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Barriers to Use Maternity Care Service in Rural Areas among Mothers Who Give Birth, in Arba Minch Surrounding District, Gamo Gofa Zone, South Eastern Ethiopia, 2017: A Qualitative Study

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Abstract

Introduction: For many women, who are in a rural or remote area has difficulties, searching maternity care is often much more challenging than for those in city or regional areas. Women suffer from limited access and the added emotional and financial costs associated with this travel. The facilities available in rural areas do not provide comparable level of clinical services as tertiary facilities in major cities. Therefore the aim of this study is to assess barriers to use maternity care service in rural areas of Arba Minch surrounding district among mothers who give birth with in the last one year, having experience of barriers.

Methods: Phenomenological study was employed. For in-depth interview 30 women with delivery experience and 4 focus group discussion were used. Convenient sampling method was used. The word documents were then exported into open code 4.03 software for processing. Coding, synthesis one and synthesis two analysis was made using open code 4.03. In order to determine similarities and differences in the responses, findings for the Focus Group Discussion (FGDs) and in-depth interview (IDIs) were analyzed separately.

Result: 30 interviews and 4 FGD were conducted to explore barrier to use maternity care service in rural areas. Of the sixty two participants, there were eight men and fifty four women. All women and men were married. The summary of findings provides the themes that emerged based upon seven themes on barriers to maternity care services were Knowledge gaps around maternal care service, Unsupportive attitudes and social norms, Financial barriers, Barriers around health service provision, fear of operation, Husbands are key influencers and Preferring home delivery by traditional birth attendants.

Conclusion and recommendation: Involvement of husband in maternal care service use. Distance, social, cultural, health service provision, misunderstanding about operation and perceptional factor which hinder women to use maternity care in rural areas should be addressed. Designing social and behavioral change strategies to overcome such barriers and collaboration is needed with organization those works on culture and social system for intervening maternity service care utilization. Accountability around health services, therefore, is an important issue for many people.

Keywords: Maternity care; Analysis; Health services; Midwifery

Abbreviations: FGD: Focus Group Discussion; IDIs: In-depth Interview; TBAs: Traditional Birth Attendants; WHO: World Health Organization; ANC: Antenatal Care; MDGs: Million Development Goals

Introduction

For many women, who are in a rural or remote area has difficulties, searching maternity care is often much more challenging than for those in city or regional areas. Women suffer from limited access and the added emotional and financial costs associated with this travel [1,2]. The facilities available in rural areas do not provide comparable level of clinical services as tertiary facilities in major cities and emergency obstetrics care is lees available. In addition, private hospitals with high level of qualified service and newer models of care such as midwifery group practices may also be less available or at further distances from these women [3,4].

The global MMR declined by 44% during the MDG era, representing an average annual reduction of 2.3% between 1990 and 2015. Almost all of the deaths occurred in low-resource settings and could have been prevented [5].

Maternal healthcare system is an important segment of medical system in every society. This is due to large number of human population involved in this health sector, coupled with the significance of this group to the overall sustenance of the human population. It is also noticed that this sector of medical system is affected by less difficult health problems, which are usually preventable [6].

Today about three fifths of all maternal deaths take place in humanitarian and fragile contexts. Every day 507 young women die from complications of pregnancy in emergency situations and in fragile States. Geography existence of the women is another factor [7].

In less industrialized countries of the world, despite all the attempts to reduce the severity of maternal and child healthcare problems, it

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still remains a scourge which continues to claim the lives of a large percentage of their populations [8].

Currently MMR in Ethiopia is 350 deaths per 100,000 live births this figure not as per the reduction figure intended at the end of MDG [5].

Births attended by skilled health personnel by percent 2007-2014 target was 90%, but the achievement worldwide was 74% and in Africa region 51%. Percent reduction in maternal mortality ratio, 1990-2013 target was 75% but achievement worldwide was 45% and in Africa region 49 percent. Antenatal care coverage percent at least one visit, 2007-2014 target was 10%, but achievement worldwide was 83% and in Africa region 77%. Unmet need for family planning by percent, 2012 target was 0% but the achievement was worldwide 12% and in Africa region 24% [9].

Maternal death which persists at unacceptably high levels in all of sub-Saharan Africa and is determined by a variety of factors including, individual women's circumstances and characteristics, logistic support in the event of emergencies and health service availability and quality [10]. Globally, maternal mortality ratio downs by 45% between 1990 and 2013, 49% in sub-Saharan Africa (SSA) [11].

