

Increasing demand for health facility birth

**A qualitative study exploring barriers and facilitators for skilled care
utilization in the Amhara Region, Ethiopia**

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This thesis is submitted in partial fulfilment of the requirements for the degree of Master of
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Summary

The current study aims to explore women's and health workers experiences and perceptions on barriers and facilitators for health facility delivery in Northern Ethiopia. Ethiopia has one of the highest maternal mortality rates in the world and few women give birth in a health facility. The World Health Organization states that the most efficient strategy to reduce maternal mortality is to secure skilled attendance at birth, which involves the assistance of skilled health workers in an enabling environment with possibilities of referral. The Ethiopian government has adopted this strategy. The factors associated with use of health facilities for birth are well known, but there is limited research on *why* women seek health facility for their delivery and what is required to increase the demand for health facility delivery.

The study was conducted in North Gondar zone in the Amhara region in Ethiopia in 2012 and used a qualitative approach. 29 participants from rural, semi-urban and urban settings were recruited. The sample included women with experience of health facility birth, women without experience of health facility birth, one husband, and health workers working in delivery wards in two health centres and one hospital. The data were collected through in-depth interviews in community and health facility settings, and non-participant observation in the hospital labour ward. The Availability, Accessibility, Acceptability and Quality (AAAQ) framework were drawn upon in the analysis of the data combined with the concepts of trust, security and authoritative knowledge. "Thematic Content Analysis" was applied as a procedural guideline.

The findings confirm that distance to the health facility, access to transport and unpredictable cost are major barriers for health facility birth. The study also found that acceptability of health facility delivery in terms of respectful attitudes, having privacy and support, and quality of care related to medical safety, may be as essential to improve as the issues regarding availability and accessibility in order to increase the demand for health facility birth. Availability and accessibility was naturally a larger barrier for use of birth services in rural areas. The acceptability of birth services seemed to vary with the location, but the perception of health workers as impolite and unsupportive dominated our findings.

The AAAQ framework was essential to identify the barriers and facilitators for health facility birth from a health system perspective. Social and cultural context related to childbirth were introduced to address additional factors. Who was trusted as a birth attendant was closely associated with who women saw as having ‘the authoritative knowledge of birth’ and the appropriate place to give birth seemed to be linked to concerns about feeling secure in both medical and social terms. This varied in the rural, semi-urban and urban settings and produced patterns in perceptions about ‘the appropriate place to give birth’. For women in the urban area, the health facility was generally perceived to be the appropriate place to give birth, while women in rural areas considered home as the appropriate place to give birth. Women in semi-urban settings differed in their perceptions on the appropriate place to give birth.

Based on the study findings I conclude that in order to increase demand for health facility delivery, one needs to address not only availability and accessibility issues which have been high on the Ethiopian health policy agenda recently, but also issues related to acceptability and quality of care. The social and cultural context also has to be taken into consideration because one needs to understand why the women choose their home before the health facility to give birth.

The thesis is based on the current guidelines provided by the Centre for International Health, University of Bergen. The chosen format is a monograph.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CS	Caesarean Section
DHS	Demographic Health Survey
HIV	Human Immunodeficiency Virus
IERB	Institutional Ethical Review Board (Gondar Ethiopia)
MoH	Ministry of Health
NSD	Norwegian Social Science Data Services
REK	Regional Ethical Committee (Norway)
WHO	World Health Organization

Definition of terms

Maternal death: WHO defines maternal death as “*the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes*” [1].

Maternal Morality Ratio (MMR) is defined as the number of maternal deaths per 100 000 live births [2]

Traditional birth attendant (TBA): Traditional and lay midwives, who provide basic pregnancy and birthing care and advice based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated [3].

Health Extension Worker (HEW); provides basic curative and preventive health services in rural communities. Should also be trained in skills to assist normal deliveries [4].

WHO’s Signal functions for BEmONC:

1. Administer parenteral antibiotics
2. Administer parenteral oxytocin
3. Administer parenteral anti-convulsant for pre-eclampsia/eclampsia
4. Perform removal of a retained placenta
5. Perform removal of retained products
6. Perform instrumental assisted vaginal delivery

WHO's signal functions for CEmONC:

Perform the 6 signal functions of BEmONC and in addition perform function 7 and 8, which are:

7. Perform safe blood transfusion
8. Perform surgery/caesarean section

Birth Preparedness and Complication Readiness: A strategy to promote the timely use of skilled maternal and neonatal care based on the theory that preparing for childbirth and being ready for complications reduces delays in obtaining this care [5]. This strategy is part of the Ethiopian National Reproductive Health Strategy 2006-2015 [4]

Birth preparedness includes:

Identifying a skilled birth attendant

Identifying the location of the closest appropriate care facility

Prepare funds for birth related and emergency expenses

Prepare transport to health facility for birth and obstetric emergency

Identify compatible blood donors in case of emergency

Health post: The lowest unit of health care facility where people can receive primary health care. Women can also get delivery care, but not all health posts have included this service today.

Health centre: The mid-level health care facility, provides BEmONC

Rural hospital: Higher level than health centre, provides BEmONC

Referral hospital: The highest level of health care facility, provides CEmONC

Kebele: Lowest administrative unit in Ethiopia, can be translated to village

Woreda: Mid-level administrative unit in Ethiopia, can be translated to district

Zone: Highest level of administrative unit in Ethiopia, can be translated to region

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Chapter 1 Introduction

The burden of maternal mortality

Every day, approximately 800 women in the world die from preventable conditions related to pregnancy and childbirth [2]. Moreover, annually some 10-15 million women suffer from morbidity caused by complications during and after pregnancy and childbirth [6]. The consequences of maternal mortality and morbidity also concern the families and the community at large. Particularly in low-income settings children who lose their mothers are at increased risk of death and other health problems e.g. malnutrition. A high mortality rate among fertile women is also a loss of resources for the society [7].

Almost all maternal deaths occur in low-income countries and more than half of these in Sub-Saharan Africa [8]. The Maternal Mortality Ratio (MMR) in Ethiopia is one of the highest in the world, almost 700/100 000¹ live births according to the Ethiopian Demographic and Health survey (2011) [9]. This is higher than the Sub-Saharan Africa average of 500/100 000 live births and vastly higher compared to high income countries which in comparison on average has a MMR of 16/100 000 live births [8]. The Millennium Development Goal (MDG) 5 aims to improve maternal health and one of the targets is to reduce the number of maternal deaths by 75% between 1990 - 2015 and to increase skilled attendance at birth [10]. Ethiopia has made little progress in reducing maternal mortality and it is very unlikely that it will reach the goal which is to decrease the maternal mortality to 248/100 000 live births by 2015.

The World Health Organization (WHO) identifies five major causes of maternal deaths: severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), obstructed labour and unsafe abortion. These direct causes account for 80% of all maternal deaths while the remaining 20% is due to indirect causes such as anaemia, malaria and HIV/AIDS, especially in Sub-Saharan Africa [2]. Most maternal deaths occur in the postpartum period (61%) and half of these within a day after delivery [11]. In Ethiopia bleeding is the major cause of maternal deaths followed by pre-eclampsia and eclampsia [2].

¹ WHO reports that the MMR in Ethiopia was 350/100 000 live births in 2010, lower than the Ethiopian DHS report 2011 who reports the MMR to be 676/100 000 live births.

Maternal deaths are preventable and health care interventions to prevent or manage obstetric complications are known. These interventions are access to antenatal care (ANC) in pregnancy, skilled attendance during childbirth, and care and support in the weeks after childbirth [2]. Skilled attendance is defined as the presence of a midwife, nurse or a doctor who has obtained proficient skills needed to manage pregnancies and deliveries and an enabling environment, which includes adequate supplies and equipment for assisting women in labour and birth, infrastructure and efficient systems of communication and referral [12]. Skilled attendance at birth and access to Emergency Obstetric and Neonatal care (EmONC) can make a difference between life and death [13]. Skilled attendance at birth is advocated as “*the single most important intervention to ensure safe motherhood*” [12]. Skilled attendants can perform deliveries either at home, in health centres or in hospitals, but it is argued that the most efficient strategy for lower income countries is to have the deliveries in hospitals or health centres with referral capacity [11].

Coverage and quality of maternal health care

Low health service coverage and inequities in the provision of essential maternal, newborn and child interventions remain challenges in many sub-Saharan African countries[13]. Few women receive the full range of necessary services to monitor pregnancy and labour as well as identifying complications, and provide life-saving interventions. There is inequitable coverage of skilled birth attendance with a 5-fold higher coverage for the least poor versus the poor in many countries[13]. Skilled birth attendance has been identified as a useful marker of health system access and equity of services delivery. In addition to poor coverage of facilities, poor quality care at birth is a bottleneck for increasing demand for facility births. Poor quality of services includes quality of clinical care and acceptability such as gender sensitivity, preservation of dignity and cultural sensitivity [13]. Together with structural barriers of accessibility these may explain the extremely low utilization of health services for delivery in many countries in sub-Saharan Africa including Ethiopia.

Quality of care and coverage of birth services in Ethiopia

Ethiopia shares with many low-income countries the challenges of limited resources, weak infrastructure, particularly roads, and a shortage of health personnel [14]. In a study conducted by Admasu et.al (2011) about availability, utilization and quality of emergency

obstetric care (EmOC)² in Ethiopia; it was found that many health centres and hospitals do not provide the signal functions³ supposed to be provided at their level. Lack of supplies, such as equipment for assisting delivery, drugs and human resources were challenges for ensuring the signal functions [14]. Pitchforth et al. (2010) reported similar findings in their pilot study to assess and understand the quality of care in a labour ward in Gondar, Ethiopia. In addition they reported infrastructure such as adequate space to facilitate and admit patients as a determinant factor for the quality of care[15]. The lack of health workers in Ethiopia remains a challenge and is a determinant for quality of care. Even though the coverage of health centres and health posts have improved reaching 90% primary health service coverage in 2010 [16],. there are still not enough health workers. Ethiopia has only 0.84 health workers per 1000 population [17]; this is much lower than the WHO recommendation of at least 2.3 health workers per 1000 population [18]. There is also inequity in the distribution of health workers; 46% of physicians and 28% of nurses are working in the capital Addis Ababa where only 4 % of the population live [19]. The Amhara region, where the current study was conducted, has only 0.74 health workers per 1000 population, which is the 4th lowest in the country [17]. Moreover, in terms of birth care, the recommended distribution of facilities who provide BEmONC of 5 per 500 000 has not been reached [20]. The Amhara region had only 0,4 facilities per 500 000 population in 2009 [17].

Factors associated with utilization of birth services

Utilization of birth services is associated with many factors; these factors are similar for many sub-Saharan countries as they struggle with similar challenges in increasing demand for birth services [21]. By utilization of birth services, I refer to women who use the health facility and are attended by skilled health workers when giving birth. Few women use birth services in Ethiopia, nationally only 10% of women give birth in a health facility, and the same percentage is found in the Amhara region [9]. The percentage that give birth in a health facility is different in urban and rural areas, while 50 % of women in urban areas use a health facility for delivery, only four percent use a health facility for delivery in rural areas. In a recent survey from North Gondar zone, where the current study was conducted, Worku et.al. (2013) found that 14% received birth services from skilled providers [22]. In the Amhara region women are commonly assisted at birth by relatives (59.5%) while some get assistance

² In this study it was referred to EmOC but the new term commonly used is EmONC, which I will further use in this thesis

³ See Definition of terms: “Signal functions for BEmONC and CEmONC”

from Traditional Birth Attendants (TBAs) (28.5 %). Less than 1% deliver with the assistance of a Health Extension Worker (HEW) [9].

Several researches have examined factors associated with the use of skilled birth services. Further in this section I present the factors that have been most important in sub-Saharan countries focusing mostly on Ethiopia and the Amhara region where the current study was conducted.

Education and wealth

The educational level of the women is a major factor determining the use of health facility delivery and of ANC. The use of ANC and delivery services increases with education; women with secondary education and above are more likely to use these services [21-26]. The reason for higher use of services among women with higher education than primary school may be because higher educated women have better awareness about the benefits of preventive health care and health services. They may also have higher receptivity to new health related information [25]. The education effect is consistent with findings in other studies; education is likely to enhance female autonomy so that women develop greater confidence and capabilities to make decisions regarding their own health [23, 27-30]. Women whose husbands have higher education also increase women's skilled attendance at birth [14, 21, 25, 29, 30]. In the Amhara region only 3.5 % of women and 4.4% of men have completed primary school and 60% of women and 45% of men in the region have no education at all [9], this could be a contributing factor for the low uptake of delivery services.

Higher household wealth increase women's use of delivery services [24]. Affluent groups are found to have a higher use of skilled attendance at birth than poorer groups. Women with lower income are more likely to deliver at home than women with higher income [13, 23, 26, 30]. Cost for transport and care in the facility including equipment for delivery e.g. gloves, decrease health service use by the poor. Higher wealth may be associated with higher education and higher status occupation which again increase the use of delivery services [21].

Maternal age and parity

Younger women are more likely to use delivery services than mothers aged 35 and above [24, 25]. A possible explanation for this could be that younger women are more likely to be literate compared to older women and older women tend to be more experienced with delivery and

may not perceive childbirth to be prone nor associated with complications. Older and experienced women might belong to a more traditional system of beliefs and thus be less likely to use modern facilities compared to younger women [25]. Grand multiparae women are less likely to give birth in a facility while primiparous women are more likely to deliver in a health facility [13, 21, 23-26].

ANC utilization

As mentioned above, women who attend ANC are more likely to use health facilities for delivery [21, 23, 25, 26, 31, 32]. The reasons for this may be that these women are more familiar with health facilities and health workers and may be encouraged by health workers to give birth in a health facility [21, 24, 25]. In North Gondar zone, Worku et.al. (2013) found that nearly 32 % of pregnant women attended ANC [22].

Access to the health facilities

Access to the health facility includes distance to the health facility, accessibility to transport, and economical accessibility. These factors affects indirectly the decision to seek care and directly how to reach the facility [21]. In addition long travel time, fast labour and if labour starts at night are factors which make women reluctant to seek health facility for delivery [24].

Women living in urban areas are more likely to receive assistance during delivery compared to women in rural areas [21, 23-26, 29, 30]. Urban women tend to have more benefits from access to services in terms of distance and transport than women living in rural areas [25].

In a study conducted among rural communities by Worku et. al (2013) in Ethiopia, cost of transport to the health facility was the most important expenditure mentioned by the women who wanted to seek the health facility for delivery care. According to this study, when referred from a health centre to the hospital, women need to pay up to Birr 1200 (67USD) to rent a vehicle to get to the health facility. Women also reported expenses to buy supplies at the hospital [32]. Currently the Ministry of Health (MoH) in Ethiopia is distributing at least one ambulance to each district. However, the problem of transportation and maternal service availability remains a challenge in the area [32].

Awareness of services and birth preparedness

Awareness of delivery services has found to be low in North Gondar. In the study by Worku and colleagues (2013), 40% of women did not have any information about skilled maternal care or the importance of birth preparedness [32]. A study conducted in Southern Ethiopia

found that only 20% of the women had identified a skilled provider for their delivery, eight percent had identified a health facility for delivery and/or for obstetric emergencies. Almost eight percent had prepared transportation and 34.5% of families had saved money for delivery and potential emergencies [33]. The low awareness of skilled delivery services obviously decreases the utilization of these services.

Awareness of risk and complications

Awareness of possible risks in pregnancy increases use of delivery services [24]. A past history of obstetric complications increase the likelihood of seeking a health facility providing delivery care in subsequent pregnancies [23]. Women who experience problems in their pregnancies are more likely to attend ANC, which also affects their decisions to seek the health facility when giving birth [24, 26]. However a study in North Gondar zone found that women did not always seek care if they had a complication. An inability to judge the seriousness of the condition combined with structural barriers such as distance, lack of transport, money and the use of traditional options at home were factors that made women reluctant to seek care. [32].

Previous use of services and perceptions of quality of care

Lack of social support from health workers and the women's negative perceptions of health workers in the health facility decrease use [21, 30]. Women's perceptions on health workers lacking sensitiveness to privacy and not receiving support when needing it the most, in addition to not being allowed to have relatives following them in the health facilities was associated with quality of care in the health facility [34]. In a study conducted in same region of this research, Kebede and colleagues (2013) found that only 25% of the women who had delivered in a health facility in the previous pregnancy opted for delivery service in the current pregnancy. This may indicate low satisfaction with their previous experience of delivery services [24]

Satisfied service users are more likely to utilize health services, adhere to recommendations, follow-ups and continued health care [35]. Satisfaction of delivery services have found to be associated with immediate maternal condition after delivery, waiting time to see the health worker, availability of a waiting area for mothers and relatives, privacy during examinations and service cost paid [35].

When people can choose between several facilities, they sometimes travel further if the target facility is perceived to have better quality of care [36]. This is also found in Tanzania; patients are bypassing nearby health centres to seek health care at distant hospitals and private facilities [37]. This illustrates that people compare the quality between the facilities they visit and bypass health facilities that they perceive to be of low quality[37]. This means that even if women have a health centre nearby they still choose a hospital, which is likely to cause pressure on the hospitals.

Women's preferences and experiences with facility versus home birth

Preferences and experiences of health facility birth

In a study conducted by Kruk et al. (2010) in a rural area in Ethiopia it was found that women strongly preferred health facilities that provided good technical quality, highly trained providers and reliable supply of medicines and functioning equipment. In addition they mentioned the importance of a respectful attitude when being assisted by health workers [27]. Women who had delivered in a hospital in Gondar preferred cleanliness, having a bed for waiting while in labour, in delivery and after delivery, and privacy during examinations and delivery[15]. Regarding having relatives with them in the delivery room, women were split in their opinions; some women preferred to have a relative with them and some thought it was too crowded and that it was sufficient to be attended by health workers [15].

Preferences of home delivery

Women's reasons for preferring home delivery has been found to be linked to cultural traditions, having the family's support at home and that they trust the TBAs in the community. Other reasons was that the labour was fast and smooth so they did not see the need in seeking the health facility for birth [23, 34]. Not seeing the necessity to seek health facility for birth is also consistent with the DHS 2011[9]. Furthermore a study conducted by Amano et al. (2010) in Southern Ethiopia, reported that the most common reasons for delivering at home was that home birth was the usual practise, the health facility was far away and women felt more comfortable at home [25]. Elderly people with high status in the community also influenced women to deliver at home which was probably related to elderly's own lack of experience with health facility birth [34]. A qualitative study by Øksnevad (2011) on home births and health facility births in Southern Ethiopia found that home birth was perceived as normal while facility births was seen as an option only if emergencies occurred. Women were sceptical to health facilities because of, among other reasons, invasive

procedures used for delivery than they were used to at home e.g. episiotomy [38]. Cost associated with health facility delivery was also a reason to deliver at home [23].

Rationale of the study

Ethiopia has one of the highest maternal mortality in the world, it is well documented that the most important strategy for reducing maternal mortality is to have deliveries with skilled attendance. In low income countries the most efficient strategy is to have deliveries within a health facility with skilled attendance, and the possibility of referral [11]. In Ethiopia 90 % of women deliver at home, most without a skilled attendant. Furthermore, 50% of women in urban areas give birth in a facility with skilled attendant and in rural areas only four percent deliver with a skilled attendant[9]. In order to reduce maternal mortality there is a need to increase health facility birth with skilled attendance. Increasing skilled attendance at birth is also a high priority for the Ethiopian government[4]. Efforts have been made to increase availability and accessibility of maternal health services throughout the country; still there is a very low use of these services. Most studies in Ethiopia that has been conducted on use of birth services has focused mainly on assessing prevalence of use of maternal health services and identifying what factors are associated with use of services. But there is a lack of qualitative research in Ethiopia and in the current study area exploring *why* women use or not use health facility for delivery and how one can increase the demand for health facility delivery. By focusing on women's and health worker's perspectives on health facility delivery in different settings in North Gondar zone we can achieve an understanding of why women choose or not choose the health facility for delivery and identify factors that are important to increase the demand for birth services.

Research objectives

Main objective

To explore women's and health workers perspectives on barriers and facilitators to increase demand for birth services in North Gondar zone, Ethiopia

Research questions

- How do women prepare for delivery and what factors influence care seeking at birth?
- How is health facility delivery perceived and experienced in rural, semi-urban and urban settings in North Gondar zone?

- What are women's perceptions on the appropriate place to give birth in rural, semi-urban and urban settings in North Gondar zone?

Ethiopia- the context of the study

Ethiopia is situated in the horn of Africa with population of almost 94 million people (projected for 2013) [39]. Ethiopia is one of the least urbanized countries in the world with only 17% of the population residing in urban areas. More than 80 % of the population lives in the regional states of Amhara, Oromya and Southern Nations and Nationalities People region (SNNP) [9]. The main religions are Christianity and Islam; half of the population are Orthodox Christians followed by Muslims and Protestants. Three percent of the population follows traditional religions [9]. The main labour force is agriculture (85%).

Ethiopia has a young population, almost half of the population are under 15 years old, the median age of the population is 16.4 years, and only four percent of the population is over 65 years. Average household size is 3.7 persons in urban areas and 4.9 persons per household in rural areas. Educational attainment is low in Ethiopia. 60% of women and about 36% of men in rural areas have no education. In urban areas 22% of women and eight percent of men have no education, which means that the level of illiteracy is high. In rural areas about 70% of women and 38% of men are illiterate while in urban areas the percentage is almost 29% and 9% for women and men respectively[9]. Exposure to mass media is low; only about 22% of women in rural areas have weekly access to print media, television or radio, in urban areas the percentage is 40 [9]. Life expectancy at birth is 54 years, under 5 mortality rate is 88 and total fertility rate is 4,8 births per woman [9].



Picture 1: Map of Ethiopia [40]

An overview of the health system in Ethiopia

Ethiopia has a three-tier health service delivery system with the Primary Health Care Units at the lowest level, general hospitals at the middle level and specialized hospitals at the highest level [41]. In 1997 Ethiopia launched the Health Sector Development Programme (HSDP) in order to increase the effectiveness of the health system [42] and in response to the prevailing and newly emerging health problems in Ethiopia. The HSDP was designed particularly to respond to the needs of the rural population [43]. The programme is a 20-years strategy aimed at achieving improved health and sustainable development [42]. In line with the global policy of primary health care for all, Ethiopia initiated the Health Extension Programme (HEP) in 2003 as a part of the HSDP. The HEP is important because it aims to reach all people with basic health services, this is done through building health posts, particularly in rural areas and having paid Health Extension Workers (HEWs) employed in the health posts as well as conducting outreach services, for instance immunization [41].

