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A qualitative study of factors influencing the utilization of institutional delivery: Insights from pastoral communities, Southwest Ethiopia

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ABSTRACT

Background & aim: The practice of institutional delivery services utilization is reported to be very low in Ethiopian pastoral community. In this regard, health programmers should gain an insight into factors influencing the utilization of institutional delivery to improve health facility delivery among these women.

Methods: A qualitative study was conducted in pastoralist communities of Bench-Maji zone, southwest Ethiopia within September-October 2017. The data were collected through in-depth interviews and focus-group discussions with women, health extension workers, traditional birth attendants, and supervisors of health extension workers. After transcription and translation, the data were thematically analyzed using Open Code software (version 3.6).

Results: As evidenced by the results of the current study, poor risk awareness, inadequate infrastructure and transport, poor quality of care, and lack of financial independence hinder easy access to obstetric care. In this regard, readily available traditional birth attendants become the best alternative to the non-responsive health system. These communities were also marginalized since they receive less health education due to their long distances to healthcare facilities. Consequently, they are encouraged to deliver at home in the belief that only complications require medical attention.

Conclusion: In order to design interventions to support pastoral women's use of obstetric services, existing barriers need to be addressed together since they jointly hinder women's access to institutional delivery.

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Introduction

Globally, maternal mortality was decreased by 45% within 1990-2013. Nonetheless, 289,000 maternal deaths were just reported in 2013 (1). Nearly 99% of global maternal deaths occurred in developing countries with the majority being in sub-Saharan Africa (1).

Ethiopia is one of the sub-Saharan African countries with high maternal mortality ratio. As reported in 2016, the estimated maternal mortality ratio in Ethiopia was 412 per 100, 0000 live births (2). The magnitude and causes of maternal mortality in the pastoral areas of Ethiopia are not fully understood. Recent reports presented by Ethiopia Demographic and Health Survey (EDHS) demonstrated that the utilization of skilled delivery services provided by skilled birth attendants (SBAs) is extremely low in pastoral areas. Moreover, more than 70% of women in predominantly pastoralist regions of Ethiopia were assisted by Traditional Birth Attendants (TBAs) at home in 2016 (2). The low utilization of SBAs and high preference for home delivery by TBAs may indicate a high level of maternal mortality in pastoral areas of Ethiopia.

Increasing access to SBAs during childbirth has been identified as a key strategy in

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decreasing maternal mortality and improving infant survival (3, 4). It has been estimated that maternal mortality could be reduced by 16- 33% if women give birth with the assistance of SBAs (4, 5). Nevertheless, delivery by SBAs remains low in many sub-Saharan African countries, including Ethiopia (6) where only 26% of women gave birth at health facilities in 2016 (2). The highest level of institutional delivery was reported in agrarian areas of Ethiopia (ranging within 27-38%) (7-10). On the other hand, the lowest level was detected in the predominantly pastoral regions of Ethiopia: 15% in Afar and 18 % in Somalia regions (2).

Published and unpublished reports in this study area have pointed to the low level of institutional delivery practices. For instance, a community-based cross-sectional study which was conducted on urban residents in two districts in Benchi-Maji zone reported that 78% of women had delivered their last baby in health-care facilities in 2015 (11). On the other hand, a 2017 Zonal Health Department report indicated that less than 20% of women from pastoral Menit communities gave birth at health facilities at the presence of SBAs (12) suggesting a high level of disparity within this zone.

The factors contributing the utilization of maternal health care services have been the subject of many research projects around the world. According to Thaddeus and Maine, women's tendency to use maternal health services is influenced by three delays: delay in the decision to seek health care services, delay in reaching health facilities, and delay in receiving adequate care at the healthcare facilities (13). In addition, a range of factors also contributes to each delay. The decision to seek health care services is influenced by culture, illness characteristics, costs, and previous experiences with the health care system. The ability to reach health facilities is affected by distance, road conditions, travel time, availability, and cost of transport. The ability to receive adequate care at health facilities is influenced by the inadequacy of supplies and equipment, as well as unavailability and poor competence of health workers (13).