Weak infrastructure and limited health service availability in low income countries 'goiter on mumps'/complicate access to health services, especially in rural and remote areas. Government health institutions may be relatively few and too far to reach and private-sector sources often favor accessible and wealthier urban areas, resulting in unequal service availability within a country. Ethiopia is with weak health care systems and fragile infrastructure. Reproductive health, like most aspects of health in Ethiopia, weak too, with significant regional distribution inequalities in access to services. Many women live in remote areas that are too far from a road, let alone a health facility where they can receive emergency obstetric care [12,13].

Reducing maternal mortality in Ethiopia presents serious challenges for the government and NGOs as only 10% of nearly three million women per year receive skilled care at birth. In 2006, the Ethiopian Federal Ministry of Health (FMOH) developed the National Reproductive Health Strategy (2006-2015) that focuses specifically on improving facility infrastructure, training health care providers and promoting referrals to health facilities for birth [14]. Nevertheless enhancing women's access to skilled care at birth remains a challenge [15]. The emphasis so far has been on task-shifting Emergency Obstetric and Newborn Care (EmONC) services from specialists to midlevel providers and improving access to EmONC by training health officers, midwives and nurses. Additionally, a large cadre of HEWs at the community level provide an opportunity to reduce the first delay-the detection of childbearing complications and the decision to seek EmONC [16,17]. According to Ethiopia Federal Ministry of Health Reproductive Health Strategy 2006 and Health Sector Development Plan (HSDPIV 2010) aim to reduce maternal death based on an enhanced referral system. Health extension workers at the community level help with birth preparedness and complication readiness and mobilization of communities to make early referral to mid-level service providers (health centers) who in turn refer to hospitals that are equipped and staffed to provide comprehensive services if required. This "flagship" or referral system is the key to reducing the delays that currently contribute to maternal mortality and disability. More recently, the Road Map focused 'on achieving targets of major components of maternal and newborn health and strengthening health system and the capacity of Individuals, families and communities to improve Maternal Health'[18]. The main objective of the Road Map was to reduce the MMR to 267 per 100,000 live births and the Neonatal Mortality Rate (NMR) to 15 per 1,000 live births by 2015. By 2014, all neighborhoods or kebeles, the smallest administrative unit in Ethiopia, should have functional, women-centered health development teams. Each team was comprised of up to 30 women who work as a team to support the HEWs to facilitate and consolidate the endorsement of the Health Extension Program (HEP). Development teams should be engaged in local-level behavior change strategies based on shared discussion and building capacity to network with other groups or institutions (e.g. village leaders, religious leaders, health providers) [18].

The health development team and HEWs are both involved with improving the uptake of key MNCH services and should disseminate information to create demand and awareness of: Pregnancy-related danger signs and the benefits of seeking skilled care.

- Birth preparedness and complication readiness importance of antenatal care, skilled birth attendance, postnatal care (PNC) and family planning
- The ill health and social consequences of Harmful Traditional Practices (HTPs) associated with pregnancy and delivery.
- Proper nutrition and micronutrients.

Despite on-going efforts to implement these strategies, the Maternal Mortality Ratio (MMR) has remained high. Currently, Central Intelligence Agency (CIA) estimates that maternal mortality rate is 350 maternal deaths per 100,000 live birth [19]. Thus the MDG target has not been achieved [5]. Similarly literatures indicated that maternity care service has not been delivered as intended. Thus this study will explore for further barriers for rural women that hinders maternity care service use.

Methods

The rational we used phenomenological approach is to better understand several women common or share experience of marries to use maternity care in rural areas.

Study area

The study was carried out in Arba Minch town surrounding district, Gamo Gofa zone, south eastern Ethiopia from April to June 2017. This district is one of the fifteen districts found in Gamo Gofa Zone. The area is located 505 km South east Ethiopia from Addis the capital city of Ethiopia and 275 from the Hawassa the capital city of southern Ethiopia. It has a population of 205,204. The district has seven health centers standing for providing health care service for the population of the district.

Study design/Tradition: Phenomenological study design was deployed.

Study period: April to November, 2017.

Study population: Purposively selected mothers who give birth within the last one year in the study area.

Sample

Scholars argue that the concept of saturation is the most important factor to think about when mulling over sample size decisions in qualitative research.

The recommendation that 25-30 participants is the minimum

sample size required to reach saturation that use in-depth interviews. Sample of 30 individual was used for in-depth interview and four FGD each FGD having 8 members from key informants (health extension workers, health development army leaders, women who gave birth and husbands) was used.

