TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ANC	Antenatal Care
BEmONC	Basic Emergency Obestetric and Newborn Care
CEmONC	Comprhensive Emergency Obstetric and Newborn Care
EDD	Expected Date of Delivery
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fisical Year
FGD	Focus Group Disscussion
FMOH	Federal Ministry of Health
HBM	Health Belief Model
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
MDG	Millinium Development Goals
MMR	Maternal Mortality Ratio
PHCU	Primary Health Care Unit
PNC	Postnatal Care
SBA	Skilled birth attendant
TBA	Tradtional Birth Attendant
UN	United Nations
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Globally, maternal and newborn health has received strong attention in the past two decades. The international community adopted the improvement of maternal health as one of the eight Millennium Development Goals (MGDs) in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015 (WHO, UNICEF, UNFPA & the World Bank Estimates 2012:3).

The world observed an average annual decline of 3.1% in maternal mortality ratio (MMR) which indicates “making progress”. This is far from the annual decline of 5.5% required to achieve MDG5. Eastern Asia is “on track” with 5.7% average annual decline, Northern Africa nearly made the target at 5.3% while Sub-Saharan Africa is making progress with an average decline of 2.6% per year. In 2010, ten countries have already achieved MDG 5 while nine other countries are “on track”, meaning they have shown an average annual decline of 5.5% or more in MMR. Ethiopia is among fifty-one countries labelled as “making progress” in MMR reduction (WHO, UNICEF, UNFPA & the World Bank Estimates 2012:27).

The World Health Organization (WHO) conducted a systematic review analysis on the cause of maternal death. The 2005 report of the World Health Organization revealed that haemorrhage (25%), hypertensive disorders (12%), sepsis (15%), unsafe abortion (13%), obstructed labour (8%), other direct causes (8%) and indirect causes (20%) are the most prominent leading factors of maternal death albeit regional distribution variation observed among causes of maternal death. However, most causes of maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to skilled care and emergency obstetric care during pregnancy, childbirth, and after childbirth, as timely management and treatment can make the difference between life and death (Khan, Wojdyla, Say, Gülmezoglu & VanLook 2006:1066; WHO 2005b:62).

In order to track the changes in maternal mortality levels, the proportion of births attended by skilled health personnel is one of the indicators to monitor progress towards the achievement of the fifth Millennium Development Goal (MDG) which aims to improve maternal health. Now many countries, including Ethiopia are working to meet the WHO recommendation of having skilled care during pregnancy, childbirth and the immediate postnatal period (WHO 2004:1).

In Ethiopia, maternal and newborn health is also among the top priority areas in the national reproductive health strategy and health sector development program IV (FMOH 2006:16; FMOH 2010:50). The Ethiopian Federal Ministry of Health (FMOH) has set targets of deliveries attended by a skilled birth attendants (62%) and MMR of 267/100,000 live births by 2015 (FMOH 2010:50). However, only 34% and 10% of women who gave birth in the five years preceding the survey received antenatal care (ANC) and delivery care from a skilled provider respectively while only 6% of women who gave birth in the two years before the survey received postnatal care (PNC) from a skilled provider (Central Statistical Agency of Ethiopia and ICF International 2012:119).

This study described and explored the individual and community perceptions and experiences of the utilisation of skilled birth attendance services. Understanding the perceptions and experiences of the individual and community on utilisation of skilled birth attendance services and reasons for not utilising skilled birth attendance services led to the development of strategies to improve the utilisation of skilled birth attendance services. The chapter introduces the study by providing an overview of the entire thesis report. It provides the background information to the study, which highlights the core issues that stimulated the researcher's interest to investigate on this topic. The chapter also highlights the research problem, aim and significance of the study, the foundations, research design and methods of the study. The conclusion to the study consists of a brief discussion of the study scope, limitations, and its overall structure.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Maternal morbidity and mortality in developing countries, including Ethiopia, continue to pose challenges to the health care delivery system. Ethiopia's rates of maternal and newborn morbidity and mortality are among the highest in the world. In Ethiopia, the maternal mortality ratio has almost remained the same in the 2011 Ethiopian

demographic and health survey (EDHS 2011) (676/100,000 live births) as it was in the 2005 EDHS (673/100,000 live births) (Central Statistical Agency of Ethiopia and ICF International 2012:270). The Government of Ethiopia is committed to achieving Millennium Development Goal 5 (MDG5), to improve maternal health with a target of reducing the maternal mortality ratio (MMR) by three-quarters over the period 1990 to 2015 (Central Statistical Agency of Ethiopia and ICF International 2012:119).

Accordingly, the FMOH has applied multi-pronged approaches to reducing maternal and newborn morbidity and mortality. Improving access to and strengthening facility-based skilled care for maternal and newborn services is one such approach, and is also a Health Sector Development Plan (HSDP) strategic objective (FMOH 2010:50).To reduce maternal and neonatal mortality, the FMOH has devised the following strategies and has been implementing them since 2006 (FMOH 2006:17-19):

- Empowering women, men, families, and communities to recognise pregnancy-related risks, and to take responsibility for developing and implementing appropriate responses to them;
- Ensuring access to a core package of maternal and neonatal health services, especially in rural areas where health facilities are limited; and
- Creating an environment supportive to safe motherhood and the health of newborn babies.

Skilled maternal care or skilled birth attendance services refers to maternity services (antenatal, delivery, and postnatal care) by a health professional with midwifery skills that can be provided at different levels (home, health centres or hospitals). In order to provide such skilled maternal care, health facilities need to have an enabling environment and skilled providers. An enabling environment includes the following:

- Functional health facilities and a reliable referral system to link the different levels; and
- Awareness and readiness of the community to utilise skilled care as well as supporting the policy and political commitment (WHO 2004:1).

Health professionals who have been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period,

and in the identification, management or referral of complications are categorised as skilled care providers (Carlough & McCall 2005:201; Hrvey, Ayabaca, Bucagu, Djibrina, Edson, Gbangbade, McCaw-Binns & Burkhalter 2004:204). In Ethiopia, skilled care providers include midwives, nurses, health officers and doctors. Cham, Sundby and Vangen (2009:2) presented a three-delay model to explain the chain of factors responsible for the high maternal morbidity and mortality in low-income countries. The first delay is by the individual, the family or both in making a decision to seek care. This delay is due to socio-economic or cultural factors which include women's status, decision-making, financial and opportunity costs. The second delay is by women failing to reach the health care facility due to physical accessibility, cost of transportation and the condition of roads (delay II). The third delay is when women take time to receive appropriate and adequate care once at the health facility due to shortage of resources or competence of personnel (delay III). In a review paper, Gabrysch and Campbell (2009:34) used the three delays model to group the determinants of delivery service usage into socio-cultural, perceived need, economic and physical accessibility.

Socio-cultural and economic accessibility factors such as higher maternal education, higher maternal age, education, household wealth, lower parity and urban residence increase skilled care use during ANC, delivery, and PNC (Agha & Carton 2011:31; Babalola & Fatusi 2009:43; Gabrysch & Campbell 2009:34; Mengesha, Biks, Ayele, Tessema & Koye 2013:130; Say & Raine 2007:816).

According to Vallières,Hansen,McAuliffe,Cassidy,Owora,Kappler and Gathuru (2013:48), Birmeta, Dibaba and Woldeyohannes (2013:256) and Tsegay, Gebrehiwot, Goicolea, Edin, Lemma and Sebastian (2013:30), heads of households with secondary or higher education were more likely to seek a skilled birth attendant or health facility delivery than heads of households with some primary education. The results of this study suggested that increasing educational access among male heads of households plays a substantial role in improving utilisation of skilled birth attendance services.

According to Sychareun, Hansana, Somphet, Xayavong, Phengsavanh and Popenoe (2012:[4-6]), the following were identified as obstacles to giving birth at health facilities:

- Distance to the health facilities and difficulties and costs of getting there;
- Poor staff attitudes, perceived poor quality of care;

- Care practices that include a horizontal birth position, episiotomies, lack of privacy, and the presence of male staff;
- The wish to have family members nearby and the need for women to be close to their other children and the housework; and
- The wish to follow traditional birth practices such as giving birth in a squatting position and lying on a “hot bed” after delivery.

This study pointed out the need for health facilities to consider accommodating the wishes and traditional practices of many rural Laotians. This was exhibited by allowing family in the birthing rooms, allowing traditional practices, and improving attitudes among staff. A case control study conducted in Ethiopia revealed that the likelihood of delivering at home was greater among mothers with inadequate knowledge of pregnancy related services, those who started attending ANC after 24 weeks of gestation, mothers having no formal education, and rural residents (Abebe, Berhane & Girma 2012:653).

Distance to the facility, advice by a health worker on place of delivery, knowledge of danger signs and a higher number of ANC visits were also found to be determinants of utilisation of skilled birth attendance service (Mpembeni, Killewo, Leshabari, Massawe, Jahn, Mushi & Mwakipa 2007:29). A study conducted in Bangladesh showed that increased numbers of ANC visits were associated with increased uptake of health facility delivery (Pervin, Moran, Rahman, Razzaque, Sibley, Streatfield, Reichenbach, Koblinsky, Hruschka & Rahman 2012:111).

Shiferaw, Spigt, Godefrooij, Melkamu and Tekie (2013:[5]) conducted a study in rural Ethiopia to address key birth challenges. These challenges included challenges related to transportation, availability of obstetric services and costs of facility delivery. The researcher used an ongoing project that gave a unique opportunity to understand why women might continue to prefer home delivery. In this study, 71% of mothers received ANC from a skilled health professional for their most recent birth; a skilled birth attendant assisted 16% of deliveries, while traditional birth attendants assisted a significant majority (78%) of the mothers. The most important reasons for not seeking institutional delivery were the belief that it is not necessary (42%) and not customary (36%), followed by high cost (22%) and distance or lack of transportation (8%). The

research identified the following reasons for the preference of traditional birth attendants over health facilities:

- Traditional birth attendants were seen as culturally acceptable and competent health workers;
- Perceived poor quality of care and previous negative experiences with health facilities;
- Women's low awareness of the advantages of skilled attendance at delivery;
- Little role in making decisions (even when they want); and
- Economic constraints during referral.

In the 2011 EDHS 61% stated that a health facility delivery was not necessary, and 30% stated that it was not customary and 14% said that the health facility was either too far or did not have transportation (Central Statistical Agency of Ethiopia and ICF International 2012:129).

A study conducted in Uganda showed that the prevalence of recently delivered women who had knowledge of three or more key danger signs (19%) or those who were birth prepared (35%) was very low. The study also showed that those who had knowledge of at least one key danger sign during pregnancy or during postpartum had been found well prepared for birth (Kabakyenga, Östergren, Eleanor & Pettersson, 2011:33). The findings also revealed that women made the final decision on the location of the birth in consultation with either the spouse or other people. The likelihood of giving birth assisted by a skilled birth attendant was very high. However, when women made the final decision alone, the likelihood of giving birth assisted by SBAs was significantly reduced (Kabakyenga, Östergren, Eleanor & Pettersson 2012:[4]).

