

# Care seeking for maternal health: challenges remain for poor women

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## Abstract

**Background:** In 2005 a Safe Motherhood Community-Based Survey was carried out on behalf of the Family Health Department to explore community values and practices surrounding pregnancy, childbirth and the postpartum period.

**Objective:** To explore the knowledge, attitudes and beliefs which influence maternal care seeking behaviour and practices in pregnancy and childbirth.

**Methods:** Qualitative data - focus group discussions and in depth interviews with women, men and adolescents- were gathered from communities distributed across Ethiopia's 11 regions. Data were analysed using Nudist software.

**Important findings:** The location of childbirth involves retaining control of the process and outcome, and securing a safe delivery. The pregnant woman is influenced by her attendants; families only seek care for complications if local or herbal, remedies and prayer are defeated. Timely care seeking is reliant on the knowledge, understanding and financial means of the husband. Distance, cost and lack of support for the cultural practices around birth are impeding factors.

**Conclusions:** Communities are aware of the dangers of giving birth at home. Women are constrained by the distance and cost in reaching and receiving care. Important traditions around birth are not recognised by health providers. Socio-cultural aspects must be addressed and incorporated into the care provided at the health facilities. [*Ethiop. J. Health Dev.* 2010;24 Special Issue 1:100-104]

## Introduction

Maternal and neonatal morbidity and mortality rates in Ethiopia are among the highest in the world and stem from a range of socio-economic, political and demographic factors. Many of these deaths are preventable. In 2000 less than 30 percent of women attended antenatal care and less than 10 percent delivered with a skilled attendant or in a health facility. Out of the expected 2.9 million deliveries a year, 2.6 million are likely to occur at home with assistance of TBAs (26%), relatives (58%), or alone (6%). Only 3.5 percent of these women are likely to receive any postnatal care (1). Obstructed labor (22%), sepsis (12%), hemorrhage (10%) and hypertension (9%) constitute the direct obstetric complications, after unsafe abortion, leading to maternal mortality (1). Estimates for maternal mortality in Ethiopia (between 1999 and 2005) are around 720 per 100,000 live births (2).

In 2005 a national Safe Motherhood Community-Based Survey was carried out on behalf of the Family Health Department (FHD) in the Ministry of Health to explore community values and practices surrounding pregnancy, childbirth and the postpartum and neonatal period, the influences of those values and practices on health seeking behaviour, and the barriers and enablers to seeking and utilizing health services. The survey was carried out across the 11 Regions of Ethiopia in 16 selected sites which represented a cross-section of livelihoods, gender roles and status, and disparity in access to maternal and neonatal health services. The details of the survey sites are reported elsewhere (3). Following the production of the final report of the Safe Motherhood Community

based Survey (SMCBS), Population Council was requested by JSI/LTK project to carry out more in-depth analysis of the data from four of the regions: Amhara, Oromiya, Tigray, Southern Nations, Nationalities and Peoples Regions (4,5,6,7). One of the objectives of the SMCBS and the main objective of this paper is: To explore the knowledge, attitudes and beliefs which influence maternal care seeking behavior and practices in pregnancy, labor and childbirth.

## Methods

The study employed qualitative rapid assessment techniques to elicit the data which enabled researchers within the selected communities to examine issues influencing maternal and neonatal health seeking behavior and practices. Data were gathered from communities distributed across all of Ethiopia's 11 regions in 16 sites in order to obtain a composite picture of community access to, and perceptions of, maternal and neonatal health services. Data collection was carried out in one to two kebeles per geographic region, depending on the relative heterogeneity and security situation of that region. The kebeles were randomly selected from pre-identified regional zones (identified according to disparity of livelihoods and religio-ethnicity), and mobilized by personnel identified by the Regional Health Boards. The experience of over 1000 Ethiopians representing all regions, dominant religions and ethnic groups were obtained through 110 focus group discussions, 241 in-depth interviews, 37 key informant interviews and 17 verbal autopsies. Participants included adolescent girls and boys, newly delivered mothers, older women, men with young children, health providers,

traditional birth attendants (TBAs) and elders. Emphasis was placed on the principles of informed consent, privacy and confidentiality and the researchers explained the objectives of the study, and a guarantee that all contributions would remain anonymous. Participants were encouraged to use local terms and concepts to describe knowledge and practices, and in doing so to construct a picture of the socio-cultural and demographic dynamics that influence maternal and neonatal health, and the care-seeking behavior of the community.

All discussions and interviews were recorded on labeled tapes, and the responses were backed up with detailed notes and observations taken by a non-participating colleague. A core group of medical anthropologists monitored the consistency and quality of data. The transcription of data, and translation into English, was initiated during the data collection process, and overseen by a medical anthropologist in Addis Ababa. The transcriptions were entered and analyzed using 'Nudist' software.