Data collection

Both FGDs and IDIs were conducted by Principal investigators. One principal investigator was facilitated/conducted the FGD/ interview, while the second one record the session using a digital voice recorder and the third investigator took notes at the time.

It was conducted in the local language, Gamogna and Amharic. To ensure privacy and confidentiality, each FGD and IDI was conducted in a quiet place and private place for in-depth interview.

Before each FGD and interview, oral consent was obtained from participants by requesting them to read/listen and sign the consent form, which was translated into Gamogna and Amharic. Then the principal investigators read short demographic questioner form and fill it before FGD and IDI.

The recruitment for FGDs was completely based on voluntary and that participant' answers were treated confidentially and anonymously.

Interview guide translated into Gamogna and Amharic, was used for both FGDs and IDIs. IDI participants were mainly asked to share their experiences regarding the research question.

Each FGD was conducted in a quiet place in each village and lasted between 1 and 1.5 h or as needed. In order to allow for free discussions among the participants, the FGDs were arranged homogeneity based on age.

Data processing and analysis

All voice recordings from FGDs and interviews was transcribed and translated into English.

To check for accuracy, twenty percent of the transcripts were back translated into Gamogna and Amharic. Then they were compared the Gamogna, Amharic and English versions for differences and similarities while listening to the original voice recording. After verification of accuracy in translation, each transcript then read aloud by a principal investigator while the other co-principal investigator listen to the corresponding voice recording. Next, each translated transcript was compared with the hand-written field notes that the principal investigator prepare during the FGDs and interviews. After proof-reading and making corrections, the transcripts for both FGDs and IDIs were saved on a password-protected computer. The word documents were then exported into open code 4.03 for processing.

Code synthesis one and synthesis two was made using open code version 4.03. In order to determine similarities and differences in the responses, findings for the FGDs and IDIs was analyzed separately.

Trustworthiness (soundness of the research)

Prolonged contact with informants (criteria based selection to mean those supposed to be experienced or having enough information was identified), including continuous validation of data was considered.

Continuous checking of data and fit between coding categories and data was carried out.

Bracketing: To mitigate the potentially deleterious effects of preconceptions that may taint the research process the principal investigator was proposed four strategies for doing bracketing that are guided by the thinking activity of reflexivity: the expectation, belief and feeling of the investigator was identified by mentality assessment so that preparation before deciding the research paradigm, deciding the scope of the literature review according to the prevailing gate-keeping policy, planning for data collection using semi-structured interviews were guided by open-ended questions and planning for data analysis using identifying meaningful information and organizing it into themes or categories methods.

Results

Thirty in-depth interviews and 4 FGD were conducted to explore barrier to use maternity care service in rural areas. Of the sixty two participants, there were eight men and fifty four women. All women and men were married. Regarding schooling majority of participants do not read and write. The barriers to use maternity care that people face in the area were traveling half or full day journey to get maternity care, lack of compassionate care from health care worker, lack favorable attitude for rural women, fear operative delivery and lack of belief or trust in health care providers. Most of all these statements were shared by all focus group subjects.

The following major themes are emerged following the findings

1. Knowledge gaps around maternal care service
2. Cultural influence and unsupportive social norms
3. Financial barriers
4. Unwelcoming conditions around health service provision
5. Long distances and hard to reach to health facilities
6. Husbands are key influencers
7. Preferring home delivery by TBA

Knowledge gaps around maternal care service

It is known that antenatal care is important, however, many women do not understand the need for different interventions at different stages of pregnancy and the importance of early pregnancy care. Attending antenatal care is to check the baby's health and the mother's health as well. Rural women people mostly do not understand that the baby's health, in fact, depends on the mother's health.

A 27 years old woman said that "*I do not know the importance of going to health station frequently during pregnancy, once I have checked it is enough until I give birth*"

As it has been said by another 32 years old women "*Most people do not go to health center is because of lack of education and most becomes in danger*"

From the above statement we understand that antenatal care somehow considered as treatment for women with problem during pregnancy. When, how much times and why antenatal care for rural women not clear yet. There are questions regarding maternity service use not addressed.

Participant number 4 in the FGD, *said health extension worker thought to me use family planning for birth spacing but get pregnant within a year after giving birth, so how would I be able to go health extension worker, I feel guilty and ashamed, I remain at home until I give birth.*

This shows that women did not realized their reproductive health

rights regarding birth spacing, number of children and the like. Health care providers are not addressing this aspect of the service.