A cluster randomized trial conducted in rural Tanzania by Magoma, Requejo, Campbell, Cousens, Merialdi and Filippi (2013:435) revealed that the implementation of birth plans during ANC can increase the uptake of skilled delivery and post-delivery care without negatively affecting women's and providers' satisfaction with available ANC services. As a result, the study suggested the consideration of birth plans along with the range of other recommended interventions as a strategy to improve the uptake of maternal health services. Another study conducted in Uganda among women who had a delivery

in the past two years identified the following indepenadent factors that favoured delivery in a health facility:

- Experiencing previous difficult delivery;
- Preference of supine position for second stage of labour;
- Preferring health workers to dispose the placenta;
- Not having difficulty with transport; and
- Being autonomous in the decision to attend antenatal care (Anyait, Mukanga, Oundo & Nuwaha 2012:132).

A qualitative study conducted by Magoma, Requejo, Campbell, Cousens and Filippi (2010:13) in rural Tanzania revealed that the failure of health care providers to consistently communicate the importance of skilled delivery and immediate post-partum care for all women during routine antenatal visits, fuel women's preferences for home birth and failure to plan for skilled delivery. The study also showed that husbands are rarely encouraged to attend antenatal sessions. Even in circumstances where husbands are encouraged to participate in antenatal sessions, messages about the importance of skilled delivery care for all women are not emphasised.

Data analysis made from 2003 Kenya Demographic and Health Surveys (KDHS) indicated that women's lifetime experiences of emotional and physical intimate partner violence decrease the odds of skilled attendance at most recent delivery. These findings suggested the importance of addressing gender power dynamics in programs seeking to increase skilled attendance at birth (Goo & Harlow 2012:1131).

Kumbani, Bjune, Chirwa, Malata and Odland (2013:9) conducted a qualitative study in rural Southern Malawi to explore the reasons why women delivered at home without skilled attendance despite receiving antenatal care at a health centre. The study identified the onset of labour at night, rainy season, rapid labour, socio-cultural factors and poor health workers' attitudes as factors related to the women delivering at home. This study also suggested a need for further exploration of barriers that prevent women from accessing health care for better understanding and subsequently identification of optimal solutions with involvement of the communities themselves.

Yakoob, Ali, Ali, Imdad, Lawn, Broek and Bhutta (2011:S7) conducted a meta-analysis on the impact of skilled birth attendance and the provision of emergency obstetric care on stillbirths and perinatal mortality rate. The meta-analysis revealed a significant reduction in stillbirth rate observed with skilled birth attendance. A systematic review and meta-analysis conducted by Tura, Fantahun and Worku (2013:18) also found that health facility delivery reduced the risk of neonatal mortality by 29% in low and middle-income countries.

Despite the recommended skilled care during ANC, delivery and PNC, the utilisation of skilled maternal care in Ethiopia remains poor. According to the 2011 EDHS, only 34% and 10% of women who gave birth in the five years preceding the survey received ANC and delivery care from a skilled provider respectively. Six percent of the women who gave birth in the two years before the survey received PNC from a skilled provider (Central Statistical Agency of Ethiopia and ICF International 2012:119). According to the FMOH, ANC coverage (at least one visit) increased from 89.1% in Ethiopian Fiscal year (EFY) 2004 (2011/2012) to 97.4% in EFY 2005 (2012/2013). The PNC coverage increased from 44.5% to 50.5% while the percentage of deliveries attended by skilled health personnel increased from 20.4% in EFY 2004 to 23.1% in EFY 2005 (FMOH 2013:10).

This study is a qualitative, exploratory, and descriptive design that intends to explore and describe the perceptions and experiences of the individual and community on the utilisation of skilled birth attendance services in North West Ethiopia. The findings from the study will guide the development of a community-based strategy to improve the utilisation of skilled birth attendance services.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Ethiopia's rate of maternal and newborn morbidity and mortality are among the highest in the world. Current estimates of maternal mortality stand at 420 deaths per 100,000 live births (WHO 2012:32). Direct obstetric complications account for 85 percent of these deaths as well as countless chronic conditions. The high maternal mortality rates are also directly related to low infant survival rates and the high neonatal mortality rate of 37/1000 live births. A key factor contributing to both high maternal and newborn mortality is the low rate of skilled care during pregnancy and delivery.

The Ethiopian government provides skilled delivery services at health centres, hospitals, non-governmental and private health facilities. Inspite of the availability of these services free of charge in government health facilities, non-skilled health personnel attend 80% of the deliveries. This situation increases the chances of maternal and newborn morbidity and mortality; hence the need to undertake the study.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of this study is to determine factors influencing skilled birth attendance services utilisation in order to develop strategies to improve the utilisation of skilled birth attendance services in North West Ethiopia.

1.4.2 Research objectives

In order to achieve the purpose of this study, a number of objectives are set. The objectives of the study are:

- To explore and describe the individual and community perceptions and experiences of utilisation of skilled birth attendance service;
- To explore and describe reasons for non-utilising skilled birth attendance service;
- To explore and describe the barriers for women to utilise skilled birth attendance service;
- To explore and describe the health care providers experience of offering skilled birth attendance service; and
- To develop strategies and to improve the utilisation of skilled birth attendance services based on the findings from the views and experiences of the health professionals and women.

1.5 RESEARCH QUESTIONS

This study sets out to address the following research questions:

- What are the perceptions and experiences of the individual and community on the utilisation of skilled birth services?
- What are the views and experiences of the health care providers with regard to offering skilled birth attendance services?
- What are the reasons for the non-utilisation of skilled delivery services?
- What are barriers for women to utilise skilled birth services?
- What are the possible strategies and interventions to improve the utilisation of skilled birth attendance services?

1.6 SIGNIFICANCE OF THE STUDY

The researcher envisages that the results of this study would help to understand the perceptions and experiences of the individual and community on the utilisation of skilled birth attendance services and contribute to the existing body of knowledge in the subject area. The findings of the current study will lead to the development of strategies that would improve the utilisation of skilled birth attendance services. These strategies would help the health system to design and implement interventions that will improve the utilisation of skilled birth attendance services. This, in turn, would contribute to improved maternal and newborn health outcomes.

The strategies are developed as a reference for policy makers, health managers, health care providers, and other stakeholders to improve utilisation of skilled birth attendance services. Policy makers should also consider the strategies in formulating policies that set out to improve the utilisation of skilled birth attendance services. The Ethiopian Federal Ministry of Health and other levels of the health system need to implement the strategies to improve the utilisation of skilled delivery services. Hence, this would ultimately contribute to the reduction of maternal and neonatal morbidities and mortalities. The strategies could be used as guidelines to help inform the education development programme necessary for the continued improvement of maternal and newborn health. Further research could be conducted on the effectiveness of the implemented strategies in the utilisation of skilled birth attendance services.

1.7 DEFINITION OF TERMS

1.7.1 Conceptual definitions

1.7.1.1 Client

The *Oxford Advanced Learner's Dictionary* (2010:1112) defines a client as a person who is receiving medical treatment. In this study, the client refers to women who receive skilled birth attendance services in health facilities.

1.7.1.2 Skilled birth attendant

A skilled birth attendant (SBA) is "an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns" (WHO 2004:1-2). In Ethiopia, specialist doctor, general practitioner doctor, health officer, midwife and a professional nurse are labelled as skilled birth attendants whereas a health extension worker, who is assigned and working at a health post level, is considered as a non-skilled birth attendant.

1.7.1.3 Perception

The *Oxford Advanced Learner's Dictionary* (2010:1132) defines a perception as a particular attitude towards something or viewpoint. In this study, perception refers to women's, health care providers', and health managers' views on the utilisation of skilled birth attendance services.

1.7.1.4 Experience

The *Oxford Advanced Learner's Dictionary* (2010:534) defines experience as things that have happened to people and influence the way they think and behave. In this study, experience refers to women's, health care providers', and health managers' experience of the utilisation or offering of skilled birth attendance services.

1.7.1.5 Maternal death

This refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, UNICEF, UNFPA & the World Bank Estimates 2012:4).

1.7.1.6 Strategy

A strategy is a long-term plan of action designed to achieve a particular goal, more often 'winning' (http://www.oxforddictionaries.com). According to Muller, Bezuidenhout and Jooste (2011:569), a strategy is a plan of action that prescribes resource allocation and other activities for dealing with the environment and helping the organisation to attain its goals. In the context of this study, strategies are proposed solutions to improve the utilisation of skilled birth attendance services.

1.8 THEORETICAL FRAMEWORK

The Health Belief Model (HBM) will guide this study and it will also guide the research questions, explain and support the findings of the study. The HBM focuses on patient compliance and preventive health care practices. The model postulates that health-seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the perceived benefits with actions aimed at reducing the threat. The HBM contains several primary concepts that predict why people will take action to prevent, to screen for, or to control illness conditions. These concepts include susceptibility, seriousness, benefits and barriers to a behaviour, cues to action, and self-efficacy (Champion & Skinner, 2008:45; Polit & Beck 2010:124).

In this proposed study, the HBM would help in explaining why some pregnant mothers take action to prevent health complications by utilising skilled birth attendance services, while others shun from utilising skilled birth attendance service. According to Champion and Skinner (2008:49), the HBM is organised into three major components that attempt to explain human behaviour towards health services utilisation, and in the case of this proposed research, pregnant women behaviour towards the utilisation of skilled birth attendance services, specifically:

- Individual perceptions of pregnant mothers regarding the utilisation of skilled birth attendance services; and
- Modifying factors which could influence women perceptions and behaviours towards the utilisation of skilled birth attendance services, including:
    - Demographic factors such as age, ethnicity;
    - Socio-demographic variables such as personality, social factors, economic factors;
    - Structural variables related to women's knowledge about the benefits of utilising and risks of not utilising skilled birth attendance services;
- Variables affecting the likelihood of pregnant mothers' initiation of actions to utilise skilled birth attendance services.

The premise of the HBM is that individual pregnant women's health beliefs are influenced by their perceptions of the skilled delivery services. Modifying factors such as maternal education, maternal age, household wealth, parity and place of residence could influence the utilisation of skilled delivery care (Agha & Carton 2011:31; Babalola & Fatus 2009:43; Gabrysch & Campbell 2009:34; Mengesha et al 2013:130; Say & Raine 2007:816). Socio-cultural factors could also influence the pregnant women's decisions as to whether or not to utilise the skilled delivery services.

Variables related to the perceived benefit might motivate the pregnant mothers to utilise skilled birth attendance services. Perceived barriers such as the health workers' negative attitudes and the lack of accessibility, perceived poor quality of care, acceptability and availability of the skilled delivery services could influence the decision not to utilise the skilled delivery services.

The premise of the HBM is that individual pregnant women's perceived threat to pregnancy related complications could influence the utilisation of skilled delivery services. According to Gabrysch and Campbell (2009:34), complications experienced during current or previous pregnancies could influence the utilisation of skilled delivery care. Health education, counselling, birth preparedness and complication readiness practices and effective social support systems are likely to initiate cues for action. Figure 1.1 below depicts the HBM constructs and their relationship among constructs.