In relation to maternal health the HEP and HEWs can contribute by providing family planning services which among others are clean delivery, promotion of birth preparedness and complication readiness, and active management of the third stage of labour [44].

Studies have been conducted on the impacts of HEP strategies on maternal health outcomes in four regions in Ethiopia, the Amhara region being one of them. Among other factors it was found that HEWs household visits increased ANC utilization and postnatal coverage [45].

However despite the efforts made by the HEP, the target of having 32% of deliveries attended by skilled health workers by 2010 were not reached [45]. According to a survey conducted by Karim et.al (2010) the HEP has not yet demonstrated any impact on improving skilled birth attendance, which is critical to reduce maternal mortality [46] and many lack the necessary skills expected of a birth attendant to tackle the major cause of maternal mortality [44].

Chapter 2 Theoretical approaches

In this study I have used the AAAQ-framework focusing on availability, accessibility, acceptability and quality. The AAAQ-framework is a human rights framework that applies to health care services and the underlying determinants of health [47]. The framework states that to ensure the right to health, all the requirements in the framework need to be fulfilled [47].

The objective of this study was to explore women's and health workers perspectives on barriers and facilitators to increase demand for birth services. In this study I have used the Availability, Accessibility, Acceptability, and Quality-framework when focusing on the

structural factors or determinants that affect people in seeking health care. To further analyze women's preferences and evaluation of the quality of care in the health facilities I have used the concept of authoritative knowledge combined with the concepts of trust and security.

The AAAQ-framework

Availability refers to whether there are enough health workers and health facilities and if they are available within a geographical area. For this study it means that delivery care, which includes skilled attendants and an enabling environment needs to be within the reach for women who need the services. Health services must be physically and economically **accessible** to everyone. Health services may be available at the local level, e.g. women may have a health centre available within reach, but the health centres may not be responsive to the women's needs. If the facility charges user fees and women have to buy the equipment like for example gloves for delivery, and they cannot afford to pay, the facility is not economically accessible. Health services must be **acceptable**. This means respectful of medical ethics, culturally appropriate and gender sensitive. Medical procedures need to be explained to the women in a way that is understandable; health workers need to be culture sensitive towards the women seeking care. Protecting women's privacy in the health facility is also one example of acceptability. Health services must be scientifically and medically appropriate and of good **quality**. Quality does not only include medical care in terms of adequate equipment and medicines, it also extends to how people are treated, in this way acceptability relates to quality in the framework. Health workers must treat women and their relatives politely and with respect. Good quality also means that women should receive health education, the health facilities and medicine must be of good quality [47].

The strength of this framework is that it takes important determinant factors into account both when it comes to seeking care and the care women should receive when they have reached the facility. The weakness is that takes only a health system perspective and it does not talk about cultural and other external factors to the health system that may affect decisions on birth place. In order to understand how women value care in the health facilities vs. home, I have used the concepts of authoritative knowledge, trust and ontological security to analyse the contribution to the AAAQ framework to skilled care utilization.

Authoritative knowledge

When looking at barriers and facilitators to increase demand for birth services in an area where home delivery is more common than health facility delivery, one has to look at birth, not only as a biological and physiological process, but also an event that is socially “marked and shaped” [48]. The way birth is understood and the practices surrounding birth influence women and their families in the choice of birth place, therefore when we talk about preferences for birth place, who decides the birth place and where women end up giving birth, one needs to look at birth also as a social event; a factor influencing the women and their kin. Brigitte Jordan (1997) talks about authoritative knowledge in connection with childbirth. Authoritative knowledge is the knowledge that matters in a particular situation e.g. childbirth. This knowledge is important to identify the basis on which people make decisions and justify their actions. “*It is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the task at hand*” [49, p. 20]. Authoritative knowledge refers to the knowledge that has precedence within a community of practice. Different knowledge matters in different settings, for example in a low technology birthing system where most women deliver at home, the authoritative knowledge lies with other women who have experienced giving birth, their mothers, elders and the local midwife. The knowledge is shared between the different actors, and the labouring woman may be more in control of her delivery since she is the one who knows her body. In a high technology birthing system the authoritative knowledge lies with the health workers in the health facilities and the labouring woman is in less control of what is happening. Knowledge based on experience from other women or the community has little value. The health workers use medical technology when assessing the labour. What a woman’s body tells her when in labour and delivery has little status in this system [49].

In this study the concept of authoritative knowledge is used to achieve a better understanding of the knowledge system that lies behind the decision making to seek or not seek health facility care and how this is linked to trust and ontological security.

Trust and ontological security

Lucy Gilson (2003) holds that trust as a relational notion between people, people and organisations, and people and events [50]. There are different concepts of trust; the most common interpretation of the concept is that trust is voluntary based on an individual’s

expectations of how others will behave towards him or her. However, there is no guarantee that these expectations will be met and trust therefore always implies risk. When trust is placed in one person or institution due to lack of choice, or in a context of inequality, the relationship of trust becomes more a relationship of dependency. Nonetheless, when the institutions protect the dependent partner, this might develop into a voluntary relationship of trust. In general, the individual's decision to trust a person or an institution depends on his/her knowledge, calculations, recognition and set of beliefs [50]. In his book "The Consequences of Modernity", Anthony Giddens (1991) talks about ontological security. Giddens says that ontological security refers to the *notion* of security, the way people feel comfortable and secure within the surroundings. A feeling of reliability from people and surroundings is central for the ontological security. According to Giddens trust and ontological security are psychologically related [51].

In this study the concept of trust and ontological security are highly relevant as the lack or presence of these factors are barriers and facilitators for increasing the demand for health facility deliveries.

Chapter 3 Methodology

Research strategy

The original plan for this study was to conduct a survey among women to assess their use of birth services combined with in-depth interviews among women and health workers. Upon arrival in Gondar I was informed that Abebaw Worku, a PhD student at the University of Gondar (UoG) was conducting a cross-sectional survey about women's use of birth services in North Gondar zone. Based on this information we decided to omit the quantitative part of the study, and instead focused on develop and pursue the qualitative part further to a more profound degree. The results of the cross-sectional study conducted by the PhD-student were included in the background section of this thesis.

A qualitative approach was found beneficial in this study. Qualitative methods can be used to gain more knowledge about people's experiences, thoughts, expectations and attitudes [52]. It explores the meaning of social phenomena as experienced by individuals themselves in their natural context [53]. Qualitative studies use an emergent design that gives the researcher the possibility to learn from, reflect and adjust during the research period. Qualitative methods tend to be holistic in the way that the researchers try to achieve an understanding of the

whole. This requires researchers to become intensely involved, giving the researcher the responsibility to continuously analyse the data, adjusting the strategy as the research develops, and to assert when the completion of the data has been attained [54]. Qualitative methods can “*reach the parts other methods can’t reach*” [55, p.32], which has been especially of value when conducting in-depth interviews with women with and without experiences of health facility birth and health workers. Qualitative research has a role in contributing to the “evidence base” of medicine because it can answer questions that experimental and quantitative methods cannot address [56].

A qualitative design in this manner was found appropriate since we wanted to achieve an in-depth understanding of women’s and health workers’ perceptions and experiences related to the research topic of increasing demand for birth services. Knowledge concerning statistical facts on factors influencing use of delivery services already exists and we wished to expand further to the understanding of *why* women use or not use delivery services. Therefore we applied a triangulation of methods using in-depth interviews and non-participant observation as data collection methods; these are further described under “Methods of data collection”.

The qualitative research interview can be seen as an interaction between the researcher and the interviewee where language data and syntax contribute deeply to areas such as beliefs and behaviour. However it is important to keep in mind that these linguistic data consist of accounts of the world, not direct representations of that world [55]. In that way a limitation of the research interview is that the participants only provide access to what people say, not what they do [55]. Non-participant observation in a labour ward was used mostly to understand and verify what the women told us during the interviews about health facility delivery.

The strength of observational methods is that they provide data on phenomena (such as behaviour) as well as on people’s accounts of those phenomena. In non-participant observation the researcher observes in the field without involvement [55].

Study design

The study was designed to include three settings; rural, semi-urban and urban settings within two areas; Dabat district and Gondar district. We conducted in-depth interviews (IDIs) in the communities and in the health facilities. In addition a follow-up of one woman and non-participant observation was conducted in the urban setting. The illustration below shows how the current study was designed.

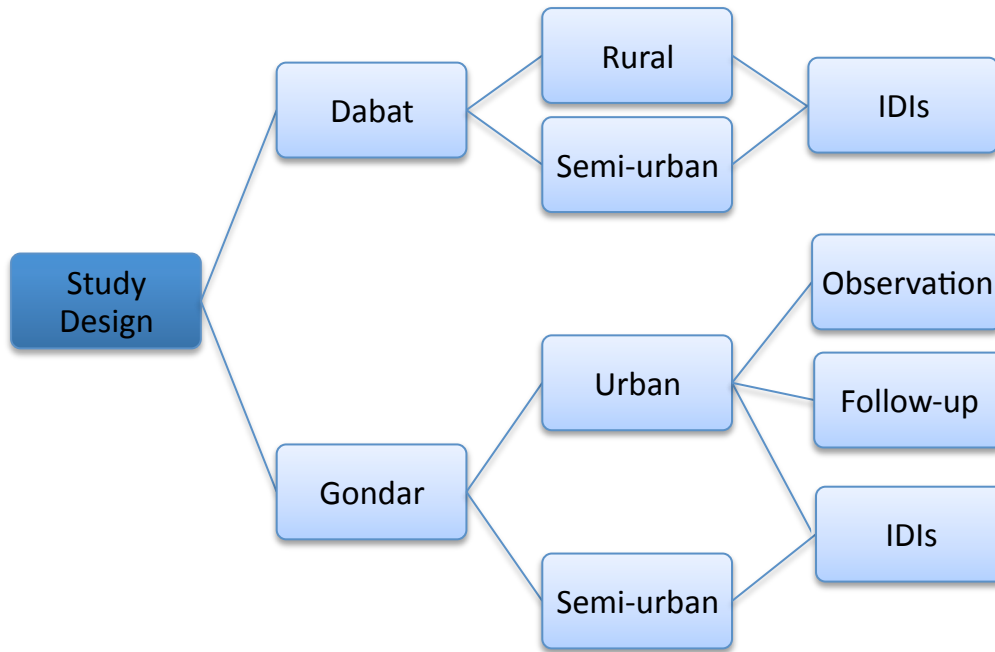
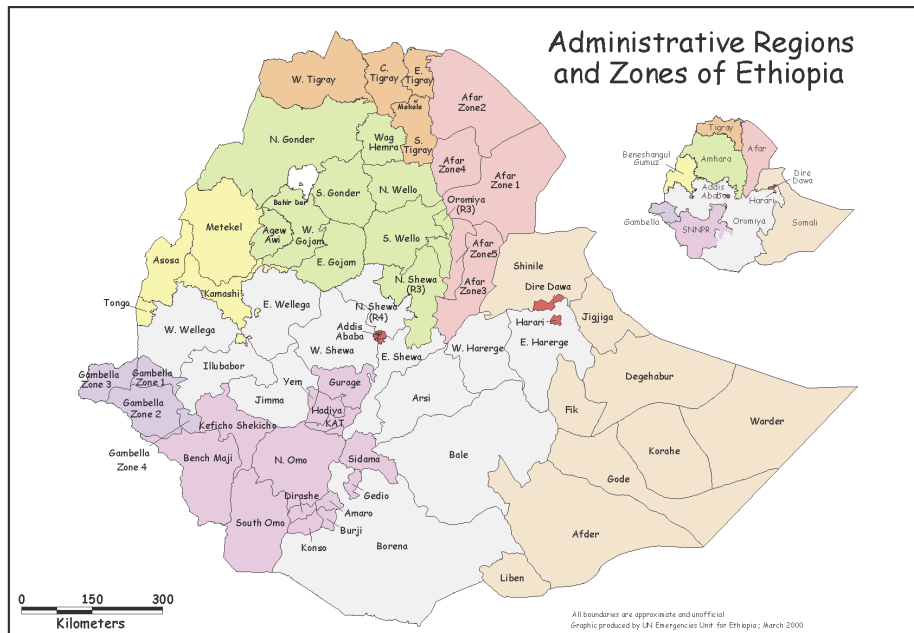


Figure 1: Study design

Study setting

The current study was carried out in the North Gondar zone, which is one of 11 administrative zones in the Amhara region situated in the North-western part of Ethiopia. The Amhara region is the second most populous region with a total population of 18 million inhabitants while North Gondar zone, located in the Amhara region, has a population of over three million inhabitants and is one of the most populous zones within the region [32]. The large majority of the population belongs to the ethnic group Amhara (89. 8%). The first language is Amharic spoken by 98 % of the population. Ethiopian Orthodox Christianity is practised by over 95% of the population in the region, while Islam is practised by 4.5% [9]. North Gondar zone has 11 districts, the zonal centre, Gondar town, is located 735 kilometres from the capitol Addis Ababa. About 84% of the inhabitants in North Gondar zone are rural dwellers [57]. The fact that North Gondar zone has a rough topography is important in order to understand the challenges in seeking health care. North Gondar zone has one referral hospital; Gondar University hospital, which is situated in Gondar town and can provide Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). Further, there are two rural hospitals and about a hundred health centres providing Basic Emergency Obstetric and Neonatal Care (BEmONC). There are also a number of health posts located in the districts within the zone. [22]. The picture below shows the administrative regions and zones of Ethiopia. North Gondar zone is coloured in green and situated in the Northwest.



Picture 2: Administrative Regions and Zones of Ethiopia [58]

Dabat district

Dabat district is located approximately 75 km north of Gondar town. The total population was 145 500 inhabitants in 2007 [57]. The majority of the population are rural dwellers. The district has about 30 000 households with an average of 4.8 people per household [57]. Six health centres and 31 health posts are found within the district. According to information received from Dabat research centre, the Dabat health centre has two midwives, 21 nurses and three Health Officers (HOs) employed. The other health centre we included had currently one midwife and 15-20 nurses and 2 HOs (information received from health workers employed at the health centre). The picture below shows a health centre in Dabat district.



Picture 3: Health centre in Dabat district (private photo)

Gondar district

Based on the 2007 census over 207 000 people live in Gondar district and there are 50 800 households. This gives an average of about four persons per household. The hospital serves approximately five million people across the region [22] and has a staff of about 400 with among others, 50 doctors and 150 nurses [59]. As a university teaching hospital a large amount of students from different parts of the country have their training in this hospital. The labour ward consists of four rooms; one waiting room for women in labour (five beds), one examination room (one bed), one delivery room (three beds), and one post-delivery waiting room (five beds). In addition beds are placed along the walls in the halls as well as mattresses on the floors both in the waiting rooms and the hallway (observational data). According to the 2012 report from the hospital, 4199 deliveries were conducted in the hospital the previous year (unpublished data received by staff at Gondar University Hospital).

Research assistants

Three female Ethiopian assistants worked with me during the study. The two first assistants worked as translators during the in-depth interviews and transcribed and translated the interviews. The third assistant worked only with transcribing and translating the interviews. The first assistant worked with me when testing the IDI-guide and during the fieldwork in Dabat district. She has a master degree in public health and a research background from

quantitative research methods. She had no previous experience from transcribing or translating interviews. The second assistant worked for me in Gondar district. She has a master degree in journalism and experience in working with Non-Governmental Organisations (NGOs) and conducting focus group interviews as well as transcribing and translating interviews. The third assistant also had a master degree in journalism and experience in transcribing and translating. All were fluent in English.

Training of research assistants

The first two assistants were introduced to the research protocol and the interview guides. Both assistants were required to read the protocol carefully and gained insight to the background for wishing to conduct the study. After this and having receiving knowledge of the methods of data collection, I trained them in qualitative methods focusing mostly on the interview situation including how to introduce themselves initially in the interviews and principles of etiquette, e.g. being respectful towards the participants and encouraging the participants to talk freely. We also focused on interview techniques of qualitative interviewing for instance natural breaks, prompting and probing, noticing the body language of the participants and the surroundings in which the interviews were conducted.

Data collection

Fieldwork was done from the end August to the midst of November 2012. Before the actual data collection started we validated the interview-guide by interviewing a woman in the urban setting who had experienced health facility delivery. The interview guide was developed in English and translated to Amharic before arrival to Ethiopia. We sought to gather first hand experience in how the participants responded to the questions; how the interview situation was encountered and if the questions were optimally formulated in Amharic. It was also an opportunity for me to observe and evaluate the research assistant, as the first research assistant did not have any previous experience within qualitative interviewing or working as an interpreter. The woman we interviewed was informed in advance that the interview was to settle if questions were adept and subsequently to be included in our interview-guides. After the interview the research assistant and I discussed how the questions could be improved. We asked the woman if she had any suggestions or felt that something should be added, or if she found anything difficult in answering. We discussed if all nuances were covered in the translation from English to Amharic, the interaction between the participant, research assistant and myself and if the fluency of the interview was good. As a result of this discussion we

removed questions that were repetitive and changed the structure of the themes in the guide so the fluency of the interview was improved.

After receiving ethical approval from the Ethical Review Board at UoG we started our data collection in Dabat district. We thought we would get a larger variation in our sample in the way that it was easier to find women who had experienced home delivery in this area as well as women who had experienced health facility delivery. Such a varied sample was a benefit in the beginning of the study because we could adjust and tweak the interview-guides and allow for scrutiny of issues mentioned by different participants with different experiences. We hypothesized from previous knowledge that in the urban setting it would be more difficult to come into contact with women who had experienced childbirth at home. After the data collection in Dabat district we continued the data collection in Gondar district.

Sampling strategy

We used purposeful sampling in the selection of the informants. A purposive sampling strategy is based on the notion that the selection of the participants should occur with a purpose in mind of contrasting participants providing broad perspectives on the research topic [52]. The purpose of using three different settings was related to our aim of understanding how availability and accessibility of the health facilities influenced the women's care seeking behaviour and how the participants perceived health facility delivery. The following illustration depicts the areas of sampling in relation to the availability and access of the facilities⁴

⁴ Debark hospital was not included in as a health facility in this study, but is included in the illustration as it is one of the hospitals used for referral of pregnant women who cannot be assisted at the health centre. Debark hospital does not provide CEmONC.

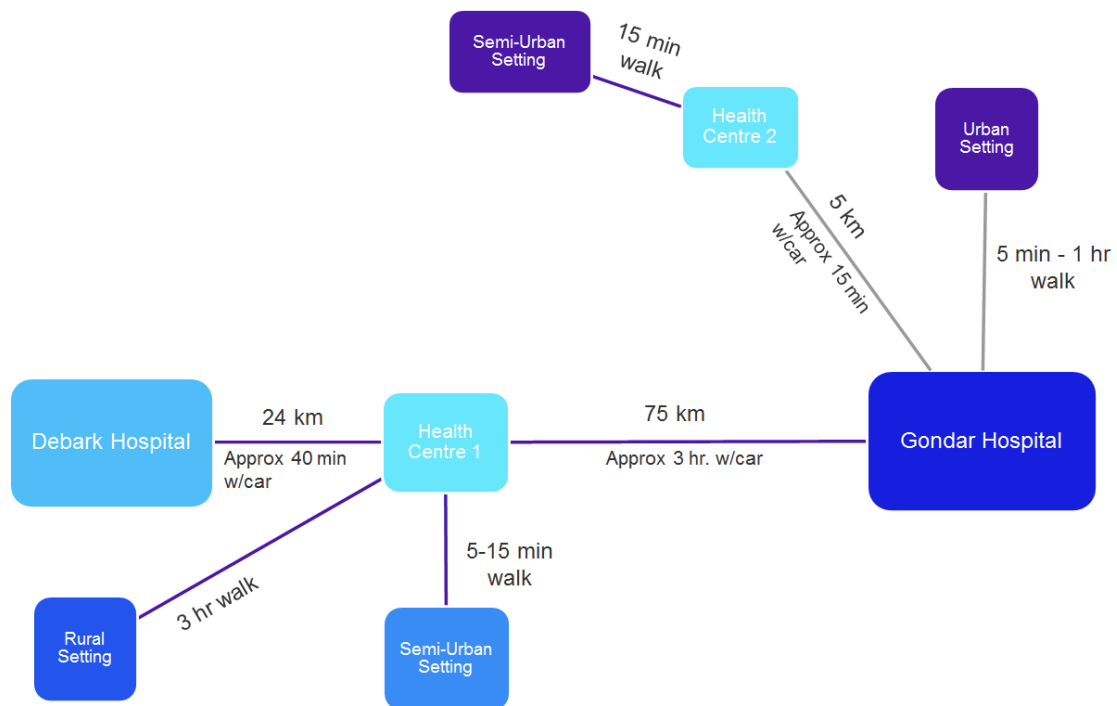


Figure 2: Sampling strategy illustrating the referral line and distance to the health facilities

Inclusion criteria

- Women with previous experience of health facility delivery
- Women without experience of health facility delivery who had delivered at home
- Health workers with experience (of at least 6 months) in conducting and assisting deliveries in health centres and hospitals

We did not include any participants under the age of 18 years because our ethical clearance did not allow this.

Recruitment in Dabat district

Recruitment was done through Dabat Health Centre and in the ANC in one health centre within the district. Dabat research centre has registers over households with women whom could be potential participants as ascertained by our inclusion criteria. Prior to the data collection in this setting, a designated person in the research centre in Dabat became familiarized with the study and asked to identify potential participants. Data collectors employed by Dabat research centre assisted us in identifying the households where the women considered for participation lived. All women but two were interviewed in their homes. The two remaining women were interviewed in the research centres' office situated next to Dabat Health Centre where they provided delivery care and ANC. These two women

were identified in the ANC clinic and asked to participate in the study by a nurse working there. The health workers were interviewed in two health centres in Dabat district. These were approached in the health centres and asked if they wanted to participate.