Cultural influence and unsupportive social norms

Many people take pregnancy as ''normal process" that requires no medical intervention. There is a norm, that women should not disclose their pregnancy outside of their family until her belly grows bigger or visible. "*I did not told anyone that I am pregnant, they should observe after my belly grows bigger, if I told somebody as I am pregnant and then miss/abort my pregnancy in case, what did I say? People should confirm my pregnancy by belly till then I should keep it secret 'AMAMARE'*." There is a sort of being unconfident by their pregnancy before viability according to the social norm. Visiting health setting exposes women to announce unconfirmed pregnancy. Other people understand that a facility delivery is safer for the mother and baby, but others believe that a normal birth takes place at home and women should be proud of it.

One participant said that "*There is a custom related factor that is some people say that crossing the river while she is bleeding is not acceptable*." Another respondent added that "*When women go to the health post to be examined they afraid to be without cloth. The tradition protects them not to be with cloth*."

Financial barriers

The findings show that women often have no money to pay for transport. In the area people carry the delivering women to health center at night no food to eat, no bed for them, even unable to pay for quality service private health care setting, in such circumstance the women feel guilty, ashamed and overcoming problem to improved maternal health, particularly with unsupportive husband characteristics added. Given their low status in the families and communities, women's health is often given low priority in the allocation of household resources. For example one participant said that "*Women do not have the money to pay for transport and no adequate transport is available.*"

Unwelcoming conditions around health service provision

The reasons why women cannot use maternity service especially delivery service is that there is unwelcoming condition in health facilities. The health care providers insult women, hate the rural women, no room for people who bring her to health center, health care providers not focused they rush all the time, no food to eat for people and me, my people have no bed for night, they are not voluntary to wake up from sleep at night, they discharge delivered women at night who come from far rural areas, no way to go to home, they are not close to where women live. Many women and their families are concerned about being treated poorly by health workers.

The participants expressed that they were mistreated by health personnel when they go to the health facilities. For example one participant said: "*The Midwives are bad-mannered, they don't want to help us and by now in the health center treatment will not go normally. The number of female nurses generally insults*."

She added that "*I was discharged at mid night, look I am her the health center is about 10 km away from here, I was carried by people, it was rainy no transportation, no relative or friend to stay the night near the health center, no food to feed people and I have too. After that suffering day I decided to give birth at my home*."

Participants explained their concern over the misuse of an ambulance. For example one participant said that: "*Ambulances were used for other office work, as a result deaths occur that may have been prevented if we had been given the ambulance timely*."

Long distances and hard to reach to health facilities

Majority of the participants stated long distance to health facilities as the big problem as people walk on average the time was estimated as four to six hours walk to the health center. Among the participant one woman stated that: "*The health post is at least two hours from the area*."

Another participant said that "*When women became pregnant they go to the health center or hospital with the ambulance and when they go back to their home they get great problem so hate going to the health center*." Since transportation is only to the health care setting but no transportation is facilitated back to home. A woman reported her experience: *They took me to the health center I give birth before I was admitted to the delivery room. After few minute they told me go to your home, it was 3 o'clock at night, it took more than two hour to my house by vehicle, I have to go the rural area, I have no vehicle, the ambulance was left, people come with me to help me are hungry no food, no room to stay at night, no relative to give me food, my people suffered a lot*.

We know that currently maternal waiting room working in almost all health centers. Despite the program mothers from rural area are not using the room or health setting are not ready to level they can provide service.

Husband characteristics as barrier to use maternity care service

Women raised the lack of their husbands' agreement as a barrier to attending antenatal care check-ups, because the husband refuses to give his pregnant wife funds to get to the health facility for antenatal care. Even he needs her to work in home rather than wasting time by going to antenatal care service. For example one participant said that "*Is your pregnancy different form the others? Our mothers and grandmothers have been giving birth simply whenever you conceived you ran there. You are not concerned about our lives*"

As the women described, decision making about going to seek health services was made by the man in the house. For example, one mother said that "*Mostly the women husband force the woman not to go to the health center.*"

From the in-depth interview women aged 28, said: *If I want to go for antenatal care, my husband say to me, you go to health center not work in the house, I only work for the welfare of our house, you do not care about our daily life. You repeatedly visit health center what did they do for you*?

Her fear is that, husbands are not supportive for pregnant women to get ANC service.

Home delivery by TBA

Although at the first participants denied that home deliveries are still taking place, it was somewhat evident that deliveries still take place at home level.