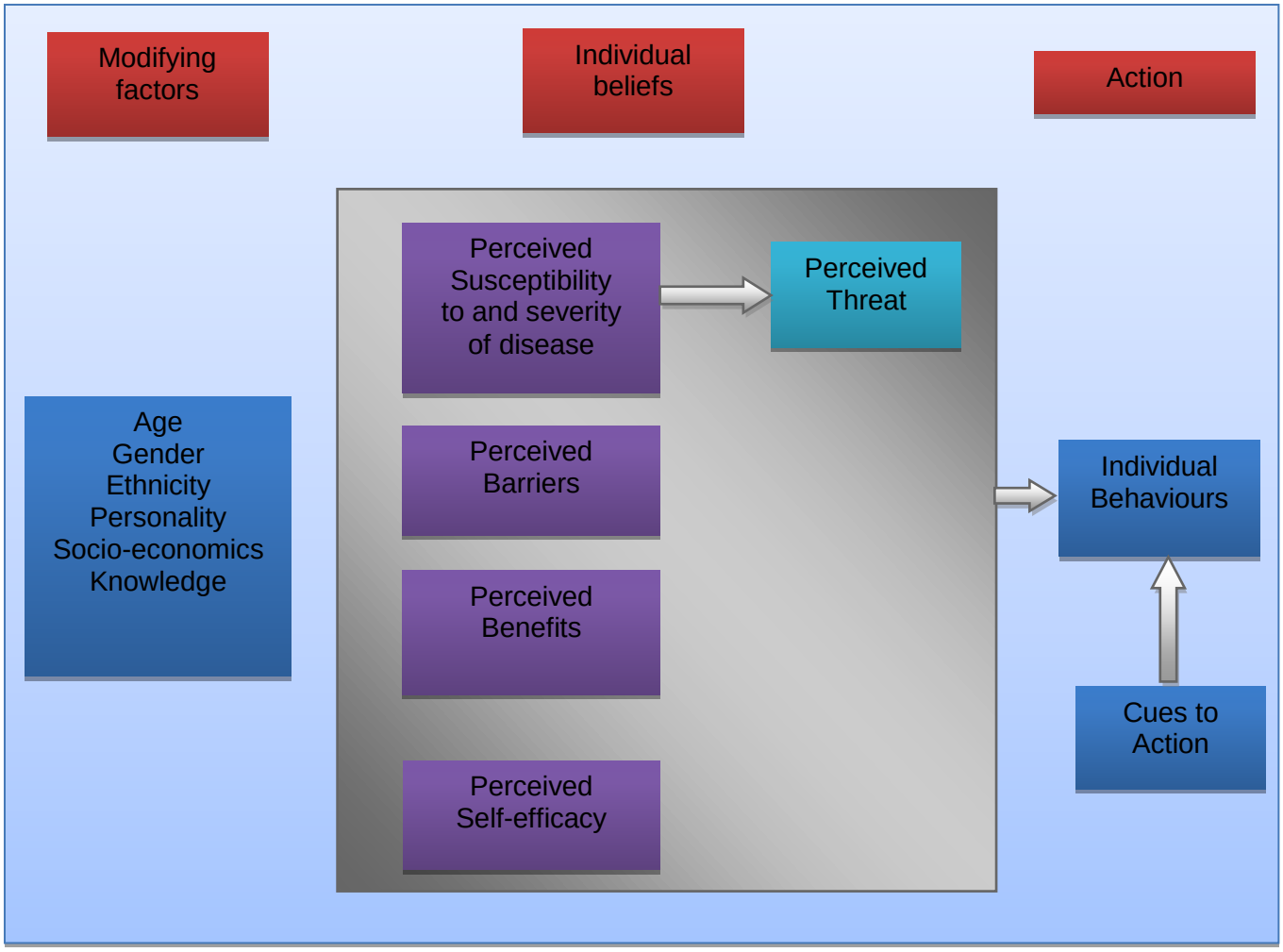

Figure 1.1 Health Belief Model

(Champion & Skinner 2008:49)

1.9 RESEARCH DESIGN AND METHODOLOGY

Saunders, Lewis and Thornhill (2009:136) describe a research design as a general plan of how the researcher will go about answering their research questions, starting from the formulation of research questions to the final analysis of data. There are two research methodological approaches i.e. quantitative and qualitative approaches. The quantitative research design is based on making observations, developing hypotheses, making predictions, and testing the predictions, while qualitative research design provides an in-depth understanding of the perspectives and experiences of various issues from the participants themselves (Lyons & Doueck 2010:85-86).

Therefore, this study uses a descriptive and explorative research design to address the research questions formulated by the researcher. The research consists of two interdependent phases that will focus on the compilation of evidence in preparation for and development of strategies.

Phase I will be the collection, analysis and interpretation of empirical data for this study. The purpose of this phase is to explore and describe the individual and community perceptions and experiences of skilled delivery care utilisation in order to develop strategies to improve the utilisation of skilled birth attendance. Phase II will be the development of strategies to improve the utilisation of skilled birth attendance. The development process of the strategies will be based on the empirical data collected and analysed during phase I.

1.9.1 Setting

The setting of the study is West Gojjam zone in Amhara regional state, Ethiopia. West Gojjam zone is one of the 11 administrative zones of Amhara regional state and has a population of approximately 2.3 million. It is located 385 kilometres North West of Addis Ababa, the capital city of Ethiopia. West Gojjam zone has 15 rural districts or woredas and 5 city administrations; 370 rural kebeles; 370 health posts;100 health centres; 1 zonal referral hospital; and 5 district hospitals.

Burie zuria and Wombrema districts are among the rural districts of West Gojjam zone. They are located about 25 kilometres away from the zonal town, Fenot selam. Burie zuria district has 19 kebeles and a population of about 110,111 while Womberema woreda has 19 kebeles and a population of 106,472.

Furthermore, Burie zuria district health office comprises four primary health care units (PHCUs) under its supervision namely: Tiatia, Kuche, Alefa and Dereqwua PHCUs and all of them will be included in this study. Womberema District Health Office also consists of four PHCUs and three of them namely: Shendi, Koki and Wogedade. PHCUs will be represented in the current study. Finally, one health post and one health centre will be selected from each of the PHCUs. As a result, a total of seven health posts and seven health centres will be included in this study. Chapter 3 provides a detailed account of the study setting.

1.9.2 Phase 1: FGDs with pregnant and recently delivered women and in-depth interviews with health extension workers (HEWs), midwives, and district health office staff

1.9.2.1 Research design and methods

Yin (2010:8-9) describes qualitative research methods as researching about persons' lives, lived experiences, behaviours, emotions and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations. Preference and/or experiences of researchers and nature of the research problems are among the valid reasons for choosing qualitative research methods. Therefore, the study employs an explorative, descriptive and qualitative research design to explore and describe the perceptions and experiences of the community regarding skilled birth attendance services utilisation, and the health care providers' experiences of offering skilled birth attendance services.

1.9.2.2 Population and sampling

The study will use a purposive sampling with sub-populations to select the study participants in this study. The samples are composed of pregnant women; women who gave birth recently; health extension workers (HEWs); primary health care unit directors; midwives who are currently working in the maternity unit; district health office maternal and youth reproductive health technical officers; and head of district health offices. The study participants will be individuals who had adequate knowledge of or experience with the research topic of interest. The saturation of information during data collection will determine the sample size for the different study participants. Chapter 3 provides a detailed account of the target population and the study sample.

1.9.2.3 Data collection procedure

The study will use semi-structured interviews and focus group discussion guides to collect data on the perceptions and experiences of the community regarding the utilisation of skilled birth attendance services and the experience of offering skilled birth attendance services. The instruments consist of open-ended questions to enhance the

richness of the data collected. The researcher will conduct in-depth interviews with HEWs, PHCU directors, midwives, district health office head and maternal and youth reproductive health technical officers. The researcher will also conduct focus group discussions with pregnant women and women who gave birth recently. All interviews and FGDs will be audiotaped. The researcher will also take down field notes on observations during data collection. Chapter 3 outlines a detailed description of the data collection procedure.

1.9.2.4 Data analysis

Data analysis will take place simultaneously with data collection. The current study will adopt an inductive thematic analysis approach, where themes that emerge from this analysis are firmly grounded in the data. The Qualitative data analysis will be conducted using Atlas ti version seven qualitative data analysis software. The basic steps for the qualitative data analysis of the current study are reading, coding, displaying, reducing and interpreting. A detailed account of the data analysis is presented in chapter 3.

1.9.3 Phase 2: Development of strategies to improve utilisation of skilled birth attendance service

Phase II will focus on the development of strategies to improve the utilisation of skilled birth attendance. The development process of the strategies will be based on the empirical data collected and analysed during phase I. It will result from the analysis and synthesis of the findings of phase I study to come up with the ultimate goal of the current study that is the development of strategies to improve the utilisation of skilled birth attendance.

This study will also culminate in the development of draft strategies from the identified themes, formulation of strategy statements and provide a rationale to support their existence and present these strategy statements as draft strategies. The draft strategies will be summarised, operationalised and developed into interim strategies. The interim strategies will then be given to expert health professionals and managers for analysis and validation before they are finalised. The researcher will present the strategies to some of the initial participants in Phase I and other experts. Final strategies will be

developed following recommendations on the validated interim strategies. The strategies will be discussed in detail in chapter 6.

1.10 ESTABLISHING TRUSTWORTHINESS

As cited in Holloway (2005:296), trustworthiness is “the credibility of the findings in a piece of qualitative research and the extent to which readers can have trust in the research and its findings”. The rigor of the qualitative research is described by trustworthiness, which ensures the extent to which the study findings can be valued. To ensure trustworthiness, the researcher employed Lincoln and Guba’s framework (Lincoln & Guba 1985 in Polit & Beck 2010:492; Shenton 2004:64) of trustworthiness in qualitative research. The research ensured trustworthiness of the findings through ensuring the credibility, dependability, confirmability and transferability in the research, which are criteria for trustworthiness (Given & Saumure 2008:895; Polit & Beck 2010:492; Shenton 2004:64). A detailed description of issues in trustworthiness, including the four criteria of trustworthiness, is discussed in chapter 3.

1.11 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from University of South Africa (UNISA) Department of Health Studies’ Higher Degrees Committee and Amhara Regional Health Bureau Research and Laboratory Department to conduct the current study (see Anexures 1 and 4). The UNISA Akaki Regional Learning Centre wrote a letter of support to the Amhara regional health bureau to conduct the study (see annexure 2). The Amhara regional health bureau wrote a letter of support to West Gojjam zonal health department. Then, the West Gojjam Zonal Health Department wrote a letter of support and granted access to the selected district health offices. Finally, the district health office heads, PHCU directors and head of health posts allowed me to conduct the study in the selected district health offices, health centres and health posts. The ethical clearance certificates and letters of support have been annexed in the current study. The current study complies with moral principles of respect for persons, avoidance of harm, beneficence and justice. Details of these are presented in chapter 3.