Recruitment in Gondar district

Recruitment of potential female participants with or without experiences in health facility birth was done through a HEW and through the ANC and delivery ward at Gondar University Hospital. A male HEW employed at a health clinic in Gondar town was contacted with help of a PhD student, Abebaw Worku, at the UoG. This HEW had addresses of households with women who fitted our inclusion criteria. We then searched for these households and asked the women if they would like to participate. Additionally, we did three interviews in the ANC-clinic in the hospital. A nurse was asked to identify possible female participants fulfilling the inclusion criteria and then inquired respectively the women if they were willing to participate. The interviews were conducted in a private room in the ANC-clinic. The observation in Gondar hospital was conducted after introducing the study to the head nurse in the delivery ward where permission was sought before observing in the delivery ward. A woman was considered for inclusion on our study, currently being in the delivery ward where, after permission, I followed her through labour and birth and we conducted an in-depth interview with her in her home the day after her delivery. Potential health workers were approached first by the head nurse in the delivery ward and asked if they were willing to participate in the research study. Then, I and my research assistant informed them about the study and asked if they wanted to participate.

Study participants and their characteristics

We conducted in-depth interviews with a total of 29 participants in rural, semi-urban and urban settings. 21 participants were women with or without experience of health facility delivery, including the follow-up case, and seven were health workers. In addition we included an interview of a couple where the woman had experienced health facility delivery. Table 1 shows the characteristics of the women who participated. The husband we included in the couple interview was 38 years old, had some primary education and worked as a trader. From our interviews with health workers two nurses and two midwives who assisted deliveries in two different health centres in Dabat district were included. All health workers in Dabat district were female; their professional backgrounds consisted of a range of one to four years of experience working in the health centres in delivery care. Three midwives working in

Gondar hospital were included and consisted of one male and two females. They had six months up to six years of experience in midwifery.

Table 1: Characteristics of women who participated in the study⁵

	Dabat district		Gondar district	
Age distribution				
20-25	3		6	
26-30	4		3	
31-38	1		3	
Geographical distribution				
Rural	4			
Semi-urban	5		2	
Urban			10	
Marital status				
Married	8		10	
In a relationship			1	
Divorced	1		1	
Education	Women	Husbands of the women interviewed	Women	Husbands of the women interviewed
Illiterate	3	4	4	1
Some Primary school	3	2	2	2
Completed Primary school	1	1	4	2
Completed secondary school	2	2	2	5
Occupation				
Housewife/farmer/seller	7		9	
State employed	2		1	
Student			2	

⁵ One woman in each district were primigravida, one woman in Dabat district did not know her age, two women in each districts did not answer how many ANC-visits they had. Two husbands in Gondar had unknown education (the women did not know).

Pregnant		
Yes	8	3
No	1	9
Mean number of own children	2.6	1.9
Mean number of ANC visits	2.3	2.9
Place of last delivery		
Home	6	3
Health facility	2	8

Methods of data collection

As mentioned above, we combined two methods of data-collection, an approach commonly termed triangulation, in order to ensure comprehensiveness of the material as well as increasing validity of the findings [60]. The main data collection method used was semi-structured interviews. The other method was non-participant observation. Further follows a description of how we used the data collection methods and some challenges faced. The discussion concerning methods and reflexivity is presented later under “Discussion of methods”.

Semi-structured interviews

Semi-structured in-depth interviews were conducted with the aim of exploring the perceptions of the participants and experiences related to birth and birth care. We prepared three different interview guides; one for women who had experienced delivery in a health facilities, one for women without experience with health facility delivery and one for health workers working in the delivery wards (cf. **appendix 4**). The interview guides contained open-ended questions to encourage conversation and also giving the interviewer the possibility to follow-up on important issues.

The interview situation

The interviews started briefly with an introduction of ourselves, followed by small talk to establish a good correspondence. We then moved on to explaining the research study. After obtaining a written consent we proceeded with conducting the interviews.

In the first interviews my translator asked the questions under each topic and then translated the participant's answers. This was initially found appropriate since it would allow the participants to open up more to the assistant, as she was a local and to encourage a fluent conversation. However after a few interviews I realised that this was not an optimal method since the research assistant only provided me with summaries of what the participants said, leaving me in little control of following up important issues addressed by the participants. Hence I changed the strategy so I could lead the interviews in gathering information and the assistant maintaining only the role of translator. A tape recorder was used in all the interviews. The research assistant and I took notes during the interviews. After each interview we had a debriefing where we talked about topics that emerged from the interviews and what should be given more or less focus. In this fashion the interview guides evolved during the course of the research.

Observation and follow up in the labour ward

I observed in the labour ward in the urban setting both before and after the interviews. I spent seven days in the labour ward in Gondar hospital gaining experience and knowledge of the daily routines as well as following one woman before, through and after her delivery. By following one woman through her whole experience of labour and birth I felt provided with a better understanding of the context of birth and women's experiences when delivering in a health facility. The same applied to the health workers. As mentioned previously the observation was undertaken in a non-participant manner where I did not participate in providing or assisting in the care of patients. Given that I did not have a working permit, this was not possible. My role was constricted to observing what was going on in the labour ward. During the observation I did not have a need of a research assistant. When I asked the woman if I could be allowed to include her in the study and conduct an interview at her home, the research assistant was contacted to translate my questions to Amharic. I had informal talks with the health workers, but did not follow any particular health worker during his or her working day. I did not use a tape-recorder during the observation, but rather took notes during the observation (in a private room) and after the working day was over. Notes included for instance the context, particular situations and body language of patients and health workers. I observed 5 deliveries during my observation time and occasionally it was difficult to distinguish the responsibilities of the health workers since at one delivery there could be 15 health workers including students observing the delivering women.

Data analysis

Data analysis started simultaneously with the data collection. In the following sub-chapters I describe the steps of analysis in this study.

Transcription and translation

All interviews apart from one were transcribed verbatim in Amharic and then translated to English jointly by three research assistants. One interview with a health worker was conducted in English and transcribed by myself. Most of the interviews were transcribed and translated while in the field. After each translation we would discuss and clarify meanings and interpretations of what the participants had expressed. Many interviews were discovered to have cultural connotations, which were difficult to fully comprehend due to my different cultural background. The translators however clarified continuously and provided cultural context when necessary.

Three interviews were transcribed and translated after leaving the field and sent by e-mail to me. The research assistants and I communicated by e-mail if I needed any clarifications or explanations about the translations.

Data analysis procedure

I used qualitative content analysis as a guideline for the data analysis. Graneheim and Lundman (2003) describe this analysis as developing meaning units, condensation, coding and developing categories and themes [61]. For my study I did not use condensation, I found this to be too cumbersome and also wanted to avoid any possible loss of important meanings within the transcribed and translated text of the different parts of my material.

A sense of the whole

When all the transcriptions and translations were obtained, they were printed out and read through to get a sense of the whole and acquire a holistic aspect. After collecting all the data in a continuous period of time, surmising an overall impression of the material was vital [52]. After this process I preferred to establish mind maps presiding over the themes emerging from the material as well as categorizing information into contemporary bulks of information. A systematic analysis was necessary and I decided to use Open Code (a computer programme) as a tool for analysing with a systematic approach of the data. The transcripts were transformed from word files to purified text files and then imported into Open code version 3.6 for analysis [62].

Meaning units and coding

Meaning units are segments containing words, sentences or paragraphs that through their content say something about a theme [55, 61]. Coding means labelling a meaning unit with a code allowing the data to be thought about in new and different ways [61]. For each meaning unit different codes were assigned to recognise what was conveyed.

Creating categories and themes

Ascertaining categories is the core feature of qualitative analysis. Categories are groups that contain codes that share commonality [55, 61]. Since many categories emerged from the material I decided to construct sub-categories for some of the categories. After this process I printed the material from Open Code to get an overview on paper. Then I assembled overarching themes linking affiliated categories together [55]. After this process I made a mind map with an overview of the most important findings to see them in light of the AAAQ-framework and the other theories used. In this way I could visualise a pattern in my findings and it assisted me in focusing on the different issues important for discussion. Below I have included an example of a specific theme, categories, sub-categories and codes used in this study.

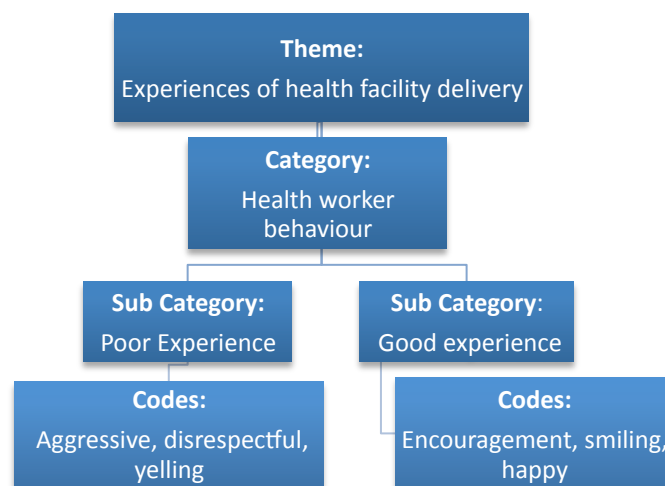


Figure 3: Example of data analysis procedure in the current study

Ethical considerations

This study has been carried out according to the ethical principles stated in the Declaration of Helsinki.

Ethical approvals

We applied for ethical clearance to Norwegian Regional Ethical Committee (REC) in April 2012. We received note that the application was outside their prerogative exempting the need for a formal approval from REC. We submitted the protocol and an application to the Norwegian Social Science Data Services (NSD) and received approval of our application (cf. **appendix 1**). The approval from NSD confirms that any sensitive data concerning the participants in the project are managed according to formal ethical procedures. After having the approval from NSD we applied for ethical approval to the Institutional Ethical Review Board (IERB) at the University of Gondar. I arrived in Ethiopia prior to the approval having been issued and received the letter of approval after a few weeks waiting (cf. **appendix 2**). When having the approval from the IERB, the Dean and the clinical director at the Gondar University Hospital were briefed about the study and I was granted permission and receiving a research permit from them before starting the data collection. The head nurses in all health facilities were informed about the study and were provided with a copy of the research permit and giving us verbal agreement before starting the data collection in the health facilities.

Informed consent

The study was explained to all participants and a consent form in Amharic was given to all participants (cf. **appendix 3**). We emphasized that participation was completely voluntary and that they had right to withdraw at any time of the interview without stating any reason. Confidentiality and anonymity was explained to all participants. We ensured that all participants understood the information given by asking them.

The consent form was read aloud for each of the women, since many of them could not read or write. For the health workers they were asked to read the consent form and give their signature if willing to participate. Written consent in form of a signature or a thumbprint was obtained from all of the participants. None of the participants refused to be interviewed. All participants agreed to be tape-recorded. One woman wanted to interrupt the interview when we almost had reached the end of the interview; this was due to a personal appointment she had to attend.

Confidentiality

All the data obtained from the participants were kept confidential. For each participant a number was assigned and the background information for each participant was stored under this number. Background information included for instance marital status and number of

children and not any names. In regard of the women we interviewed, only the number of the village was obtained, but not their house number. Since the study was performed in a handful of houses in different villages we could remember which houses we had visited without registering the house numbers. The background information during the course of the study was kept in a locked drawer in a locked room by myself. The tape recordings were stored in four password-protected computers. The research assistants signed a contract ensuring that all the information collected from the informants was to be kept confidential. After I received all the transcriptions and translations from the data collection it was ensured that the translators had deleted all the tape recordings and the transcripts from their computers. All confidential information from the fieldwork is to be deleted within December 2014.

Chapter 4 Findings

The findings in this study are presented in three major themes, which are: “Preparing for delivery- delivering at home or in a health care facility”, “Perceptions and experiences of health facility delivery” and “Is it necessary to deliver in a health facility?” Each of these themes has several sub-themes and categories. Under each theme women’s, husbands and health workers’ perspectives are presented. Finally, under each of the three major themes, I have summarized the findings. Background information about the participants is included in parenthesis behind the quotes. “Experience” means that the women have experienced health facility delivery while “no experience” means that the women have no experience with health facility delivery. All names used in quotes or where I present small cases are acronyms.

1: Preparing for delivery – delivering at home or in a health care facility

Under this theme the aim is to explore factors that affected the planning of birth place; who takes part in the decision making of delivery place; how women and their families prepare for delivery and how women and health workers perceive the health facilities as available and accessible. All these factors are important in the planning of delivery and where women finally deliver, whether at home or in a health facility.

When asking the women where they planned to give birth, we saw a pattern emerge from the different settings; women from the rural setting mostly planned to deliver at home, while for the women in the semi-urban settings, some planned home birth and some were preparing for

birth in the health facility, and finally, women in the urban setting had all planned for health facility birth.

Who has a say in the choice of delivery place?

The majority of the women lived with their husbands and their children, only a few women reported living with their mother, mother-in-law or grandmother in addition to their husbands and children. It was clear that their social network influenced them in the decision-making.

Women and husbands

The husbands were involved in the decision-making in all three settings, mostly encouraging and supporting the women in seeking the health facility for delivery.

“My husband encourages me (...) He already gave me his opinion about the advantages of the health centre, and delivering within the health centre. Even when he’s away from home he tell the neighbours to keep an eye on me so I don’t give birth at home” (Pregnant woman, age 25, experience, semi-urban)

Women reported that it was normal to discuss with their husbands about where to give birth.

“I share ideas with my husband. He advised me to go to the hospital.” (Pregnant woman, age 23, no experience, urban). However most of the women said that they had the final decision making regarding birthplace. They also claimed that they might decide against their husband’s opinion that they should deliver in the health facility like the woman below says:

“Just if I say I will deliver at home, I have the right. I will go [to the health centre] if it is intense” (Pregnant woman, age 24, no experience, semi-urban)

“I can decide [where to give birth], even if my husband is the one who is providing [for me]. I want to deliver within the home; so then I deliver at home. Even if he told me to deliver within the health facility I don’t want to go there, I want to deliver at home.”(Woman age 32, no experience, semi-urban)

Family and neighbours

When asking women about influence on their decision making from their families and neighbours, different opinions came up. It was mostly in the semi-urban and rural setting that the family and community had the opinion that women should deliver at home.

“They [family] will say “she will not go she will give birth in her home” (Pregnant woman, age unknown, no experience, rural). However we also found that the women with rural origin, now living in the urban setting, were influenced by their mothers to deliver at home. These mothers had no experience in the health facility delivery.

“My neighbours tell me that giving birth in the hospital is better, but my mother said, “You will die if you go to the hospital- it will be with a CS (Caesarean Section)”. She [mother] said, “for all five children I gave birth here [at home], why [should] you go then?” (Pregnant woman age 27, no experience, urban)

Some women reported that their families did not influence them much when deciding where to deliver. *“They (family) don’t give any opinion either to deliver within the health care facility or at home.” (Pregnant woman age 24, no experience, rural).*

Health workers by contrast held that the family had a central role in the decision-making process regarding seeking health care for delivery.

“It’s the family as a whole that decides. They pass the labour time at home, and then they will come [to the hospital] after 12 hours or days. So this means that if there are not complications she will deliver at home (...). The mother does not decide, mostly the relatives are the ones who will decide. In addition there is no male involvement [in the decision]” (Health worker, 6 yrs experience, urban)

Health workers

The ANC-clinic provided women with pregnancy control and it was an opportunity for health workers to support and advice women about the birthplace.

“The health workers also told me. At the time of visiting the ANC, they told me that I should give birth there [in the health centre]; they told me “you should give birth in the health

centre, when you get sick come and tell us, we will support you” (Pregnant woman age 26, no experience, semi-urban)

The HEWs were important in the communities; they were perceived as easy to contact and seemed to be accepted. They would visit pregnant women to give health education and advice about delivery place. *“Almaz [HEW] always came to my house and told me that I should give birth in a health facility.” (Woman age 28, experience, urban)*

“They [HEWs] are available in every kebele (...) they were the ones who took me to the ANC and they were telling me that “if it is difficult we will send you there [to the hospital] because we do not have the equipment that they have” (Woman age 22, experience, urban)

Health workers also gave information and advice about pregnancy and delivery at public meetings in the community. Health workers tried to attract the women to deliver in a health facility by telling them about the advantages of giving birth in a health facility and the disadvantages of homebirth. They emphasised the “trouble” involved in home birth in addition to the medical risks and argued that it would be both easier and safer to deliver in a health facility.

Amete (35 years) had lived in a village near Gondar her entire life. She had delivered a healthy baby boy in her home just two weeks before the interview. She was the mother of six; all of them delivered at home. In the recent years an asphalt road to Gondar had been constructed and a health centre had been built just 10 minutes walk from her house. Amete was active in the community and attended meetings when possible. She said:

“At the meeting doctors told us “you should give birth in a health centre, don’t give birth at home” (...) they say “don’t get into all this trouble at home, go to a health centre” (...) When there is a meeting or when we go for vaccination doctors give us information. They used to say “why don’t you go to a health centre earlier before hit by wind, before becoming dull or before your nerve is cold? If you go earlier you will give birth well and the baby will be healthy.” They also say “nowadays the road is of asphalt so it doesn’t cost you much, go to Gondar”

The quote above illustrates how health workers influenced women to deliver in a health facility, it also shows that despite health worker's efforts, still many women decided or ended up delivering at home, like Amete who delivered all her six children at home.

Getting ready for delivery

The majority of the women reported that they had prepared for delivery. However, women had a different perception of birth preparedness than what we saw as preparedness for delivery, it is important to note that when we talk about preparedness in this section it is what women feel is important to prepare for before and after delivery. We asked women general questions on how they were prepared; this also included the "medical" preparedness⁶, e.g. preparing a blood donor. Only one woman had prepared for a blood donor as she had heard about it on the radio. For the women in this study, preparedness included clothes and food to bring to the health facility and to have it ready for after delivery; assistance to go to the health facility; money for transport to the health centre or referral from the health centres to the hospital; equipment if they delivered on the way to the health facility or equipment for the actual delivery in the health facilities. The "medical" preparedness was to have money for emergencies, for instance needing a CS.

Clothes and food

Most of the women had prepared clothes, *gabi* (two-layered cotton cloth that they wrap around the baby and themselves) and towels for themselves and the baby regardless of whether they would deliver at home or in the health facility. "We just prepare with a towel and a *gabi* for the baby" (Woman age 32, no experience, semi-urban) When we asked women about preparing for delivery, a common answer was that they had prepared for the celebration after delivery. The same woman said: "Traditionally we mill wheat; we prepare a crop for gruel for after delivery."

Assistance to go to the health facility

Having someone assisting the women to the health facility was perceived as essential for the women, not only for support to go there, but also if anything unexpected happened on the way to the health facility, or if they needed for instance medicine for delivery. "It is very difficult [to go alone]; at least you need to have a person to buy you the drugs." (Woman age 26, experience, urban)

⁶ See terms and definitions: Birth Preparedness

“If the pain is intense, [I need somebody to] support me to go to the health facility, to beg for car and other things, buying medicines if needed. So having someone is a must. My neighbours also support.” (Pregnant woman age 25, experience, semi-urban)

Preparing assistance to go to the health facility beforehand was not perceived as necessary as most of the women had a good social network and there was always someone who could assist them; either to accompany them to the health centre or taking care of the children at home while the mother was away. It seemed normal and easy to find someone before asking in advance. Even women who lived far from the health facility would not prepare for assistance before labour started. A woman living 3 hours walking distance from the health facility said: *“I have enough money. And I can also find someone who can accompany me easily. Even if I am not prepared I have the neighbours”* (Pregnant woman age 24, no experience, rural)

Equipment for delivery

“There may not be medicines [available at the health facility]; so we may need to buy them from outside the health care facility (...) We need to bring gloves” (Pregnant woman age 30, experience, semi-urban). It was not unlikely that the women would deliver on the way to the health facility, especially if they lived far from the health facility. They would prepare with gloves and other equipment so that if in case they delivered on the way to the facility they would at least have someone who were willing to assist them.

“I prepare money for teef [grain to make the local staple food injera]. I prepare gloves, clothes for me and for my child. If in case I deliver while travelling.

I: Do you have to bring money?

R: Yes, some money

I: Is it necessary to bring gloves?

R: No it is not. Everything is from here [facility] but I take it in case if the labour comes fast and I may deliver while travelling. No one will touch you so in order not to harm others as well as myself.” (Pregnant woman age 25, experience, semi-urban).

Money

Money was perceived as the most important thing to prepare, especially if women planned for a health facility delivery. To deliver in a health facility was not free of charges. In the health centre this meant that the women were mostly required to bring equipment like gloves, and to buy the necessary medicines from the pharmacy. This was also the case for delivery in the hospital, but in addition there was a fee for the use of beds within the hospital.

The majority of women in all settings mentioned the need for money for a health facility delivery. As one woman said *“We need to take money, how can anyone go without money?”* (Pregnant woman age unknown, no experience, rural).

“Money is not worth more than your health-you might die [at home]. For sure there are people who cannot afford that [facility delivery], but many women also save money for delivery emergencies. In rural areas women even save money for coffee-ceremonies after delivery. Instead they should spend this money in the hospital to get a safe delivery.” (Woman age 26, experience, urban)

In semi-urban and rural settings money was saved for the celebration after delivery, but it was also very important to save money in case of being referred to the hospital and the fees in the hospital.

“I save money if for example I may be referred to Gondar” (Pregnant woman, age 30, experience, rural)

“It is not free of charges [to deliver in a facility], for example in the hospital, everything cost there. If I have money I will save, thinking if I got sick and from here [the health centre] to the hospital- if I go to Gondar [hospital]” (Pregnant woman, age 30, no experience, semi-urban).

In the urban setting, money was needed for equipment and emergencies within the hospital.

“Unless I will have complications and if I give birth peacefully I will only pay for the gloves; there will not be any other things. I might be in need of blood or I might need to have a CS. So

I don't know the amount of money I will pay; I will be prepared for all these things that can happen.” (Pregnant woman age 35, no experience, urban).

Having money meant receiving the necessary care in the health facility. Blood transfusion for emergencies needed to be paid for unless their relatives could donate.

“(…) Because she saved money she managed to do what she needs. Therefore money is vital. If you do not have money and if your relatives cannot give you their blood you will lose everything. Therefore, I can say that money is vital.”(Pregnant woman age 23, no experience, urban)

Perceptions of distance and availability of transport

The perceptions of distance and availability of transport was also a part of deciding where to deliver and the preparation for delivery. In the rural and semi-urban settings the perceptions of distance and the availability of transport differed naturally depending on where they lived. Women living close to the health centre, approximately 5-30 minutes walking-distance, did not see distance and transport as a great barrier for seeking birth care. In the rural setting, far from the health facility the distance and availability of transport was perceived as a barrier for seeking care. In the urban setting almost all women reported that the hospital was easy to access but still there were barriers if for example labour started at night when it was difficult to find transport.

