).

Please see the article below for further discussion.

Reflection on the research methods

Doing fieldwork for the first time is a learning process with many challenges. Good and bad experiences were done, some limitations were reviled during the fieldwork and were sometimes able to do something about at that time, and others were reviled later. Even though the limitations that are reviled later are impossible to change, it is important to be aware off and reflect around how it might possibly influence the research. In addition to this it is also important to reflect about my own position in the study and how it might have influenced the study (Malterud, 2003).

The data collection methods used in this study intended to obtain depth and holistic views related to practices around childbirth, the context it takes place and health seeking behaviour related to delivery. Using qualitative methods to gain in-depth knowledge and understanding have much strength, but there are also some potential challenges using this method, and maybe particularly related to the researcher self, as the researcher is one important instrument.

Mays and Pope (2000) states that more “quantitative concepts” like validity and relevance also can be assessed in qualitative research, adjusting them to the qualitative research (Mays and Pope, 2000). It is suggested that the term credibility is used in qualitative research as an alternative to internal validity, and relevance or transferability instead of external validity, asking question whether or not the findings can be applied in other settings (Malterud, 2001).

Credibility

This section is based on Mays and Popes suggestion on how to improve the credibility of the findings. Among Mays and Popes suggestions, *triangulation*, *reflexivity* and *clear exposition of methods of data collection and analysis* will be discussed (Mays and Pope, 2000).

Triangulation:

Triangulation of qualitative data collecting methods- using in-depth interviews, focus group discussions and observation, as well as triangulation of sources- interviewing different categories of informants about the same issue, were applied in the study to ensure comprehensiveness of the data and the phenomenon being studied (Mays and Pope, 2000). As highlighted by Mays and Popes, triangulation somehow assumes that strengths and weaknesses will be compensated in another by using different methods. Hence ensuring comprehensiveness of the data may rather be used as a result of the triangulation, then as a test of validity (Mays and Pope, 2000). We believe and agree that by triangulating the methods we got a more comprehensive set of data, rather than if we had only used one method, but I will argue that the triangulation also to some extent increased the validity, e.g. things that was told during in-depth interviews was confirmed through observation.

Reflexivity:

The researcher being an instrument in qualitative methods makes reflexivity over the researcher’s own background an important part of the aspects of validity in qualitative research (Malterud, 2001, Patton, 2002, p.65). The researcher’s background and pre-assumptions are possible influential factors to both the data collection and the interpretation of the data; reflexivity over these factors that potentially shape the data collection is therefore important (Malterud, 2003). Aware of this, reflexivity of both

the researcher and the research assistant was discussed both prior, during and after the data was collected.

The researcher: To be in an area, with a different social and cultural context and with lack of language skills the challenges can be many. That I came with another cultural background, as well as being a nurse, were factors that more or less could create a gap between the informants and I, and could possibly restrict the informants' sharing their valuable information. I believe that being married to an Ethiopian from that area and living with his family reduced the gap between the informants and I to some extent. In addition I tried to reduce the differences by e.g. being sensitive to their dress code (wearing long dresses or skirt) and to be sensitive regarding social and cultural norms.

Being a nurse may have coloured me as a researcher, but being in the field and during interviews I think being a mother myself, previous experience related to childbirth in Ethiopia, and coming from a society where everything regarding safety around childbirth is full filled coloured me more as a researcher and made me much involved and engaged in the informants experiences and information; resulting in laughter, tears, reflections and discussions after the interviews. But even though I myself didn't considered that I being a nurse affected me as a researcher during the data collection, it was a possible and realistic challenge that it would affect the informants view about me and hence restrict their openness towards me. Being aware of this the data collection started in the community and we tried to have as little as possible to do with the health centre. We cannot be sure, but from the experience we got through the interviews and what is seen from the result, does it not seem like the fact that both the researcher and the research assistant being nurses restrict the informants' openness towards us. I believe this can both be explained from what is mentioned above, as well as the fact that being in a small community most of the informants knew that my mother in law is a known elderly woman with good abilities to assist during childbirth, which may have probably been an important factor regarding how the informants perceived- and trusted us, and maybe reduced the distance between us. In addition we also experienced that us being nurses sometimes opened up for questions that would not have been asked if we had not been health professionals.

The research assistant: Since the topic was related to females, female research assistance was preferred because we expected the female informants to be shy and more restricted to talk to a male interviewer. Nonetheless as we entered the research area we found it difficult to find a suitable female research assistant. As we stayed in the area people soon started to ask questions, and as we told about the study, people started to share their stories with us. They told us freely and detailed and asked us sometimes intimate questions. With this experience, we found that it possibly was not a severe obstacle that the assistant was male. From the experience we did during the interviews it didn't seem like the fact that the interviewer was a male influenced their answers, although we cannot say this for sure. There might have been things we missed that would have emerged if a female interviewer were used. There can be different reasons to their openness towards a male interviewer; in this case he being a nurse could have been an advantage, knowing that he as a nurse is used to handle different issues around female health. In addition we got the impression that people trusted him, while many knew his mother that is known by many to help during childbirth.

Clear exposition of methods of data collection:

As mentioned above triangulation of in-depth interviews, focus group discussion and observation were used to collect the data; in addition field notes were taken.

Regarding the setting of the interviews we discussed in advance regarding what would be most suitable for the informants as well as where they could feel relaxed and able to talk freely. The women were mainly interviewed at their homes as this was expressed to be more suitable for them. By many means it was strength to conduct the interviews at the informant's home. The informants were in their own safe environment, creating a setting where the informants were the host and we the guests. We experienced that this lead to a more relaxed atmosphere and enabled the informants to speak more freely. But performing interviews at home also involved some challenges and interruptions, like breastfeeding, curious children and neighbours, and other family members staying in the room. We solved this problem with spending some time talking to everyone at first, and then explaining them our purpose and asking them politely for some time alone with the informant, something that worked out very well. As the women have many tasks during the day we always when arranging appointments asked what time at the day that suited them best for

being interviewed. The interviews of the women attending ANC sessions took place at the health centre which may have restricted them to speak freely; even though the interviews were conducted in private rooms, with only the researcher and the research assistant present. The focus groups were conducted in our home. Even though we lived together with a family, in a house with the same standard as the others in the village, and had a 'coffee ceremony' to 'break the ice', they seemed to feel like guests and didn't talk openly and freely as we had experienced from the in-depth interviews. Also the fact that we were inexperienced in conducting focus group discussions was also probably a major factor that resulted in that we didn't manage to get a dynamic discussion in the focus groups.

Clear exposition of methods of data analysis:

It was the research assistant who transcribed and translated all the material, this was an advantage because he had conducted the interviews himself and he was familiar to the material and the context where the interviews were performed. On the other hand would it possibly increase the reliability if a second person had participated in the translation of the transcripts. The researcher mainly did the coding and further analysis herself, but during the whole process I was able to discuss with the research assistance about issues that were not clear and we were also able to discuss the interpretation of the findings; in addition there was a continuous discussion and follow-up with the supervisor of the study.

Transferability and Relevance

Qualitative studies do not aim to generalize the data, and are in principle only applicable to the setting being studied (Malterud, 2001). But through thorough and critical reflection and discussion are *transferability* and *relevance* aims in qualitative research. Malterud (2001) states, "external validity asks in what contexts the findings can be applied" (Ibid, p.484). And that it is an aim for the researcher that the findings can be transferred and used by others in other similar settings or groups (Malterud, 2003). To be able to ensure transferability it is important to make the reader known about data collection methods and the steps in the data analysis (Pope, et.al, 2002), as shown in the previous section under credibility.

The informants, except the health workers, were mainly farmers and had no or little formal education living in a rural setting. Even though the practices around childbirth can vary within the different ethnic groups in Ethiopia, do I believe that the study is relevant to other rural settings in Ethiopia, and that the research question and the topic being studied are relevant for other rural societies in Africa as well.

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Article

The journal we consider is *BMC Pregnancy and Childbirth* that is an open access journal.

**Home birth versus facility birth:
A qualitative study on perceptions and practices from rural
Ethiopia**

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Abstract

Background: The number of global maternal deaths is still unacceptably high, and the women suffering are highly unequally distributed between and within countries. Ethiopia have the recent years done much to increase the availability of birth attendants to provide safe deliveries to women in childbirth, for example in connection with the ambitious Health extension workers program, but the country still has an unusually low number of births attended by skilled birth attendants. The aim of this article is to explore the context behind the low number of births attended by skilled birth attendants in a rural Ethiopian setting exploring perceptions and practices related to homebirth and health facility birth respectively. The availability, accessibility, acceptability and quality framework (AAAQ) is employed in the discussion of the data.