The reasons behindwhy women's preference for home delivery and their reluctance todo not like to go refer to the health facilitiesy for delivery is not adequately investigated. Studies conducted in other pastoral areas of Ethiopia and Sudan suggested that low educational level of pastoral women and lack of awareness of institutional delivery discouraged them from using health facilities for delivery care (14, 15). Limited knowledge of the expected date of delivery (EDD) and the absence of delivery planning among pastoralist communities was also reported to contribute to home delivery rates in Ngorongoro, Tanzania (16).

In some East African pastoral communities, gender norms and decision-making power have been recognized as potential barriers for the utilization of institutional delivery (15, 17, 18). In addition, long distance and inability to pay for transport dissuade pastoral women from seeking delivery care at health facilities (17, 18). Given the difficulties in accessing health facilities due to long distances and lack of transport, health workers are often the last option for women who require attention beyond the capacity of TBAs (19).

Home delivery and the use of TBAs in pastoral areas could be also linked to negative attitudes towards the quality of services provided by health-care facilities (17). Byrne et al. found that while the pastoralist Maasai communities in Kenya acknowledged that health workers are in the best position to manage complicated deliveries, they are often viewed as cold and sometimes disrespectful (20).

Pastoral women prefer to give birth at home with TBAs since they bring comfort to women during delivery, mediate between women and their husbands, are easily accessible, and assist women in domestic responsibilities to give her time to rest and heal (20). In resource-restricted countries, such as Ethiopia, TBAs may play a key role during pregnancy and after childbirth. For instance, in the Afar region of Ethiopia where many pastoralist communities reside, trained TBAs were reported to be key health educators in the community, encouraged antenatal care visits (ACV), and promoted postnatal hygiene. Nonetheless, despite their pivotal role, TBAs may cause unnecessary delays during childbirth by referring women to healthcare facilities only after the development of life-threatening complications (21).

Despite the low level of institutional delivery practices in this study area, its contributing

factors have not yet been sufficiently explored. With this background in mind, this qualitative study aimed to investigate the possible reasons behind the non-utilization of healthcare facilities for delivery among pastoral Menit communities.

Materials and Methods

The current study was conducted in two pastoral districts, namely Menit-Shasha and Menit-Goldia of Bench-Maji zone in the Southern Nations Nationalities and Peoples' Regional State (SNNPR) within September-October 2017. The total population of Menit-Shasha and Menit-Goldia in 2017 was 55, 680 and 115,536, respectively. Women of reproductive age constitute approximately 16% of population (12). Livestock rearing is their principal source of income. These communities are settled in certain areas; nonetheless, sometimes they move to rivers and springs during dry seasons in search of water.

In Ethiopia, women are expected to attend at least four ANCs during pregnancy. In rural areas, health extension workers (HEWs) should provide the second and third ANCs. Thereafter, women are referred to healthcare centers for the fourth ANC. There are seven healthcare centers in the two districts which are equipped to provide basic emergency obstetric services. These centers provide both preventive and curatives services, including maternal healthcare services. After the fourth ANC, women are advised to wait at a maternity waiting home until labor starts, and she will be transferred to the delivery room when labor starts. More complicated cases are usually referred to Mizan-Tepi Teaching and Referral Hospital where healthcare professional can perform emergency surgical procedures and provide blood transfusions, as well as other specialized services. There are also 61 health posts where HEWs operating at the community-level mainly provide preventive services. In Ethiopia, women are not supposed to pay for delivery care services. However, they have to cover indirect costs, such as payment for transportation and medicines.

A qualitative approach was used for the current study since little is currently known about the reasons behind pastoral Menit women's reluctance to seek delivery care at health facilities. In-depth interviews (IDIs) and focus group discussions (FGDs) were used for data collection. The participants of the current study included women, TBAs, HEWs and HEW supervisors which were selected using purposive sampling method. Triangulation of qualitative data via the use of different methods, different types of informants, and different sites increase the credibility of qualitative studies (22).