1.12 STRUCTURE OF THE THESIS

This thesis report consists of six chapters and the following section outlines the content of each chapter:

Chapter 1: Orientation of the study

The chapter gives an overview of the whole study. It discusses the background, research problem, statement of the research problem, aims and objectives of the study, significance of the study, the theoretical framework, the research design and methodology, ethical consideration, trustworthiness and the layout of the thesis.

Chapter 2: Literature review

This chapter reviews the literature on issues pertaining to skilled birth attendance services. The chapter highlights the theoretical concept for utilisation of skilled birth attendance services, describes the theoretical framework and provides reasons for the non-utilisation of skilled birth attendance services, sketches out the determinants of skilled birth attendance services utilisation, skilled birth attendance service and maternal and newborn health outcomes, and highlights the strategies to improve the utilisation of skilled birth attendance services.

Chapter 3: Research design and method

The chapter presents the study's research paradigm and research design, data collection approach and methods, data collection instruments and data analysis, trustworthiness and finally ethical considerations.

Chapter 4: Analysis and presentation of the research finding

The chapter discusses the analysis of data and describes the research findings.

Chapter 5: Discussion of the research findings

The chapter presents and discusses the research findings.

Chapter 6: Development of strategy to improve the utilisation of skilled birth attendance services

The chapter explains the process of developing the strategy and presents the final strategies.

Chapter 7: Conclusion and recommendations of the study

This chapter deals with the conclusion, recommendation, further research, and limitation of the study.

1.13 CONCLUSION

This chapter presented and discussed the general overview of the study. The background problem, significance of the study and the research problem, the purpose of the research, the objectives and the research question for this study were also discussed. The research design and methods, including the data collection, data analysis, study setting, the ethical considerations and trustworthiness also form part of this chapter. The next chapter reviews the literature that relates to the focus of the current study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a review of literature on the existing body of knowledge regarding skilled delivery care, international, regional and national progress towards millennium development goal 4 and 5, determinants of the utilisation of skilled birth attendance, reasons for not utilising skilled delivery care and strategies to improve the utilisation of skilled birth attendance. Relevant studies were identified through a review of research articles found through electronic search and the UNISA Library.

According to Polit and Beck (2010:170), a literature review is a critical task that summarises relevant literatures to provide background information on the existing body of knowledge about the area of interest and inspires new research ideas. It also forms the basis for the current study and helps to interpret the findings of the study. Saunders et al (2009:61) also state that the main purpose of reviewing literature is to get a better understanding of the research area from previous research works and the trends that have emanated to date.

2.2 DESCRIPTION OF THE THEORETICAL FRAMEWORK

Theories are abstract but come alive in public health and health behaviour when they are filled with practical topics, goals and problems. Theories can be used to guide research undertakings. Theories have concepts as their components, which are the building blocks. When concepts are developed or used for a particular purpose, they become constructs. Variables are operational forms of constructs; they specify how a construct should be measured. Several theories combined can explain a specific problem or form models. Different theories are best suited to different situations. The adequacy of a theory is more often assessed in terms of three criteria:

- Its logic or internal consistency in not yielding mutually contradicting derivations;

- The extent to which it is parsimonious or broadly relevant while using a manageable number of concepts; and
- Its plausibility for fitting in with prevailing theories in the field" (Glanz, Rimer & Viswanath 2008:26).

In line with these facts, the Health Belief Model has been chosen for the current study.

2.2.1 Health Belief Model (HBM)

According to Julinawati, Cawley, Domegan, Brenner and Rowan (2013:679), the Health Belief Model (HBM) is a conceptual framework used for understanding health behaviour and why individuals did or did not engage in a wide variety of health related actions. It is most widely used in health behaviour research to change and maintain health related behaviour, and as a guiding framework for health behaviour interventions (Champion & Skinner 2008:45). The HBM embraces several constructs that predict why people will take action to prevent, to screen for, and to control disease conditions. These constructs include, but are not limited to the following:

- Susceptibility (the likelihood of contracting a disease or condition);
- Seriousness (one's belief in the intensity of the medical condition and its undesirable outcomes);
- Benefits (one's belief that outcomes can be positively affected by engaging in a particular health behaviour);
- Barriers to behaviours (an individual's perception of the difficulties stopping them from following a specific health-related behaviour);
- Cues to action (factors that trigger actions); and
- Self-efficacy (belief in one's own ability to do something) (Champion & Skinner 2008:46; Jones, Jensen, Scherr, Brown, Christy & Weaver 2015:568; Julinawati et al 2013:679).

A study conducted in Zimbabwe used the HBM to identify factors influencing adolescents' non-utilisation of ANC services. The different components of the model are explained in relation to the study. Perceived benefits are related to pregnant women's adequate knowledge on ANC benefits. Perceived barriers include high ANC fees, unfriendly attitude of health workers, poor family and social support system, fear of HIV

testing, positive HIV status, and limited decision making power (Chaibva, Roos & Ehlers 2009:20).

A study conducted in China used the HBM to identify factors influencing the decisions that women make on their mode of delivery. The women's perceptions of vaginal delivery and caesarean delivery were assessed based on the five constructs of the health belief model. Among women who chose vaginal delivery, labour pain and post-partum haemorrhage were the perceived susceptibility. The perceived benefits of vaginal delivery were that it is a normal or natural process, allows early breast-feeding and ensures fast recovery. The perceived severity of foetal injuries and perineal tears were less as compared to caesarean delivery. Advice from friends, relatives and health professionals were found to be a cue for action. Whereas, abdominal wound infection and a long recovery time were pereceived suceptiblity of cesrean section preference. Furthermore, caesarean delivery had perceived benefits of avoid prolonged labour, prevent labour pain, minimise fear associated with prolonged labour and foetal injuries, and a faster and convenient way of delivery. It was also indicated that the perceived severity of anaesthesia usage, uterine scar raptures, and scar adhesion formation was less than their counterparts. The restrictions placed by the hospitals on caesarean delivery maternity room were found to be the perceived barrier. Advice from health care professionals, negative stories about vaginal delivery, and a family history of difficulty in childbirth were all cues to action for those who chose the caesarean delivery (Loke, Davies & Li 2015:8).

2.2.2 Justification for using the chosen theoretical framework

This theoretical framework best fits this study's area of interest. The HBM deals with the health seeking behaviour component of the study. It is concerned with why people take actions to screen or control illnesses. The barriers or enabling factors for the utilisation of skilled birth attendance services are best explained within the construct of this model.

The HBM helped to answer the research question: "what barriers and enablers influenced women's utilisation of the skilled birth attendance services?" The issues addressed in the research include perceived quality of care, influencers or motivators of using the skilled birth attendance services in previous or subsequent childbirth, and perceptions and experiences of the community regarding the utilisation of skilled birth

attendance. Besides, it helped to answer the comprehensive research questions of skilled birth attendance services. The model helped the researcher to maintain the focus of the study. It also assisted in organising the literature review, developing the data collection instrument, presenting and discussing the findings as well as making recommendations.

2.3 FACTORS AFFECTING THE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICES

This section presents factors affecting the utilisation of skilled birth attendance services in terms of the HBM's major tenets.

2.3.1 Perceived susceptibility

According to a cross-sectional study conducted in Ethiopia, knowledge of the required ANC visits and experiences of a pregnancy or delivery problem were positively associated with delivery by a SBA. Besides, women with an excellent perception about the quality of maternal health care at the nearest health facility were more likely to deliver assisted by a SBA compared to those who perceived the quality to be poor or average. Women who decided together with their husbands on a delivery place had a 4-fold increase in the odds of delivery by a SBA than those who decided unilaterally. Furthermore, women who were well prepared for the birth of the baby were more likely to deliver assisted by a SBA compared with those that were not well-prepared (Wilunda, Quaglio, Putoto,Takahashi, Calia, Abebe, Manenti, Riva, Betrán & Atzori 2015:5). Phiri, Kiserud, Kvåle, Byskov, EvjenOlsen, Michelo, Echoka and Fylkesnes (2014:1) report that a study from Kenya, Tanzania, and Zambia revealed that women who had repeated exposure to ANC services and received HIV related counselling and testing were more likely to utilise skilled birth attendance services.

Afulani and Moyer (2016:[3]) revealed that women's current health status, reproductive factors, prior health status or pregnancy complications, health knowledge, socio-economic, and socio-cultural factors influenced the perceived need for skilled birth attendance services. As cited in Bohren, Hunter, Munthe-Kaas, Souza, Vogel and Gülmezoglu (2014:5), women's prior delivery experiences and birth outcomes could inform their subsequent place of delivery.

2.3.2 Perceived severity

A study conducted in rural Bangladesh to examine factors associated with the utilisation of maternal health services revealed that women, having had a life-threatening condition, had a high likelihood to seek treatment for their maternal morbidities from a doctor or nurse (Chakraborty, Islam, Chowdhury, Bari & Akhter 2003:335).

According to a study done in rural Laotians, women and families expressed their preference for health facility childbirth if the labour is prolonged, there is excessive bleeding, or the baby is in breach presentation (Sychareun et al 2012:7).

A qualitative study conducted in Northern Ethiopia found that women thought that there was little that could be done at home or by TBAs when complications happened; therefore, health facilities are better prepared to manage obstetric complications (Gebrehiwot, Goicolea, Edin & Sebastian 2012:4).

2.3.3 Perceived benefits

According to a study in rural Gambia, women's perception that health care workers have the ability to handle complications, and the possession of the necessary equipment and skills were identified to be facilitators of childbirth at health facilities (Lerberg, Sundby, Jammeh & Fretheim 2014:41).

A qualitative study conducted in rural Tanzania revealed that mothers believed that maternal health services are beneficial. The services were utilised both during physical illness and during routine visits. Women claimed that health facilities have the advantage of providing investigations such as ultrasound to follow the development of the foetus in the uterus and treatment services. They also believed that health workers are well prepared to handle complications. Besides, they have received health education and advice from health workers with respect to nutrition, routine services, danger signs, and importance of skilled birth attendance services (Mahiti, Mkoka, Kiwara, Mbekenga, Hurtig & Goicolea 2015:5).

2.3.4 Perceived barriers

An analysis of the 2008 Nigerian Demographic and health survey employed the HBM to explain how perceived barriers affect the use of maternal health services by expectant mothers. Hence, getting permission to go for treatment, getting money for treatment, distance to health facility, transport cost, not wanting to go alone, concern that there may not be a female provider or any health provider, and concern that drugs may not be available were identified to be the perceived barriers for utilisation of maternal health services (Ajaegbu 2013:3).

Studies conducted in Nepal noted the following as the perceived barriers to access delivery care:

- Health facilities located far away;
- Unavailability of skilled female health workers;
- Women and families oblivious of delivery care;
- Inadequate availability and accessibility to delivery care;
- No time to go due to household chores;
- Lack of money; and
- Perceived lack of transport (Dhakal, Teijlingen, Raja & Dhakal 2011:373; Onta, Choulagai, Shrestha, Subedi, Bhandari & Krettek 2014:[1]).