Methods: This is a triangulation study employing in-depth interviews (31), focus group discussions (2) and one observation. The data analysis is based on Malterud's model for "Systematic Text Condensation".

Results: Homebirth was found to be highly elaborated and highly valued among the informants. A key finding was that home was perceived as the normal and optimal place to deliver a child, while health facilities were sought in cases of emergency. A strong desire for emergency obstetric care in reachable distance from people's homes strongly emerged illustrating that health facilities was to be used if it was a matter of saving the mothers life.

Conclusion: Drawing upon the AAAQ framework, 'acceptability' emerged as the most important determinant influencing the decision on where to give birth. The health facilities simply were not found to be suitable of acceptable places for normal deliveries. The results however strongly revealed that there was substantial openness for the seeking of assistance either with TBAs or at health facilities whenever emergency occurred, but the lack of availability of emergency obstetric care services emerged as severe indicating the relevance of the 'accessibility' and the 'availability' dimensions of the AAAQ framework

Key words: perceptions, practices, home births, health facility births

Introduction

Around 99% of all global maternal deaths are found in low-income countries (WHO, 2010b), with 50% of the maternal deaths occurring in only six countries, Ethiopia being one of them (Hogan, et.al 2010, p.1609). The figures powerfully illustrate the global discrepancy regarding access to maternal health care. Until recently the annual number of maternal deaths has been estimated at around 500.000. Recent figures report a sharp decline in maternal deaths to around 350.000 (Hogan, et.al; 2010, p.1609). But even though this indicates that there has been a very positive development, the numbers are still unacceptably high, knowing that the large majority of the maternal deaths are avoidable if necessary treatment is given (Abdella, 2010).

Maternal health is placed at the core of the global health agenda, focused through millennium development goal five (MDG5), which aims to reduce maternal deaths by three quarters between 1990 and 2015. The aim is further to achieve universal access to reproductive health by the year 2015 (WHO, 2010a). The World Health Organisation's (WHO) prime strategy to achieve MDG5 is to ensure that every delivery is assisted by a skilled birth attendant at a first level facility and with the possibility of back up if complications occur. The "back-up" to save the lives of women with obstetric complications that arise during pregnancy or childbirth is defined as Emergency Obstetric Care (EmOC) (World health report, 2005, p.71-72, Paxton, et.al, 2005). The availability and access to these interventions however remain an enormous challenge in many developing countries where health facilities are few and are equipped with poor resources (Miller, et.al. p.2003). In the developing world today, less than 62% of the women receive assistance from a skilled birth attendant during childbirth (WHO, 2008, p.2). The disturbing maternal mortality rate in Ethiopia has been linked to the fact that only 5,8% of all births are attended by a skilled birth attendant (SBA) (CSA, 2006, p.116). This number is low compared to the African region as a whole where it is estimated that 46% give birth assisted by a SBA (WHO, 2010c). The qualitative study on which this paper is based aims to explore perceptions and practices of home- and facility based birth with the aim to enhance the understanding of the low number of births attended by skilled birth attendants in Ethiopia. The study draws on the AAAQ framework: Availability ("in sufficient quantity"), Accessibility (affordable, non-discrimination, physical),

Acceptability (ethically, culturally, confidentiality) and Quality (scientifically and medically) in the discussion of the findings. The AAAQ are four criteria in General Comment 14 that was made to evaluate the right to health (article 12, see OHCHR, 2007, p.4). (OHCHR, 2008, p.8-9).

Ethiopia indeed has one of the world's highest maternal mortality figures with 720 deaths per 100,000 live births (WHO, et.al., 2007, p.24), and the lifetime risk of maternal death in Ethiopia is 1 in 27 (Ibid, p.24) compared to 1 in 48.000 in Ireland (Ibid, p.1). Making the scenario even grimmer; maternal deaths have been depicted as “the tip of the iceberg”, while maternal morbidity has been described as “the base of the iceberg” (Lindstrand, et.al. 2007). The Ethiopian Ministry of Health (MoH) estimates that 20.000 women die and 400.000 more suffer from pregnancy and birth related disabilities annually in Ethiopia (Ministry of Health, 2009).

There are a number of reasons behind the low numbers of births attended by skilled birth attendants in Ethiopia. Maternal age, marital status, religion and ‘traditional’ beliefs are some of the factors that can influence the decision on where the woman will give birth (Gabrysch and Campbell, 2009). In addition can long distances, lack of transportation, poverty, the quality of care in the health system and socio-cultural factors influence decisions on where to seek care (Abdella, 2010). There is moreover a relationship between the mothers’ formal educational status and the usage of both antenatal care (ANC) - and delivery services (CSA, 2006; Das, et.al, 2010). In Ethiopia women with secondary or higher education are 52% more likely to give birth at a health facility compared to women with no education (2%) (CSA –EDHS, 2006, p.116). In addition is health knowledge, perceptions and previous experiences important factors to get a further understanding of the low number of births attended at a health facility (Gabrysch and Campbell, 2009). Lack of awareness related to complications that can occur during and after childbirth, and the advantages of giving birth at a health facility, are highlighted by researchers as important determinants influencing the decision to seek care (Muleta 2004, p.15; Gabrysch and Campbell, 2009, p.8).

With Ethiopia’s high population mainly living in rural areas (85%) (MOH Ethiopia, 2009), and with a very low number of health workers (0,03 doctors per 1000, 0,21

nurses per 1000 and 0,01 midwives per 1000 (WHO, 2006), it is an enormous challenge to achieve the goals spelled out in the strategy from WHO. In an effort to confront the challenges the Ethiopian government has initiated a Health Extension Program (HEP). The health extension workers (HEW) are females and living at community level and are trained for one year; where maternal and child health, health education and communication are some of the major topics they are trained in. The HEWs are supposed to have skills to attend normal deliveries, to detect women at risk and to refer them when needed (Wilder, 2008; Moh. Ethiopia, 2009; Karim, et al. 2010). It has however been argued that the HEW's lack the ability to handle the major causes of maternal deaths (Afework, 2010) and in order to operate efficiently they are dependent on an efficient referral system. In addition to the HEP, non-physicians are trained in Ethiopia to perform surgical interventions in an attempt to make comprehensive EmOC services more available for the majority of women living in the rural areas (Seifu, et.al., 2011, p.138).

Another barrier to the WHO strategy is related to the fact that women may not wish to give birth at a health facility even when it is available (Thaddeus and Main, 1994:1093, Das, et.al, 2010, Mushi, et al., 2010). Jordan (2003) states that practices connected to pregnancy and childbirth are deeply embedded in culture, and a time when both mother and child are vulnerable and perceived to be in danger. She further writes that "In order to deal with this danger and the existential uncertainty associated with birth, people tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context", (Jordan 1993, p.4).

In Ethiopia, as in many other poor countries, it is common that relatives or traditional birth attendants assist during childbirth (Campbell and Graham, 2006, p.1293). Ethiopian Demographic Health Survey (EDHS) indicates that more than 60% of the births are assisted by family members or others and less than 30% are attended by TBAs, (CSA, 2006, p.117). There is still a lack of knowledge on the culturally embedded reasons behind the high number of home births, and it is deemed important to gain increased knowledge on the social and cultural context of pregnancy and

delivery to enhance our understanding of decision-making processes related to childbirth (see e.g. Knutson 2004, p.27).

Methods

The study was conducted in a rural area west in the Oromia Region, Ethiopia. The specific study location was Agemsa, a village under the Ameru district in east Wollega zone. The majority of the population is of Oromo ethnic origin and Afaan Oromo is the first spoken language. A health centre that may perform basic emergency obstetric care is located in Agemssa, but to reach services that provide comprehensive emergency obstetric care, the inhabitants have to travel 164 kilometres to the hospital in Nekemte.

As the aim of the research was to gain in-depth information about perceptions and practices related to childbirth a qualitative research design was deemed appropriate. The study consisted of two parts: one community based and one health facility based part. The data collection was carried out from June 2010 until October 2010 by the first author of the present paper. In-depth interviews (IDI's) and focus group discussions (FGD's) were the main methods used to collect the data. Unstructured observation during observation of a home delivery- a delivery that ended at a health centre- was also a part of the study. The aim of the latter was to observe the delivery in its actual context (Hudelson, 1994). Participant observation was an integral part of the study in the sense that daily life activities was attended together with other women in an attempt to gain a rudimentary understanding of the daily life and the context the informants lived in. A research assistant well acquainted with the study area and the data collection methods worked together with the researcher throughout the research period. Semi-structured interview guides and topic guides were used for the IDI's and the FGD's respectively. The guides gave the discussions direction focused around key topics related to perceptions surrounding birth giving in home versus facility-based settings. The open nature of questions and the flexibility of the sequencing of the questions allowed for follow up of topics that emerged during the interviews. Major topics brought up in the interviews were practices surrounding homebirth and health facility birth respectively, related perceptions of the two types of delivery with a particular exploration of decision making processes on where to give birth.