A total of 43 subjects participated in the FGDs and IDIs. All of the interviews were audio-recorded and lasted between 45 min to 1 h. The sample size was determined based on data saturation. We considered data saturation if similar ideas were generated by interviewing three participants. Pretested interview guidelines with probing questions were used for both the IDIs and FGDs (additional File 1). All of the subjects were interviewed face-to-face, and none of them refused to participate in the study.
In-depth interviews: The IDIs were conducted with women (n=6), TBAs (n=3), HEWs (n=2), and HEW supervisors (n=2).

The first groups of participants who had IDIs were women. Women who had given live birth in the preceding year were purposively selected with the assistance of HEWs who were familiar with the communities. Predefined inclusion and exclusion criteria were used to select women for the interview. Inclusion criteria entailed women older than 25, those with some schooling, and women who had given birth at a healthcare facility or at home. On the other hand, the women who did not give live births (gave stillbirths) were excluded since they may not provide useful information due to their unpleasant past experiences. Women were interviewed at their homes in private to ensure their confidentiality. IDI guides for women were structured to elicit information regarding reasons for home delivery, ease of access to health facilities, perceptions of services delivered by health facilities, and the role of TBAs.

IDIs were also conducted with TBAs. The HEWs helped to identify TBAs with at least four years of experience in the area. Four-year experience was a rough cut point which was decided by primary investigators. More experienced TBAs were believed to provide more accurate information concerning the topic

of interest. Recently, TBAs have been abandoned by the government to assist delivery at home; accordingly, TBAs with less experience may not provide information about the topics of interest. Consequently, only highly experienced TBAs were included in the current study to obtain more precise information. The TBAs were also interviewed about the reasons for home deliveries, accessibility to health facilities, and qualities of care at health facilities, as well as their role in the community at their homes.

Furthermore, we conducted IDIs with HEWs and HEW supervisors to further explore the barriers which discourage pastoral women from seeking institutional delivery. HEWs and HEW supervisors with at least one year of experience were invited for IDIs. They were asked about the reasons for home deliveries, accessibility to health facilities, and qualities of care at health facilities.

Two research assistants with a tertiary level of education and fluent in the local language (Menitegna) conducted the IDIs with women and TBAs. Since HEWs and HEWs supervisors could speak the national language (Amharic language), the interviews with HEWs and HEWs supervisors were conducted in Amharic language by two of the principal investigators (B. B and K. M).

In addition to IDIs, the use of FGDs can provide a feedback effect among the groups that spurs further conversations. This, in turn, provides information that may not have been collected in the IDIs (24). Nearly all HEWs (30/32) agreed to take part in FDGs and two HEWs who had participated in the IDIs were excluded. A total of four FGDs were conducted with groups of 6-9 HEWs.

HEWs with a minimum of one year experience were included in the FGDs. An invitation letter with proposed interview dates was sent to each HEW. The FGDs were conducted at meeting halls of centrally placed health centers in each district. This place was selected for two reasons: 1) We believe that HEWs may be more reserved and feel disempowered talking in their office than the centrally located meeting halls, 2) Centrally located place would be convenient for the HEWs. Using a similar interview guideline, health workers' perspectives on the factors influencing institutional delivery were explored during the discussions. One of the research assistants recorded the FGDs and the principal investigator (K. M) facilitated the discussion. FGDS with HEWs were conducted in the national language (Amharic language).

All recordings were transcribed and then translated into English. Two of the investigators (B. B and K. M) reviewed the transcripts prior to analysis.

To guide coding, a codebook was created by B. B and K. M using one transcript from each group of participant. The codebook includes the definitions of themes used for narrative texts coding. Thereafter, the codebook was distributed among coders (B.B and K. M) and further revision was made to the codebook. Any disagreement was resolved by A. H. Data were analyzed in Open Code (version 3.6) using a thematic analysis approach (24). The analysis of the present study was primarily deductive. Using a deductive approach, the themes related to "three delays model" concept provided by Thaddeus and Maine (13) were identified in advance. These themes were used to guide the exploration of access barriers experienced by women.