Easy access

“I didn't face problems with access. But there are others who may face problems with transportation and distance at the time of delivery” (Pregnant woman age 27, experience, semi-urban). In the semi-urban and rural setting within Dabat district they had one ambulance stationed at Dabat health centre. Women who “belonged” to this health centre had the perception that transport was easily accessible. *“No, there will not be a problem because the health centre [nearby] has an ambulance; in addition we can get a mini-bus.”* (Pregnant woman age 26, no experience, semi-urban)

“I don't know anyone who faces problems to get to the hospital, because we find it [ambulance] day and night. So we call for an ambulance” (Pregnant woman 23 years, no experience, urban)

All the women interviewed in the urban setting had fairly easy access to transport in the way that they lived close to the roads and some women lived within walking distance to the hospital. Women living close to the hospital reported that it was normal to give birth in health facilities because it was nearby where they lived.

“My kebele is around the hospital, so no one gives birth at home, they all give birth in the hospital”(Pregnant woman, age 23, no experience, urban)

Too far to walk

The women who reported distance as a problem were the ones who lived more than one-hour walking distance from the health facility. Some women were aware of the benefits of delivering in the facility, but reported that they did not give birth in a health facility because they did not live nearby it. *“Health centre is good for us, but it is difficult to seek the health centre because we are in a rural area (...) there is no health centre within this area”*

(Pregnant woman, age unknown, no experience, rural). Some of the women reported that they planned to deliver in a health facility but when the labour started they were visiting relatives in areas far from any health facility, and they perceived the distance as too far to reach the health facility before delivery. *“There was no health facility. The one we have was too far from where we live. When my labour started I was at home [the parent’s home], I decided to give birth at home”* (Woman age 28, experience, urban). Women living far from the roads and in areas where vehicles could access the areas due to rough terrain, reported difficulties in accessing transport. *“There may not be any [transport], because we are alone here (...) we go on foot or by bed [stretcher], there is no car.”* (Woman age 30, no experience, rural). Another woman supported her views: *“Our district is not suited for having any vehicles because it is rural”* (Pregnant woman age unknown, no experience, rural)

In the urban setting, accessing transport at night was more difficult since it was less traffic and less bajajs (motorcycle-taxis) operating. The women also needed to know the phone number of the people operating the ambulance, which was not always easy to access. The woman below had problems finding transport and needed help from relatives and neighbours to find transport in order to get to the hospital. She said:

“Bajajs are usually not accessible at night unless you have their phone number, but an ambulance can come quickly if you have their number. (...) It was a bit difficult to find their phone number; we did not have their number.” (Woman age 22, experienced, urban).

Sometimes the ambulance was not in use or broken down so they could not count on it to pick them up. *"They told us that the ambulance was not working, so we were forced to call for a bajaj, this is also a problem"* (Woman age 28, experienced, urban).

Accessibility seen from health worker's perspectives

Health workers reported that access to the health facilities in terms of distance and transport still was a major barrier for the women and their families in seeking the health facility for delivery. They reported that many women planned on beforehand for a health facility delivery, but could not fulfil their plans due to distance and availability of health facilities nearby. *"Even if they decide to come [to the hospital] they will give birth at home because they may not have a health facility in their surroundings."* (Health worker, 6 years experience, semi-urban)

"Most of them give birth here [hospital] unless they are from far areas" (Health worker, 5 years experience, urban)

Since the ambulance used for referral from the health centres to the hospitals was stationed in one health centre within Dabat district, health workers in other health centres reported difficulties in accessing this ambulance. *"There is a transportation problem, there is not any ambulance, the ambulance is found at the [other] health centre"* (Midwife, 1-year experience, semi-urban).

The health workers also mentioned user fees for transport as a barrier for women. As referred to in the background section, the MoH are now distributing ambulances free of charges to all districts in Ethiopia, however in this study we got different reports from the health workers about user fees for ambulance as illustrated in the following two quotes: *"The ambulance is found at Dabat health centre and the cost is very high; it may cost up to 600 birr [33 USD] at a time (...) Paying 600 birr for an ambulance is too much for them, they cannot even pay 10 birr."* (Midwife, 1 year experience, semi-urban)

"There is an ambulance that came to the health centre less than a year ago. Before this, the women's family would pay for the petrol and a per-diem for the driver and the professional

[who accompanies the woman to the hospital] but these days it is free” (Midwife, 7 years experience, semi-urban).

Consequences of poor accessibility to the health facilities

Both women and health workers mentioned how the difficult access for many women could result in delay in reaching the health facility and thus delay in receiving the immediate care that could save lives. The inequity in accessibility to the health facility both in rural and urban areas is manifested through this woman’s statement:

”There was a woman who had the same complication as I had [bleeding]; she managed to come back after three days to the hospital just because she was in the city. If she were in her rural home she would have been dead” (Woman 28 years, experience, rural)

“The shortage of the transport might [cause delay in treatment and] get the mother into very dangerous things like eclampsia or obstructed labour, they died because of [delay in or not accessing] transport. The health facility is so far away and the transportation systems are not sufficient.” (Midwife, 6 months experience, urban).

Summary

The pregnant women we interviewed in the different settings had different plans for where to deliver. The women in the rural setting who had never delivered in a health facility mostly planned home delivery. For the women living in semi-urban settings, some women had planned to deliver in a health facility while some had planned to deliver at home. All urban women told us that they planned facility delivery.

Women seemed to have the final say when deciding seeking care for delivery, however they knew their kin’s perceptions about delivery and this might have influenced them in their decision. In all settings husbands seemed to play the most important role as a part of the decision-making process. Contrary to what the women reported about decision-making, the health workers reported that the women themselves had no say in the decisions; their kin decided. Some families had the perception of poor quality of care in the facility. This may have affected women’s decision to seek care. Women were advised to deliver in a health facility by health workers in the ANC-clinic, by health extension workers in the community and in public meetings.

The majority of women prepared clothes and food for delivery. Money was perceived necessary to prepare for most women in all settings. It was seen as something they should not come without. Distance and transport was naturally a bigger barrier for women living in rural and semi-urban settings than for women living in the urban setting. Regardless of their awareness about this, women did not seem to plan how to get to the facility on beforehand. Assistance to the health facility was easy to find and did not require planning. Urban women found it more difficult to access the facility if labour started in the night due to difficulties in finding transport. Some urban women reported difficulties in accessing the ambulance because they didn't have the number for the ambulance. Ambulance services were reported by some to be free of charges and some to be too expensive for the women and their families. Both women and health workers reported the potential fatal consequences of poor accessibility to the health facilities, emphasizing the inequities in urban versus rural areas.

2: Perceptions and experiences of health facility delivery

This theme describes how women perceived and experienced health facility delivery and health workers perceptions on the issues brought up by the women. It starts by exploring what women expected of the health facilities and what they were concerned about regarding the quality of care in the health facilities. Further I present their experiences of health facility delivery; delay in receiving care, how they perceived the health workers behaviour, the importance of support while in labour and delivery and finally, having privacy in the delivery ward.

Expectations and concerns about delivery services

Women were concerned about the quality of care in the health facility. At the same time almost all women reported that they expected to have a safe delivery if they decided to deliver in a health facility. In some cases it was difficult to get an answer when we asked about expectations and concerns about health facility delivery, in most of these cases it was women who did not have any experience in delivering in a health facility who found it difficult to answer since they had never been to the health facility to give birth. However when we talked more around the issue of health facility delivery and probed, they answered quite clearly what they were concerned about and what they expected.

“I expect to have a safe delivery”

The most important issue that came up was to have a safe delivery. In this context a safe delivery meant that the outcome of delivery was good; that they would survive and have a healthy baby. It also meant being monitored and followed up by the health workers as well as receiving the necessary medicines for delivery.

“I will expect that they maintain my health.” (Pregnant woman age 27, no experience, urban)

“For them to tell me the condition of the foetus at the time (...) that is the biggest issue.”
(Pregnant woman age 26, no experience, semi-urban)

Women expected to receive care that could not be given at home e.g. injections and medicine. When asking what the medicine and injections were for almost all perceived it to be for energy. Lacking energy to push was something women had experienced at home, maybe because of prolonged labour. The women reported that if they had problems to deliver at home they would seek the health facility on order to receive medicine that would give them energy and thus have an easier delivery. In the urban setting where women were mostly familiar with health facility delivery they reported that one of the benefits with delivering in a health facility was that they would be given glucose and thus energy to push.

“[I expect] not to have much bleeding, and to give me an injection when I loose energy”
(Pregnant woman, age 30, no experience, rural).

“I need them to give me medication and to follow me properly. This is all, what else can they do for me?” (Pregnant woman, age 24, no experience, rural).

Removing the placenta was something that might be problematic at home, and perceived dangerous if this was unmanageable at home, therefore they expected to have this removed in the health facility. *“I expect to have a safe delivery and to remove the placenta.”* (Pregnant woman, age unknown, no experience, rural)

A fear of not being safe

Women were concerned about the safety in the hospital. Concerns about safety included many of the factors women reported above but the most important concern was naturally that the women and their babies survived the delivery.

“What I was worried about was that I didn’t think I would give birth well. That is why I was worried until I gave birth. I had butterflies in my stomach, I did not think I would give birth to him peacefully.” (Woman, age 38, experience, urban)

“I was worried whether I would come out safe or not. But it went well. In addition [I was worried] about the length of the labour. I was worried about the life of the baby” (Woman 25 years, experience, urban)

“I was only concerned about how I would come out [the outcome of delivery]. It is stressful, because women shout while they are in delivery. You will only be thankful if you come out [survive] from that place” (Woman 28 years, experience, urban)

Women’s families were also worried about the safety in the health facility. The fear of not being safe in the health facility also became a disincentive for seeking facility care for delivery as the woman below explains.

“My family told me to deliver at home. At the time of labour they told me to stay at home, if not they [health workers] may drop the baby on the floor” (Pregnant woman 25 years, experience, semi-urban).

Health worker’s views on the importance of a safe delivery

Health workers also reported the issue of safety. In addition to structural barriers like distance, transport and fees, health workers reported that a having a safe delivery in the health facility was a pull factor towards the health facility. At the same time women’s fear of not being safe in the health facility would push them away.

“There are rumors that there are no safe deliveries (...) that there is no difference in delivering at home or in the health care facility (...) some people say that there is not enough

services, they say: “they may kill my baby”. They think like this” (Health worker, 6 months experience, urban)

Feeling safe in the health facility

Not only did the issue of safety come up as having a good outcome and being attended by skilled health workers, the *feeling* of safety in the health facility was also something women were concerned about. The feeling of safety was associated with having someone with them during delivery; someone they knew and felt comfortable with. Not knowing the health personnel seemed to be a bigger concern in the urban setting than in the rural and semi-urban setting. “I was worried because I do not know them; I thought they have the skills, anyways they are better than the other people at home- like traditional birth attendants.” (17. Woman age 26, experience, urban). For women who had never given birth before it was frightening not to have anyone they knew for support. “I was scared at first, but after a while I got used to them...I wanted someone beside me...I was scared of them”. (Woman, age 22, no experience, urban)

Concerns about not having skilled health workers

Not having skilled and experienced health workers was a concern for both women who had experienced and not experienced health facility delivery. Skills and experience of the health workers seemed to be related to women’s perception of safety in the delivery ward. Being attended by students was a major concern for most of the women. A student was associated with not having enough skills and experience in following and delivering the women.

“I was scared of the students; I did not think that it would be alright when they touch you many times” (Woman, age 22, experience, urban).

“I was worried whether I would face students. As I feared they were the ones who gave me the health care services” (Woman, age 28, experience, urban)

Experiences of being attended by unskilled health workers

A woman in the urban setting had delivered her last child in the hospital and reported that the students who were attending her were lacking skills and experience. She said:

“There were students who assisted our delivery, and they were impatient. They left the placenta inside me. Because they are impatient they did not examine me. After I gave birth I

rested there for 5 hours but no one came and asked me whether I was bleeding. I think they were impatient because there were a lot of women delivering. After 3 days my face got swollen. Then at the hospital I got a specialised doctor and he was amazed by what had happened. Then they cleaned the uterus. They were impatient. I almost died.” (Woman, age 28, experience)

“It would be good if they would be careful. In my case it was because they were not careful that my baby had bleeding [from the cord]. They are also hasty. It would be good if they could improve this (...) she [showing her child] was about to fall on the floor until he cut the umbilical cord; it was me who threw her on my stomach and saved her because I was on the edge of the bench. And because of their fault she bled that much and spent the night sick. Thus it would be good if they would be careful and not be hasty.” (Woman 26 years, experience, urban)

Concerns about the lack of midwives on the health centre level

Women who had planned to deliver in a health centre or who had previous experience with health centre delivery were concerned about the lack of health workers and thus not having skilled health workers to attend their delivery. Many were also concerned about the health facilities not having adequate equipment.

“There are not enough [health workers]...I may worry about lack of health care. If there is adequate materials and if there are enough health workers [women will come to the facility] If there are not enough midwives, us coming to the health facility is meaningless (Pregnant woman, age 25, experience, semi-urban)

Health workers also brought up this issue. A health worker in a semi-urban health centre reported problems with lack of health workers on the health centre level. She also reported health workers lacking necessary skills in delivering women and consequences this may lead to.

That is a problem; here I am alone; that means only one midwife (...) if a regular midwife is added that will be good to provide good service. If there is [high] workload you will become tired, they [women] may not be examined well. In fact I work as well as I can, but it will be good if professionals are added, for this not to be a barrier. (...) If every professional is trained with neonatal resuscitation it will be good because there are people who do not know

how to resuscitate, consequently the life of a baby will be lost. Instead of using your hands to resuscitate, you will bring out the secretion immediately...they can't; for this a baby's life might be lost" (Health worker, 4 years experience, semi-urban)

A midwife from the other health centre supported her views:

"There is lack of adequate health workers. There is only one midwife; me, to assist deliveries and there are some clinical nurses, but I am the only one who is responsible for the deliveries. It is better to have another midwife to support me (...) and also the assistance at the delivery time may not be skilled (...) if the assistance is not skilled she may not come" (09. Health worker, 1-year experience)

In the urban setting the health workers reported that the number of staff was sufficient. As one health worker in the hospital said: *"I think we are more than enough, there is a huge amount of professionals"* (Midwife 24 yrs, 6 months experience).

Experiences of delay in receiving care

Many women reported waiting for admittance or not being admitted to the delivery room when they felt it was necessary. This was mostly a problem in the settings where women lived far from the health facility and where it was difficult accessing transport. Being sent home could result in the women delivering in their homes, on the way to their homes or on their way back to the facility. Eden's story presented below illustrates the problem.

Eden (30 years) had decided to deliver her fourth baby in the health centre despite the advice from her family to deliver at home. Her home was close to the facility (15 min walk). When labour pressed strongly she brought the clothes she had prepared for herself and the baby, gloves, blade and thread to cut and tie the umbilical cord just in case she would deliver on the way to the facility.

"At the time I was labouring they told me that I was not ready to deliver. I returned home. I came back again and they told me the same, three times this happened. At the last time I delivered the baby on the steps [of the health centre] (...) the birth assistant came to me and said "why here? But he was afraid of his superiors I guess and immediately let me enter the facility. I gave birth outside the delivery room on the floor. He [the assistant] said "why didn't you call me sooner?" and I told him that he sent me back home, that's why I delivered

immediately. When I delivered on the floor they came and helped, there was a woman who was a traditional birth attendant who supported me. I had brought a new blade and a thread and a piece of cloth.”

Nowhere to wait

The issue of waiting is something that reaches deep. On the health centre level lack of resources and health workers made it difficult to handle many women at the same time. Not having enough waiting rooms or beds for the labouring women did not give the health workers many alternatives in having all women to wait in the health facility, and they had to prioritize the women who were in most need of a bed or a place to wait. A health worker reported these challenges. She said:

“If the waiting room were much wider the mothers would wait there while labouring. They would not go back home before delivery. Now, what the main problem is, currently we have only one waiting room. If that room is already occupied we can’t admit another woman to the waiting room, and the couch [delivery bench] is not comfortable. I checked her [the labouring woman] and told her to wait. At that time they wanted to go home and have a rest. They left and she delivered at home.” (Health worker, 4 years experience, semi-urban)

Perceptions and experiences of health worker’s behaviour

Women had different perceptions and experiences of health worker’s behaviour in the health facilities. Women who had never delivered in a health facility mostly perceived the health workers to behave inappropriate towards the women and their relatives. Women who had experienced health facility delivery had both good and poor experiences of how they were treated in terms of care and communication between the health workers and the women.

“They are good for the lucky ones”

Being treated with respect as well as good communication between the women and the health workers were associated with a good experience in the health facility. Many women had the perception that only “the lucky ones” got good care. In all settings women had experienced health workers being aggressive or rude and seemed to feel subordinate to the health workers.

A woman who had delivered her three children at home, but had accompanied friends and relatives when they delivered in the health facility, reported factors that could influence many women to deliver at home instead of a health facility. She said:

“They are good for the lucky ones. I never delivered there, but I have accompanied others (...) I heard that they yell at them and put their legs there [open on the delivery bench]. So it is better to deliver at home to have privacy (...). They are not that much cooperative. I don’t like their behaviour (...) they don’t have good communication. At home we may have different alternatives but there they don’t even hear us (...) even if we tried asking them something, they told us “you can treat the women if you think you are the doctor.” (Woman age 32, no experience, rural)

She also suggested how the experience of the health facility could be improved; *“If there is cooperation, this is the big issue. If there is cooperation then it is the same delivering at home or within the health facility. Then we may deliver there without any difficulty.”* This quote illustrates the importance of communication and good interaction between health workers and women and their relatives or friends who accompany the women and how important these factors are in increasing the demand for delivery within the health facilities.

How health workers behaved towards women could seem accidental, meaning that they never knew how they would be treated. It was not obvious that they would be received and treated with respect when they came to the health facility.

“The hospital doctors have different characters. Some are good and some treat you badly, there are some doctors who even say, “Hey leave this place!” when you are in labour. Some doctors will assist the delivery with a smile on his or her face and making jokes. So it is according to your luck” (Pregnant woman, age 23 yrs, no experience, urban)

“There are people whom they have pity for; I do not know whether it is for all or just for me [that they did not show pity] (Woman, age 22, experience, urban)

According to the women and also the husband we interviewed, people were treated differently. Particularly this concerned women and their relatives who came from rural areas

to the hospital to deliver. *“Especially to people from rural places, they do not even consider them as human beings”* (Woman, age 28, experience, urban)

It was a common perception that people from the rural areas was not accustomed to the way things were done in the urban areas.

“Yes you know it [that people are treated differently]. I could not tell you who they treat better and who they treat worse, because they did not allow me in the delivery room. However as I have seen from outside, because the rural people do not know the rules and regulations of the urban people they [the health workers] are a bit aggressive. Someone who knows the rules and regulations will be benefited” (Husband, age 38, urban)

Women were concerned about the unequal treatment of women, and as one woman said:

“If the hospital receives women with good care, if they give equal treatment for all, people will go to the hospital. However if they let them down, they will give birth at home and they will face a problem.” (Woman, age 28, experience, urban)

Poor communication

There seemed to be poor communication and a lack of communication between the women and the health workers in the health facilities. This is also something I observed myself in the hospital in the urban setting. Not only did the health workers keep the information about the women to themselves, there also seemed to be a hesitation among women to ask the health workers about their situation. In the hospital relatives were not allowed to be in the delivery room with the women. Relatives would be notified if the women’s situation were critical and if in need of surgery. In these cases relatives were allowed to enter the delivery ward to give their consent to further treatment. The women had heard about relatives only being allowed to enter the room if their situation was critical. Moreover when health workers communicated between each other they would use a mix of English and Amharic, and as a result very few women could understand what was said.

The woman below was concerned about having a CS, she had been in labor for 48 hours, and when she saw her husband entering the waiting room for women in labor she worried;

“When he [her husband] got in, I thought “are they going to make him sign?” because they don’t speak Amharic you will be confused. When they speak while looking at the paper you will be alarmed, it looks like something is wrong, and I was thinking that if I need an operation I will know it if I see him” (Woman age 22, experience, urban).

Poor communication also included the lack of information women received from the health workers before, during and after birth. We asked women what information they received when they were delivering in the health facility e.g.: “Did they tell you what medication they gave you?” “What was the medicine for?” “Did they tell you the sex of the baby and how much did the baby weigh?” Very few women had received this information and they did not seem to ask the health workers about these issues. The same woman quoted above gave birth to a baby boy. She said: *“I did not hear them [health workers not telling her about her baby], they did not talk to me. I was happy because I delivered safely, but after I was disturbed and thought, “why didn’t I ask?”* This quote is a good example of how the interaction between health workers and the women was in the labour ward. When I was observing in this ward I saw health workers who seemed to have a good relation with the women, but there were many cases where women seemed to be too embarrassed or felt too inferior to ask questions, they had great respect for the health workers and did what they were told and it was not common to ask questions about the care they received.

Rudeness and aggressiveness

Many women reported health workers to be rude and aggressive when admitting them to the delivery room, during examination and while in delivery.

“When I was in labour I got there and told them that I am sick but they said “why don’t you wait outside; you are not yet ready to deliver; don’t bother us”. No one was smiling (...) when he treated me like that I was very upset and felt disgraced” (Woman, age 28, experience, urban).

“There was a woman, she went there [to the health facility] to deliver and I heard them insulting her. While she was in labour there were health workers who said, “you are making us deaf” (Pregnant woman 30 years, no experience, rural)

Such behaviour from health workers was clearly a discouraging factor for seeking care at delivery for many of the women. Women also reported how they wanted the health workers to behave in order to make delivery in the health facility a better experience.

“At the time of delivery they shouldn’t be aggressive, rather they should encourage us (...) if they treat us with a smiling face, then it encourages us to attend the health care facility. Some women may deliver at home because of this reason” (Pregnant woman, age 30, experience, semi-urban).

“I would be happy if they are patient, that means if they can care for me as a friend”
(Pregnant woman 26 years, no experience, semi-urban)

Encouragement from health workers

Women had also experienced being taken well care of in the health facility.