### Results

The decision to choose the location for the birth (which is frequently within the home) is largely determined by the husband and sometimes other senior family members such as the mother-in-law or older sister-in-laws. The main overriding factors that contribute to the decisions and prevent women from accessing care during birth include: the lack of awareness of the decision makers as to the importance of skilled attendance at birth; the rapid onset of complications; the lack of accessible roads, harsh terrain and weather conditions, and high transport costs to reach the facilities; and the high costs of treatment within the facilities. TBAs (both trained and untrained) said they only send the mothers to deliver in the hospital if there is a severe complication. Many women prefer giving birth in the comfort of their own home. Often facilities do not allow close relatives or friends to be around the mother during labor, yet that support is known to sustain the woman during the birthing process. However some fathers from the region indicated that their most recent children were born in hospitals but this was due to a recognized problem during pregnancy or early labor.

Preference for the exact location of birth is within the home where women feel most comfortable; either inside her bedroom, on the floor next to the fireplace in the kitchen where it is warm or another secluded area. By tradition, the husband does not normally enter the delivery room but he should be around the house: *'It is important for the husband to be around, because if the wife encounters severe complications during childbirth, he can take her to the hospital'* (woman Oromiya).

Findings also indicate that men are reluctant to go away when their wives are in their late stages of pregnancy "... last time when I was asked to go for a training, I refused because it was almost time for my wife to give birth and she was weak... But they forced me and I went. But I couldn't follow the lesson attentively..." (Amhara). One man from Oromiya stated: *"I held my wife's hand and supported her body. I shared her anxiety as well"*.

The recognition of obstetric complications was relatively consistent across genders, although women, men and TBAs varied in the responses they considered to be appropriate. Recognition of the cause and severity of the complication directly correlates to subsequent care-seeking behavior. The protagonists involved in the decision-making process are not limited to the woman experiencing the complication: the TBA or birth attendant, the husband, and various relatives, all influence the decision to varying extents. TBAs and elder women are the groups most likely to recognize the significance of complications and to recommend an effective course of action.

The response to complications reflects the dichotomy between theory and practice. The strong religious foundations of all the communities, both Christian and Islamic, are manifest in a philosophical acceptance of unfolding events: 'God's will' is often cited as an explanation or justification, and the prevailing belief in prayer as a strategy may contribute to delays in taking more proactive steps. *'If a mother is in this kind of situations, her only hope is to pray to god. It is rather better than going to a hospital'*. Thus the first response to a problem is to pray, and subsequently, if no improvement is observed, to apply local/herbal solutions to the complication, and, as a last resort, to refer to a health facility.

There is a strong trans-regional association of a heavy workload during pregnancy with subsequent complications "...the fetus will also be damaged or negatively affected inside due to heavy tasks of the mother during pregnancy" (SNNPR). Inadequate birth-spacing combined with poor nutrition during pregnancy (Amhara) are thought to physically weaken the mother and extend labor. Some women acknowledged that a young mother is physically unprepared for childbirth and therefore more susceptible to complications.

The majority of all respondents identified breech presentation, prolonged labor, maternal exhaustion retained placenta, prolapsed uterus and excessive bleeding in the mother and stillbirth in the infant as the main problems during childbirth and why they will seek care at health facilities. Hemorrhage is the most

frequently cited complication and most common cause of maternal death. Men in SNNPR however perceived bleeding as normal during a woman's first delivery. Women are expected to deliver the 'second baby' (the placenta) into a hole, but excessive bleeding is a frequent complication. Some complications are recognized as worthy of referral, while others are considered as 'normal' despite variations in severity: *'If the child's position was not correct, they would have taken me to the hospital. But since it was correct, they just waited until I delivered'*. This was despite the fact that the woman was losing a considerable amount of blood: *They let the blood flow out because they said I wouldn't have stomach aches after the blood has flown out'* (Oromiya). Participants from Oromiya said that delivery could also be complicated by female genital cutting which scars the genitalia and causes prolonged/obstructed labor.

Many women indicated that when complications do occur during pregnancy, labor and childbirth, there is some laxity in making the decision to take her to the hospital. The husband will sometimes insist on waiting for some time, presuming that the situation might somehow rectify by itself. Nevertheless, some men do recognize negative consequences for women who deliver at home; Labor pains occurring when the mother has no one to assist her as people are working in farms, or labor occurs at night, or midwives are located far away. Even if the midwife is present then there are still complications such as the lack of mechanisms to curb excessive bleeding and the lack of knowledge in discerning and recognizing complications. They often delay in informing the mothers during labor and delivery of any impending complications which can result in death ... *"We stay at our home and we give birth, by the time they tell us of complications, it is already dangerous ... we just die we do not have an option because we cannot afford to pay for a car to take us to hospital"* (woman from Amhara).

Traditional healers are often sought to remedy complications. Some believe that the placenta will be delivered when the woman takes herbs or other traditional medicine or procedures: *"it will come out, or else she may die"*. Another remedy described by a TBA in Amhara included tying cloth tightly around the woman's waist to prevent the placenta disappearing further into her body. An untrained TBA from SNNPR remarked: *"... They called me to discard the placenta. I helped the birthing mother by massaging her back and waist. For the cases where the placenta failed to come out, I would just insert my hand inside the mother and drag out the remnants..."*.