Emerging codes were examined to see how well they fit with themes suggested by "three delays model". The themes were compared across the transcripts in order to assure consistency of the presented data and the findings. Themes were also compared across different groups of participants to establish the range and similarities of the participants' views on the factors influencing the utilization of institutional delivery (additional File 2). Furthermore, they were checked to ascertain that they had not been over or under-represented. To improve the trustworthiness of the results, HEWs and HEW supervisors were invited to comment on the research findings and themes.

Ethical clearance was approved by Mizan-Tepi University College of Health Sciences Ethical Committee under the protocol approval number: MTU/0022/08/17. It is noteworthy that all of the participants were provided with the aim and potential benefits of the study. Before the commencement of the study,

informed oral consent was obtained from all subjects and approved by the ethical committee.

Results

Mothers who were interviewed were all married and none of them had any secondary or tertiary education. TBAs had the same educational level as mothers; however, they were 20 years older. All HEWs had completed secondary education which is reflective of the recruitment criteria for this position. The background characteristics of all study participants are presented in Table 1.

Table 1. Background characteristics of study participants

Characteristic	Mothers	Traditional birth attendants	Health extension workers	Supervisors
Age (years)				
18-24	1	0	6	1
≥25	5	3	26	1
Gravidity				
One	1			
Two	2			
More than two	3			
Para				
One	1			
Two	2			
More than two	3			
Sex				
Female	6	3	32	0
Male	0	0	0	2
Marital status				
Married	6	2	14	1
Unmarried	0	1	18	1
Educational level				
None	4	1	0	0
Primary	2	2	0	0
Secondary	0	0	32	0
College/university	0	0	0	2

The barriers identified by women, HEWs, TBAs, and HEW supervisors are grouped according to sources of delays that were considered as major themes. The major and minor themes are described in more details below (Table 2).

Table 2. Framework analysis of transcript data: major and sub-themes

Sub-themes	Major themes
Lack of awareness, traditions, lack of decision-making power, perceived poor quality of care, trust in TBAs, easy access to TBAs, comfort with TBAs, and competence of TBAs	Delay in seeking care at health facilities
Long distance, non-access to roads, and unavailability of transport options	Delay in reaching health facilities

Delays in seeking delivery care at health facilities

Lack of awareness

This sub-theme describes women's awareness of the importance of giving birth at health facilities and the consequences of home delivery. Lack of awareness about the importance of trained delivery attendants and the risks associated with home births was cited as a major barrier to institutional delivery by all groups. Youngerand more educated women who had a better understanding of these risks were described as more likely to deliver at health facilities. On the other hand, households located

in more remote areas had little access to health education provided by HEWs.

"Most of us have no education. Women are not aware of the benefit of institutional delivery. If you go far from here, there are pastoral people who are not aware of the benefit of institutional delivery. It is good. The young women started to use institutional delivery." (Woman, para1, 19 years old)

Traditions

The sub-theme of traditions refers to different traditional practices during pregnancy and childbirth that may discourage women from using delivery care provided by health facilities. From generation to generation, women in these communities have given birth to their children at home. Women who had given birth at home described this an accepted practice for generations.

"Our grandmothers delivered their child at home without any problem. We are following what they were doing." (Woman, para 6, 35 years old)

HEWs mentioned that sometimes women who manage to deliver on their own without any assistance are respected and considered brave by the community.

"The communities believe that women who deliver alone are brave. Due to this, some women go to the forest and give birth there. Nobody attended the birth." (HEW, 26 years old, IDI)

Male HEW supervisors believed that it is difficult for HEWs to encourage women to access maternal health care services and refer them for delivery care since in this community women prefer not to speak about pregnancy and women's issues.