A qualitative evidence synthesis of low and middle-income countries indicated that the perceptions of the birth process as a natural rite of passage, unfamiliar and undesirable birth practices in health facilities, fear of cutting, lack of privacy, and lack of supportive attendance during facility childbirth emerged as barriers for health facility childbirth. Furthermore, factors such as perceived poor quality of care in health facilities, mistreatment and abuse by health workers, neglect and delays in receiving care at the facility, and inadequate health facility staff and infrastructure were also identified to be barriers to the utilisation of skilled birth attendance services. Besides, the perceived stigma and discrimination in relation to fear of compulsory HIV testing in health facilities, fear of HIV status disclosure, and fear of treatment disparities among HIV positive women barred women from the utilisation of skilled delivery care (Bohren et al 2014:4).

2.3.5 Perceived self-efficacy

A study was conducted in Kenya to determine factors associated with skilled birth attendance utilisation among pregnant women attending antenatal care. Out of 324 pregnant women who agreed to participate in the study, 46% delivered at home while 54% of them gave birth in health facility. Besides, women with secondary school education and above were more likely to choose skilled attendance at delivery compared to those with less education, and women with previous pregnancies were less likely to utilise skilled attendance during delivery compared to nulliparous women. Women with male partners who had greater than a secondary school education were more likely to delivery with an SBA present and there was a trend for pregnant mothers accompanied by their spouses to the delivery to be more likely to deliver in a health facility when compared to those accompanied by other birth companions. Access to a vehicle as a mode of transport to the place of delivery was strongly associated with increased likelihood of delivery with an SBA (Kimani, Farquhar, Wanzala & Ng'ang'a 2015:2).

According to Amoakoh-Coleman, Ansah, Agyepong, Grobbee, Kayode and Klipstein-Grobusch (2015:4), women who are less likely to have skilled attendance at delivery can be identified during antenatal care by using data on wealth status class, health insurance coverage, residence, history of previous birth complications and religion, and targeted with interventions to improve skilled attendance at delivery.

2.3.6 Cues to action

A parturient woman may not be in a position to take a decision to seek facility-based delivery; however, the decisions were often made by elder women, husbands, and significant others. While the influence of some actors may facilitate accessing skilled care, the involvement of too many actors often results in the delay or prevention of facility-based births. Elder women have the greatest influence and decision-making power regarding delivery location across Asia and sub-Saharan Africa. Husbands play various roles in facilitating or preventing their wives from accessing facility-based deliveries. Families with social connections to skilled providers may be more accepting of the biomedical approach to maternity care and thus more willing to seek a facility-based delivery. More importantly, a relative or friend working at a nearby facility can

often arrange quicker admission or quality treatment of a parturient woman (Bohren et al 2014:4).

2.4 THE THEORTICAL CONCEPT OF SKILLED BIRTH ATTENDANCE

The United Nations Office of the High Commissioner for Human Rights (United Nations 2010:2) stipulates that universal access to reproductive health and the provision of quality obstetric care to improve maternal health is a matter of women's rights to life and health. As part of the effort to meet this basic women's human right and improve maternal health (millennium development goal 5) in particular, the United Nations (UN) has set two targets that have been planned to be achieved between 1990 and 2015.The first target is to reduce the maternal mortality ratio by three quarters between 1990 and 2015. The second one is to achieve universal access to reproductive health by 2015 (Islam & Yoshida 2009:2; WHO 2005a:18). According to United Nations (2003:31), the two basic indicators to monitor the progress of the first target are maternal mortality ratio and the proportion of births attended by skilled health personnel. Hence, accessing and provision of skilled delivery care at every birth is a critical intervention to reduce maternal and neonatal morbidity and mortality and improve maternal and neonatal health.

In recognition of the pivotal role of the skilled maternity care in reducing maternal and neonatal morbidity and mortality, the World Health Organization (WHO), International Confederation of Midwives (ICM) and International Federation of Gynaecology and Obstetrics (FIGO) are advocating a continuum of skilled care during pregnancy, childbirth, and the immediate postnatal period. The World Health Organization defined skilled care as care provided by an accredited and competent health professionals, who have the necessary equipment and functioning health system at service delivery points including functioning transport and referral systems, to women and their newborns during pregnancy, childbirth and immediately during the postnatal period. From the definition of skilled care above, varied health professionals, whose professional titles may vary according to the specific contexts of countries, can provide it. In order to avoid dilemmas over professional titles, it has been agreed to use the term skilled birth attendant in lieu of skilled care providers. A skilled birth attendant (SBA) is "an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal

(uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns" (Adegoke, Utz, Msuya & van den Broek 2012:5; WHO 2004:1-2). In Ethiopia, specialist doctor, general practitioner doctor, health officer, midwife and nurse professions are labelled as skilled birth attendants whereas a health extension worker, who is assigned and working at a health post level, is considered as non-skilled birth attendant.

There may be variations regarding labelling of health professionals as skilled birth attendant based on geographical settings, economic status of countries and levels of the health systems. However, all skilled birth attendants, wherever they are, must have the core midwifery skills and abilities (WHO 2004:3). A study conducted in nine sub-Saharan African countries from 2009-2011 revealed that 21 different categories of health professionals reported to be skilled birth attendant. The type and number of emergency obstetric and newborn care (EmONC) signal functions legislated to provide and reported performed varied substantially between these cadres and countries. Parenteral administration of antibiotics, uterotonics and anticonvulsants were reported performed by most SBAs. In contrast, manual removal of retained products of conception and assisted vaginal delivery were reported as the least provided signal functions. Utz, Siddiqui, Adetoro and Van Den Broek (2013:1064) state that in a study conducted in four South Asian countries (Bangladesh, India, Nepal and Pakistan), 13 healthcare providers were considered as SBA. But, a low percentage of these SBAs accounted to perform EmONC life-saving interventions in South Asia. Parental administration of antibiotics, oxytocics, and newborn resuscitation were provided by all these SBA. The administration of anticonvulsants varies across countries. However, manual removal of the placenta, removal of retained products of conception and assisted vaginal delivery are not performed by all SBAs required to provide skilled birth attendance services. According to Ith, Dawson, Homer and Whelan (2013:300), a descriptive qualitative study in Cambodia showed that a wide gap existed between evidence based standards of care known to reduce maternal morbidity and mortality and SBAs' actual practice during labour, delivery and the immediate post-partum period. Another observational study in Cambodia revealed that the current SBA practices during labour, birth and the immediate post-partum period were not consistent with evidence based guidelines and standards (Ith, Dawson & Homer 2012:60). According to Harvey, Blandón, McCaw-Binns, Sandino, Urbina, Rodríguez, Gomez, Ayabaca and Djibrina (2007:783), a wide gap had been observed between the current evidence

based standards and skilled birth attendant competence to manage selected maternal and neonatal complications. Therefore, a wide variation has been observed between the number and type of cadres labelled as SBA among countries and the current evidence based standards and SBA actual practice.

The successful provision of skilled birth attendance services requires the provision of an enabling environment in the health system. The term enabling environment in this case to means a well-functioning health system. For the health system to provide successful skilled birth attendance services, the following enabling environment must be in place:

- Regulatory frameworks, policies, standards and protocols;
- Adequate human resources and management systems;
- Availability of essential drugs, supplies, equipment and effective logistic management system;
- Facility and infrastructure maintenance system, transport and referral system; and
- Quality improvement mechanisms and functioning linkages between the health services and community (WHO 2004:14).

A qualitative study conducted in western Nepal on providers' perspectives on the enabling environment required for skilled birth attendance services. The providers indicated activities like capacity building through training and ongoing professional development, supportive supervision, appropriate infrastructure, sufficient supplies and equipment as an essential component of an enabling environment. Moreover, an enabling environment also reported to embrace support from communities and other health professionals and rapid referral mechanisms to provide quality skilled birth attendance services. In this study, training of SBAs, drug supply, community and health manager support were among the components of the enabling environment reported extant in all facilities. Less than half of the facilities were found to have adequate infrastructure, equipment and rapid referral mechanisms. However, none of the SBAs working outside the referral hospitals reported the presence of supportive supervision and continuous professional development. Providers who worked as sole SBAs felt uneasy to provide quality care for the management of life threatening obstetric complications. Hence, the providers suggested a deployment of more than one SBA in health facilities to receive strong attention (Morgan, Soto, Bhandari & Kermode 2014:7-

9). The provision of an enabling environment for skilled birth attendance is required for SBAs to fully exercise their skills and improve maternal and newborn health (Carlough & McCall 2005:205; Morgan et al 2014:9).

2.5 PROGRESS TOWARDS MILLENNIUM DEVELOPMENT GOAL 5

A number of initiatives launched in recent years are targeted towards the achievement of the fifth millennium development goal (MDG 5: improving maternal health), most notably the launch of the global strategy for women's and children's health in 2010 by the United Nations secretary general Ban Ki-moon (WHO 2014:3). The global strategy for women's and children's health states that the 49 lowest income countries are expected to ensure that an enabling environment created in the health system and 19 million more women would give birth supported by SBAs. This would result in a reduction of 570,000 maternal deaths between 2011 and 2015 (Ban Ki-moon 2010:12). To achieve the MDG 5, the United Nations has set a target of reducing the maternal mortality ratio by three quarters and 90% of births were attended by SBAs between 1990 and 2015 (Adegoke & Van den Broek 2009:33; WHO 2005a:18).

Globally, the maternal mortality ratio (MMR) has declined by 45% from 380 per 100,000 live births in 1990 to 210 in 2013, which is an average annual decline of 2.6%. Between 2005 and 2013, the maternal mortality ratio has decreased annually by 3.3% on average. In addition, the global adult lifetime risk of maternal mortality (the probability that a 15-year-old woman will die from maternal causes) was also estimated at 1 in 190 in 2013. Regionally, all geographical regions have shown a MMR reduction of 37% or greater between 2005 and 2013. The highest decline was observed in Eastern Asia (65%) followed by Southern Asia (64%), Northern Africa (57%), South-eastern Asia (57%), Oceania (51%), sub-Saharan Africa (49%), Caucasus and Central Asia (44%), Western Asia (43%), and Latin America and the Caribbean (40%). The MMR in developing regions (230) was 14 times higher than in developed regions (16). The developing regions contributed for 99% (286000) of the global maternal deaths. Of these, the Sub-Saharan African region alone accounted for 62% (179,000) followed by Southern Asia (69,000) and the Oceania region with the fewest maternal deaths (510) (WHO 2014:21-23). Therefore, despite the substantial progress that has been made in the reduction of MMR, the world is still falling short of achieving the MDG maternal mortality ratio target.