“They told me to be courageous. Sister Tibeba who assisted me was well skilled. She took good care of me. She told me to have courage and to push, at last I gave birth. Because she encouraged me I delivered happily.” (Pregnant woman, age 25, experience, semi-urban)

“They were saying “be courageous, be courageous”. When I was in stress they were saying “do not worry you are about to finish: it is just a little that you are left with” and because it was my first baby, both male and female [health workers] assisted me by saying, “Is it your first? Do not worry, do not worry.” (Woman, age 38, experience, urban)

Health worker’s perspectives: Saving lives, not satisfying the patients

Health workers acknowledged that they did not prioritise fulfilling women’s needs of emotional and supportive care. A health worker in the hospital illustrates this conception. She said:

“How we work here is only to give delivery service for the women, not to attain their satisfaction. We work to reduce the risk that the mother and the child will face, not to satisfy them” (Health worker, 6 yrs experience)

Many women who had delivered in the hospital reported that they were not receiving the care they felt they needed. Women who had their first delivery were unsure of how to take care of the baby, as they were inexperienced. The uncertainty came up during the in-depth interviews

with the women. One of them said she had to rely on her mother to show her how to take care of the baby, and that she didn't dare to hold the baby for the first two weeks. Health workers did not see the need in giving this "extra" care as the health worker below reports:

"Most health workers don't give attention for this [showing the women baby-care] only for complications for the mother or the baby." (Health worker, 6 months experience, urban)

"I work by feeling their feelings"

Even though health workers reported that the focus on emotional care for the women were not a high priority they agreed that their approach was important to attract women to deliver in facility.

"Your reception to the mothers should be good (...) when they face problems- mostly vomiting, I think of myself facing the same problem. So I work by feeling their feelings (...). You should think: "what shall I do to attract women to come here?" (Health worker, 6 yrs experience, urban)

Health workers acknowledged that their inappropriate behaviour could push women away from the health facility. *"It is the professional's negligence and approach. They will say "if I go there and if they talk to me nicely I will deliver there." one cannot say that we are perfect"* (Health worker, 4 years experience, semi-urban)

The importance of support while in delivery

It was normal and natural to go with someone to the health care facility as mentioned previously. A majority of the women wanted to have a relative with them during delivery in the health facility; having someone they knew in the delivery room seemed to be associated with feeling secure as mentioned previously. In the urban setting in the hospital relatives were not allowed in the delivery ward while on the health centre level women were allowed to have one relative or friend who were with the women through her labour and delivery in the health centre.

Relatives increase the feeling of security

On the health centre level having a relative accompanying the women was mostly seen as a benefit for both women and the health workers. Women expressed a feeling of helplessness

without someone they knew in the delivery room. *“What am I supposed to do if they [relatives] are not allowed? [In the delivery room]”* (Woman, age 32, no experience, rural)

In the urban setting, where the majority of the women had experienced health facility delivery, most of them were aware that relatives were not allowed inside the delivery room. Some women expressed a disappointment that husbands were not allowed to be present during their stay in the labour ward as the woman below reports:

“Because it is not allowed how could I call him [husband]? However I would be happy if I have him with me (...) when they sent him out I felt so bad. They allowed no one; only females can be inside the delivery room for a minute. You will be happy if you can have your own person, but they do not allow anybody” (Woman, age 28, experience, urban)

On the health centre level relatives supporting the women in the delivery room was mostly seen as a benefit from the health worker’s perspectives as many women were shy towards the health workers.

“If she wants, we allow them [relatives] within the delivery room at any time starting from the first step of the delivery to the end of the delivery, but we don’t allow them to be more than one, rather we are happy if one of her relatives supports her (...) because she is not willing to tell us everything, rather she tells everything to one of her relatives. We let them in to hear from them what she wants.” (Health worker 4,5 years experience, semi-urban)

However different health workers had different perspectives.

“You will not have the freedom to work”

Having relatives accompanying the women was also perceived to be difficult for the health workers when doing their work as reported by this health worker: *“In case it [the delivery] is complicated they become aggressive, these kinds of things may get in the way when giving the service”* (Health worker, 1-year experience, semi-urban)

“Sometimes some women ask for their relatives but they [relatives] are so stressed. We do not want to see that, they are the ones who will be stressed even more than the delivering women. You cannot work properly because they will comment on the procedure you are performing.

That is why you do not allow them, because you will not have the freedom to work” (Health worker, 6 yrs experience, urban)

The quote above illustrate that people might not be familiar with the health centre and their “rules”. Relatives seemed uncomfortable with leaving their women to the health workers. They were not familiar with the procedures, which may result in interfering with what the health workers were doing.

“Sometimes they might distress her, when they see the way she lies on the bed they may tell her to change her position or something else that may not allow us to deliver her properly” (Health worker, 8 years experience, semi-urban)

“It is not comfortable for us to work as well as for the mother who is at delivery. And sometimes some of the relatives may complain at things that do not concern them. (...) There are some things the relatives may not allow us to do. They may ask you to do this and that which is not necessary” (Health worker 4,5 years experience, semi-urban).

Having relatives in the examination or delivery room might make the women shy to be examined, it might not be appropriate to be uncovered in front of relatives, especially men. This was however not mentioned by any of the women in this study, but the health workers brought it up as a barrier for doing their work, as this health worker says:

“Sometimes she is afraid and refuses any procedure [if the relatives are there]. She will develop a different behaviour, like she will be spoiled. For example, to examine the uterus while in front of men is not a custom in the country even in private clinics” (Health worker, 6 years experience, urban)

“They put a black spot on you”

In the health centres, in particular, health workers were commonly made accountable for how the outcome of delivery was. The smaller communities provided a setting where most people knew each other. For the health workers this could be a benefit in the way that women might be more comfortable being taken care of by someone they were acquainted with, but also a disadvantage because they were made responsible if something went wrong.

“It is not allowed in the hospital [to have relatives in the delivery room], but here [in the health centres] because it is allowed as a tradition it is a problem that you cannot eradicate. They even say that 3-4 people should be with her [the woman] (...) they will make you accountable for everything that occurs. Because the room is narrow and [because] they will suspect you for many things we allow one person only (...) In the hospital there is no problem but here they know who assist the delivery, who does what and everything. So they put a black spot on you” (Midwife 37 years, 4 years experience)

Confidentiality

Having relatives in the room might have increased women’s feelings of security but it was also a factor that could threaten women’s confidentiality as brought up by the health workers.

“There may a sense of nervousness from the women. There are people who want to have the examination alone with the professional. If one mother comes here knowing that she is HIV-positive from another institution and if she comes here with another person she will say I am free [HIV-negative] so I will not be tested. However if she is alone she will have the privacy (...) they believe that we do not tell them [the relatives] their secrets” (Health worker, 4 years experience, rural)

Perceptions and experiences of privacy

Women who had never been in a health facility to deliver were concerned about being exposed and to uncover their bodies to strangers. Most of the women in rural areas were used to deliver at home covered up with clothes and blankets and surrounded by people they knew. Privacy in this context meant not having their bodies uncovered and not having excess health workers in the delivery room.

“I will be shy”

Women who had never been to a health facility expressed worries about delivering in a health facility due to the lack of privacy.

“For that I will be shy [delivering in a room with other women and many health workers]. Yes I will be shy. Someone who is used to deliver at home will be trembled” (Woman age 35, no experience, semi-urban)

Some women had experienced lack of privacy when coming for antenatal care and had the perception that the privacy would be the same as in the delivery room as in the ANC.

“No I do not think I will have the same privacy [in the facility] as at home. There will be many people. It is not ok. Even when we are in the ANC they examine us while all are beside us, so I also think that there [delivery room] will be the same issue” (Pregnant woman, age 35, no experience)

Excess number of “irrelevant” people in the delivery room was also mentioned:

“Yes there were others, even the sanitary worker was there, this is not good. For the doctor it is a must [to be there]. It should be privacy” (Pregnant woman, age 30, experience, rural).

As mentioned previously students were perceived to not be skilled enough to take care of the women, it also came up as an issue regarding privacy.

“Previously I was not [concerned], but nowadays privacy is a big issue for me because there are students who attend the entire delivery” (Pregnant woman, age 25, experience, rural).

“Everyone is like you”

Some women reported that privacy was not a big concern as they knew there would be little privacy in the labour room and since there were also other women that were in the same situation as them:

“I did not think about that [privacy] at the time; I did not think it was possible [to have privacy]. In addition because it was my first, I did not know how it would be. However I did not expect to be alone. If it could be [privacy] it would be good. I did not think that it would be possible to be covered up while you are like that with all the fluids that you have, but if that were possible it would be good. However you see everyone is like you, so it means nothing.” (Woman, age 25, experience, urban).

“They don’t want to lose their privacy”

Health workers reported that the lack of privacy in the health facilities was a strong factor pushing women away from the health facility and resulting in home delivery.

“They want their privacy, they don’t want to be exposed. Even when we ask them why they did not come to the health care facility they don’t want to come because they don’t want to lose their privacy” (Health worker, 1,5 years experience, semi-urban)

The health workers in the urban setting reported that it was mainly the rural women who needed to have privacy during delivery.

“My family lives in a rural area and I know that they do not want to open their legs like that [lithotomy position] to deliver because at home they will be alone, not in front of many people, but here with the midwives... they have privacy there [at home]; they will also have a separate room to give birth. Thus they do not like to be naked for six and above people. They do not only hate to give birth here [in the hospital], but they also do not want their children to come and give birth here” (Health worker, 5 years experience, urban).

Crowdedness in the hospital was also observed. When observing one woman in delivery there could more than ten people from different health backgrounds including students. Everyone was observing the woman in her delivery. For me it was difficult observing due to the crowdedness in the room. However it was clear that the women seemed uncomfortable with so many people observing them. The quote below illustrates the challenge of crowdedness.

“Because of so many people in the room the women become shy. They do not want to be uncovered. These days they prefer to go to a private health facility because there is privacy. For example, for one mother, a midwife, a master health officer, a resident, and an intern can follow her. When the intern examines her, the midwife will assist and if they find any problem they will tell to a resident or to a specialist. Because of many people [she become shy]. In the private health facility only one person can follow a woman, but here it may be 4 to 5. Even though the care is good the woman will be stressed. Usually it is the rural mothers who come to the hospital, and they do not know about being naked. They do not want to be naked not only for us even for their husbands. So it is very difficult. There is no privacy” (Health worker, 6 years experience, urban)

Interestingly the health worker above mentioned that women preferred seeking private facility for delivery since they would experience a greater sense of privacy there than in Gondar

University hospital. However to deliver in a private clinic is too expensive for most women and therefore not an option.

Summary

Women's biggest concern for facility delivery was the safety, which included a live child and mother, having skilled care at delivery and the feeling of safety in the delivery room. Feeling safe was associated with having someone they knew and trusted to follow them through the labour and delivery. Not knowing the health personnel seemed to be a bigger concern in Gondar than in rural areas. On the health centre level women were concerned of the lack of midwives to attend their deliveries, this was also a concern brought up by the health workers.

Waiting to be admitted to the delivery room seemed to be a disincentive for seeking care, especially in rural areas. In the urban setting waiting was also a frustrating factor, but in rural areas where women lived far from the health centres this could have bigger consequences than for women in urban and semi-urban areas where women lived closer to the health centres. Health workers brought up the challenges of not having waiting rooms for the labouring women, causing the women to return to their homes and give birth there instead of the health facility.

Many women who had never delivered in a health facility had a negative perception of the health worker's behaviour towards patients in the health facility. This is something they had heard about, and also witnessed when accompanying others. Women who had delivered in a health facility had both positive and negative experiences. The good experiences of health facility delivery were associated with encouraging, smiling and supportive health workers and receiving skilled care. The negative experiences were associated with aggressiveness, poor communication and disrespect. Being treated differently involved that it was random who received good care and that rural people were treated different than urban people. Many women who had experienced health facility delivery would explain inappropriate health worker behaviour as "maybe it was only me they treated bad" or that "it was just not my luck". The health workers were aware that women might not come to the health facility due to being treated poorly, they emphasised the priority of giving the absolute necessary care, not satisfying the women.

Assistance from relatives during delivery was mostly perceived as a benefit for women and health workers, however some health workers reported that relatives interfere with the possibility of giving adequate care. Moreover women felt more secure when relatives could attend their deliveries.

Although all women would like to have privacy when delivering they seemed to have an understanding that this was not possible, especially in the urban setting. In the semi-urban and rural setting women feared not having privacy. Health workers reported privacy as a big issue, particularly for rural women and that it could be a decisive factor not to come to the health facility.

3: Is it necessary to deliver in a health facility?

“It is not necessary” is the most frequent reason women reports for not seeking the health facility for delivery [9]. In this chapter the aim is to explore the different informants’ perspectives on the necessity of seeking the health facility for delivery and to understand their reasoning behind seeking care or not seeking care. I look at women’s perceptions on where it is normal to give birth; at home or in the health facility, perceptions of complications at the time of labour and delivery, the challenges of giving birth at home, and finally how women see the health facility as a problem solver.

The appropriate place to give birth

When asking the women what they considered as the appropriate place to give birth we got different answers. In the rural setting all women reported that what they considered appropriate was to deliver at home. In the semi-urban setting women had different views; for some health facility was appropriate and for some delivering at home was the appropriate place. In the urban setting all women said that delivering in the hospital was normal and appropriate and delivering at home was not appropriate anymore.

It is normal to give birth at home

“To be like the community. Most of the time it is at home [that is normal to deliver]” (Woman, age 32, no experience, semi-urban). There were benefits of delivering at home, like being more comfortable, the same woman continued: *“At home it is like what I want [it to be](...) I am the only one, I think, who did not forget the traditional way”*. Many of the women who had only delivered their children at home saw their home as a familiar setting

where they felt comfortable. Giving birth at home was also a part of being like other women who delivered at home or to follow the “traditions” of home birth. A woman we interviewed in the semi-urban setting had delivered all her children at home. She said:

I: You were 15 years old when you delivered your first baby. Were you afraid to deliver at home?

R: I did not [fear]. Have I not grown up with milk? Why should I fear? I did not fear. My mother also gave birth at her own home; she never went to a health facility. My elder sister also gave birth in her own home; she did not know [a health facility to deliver]. Thus I thought I would be as my mother and my sister; I did not think I would be like the other women [that give birth in a health facility]” (Woman age 35, no experience, semi-urban)

Urban women had the perceptions that it was more normal to deliver at home when living in a rural area. *“In the rural areas it is their tradition that they do not go to a hospital, they give birth with the assistance of a traditional midwife” (Woman, age 22, experience, urban).*

“In Western Belesa (rural area) it is normal to deliver at home, but here [in urban setting] it is in the hospital” (Pregnant woman, age 27, no experience, urban)

A shift of thinking

Although women with no experience of health facility delivery perceived their home to be the appropriate setting for birth, they also reported that nowadays health facility delivery was more normal and accepted in the communities and more women chose to deliver in a health facility than before.

“It is cultural influence [that makes women deliver at home]. Before it was because our thinking had not changed. However now it has changed, especially in the urban areas. Currently there is a change in rural areas too” (Pregnant woman, age 23, no experience, urban)

“In old times people influence you to give birth at home, but now all advice you to give birth in a hospital, it becomes an old time story” (Woman 28 yrs, experience, urban)

A woman in the urban setting had delivered her 3 children at home. She was currently pregnant and had moved from a rural area in the Oromia region to the urban setting of the current study, and she planned to deliver in the hospital. She said:

“These days everyone go to the hospital. Here [in the urban setting] there are no women who give birth at home (...) now hospital birth is growing there too [in rural areas]. It is not like the past, it is changing” (Pregnant woman, age 35, no experience, urban)

Knowledge of complications

Women mentioned the most common complications that can arise during delivery. Bleeding after birth was almost always mentioned. Most of them mentioned retained placenta and bleeding as something that was very much feared. Some also mentioned complications like prolonged labour and malpresentation of the baby in addition. Women reported that they needed skilled care and most often that they had to seek this care in a health facility to manage these complications. TBAs were not considered skilled enough to manage these complications at home.

“If there is bleeding we may die and the other is the position of the baby’s may not be proper” (Pregnant woman age 24, no experience, rural)

“Yes there is danger if there is bleeding, the other is foetal distress, cutting the cord, if she for example delivers accidentally [fast] she may not find someone to help her. These kinds of complications may arise, so the child may be harmed as well as the woman”
(Pregnant woman, age 25, experience, semi-urban)

Having had previous deliveries without complications seemed to lower the women’s perceptions of risk.

“There are people, who give birth without complication, but also there will be people with complications; it’s determined according to the person [health history]. For example I always give birth without complications; I do not have prolonged labour.” (Woman age 26, experience, urban)

“I do not know. It cannot be fully dangerous [to give birth]. I say it will not always be dangerous” (Pregnant woman 25 yrs, no experience, rural)

Seeking care only if complications

From the quotes above we learn that women knew about complications that could occur during labour and delivery. The knowledge of complications was more or less similar in all settings. Under this theme we saw a clear difference in the reports from the women in rural and semi-urban setting versus the urban setting. In the rural and semi-urban setting women would mostly seek care only if they had problems during labour and delivery while in the urban setting they would seek care regardless of facing problems or not.

“We go to the health centre if complications arise”

When asking the women if it was necessary to deliver in a health facility, most of the women in all settings confirmed that this was necessary, although women who were used to deliver at home did not follow this practise. They would go only if they had a problem.

“I have planned to deliver at home, but if the labour is intense then I will run to the hospital (...) we go to the hospital if the pain is intense, but it is not normal to run to the hospital like the people in the urban areas, [they go] even if labour is fast.”

(Pregnant woman, age 24, no experience, rural)

“I go because I am sick. I don’t have other reasons; I become sick because of the load of work (...) it is at home [that is normal to deliver], we come to the health centre if any complications arise (...) if I did not feel this pain why should I prefer the health centre?”

(Pregnant woman, age unknown, no experience, rural)

Some women had the perception that it was not acceptable or normal to seek the health facility for delivery unless they faced any problems.

“We cannot go [to a health centre] unless we are sick (...). If placenta refuses to slip [retained placenta] we go to a health centre, and when we feel sharp pain after delivery

(Pregnant woman, age 25, no experience, rural)

Women who had never delivered in a facility reported that only the ones with a health problem would seek assistance in a health facility for delivery.

“There is someone I know who delivers at the hospital because she was very much sick”
(Pregnant woman age unknown, no experience, rural)

“My sister used to give birth at home. It is those whose back [pelvis] is narrow and those who have uterus difficulties that go to a health centre, but those who are healthy do not go there. I do not have any friends who gave birth in a health facility. There is one woman in this community; I heard she gave birth in the health facility, but I do not hear about anybody else (...) her waist is thin and she gave birth after a long time, so she went there because she feared.” (Woman, age 35, no experience, semi-urban).

Women would try to deliver at home first; if this was too difficult they would seek the health care facility. The quote below illustrates the possible consequences of attempting to deliver at home first and seeking care too late. The distance to the health facility and adequate care further complicated the situation. The mother and her children did not survive.

“I know that Kasahun’s wife, she was delivering twins [at home], but after she delivered one it was difficult to deliver the other one, the baby was swollen and she went to the health care facility. After delivering the babies removing the placenta was difficult, the gloves was left in the uterus (...) she went to Debark first, as Debark told her it is above their ability then she went to Gondar hospital.” (Woman, age 32, no experience, rural)

Health workers also reported that women came to the health facilities only if they faced complications.

“They only come if it is prolonged labour, especially those who are in remote areas, they bring them here late, they bring them here if the labour is prolonged for about 3 or 5 days, if not they won’t.” (Health worker, 4 years experience, semi-urban)

The mothers are just visiting the health care facility if there are complications. They say “every time I gave birth the labour is not intense so why should I [come]?” They come to the health facility if they face with prolonged labour, if the labour is intense”.

(Health worker, 1,5 years experience, semi-urban)

Health workers brought up the issue of women not seeing the advantages of health facility delivery and thus only seek care if they had complications. The women believed that their delivery would be without complications and since it was better for them to deliver at home they would hesitate travelling to the health facility for delivery.

“If it is a fast labour they usually give birth at home that means that they do not think that “if I go there I will get these and those advantages”, they only think about the good sides of giving birth at home. There are those who think that “I will give birth at my home, I will not bleed, and the placenta will not be retained. If the labour is fast and I give birth in my home there will not be any problems”. However women who have the awareness will come directly here [to the health centre], but for those who does not have awareness it is the thinking that keeps them there; “if I give birth easily at home, why should I go there?” but if it is a prolonged labour they will come.”(Health worker, 4 yrs experience, semi-urban)

“Lets go if she delivered safe”

Relatives played an important role in the safe outcome of delivery. Their perceptions of giving birth and their awareness of complications that can occur before and after delivery played an important role, particularly in the semi-urban and rural setting where they could accompany the women in the labour room. Women giving birth in health facilities should wait six hours in the health facility to avoid postpartum complications. In this study, in the semi-urban setting in particular, it was revealed that the women or their relatives almost never considered waiting six hours.

“It was around 30 minutes (waiting after delivery). They told us to stay in case if bleeding happens, then they injected me. I stayed for at least 30 minutes. Because my relatives who were standing outside were saying, “let’s go if she delivered safe.” We did not stay longer”
(Pregnant woman, age 25, experience, semi-urban)

Health workers seemed frustrated because relatives would bring the women home almost immediately, but also it seemed that after only few hours they would themselves let the women leave as reported by this health worker:

“They are not willing to stay even for one examination. However we do not forcefully discharge them before two or three hours stay. They (relatives) want to take them right away; this is taken as a tradition. It is we that force them to stay because we are responsible. For observation in the 4th stage they should stay for six hours, but here we discharge her after taking vital sign once and we do breast attachment” (Health worker, 4 yrs experience, semi-urban)

In another health centre health workers they did not allow relatives to interfere.

“Just to prevent so many complications we allow the woman to stay for six hours. Maybe the relatives want to take the woman but we do not allow the relatives to take her out of the health care facility. Because they are coming from areas far away it is very difficult if complications arise so we allow the woman to wait up to six hours regardless of the interest of their relatives.” (Health worker, 1-year experience, rural)

Nothing at home

Women reported problems in having someone to attend their deliveries at home and lacking adequate equipment to assist in delivery at home. If relatives could not attend their deliveries at home they had to rely on TBAs or HEWs in the community. In this section “nothing at home” refers to challenges women faced when giving birth at home.

No one to assist at home

Women reported that it was more difficult to have someone to assist them at home nowadays than it was earlier. *“It is in a hospital [that it is good to deliver]. At home there is no one who will assist delivery”* (Woman, age 38, experience, urban).