"In this community, nobody tells you whether a woman is pregnant or not. They do not want to expose pregnancy." (HEW supervisor, 27 years old)

In addition, some women overlooked the need for delivery care at a hospital if the pregnancy was expected to proceed normally. Complications during labor require attention from health workers who are better equipped to manage these, as compared to TBAs.

"First we should have to consult a traditional birth attendant. If labor is normal, she follows the birth. If we are unlucky and complications arise, she will refer us to the clinics. They are very cooperative." (Woman, para 6, 35 years old)

Lack of decision-making power

This sub-theme describes the decision-making process, control of resources, and the impacts of decision making on women's ability to seek maternal health care services in health care facilities. All groups restated the reliance of women on their husbands for support and permission to access health facilities. HEWs mentioned husbands being the gatekeepers through whom they need to operate in order to access women.

"Mothers in our communities have many challenges. One of them is the husband's influence. In order to meet mothers, you should have to meet her husband first. Thereafter, upon his permission, you can communicate with her. If you communicate her without his permission, he may insult you. Due to this, we fear to communicate with mothers without husbands' permission." (HEW, IDI, 28 years old)

This control is related to marriage practices where dowry is provided by husband as a payment for decision-making power.

"There are some women who want to give birth at clinics. But their husbands do not allow them to do so. It is culturally accepted that the male decide on everything. He gives many cattle and guns to my families before marriage. If I complain, my families do not accept. They allow my husband to control me." (Woman, para 2, 30 years old)

"The issue of culture is also another problem. It is their norm! The husband gives up to 20 cattle and guns to her family to marry his wife. After marriage, he considers her as his slave. Every household activity, including child care, is considered her duties. But she is not allowed to control household assets." (HEW, IDI, 24 years old)

Perceived poor quality of care at health facilities

This sub-theme illustrates participants' perception of the quality of care provided by health facilities and its impact on the utilization of health facilities for delivery. In this regard, women reported instances of verbal abuse and neglect at healthcare facilities. They also mentioned that mistreatment by midwives, the

unwanted presence of male health workers, and lack of privacy during delivery disgrace pregnant women.

"It was not like delivery at home with TBAs. At the health center, they did not cover my body. Many people enter and some of them laughed at me. This is not accepted in our culture. There is a bed at the health center. She forced me to lie on that bed. I stayed there for many hours, and. I was not comfortable with that. I asked to stand and walk around; nonetheless, I was not allowed." (Woman, para 2, 24 years old)

"Giving birth at the clinic is good. It prevents us from bleeding. But the nurses are not good. I delivered at a clinic a few weeks ago where they shouted at me. They spoke unnecessary words. If you react, they will beat you." (Woman, para1, 19 years old)

HEWs acknowledged women's concerns about the quality of care provided at health facilities and their dissatisfaction with service provision. When women are mistreated, disrespected, or neglected by health workers, HEWs feel that their efforts were in vain. HEWs also complain that women would be thoroughly disappointed with them when they have unpleasant experiences at health facilities. Mistreatment of women at health facilities creates a sense of resistance in community and reduces the compliance of women to referrals made by HEWs. HEWs continue to persuade pregnant women to use the health facilities; nonetheless, bad experiences shared by women who have delivered there tend to waste their efforts.

"Women complain about poor quality of care at the health centers or hospitals. I do not want to blame health professionals, particularly midwives. However, to increase the utilization of health facility service in our area, the quality of care needs to be improved. After all the efforts we put into the identification and referral of pregnant mothers to health facilities, we expect that our mothers be provided with respectful maternity care. If they are not, they blame and insult us. Sometimes they discourage other mothers from referring to health facilities for delivery care." (HEW, 27 years old, IDI)

"We raised and discussed this issue with health professionals and district health officers. Mothers in our community will not return if they do not get appropriate care at health facilities. In fact, health centers are confronted with serious problems. We should respect our mothers." (HEW supervisor, 24 years old)

Lack of supplies and equipment at health facilities also affect timely delivery of obstetric care, particularly when families cannot afford to provide these necessities themselves.