Informants to the individual interviews in the community-based component consisted of women who gave birth at home, elderly women, husbands and TBAs, while the informants in the facility based component consisted of women who gave birth at a health facility, women attending antenatal care services (ANC) and health workers.

Number of study participants: in-depth interviews	N = 31	Number of study participants: Focus group discussion	N = 9
Women who gave birth at home	6	Women who gave birth at home	5
Elderly women	4	Women who gave birth at health facility	4
Husbands	5		
TBA	1		
Women who gave birth at health facility	6		
Women attending ANC	5		
Health Workers	4		

Table 1

Purposeful sampling (Patton, 2002) was used to recruit informants for the study. This implied that particular categories of individuals who were differently positioned to the study topic were sought. Before start up the recruitment process and the data collection process were discussed with the administrator of Agemssa and the director at the health centre. The informants were recruited through informal talks. The study participants in the community component were interviewed at home, while the participants in the health facility component were interviewed at the health centre, except the women who had given birth at health facility who were also interviewed at home. The informants were either recruited through informal talks, or people suggested possible “information-rich cases” that could be relevant for the study. Regarding the ANC attendants the nurse informed about the research and volunteers to the study remained after the consultation. The health workers were interviewed during a break. All the interviews took place in a private room at the health facility.

All the IDI's and FGD's were recorded by a digital recorder. The data material was transcribed and translated from Afaan Oromo to English by the research assistant who had both linguistic and cultural knowledge. The analysis was based on Malteruds (2003) 'Systematic Text Condensation', consisting of the following four steps: 1) *Sense in the whole*: In this step the material was read and reread to get a total impression of the material, to search for recurring themes/patterns as well as for nuances. Themes that emerged while reading were noted down. 2) *Discrimination of meaning units*: During this stage pieces of text that was relevant for the research questions were sorted out. 3) *Transformation and abstraction of meaning units*: In this part of the analysis the code-groups were scrutinized one by one. Due to a rich material, subgroups were created under each code-group (theme). The content of the material were condensed, and a large number of quotes were at this point extracted and systematized and used to illustrate the condensed text. 4) *Synthesis into a consistent statement*: in the last step the importance of the meaning units were summarized (Malterud, 2003).

The Norwegian Social Science Data Service (NSD) approved the study, and Ethical clearance was obtained from the Oromia Regional Health Bureau in Ethiopia. A letter of support was obtained from the Oromia Regional Health Bureau to the Zonal office in Shambo. The Zonal office further provided a letter of support to the health centre and administration in Agemssa. An informed consent form translated from English to Afaan Oromo was read, explained and obtained from all the participants. The principles of confidentiality and anonymity were explained to each informant.

Findings

Homebirth

When a woman is to give birth the news are commonly rapidly spread and neighbouring women and female kin's will come to offer their help. Close family and those with most experience will move inside helping the woman while others will wait outside. A large group of people may gather. When it is confirmed that things seem to progress well many of the people sitting outside will return home and await further news. If the husband is around he will normally wait outside together with others. The helpers are commonly elderly females, commonly family members such

as mother or the mother in-law (depending on who is living nearby) as well as sisters, but also non-related neighbours are commonly present. The TBA is normally not called upon if difficulties do not occur. In order to move close to the birthing situation a description of a birth, which was followed through its diverse phases, is presented below:

Home birth and facility birth in Agemssa: The case Gaaddisee (pseudonym)

It is early morning. On our way to visit a family a woman comes running towards us saying, “Come! Come and help! My daughter (in law) is going to give birth”. We followed her. It was dark inside the little house, but with the light coming from the open door I could see a woman sitting on a mattress made of straw (*daajjaa*) in the corner. Gaaddisee was wearing her dress and a blanket was covering her body. She was leaning towards the wall in a ‘leaning sitting position’. In front of her legs there was a stick with two stones behind to push against during contractions.

After a short while elderly ladies started to enter the room. They released their traditional waste ties (*sabbat*), and kneeled down and prayed before they greeted the labouring woman and asked her how she was doing. Then they engaged in diverse tasks. One woman placed herself behind the labouring mother in a sitting position so that the labouring mother was able to rest against her. The old woman held her arms around her touching her abdominal sides carefully while talking to her, saying: “be strong you clever lady, be strong as you are, be strong” (*Cimtuu koo jabaadhu, ciniinnadhu ittani jabaattuu koo; jabaadhuuti ittani*, Afaan Oromo). Two other women were supporting her knees. The other women present were talking while making a fire for warmth and to heat water. The mother in law prepared a thread and a razor blade for the cutting of the umbilical cord, and found a blanket to wrap the child in. Gaaddisee was in focus, and the coming hours the women continued to pray and to encourage her. The atmosphere seemed very relaxed.

‘Gaaddisee’ was silent and answered the women in the room merely in brief terms. She was sweating. When the contractions came she pushed against the stick on the ground, while the assistants supported her knees, while the old woman sitting behind her supporting her back and dried the sweat from her forehead. Her body

was tense, and it looked like she was going to scream during the contractions, but she bit her teeth's together and held her breath. When there was a break from the contractions she breathed out. It is not acceptable for a woman to make powerful sounds during delivery the women said. It would be a shame if she does.

Hours went by, but there was little progress in the birthing process, and the woman in labor seemed to become weaker. The mother in law who would have the responsibility to receive the child inserted her hand under the skirt, without looking, to feel if there was progress. She silently gave a sign that there was little development. I sensed that the atmosphere grew tenser, the mother in law in particular showed signs of being nervous (after around 6 hours). She sent a woman to search for the TBA. The TBA was known for her massaging skills and for her particular skills in attending difficult deliveries. Through the small door opening I could see the husband was walking back and forth in the compound. Eventually he came to the door and asked how things were going; he seemed stressed and uncomfortable with the situation. I had been told that this woman had lost her two previous children during childbirth. The woman who went to search for the TBA returned after a short while, but alone; the TBA was not around. The husband came to the door again after a while, and told the women that he wanted his wife to deliver at the health centre. The women in the room were provoked and all stood up and protested to the husband's suggestion. They refused, saying it was too early to bring her there, and that they should give it more time and first try to massage her with butter. The mother in labour seemed exhausted, but she managed to express that she didn't want to go to the health centre, - that she wished to deliver home in the presence of God and Saint Mary. The massage, the encouragement and praying thus continued. It gradually became warmer inside the small house as the hours went by.

Suddenly the husband moved into the compound with a stretcher together with people who would help him carry his wife. The women again refused saying they should wait, and Gaaddisee got very upset and said repeatedly: "I don't want to go! They will take off my clothes; don't let them take off my clothes! They will cut my body with scissors!" But the husband got the final say, and with the helpers they placed the woman on the stretcher and carried her to the health centre located only

some five minutes walking distance away. The women present, eight in all, followed along. I moved with the group to the health centre. Gaaddisee was carried directly to the delivery room. The nurse closed the door forcefully right in front of the women who were all on their way in. I could see by their looks that they were surprised and upset when they were not allowed to enter. They waited outside (while I was allowed to enter the room). Gaaddisee asked the nurse not to take off her clothes. The nurse respected her wish, and found a sheet and covered her from the abdomen to her feet while she pulled up her dress to listen to the child's heartbeat. But when the nurse was to examine her she removed the sheet forgetting the woman's shyness. Gaaddisee tried to pull her dress downwards and tried to refuse when they started to examine her. It was clear that she felt highly uncomfortable when her body was exposed.

After some hours with struggle Gaaddisee finally, and still in silence, delivered a healthy boy. The group who had waited outside were relieved to hear that everything went well, but one elderly woman commented that she could have delivered in the natural way at home if they had given her more time.

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“Everybody is born at home, and it is natural to keep on doing that” (elderly woman – 56 yrs).

To give birth at home was an expressed desire among all the informants interviewed in the community-based component as well as among the women attending the ANC. This is where babies always have been born informants said, and was looked upon as the normal place to deliver. Home births moreover signal that you have had a healthy pregnancy and delivery: *“We give birth at home because it shows that everything is fine”* (Woman who gave birth at home –25 yrs). In contrast, birth giving at health a facility was looked at as an unnatural place to deliver: *“They deliver at home because they want to, and because it shows that there are no difficulties that force them to go to a hospital. Being well is being lucky which makes ladies give birth at home. Everybody thinks that trying first at home before going to a health facility is normal”* (elderly woman – 62 yrs). Seeking help from a TBA was also done primarily when obstacles occurred during delivery: *“If they think that if everything is ok with the pregnancy, it is natural here to give birth at home, they prefer the home. Some even*

don't want to come here to me, because they feel that it will be ok to deliver at home. In case it becomes challenging, they come here or go to the health center” (TBA – 46 yrs).