“Nowadays there is no one who can assist delivery [at home] as it was in the past times; now they want us to give birth there [in the facility]”. TBAs were reluctant to assist deliveries at home; they were rather important actors in influencing the women to deliver in the health facility. The same woman continued, “They [TBAs] do [assist] but they usually are begged [to do it] (...). It is not money but fear. Some of them assist you by buying gloves, but most of them refuse to assist delivery and they tell us to go to a health centre” (Pregnant woman, age 30, no experience, semi-urban). Another important issue raised was the TBAs fear of assisting women in home deliveries. The reluctance to assist included the fear of contracting

HIV/AIDS and the government policy of having more deliveries in health facilities, making home birth “a bad practice”.

Fear of blood

The fear of being in contact with blood and thus fearing being infected with HIV made it difficult for women to find someone who were willing to assist them.

“At home only those neighbours who have HIV may help us” (Pregnant woman, age 32, experience, semi-urban)

“Because these days no one wants to touch your blood. For example for this child [pointing at her daughter who was born at home] the birth attendant I know assisted the delivery. However nowadays everybody is afraid of blood.” (Woman, age 25, experience, urban).

Some women also had the perception that it was women with HIV/AIDS that went to the health facility to deliver due to the difficulties of finding someone to assist at home.

“It is those who have HIV who go there [to the hospital]. It is said that we should be careful of razor, needle and knife. Then they [TBAs] start to say no to deliver women [with HIV/AIDS]. So it becomes in the health centre that women give birth. However if she is healthy she will give birth at home” (Woman, age 35, no experience, semi-urban)

No services at home

Women saw the health facility as a setting where they could be assisted with adequate equipment and have benefits like e.g. vaccination for the baby immediately after delivery.

“No it is not safe delivering at home. If you give birth at home there is no vaccination for the baby and the mother will have more bleeding. If she has more bleeding she will suffer and if she lacks energy there is nothing that she will be given at home, but if she is in a health facility she will have glucose” (Woman, age 32, experience, semi-urban)

“Even if here [at home] they do ten things it would be nothing. But if you go to a health facility they will inject you and if there is a problem they will find a solution. But here [at home] there is nothing they will do if any problem occurs. It will only make you lose your

energy and after that you will go to a health centre” (Woman, age 35, no experience, semi-urban)

“At first I wanted to deliver at home, but elders did not allow me. I told them that I don’t want to go to the hospital. They told me that “if you got sick, what do we have to give you; we can’t even get gloves nearby. Moreover what if you bleed to death?” (Woman, age 28, experience, urban)

“If you have bleeding or any other things, here [hospital] they will immediately assist you, so nothing is similar to hospital. There [at home] you will bleed to death because there is nothing” (Pregnant woman, age 23, no experience, urban)

Some women mentioned traditional methods for assisting delivery as not being sufficient enough for a woman delivering at home. *“Yes [it is dangerous] because they work only by using the tradition (...) if the mother has prolonged labour they will only do things like superstition” (Pregnant woman, age 26, no experience, rural).*

Traditional delivery methods may be dangerous so it is better to deliver in a health care centre (...) the traditional birth attendants may lead us to complications as well as to death if we deliver at home (...). “If they [health workers] don’t teach them [women] that home birth is not good, they will deliver at home. Tradition is bad, some of them want to deliver at home secretly, or some of them may want to deliver at the health care facility secretly” (Pregnant woman, age 30, experience, rural).

“It is called bad practise”

As mentioned above home birth was seen as bad practice and TBAs was reluctant to assist home deliveries due to this.

“I deliver alone. I always give birth on a day when everyone is at work; I give birth at my home and I receive my baby; I never went to a health centre for all my six children (...) They [HEWs] help, when we tell them that we are sick they will send us to the health centre. Even if the traditional midwives come to assist you, it is not like it used to be because it is called bad practise [to deliver at home]. It is said that it is bad practise, they [women] should go to a health centre (...) (Woman, age 35, no experience, semi-urban).

The health facility as problem solver

Even though many women in this study (particularly in rural and semi-urban settings) planned home delivery and even though women had poor experiences and perceptions regarding health workers behaviour, almost all women saw the health facility as a problem solver, in the way that they trusted the health facility to help them and solve problems if they sought assistance for complications.

“Within the health care facility it is easy to resolve it”

All women agreed that if complications arose it would be easier to handle them in a health facility. *“It is dangerous if any complication arise at the home setting, like removing the placenta. If the woman is coming to the health centre it is very easy to manage this kind of complications”* (Pregnant woman age unknown, no experience, rural)

“How can it be possible to deliver without any complications? If there is bleeding, If the position of the foetus is not proper, the baby may come out with his head or with his legs so within the health care facility it is easy to resolve it” (Pregnant woman 24 yrs, no experience, rural)

“To have a safe delivery”

Giving birth in the hospital would be safer, still many of the women below had never been in a health facility when delivering their children.

“For my security, to get help if there are sometimes problems that occur while delivery (...) it is good to deliver in a health post for good health and security. For me and for the child” (Pregnant woman 26 yrs, no experience, rural)

“To have a safe delivery [the reason why this woman plans facility delivery] it is dangerous if any complication arise in the home setting like removing the placenta. If the woman comes to the health centre it is very easy to manage this kind of complication (Pregnant woman 30 yrs, no experience, rural)

“If there are complications when you give birth, they will take the baby out with an operation so in this way hospital birth is life saving” (Woman 28 yrs, experience, urban)

Some women had the opinion that the health facility should be sought as soon as labour started. This could be lifesaving

“First she must go to the health care facility. If it is above their ability they may refer her to Gondar hospital. Any woman must go to the health care facility as soon as her labour starts then the life of the mother as well as the life of the baby will be saved.”

(Pregnant woman 30 years, experience, rural)

“It is better to deliver within the health care facility to eliminate the complication if arisen”

(Pregnant woman 25 yrs, no experience, rural)

“It [health facility] is good for your healthiness. For example if you bleed much they will give you an injection but if you are at home you will bleed to death.” (Woman 28 yrs, experience, urban)

Summary

In the rural and semi-urban setting women perceived home birth as more normal than health facility birth, however women reported that times were changing and health facility delivery was more acceptable in the community now than before. In the urban setting it was more normal to give birth in the health facility. It was more difficult nowadays to find someone who could assist delivery at home; the TBAs were not to be relied upon as much as before; home delivery was seen as a bad practice and the impact of HIV/AIDS hindered the TBAs in assisting home deliveries, rather recommending facility deliveries. Most women who had experienced facility delivery in both rural and urban settings perceived home birth as dangerous and there was no treatment for complications at home. Both in rural and urban areas women were aware of the most common complications that could arise in a delivery and that health facility could solve the complications if they arise. Still the women in rural and semi-urban settings mostly sought health facility care only if they had complications. Urban women would deliver in a health facility regardless of facing complications or not. Seeking care only if complications were also reported from the health workers and they emphasized that this was mostly normal among rural people.

Waiting for 6 hours after delivery is rather an exception on the health centre level. Relatives play an important role in deciding when to leave the health centre after delivery. On the hospital this was followed after regulations. Relatives played a smaller role here since they were not allowed in the delivery room.

Chapter 5 Discussion

This chapter starts with a discussion of the main findings of this study where the aim is to understand women's and health worker's perspectives on barriers and facilitators to increase the demand for birth services. The main findings will be discussed in light of the AAAQ-framework as presented in the theoretical approaches. The AAAQ framework takes a health system perspective on barriers to health facility delivery and does not account for factors outside the health system that may influence birthing place. To analyse these social and cultural factors on community, family and individual level, I use the concepts of trust (Gilson 2003), security (Giddens 1993) and the concept of authoritative knowledge (Jordan 1997).

In the second section of this chapter I will discuss and reflect upon the methodology used in this study.

Discussion of the findings

Perceptions on Availability and Accessibility of health facilities

Distance and the need to improve access to transport

Women from different settings in this study had different perceptions on availability and accessibility of the health facilities. Naturally, women who lived far from the health facilities perceived the health facility as unavailable and difficult to access in terms of distance and transport. Women who reported difficulties of access were also the ones who had never experienced health facility delivery and some of them reported that the distance and lack of transport in rural areas were the reasons for delivering at home. The health workers also confirmed this. Women's reluctance to seek care due to long distance and difficulties in accessing transport has been reported as a major issue in other studies both from Ethiopia and elsewhere [24, 29]. The most famous study in this area of research is Thaddeus and Maine's study "Too far to walk" from 1994 [42]. Unfortunately, poor availability and accessibility in terms of distance and transport seem to persist as a major barrier to safe delivery practices in

rural areas of sub-Saharan Africa, even 20 years after this study. In my study, women living closer to the health facilities and to the main roads generally saw health facilities as available and accessible to them. For these women, access was seen as a problem primarily at night.

A number of studies have pointed out that access to birth care is a major issue of inequality between rural and urban areas [21, 23-26, 30], not only because of the distance and the access to the health facility, but also because of the difference in the social and educational level of the women in rural and urban areas. Urban women are more likely to have higher education, higher frequency of ANC visits, higher household wealth and they live closer to the health facilities and the roads, which makes it easier for them to access the health facilities [21]. My study also confirms this.

The need for better coverage in rural areas

It is a health policy priority to increase coverage in order to reduce the distance to birth care and reduce costs [4]. Ethiopia has expanded its health service coverage remarkably since the initiation of the HEP in 2003 [17] by building health posts and employing HEWs trained in basic health service provision, including maternal health care. The programme has improved availability of health services particularly in rural areas. However, studies from 2010 on the HEP and its effectiveness has demonstrated that even though health posts and HEWs have improved availability in terms of geographical distance, the accessibility of birth services is not satisfactory since not all health posts and HEWs provide delivery services for women in the nearby areas [43]. In this study, women in the rural areas reported that they did not use the health posts or HEWs for birth services, which might indicate that these services were not available, nor accessible or might be perceived to have poor quality in this area. However, some reported that they could get ANC from the HEWs. The fact that HEWs in health posts or in outreach services can provide ANC for women in rural areas may have an impact on the women's and their families choice of birthplace. It has been widely documented that women's use of ANC services is related to higher use of delivery services [21, 23, 25, 32, 33]. By giving the women information and support, and making a first contact, the health workers can encourage the women to deliver in a health facility [21]. This indicates that the availability and accessibility of ANC services are very important to increase the demand for delivery within health facilities in Ethiopia.

The need for predictability of cost

Access is also a matter of cost. The system of user fees both in the hospital and for transport reduces the accessibility of health facility delivery. If the fees are too high for the women and their families, the health facility is not economically accessible [47]. The majority of the women in all three settings had saved money for their delivery; this was both for before delivery and for the celebration after delivery. Other studies have also found that money is the most important factor when preparing for delivery in a health facility [33] and that the cost of services is a factor influencing their decision making to seek health facility care [38]. Also health workers reported that the fees for transport constituted a barrier for the women and their families. The Ethiopian government has reported that all ambulances now are free of charge [33], however, in this study we got different reports on this issue, suggesting that this has not been implemented everywhere in Ethiopia. The fact that women have to save a lot of money to buy equipment for their delivery, for a bed in the hospital (in the urban setting), and for emergencies like blood transfusion, may work as a disincentive to seek health facility birth care. Even though health workers held that they would not deny a woman care if she came without money or equipment, women and their families might feel embarrassed and shameful to come without anything. Furthermore, as found in the study by Øxnevad (2011), delivering in a health facility, particularly if women face complications, put families into debt for many years [38]. The unpredictability of cost is likely to be a barrier for use of delivery services also in this study area.

Acceptability and Quality

The need to improve safety

In the AAAQ framework, quality refers to the medical quality of care as well as quality of care in terms of respect, while acceptability of care refers to medical ethics and culturally appropriate care and good communication [47]. As these two requirements overlap, they will be discussed together.

According to the women in this study, quality was primarily a concern of safety: being attended by skilled health workers, not being sent home while in labour and having support from relatives and health workers in the delivery room. The women also talked about the importance of privacy, satisfactory communication and support, and respect between health workers, women and their relatives. These were the most important factors that influenced

women's experiences of giving birth in a health facility and their perceptions towards the health facility and the health workers. The primary concern for the women was to have a safe delivery, meaning that both mother and child would survive. They worried about the safety in the health facility and at the same time they expected that when delivering in a health facility, they would be safe and have a good outcome. Interestingly enough, in this study we found that the kin reported the lack of skilled care at the health facility e.g. dropping the baby on the floor, as an important reason for giving birth at home.

Safety was associated with being attended by skilled health workers, if they were not skilled it would be no point in seeking the health facility for delivery, they might as well deliver at home. On the health centre level, the lack of midwives was reported from both women and health workers. Many women thought of the midwives as the main providers of skilled care and according to health workers at one of the health centres, there should be one midwife employed in each health centre in addition to nurses and health officers. Having only one midwife is likely to put pressure on the midwives working in the health centre. The nurses also assist deliveries and have been trained to do so, but the women seemed to lack trust in other health workers than midwives and did not perceive that they had the necessary skills and knowledge.

Women perceived students in the health facilities as a problem. Many feared being taken care of by students, and if something went wrong or did not go as expected they blamed the students. From my observations in the hospital the communication was poor, procedures were not explained and women did not receive much information. The health workers often did not inform about their professional identity and women rarely knew if a nurse, doctor, midwife or student assisted them. The health workers wore no sign on their uniform stating their profession. The confusion this may have caused and the poor communication between the health workers, the students and the women, may have made the women feel insecure.

Women seemed to hesitate to ask health workers questions about the care while in labour, delivery and after giving birth. It was the health workers who had the knowledge of birth care and hence the authority in this setting, while the women had little say and were expected to adhere to the instructions of the health workers. The health workers stressed that their concern was medical safety and because of heavy workload, emotional support was not their priority.

Poor attitudes and lack of support from health workers have been reported in other studies as well [38, 63].

The need to make health facility birth predictable

Women seemed to be treated differently in the health facilities. Interestingly many women explained this behaviour as “it was just not my luck” or “the lucky ones get good care”. These comments suggest that receiving satisfactory care seems to be random. Another interesting finding was that even though women reported poor attitudes from the health workers and had a poor experience, they reported that they still would seek health facility care for subsequent pregnancies, this finding is divergent from other studies which found that women who report poor attitudes from health workers and poor experiences tend to deliver at home or in a different health facility [24]. The women’s loyalty despite receiving poor care could reflect the fact that their expectations of care in the health facility were low. They wanted to be treated with respect and to have support, but this was for many women not expected.. Women’s low expectations to health facility birth may be related to their perception of “having nothing at home”, giving them no choice in delivery place. The perception of “nothing at home” was only reported from women in the semi-urban and urban setting who had delivered in the health facility previously or who planned to deliver in a health facility in their current pregnancy. They perceived the health facility as the place for a safe delivery and even though they reported poor experiences in terms of health worker behaviour, they were happy as long as everything went well, referring to the survival of mother and child.

The need to improve privacy

Having privacy in the health facility was important for most of the women even though some women mentioned that privacy was nowadays not as important as before as “*everyone is the same*”. The issue of privacy was different in the hospital and the health centre. In the hospital, the delivery room was crowded with other women who might deliver at the same time and a crowdedness of health workers, while in the health centre there was one delivery bench where one woman would deliver assisted by one or two health workers in addition to having a relative for support, which was not allowed in the hospital. For most women it was important to be covered up while in delivery. Women who were used to deliver at home were also used to have privacy in this sense. Positioning was another important issue. Having their legs up (lithotomy position) on the delivery bench was not comfortable and was unacceptable for many women. Women commonly wanted to be able to choose the position themselves. From

the health worker's perspectives the lithotomy position was the easiest and most convenient in order to have a safe delivery, they just followed procedures. Women were also concerned about the crowdedness in the labour ward in the hospital and having unnecessary people around, like cleaners. From the observation in the hospital, these reports were confirmed. The lack of privacy in health facilities was also mentioned in Øksnevads study [38] and seem to constitute a barrier to health facility delivery in Gondar region and beyond.

Concerns about being sent home

Particularly on the health centre level, women were concerned about not being admitted to the delivery room when needed. Being sent home while close to delivery was something they feared and several women reported to have experienced this. The health workers explained that the reason for not admitting the women was lack of space, therefore they sent them home. As a result some women ended up giving birth at home, some on the way to their homes or on the way back to the health facility. Sending women home may work as a disincentive for seeking health facility care; it is likely to put stress on the women and to cause distrust in health workers and in the health system. Women in the urban setting also mentioned delays in receiving care after reaching the hospital. However, in this setting the consequences of being sent home may not be as serious as the health facility is situated close by and the women have easier access to transport than women living in the rural areas. The delay in receiving care is related to poor quality care. Women are not only sent home because of lack of space, it could also be due to poor skills of health workers to evaluate the women.

As mentioned previously, skilled health workers constitute a facilitator for seeking delivery care. An approach to improve skilled care utilization is to have maternity waiting areas for the women [64, 65]. There have been conducted studies on maternity waiting areas (MWAs), these have been carried out to evaluate the role of the waiting areas in reducing maternal complications and mortality [64, 65]. MWAs were first and foremost established to attend the women with high-risk pregnancies [64, 65], and the use of MWAs to increase facility birth for women from remote areas with normal pregnancies is less researched. To my knowledge the Ethiopian government is currently working on a strategy to establish a network of MWAs on all levels in the health referral system. The findings of this study would support such a strategy to increase skilled attendance if it is feasible and acceptable to the women and the communities concerned.

Where is the appropriate place to give birth?

In this section I will discuss the decision making and what women in rural, semi-urban and rural areas consider to be the appropriate place to give birth drawing upon the concepts of authoritative knowledge, trust and ontological security.

Decision making

For the women in the rural setting who all had delivered their babies at home, the appropriate place to give birth was their home, while in the urban setting all women found the health facility to be the appropriate place to deliver. In the semi-urban settings we got mixed opinions from the women.

The perceptions and attitudes of the women themselves and their families shaped their decision making on where to give birth. Interestingly, in this study all women reported that they were the ones making the final decision on where to give birth. Other studies have associated women's low autonomy and empowerment with low utilization of health services [21, 66]. In the current study we found that women perceived themselves to have the autonomy to seek the health facility for birth or to give birth at home. Another interesting finding was that the husbands were the ones who seemed to encourage health facility delivery and women discussed with their husbands where to deliver. Some of the women reported that it was their wish to deliver at home, and that this was the option that they preferred. As some women told us, their husbands wanted to take them to the health facility, but they decided to deliver at home. Women's perception of home birth as desirable was also found in Øksnevads study from Southern Ethiopia; the women were hesitant to seek the health facility and the husbands seemed to have the final decision making power, insisting the women should go the health facility due to difficulties at home [38]. In our study it seemed that women had more autonomy and usually made the decision on birthplace together with their husbands. The influence of the family on the women's decision about birthplace should however not be underestimated. Although most women said that the kin did not decide on birthplace, the kin clearly stated their opinions on where their women should give birth. Particularly in the rural setting, the opinions were that women should deliver at home because the family worried about the lack of skilled care during labour and delivery. We cannot be sure that these perceptions had an impact on their decision on whether or not to seek care, but these findings at least suggest that the kin's perceptions probably had an influence since many women planned or ended up delivering at home. These women reported that the reasons for choosing

home birth was that it was more comfortable at home, the health facility lacked privacy and they wanted to be like their mothers and sisters who had always delivered at home. From the literature we know that women who give birth at home (96% in rural areas in Ethiopia) are most commonly assisted by their relatives [9]. To further discuss the appropriate place to give birth, we have to look at how women perceive the people present at home birth versus the people present at health facility birth, which brings us further to the concept of authoritative knowledge, trust and ontological security.

The dynamics of authoritative knowledge

One of the important factors influencing women in the decision to seek care for delivery is their perception of authoritative knowledge when it comes to birth care [49]. Who is the authority they should place their trust in? Women who were used to deliver at home, saw the home as an appropriate setting for giving birth, and the fact that women who give birth at home are most commonly assisted by relatives, might suggest that relatives are highly trusted by these women. Many seemed to see the relatives, particularly elders, to have the knowledge that counts when giving birth [49]. This probably influenced the women's decision on where to give birth. Why and how authoritative knowledge is attributed to the mothers and relatives of the women in labour probably depends on their age, their own experience of giving birth and assisting birth and their roles and responsibilities during a delivery. From Øksnevads study in Southern Ethiopia [38], each person assisting during home birth had a specific role during the woman's labour and birth. One would sit behind the labouring woman, supporting her, others would support her knees to reduce the pain and one would check the cervical opening. They would also pray and encourage the woman verbally [38, p.26]. Although home delivery was not the focus in this study, we got a general understanding of the importance of the home as a birth setting and rural women seemed to have a high trust in their relatives and their knowledge and skills in assisting deliveries. The women in rural areas tended to place trust and authoritative knowledge in women with no formal midwifery training, but with experience of birth care in their home communities. In case of complications, the women saw the need to deliver in a health facility, and perceived the health facility and the staff as problem solvers. This indicates that the issue of authoritative knowledge and authority in the birth setting depends on the situation at hand, the appropriate place to give birth is subject to negotiations and amenable to change.

For women in the urban setting and for some women in the semi-urban setting, the health facility was perceived as the appropriate place to deliver. It is important to note that these women had also experienced health facility delivery previously or were first time pregnant, and most of them lived close to the health facilities or the big roads. They were most likely more familiar with the advantages of modern medicine and had more education than rural women. They also seemed to have a greater trust in the health workers. They referred to home birth as a non-option as they had “nothing at home”. Home birth would get them into trouble, it was not safe and TBAs were not to be trusted to have the knowledge that could guarantee a safe delivery. Also, TBAs was perceived as “bad practise”. Some of their relatives had the perception that home birth was more appropriate and tried to influence them to give birth at home, but they still chose or felt it was necessary to deliver in a health facility. From these women’s perspectives authoritative knowledge of birth was vested in the health workers.

Interestingly, some women in each of the settings reported that times were changing now, health facility delivery was more appropriate and normal nowadays and as one woman in the semi-urban setting said “*home birth is becoming an old-time story*”. This might suggest that the authoritative knowledge has shifted in the urban and semi-urban settings in contrast to the rural setting where the knowledge of birth still seems to be vested primarily in people within the local community. It was clear that for women in the urban setting and for some women in the semi-urban setting the home was an inappropriate place to deliver, because they did not have anyone who could assist them at home, and TBAs only used traditional methods if problems should arise during delivery, which was not accepted by these women. In addition, the women had no equipment for delivery at home. They felt that the health workers had the necessary knowledge to guide them through delivery and therefore they planned for health facility delivery.