"A few months ago, my neighbor delivered at a health facility. She suffered from bleeding; however, there was no medicine. She was also asked to buy drugs. She is poor and could not afford it. The governments need to consider this." (TBA, 30 years old)

In addition, disagreement between health facility practices and cultural preferences discouraged some women from seeking delivery care. Among this community, the absence of midwives who could speak Menitegna poses a daunting challenge to women.

"Even though I have not delivered at a hospital, I heard from my neighbor about the midwives, they cannot speak our language. They invite male translators and expose women's bodies to others. In our culture women are not allowed to expose their bodies. If she exposes her body, her husband and other people insult her. It is believed to affect the dignity of families." (Woman, para 4, 27 years old)

Women in this community often prefer to give birth using a squatting rather than supine position; however, it is often not tolerated at the health facilities.

"Women do not want to lie down during delivery. They want to walk around. They usually deliver in kneeling or standing positions. Recently, health workers have suggested that delivering in standing position causes epilepsy. But we know their preference and culture and respect them. That is why they prefer us." (TBAs, 35 years old)

"Health facilities are good, they save many women's lives. In the past, some pregnant women died of bleeding. Now health facilities have saved many lives. But the problem is the presence of male doctors and many other people during delivery. Some of them insult us. It is good if they allow women to choose their own delivery position." (Woman, para 4, 28 years old)

Availability, trust, comfort, and competence of traditional birth attendants

HEWs viewed TBAs as health promotion

partners. They mentioned that TBAs can reinforce such messages as the importance of personal hygiene, recognition of danger signs in pregnancy, and child immunization. One HEW described the trusted position TBAs hold as an asset in health promotion:

"In our community, there are many traditional birth attendants. To tell you frankly, the communities have a lot of trust in them. I think one of the reasons is that they can speak their language and know their culture. This is good for us since we use them as partners. They provide education, refer mothers to us and to health facilities for delivery." (HEW, 28 years old, FGD)

TBAs also considered themselves health promotion partners providing health education to the community and even encouraging women to deliver at health facilities. They are well aware of the government's policy forbidding them from providing delivery services and acknowledge that handling complicated deliveries may be a challenge for them. Nevertheless, they could not understand why they are not allowed to assist normal deliveries.

"In the past, mothers referred to us for delivery. Now, we do not provide delivery care. Some mothers still prefer us; however, the government does not allow us to give delivery services. Instead, we identify and refer pregnant mothers for institutional delivery. We also teach the communities about immunization and pregnancy. The communities believe and trust us. They want to give birth at my home; however, I refer them to health centers since I cannot manage if complications arise. But I am disappointed that we are not even allowed to attend normal labor." (TBAs, 35 years old)

TBAs are valued by community for several reasons. They are believed to be adequately competent to handle deliveries that proceed without complication and have successfully supervised home deliveries for generations. They also live within the communities; therefore, they are within easy reach of women. However, despite easy access to TBAs and community trust in them, pregnant women would be made to seek health facilities after labor complication.

"We regard them as our mothers and trust them. Their care during delivery is good. When labor starts, we call them. They are supportive and experienced. There is no need to travel such a long distance. Traditional birth attendants are available around us. If we call them, they will come soon. They tell us to refer to clinics if labor is abnormal. It is very difficult to reach health centers. I do not know why we are forced to go to health centers." (Woman, parity 4, 27 years old)

"Traditional birth attendants are available around us. We consult them first and if labor is normal, she helps us with the birth. If we are unlucky and complications arise, she will refer us to the clinics. TBAs also know our culture, as opposed to health workers, and they can speak our language." (Woman, para 3, 26 years old)

In sharp contrast to intimidating health facility settings, TBAs provide mothers with personalized care, accommodate preferred birthing positions, safeguard their privacy, and speak the same language. Owing to this, women prefer to give birth at home with TBAs instead of searching health facilities for delivery care.