Also the husbands interviewed said that as long as everything was normal they wanted their wives' to deliver at home, but as soon as things seemed problematic they would take her to a health facility. *“I prefer her to deliver home. But if problems occur, I will take her to a health facility. I prefer home delivery because it is my pleasure, it shows that she is healthy, and we jump over the carrying and the payments as well”* (husband – 43 yrs). Family members and neighbours normally will also influence on decision related to where the woman delivers and when and where to seek help if needed. It is however commonly the husband who finally decides and if he is not at home it is the woman's mother/mother in law who will decide.

Some informants had experienced pressure from family and the surrounding community during the decision making process on where to seek help, and would commonly reveal their strong desire for the woman to deliver at home. One informant experienced that when her husband was away it was her mother in law who would make the decision, but that men at times could overrule their decision as in the case above: *“Most of my family didn't want me to go to the hospital though the contraction stayed four days on me. Then, my brother fought the elderly women present and said that I should go to hospital whatever the result will be, even death”* (woman, home birth – 25 yrs). The fear of being criticized if going to a health facility to deliver without having a true problem was mentioned as a factor that would often delay the decision to seek assistance *“If you just decide to take your wife to a health facility for delivery without any confirmation that she is in trouble the others will talk about you saying, ‘Why did they go while she could give birth at home in a natural way?’ Personally I prefer that people take women to the health facility only when it seems difficult”* (elderly woman – 62 yrs).

“If problems occur, I will take her to a health facility”

Not all the women interviewed attended the antenatal care (ANC) sessions. Even if they were satisfied with the service at the ANC sessions all the informants interviewed at the ANC answered that they would give birth at home and only go to

the health facility if complications occurred; *“I will give birth just at my home, except if problems occur”* (ANC attendant –18 yrs). It was mentioned by these women that as long as their pregnancy was found to be normal during the ANC visits, they felt it was safe to deliver at home. The health workers said that information about risk factors during delivery and advantages of health facility birth was given during the ANC sessions, but that the women nonetheless preferred to deliver at home. *“I think it depends on how the one who checks the lady at the ANC sessions talks. We are strict to the ladies who are in high risk, and tell them to come and deliver here at the health centre. We do efforts to make them come here though many of them prefer home delivery”* (health worker – 20 yrs).

People said that they commonly waited as long as possible, 2-4 days or more at home, depending on the situation, before they sought help from a health facility. Bleeding and retained placenta was seen as emergency situated that demanded immediate assistance, while obstructed labor tended to delay the decision to seek care with the hope that the child eventually would come. *“People wait a long time until they decide to move to the health facility, saying that everything will be ok”* (woman, home birth – 30 yrs). Should problems happen, the women did however express that they were grateful for the existence of emergency services; *“I thank God for he gave wisdom to human beings so they could help each other. They could make medicines and they could cure me when I was to die”* (woman, facility birth – 27 yrs).

Among the total of 40 informants in the study (IDIs and FGDs), none said they would deliver at a health facility as their first choice. The health workers who were interviewed said there were a few women who came to deliver at the health centre without having problems. These were primarily women who were particularly told by health extension workers to deliver at a health facility, or women who were educated and had gained a different understanding of the use of giving birth at a health facility, *“Those who have better knowledge prefer to deliver here (at the health centre), but they are not many. In general they prefer to give birth at home, and will come here only if complications occur”* (health worker – 23 yrs).

A general skepticism and fear related to delivery at health facilities was expressed in the interviews, a skepticism that was often related to the methods used there.

Episiotomy and vaginal examinations were particularly talked of as problematic. Informants held that the wound caused by episiotomy healed much slower, while the one formed naturally healed faster. “... *it (the episiotomy) heals slowly; but when we give birth at home, is it said that the wounds formed naturally is saint Mary’s and heals faster. Therefore, we prefer to give birth at home. That’s why elder people wish us to give birth at home as well*” (woman, home birth – 25 yrs). Regarding the vaginal examination they didn’t only find it very uncomfortable, they also feared that it could hurt their unborn child: “*The person inserts their hands in the lady, and then the baby’s extremities will be damaged*” (woman, home birth – 25 yrs). As we saw during the case above, exposure of the body during delivery due to the taking off of the clothes, and the birthing position were mentioned as other reasons for the women not to deliver at the health facility; “*There are some who are too shy to go to health facility. They fear showing their body to the health personnel, and thus prefer to deliver at home*” (elderly woman – 56 yrs).

Some moreover feared that the health workers wouldn’t keep their confidentiality, and revealed a lack of trust in the health workers. Some of the health workers were aware of this problem; “*They have a lack of knowledge about the responsibilities of health workers, they fear that health workers will not keep their privacy*” (health worker – 22 yrs). The fact that the health workers were strangers to them, and that the care and support the women valued from giving birth at home seemed to lack among many of the health workers made people feel that the health workers didn’t really care about them, nor about the result of the delivery; “*Many think that the personnel don’t care about the woman in childbirth, which may result in problems for the mother and baby... it is much better at home*” (woman, home birth – 40 yrs). The health workers themselves mentioned that their conduct could be a factor that made people stay away; “*We health workers must try to attract them with good talks, with smooth sounds and not act angry or as superiors. We should be humble and make them wish to come to us. So, we have to shape up*” (health worker – 23 yrs). Also the young age of the health workers reduced women’s trust in them because it was perceived that their low age implied less knowledge and experience “*some people complain that the health personnel may not have enough knowledge because many of them are young and fresh*” (woman, facility birth – 26) yrs.

The long distance to comprehensive emergency obstetric care services

Many of the informants were concerned about the fact there were no comprehensive emergency obstetric care services available nearby if serious problems occurred during a delivery. All interviewed had a maximum walking distance of 30 min to the health centre, but comprehensive emergency obstetric care services were located around 165 kilometers away, which meant that depending upon availability of a car and the road conditions would take around five hours “*We have a too long distance to be treated. Had we had hospitals here, many people wouldn't have died. The health centre we have here can't carry out any operation, and the women are suffering on the way to the hospital and some die before they reach it*” (woman, home birth – 30 yrs). In addition to the long distances to get to EmOC services, people had difficulties finding a car when needed; “*There is a huge problem when it comes to transportation, there are few cars available. Many also live far away in places that no car can reach*” (health worker –20 yrs). The costs were also mentioned as one of the barriers to seek health care during delivery. It was not the money to cover the fees for the delivery service that worried the informants most, but the payment of the transport, i.e. all the money needed to rent a car. Car rental from Agemssa – Nekemte meant paying around 2000-2500 ETB, which is equivalent to around 87-109 Euro). This could lead people into debt for years; “*It is not so dangerous cost wise if we go to health centre nearby, but when it is a serious problem and it is a must to go far from here to Nekemte... Transportation costs much, especially if we need to rent a car*” (woman, home birth – 25 yrs). But even when poor, most informants said that money would not be a barrier if the problem was serious and the life of the mother was in danger. They would then borrow money from someone; “*If something happens, our being poor will not restrict us from going to a health facility*” (woman, home birth – 25 yrs).

The challenge when EmOC are needed: the case of Ayantu (pseudonym)

The story of Ayantu reveals some of the challenges encountered when EmOC services are needed. Ayantu started the labor at home, but the birth did not progress well and the child didn't come out. They called for the TBA for help, but still even the TBA didn't manage to deliver the child. Finally, after close to three days she was brought to the health centre nearby. The group that followed Ayantu was told to

immediately bring her to the hospital for caesarian section. The relatives started to look for a car. Ayantu explained:

The contractions began on Wednesday and we went to find a car on Friday in order to get to the hospital. It was not so easy to get a car. Friday evening we found one and reached the hospital at nighttime. Then they helped me. The dust was wearing me on the way there. I lay on the back of the car, not inside. It was not as easy as I talk now. I was unconscious. They said that had we come less than one hour later I would have lost my baby and maybe died myself as well. I heard that the baby was very much green and almost dead but they managed to save it. (woman, facility birth – 38 yrs).

