

'Waiting-to-see' if the baby will come: Findings from a qualitative study in Kafa Zone, Ethiopia

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Abstract

Background: Much of the quantitative research on maternal mortality in developing countries focuses on the need for health service interventions such as skilled attendants at birth and emergency obstetric and newborn care. A growing number of studies document the need for a more comprehensive perspective and include the macrostructural, that is, the social, cultural, economic and political determinants of health.

Objectives: To examine the salient aspects of birth at home and variables that influence decision making around transfer to a health facility during prolonged/obstructed labor.

Methods: Ethnography using participant observation and semi-structured interviews was conducted in 2007. A total of 56 mothers in Kafa Zone were selected: 20 in-depth interviews with women who gave birth at home; four who gave birth in a health facility; and 32 during antenatal care. Interviews were also conducted with health staff from Bonga Hospital and 15 health centers or health posts. Analysis followed a process of data reduction, data display and conclusion drawing/verification with the data organized around key themes.

Results: Most women gave birth at home assisted by their neighbor, mother, mother-in-law, or husband. It is likely women who gave birth at home feel 'safe' because that is where birth normally takes place and where they feel supported by close relatives and neighbors. Prolonged labor or 'waiting-to-see' if the baby would come was somewhat normalized and resulted in considerable delays to seeking assistance. Women felt it was 'unsafe' to go to a health facility because of the very real possibility that they would die on the way.

Conclusion: The findings highlight the importance of educating the local communities to recognize pregnancy related risks and to develop and implement appropriate responses, especially early referral, as communities play an important mobilizing role to health services. [*Ethiop. J. Health Dev.* 2013;27(2):118-123]

Introduction

Evidence-based medicine utilizing both quantitative and qualitative approaches is becoming increasingly common as studies document the need to take a comprehensive perspective and include 'the macro-structural i.e., the social, cultural, economic and political determinants of health' (1) to better understand the problems of maternal mortality. Quantitative studies from Ethiopia provide data on maternal mortality and morbidity levels and the low utilization of modern health services particularly in rural areas (2-9). Ethiopia is committed to achieving Millennium Development Goal (MDG) 5 by improving access to and strengthening facility-based maternal health services (4), and by increasing institutional deliveries by skilled health workers to 62% by 2015 (10), but some studies have concluded that Ethiopia is unlikely to meet these targets (11, 12). This quantitative data provides a strong basis to determine policy and practice to improve the accessibility and quality of maternal health services. On the other hand, qualitative data can examine the socio-cultural environment that underpins community beliefs and practices about maternal health.

Many qualitative studies examine how maternal and neonatal health are influenced by the socio-cultural environment which 'creates, sustains and enforces community beliefs and practices' (13) that often result in delays in seeking outside care during childbirth. One

study calls for a holistic approach emphasizing improved access to health care and education, enhanced social status and mechanisms to alleviate poverty as the factors influencing health are multiple and complex (14). Some studies focus on key behaviors around contraception and antenatal care (ANC) and call for improved quality and availability of health services and workers, community organization and participation, and health education (15), improved promotion of family planning and interventions by health extension workers (HEWs) or skilled health workers (12). Other studies call for better relationships between health providers and communities to encourage mothers to seek care for their newborns (16). Some authors have examined the social context for reproductive health decision making as women need their husband's permission to use contraceptives or find ways to access contraception secretly (17-19).

Quantitative and qualitative research on CARE international's Safe Motherhood programs in West Haraghe Zone determined the barriers to prompt and effective treatment of obstetric and neonatal complications and the interventions undertaken to increase the availability and quality of Emergency Obstetric and Newborn Care (EmONC) (20-22). The results demonstrated that it was counter-intuitive to educate and motivate the community to seek EmONC before addressing accessibility and quality of health

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services. Training traditional birth attendants (TBAs) resulted in significant improvements in infection prevention, provision of Vitamin A and iron, health education related to family planning and referral for high risk mothers. Following major renovations in two hospital maternity units and a new record keeping and data collection system, brought about a significant change to the UN process indicators: doubling the Cesarean section rate; and increasing the met need for EmONC from 2 percent in 2001 to 4.5 percent in 2004. The result was a 35 percent decline in the case fatality rate.

Maternal health care has been emphasized as a public health issue, but the reduction of maternal mortality is a central MDG so it is important to assess maternal health in terms of development: a woman’s ability to access and utilize ANC and skilled attendance at birth is affected by her status and empowerment ‘measured by education, employment, intimate partner violence, and reproductive health’ (23). Yet there are many barriers that affect a woman’s ability to access maternal health services: health service availability alone is not enough to increase utilization.

This paper is part of a larger qualitative study that explored the place of MDG 5 in the Ethiopian national development agenda (18). It examines the salient aspects of birth at home and the variables that influence decision making around the transfer to a health facility during prolonged/obstructed labor. This paper describes how prolonged labor is ‘normalized’ during birth at home in Kafa Zone resulting in considerable delays to seeking skilled delivery assistance.