"We know them very well. Their care is good. They keep our secrets and do not expose our bodies." (Woman, para 6, 35 years old)

"…..mothers still prefer traditional birth attendants. There is fear of verbal abuse and negative attitudes from health professionals. They also do not allow mothers to give birth in their preferred delivery position." (HEW, 30 years old, FGD)

Delays in reaching health facilities for delivery care

The second sets of delays are mostly centered on physical barriers hindering timely access to health facilities. The combination of long distance between health facilities and houses, poor road networks often made impassable by heavy rains, and difficulties in finding transport, particularly in more remote areas, pose daunting challenges to women. Many women also cannot afford to pay for transport and have to walk long distances if they wish to deliver at health facilities which may be impossible for women who are in labor or have developed complications.

"I cannot say by plane (laughing). I traveled on foot for two hours. My house is way far from the clinic. After we traveled for two hours, we arrived at a small city. But we could not get a car. We stayed one day. In the next day, we took a bus and traveled to the hospital which is extremely far from the city." (Woman, para 3, 26

years old)
"…my house is far from facility center. It takes 3 hours to reach the health center. Of course, there is a bus after we have traveled for one hour on foot. But it is costly. We cannot afford 30 birrs." (Woman, para 4, 28 years old)
"Women who are living in the city and around the road use cars. But women who are living far away have no option. They travel on foot. There is no car. As you see, the road is not suitable. In some areas there are forests, and there are hills in some other areas. We usually use traditional transport." (Woman, para 1, 19 years old)
Some women pointed to the need for more ambulances to transport women to health facilities.
"They can go either on foot or by ambulance. But the ambulance is rarely available. The health extension worker advised mothers to go early using a private car instead of waiting for the ambulance; nonetheless, women do not want to pay." (TBA, 30 years old)
However, as emphasized by the HEW supervisor, reliance on ambulances to transport laboring women to health facilities is not a sustainable option since they are reserved for emergency situations.
"We have an ambulance but we use it for emergency cases. As you see, there is a transportation problem. Women often travel a long distance to reach the nearest health facilities. Roads are not suitable for buses. Women also do not want to pay for transportation." (HEW supervisor, 27 years old)

Discussion

As evidenced by the obtained results, barriers to the optimal utilization of obstetric services among Menit women are similar to those experienced by other women in low-resource settings. According to Menit women, community-based HEWs and TBAs, barriers in accessing facility-based delivery services are mostly centered on the first and second delays. However, the quality of services which are provided by health facilities influences women's decision about seeking delivery care at those centers.

The sharp contrast between uncooperative, ill-equipped health workers at hard-to-reach health facilities and personalized, culturally-acceptable care received from village-based TBAs discourage women from seeking delivery care at facilities. Perceived and actual disrespectful maternity care and abuse has been documented (25, 26) which contribute to the low proportion of facility deliveries across various setting (27, 28).

Within Ethiopia, observers reported at least one instance of mistreatment against women in almost 40% of health facilities evaluated in Tigray, Amhara, Oromia and SNNP regions (29). In a similar vein, instances of abuse and neglect were described as important contributors to low uptake of antenatal care services in pastoralist communities of Kenya (20).

As illustrated in the present study, women and TBAs themselves acknowledge that health workers are in the best position to manage delivery complications. They believed that normal delivery can be safely managed at home with TBAs. This is consistent with the findings reported in Asia and Africa (3, 28), including other parts of Ethiopia (30). A belief that normal delivery can be managed at home with TBAs may cause unnecessary delays. A qualitative study conducted in 11 zones in Ethiopia confirmed that TBAs extend delays by referring laboring women to healthcare facilities when complications which are beyond their capacity arise (31).

Another study conducted in Butajira district in the southern regions of Ethiopia reported that TBAs sometimes continued to provide care to women even after the development of life-threatening complications which sometimes resulted in death (32). TBAs are also valued for their ability to provide easily accessible care during pregnancy, delivery, and postpartum period. Being a part of the community where women reside means they speak their language and are familiar with preferences and important cultural rituals. These aspects were important to women from pastoralist communities in Kenya who discussed their preferences for delivery locations (33).