Discussion

Triangulation of qualitative data collecting methods- using in-depth interviews, focus group discussions and observation were applied in the study. In addition triangulation of sources- interviewing different categories of informants about the same issue were applied to ensure comprehensiveness of the data and the phenomenon being studied (Mays and Pope, 2000) to improve the credibility of the findings. During the whole process the researcher was able to discuss with the research assistance about issues that was not clear and we were also able to discuss the interpretation of the findings. Related to the informant groups in this study, it is a weakness, though the researcher and assistant strived to find some, that those women who gave birth at health facility as the first choice is not included in the study. It would have broadened the picture as a whole and the discussion as well.

One of the major challenges using qualitative methods, are particularly related to the researcher self, thus reflexivity of both the researcher and the research assistant was discussed both prior, during and after the data was collected (Malterud, 2001, Patton, 2002: 65). The researcher coming with another cultural background was a potential to create a gap between the informants and I. In addition was both the researcher and the research assistant nurses, the fact that this potentially could make the informants associate us with the professional health sector and thus restrict their openness towards us was discussed prior to the study started, and the interviews started in the community based component to avoid any additional associations. The research

assistant coming from the study area and in addition having a mother who was known for her skills during attendants of deliveries was most probably a crucial factor making the informants welcoming us as well as seemingly trusting us with openness and willingness to participate in the study.

It is likely that the findings have quite some degree of relevance also in other Ethiopian rural settings, knowing that practices around childbirth can vary within the different ethnic groups in Ethiopia.

Factors influencing the place of delivery

Let us at this point return to the AAAQ framework in an attempt to assess the degree to which the ‘availability’, ‘accessibility’, ‘acceptability’ and ‘quality’ concepts seem relevant in enhancing our understanding of the material at hand. The framework in its origin was stated in Comment 14 to evaluate the right to health (article 12) (OHCHR, 2008, p.8-9) and will in this discussion be used to indicate where the main barriers to give birth at health facilities may lie.

With the above study findings fresh in mind the relevance of the so-called acceptability dimension of the AAAQ framework seems to stand out clearly. The major finding in the present study was a substantial emphasis of the home as the natural place to deliver your children. In fact, even though quite some attempts were made to interview women who preferred to give birth at a health facility, we did not manage to encounter even a single woman of this category, although according to the nurses such women did at times show up. As we saw, among all the categories of the study informants, except for the health workers, home was perceived as not only the natural place to give birth, it was seen to be the optimal place to give birth. The strong “norm” to give birth at home, and which signaled a healthy pregnancy and successful birth, indeed seemed to cause pressure on the woman to deliver at home. As we saw women who gave birth at health facilities without having a severe problem, could be criticized. This seemed to influence the decision-making process, and even though it was the husband who was said to make the decision, his decisions was influenced by the woman herself, the family and even neighbors (elderly females)

as well, similar findings has also been found in other African settings, like Tanzania and Uganda (Urassa, et.al., 2009, P.225; Kyomuhendo, 2009, p.232).

Notions of the “naturalness” of home birth were furthermore strongly associated with the health and wellbeing and to the safety of the home compound and its surroundings, that is in line with findings from other settings as well (Adamu and Salihu, 2002; Magoma, et al., 2010). Cherishing of the home birth as the ideal birth was linked to the social dimensions of the birthing situation; relatives and neighbors gathered in the compound, and the women entering the house remained inside together with the woman in labor until the very end. The continuous encouraging words and the chatting seemed to create a supportive and compassionate atmosphere. Elderly women sitting behind her back and in front of her legs gave her close bodily support through slow massage, through the wiping of sweat from her body and through encouraging words. Despite the warmth from the fire in the room, the blanket remained over the woman’s body preventing exposure of intimate parts. The prayers continuously presented to God and St. Mary for support at this vulnerable time moreover enhanced an experience of being in the right hands. What emerged through talk and observation was a highly valued birthing practice, a social and cultural elaboration of a most critical life event. The enormous trust given to elderly women and to traditional birth attendants is commonly linked to the respect for the experience they have in helping women at a most precarious time in their lives and that fact that they are all well known persons living in the community (Urassa, et.al. 2009, p.222),

Perceived benefit- as well as *quality* of care at health facilities are one important factor reducing the acceptability to give birth at a health a health facility (Kerber, et.al., 2007, p.1363), and turned out to be one important influential factor. Health knowledge, perceptions and previous experiences are important factors to get a further understanding of the low number of births attended at a health facility (Gabrysch and Campbell, 2009). Lack of awareness of complications that can occur during and after childbirth, and the advantages of giving birth at a health facility were mentioned among the health workers as possible factors preventing the decisions to seek professional care, and are also highlighted by other researchers as important determinants influencing the decision to seek care (Muleta 2004, p.15; Gabrysch and Campbell, 2009, p.8).

In stark contrast to the home delivery, births taking place at a health facility were associated with birthing situations that were not normal, that were not proceeding in a proper and healthy manner, but were characterized by obstacles, by situations of bleeding or conditions where after days of labor did not lead to the baby being born, obstructed labor, i.e. both situations posing severe danger to health and life of both the woman and the baby in her womb. Skepticism, lack of trust i.e. lack of *acceptability* was moreover voiced against diverse practices from exposing the woman's body to vaginal examination and episiotomy, that is also found by researchers in other settings (Adamu and Salihu, 2002; Magoma, 2010). Strangely enough Caesarian section was not mentioned a lot, and was not met with the same critique. Health workers being strangers to the women in labour were moreover met with skepticism as it was not believed that they could possibly have the same expertise nor could they have the same desire to assist the woman in labour as their mothers, mothers in law, other kin or neighbors. Also other studies have revealed that the care provided by relatives or by TBAs is perceived to be more personal, and is taking place in a manner where norms and practices are respected (Mathole and Shamu, 2009, p.205). In the present study we found that the assistance of traditional birth attendants was commonly sought before help at a health facility was sought. Family members assisted the delivery while the TBA became an option primarily in case of difficulties while health facilities were sought as a third option. This finding is in line with the figures of the Ethiopian Demographic Health Survey (EDHS), which reveal that more than 60% of the births in Ethiopia are assisted by family members, neighbors or others, while less than 30% are attended by TBAs. The small remaining figure is made up by births attended by skilled birth attendants (CSA, 2006, p.117).

In the health facilities there were rarely staff that gave the women soothing and encouraging words, far less one would find staff who would pray to God and Mother Mary in ways that would give women the strength to carry through the immense hardships of labour. A strong wish to avoid the health centers thus emerged in the informants' accounts. In fact, the ANC's sessions were seemingly sought by the women primarily to assess whether or not a pregnancy was found to proceed in a smooth, taking that as a go ahead to give birth at home. Antenatal care is to introduce the women to the health facility with the intention that the woman will more readily seek assistance from the health facility during childbirth. In addition ANC intends to

detect and predict possible complications (Magoma et.al; 2010, p.1.2). Research has however demonstrated that there is not clear evidence that ANC attendance has contributed to a reduction in the maternal mortality rates, one reason being that a majority of the challenges that occur during childbirth cannot be predicted or prevented through ANC screening of 'high risk mothers' (Miller, et.al, 2003, p. 13; Campbell and Graham, 2006). A 'confirmation' of not being a 'high risk mother' can thus potentially mislead the women to believe that everything will be fine also during childbirth. This finding emerged strongly in the accounts of the women in the present study.

The study findings strongly indicate that there is an enormous lack of trust in – or to use the vernacular of the AAAQ framework – *acceptability* of health facilities as natural locations to give birth. The facilities simply were not perceived to provide laboring women in the sense of safety, comfort and support and the sense of health and wellbeing that a successful home birth would generate. The study findings in the same vein nourishes the findings of Jordan's (1993) classical work which so forcefully reveal that birth giving and practices related to childbirth is a social- and cultural event as much as a physiological event. They are life events that are culturally elaborated and made meaningful to the point where barriers to leave the home behind become very high. The implication is that the birthing situation may reach quite dramatic points before people leave the home and seek assistance at a health facility.

Even though a highlighting of home birth as the ultimate location for birth giving, and strong lack of *acceptance* of birth giving at health facility emerged strongly in the study, the findings also revealed that both the *availability* and *accessibility* of appropriate health facilities were highly relevant factors to consider in a birth giving context. The health centre was located within a maximum walking distance of 30 minutes from the informants in the present study, but the distance to comprehensive emergency obstetric care services was extensive, and implied many hours of travel and enormous cost in terms of car rental. *Availability* and *accessibility* challenges indeed emerged both in the present study and in other studies (Thaddeus and Main, 1994, p.1094-95 and Gabrysch and Campbell, 2009) as important and decisive actors when the need for comprehensive emergency obstetric care arises. Long distance to the hospital, poor infrastructure, lack of transportation and search for funding for car

rental may lead to substantial delays in reaching the health services needed. The serious concern expressed by the informants regarding lack of available and accessible comprehensive emergency obstetric care services revealed that even though socio-cultural factors certainly may influence delays in the decision making process to seek care, assistance will normally be sought when delivery turns truly problematic. This has also been found in other studies (Cham, et.al., 2005).