The importance of trust and security

Women’s notion of trust and security is highly personal and individual and are important factors when we investigate the barriers and facilitators in relation to health facility delivery. The poor attitude, communication and lack of support from health workers that was reported in the interviews and also observed during my fieldwork, constitute a barrier to seek health facility delivery. This links directly to how women feel secure and place trust in the health facility. Women in all three settings expressed a fear of being taken care of by strangers. This fear was not reported so much in the rural and in the semi-urban areas as in the urban areas.

This could be associated with relatives being allowed to accompany the women who gave birth in the health centre, supporting the women through their experience, something described as a benefit by the women and by some of the health workers. The women in rural and semi-urban areas were more likely to know or be acquainted with the health workers, indicating that women commonly feel more secure having someone they know to assist them in delivery or relatives being present.

On the hospital level most women knew that they were not allowed to have a relative accompanying them, which many expressed was making them feel stressed in addition to receiving care from strange health workers. However, women in the urban setting seemed to be familiar with the health facility setting and the “customs” in the health facility. Even though many wanted relatives to accompany them, they seemed to understand that the rules and regulations of the hospital did not allow this and most of them did not ask. From a health worker’s perspective, relatives were not allowed because of lack of space and to protect the privacy of the other women in the delivery room. However, they said that if it were possible, the presence of relatives would probably be a benefit, making the women feel more at ease. A positive experience in the health facility would establish a *voluntary relationship* of trust between the woman and the health facility and probably constitute a facilitator for health facility delivery. In this study it seems that some women, particularly in the urban setting, had developed an *involuntary trust* towards the health facility and the health workers. This means, as Gilson (2003) describes, that when trust is placed in one person or institution due to lack of choice, the relationship of trust becomes more a *relationship of dependency* [50]. Women in this study mentioned that they had no choice but to deliver in the health facility, as they had no one to assist them at home. The situation is not the same in the rural and semi-urban areas. In these settings the majority of the women who experienced or planned home delivery were assisted by relatives or neighbours, or as a last option, TBAs. However, as illustrated in the findings chapter, the TBAs are seen as a “bad practice” by the government and TBAs are reluctant to assist home delivery due to the disapproval of the government. This limits women’s choice of delivery place also in these areas and place them in an involuntary trust-relationship. However, as Gilson says, if the institutions manage to protect and care for the dependent partner, the involuntary trust might develop into a *voluntary relationship of trust*, maybe resulting in an increase of demand for health facility delivery [50]. If women are supported, treated with respect and feel secure in the health facilities they are likely to develop a trust in the health workers and have a good experience which will encourage them

to deliver in a health facility in a subsequent pregnancy, and also recommend other women to choose the health facility for delivery.

Discussion of the methodology

In the following section, I will discuss and reflect on my role as the main researcher of the study and reflect upon the methods of data collection and analysis.

Reflexivity

Reflexivity refers to the researcher's sensitivity to the research process and his/her influence on the collected data. The researcher's prior assumptions and experience can influence an investigation regardless of the precautions the researcher has made to avoid this [52, 60].

Presentation of the main researcher

I have a bachelor's degree in nursing and have been working as a nurse since 2009 until today. During my nursing studies, I had a 3-month practical placement in a hospital in Tanzania, an experience that further encouraged my interest for the study of international health, especially within the field of maternal and child health in low-income countries. The experience from the hospital in Tanzania had provided me with a certain insight and understanding of how it would be to work and live in a low-income setting for a period of time, as well as a glimpse of what I might find in Ethiopia.

Background as a nurse

During the interviews I presented myself to the participants as a nurse and a student. My professional background as a nurse might have affected the women associating me with the health care facilities and giving answers they thought were appropriate. We tried to meet this challenge by emphasising that we were not in any way connected to the health facilities. Nevertheless we suspect that the data may have been subject to social desirability bias. When interviewing the health workers, being a nurse might have been an advantage in the way that we shared the same profession, although in different settings. It might have made it easier for them to open up to me and at the same time it was easier for me to understand their stories. Being a nurse from a high-income setting might also affect the health workers in a negative way. Gondar University Hospital is a teaching hospital, and people from abroad, including researchers, teachers and medical teaching staff come to train Ethiopian students and health workers. Health workers may have associated me with these groups/professions and social desirability might therefore have affected their answers as well. For instance, when asking if

they could tell us what procedures and care was given to a pregnant woman from being admitted to being discharged, they might give us the “textbook” answer. We could not be sure if this was the case in our study, but we tried to limit this by spending time to establish rapport, and emphasizing anonymity and confidentiality of the information we received. As the health workers seemed comfortable to talk, I think that my background as a nurse was more an advantage than a limitation.

Cultural background and language

I believe that coming from a different cultural and social context may have created a distance between the informants and me. To decrease this distance I tried to be culturally sensitive, respecting the informants by being polite and by learning useful phrases in Amharic such as greetings that I used when conducting the interviews. In addition, I greeted and had small talks with other people who were with the women before the actual interviews were conducted. Coming from a different country, having a different cultural background, might also have been an advantage in the way that the participants might have perceived me as neutral, consequently making it easier for them to open up and talk freely about their experiences of birth.

Before and during the data collection, I involved myself in the social life in Gondar town by making local friends and having good contact with my research assistants, which in turn eased the process of getting to know the culture and traditions in the study setting. In general, I felt that my different background and culture was not a big barrier, but definitely a challenge since I was a stranger to the context and culture. However the participants seemed to be comfortable and open in the interviews. Being a woman possibly strengthened the study as the women we interviewed might have felt more comfortable talking to another woman about pregnancy and childbirth.

The language was a huge barrier throughout the research study. As I do not speak Amharic, I could not understand what was conveyed to the patients. The interaction between the health workers and the women could partly be evaluated in terms of body language, but not in what was said directly to the patients. However, during the period of observation I asked health workers to translate when perceived as relevant from an observed situation.

During the in-depth interviews I was not able to control what the research assistants asked the participants or how they followed up with probing. Changing the interview strategy by me

leading the interviews limited the effect of the language barrier. Nevertheless, I could not be sure of what the research assistants told or asked the participants, nor how they interpreted the meanings of what the participants told us before translating to me. The language was also a barrier in the way that it did not give me any possibility to check the transcriptions and translations from Amharic to English and information in the translations may have been lost. However, this problem was limited as “controlled” the interviews by selecting a few interviews from each assistant and probed for ambiguous interpretations by being transcribed and translated by the first research assistant then given to the second research assistant who transcribed and translated the same interview. The same procedure was followed throughout the research. There were no major differences in the transcription and translations.

Research assistance

I chose to use female research assistants because I felt, particularly in the in-depth interviews with the women, that they would open up more and talk more freely about their experiences of childbirth. Ideally, I would have used only one research assistant for this study, especially during the data collection. Conducting interviews is a learning process and one usually improves during the course of the research and the interaction between the researcher and the research assistant also improves. Having to find a new research assistant meant that I had to start this process all over again and it might have affected the interview situation including the responses we got from the participants. However, I was not able to change this, as the first research assistant could no longer work for me in the Gondar district due to other work commitments. It was a benefit that my second assistant had experience in conducting focus-group discussions and transcribing and translating interviews from Amharic to English. This made the process easier for me although I had to go through the same training in qualitative research tools with her. On the other hand, using different research assistants could add new elements to the research.

I and the research assistants were strangers to the informants, which could affect the participant’s openness in the interviews both in the way that they might feel more comfortable talking with strangers being neutral but it also might have been a limitation since the assistants were Ethiopians and the participants might think that the information would not be kept confidential. Starting the interviews with small talk and trying to make the participants feeling comfortable, hopefully limited the distance between the participants and us. The research assistants spoke Amharic as the mother tongue, although when visiting some women,

especially in the rural setting some local expressions were difficult for the assistants to understand. However, I don't think this affected the interviews much as the women were happy to explain what they meant by the expressions and terms they used when being interviewed.

Triangulation

By using triangulation the researchers compare results from either two or more methods of data collection in order to increase the validity of the findings. However, we cannot say that using triangulation is a genuine test of validity, as it assumes that weaknesses in one method will be compensated by strengths in another, triangulation is rather a way of ensuring comprehensiveness and producing a more reflexive analysis of the data [60]. In this study, two methods of data collection were used; in-depth interviews and non-participant observation. Interviewing women and health workers from urban, semi-urban and rural settings has given me different perspectives and a broader picture of the research topic. Interviewing both women who lived close by and far away from health facilities gave us a perspective of the importance of structural barriers that influenced the choice of delivery place and how these barriers interacted with cultural preferences.

By including health workers from both health centre and hospital level, we were able to identify specific challenges on different levels in the referral system that were relevant to increase the demand for birth services. During the course of the research it became clear that including TBAs and HEWs would have added even more variety to the data, but since we did not have ethical clearance for this I was not able to recruit additional informant groups after the research was cleared. This limited my possibilities to fully utilize the flexibility of a qualitative research design.

Clear expositions of methods of data collection and analysis

In order to enable the reader to decide whether or not the data supports the interpretation sufficiently, it is important to give a precise description of the process of data collection and analysis [60]. The methods used in this study have been described in the methods chapter, further in this section I reflect on the interview setting, non-participant observation, research fatigue in the study area and the data analysis.

The interview settings

The in-depth interviews with the women in this study were mainly conducted in the participants' homes. The homes of the women provided a safe environment and the women could talk freely. Curious neighbours and mostly children were following us around in the village and saw where we were visiting. This could have affected the women when being interviewed in the way that they might want to finish early or did not want other people to see that they were interviewed. We tried to become familiar with the study settings and talked to the neighbours and children. In the Dabat district we had the designated person at Dabat research centre showing us around in the villages and where the women lived. This was a benefit since he was well known and respected in the community. When visiting the women, we asked neighbours and children politely if we could have some privacy, this seemed to be well accepted and respected. The families living with the women seemed to understand that privacy was needed. The ANC as an arena for some of the interviews on the other hand may have compromised women's free and open talk since many questions were about quality of care in the health facility and they might feel obligated to give us positive feedback on these issues. We tried to limit this effect by having the interviews in private rooms and by emphasising our role of researchers not in any way connected to the ANC or the hospital. Still, we cannot be sure that the women felt confident and "safe" during the interviews conducted in the health facility. For the health workers, all interviews were held in the different health facilities, and this seemed to be unproblematic for them. We were aware that the participants might fear other health workers like for example the head nurse hearing their answers or that the information we received from them was not held confidential. This was limited by having the interviews in private rooms. In the health centres this was not a problem because there were less people at work and we did not get interrupted. In the hospital it was more crowded and some of the interviews were interrupted. When we asked for privacy, this was respected and the interviews continued.

Non-participant observation

The observation was conducted in the labour ward in the hospital. According to Malterud (2011), the description of an event or a situation can be different depending on the observer. Having an "outsider" perspective can be a privilege, because it gives an overview of the interaction between people and a holistic picture [52]. It is however a possibility that the researcher in this situation may misinterpret or misunderstand what is going on or that the meaning of what is going on can be misunderstood [52]. The observation in this study was

used as an approach to understand and being able to contextualise what the participant told us in the interviews about health facility delivery.

The observation lasted seven days and I observed five deliveries during this time. I acknowledge that this was a short period of observation but it broadened my perspective on health facility delivery and I obtained an understanding of what women and health workers were talking about in the interviews. Also, observing health workers' interaction and communication with the patients as well as the working conditions in the health facilities gave me a broader picture of the situation. Another barrier in the delivery ward was the overcrowded rooms with health workers and particularly an overrepresentation of students from different backgrounds sometimes making it difficult for me to observe what was going on.

Research fatigue

Researchers connected to Dabat Reseach Centre have been conducting research in Dabat district since 1996. We do not know if and how many of our informants in Dabat district had participated in research before, but it is possible that women and health workers in this area were "research fatigued". This may have affected our results; they may have given short answers, wanting to finish quickly and answer according to what they thought we wanted to hear. We were aware of this possibility before entering the field, but we did not experience research fatigue as a problem for our informants. Overall, women seemed happy to share their birth experiences and perceptions with us. One should perhaps not exclude the possibility that their previous exposure to research may have made them more relaxed and open to answer private questions. We focused on making the participants feel comfortable and emphasised that they could interrupt or stop the interviews at any time, and if they were tired we could come back at another time. None of the participants showed any sign of discomfort and none wished to withdraw.

Data analysis

I used thematic content analysis as the method for analysing the data. For a student who has never worked with qualitative methods or doing research, this was an appropriate approach with a clear and straightforward description of the analysis. I also found this approach to fit my study objectives since the aim was to present the participants own perceptions and experiences of health facility delivery and their perspectives on how the demand for birth services could be increased.

Transferability and relevance

The relevance of research can be evaluated on the basis of its contribution to the research field. The research can either add to knowledge or increase the credibility of existing knowledge. The objective for qualitative research is not to generalize the data obtained [52], rather discover how the findings of the research can be transferred and applied in a different setting than where they were generated. This can be done through providing detailed research reports and information of data collection methods and analysis to the reader [60].

The relevance of this study builds on the global imperative of reducing MMR, an objective within the MDGs and one of Ethiopia's strategies for improving maternal health. The research topic of this study is not new. Many studies in both high and low-income countries, including Ethiopia and other sub-Saharan African countries, have been conducted. As mentioned in the background section in this thesis, the factors associated with use of delivery services are well known. We also know that despite the effort Ethiopia has made to improve access to health services, the result is not satisfactory. Our aim was to discover the perspectives from women and health workers from different settings and use their stories to understand how the demand for birth services can be increased. We know that the use of services is low in other sub-Saharan countries as well, and in areas where the MMR is high, similar barriers to receive skilled care have been found. Therefore this research can contribute to other research that has been conducted in the same area of interest, emphasising a higher focus on women's and health workers perspectives from different settings.

Chapter 6 Conclusion and recommendation

Conclusion

Availability and accessibility are larger barriers in rural and some semi-urban areas than in urban areas. Acceptability and quality of care within the health facility is obviously very important in all settings and constitute crucial factors to increase demand for health facility birth and to improve women's experience of health facility birth. Authoritative knowledge, ontological security and trust address the social and cultural context of birth. These concepts in addition to the AAAQ framework are important when it comes to identifying measures that can increase the demand for health facility birth. The AAAQ framework is very useful from a health system perspective, but social and cultural context is also important to complement the

framework, particularly in an area where home birth still prevails as the most common practice on a country basis.

Recommendations

Based on the current study I make the following recommendations to increase the demand for health facility delivery:

- Improve accessibility of health facility delivery by distributing phone numbers for the ambulance
- Improve the communication skills, attitudes and emotional care provided by the health workers through more staff, particularly on the health centre level, and better training of the students in the hospitals.
- Ensure privacy in the health facilities, particularly in the hospital, by letting one or two health workers attend each woman. Ensure privacy by covering the women up so they are not exposed unnecessarily and set up curtains between each delivery bench.
- Install new delivery benches reducing the risk of dropping the baby on the floor and allow the women to choose birthing position unless medically indicated.

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Appendixes

Appendix 1: Ethical recommendation NSD

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Harald Hårfagres gate 29
N-5007 Bergen
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Tel: +47-55 58 21 17
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Karen Marie Moland
Senter for internasjonal helse
Universitetet i Bergen
Postboks 7804
5020 BERGEN

Date: August 13th 2012

Ref: 30804 HIT/RF

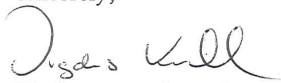
Your date:


Your ref:

CONFIRMATION

The Data Protection Official for Research at the Norwegian Social Science Data Services (NSD) finds that the processing of personal data in relation to the project "Experiences of Giving Birth in a Public Health Facility and Factors Contributing to an Increased Demand for Birth Services in North Gondar zone, Ethiopia" is in accordance with the Norwegian Personal Data Act, ref. our letter to Karen Marie Moland and Jeanette Angelshaug dated June 13th 2012.

Sincerely,


Vigdis Namtvedt Kvalheim


Hildur Thorarensen

✓ Copy: Jeanette Angelshaug, Erleveien 44 A, 5097 BERGEN

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrr.svarva@svt.ntnu.no

TROMSØ: NSD, HSL, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. martin-arne.andersen@uit.no

Appendix 2: Ethical recommendation Ethiopia

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ጎንደር፣ ኢትዮጵያ



University of Gondar
General Director, Research &
Community Service Core Process
Gondar, Ethiopia

ቁጥር: የም/ህ/አገ/05/ _____ /2004
ቀን _____ / _____ /2004
Ref/No. RCS /05/ _____ 2012
Date _____ / _____ /2012

To: Jeanette Angelshavg
University of Gondar

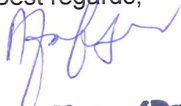
Subject: Ethical Clearance

Your research project proposal titled “**Experiences of giving birth in a public health facility and factors contributing to an increased demand for birth services in North Gondar Zone**” has been reviewed by the Institutional Ethical Review Board of University of Gondar for its ethical soundness, and it is found to be ethically acceptable.

Thus, the Research and Community Service Core Process Office has awarded this ethical clearance for the above stated study to be carried out by **Jeanette Angelshavg** and co-investigators as of, September 20, 2012 for one year.

The investigators are expected to submit research progress report to the Research and Community Service Core Process Office of the University of Gondar.

Best regards,


Afework Kassu (Dr.)
General Director for Research
& Community Service



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P.O. Box 196
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Gondar, Ethiopia

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Cable A.A.U. PH. Telephone PBX
Fax - 251-058-114 1240 President office
058 114 1233 V/P/for A/ & Research
058 114 123 Research & Community Service Core Process
URL Address:- WWW.ugondar.edu.et

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058111 01 74
058 114 1231
058 114 1236
058 231 1130

Appendix 3: Consent forms

English version

**Request for participation in the following research project:
Experiences of giving birth in a public health facility and factors
contributing to increased demand for birth services in North Gondar zone,
Ethiopia**

The following information to be read aloud to the potential participant:

Background and purpose of the study

This is a request for you to participate in a research study that intends to explore how women experience giving birth in a health facility and what factors contribute to more women choosing facilities for delivery. We would like to gain more information about what is needed from the health care institutions in order to increase health facility births. This study is linked to a larger study that aims to investigate prevalence and risk factors (particularly related to child birth) for urinary incontinence, fecal incontinence and pelvic organ prolapse. The University of Gondar, Ethiopia and the University of Bergen, Norway are responsible for this research project.

What does the study entail?

In the study we wish to conduct in-depth interviews and case studies with the aim to explore different aspects of giving birth in a health facility and what factors are important to increase health facility births. We would like to get both pregnant women's and health personnel's perspectives regarding this issue. The interviews will be conducted in your local language by my collaborator who will function as a translator, and myself.

Potential advantages and disadvantages

Your participation in the research project will be valuable as it contributes to informing health care planners in Ethiopia about the needs of Ethiopian women when it comes to giving birth in a health facility. This will make it possible to improve the health care and services of women who would like to give birth in a health facility in Ethiopia.

Potential disadvantages of your participation in the study include the time you will spend on the interview.

What will happen to the information about you?

The data from the interview will be tape recorded upon your consent, and notes will be taken during the interview. The registered information will only be used in accordance with the

purpose of the study. All the data will be processed without using your name, your ID number or other directly recognizable type of information. All data will be stored in a secure way, and only authorized project personnel will have access to the data. Data will be deleted by the end of year 2014 (Ethiopian calendar). It will not be possible to identify you in the published results of the study.

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time without stating any particular reason. Withdrawal from the study will not have any consequences whatsoever. If you later on wish to withdraw your consent or have questions concerning the study, you may contact Principal investigator of the study Jeanette Angelshaug, phone number: _____

E-mail: Jeanette.angelshaug@student.uib.no

or Professor Yigzaw Kebede at the University of Gondar, College of Medicine and Health Sciences, Mobile number: 0913997933

E-mail address: gkyigzaw@yahoo.com

Consent for participation in the study

I am willing to participate in the study.

Signature of participant

Or thumbprint of participant:

Amharic version

መግለጫ 6: የሚጃ ደብዳቤና የስምምነት ቅጽ

በሚከተለው የጥናት ፕሮጀክት ላይ እንዲሳተፍ የቀረበ ጥያቄ "በሰሜን ጎንደር የመንግስት የጠፍ ተቋማት ወስጥ የሚከተለው የወሊድ ግልጋሎት ልምድ እና በወሊድ አገልግሎት ፍላጎት መጨመር የሚደረግ ጥናት"

መሳሻና ዓላማዉ

ይህ ጥናት እናቶች በጠፍ ተቋም ወስጥ ስለወሊድ ያላቸውን ተሞክሮና ምን ዓይነት ሁኔታዎች በፈጠሩ ብዙ እናቶች በጠፍ ተቋም እንዲወልዱ እንደሚያስችሉ የማይሰስ ነው። በጠፍ ተቋማት የሚወልዱ እናቶች ለመጨመር ብዙ መረጃዎችን ማግኘት ያስፈልጋል። ይህ ጥናት "ሽንትና ዐይነ ምድር ለመቆጣጠር አለመቻል የሚኖረው አካላዊ፣ ማህበራዊ እና መቅረብ አንድምታ በገጠራ እትዮጵያ በሚኖሩ ሴቶች መካከል" ከተሰኘ ከሌላ ጥናት ጋር የተያያዘ ነው። ጎንደር ዩኒቨርሲቲ ከኢትዮጵያ እና በርገን ዩኒቨርሲቲ ከኖርዌይ የጥናት ፕሮጀክቱን ባንድነት ያካሂዳሉ።

ጥናቱ በምን ላይ ያተኩራል?