The other participant said that: "*Some women say giving birth in the health center will bring problem in the womb therefore we do not have to go*." Another participant supplementary: "*Some pregnant women give birth without any pain*."

As matter of fact, there were others who convicted the practice of delivering at TBAs; they consider that it was risky because of complications that may happen at the time of delivery.

Discussion

Different factors were considered by the participants as barriers

to maternity care service use. The "barriers" identified are especially useful in clarifying why reducing maternal death in Ethiopia presents serious challenges for the government [20].

The study come up with knowledge gaps as one factor that impedes pregnant women to use antenatal care service, delivery. This finding coincides with studies conducted in a far region, South Asia and SSA indicated that utilization of maternal health services is extremely affected by lack of awareness [21,22].

People believe that pregnancy is ''normal process" no medical intervention needed and that women should not expose their pregnancy outside of their family until her belly grow up [23-25]. Some other people understand that a facility delivery is safer for the mother and baby, but others believe that a normal birth takes place at home and women should be proud of it.

The study explained that barriers to improved maternal care service especially regarding to financial issue women's health often given low priority.

In this study one of a barrier that hinders the use of maternal health care service was health service provision. Although the need for pregnant women to use maternal health service was appreciated, participants indicated that it is also important that the health workers treat them with respect and preserve their dignity. Many participants bemoaned the behavior portrayed by some health workers who shout and insult while giving service. The more patients are mistreated, the more they become dissatisfied and the more they tend to shun away from its utilization. This study agrees with a study cited by World Health Organization (WHO), which established that one reason for low ANC utilization was rude health staff [8].

The study identified long distances to access health centers as one factor that hinders pregnant women to use maternity care service [26-28]. This finding concurs with several other studies conducted in Nepal and other countries such as north Australia, Sudan which found long distance as barriers to the use of maternity care service [3,4,20,25].

The finding that lack of their husbands' agreement as a barrier to attending antenatal care check-ups, largely because the husband refuses to give his pregnant wife funds to get to the health facility for antenatal care. Generally, decision making about going to seek health services was made by the man in the house [29,30].

Another finding in this study was that home delivery were favored by some participants not only because they are within home but also because the women will not stay away from home for a long time and home delivery do not demand more items required for delivery than at the health facilities [30-32]. The length of stay and demand for materials needed for delivery at the health facilities then was a barrier to the use of health facilities during delivery.

Conclusion and Recommendation

We have identified different barriers faced by women to access maternity care service in the domain of Knowledge gaps around maternal care service, Unsupportive attitudes and social norms, Financial barriers, Barriers around health service provision, Long distances to access health facilities, Husbands are key influencers and Preferring home delivery by TBA. By this barrier we have classified factors at the institution level, personal mediated and internalized level must be addressed to improve maternity care service.

Social, cultural and perceptional factor which hinder women to use maternity care in rural areas should be addressed through social and behavioral change strategies. Designing strategies to overcome such barriers and collaboration is needed with organization those works on culture and social system for intervening maternity service care utilization. Information education and communication interventions targeting behavior change should address such socio-cultural beliefs of communities

Looking at these findings, the responsible bodies should seek to develop and implement interventions to improve the barriers associated with maternal service utilization and the attitudes of health workers. In particular, it is recommended that interventions should be framed in order to reduce risks associated with birth, promote improved client behaviors in health workers that lead to reduced risks during delivery and improve health facilities.

Allegations of immoral practices such as, using ambulance for another purpose, urgent corrective measures should be taken. Accountability around health services is an important issue for many people. Magnifying the valuable role of husband as one of important part in maternity care service.

Declarations

Ethical approval and consent to participate

The proposal was approved by the Arbamich University, College of medicine and Health Science Institutional Ethical Review Board. An official letter was written from the Arbamich University, College of medicine and Health Science to Gamo Gofa Health department and respective selected districts, Health and Administrative Offices to seek the essential cooperation. During data collection, individual informed verbal consent was obtained from the study participants. Each respondent was informed about the purpose of the study, procedures of selection and assurance of confidentiality moreover their names was not registered to minimize social desirability bias and enhance confidentiality. Individuals was free to withdraw from the interview at any time.

Availability of data and materials

The datasets text and audio used and/or analyzed during the current study can be obtained from the corresponding author on reasonable request.

Competing interest

The authors declare that they have no competing interests.

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Authors' contributions

GE, MS and ND are participated in conceiving the study and wrote the proposal. Conducted data collection together. All the authors had read and approved the final draft of this manuscript.

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