According to the WHO, MMR is considered to be high if it is ≥300–499 maternal deaths per 100,000 live births and extremely high if it is ≥1000 maternal deaths per 100,000 live births (WHO 2014:21; WHO 2012:22). None of the MDG regions had extremely high MMR while the Sub-Saharan Africa region was the only MDG region with very high MMR (510/100,000 live births) and highest adult lifetime risk of maternal mortality in women (1 in 38) (WHO 2014:21). At the country level estimates, Ethiopia was one amongst the ten countries that contributed 58% of the global maternal deaths in 2013, with a MMR and life time risk of maternal mortality of 420/100,000 live births and 1 in 52, respectively (WHO 2014:32). It is also one of the countries considered as "making progress" in improving maternal health as the average annual decline in MMR (i.e. 5% for Ethiopia) between 1990 and 2013 was in the range of 2-5.5% (WHO 2014:38).

One of the critical interventions for reducing maternal morbidity and mortality is ensuring that a SBA attends every birth. In developing regions, the proportion of deliveries attended by a skilled birth attendant improved from 56% in 1990 to 68% in 2012. Southern Asia and the Sub-Saharan regions had the lowest skilled birth attendance services coverage but now it has increased by 10% or more since 2000. Despite improvements in access and utilization of skilled birth attendance services, there are still huge disparities between rural and urban areas. More than 32 million of the 40 million births not attended by skilled birth attendants in 2012 were from rural areas (United Nations 2014:29-30). In Ethiopia, only 15% of births were delivered at a health facility in the five years preceding the survey (Central Statistical Agency [Ethiopia] 2014:45). Albeit the percentage of health facility births continues to be very low, there has been improvement in the past few years. The proportion of health facility births reported in 2014 was 50% and 100% higher from 10% and 5% reported in 2011 and 2005 respectively (Central Statistical Agency [Ethiopia] and ICF International 2012:126). However, this still falls very far short of the MDG target to increase the proportion of births attended by skilled birth attendants to 90% by 2015.

2.6 DETERMINANTS OF UTILISATION OF SKILLED BIRTH ATTENDANTS

Skilled care at every childbirth is a very crucial strategy in decreasing maternal and neonatal morbidity and mortality, yet many women in developing regions deliver outside of a health facility without an SBA. According to the 2014 MDGs report, 40 million births

in developing regions were not attended by an SBA in 2012 (United Nations 2014:28). As it is explicitly indicated in many studies, many factors that contribute to this problem were identified. Gabrysch and Campbell (2009:3) reviewed more than 80 original and reviewed articles to identify twenty determinants for the utilisation of skilled delivery. These determinants are further categorised into four broad thematic areas. These are socio-cultural factors, perceived benefit or need of skilled delivery care, economic accessibility and physical accessibility.

Numerous socio-cultural factors basically influence the decision to seek skilled delivery care (Cham, Sundby & Vangen 2009:2; Gabrysch & Campbell 2009:3; Thaddeus & Maine 1994:1093). Findings from many studies showed that women with a higher level of education have a higher likelihood of skilled care use during childbirth (Kawakatsu, Sugishita, Oruenjo, Wakhule, Kibosia, Were & Honda 2014:4; Mengesha et al 2013:[4]; Moyer & Mustafa 2013:4; Worku, Yalew & Afework 2013:6). The husbands' educational level is also one of the social factors that influence the use of skilled delivery care. A review of articles in Gabrysch and Campbell (2009:8), Moyer and Mustafa (2013:4), studies conducted by Sakeah, Doctor, McCloskey, Bernstein, Yeboah-Antwi and Mills (2014:6) and Vallières et al (2013:4) revealed that women with more educated husbands are more likely to use skilled birth attendants during delivery.

A prospective follow-up study conducted in South West Ethiopia by Tura, Afework and Yalew (2014:6) indicated that women whose husbands were employed or were merchants, were more likely to use skilled care during childbirth in contrast to women whose husbands were farmers. Similarly, a study in Northern Nigeria revealed that women with husbands who were civil servants or merchants utilised skilled birth attendance than others (Adewemimo, Msuya, Olaniyan & Adegoke 2014:e10). The findings of the systematic review on drivers and deterrents of facility delivery in Sub-Saharan Africa also pointed out that women whose husbands engaged in non-agricultural occupations are more likely to deliver in a health facility. Consequently, the husbands' occupation has also been identified as an important predictor of SBA during childbirth.

Likewise, women autonomy in the household and community appeared to affect women's access to and utilisation of health services. The different dimensions of women autonomy like their position in the household, financial independence, mobility

and decision making power on seeking self-health care can all influence the use of skilled birth attendants. Studies conducted in Nigeria, Ethiopia, Tunisia, India and Korea showed that women were not allowed to make decisions on their own to seek health care; the decision often rested with the spouses and senior family members like mothers-in-law. In addition, in societies where women mobility is limited due to cultural reasons or required to have approval for travel from spouses or mothers-in- law, efforts to seek and access care may be hindered (Gabrysch & Campbell 2009:[8]; Thaddeus & Maine 1994:1098). In Rwanda, a research done in the Bugesera district found that those women involved in the management of household finances were virtually two times more likely to use skilled care during childbirth (Joharifard, Rulisa, Niyonkuru, Weinhold, Sayinzoga, Wilkinson, Ostermann & Thielman 2012:6). According to Kabakyenga et al (2012:[4]), women who made the final decision on location of birth in consultation with their spouses or other people, the likelihood of them giving birth with the assistance of SBA was very high as compared to women who made the final decision alone. Therefore, socio-cultural factors, such as maternal education level, husband's educational level and women autonomy were found to be important predictors of the utilisation of skilled delivery.

The findings from a study conducted in Western Kenya showed that better awareness of health issues was significantly associated with a health facility delivery (Kawakatsu, Sugishita, Oruenjo, Wakhule, Kibosia, Were & Honda 2014:4). Another prospective follow-up study in Ethiopia also indicated that women who knew three or more key danger signs during labour were more likely to use skilled delivery care as compared to women who did not know any danger signs (Tura et al 2014:6). Thus, maternal health knowledge is also a determinant factor for the utilisation of skilled delivery.

It was also evident in studies by Kabakyenga et al (2012:[4]) and Tura et al (2014:6) that women who were well-prepared for birth and ready for birth complications during pregnancy were more likely to use skilled delivery care contrary to those who were not well prepared. Birth preparedness and complication readiness intervention can enhance the uptake of skilled delivery during childbirth and postnatal period if implemented properly (Magoma et al 2013:441).

Furthermore, women interactions with the health system and health facilities may impact the use of SBA during childbirth as it provided an opportunity to promote key

health messages and practices and to provide a broad range of intervention packages (Gabrysch & Campbell 2009:9). In countries as diverse as Mexico, Rwanda, Kenya, Ethiopia, Cambodia and Sub-Saharan regions, the high frequency of ANC visits during pregnancy were a robust positive predictor of the utilisation of skilled birth attendants during delivery (Barber 2006:423; Joharifard et al 2012:6; Kawakatsu et al 2014:4; Kitui, Lewis & Davey 2013:5; Mengesha et al 2013:[4]; Moyer & Mustafa 2013:4; Tura et al 2014:6; Yanagisawa, Oum & Wakai 2006:242). Besides, women who utilised skilled delivery services in their previous deliveries are most likely to use it in the current delivery as most of the determinants that influenced the use of skilled delivery care in the previous deliveries may remain unchanged and the current pregnancy is influenced by the same factors. But, women continue to give birth in the same facility as long as the previous health facility deliveries went well, otherwise, mothers may abscond from using it (Gabrysch & Campbell 2009:10). According to Adewemimo et al (2014:e10) and Joharifard et al (2012:6), the past history of hospital births and delivering penultimate babies in health facilities were positive predictors of the utilisation of SBA during childbirth respectively. In contrast, a study conducted in North West Ethiopia revealed that previous use of health facility delivery was independently and significantly associated with 45% decreased likelihood of re-attendance for health facility delivery (Kebede, Gebeyehu & Andargie 2013:82). Regarding previous experience of complication as a determinant factor for health facility delivery, women who experienced complications in the previous deliveries or loss of a newborn could make them recognise the dangers of home delivery without SBA and the benefits of utilising skilled delivery during childbirth. Moreover, women who received special interventions in the previous deliveries like caesarean section will be motivated to visit a health facility in the subsequent deliveries since it is associated with obstetric risks (Gabrysch & Campbell 2009:11).

As it was observed in studies conducted by Fapohunda and Orobaton (2014:179), Kabakyenga et al (2012:[4]), Kebede et al (2013:82), Kitui et al (2013:5) and Worku et al (2013:6), primiparities were significantly associated with a high likelihood of using skilled delivery care as compared to any other birth order categories. The first birth perceived to be more difficult by the community, women do not have previous experience on delivery, often family members give high value for the index pregnancy and health care providers recommend health facility delivery for primiparous mothers. As a result, primiparous women are encouraged to use SBA during childbirth. However, multiparous

women are less likely to utilise skilled delivery care particularly if they experienced no problems during the previous deliveries (Gabrysch & Campbell 2009:10).

According to Hazarika (2011:1384), Hounton, Chapman, Menten, Brouwere, Ensor, Sombie', Meda and Ronsmans (2008:47), Kawakatsu et al (2014:4), Kitui et al (2013:5), Say and Raine (2007:814) and Tura et al (2014:6), household wealth was discerned to be the strongest determinant of skilled delivery utilisation. Women living in affluent households were more likely to use SBA during childbirth as compared to their poor counterparts. Moreover, households that had health insurances were also significantly associated with the utilisation of health facility delivery (Joharifard et al 2012:6).

The urban-rural residence differentials in utilising skilled delivery care showed that significant differences were observed in favour of urban women than rural women. Women from urban areas were more likely to use health facility delivery as compared to rural women. Urban women tended to have better access to health services and most health promotion activities targeted urban areas, whereas, rural women were already influenced by deep rooted cultural values and practices that are antagonising contemporary health care practices (Gabrysch & Campbell 2009:13; Hazarika 2011:1384; Kitui et al 2013:5; Kebede et al 2013:82; Mengesha et al 2013:[4]; Say & Raine 2007:814; Tura et al 2014:5).

According to Gabrysch and Campbell (2009:13) and Thaddeus and Maine (1994:1094), distance to health facilities affects the use of health services in two ways: as a disincentive to seeking health care and as an actual obstacle to reach health facilities after a decision has already made to seek care. Lack of transportation and poor quality of roads synergise the obstacle effect of distance on the use of health services, and its disincentive effect becomes more prominent when women have serious complications or reputation of health care provider is not good. Even though the health facilities can be located in a convenient place or close by, the service is underutilised if the quality of service is perceived poor. The vast majority of studies that included distance as a variable, reported a high use of skilled care at childbirth by women who lived closer to health facilities (Choulagai, Onta, Subedi, Mehata, Bhandari, Poudyal, Shrestha, Mathai, Petzold & Krettek 2013:7; Gabrysch, Cousens, Cox & Campbell 2011:[5]; Hounton et al 2008:47; Joharifard et al 2012:6; Kawakatsu et al 2014:4; Kebede et al 2013:82; Phiri, Fylkesnes, Ruano & Moland 2014:7). Some, however, found no effect of

distance on the use of skilled delivery care. One study in Kenya showed that women living far from health facilities were less likely to use skilled delivery care in a bivariate analysis, but not in a multivariate analysis (Kitui et al 2013:3-4). Furthermore, studies conducted in Ethiopia and Zambia also showed that women who had better access to basic emergency obstetric and neonatal care (BEmONC) facilities were more likely to use skilled delivery care (Gabrysch et al 2011:[5-6]; Tura et al 2014:5).