Cost is often mentioned as an important factor influencing the decisions to seek care at health facilities (Gabrysh and Campbell, 2009, p.12). Some of the informants did mention cost of delivery care at the health centre as a factor influencing the decision to seek health care, but it did not emerge as a major actor. Montagu et.al (2011) similarly found that costs linked to a facility birth was commonly not a major reason for women to deliver at home; their study findings indicated that cost was only mentioned by 7% of the poorest women as a reason for not seeking delivery services at health facilities (Ibid, p.4). Informants did reveal however that covering the costs for transportation in case of emergency could amount to sums that would lead them into depth for many years, and in addition could the time spent in borrowing the money influence the delay in reaching the health facility (Filippi, et.al, 2006).

Interventions to reduce maternal mortality

There is a serious ongoing discussion around the effectiveness of different interventions, their roles and their ability to reduce the maternal mortality. The substantial emphasis on facility-based birth has been a prime strategy as skilled birth attendants have mainly been located in the health facilities. This study has demonstrated however that availability and accessibility of health facilities or skilled birth attendants may not be enough to secure women to deliver at a health facility. This finding is supported by a number of other studies that indicate that increasing the availability of health services does not necessarily lead to an increase in utilization (Thaddeus and Main, 1994, p.1093; Das, et.al, 2010; Mushi et.al., 2010; Montagu et al, 2011, p.6). Ethiopia provides us with an example where there has been a tremendous increase in primary health care services over the past few years, but there is nonetheless a gap between availability and per-capita utilization (Seifu, et.al.; 2011, p.127). Indeed, Ethiopia has proved to have one of the lowest utilisation levels of skilled birth attendants in the world (ibid).

In Ethiopia there has since 2003 been a focus on community based health extension workers as was mentioned above, where one of the aims is to make safe deliveries more available (Moh Ethiopia, 2009), at the same time the woman can be at home, able to fulfill her desire and valued practices. The results of a study done by Karim, et.al (2010) write that in this way community based primary health care program “can lead to improved maternal healthcare utilization” (Ibid, p.99). There are however numerous potential challenges involved. First of all, the health extension workers must be accepted as female elders who are let into the women’s homes. This is not at all an obvious scenario, and strongly depends upon who these women are perceived to be by the house where a woman is to give birth: what kinds of relationship or kinship does she the HEW have with the one she is to assist? What is her age? Has she given birth to one or more children? Does she have a religion that is in line with the one in the home she is to visit? Does she reveal a fundamental respect for culturally constituted local beliefs and practice? Motivations that is strongly embedded in the society are thus not only solved merely by increasing the availability of health facilities (Montagu, et.al., 2011, p.7), or by numbers of HEW, but need to be developed in line with people’s wishes if they are to be used. What is more, in case of complications the HEW is still fully dependent on an effective referral system (Miller, et.al, 2003, p.15; Abdella, 2010, p.121), which to this point remains an enormous challenge in most rural areas in Ethiopia. EmOC services are still extremely scarce. There has thus been a growing and simultaneous focus on the importance of emergency obstetric care services in the effort to reduce the number of maternal deaths (Paxton, et.al., 2005, p.189). Emergency obstetric care moreover has to be available, accessible and acceptable for the women and their families (Miller, et.al, 2003, p.14; Montagu et al, 2011, p. 7).

Comprehensive EmOC services do indeed tend to be placed in urban areas (Paxton, et.al, 2006, p.303). There are emerging attempts at finding alternative ways of approaching the challenges linked to the low availability of EmOC services. In order to meet the needs and use the existing human resources there is an ongoing task-shifting initiative in Ethiopia, training health officers to perform Caesarean sections, an initiative which seem to demonstrate interesting progress (Seifu, et.al., 2011, p.138).

Conclusions

We started out by referring to WHO's strategy to reach the MDG5 which aims at making every woman deliver at a first level health facility by a skilled birth attendant with the possibility of back up if complications occur (World health report, 2005, p.71-72). Availability and accessibility of these services are essential. This study has however primarily indicated the immense importance of local acceptability of the health services that are to be provided. What is more, it is difficult to see that unless at least parts of the culturally embedded content of home birth is respected and is allowed to live on it will be difficult to ensure an openness to new maternal health interventions such as acceptance at large scale of assistance by HEW at home. On the bases of this study's findings it is far easier to envisage utilization of comprehensive emergency obstetric care services, as in crisis conditions at least the study informants in the present study were willing to go to extreme lengths to save mother and child. Indicating that the importance of *acceptability* regarding facility births were different between care seeking during 'normal' deliveries and in case of complications.

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I would like to thank and acknowledge all the informants for their contributions and for sharing their time and effort in this study. My gratitude goes further to the local administrative unit and the administration at the health facility in Agemssa for discussions as well as open to facilitate if needed. My final thanks go to Geremew Wakjira who performed all the interviews together with me, as well as transcribed and translated all the data material collected and who has contributed with valuable comments during the phase of analysis.

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Appendixes

Appendix 1) Informed consent

Informed consent

My name is Mette Øxnevad and I am a Master student at the Centre for International Health, University of Bergen, Norway. My supervisor is Professors Astrid Blystad, at the Department of Public Health and Primary Health Care; University of Bergen, Norway. As part of my study, I am doing a research project entitled: *Perceptions, practices and health seeking behaviour related to facility- and home based birth: A qualitative study from rural Ethiopia.*

In this research I wish to explore the context behind the numbers of maternal mortality and morbidity, to get in-depth information about choices people make, the practises they have, and their health seeking behaviour in relation to childbirth. There will be an interview where I have some questions regarding this topic. This is a voluntary study. It is your right to refuse to answer the questions, and to withdraw from the study at any time without giving any reason for it, and with no consequences. The information that you are going to give will be tape-recorded upon your consent, and notes will be taken without revealing the name of the participants. The recordings and transcriptions will only be used by the researcher and the assistant, and will be handled with strict confidentiality. All the information will be deleted after I finished with the thesis, by end of May 2011. Feel free to ask questions at any time before, during or after the interview.

If you understood the information above and agree, please sign below.

Thank you so much!

I understand the purpose of this study and I hereby consent to participate

Participant: _____

Date: _____

Appendix 2) Ethical clearances

1) Approval from the Norwegian Social Science Data Service (NSD) (Norwegian)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



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5018 BERGEN

Vår dato: 23.03.2010

Vår ref: 23916 / 2 / LT

Deres dato:

Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 02.03.2010. Meldingen gjelder prosjektet:

23916

Behandlingsansvarlig
Daglig ansvarlig
Student

A qualitative Study into Perceptions and Practices linked to Childbirth, and the Preferences and Barriers that lay behind the Decision on where to give Birth
Universitetet i Bergen, ved institusjonens overste leder
Astrid Blystad
Mette Øxnevad

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

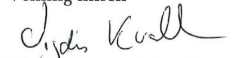
Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i melde skjemaet, korrespondanse med ombudet, vedlagte prosjektvurdering - kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 26.05.2011, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Vigdis Namtvedt Kvalheim


Lis Tenold

Kontaktperson: Lis Tenold tlf: 55 58 33 77

Vedlegg: Prosjektvurdering

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2) Approval from the Norwegian Social Science Data Service (NSD) (English)

Norsk samfunnsvitenskapelig datatjeneste AS
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Date: May 14th 2010

Ref: 23916 KH/RF

AFFIRMATION

The Data Protection Official for Privacy in Research, Norwegian Social Science Data Services (NSD), finds that the processing of personal data in the project "A qualitative Study into Perceptions and Practices linked to Childbirth, and the Preferences and Barriers that lay behind the Decision on where to give Birth" is in accordance with the Norwegian Personal Data Act, ref. our letter to Astrid Blystad (supervisor) and Mette Øxnevad March 23th 2010.

Yours sincerely,

Bjørn Henrichsen

Kjersti Håvardstun

Avdelingskontorer / District Offices:

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TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

3) Ethical clearance from the Oromia Regional Health Bureau



BIIROO EEGUMSA FAYYAA
BUREAU OROMIYAA

OROMIA HEALTH
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Lakk /Ref. No. BEFO/HBTPH/1-18/455
Guyyaa /Date 5-11-2002

To whom it may concern

The ethical Review committee of the Oromia Health Bureau has reviewed the research proposal submitted by by Mette Oxnefrom Bergen university that is entitled "Perceptions, Practices and Health seeking behavior related to facility and home based birth" A qualitative study from rural Ethiopia; please find the attached here with two pages reviewed result of the approval of the proposal.