Methods

The ethnographic method is suited to studying international development because it is ‘informed by the theoretical perspective that assumes the interconnectedness of the different facets of life-political, economic, social, and cultural’ (26). Ethnography searches for ‘patterns of meanings and emotions that make up culture and how these make sense of actions in everyday life’ (27), such as the effect of time and distance in seeking health care services (28, 29). In this study women were asked to describe their last birth experience, where the birth took place, who attended during the labor, and whether they attended ANC.

Protecting the rights of the participants and emphasizing the voluntary nature of the interviews, confidentiality and the right to withdraw at any time are the starting points for ethically based qualitative research. Ethical clearance was sought and approved from Deakin University Human Ethics Committee. The Ethiopian Federal Ministry of Health provided letters of introduction to health facilities in Kafa Zone. Informed consent, either orally or in writing in English, Amharic or Kafficho was obtained from all participants. To ensure privacy, each

participant was given a pseudonym and the results de-identified.

Participants

Semi-structured interviews with 56 women were conducted: 20 women gave birth at home and four in a health facility. Sampling was purposive snowballing through introductions by my interpreter and her family and then by women in Bonga, Sheyka, Chiri, Wushwush and Deckia. All the women were, or had been married. Most lived in the context of poverty but were experiencing social change: 11 women had received some education ranging from three months during the Dergue to Grade 8. A further 32 women were interviewed during ANC at Chiri Health Center, Deckia Clinic or Bonga Hospital.

Interviews were also conducted with three senior administrative staff from the Zonal and *Woreda* health offices, seven non-government organizations (NGOs), Bonga Hospital and from 15 health centers or health posts visited by the researcher. The results of these interviews are reported in my doctoral thesis (18).

Location of the Study

The study was located in semi-urban and rural areas in Ghimbo and Decha *woredas* in Kafa Zone. Kafa is dominated by steep hills, gorges and streams and has large areas of natural forest renowned for their high biodiversity values that are the habitat of wild Ethiopian coffee. Participant observation was used to describe the research setting, particularly how walking defines an approach to living where all activities and decisions are framed by time and distance (30).

Method of Analysis

Analysis of interview data followed a process of data reduction, data display and conclusion drawing/verification occurring concurrently: as interview data was transcribed, the data was organised around key themes. (31).

Results

Local communities in Ethiopia perceive that the knowledge and resources to ensure a healthy pregnancy are ‘generally available within the community’: this includes advising women not to travel long distances, not to expose themselves to the sun during pregnancy (13), nor to cold while going to or staying in the health facility; and not to expose ones’ body to others (20). Most women gave birth in the privacy of their home with the assistance of their neighbor, mother, mother-in-law, husband or sister. This included women who lived five minutes’ walk from the clinic in Deckia, 45 minutes’ walk to Bonga Hospital, or eight hours walk to Chiri Health Center. One woman described how she felt ‘alone’ during birth by saying that no one was there to watch over her, even when she was *at death’s door*. Although her husband was with her, she lived far from

her family, and had no close friends or neighbors to call on for support.

Two of the four women who delivered in a hospital or health center planned to do so after attending ANC. Reasons for attending ANC were: referral by a HEW; to find out the position of the baby; to receive a Tetanus Toxoid vaccination; feeling unwell; or to enquire about family planning to prevent future pregnancies. Younger women were more likely to attend ANC but formal education appeared to have had limited influence on whether women attended ANC or received appropriate treatment for complications during childbirth.

Women stated that the main role for the birth assistant during labor was to hold the women tightly on the shoulders from behind so she felt supported and to massage the abdomen with *kibbi* (butter) or hair food (Vaseline). Most women reported that someone had massaged their abdomen during labor to deal with pain and speed up the labor. By contrast, health practitioners stated that abdominal massage and shaking the women were causes for stillbirth, uterine rupture, bleeding and even death.

Women needed to be 'strong' during childbirth as this was associated with the length of labor: *If I am strong it takes one hour ... my legs and my back are shaking and they say don't be afraid.* Although women expected to experience pain they would plead to *Maryam* (Mary) for help because she is associated with childbirth.

A number of women said that birth needs to take place in a special hut and that it needs to be kept secret or hidden because if other people know it might bring bad luck and make the labor too long. Another cause of prolonged labor was thought to be unpaid debt; if a woman's husband owed money and had not paid it back, the owed person had cursed them. One woman in Sheyka explained how passing birds could bring good or bad luck: *If we hear a bird say 'koi, koi, koi' it's not good for her, something might happen to her, she might die.*

Prolonged labor was described by many women who had been, or knew women who had been in labor for many days: *hoping the baby would come.* Raydet from Wushwush was in labor for five days at home before she was transferred to Bonga Hospital for a forceps delivery. Yet Tigiste from Chiri provided an evocative example of how long labor should be before a woman needs to be taken to the health center: *We decide, for example, if labor starts at dusk, and it stayed overnight, and the daybreak is over and in the morning it is time to prepare coffee and the woman is still screaming, and no one has prepared coffee, it is time to think about the health center.*

Decisions about referring a laboring woman to a health facility were made by the women's husband, close relatives and neighbors, and sometimes even village

elders or witchdoctors. With only one exception, all the women and health workers stated that the financial cost of treatment was a problem. Two women said that poor women might die because they could not afford medicine or to go to the hospital. Women and health workers explained how negotiations about payment for the registration card, gloves, and antibiotics created extra delays at the hospital.