In the event of complications, the TBA generally guides the families when problems exist and advises the care givers present to escort the women to a health facility. Sometimes TBAs provide a referral letter. That makes it easier for the woman to get an emergency treatment at

the facility. The husband is expected to seek for credit facilities in case money has to be raised for transport if there is a complication. He will sell a cow or borrow from neighbors and friends to foot the bill – but often this takes place only once the complication has occurred. However if there is no money then nothing is done... *"... If she does not have money, she might die. The only thing we can do is to go to her funeral..."* (Father, Amhara).

Although mothers were fatalistic about not being able to make use of health facility services, due to lack of money, long distances, and or knowledge, many concurred that there were merits of going to the health facilities. They recognized that the health providers are experienced and qualified with the ability to handle complications especially if the woman bleeds or has a retained placenta. The providers will also refer to a higher facility if necessary. The provider also checks the baby and gives advice on how to care for the babies, including importance of immunization. The following cases illustrate the recognition of health providers' expertise and the influence of education and financial resources:

*"A woman became ill when she was about to deliver. They took her to Ambo Meda, then to Addis Zemen, then to Gondar because it was beyond their capacity. She had a cow and she sold it for 800 birr to cover transportation costs. She was able to get good medical care and returned healthy. If it was us (the poor), we could have died"* (woman Amhara).

*"If my husband does not have money, he may say 'why should I take you to a facility', out of ignorance. He will take me there only when the illness becomes serious or when I am close to death. If we had a facility here, I could just go without telling him and tell him to pay after I get treated"* (woman Amhara).

In contrast a number of respondents said they did not believe the health facilities offer anything that cannot be done at home. The main deterrent includes the added expenses in terms of food, service provision and transport costs to the facility. Some believe that the health providers do not help at all and certainly do not offer the newly delivered mother the variety of specific foods around childbirth nor recognize the cultural ceremonies to ward off evil spirits. In addition many fathers believe that the mothers should stay in the facility two or three days to recover from the birth and not put themselves and newborn at additional risk traveling so soon after birth. Maternal mortality is perceived to be due to delays of health service delivery or due to negligence of the health professionals. Community members believe there are a lot of unnecessary referrals whenever a complication is realized thus wasting time while moving from center to center leading to eventual deaths.

## Discussion

The socio-cultural environment creates, sustains and enforces community beliefs and practices, which in turn, influence the status of maternal and neonatal health. Understanding the context in which such beliefs and practices evolve is central to developing strategies to address health issues, as the outcomes of interventions are highly dependent on community acceptance and attitudes.

The location of childbirth involves a balance between retaining control of the process and outcome, and securing a safe delivery. The majority of births continue to occur in the community, with unskilled attendants. Factors that contribute towards community births include the fact that mother and family retain control and ownership over the process and outcome of childbirth and they have community care and support especially in carrying out the cultural elements surrounding childbirth. Other factors that influence the decision include: the identity and knowledge and education level of the decision-maker and the financial resources of the household. The male role during childbirth is primarily as a decision-maker, but the community does value the emotional and practical support offered by husbands especially in the event of complications, in order to facilitate referral and the necessary resources. The existence and perceived severity of an obstetric complication as well as the perceived capacity and skills of available health providers, contribute to the decision on where to give birth.

Physical distance from expert care is a well recognized factor contributing to maternal morbidity and mortality (8). Historically, single solutions over the last few decades such as the promotion of ANC and use of TBAs have not resulted in reductions in maternal morbidity and mortality (9). While it is recognized that emergency obstetric care can save lives, delays in deciding to seek care and reach care mean that these services are underutilized.

TBAs are a key variable in the outcome of childbirth: they influence the birth preparedness, the progress and hygiene of childbirth, and the recognition and referral of complications. Community members with higher levels of education and exposure to information are more likely to recognize the potential benefits of formal health care, and to respond to complications at an earlier stage. Community knowledge and recognition of danger signs such as bleeding, retained placenta and obstructed labor are broadly consistent with bio-medical recommendations. A number of respondents implied that women who deliver in a health facility are perceived to have relinquished control over the process to health

providers who appear to be insensitive to traditional elements of childbirth and their attitudes alienate clients. In addition, shortages of trained personnel, lack of equipment, drugs and other commodities mean that when women and their families do seek care, the nearest facilities are ill equipped to deal with the problems and have to be referred elsewhere.

## Conclusion

Although expectant mothers benefit from high levels of community support, both moral and practical during pregnancy and childbirth, very few decide on delivering with a skilled attendant. Many prefer delivering at home in the company of known and trusted relatives and friends where customs and traditions can be observed. Even though communities are aware of the dangers around childbirth, contingencies for potential complications are rarely discussed or made. Such that most families hope or pray that things will turn out well. When things go wrong precious time is lost in finding resources and man power to assist in the transfer to a health facility. However it has to be recognized that the women and their families are constrained by a number of factors which include distance and cost in reaching a facility as well the fact that important traditions and customs around birth are not recognized by health care providers. Until these socio-cultural aspects are recognized by the health care providers and incorporated into the care provided at the health facilities we will continue to see women giving birth at home.

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