በጥናቱ በጠፍ ተቋማት ወስጥ መወለድንና ከዚያ በተያያዘ ማልኩ በምን ዓይነት ሁኔታ ~~ቆዩ~~^{ላቸው} እናቶች በጠፍ ተቋማት እንዲወልዱ ማድረግ እንደሚቻል ከእናቶችና ከጠፍ ባለሙያዎች ጠለቅ ያሉ ቃለ ምልልሶች ይካሄዳሉ። ቃለ ምልልሶቹ በተርጓሚነት በሚያስተባብሩልኝ ረዳት አጋኝነት በአካባቢው ቋንቋ ይካሄዳል።

ሊኖሩ የሚችሉ ጥቅሞችና ጉዳዮች

በጥናት ፕሮጀክቱ በሚኖርዎ ተሳትፎ ኢትዮጵያ ወስጥ ያሉ የጠፍ እንክብካቤ ዕቅድ አወጣጫዎች በጠፍ ተቋም ስለመወለድ መረጃ እንዲኖራቸው ይረዳል። ይህ ደግሞ ከወሊድ ጋር በተያያዘ እናቶች የተሻለ አገልግሎት እንዲያገኙ ይረዳል። በጥናቱ ላይ ቢሳተፉ ምን ዓይነት ስራ ላይ ቢወሉ ገቢ ሊያገኙበት የሚችሉበትን ጊዜዎትን ሊሻምታት ይችላል።

ራስዎ በሚከተሉት መረጃ ላይ ምን ይከሰታል

በቃለ ምልልሱ የሚሰጡት መረጃ በራስዎ ስምምነት በመቀረጸ-ድምጽ ይቀረጻል። እንዲሁም በሚከተለው የተመዘገበው መረጃ ለጥናቱ ዓላማ ብቻ እንዲወልድ ይደረጋል። ሁሉም የመረጃ አሰባሰብ ሂደት ስምምነት የሚታወቁ ደብተርዎን ወይም ሌሎች በቀጥታ የሚታወቁባቸውን የመረጃ ዓይነቶች ሳይጠቅስ ይካሄዳል። ሁሉም መረጃዎች ደህንነታቸው ተጠብቆ ይቆያሉ። አጥኚው ብቻ መረጃ ማግኘት ይችላል። በ 2014 ዓ.ም መረጃው ይሰረዛል ። ታትም በሚጠቀሙ የጥናቱ ወጠታ ላይ እርስዎ ጥናቱ ወስጥ መሳተፍዎን ማወቅ አይቻልም።

የበጎ ፈቃድ ተሳትፎ

በጥናቱ መሳተፍ በጎ ፈቃደኝነትን ይጠይቃል። በጥናቱ የመሳተፍ ፈቃደኝነትዎን ያለምንም ቅድመ ሁኔታ ማቆረጥ ይችላሉ። ከጥናቱ መወጣት ወደፊት በማይገኙት ህክምና ላይ የማይስከትልብዎ ችግር አይኖርም። ጥናቱን በተመለከተ ቆይተው ፈቃደኝነትዎን ለመሰረዝ ወይም የማይነሱቸው ጥያቄዎች ቢኖሩ ጥናቱን የምታካሂደውን ጃኒት እንገልጽሁ። በ-----
--ስልክ ቁጥር (የኢሜል አድራሻ Jeanette.angelshaug@student.uib.no)
ወይም ፕሮፌሰር ይግዛዉ ከበደን ከጎንደር ዩኒቨርሲቲ የህክምና ጤና ሳይንስ ኮሌጅ በተንቀሳቃሽ ስልክ 0913997933 ((የኢሜል አድራሻ gkyigzaw@yahoo.com) ማግኘት ይችላሉ

በጥናቱ ለመሳተፍ የሚደረግ ስምምነት

በጥናቱ ለመሳተፍ ፍቃደኛ ነኝ

(የጥናቱ ተሳታፊ የራሷን/የራሱን የቃል ስምምነት ትሰጣለች/ይሰጣል የጥናቱ አስተባባሪ ስምምነቱን ይመዘግባል)

ስለ ጥናቱ መረጃ መሰጠቴን አረጋግጫለሁ

(ፊርማ በጥናቱ የነበረው ማፍ ቀን)

Appendix 4: Interview guides

a. Interview guide for women who have given birth in a public health facility

Start by reading the informed consent form and explain to the participant the purpose of this interview

Purpose of interview

The purpose of this interview is to explore what factors contribute to women's choice of birthplace and women's experiences of giving birth in a public health facility. We hope your answers can tell us what factors contribute to an increased demand for birth services and also about your personal experiences with giving birth in a public health facility. This interview is a part of a research project entitled " *Experiences of giving birth in a public health facility and factors contributing to an increased demand for birth services in North Gondar zone*".

In this interview we will talk about what made you decide to give birth in a public health facility, what you think about giving birth in a public health facility, if you had any problems in accessing the health care facility when you gave birth last time, how your experiences was in the health care facility and what you think can improve in the birth care of delivering women. The information you give us will be very important in our research and we appreciate your participation.

If you permit this interview will be tape-recorded. We ensure you that all identifying information will be destroyed as soon as all data has been collected. The information we receive from you will be kept confidential and the health personnel in the antenatal clinic will not see your responses. This interview will approximately take 1, 5 hours.

Serial number of interview:

Date:

I- Background information:

Location of interview: _____

Participant's address: _____

Age: _____

Education: _____ (grade completed)

Husband's education: _____ (grade completed)

Occupation: _____

Husbands occupation: _____

Marital status: _____

If married, age at first marriage: _____

Living with: _____

Number of children: _____

Age of children: _____

Age at first delivery: _____

Number of ANC-visits in last pregnancy: _____

Number of ANC-visits this pregnancy _____

Place of last delivery: _____

II- Decision making on where to give birth

First we would like to talk about what made you decide to give birth in a health facility and what your thoughts are around giving birth in a health facility.

1. Influences on choice of birth place

- Can you please tell me why you gave birth in a health facility the last time you delivered?
- Did you plan on beforehand to give birth in the health facility?
- What preparations did you make before delivery?

Potential probes:

- Save money

Identify transport

- Identify blood donor
- Find someone who could assist you to the health facility

- Who is the main decision maker in your family when it comes to seeking health care?

Potential probes:

- Joint decision making
- You
- Husband
- Mother in law/paternal kin
- Mother/maternal kin

- Did your partner have an opinion about delivery place?
- How did he affect the choice of place for delivery?
- Did other people influence your choice of delivery place?
- Who influenced you?

Potential probes:

- Mother
 - Mother in law
 - Sisters/brothers
 - Neighbours
 - Nurse/midwife in the ANC
 - School
 - Radio/TV/news-papers/adverts
- Can you please tell me in what way they influenced you?

2. Norms and expectations

- Can you please tell me what is considered normal in your community? To give birth at home or in a facility?
- Where did your sister give birth?
- Where did your friends give birth?
- Which places do you think are appropriate for giving birth? Why?
- Where did your kin and friends expect you to give birth?

3. Risk and safety

We would like to ask you about what you think if giving birth in health care facility.

- Do you think it is necessary to give birth in a health facility? Why/why not?
- When do you think it is ok to give birth at home, and when is it not ok?
- Do you think it is safe to give birth in a health facility?
- Do you think it is safe to give birth at home?
- Do you know anybody who had complications during birth? If so, do you know what kind of complications they experienced?

Potential probes:

- Bleeding
- Infections
- High blood-pressure
- Obstructed labour

When did this complication occur?

- What was done when the complication occurred?
- Why do you think this complication occurred?

- Do you think anything could have been done to prevent this complication? What could have been done?
- Do you think anyone can be responsible for the complication?

Potential probes:

- Health personnel
- Family/relatives/friends
- Do you think it is possible to give birth without any complications?
- Are there situations in which facility birth is important and life saving? What are these situations? Can you give me an example?

III- Barriers to give birth in a health facility

Now we would like to talk about if you may have faced problems getting to the health care facility and other problems that might be barriers to giving birth in a health care facility.

1. Access to care

Can you please tell us if you had any difficulties in accessing the health care facility to give birth?

Seeking permission

- Did you have to seek permission to go to the health centre to give birth?
- If yes, whom did you ask for permission?

Potential probes:

- Husband
- Mother
- Mother in law
- Sisters/brothers

Distance and transport

- Was distance a problem for you to access the health care facility? How?
- Did you have problems with finding transport? What problems?

Potential probes:

- Money for transport
- Finding a driver
- Finding a car
- Finding other transport

Company and support

- Is it normal to go alone to the health care facility when giving birth?

- Was it difficult to find someone who could accompany you to the health care facility?
- Who accompanied you to get to the health facility?

Potential probes:

- Husband
- Mother
- Mother in law
- Sisters/brothers
- Neighbours
- Traditional Birth Attendant
- How did they help you?

Charges/fees

- Is health facility birth free of charge? If not, how much did you have to pay?
- Did you have any problems to get the money to go to the health care facility? Did you save money to be able to go there?
- Was there anything in particular you had to bring with you to the health care facility?

Potential probes:

- Money
- Delivery kit
- Gloves
- Sheets
- Clothes for wrapping the child
- Food and drinks

Concerns about the health care in the facility

- Did you have any concerns about the health care provided in the health facility? What concerns did you have?

Potential probes:

- Were you concerned that the health care provider was not female?
- Were you concerned that there might not be a skilled health care provider to take care of you? (Skilled means doctor, midwife or nurse)
- Were you concerned that there might not be any drugs for pain relief?

- Were you concerned that no one would take care of your family at home when you were away to give birth in the health facility?

IV- Experiences of giving birth in a health care facility

Now we would like to talk about what you think is important in the care of delivering women and how your personal experience was when you last time gave birth in a health care facility

1. Perceptions on quality health care

- How do you perceive good care during labour and delivery? What is important for you during delivery?

Potential probes:

- A friendly welcome when you arrive?
- Having a relative/friend with you during labour?
- Having a friend/relative with you during delivery?
- Having a friend/relative with you after the baby has been delivered?
- Not having pain and receiving adequate pain relief?
- Being treated with respect? Can you please explain what respect in this context means to you?
- Privacy during examination and delivery
 - No one else in the room other than the health care personnel caring for you
 - Being covered by sheets, not exposing your body other than necessary
- Receiving information about the progress of labour
- Receiving advice from health professionals

2. Experiences of birth care

- Can you tell us how you experienced giving birth a facility the last time you gave birth?
- How did you experience the care that you received?

Potential probes:

- How was it a good experience?
- How was it a bad experience?

3. Experiences of health care procedures

- Did you get any pain relieve during labour and delivery?
- Do you remember what kind of pain relief you received?

- Can you remember if you received information from health care workers during your labour and delivery? What information did you receive?
- Did they give you any advice right after you delivered your baby? What advice did they give you?
- Do you remember what procedures the health care workers performed?

Potential probes:

- Listening for your baby's heartbeats?
- Measure your blood pressure?
- Measure your temperature?
- Encourage you to empty your bladder often?
- What other procedures did they do?
- Were you allowed to hold your baby just after he/she was born?
- Did they encourage you to breastfeed your baby soon after he/she was born?
- Did they show you and give you advice on how to breastfeed your baby?
- Did you feel that you were given privacy during examination and delivery? How did they maintain your privacy?
- Did they give you something to drink? Did you get food?
- Did they examine you after the baby was delivered?
- Did they examine the baby after he/she was born?

4. Support during labour and delivery

- Would you have liked to have someone else than health personnel with you during labour and delivery? Who?
 - Husband
 - Family
 - Relatives
 - Friends
- If yes, why was this important for you?
- Did you have someone with you during the delivery? Were they with you at all times? If not, when did they have to leave you?
- Were there health professionals with you during the entire delivery?
- Did you miss someone during your delivery? Who did you miss?

- Was this birth any different from earlier births you have had in a facility? How was it different?
- Was there anything you missed in the provision of care during your facility delivery? What did you miss?
- Have any of your family/friends given birth in a health facility? How do they talk about this experience?

V- Improvements in health care and preferences for this birth

We would like to talk about how the health care of delivering women can be better and how we can get more women to give birth in the health care facility.

1. Improvements

- What are the major problems in the provision of birth care services that you think need to be improved?

Possible probes:

- Friendly support and respect during labour and delivery?
- Adequate equipment to assist during delivery?
- Charges?
- Not necessary to bring own equipment such as for example gloves?
- Lack of staff?
- Not receiving pain relief/not receiving enough pain relief?
- Not receiving privacy during examination and delivery?
- Not allowed to have relatives/friends to accompany you in the facility?
- Not allowed to have relatives/friends to accompany you at all times of labour and delivery

2. Preferences in this pregnancy

Now we would like to talk to you about where you would like to give birth in the current pregnancy and the reasons for your choice.

- Would you like to give birth in a facility in this pregnancy?
 - If yes, can you please explain why?

Potential probes:

- Because it is safe to give birth in a health facility

- Because I had a good experience last time I gave birth in a health facility
- Because pain relief/drugs are administered
- Because they have necessary equipment to assist before, during and after delivery
- Because they give good care in the health facility
- Because there are no one to take care of me at home
- If no, can you please explain why not?

Potential probes:

- Because it is safe to give birth at home
- Because I had a bad experience last time I gave birth in the health facility
- Because the quality of care is poor in the health care facility
- Because it is costly to give birth in a health facility
- Because I would like to have my family close
- Because I cannot leave my children/family
- Because it is customary to give birth at home
- Because my family wants me to give birth at home
- Because it is difficult for me to reach the health facility
- Where would you like your sister or daughter to give birth? Can you please tell me why?

3. Increasing demand

- How do you think we could increase the number of women giving birth in health facilities?

Possible probes:

- Free services
- Not needing to bring own equipment
- Ensure skilled providers
- Ensure female health care providers
- Ensure pain relief
- Ensure good quality health care/friendliness/respect/privacy

b. Interview guide for pregnant women who have never given birth in a health facility

Start by reading the informed consent form and explain to the participant the purpose of this interview

Purpose of interview

The purpose of this interview is to explore what factors contribute to women’s choice of birthplace. We hope your answers can tell us what factors contribute to an increased demand for birth services and your reasons for giving birth in a public health facility or at home. This interview is a part of a research project entitled” *Experiences of giving birth in a public health facility and factors contributing to an increased demand for birth services in North Gondar zone*”.

In this interview we will talk about what made you decide to give birth in a public health facility or at home, what you think about giving birth in a public health facility, if you have any problems in accessing the health care facility, what you expect in terms of services provided in the health care facility, and what you think can improve in the birth care of delivering women. The information you give us will be very important in our research and we appreciate your participation.

If you permit, this interview will be tape-recorded. We ensure you that all identifying information will be removed from this interview and destroyed as soon as all data has been collected. The information we receive from you will be kept confidential and the health personnel in the antenatal clinic will not see your responses. This interview will approximately take 1, 5 hours.

Serial number of interview:

Date:

I- Background information:

Location of interview: _____

Participant’s address: _____

Age: _____

Education: _____ (grade completed)

Husband’s education: _____ (grade completed)

Occupation: _____

Husbands occupation: _____

Marital status: _____

If married, age at first marriage: _____

Living with: _____

Number of children: _____

Age of children: _____

Age at first delivery: _____

Number of ANC-visits so far in this pregnancy: _____

Place of last delivery: _____

II- Decision making on where to give birth

First we would like to talk about where you plan to give birth, the reasons for your choice and your thoughts around giving birth in a health facility or at home.

1. Influences on choice of birth place

- Can you please tell me where you plan to give birth and your reasons for your choice?
- Who is the main decision maker in your family when it comes to health care?

Potential probes:

- Joint decision making
- You
- Husband
- Mother in law/paternal kin
- Mother/maternal kin
- Is it entirely your decision where to give birth?
- Does your partner have an opinion about delivery place?
- How does he affect the choice of place for delivery?
- Have other people influenced your choice of delivery place?
- Who influences/influenced you?

Potential probes

- Mother
- Mother in law
- Sisters/brothers
- Neighbours
- Nurse/midwife in the ANC
- School

- Radio/TV/news-papers/adverts

- Can you please tell me in what way they have influenced you?

2. Norms and expectations

- Can you please tell me what is considered normal in your community? To give birth at home or in a facility?
- Where did your sister give birth?
- Where did your friends give birth?
- Which places do you think are appropriate for giving birth? Why?
- Where did your kin and friends expect you to give birth?

3. Risk and safety

- Do you think it is necessary to give birth in a health facility? Why/why not?
- When do you think it is ok to give birth at home, and when is it not ok?
- Do you think it is safe to give birth in a health facility?
- Do you think it is safe to give birth at home?
- Have you made any preparations before you will give birth?
- What preparations have you made?

Potential probes:

- Saved money
- Identified mode of transport
- Identified blood donor
- Found someone who can assist you to the health facility
- Do you know anybody who has had complications during birth? If so, do you know what kind of complications they experienced?

Potential probes:

- Bleeding
- Infections
- High blood-pressure
- Obstructed labour
- When did this complication occur?
- What was done when the complication occurred?
- Why do you think this complication occurred?

- Do you think anything could have been done to prevent this complication? What could have been done?
- Do you think anyone can be responsible for the complication?
 - Family
 - Health personnel
 - Other reasons
- Do you think it is possible to give birth without any complications?
- Are there situations in which facility birth is important and life saving? What are these situations? Can you give me an example?

III-Expectations to health facility birth

We would like to talk about your expectations of the health care facility when it comes to care and services.

Can you please tell us what you expect in terms of services and care provided in a delivery ward?

1. Quality of care

- How do you expect to be received at the health care facility when you will deliver your baby?

Potential probes:

- Friendliness from health care personnel
- Being treated with respect

- How do you expect to be treated during labour and delivery? What is important for you?

Potential probes:

- Privacy during examination and delivery?
- No one else in the labour room other than the health care personnel caring for you
- Being covered by sheets, not exposing your body unnecessary
- Pain relief during labour and delivery?
- Health care personnel attending you at all times?
- Permission to bring family/friends/relatives in the labour room?
- Permission to have family/friends/relatives in the labour room at all times?

IV- Barriers to give birth in a health facility

Now we would like to talk about if you might have any problems reaching the health care facility and other problems that might be barriers to giving birth in a health care facility.

1. Access to care

- Can you please tell us if you have any difficulties in accessing the health care facility to give birth?

Seeking permission

- Do you have to seek permission to go to the health care facility to give birth?
- If yes, whom did you ask for permission?

Potential probes:

- Husband
- Mother
- Mother in law
- Sisters/brothers

Distance and transport

- Is distance a problem for you to access the health care facility? How?
- Do you have problems with finding transport? What problems?

Potential probes:

- Money for transport
- Finding a driver
- Finding a car
- Finding other transport

Company

- Is it normal and acceptable to go alone to the health care facility when giving birth?
- Is it difficult to find someone who can accompany you to the health care facility?
- Who can accompany you to go to the health care facility?

Potential probes:

- Husband
- Mother
- Mother in law
- Sisters/brothers

- Neighbours
- Traditional Birth Attendant

Charges/fees

- Is health facility birth free of charge? If not, how much do you have to pay?
- Do you have any problems to get the money to go to the health care facility?
Have you saved money to be able to go there?
- Is there anything in particular you have to bring with you to the health care facility?

Potential probes:

- Money
- Delivery kit
- Gloves
- Sheets
- Clothes for wrapping the child
- Food and drinks

Concerns about the health care in the facility

- Do you have any concerns about the health care provided in the health facility?

Potential probes:

- Concerns that the health care provider might not be female?
- Concerns that there might not be a skilled health care provider to take care of you? (Skilled means doctor, midwife or nurse)
- Concerns that there might not be any pain relief?
- Concerns that no one will take care of your family at home when you are away to give birth in the health facility?

Do you know anyone who had problems with accessing the health care facility to give birth?
Can you please explain what problems they had?

c. Interview guide for in depth interview with health personnel working in the delivery ward

Start by reading the informed consent form and explain to the participant the purpose of this interview

Purpose of interview

The purpose of this interview is to explore what health workers in a public health facility see as good quality birth care and to explore challenges faced by health care workers in providing birth care. This interview is a part of a research project entitled " *Experiences of giving birth in a public health facility and factors contributing to an increased demand for birth services in North Gondar zone*". The overall aim of this research project is to explore factors contributing to an increased demand for birth services, which are seen important in the challenge of decreasing maternal mortality in Ethiopia. We hope your answers can tell us something about the challenges for health personnel in providing good quality birth care. In this interview we will talk about your responsibilities in the delivery ward, what procedures is normal in the care of delivering women, what you see as challenges in the care of delivering women and what do you think can and should be improved in the care of delivering women. The information you give us will be very important for our research and we appreciate your participation.

If you permit, this interview will be tape-recorded. We ensure you that all identifying information will be removed and destroyed as soon as all data has been collected. The information we receive from you will be kept confidential. This interview will approximately take 1, 5 hours.

Serial number of interview:

Date:

Facility:

I- Background information:

Sex: _____

Age: _____

Health care education: _____

Years of experience in nursing/midwifery _____

Professional training: _____

II- The quality of care of delivering women

First we would like to talk to you about your responsibilities at your workplace and how the women are cared for in the delivery ward.

1. Responsibilities in the delivery ward

- What are your responsibilities in the delivery ward?
- Can you tell me what happens when a woman comes to your health care facility for delivery?
- What procedures do you follow?

Potential probes:

- Friendly welcoming the women
 - Measure BP?
 - Take urin sample
 - Listen for babys heartbeat
-
- Do you explain the procedures during examination and delivery?
 - Who attends the delivering women? Is there someone with the women during the entire delivery?
 - Are women allowed to have someone (family, friends, relatives) with them during all stages of delivery? If not, during what stages are they allowed having them there?
 - If the women are not allowed to bring someone with them, what are the reasons?
 - Do you or your colleagues administer pain relief/drugs to the women in labour?
 - What kind of pain relief/drugs?
 - Do you examine the women after delivery? How many times is the woman examined?
 - Do you examine the baby after he/she is born?
 - How many hours after the delivery do you usually examine the women?
 - How long do the women and their babies stay in the hospital after delivery?
 - Do the women come back to the health care centre for examination?

2. Barriers for providing good care in the health care facility

Now we would like to talk about factors that may prevent you and your colleagues from giving quality care.

- What are the barriers for providing good quality care in your work place?

Potential probes:

- Lack of equipment?
 - Lack of skilled staff?
 - Shortage of staff?
 - Lack of time?
 - Power shortages?
 - Unreliable water supply?
 - Not enough space?
 - Lack of hospital beds?
 - Lack of knowledge?
-
- If you had any extra professional training during your time as nurse/midwife, how has this helped you in providing care to the pregnant women?
 - Do you feel safer in your work with this additional training? How?
 - If you don't have additional training, do you feel safe and comfortable in the procedures you perform?
 - Do you feel you have enough knowledge to take care of the delivering women?
-
- What do you think are the advantages of giving birth in the health facility where you work?
-
- Do you know why women prefer home births instead of giving birth in the health facility?
-
- If you had a project with the aim to have more women to give birth in health care facilities. How would you go about it?

Potential probes:

- Improve circumstances before birth (at home/transport/distance etc...)
- Improve circumstances at the health care facility, during delivery?
- Improve circumstances after delivery