Meseret was an in-patient at Chiri Health Center. Two weeks earlier she had been referred from Deckia Clinic (two to three hours from her home) with swollen ankles and breech presentation. Although she had agreed to deliver at Chiri, she went home to wait until the baby was due. The labor started in the night, *nine days early.* After some time, her husband started to organize the neighbors to carry her. They made a stretcher and borrowed money from Meseret's cousins. The journey took about eight hours over mountainous terrain. Around 20 men helped to carry her. Along the way, Meseret was in terrible, agonizing pain, tied to the stretcher. She said she cried the whole way. Half way to Chiri, they *knew the baby had died.* Later the health officer told me that Meseret had been in labor at least two days and though the baby's body had been born, the head was stuck. What Meseret did not say was that only the day before her labor started, her neighbor's child had been washed out of his father's arms when they were trying to cross the river on the way to Chiri for medical care. Meseret delayed because she was afraid of crossing the river which was in flood during the rainy season.

Birke recalled how she had been in labor for three or four days. Her family kept hoping the baby would be born but the labor continued. Birke was carried by stretcher for five hours to the road at Gojeb and eventually taken by bus to Bonga. In Bonga Hospital she was in labor for another two days. The baby died but they did not remove it as she needed a blood transfusion which could not be done at the hospital. Birke's husband went home, sold their ox and borrowed extra money for her treatment and the cost of transportation. Finally, Birke was taken to Jimma Hospital where the dead baby was removed by Cesarean section. Birke left her husband because of ongoing ill health and now lives with her elderly mother and relatives in Sheyka.

In summary, even though most women knew that things could go wrong during birth, techniques to deal with prolonged labor at home included shaking the woman, shouting, massaging her abdomen or binding it with cloth, and praying to *Maryam*. Many women knew of others who were taken to the health center or hospital during labor but died on the way. And, if labor was at night it meant waiting until the morning as no one travelled at night including NGO personnel from Chiri Health Center who had two vehicles at their disposal.

Discussion

Around 15 percent of live births in Ethiopia are expected to develop serious obstetric complications: in sub-Saharan African countries the most common causes of direct maternal death are hemorrhage, sepsis, prolonged and obstructed labor, pregnancy induced hypertensive disorders, and complications of unsafe abortion (32). After listening to the women’s stories there appeared to be two ways to think about birth: at home and in the hospital [and health center] (33). In most cases, from the women’s point of view, home was the first ‘choice’ for the location for birth—the biomedical option was ‘chosen’ only when something went wrong or the situation was deemed to be ‘abnormal’ after a number of days. Some women believed that negative outcomes could be attributed to bad spirits, birds or debt (13). Like women in other cultures where the ideals of courage and stoicism at birth are important (34), women needed to be ‘strong’ during childbirth. Essentially, ‘normative health behavior’ was characterized by exploring traditional methods first and ‘waiting-to-see’ if things improved on their own because of the very real possibility that women could die ‘on the way’ (35) to a health facility.

The Three Delays model is a useful tool that shows the dissonance between the socio-cultural and biomedical understandings of health-seeking behavior (13). In essence, it is a medical model of maternal survival based on the understanding that most maternal deaths caused by direct causes are preventable with prompt medical intervention (28). Delays in receiving care are a prominent factor in maternal death: delays in deciding to seek care; delays in reaching appropriate medical facilities; and, delays in receiving quality care at the medical facilities. Although women and health workers reported that cost was a major barrier, delays in deciding to seek care for prolonged/obstructed labor were common. Women were not always involved in decisions about their health (4, 17, 18, 36, 37), but when a decision to seek medical care was taken, the importance of relationships with relatives and neighbors became paramount as they would be asked to lend money, help make a stretcher and carry a woman to the nearest health facility. Mountainous terrain, the long distances and lack of transportation also contribute to delays.

Women walk long distances to attend ANC and family planning, but achieving the goal to increase skilled birth attendance in rural Ethiopia to 62% by 2015 (10) is not likely to be reached in rural Kafa Zone.

Conclusion

Substantial effort has been made to build more health facilities and employ more skilled birth attendants in Ethiopia. This study shows that qualitative research can help explain why the availability of health care services alone is not enough to increase utilization or to achieve skilled attendance at birth. Most women interviewed gave birth at home with the assistance of their neighbor, mother, mother-in-law, or husband. The experiences of

women such as Meseret or Birke illustrates that once people recognize there is a problem such as prolonged/obstructed labor, there are many delays at both community and facility level before women receive EmONC. The findings of his study highlight the importance of educating local communities to recognize pregnancy related risks and to develop and implement appropriate responses, especially early referral, as rural communities already play an important mobilizing role to EmONC at health facilities that did not exist 10 to 15 years ago.

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