The perception that deliveries can proceed safely outside of health facility settings may partially be due to a lack of awareness regarding the risks associated with giving birth. This may be particularly higher among distant households not easily reached by HEWs who disseminate health education to the communities. More

research is required in this pastoral community to establish the levels of HEW contact, awareness of risk, and available services and identify households that are marginalized due to distance.

Furthermore, the heavy reliance on support and approval from husbands may pose a challenge to those women who may be more inclined to give birth at health facilities.

Women in pastoral communities in the southern region of Ethiopia often have only limited control over key productive resources, such as livestock and land. (34). According to several groups which were interviewed, cultural traditions surrounding marriage and wife's position adversely affect access to health facilities for delivery. Husband provides the dowry and assumes full control over his wife and her decision-making. In fact, HEWs have trouble directly accessing women and stated they often had to first refer to husbands multiple times.

A better understanding of male's perspective on the use of obstetric services is necessary to appropriately target and apply interventions in this community.

Male spouses have been reported to act as both facilitators and hindrances in various settings(28). It is of utmost importance to investigate the nature of men's resistance to facility-based deliveries in this community. Is it driven by financial constraints, poor awareness of risks of home deliveries, concerns about household management, or simply lack of respect for women? It will be equally essential to identify other key decision-makers in this community since pregnancy and childbirth are often considered to be women's domains in certain African settings(35) suggesting senior women, such as mothers-in-law may be significant in this regard. Furthermore, in some cases, husbands are willing to actively support their wives during pregnancy and delivery; nonetheless, they are discouraged by the absence of "couple-friendly" health service settings or are excluded by women themselves (35).

In addition, women's preference for the kind of male involvement in this communities is not fully known yet. In South Africa for instance, some women wanted their husbands to be involved in antenatal and postnatal care. However, they do not want their husbands to be present during delivery, while some others regarded the presence of their husbands as a "protection against the nurses" (36).

It is widely accepted that population-specific practices are "framed as cultural barriers" to the utilization of services in some instances (37). Nonetheless, a distinction needs to be made between preferences that a responsive, people-centered health system (38) should endeavor to integrate and those that inflict considerable harm to users. This requires the careful assessment of communities rather than relying on assumptions about cultural practices that are often dismissed as un-modern and damaging. In the present study, for instance, women's preference for alternative birthing positions, the presence of family during delivery, and the freedom to walk around during labor should be considered.

In addition, the recruitment of sufficient number of female midwives to enable women to deliver in comfort and dignity, as well as the mobilization of health professionals that can speak the local language, needs to be considered. Furthermore, more efforts are required to ensure that women are aware of their right to access maternal services. In fact, some evidence demonstrated that those interventions which promote this awareness among women and their communities can even improve the utilization of services (39).

To improve the trustworthiness of obtained results, we followed different approaches of data collections, including IDIs and FGDs. Some participants (HEWs and HEW supervisors) were also invited to comment on the research findings and themes. The fact that all of the data collectors were male might have exerted an impact on obtained information. However, efforts were made to develop a good rapport with female participants through respectful approaching, clarifying women's response, and using encouraging gestures and words during the data collection process. In the current study, husbands' opinions were not explored due to financial constraints; nevertheless, their view were explored through the lens of women, TBAs, HEWs, and HEW supervisors.

Conclusion

As evidenced by the obtained results, pastoral women's tendency to deliver outside health facilities can be attributed to some factors. They include limited awareness of risks associated with home delivery, lack of financial resources, long distances between houses and health facilities, inadequate infrastructure and transportation, lack of decision-making power, and substandard care at health facilities. Consequently, these factors fuel social norms in favor of home deliveries with TBADs. Moreover, it is essential to develop a better awareness of the most influential barriers to the utilization of institutional delivery services to appropriately target and apply interventions.

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Conflicts of interest

Authors declared no conflicts of interest.

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