2.7 REASONS FOR NON-UTILISING SKILLED BIRTH ATTENDANCE

The estimates for the absolute number of non-skilled birth attendants in South Asia and Sub-Saharan countries indicated that there would be between 130 and 180 million births from 2011-2015 (90% of these in rural areas) (Crowe, Utley, Costello & Pagel 2012:5). In Ethiopia, non-skilled birth attendants among women who gave birth in the five years preceding the survey (Central Statistical Agency [Ethiopia] 2014:47) attended 85% of births. Therefore, numerous researchers have tried to explore the reasons for not utilising skilled care during childbirth and this will be reviewed in the forthcoming paragraphs.

A qualitative study in Nepal examined the perceptions and experiences of service users and providers regarding barriers to skilled birth care and explored possible solutions to overcoming such barriers. The major barriers for skilled birth care were inadequate knowledge of the importance of services offered by SBAs, distance to health facilities, unavailability of transport services, and poor availability of SBAs. Other barriers included poor infrastructure, meagre services, inadequate information about services and facilities, cultural practices and beliefs, and low prioritization of birth care. Moreover, the tradition of isolating women during and after childbirth decreased the likelihood of women utilising delivery care services at health facilities (Onta et al 2014:4). Another study in Nepal showed that the most perceived problems to access skilled delivery care were health facilities located far away (30.4%), unavailability of skilled female health workers (9.6%), women and family members unaware of delivery care (54.3%), no delivery care at local level (6.5%), no time due to work in the home (2.9%) and no money (21.7%) (Dhakal et al 2011:375).

A qualitative study conducted in Lao PDR explored why women and their families preferred home deliveries over health facility deliveries. The main reasons for not

utilising skilled delivery care were distance to health facilities, difficulties and costs of getting there; attitudes, quality of care and care practices at the health facilities, including a horizontal birth position, episiotomies, lack of privacy, and the presence of male staff; the wish to have family members nearby and the need for women to be close to their other children and the housework; and the wish to follow traditional birth practices such as giving birth in a squatting position and lying on a “hot bed” after delivery. In addition, the decision about where to give birth was commonly made by the woman’s husband, mother, mother-in-law or other relatives in consultation with the woman herself (Sychareun et al 2012:4).

Research conducted in Karachi revealed that the two main reasons for home deliveries were family tradition (72.8%) and lack of affordability (68.6%). These were followed by insufficient time to reach the hospital (7.3%) and inaccessibility of maternity services (1.5%) (Shah, Rohra, Shams & Khan 2010:557).

A qualitative study in West Java province in Indonesia explored the perspectives of community members and health workers about the use of skilled delivery care services. Cost, physical distance, preference of home delivery and convenience of home delivery for taking care of other family members were identified as factors deterring the use of health facility delivery (Titaley, Hunter, Dibley & Heywood 2010:8).

A qualitative research conducted in rural Southern Malawi investigated the reasons why women delivered at home without skilled birth attendants despite receiving antenatal care in a health centre. In this study, the main reasons for giving birth at home were the onset of labour at night, rainy seasons, rapid labour, socio-cultural factors and negative health care providers' attitude (Kumbani et al 2013:5).

According to Crissman, Engmann, Adanu, Nimako, Crespo and Moyer (2013:21), a qualitative study was carried out in Ghana in order to understand the barriers to SBA and health care facility delivery. The pregnant mothers revealed that the barriers to the utilisation of SBAs and health facility delivery included maltreatment by health facility midwives, costs associated with institutional delivery despite abandonment of facility fees, lack of a support person, difficulty in obtaining transportation and precipitous labour.

A study in rural Kenya explored relationships between women's perceptions of HIV-related stigma and their attitudes and intentions regarding health facility childbirth. Women who anticipated HIV related stigma from their male partners had lower adjusted odds of having positive attitudes about giving birth at the health facility than women who did not anticipate it (adjusted OR=.63, 95% CI 0.50–0.78). Furthermore, negative attitudes about health facility birth were strongly related to women's intentions to give birth outside a health facility (adjusted OR=5.56, 95% CI 2.69–11.51) (Medema-Wijnveen, Onono, Bukusi, Miller, Cohen & Turan 2012:[5]).

A qualitative study in Southern Tanzania revealed that lack of money for services and food, lack of transport, sudden onset of labour, short labour, staff attitudes, and lack of privacy were the reasons mentioned for not utilising skilled delivery services. Besides, traditions and cultures and the decision making power in the household also contributed for this (Mrisho, Schellenberg, Mushi, Obrist, Mshinda, Tanner & Schellenberg 2007:865).

A cross-sectional survey conducted in rural Gambia aimed at identifying the most important barriers for use of skilled attendance during childbirth. The most common reasons mentioned for not utilising skilled delivery care were not having enough time to go to health facilities (75%), poor services (10%), respondents didn't think it was necessary (8%), facilities too far (10%), too expensive (5%), nobody to care for children (4%) and husband/family didn't think it was necessary (1%) (Lerberg et al 2014:38).

A qualitative research was carried out in Uganda to identify the perceived barriers in the utilisation of institutional delivery in two districts in Karamoja. The following four themes emerged as barriers to utilising health facility delivery: socio-cultural factors, perceived benefit/need, economic and physical inaccessibility. Under the theme of socio-cultural factors, the barriers identified were categorised as traditional beliefs and practises, less involvement of men in maternal health and women's domestic chores. Lack of knowledge, lack of infrastructure, supplies and drugs, shortages of staff, perceived poor quality of care, bad staff attitude, role of TBAs and lack of community involvement in health planning were the barriers identified under the theme of perceived benefit/need. The third theme was economic inaccessibility that consisted of barriers like lack of income, lack of food at home and at the health facilities, and users' fees. Lastly, under the theme of physical inaccessibility; insecurity due to inter-clan feuds, bad terrains and

lack of transportation means were the barriers categorised under this theme (Wilunda, Quaglio, Putoto, Lochoro, Oglio, Manenti, Atzori, Lochiam, Takahashi, Mukundwa & Oyerinde 2014:5-9).

According to Oyerinde, Harding, Amara, Garbrah-Aidoo, Kanu, Oulare, Shoo and Daoh (2013:864), a qualitative evaluation of why women preferred to use services provided by TBAs as compared to health facilities identified the following as the main reasons for women choosing services provided by TBAs over health institutions delivery:

- The cost of services;
- Geographic inaccessibility of health facilities;
- Trust in vast experiences and compassionate care of TBAs;
- Poor facility infrastructure; and
- Absent staff and perceived poorly stocked health facilities that could not provide a continuum of care services.

In studies in Ethiopia, women who did not deliver at a health facility were asked for the reasons they chose not to do so. The major reasons were that mothers thought it was unnecessary, not customary,and that health facilities were either too far or they did not have transportation (Central Statistical Agency [Ethiopia] 2014:48; Central Statistical Agency [Ethiopia] and ICF International 2012:128). A mixed study in Ethiopia tried to understand the reasons why women continued to give birth at home, if key challenges related to transportation and access to emergency obstetric care was already addressed by the ongoing project. The most important reasons for not seeking health facility delivery were the belief that it is not necessary (42%) and not customary (36%), followed by high cost (22%). Distance or lack of transportation (8%), facilities not open (4.7%), did not trust the services or poor quality of services (1.9%), and husband or family disallowed them (0.5%) also accounted for this. The group discussions and interviews identified several reasons for the preference of traditional birth attendants over health facilities. To this end, TBAs regarded as culturally acceptable and competent health workers, poor quality of care, and previous negative experiences with health facilities emerged as prominent reasons. In addition, women's low awareness on the advantages of skilled birth attendance services, women's little role in decision making, and economic constraints during referral contributed to the low level of service utilisation (Shiferaw et al 2013:[4]). A qualitative study was conducted in south central

Ethiopia to make an in depth assessment of why mothers did not utilise health facilities for childbirth. The participants identified multiple factors that hampered the utilisation of health facilities for childbirth that can be categorised into two major themes; client related factors and health facility/staff related factors. The client related factors comprised of the following subthemes: decision making on the place of delivery, reliance on Traditional Birth Attendants (TBAs), and misconceptions about the services provided at health facilities. This theme also further categorised in to family members disallowed to be present at the time of labour and delivery, lack of privacy, traditional and/or spiritual factors, economic factors and accessibility to health care facilities. Under the theme of facility/staff related factors, the subthemes that emerged were poor reception, refusal of admission of expectant mothers at health facilities, lack of privacy, information gap, incompetence and shortage of staff, and materials at health facilities (Roro,Hassen, Lemma, Gebreyesus & Afework 2014:[3-5]). In a case-control study carried out in Bahirdar, Ethiopia to examine factors associated with home delivery, the likelihood of delivering at home was greater among mothers with inadequate knowledge of pregnancy related problems (AOR=62, 95% CI: 3, 128.1), those who started attending ANC after 24 weeks of gestation (AOR 8.7, 95% CI: 2.2, 33.3), mothers having no formal education (AOR 4.2 95% CI 1.63, 11.27) and rural residents (AOR=3.6, 95%CI: 1.4, 9.0) (Abebe et al 2012:[3]).

2.8 SKILLED BIRTH ATTENDANCE AND MATERNAL AND NEONATAL HEALTH OUTCOMES

2.8.1 Skilled birth attendance and maternal health outcomes

Taking in to account the assumption of the presence of certain competencies as well as the availability of essential drugs, equipment and referral, virtually between 16% and 33% of all maternal deaths could be averted through primary or secondary prevention of the four main obstetric complications (obstructed labour, eclampsia, puerperal sepsis and obstetric haemorrhage) by the presence of SBAs at delivery (Canavan 2009:11; Graham Bell & Bullough 2001:113).

A sub-Saharan Africa regional review of literature on facility based delivery and maternal and neonatal mortality revealed that trends indicating areas with high skilled birth attendants and health facility delivery have generally lower maternal and neonatal

mortality, though the trend is not uniform across all areas. Health facility delivery and maternal mortality had a significantly inverse relationship (Pearson's correlation coefficient of -0.69, p=0.008). Furthermore, health facility delivery rates and rates of early neonatal mortality were also inversely correlated (Pearson's correlation coefficient of -0.41, p=0.08) (Moyer, Dako-Gyeke & Adanu 2013:37-38).

A systematic review and meta- analysis was carried out to explore the reasons for variations in hospital maternal mortality ratio between studies from Sub-Saharan Africa. The pooled hospital MMR for sub-Saharan Africa was 957 per 100 000 live births, although there was strong evidence for between-study heterogeneity. Regional estimates varied from 294 per 100 000 live births in Southern Africa to 1338 in Western Africa. The multivariate analysis revealed that there was strong evidence that the percentage of women with skilled birth attendance (p-value 0.03), the African region (p=0.06), and less strongly, the type of hospital in the country (p=0.1) remained independently associated with the hospital MMR. These variables together accounted for 44% of the variability between studies (Montoya, Calvert & Filippi 2014:17).