With Regards

Amma Ashemfi (BSc.)
Public Health Emergency Management
and Health Research Core Process
Manager

Chairman, Ethical Review Committee.

CC

◆ Mette Oxnevad

Bergen

Tessoo: Tel: 011-371-72-77, Fax 011-371-72-27 Box. 24341 E-mail:
ohbhead@telecom.net.et Address: ADDIS ABABA/FINFINNE-ETHIOPIA

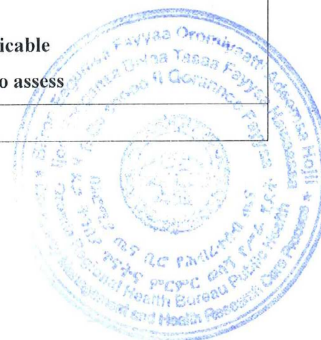
**Oromia Regional State Health Bureau, Public Health Emergency
Management and Health Research Core Process**

Ethical Review Committee

Ethical Review Form

Tele: 011-371-72-27, E-mail: ohbhead@telecom.net.et, P.O. Box: 24341 Addis Ababa,
Ethiopia.

Criteria/Item	Rating
1. Consent form ◆ Does the consent contain all the necessary information that subject should be aware of?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> Requires revision <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Not attached
2. Are the objectives of the study clearly stated	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. Are provisions to overcome risks well described and accepted? ◆ Justice ◆ Beneficence ◆ Respect for a person	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> Not well described <input type="checkbox"/> No <input type="checkbox"/> Not applicable
4. Are the safety procedures in the use of vaccines, drugs, and other biological products acceptable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not applicable
5. Are the procedures to keep confidentiality well described?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
6. Are the proposed researchers competent to carry out the study in a scientifically sound way?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unable to assess
7. Does it have material transfer agreement?	<input type="checkbox"/> Yes



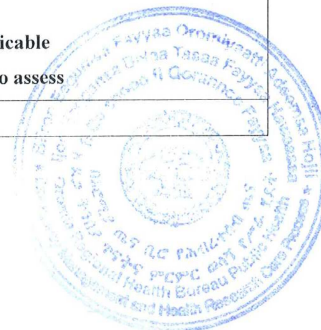
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7. Does it have material transfer agreement?	<input type="checkbox"/> Yes



4) Letter of support from the Oromia Regional Health Bureau to the Zonal office in Shambo (Afaan Oromo)



**BIIROO EEGUMSA FAYYAA
BUREAU OROMIYAA**

**OROMIA HEALTH
የኦሮሚያ ጤና ጥበቃ ቢሮ**

Lakk /Ref. No. BEFD/HBJFH/1-18/4505
Guyyaa /Date 5-11-2002

**Waajjira Eegumsa Fayyaa Godina Horroo-Guduruu Wallaggaa tiif
Shaambuu**

Dhimmii: - **Deeggarsa kennnu ilaala**

Akkuma mata-dureerratti ibsuuf yaalametti **Mette Oxnevad "Yunvarsitiin Bergen"** ti MA barachaa jiraachuusaanii Yunvarsitiin kuni fi dhaabbanni "Norwegian Social Science Data Services(NSD)" jedhamu xalayaa barreessaniin nuu ibsaniiru.

Kanaafuu, qorannoo mata-duree "**Qualitative study on Perceptions, Practices and Health seeking behavior related to facility and home based birth in Amuru Woreda**" jedhamu irratti Aanaa Amuruu keessatti gaggeessuuf piropozaalii isaanii nuuf dhiyeessaniiru.

Haaluma kanaan koreen "**Ethical clearance**" Biiroo keenyaa piropozaalii isaanii xiinxalanii erga ilaalanii booda akka hojjatan mirkaneessaniiru. Kanaafuu, qorannoo gaggeessan kana irratti gama keessaniin deeggarsa barbaachisaa ta'e hunda akka gootaniif isin beeksisaa, aadde Mette Oxnevad illee qorannoo kana erga adeemsisanii qaaccessaniin booda fiiriisaa kooppii lama Biiroo keenyaaf akka dhiyeessitan isin hubachiifna.

CC:

◆ Aadde **Mette Oxnevad**
Bakka jiranitti



Nagaa Wajjin

[Signature]
Girmaa Ashannaaffii (BSc.)
Gaggeesaa Adeemsa Hojii Ijoo Hoggansaa
Balea Tasa Fayyaa Hawaasaa, Qu'annoo
fi qorannoo Fayyaa

Tessoo: Tel: 011-371-72-77, Fax 011-371-72-27 Box. 24341 E-mail:
ohbhead@telecom.net.et Address: ADDIS ABABA/FINFINNE-ETHIOPIA

Appendix 3) Definitions

Let us at this point introduce a few central definitions.

Maternal mortality is defined as: “the death of a woman from any cause while pregnant or within 42 days of termination of the pregnancy by abortion or delivery” (Lindstrand, et. al. 2006, p.235).

Maternal mortality ratio (MMR) “represents the number of maternal deaths per 100 000 live births”(Ibid, p.236).

Lifetime risk of maternal death refers to a woman’s “lifetime risk of maternal death in any particular pregnancy multiplied by the total number of times she is likely to become pregnant” (Wall, 2002:896). Comparing Niger and Ireland you find that a woman’s lifetime risk of dying from pregnancy-related complications is 1 in 7 in Niger versus 1 in 48 000 in Ireland (WHO et. al. 2007, p.1). In Ethiopia the figures are 1 in 27 (Ibid, p.24).

“*Maternal morbidity* refers to all complications of pregnancy, delivery and abortion”. (Lindstrand, et al. 2006, p.239). Obstetric fistula is an example of one devastating complication related to obstructed labour.

Skilled Birth Attendant (SBA): “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (WHO, 2011, p.1).

“A *Traditional Birth Attendant* (TBA) is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants” (WHO, 1992, p.4).

“A *trained Traditional Birth Attendant* is a TBA who has received a short course of training through the modern health care sector to upgrade her skills” (WHO, 1992 , p.4).

The World Health organizations' handbook of monitoring emergency obstetric care (2009) use the following functions to identify basic and comprehensive emergency obstetric care:

Basic emergency Obstetric Care: “administer parenteral antibiotics”, administer uterotonic drugs like oxytocin, “administer parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulfate), “manually remove the placenta”, “remove retained products”, “perform assisted vaginal delivery” and to “perform basic neonatal resuscitation (WHO et.al; 2009, p.7)

Comprehensive emergency obstetric care: Comprehensive EmOC services imply all the basic EmOC services mentioned above. In addition Comprehensive EmOC services perform e.g. cesarean section and blood transfusion (WHO et al.; 2009, p.7).

Appendix 4) Interview guides

1) Interview guide for women in childbearing age

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- Age
- Work
- Educational status
- Number of children
- Marital status
- Ethnic group

2. How did you find out about your pregnancy or previous pregnancies?

- Signs & symptoms

3. Did you seek advice from someone when you first learned you were pregnant?

- Mother, mother in law
- TBA's/"experienced mothers"
- religious leaders, healers,
- ANC / health personnel

4. How was your pregnancy?

- Normal
- Nausea
- Bleeding
- Back pain
- Other

5. How did your lifestyle change during the course of your pregnancy?
 - Food-intake
 - Workload

6. Have you experienced any problems/complications during your pregnancies?
 - If yes, what happened?
 - What did you do?
 - Asked advises from relatives, TBA's, health personnel, healers, etc.?

7. When delivery is approaching, what kinds of preparation do you do?
 - Finding a birth attendant
 - Preparation of the home
 - Any preparation in case of complications? like saving money to go to health facility, planning for transportation?
 - Other

8. Where did you give birth to your child/children?

9. Can you please tell me where you prefer to deliver?
Why?
Probing if it is home:
 - Distance
 - Money
 - Traditions/practices – if yes, what kinds?
 - Previous experience from health facility?
 - Birth attendantsProbing if it is health facility:
 - Safety
 - Don't know people to help with home delivery

10. Can you please describe for me a home delivery? (If she delivered at health facility, go to interview guide 2)

- Who are attending?
- Who is present in the room?
- Birthing practises – who does what?
- Expression of pain?
- Stomach rubbing with butter?
- Prayers?
- Song / dance?
- Others?

11. What will you do just after the delivery?

- Who remove the cord, placenta and blood?
- What do you do with it?
- Take rest?
- Eat – what kinds of food?

12. What will be done with the baby just after it is born?

- Feed the baby? With what (breast milk, cow milk, water)?
- The cord tip on the baby?
- Will it stay with you, or others soon after?
- Prayers?
- Others?

13. Can you mention complications that can arise during or after the delivery?

- Bleeding
- The baby will not come out (Obstructed labour)
- Fever
- Etc

14. What are the reasons for such complications?

- Gods will
- Curse

15. Have you experienced complications during pregnancy, childbirth or after giving birth? Or do you know someone who had?

Probe:

- Sister, neighbour?
- If yes, what happened?

16. What will you do if complications arise during birth giving?

- Who will you seek help from first? (TBA's, healers, health personnel?)
- Pray
- Other practises/rituals?

17. Who will decide where to seek help and when if complications arise?

- Husband?
- Mother?/Mother in law?
- You self?

18. What are the barriers to seek help?

- Money
- Distance/Transport
- Language
- Lack of courtesy at health facility
- Lack of trust to the health facility
- Previous experience or others experiences
- Others?

19. Can you give me one example on someone who has delivered at a health facility? (If she didn't give birth in a health facility herself)

- How was their experience there?
- How was they treated?
- What did they find to be different from giving birth at home?

- Thank you so much!

2) Interview guide for women who have delivered at a health facility

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- Age
- Work
- Educational status
- Number of children
- Marital status
- Ethnic group

2. Was it your first time to deliver at a health facility? If not, for how many times?

3. Why did you choose to deliver at the health facility?

- Previous experience
- Complications last pregnancy
- Encouragement from family and friends

4. Can you please tell me your experience from giving birth at a health facility?

- People being present at delivery (male workers, family members)?
- Privacy?
- Practises
- Language barriers?
- Sounds and smell?
- Respectful conduct?
- Good/bad experience?

5. Was there anything you missed?

6. Have you also delivered at home before, if yes, can you please compare it from giving birth at a health facility?

- Thank you so much!

3) Interview guide for husbands/partners

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- Age
- Work
- Educational status
- Number of children
- Marital status
- Ethnic group

2. When were you told about your wife/partner's pregnancy?

- Soon as your wife/partner got to know it?
- After days, weeks, months?
- Nobody told you, you knew it by seeing her growing stomach?

3. Who told you about the pregnancy?

- Wife/partner
- Mother, family members

4. Did you give any advise, instructions or prohibitions for you wife/partner during pregnancy? In that case, what was it?

- Eating habits
- Work load
- Seeking for medical advises (popular-, folk and professional sector)
- Visiting an antenatal clinic

5. Depending on the problem, if your wife/partner experienced any problems during pregnancy, what will you advise her to do?

- Pray
 - Take a rest
 - Go to her mother
 - Seek advise from a TBA/"experienced mother"
 - Healer
 - Go to a health facility
6. When the delivery is approaching, is there anything you will do for preparation?
- Support your wife?
 - Will stay out of the house?
 - Arranging for transport and money in case it will be needed
7. Where do you prefer your wife/partner to deliver?
- Home
 - Health facility
8. Why do you prefer that?
9. Who decides where your wife/partner should deliver?
- Mother in law, your mother
 - You (Husband/partner)
 - Your wife/partner
 - The eldest in the household
 - Others?
10. Do you know any complications that can arise during pregnancy, childbirth or after birth?
- Bleeding
 - The baby will not come out (Obstructed labour)
 - Fever
 - Other?

11. Do you know the reasons why these different complications arise?

- The will of God
- Punishment – what kind?
- Physiological reasons
- Other?

12. Have you experienced that your wife, neighbour, sister have suffered from such a complications? If yes, can you please tell me?

- Thank you so much!

4) Interview guide for Traditional birth attendants

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- Age
- Work
- Educational status
- Number of children
- Marital status
- Ethnic group

2. Can you remember when you started as a TBA/ attending deliveries?

- When you were in childbearing age?
- After all children was born
- After menopause

3. Can you please tell me why you started?

- You always wanted
- Need for it in the community
- It has been a duty in your family for generations
- You needed money

4. How does the community give value to this task?

5. Why do you think most women deliver at home?

- They feel safer home
- That has been done for generations
- Long distance
- Money

6. Do women seek your advice during their pregnancy as well? If yes, what do they commonly seek advice for?
 7. Can you normally help them with their questions/problems? If not, what do you do?
 - Wait and see?
 - Other?
 8. When you are going to attend a delivery do you need to prepare yourself?
 - If yes, in what way?
 9. Can you please describe a “normal” delivery attendance?
 - Number of people in the room?
 - Who is in the room?
 - Rituals
 - Prayers, songs, sayings
 - Birthing practises
 - Position/pushing
 - Belts
 - What is done with the placenta?
 10. What happens when there are complications during delivery or after birth?
 - Practises of handling obstruction
 - Practises of handling bleeding, fever
 11. Can you please give me an example of a delivery where there were complications?
 12. Have you experienced, or know somebody, that died during labour, or just after giving birth? If yes, can you please tell me what happened?
 13. What do you think about giving birth at a health facility?
- Thank you so much!

5) Interview guide for women attending antenatal clinic sessions

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- Age
- Work
- Educational status
- Number of children
- Marital status
- Ethnic group

2. How did you know that you were pregnant?

- Self-diagnosis? – What kinds of symptoms/indications?
- A doctor's diagnosis?
- Others?

3. After you knew about your pregnancy, when did you seek the antenatal clinic?

- days, weeks, months

4. Do your husband/partner, mother/mother in-law agree that you attend these sessions?

5. How often do you attend these sessions?

6. How do you find these sessions?

- Informative/useful/useless

7. How has the pregnancy affected you?

8. Have you had any problems in your pregnancy so far? If yes, what kinds of?

- Nausea
- Back pain
- Bleeding
- High blood pressure?
- Others?

9. Do you seek advises from other places as well?

- TBA's, experienced mothers
- Healers
- Religious leaders
- Family members

10. Where have you decided to deliver?

- Why did you decide that?
- Was it your choice?
- Did your family agree? – any pressure?

- Thank you so much!

6) Interview guide for health workers

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information
 - Age
 - Work
 - Educational status
 - Number of children
 - Marital status
 - Ethnic group

2. How do you like your job here at the health facility?
 - Nice to help people?
 - Challenging?
 - Good/bad work environment?
 - Tiresome?
 - Little payment?

3. Women attending antenatal sessions, do they normally deliver at home or here at the health facility?
 - Do you know why? / Reasons for that?

4. Most women in Ethiopia deliver at home, why is that?

5. What do you think about to give birth at home?

6. What do you think about the job the TBA's do?

7. Do you have any form of contact / cooperation with them?

8. Do you have any suggestions on how to make more women deliver at a health facility with skilled birth attendance?
 - Which factors do you think could contribute to get more women to deliver at a health facility?

9. What do you think is the way to reduce maternal mortality?

Thank you so much!

7) Interview guide for elderly women

Date of interview: _____

Location: _____

Introduce the purpose of the interview, and assure confidentiality of information they are going to provide.

1. Background information

- a. Age
- b. Work
- c. Educational status
- d. Number of children
- e. Marital status
- f. Ethnic group

2. When did you start to attend deliveries? Why did you start?

3. Why do you think many women in labour call for you when they need assistance during homebirth?

4. Where do you think most women in Ethiopia deliver? And why is that?

5. Can you please describe for me a home delivery? What will be your main tasks?

6. What do you think about giving birth at a health facility?

7. Do you know about any complications that can occur during before, during or after delivery?

8. Have you experienced such complications? If yes, what happened? What did you do?

Thank you so much!

Appendix 5) Topic guides for focus group discussions

1) Topic guide for FGD with women giving birth at home

1. Where do you prefer to deliver? And why?
2. Who decide where you should deliver?
3. Where do you think most women in Ethiopia deliver? And why is that?
4. Can you please describe for us a home delivery?
5. Is it good or bad to deliver at home? And why? What is good/bad?
6. Is it good or bad to deliver at a health facility? And why? What is good/bad?
7. Is there something that can go wrong during a home deliver? What?
8. In case of something wrong happen, depending on the problem, what will you do?

2) Topic guide for FGD with women giving birth at health facility

1. Where do you prefer to deliver? And why?
2. Why did you give birth at a health facility?
3. Who made the decision that you should deliver at a health facility?
4. Where do you think most women in Ethiopia deliver? And why is that?
5. Is it good or bad to deliver at a health facility? Why? What is good/bad?
6. Is it good or bad to deliver at home? And why? What is good/bad?
7. If you will be pregnant again, where would you like to deliver?