A quasi-experimental study conducted in Burkina Faso to compare pregnancy related mortalities within the intervention district (facilities covered by skilled care initiative versus areas not covered and between intervention districts and a comparison district. The pregnancy-related mortality risk declined over time in the skilled care initiative intervention area (34% reduction, P=0.074), but the speed of decline was not significantly different from that seen in the non-skilled care initiative area (2% reduction, P=0.933) or in comparison district (10% reduction, P=0.488). The pregnancy related mortality risk decreased with increasing proportions of women giving birth in health facilities (P=0.065) within the health facility catchment area. Hence, women living in an area where more than 60% of women gave birth in an institution, had a 28% lower odds of pregnancy-related mortality (95% CI - 5 to 51) than women living in areas where only 30% or fewer had given birth in a facility (Hounton, Menten, Ouedraogo, Dubourg, Meda, Ronsmans, Byass & Brouwere 2008:56).

The findings from the case control study in Western Kenya, on the contrary, showed that the risk of occurrence of obstetric complications were higher in facility-based deliveries (adjusted odds ratio 'AOR' 1.43 (CI 1.02, 2.01), compared to home deliveries, AOR, 0.70 (CI 0.50, 0.98) $p < 0.05$ (Liambila & Kuria 2014:4-5).

2.8.2 Skilled birth attendance and neonatal health outcomes

A systematic review and meta-analysis was conducted with the aim of determining the pooled effect of health facility delivery on neonatal mortality. The findings revealed that health facility delivery had a statistically significant effect on neonatal mortality. It has resulted in a 29% reduction in the risk of neonatal mortality. The stratified analysis showed that the effect was higher in areas where the coverage of health facility delivery was high. When the convergence of the health facility delivery was above 50%, there was a reduction of about 40% in neonatal mortality as compared to 26% reduction when health facility delivery was less than 50% (Tura et al 2013:[4-5]).

A regional multilevel analysis was carried out to explore whether skilled birth attendants had a protective effect against neonatal mortality in three different regions of the world. The analysis garnered data from nine diverse countries for which most recent demographic and health survey data were available. A multilevel logistic regression was employed to understand the impact of health facility delivery on neonatal mortality during the first day and week of life. The direction of the effect of skilled delivery on neonatal mortality was largely dependent on the geographic region. While having a skilled birth attendant at delivery was protective against neonatal mortality in Latin America/Caribbean, in Asia there was only a protective effect for births in the first week of life. In Africa, SBAs were associated with higher neonatal mortality for both outcomes, and the same held true for deaths on the first day of life in Asia. Many women in Africa and Asia gave birth at home unless a complication occurred, and thus skilled birth attendants might be seeing more women with complications than births attended by unskilled birth attendants (Singh, Brodish & Suchindran 2014:246).

A systematic review of evidence was conducted on the effect of community-based skilled birth attendants in improving perinatal and intra-partum related outcomes based on four observations before and after intervention data and two quasi- experimental studies. The pooled effect of community based skilled birth attendants resulted in a 12% reduction in all causes of perinatal mortality and a 22-47% reduction in intra-partum related neonatal mortality (Darmstadta, Leea, Cousensc, Sibleyd, Bhuttae, Donnayb, Osrinf, Bangg, Kumara, Wallh, Baquia & Lawnh 2009:96).

According to Yakoob et al (2011:[3]), a meta-analysis of the impact of skilled birth attendance and emergency obstetric care on stillbirths and perinatal mortality revealed that the pooled analysis of the two before and after intervention studies showed community based skilled birth attendants resulted in a 23% significant reduction in stillbirths (RR=0.77; 95% CI: 0.69–0.85). Furthermore, the pooled analysis of four studies showed a 12% significant reduction in perinatal mortality (RR=0.88; 95% CI: 0.82–0.95).

To explore the influence of distance to delivery care and of the level of care on early neonatal mortality in rural Zambia and Malawi, the influence of distance and level of care on facility delivery, and the influence of facility delivery on early neonatal mortality, pooled data from 2004 Malawi and 2007 Zambia demographic and health survey was utilised. As a result, no association was observed between distance to care and early neonatal mortality in Malawi, either crudely or adjusted for a wide range of confounders (OR 0.97, p=0.89), while in Zambia, longer distance (per 10 km) was associated with lower early neonatal mortality both without and with control for confounding (OR 0.55, p=0.01). The level of care provided in the closest facility showed no crude or adjusted association with early neonatal mortality in either of the two countries. In both countries, distance to care was strongly associated with facility use for delivery (Malawi: OR 0.35 per 10 km, 95%CI 0.26–0.46) both in bivariate and multivariate analysis. However, early neonatal mortality did not differ by frequency of facility delivery in the community (Lohela, Campbell & Gabrysch 2012:[4-5]).

A longitudinal observational data generated from demographic and health surveillance systems in rural Southern Tanzania were used to assess the association between neonatal mortality and the place of delivery. Three cohorts of singleton births (born in 2005, 2006 and 2007) were followed from birth until 28 days. Neonatal mortality for health facility singleton deliveries were 32.3, 28.9, and 33.2 per 1000 live births in 2005, 2006 and 2007 respectively, while neonatal mortality for community singleton deliveries was 29.7, 26.9 and 27 per 1000 live births in 2005, 2006 and 2007 respectively. Neonates born in a health facility had similar chances of dying as those born in the community in all the three years of study. Adjusted relative risks (ARR) for neonatal deaths born in a health facility in 2005, 2006 and 2007 were 0.99 (95%CI: 0.58−1.70), 0.98 (95%CI: 0.62−1.54) and 1.18 (95% CI: 0.76−1.85), respectively. Therefore, no

evidence was found to suggest that health facility delivery was associated with better survival of neonates (Nathan & Mwanyangala 2012:3-4).

2.9 INTERVENTION STRATEGIES TO IMPROVE THE UTILISATION OF SKILLED BIRTH ATTENDANCE

Review of literatures carried out on studies conducted in South Asia to look at the demand side barriers to seeking care as well as strategies to increase facility delivery in rural South Asia. The review identified the establishment and use of maternity waiting homes, financial incentives, education and empowerment, and improving access and equity through participatory women's support groups as strategies that can improve the utilisation of facility based skilled delivery in South Asia (Metcalfe & Adegoke 2013:102).

In three districts of Cambodia, a health equity fund and voucher schemes were introduced in 2005 to improve access to skilled delivery care for poor women. An operational analysis of these schemes was carried out to assess their effectiveness in improving access to skilled birth attendants for poor women. The study revealed that health facility delivery increased exponentially from 16.3% of the expected number of births in 2006 to 44.9% in 2008 after the introduction of these schemes. The increment was more pronounced than comparable districts devoid of health equity funds and voucher schemes. In 2008, beneficiaries of these schemes accounted for 40.6% of the expected number of births among the poor women (Ir, Horemans, Soukn & Van Damme 2010:6).

A cluster randomised implementation trial was underway in the western and hilly regions of Nepal from October 2012 to October 2014. The objective of the implementation trial was to measure the effectiveness of an intervention package aimed at increasing the utilisation of SBAs during childbirth. The components of the intervention package were increased family support for pregnant women to reach a facility for childbirth, availability of funds to support pregnant women and families to seek childbirth care with a skilled SBA, availability of transportation to a facility for childbirth, development of a women friendly environment in the health facilities and the establishment of mechanisms to improve the security of SBAs. The final evaluation of the intervention was planned by October 2014 (Bhandari, Subedi, Thapa, Choulagai, Maskey & Onta 2014:5).

A systematic review of literature was carried out to describe mechanisms to integrate traditional birth attendants (TBAs) with the formal health system to increase skilled birth attendance and examine components of successful integration. Five mechanisms for the following TBA integration were identified: training and supervision of TBAs, collaboration skills for health workers, inclusion of TBAs in facility-based activities, systems for communication between TBAs and SBAs, and defining roles for TBAs and SBAs. Furthermore, five complementary activities were commonly employed in conjunction with TBA integration: specific selection of TBAs, community participation, accessibility changes, health systems development, and improved affordability. Several components of TBA integration were clearly associated with the increase in skilled birth attendance. The impact of TBA integration on skilled birth attendance ranged from a 15% below control to a 58% increase from baseline — in study sizes from 35 to 153,000 live births. The level of impact on skilled birth attendance depends on the combination of integration mechanisms and complementary activities (Byrne & Morgan 2011:128-132).

In a study in Kenya, TBAs were recruited to attend meetings in which they were oriented to educate pregnant women about the importance of giving birth at a health facility. TBAs were given a small amount of allowance for each pregnant woman they brought to the health facility for skilled delivery. During the year preceding the intervention, 19.5% (102/524) and 20.0% (413/2068) of pregnant women had SBA deliveries at intervention and control facilities, respectively. The proportion of pregnant women who delivered at intervention health facilities during the study period was 49.3% (217/440) compared with 20.8% (415/1995) at control facilities ($P<0.001$). An increase of 113% in skilled birth attendance was observed in the intervention health facilities during the study period as compared to the year preceding the intervention (Tomedi, Tucker & Mwanthi 2013:154).

In 2005, the Kenyan government launched the implementation of a community midwifery programme. The aim of this program was to increase women's access to skilled care during pregnancy, childbirth and postpartum period within their communities. In 2011, a qualitative research was conducted to evaluate the implementation status of the community midwifery programme. The findings revealed that the provision of individualised care, living in the same community with clients which

made community midwives easily accessible and culturally acceptable, and flexible payment options as opportunities and socio-economic issues, unavailability of logistics, problems of transportation for referrals and insecurity were the challenges in the implementation of the programme (Mannah, Warren, Kuria & Adegoke 2014:5).

A study was conducted in Liberia to determine whether maternity waiting homes increased skilled birth attendance in the rural primary clinics. The present analysis was carried out half way through to a large cohort study in which five communities received the establishment of maternity waiting homes (intervention group) and five communities did not have (control group). Consequently, communities with maternity waiting homes showed substantial increase in skilled birth attendance rate from baseline to post intervention (10.8% versus 95.2%, $P < 0.001$). Additionally, lower rates of maternal and perinatal deaths were reported from communities with maternity waiting homes compared to those without the intervention, but the difference between the two groups reached statistical significance for maternal deaths only (Wald $\chi 2=4.22$, df=1, P=0.040) (Lori, Munro, Rominski, Williams, Dahn,Boyd, Moore & Gwenegale 2013:116). Maternity waiting homes improved physical access to obstetric facilities and increased skilled birth attendance and this in turn, improved maternal and newborn health outcomes (Nabudere, Asiimwe & Amandua 2013:209).

A cluster-randomised controlled trial research was carried out in Zanzibar to examine the association between mobile phone intervention and skilled delivery attendance in settings with limited resources. The study showed that 60% of women in the intervention group and 47% in the control group gave birth with the assistance of skilled birth attendants. The intervention effect was pronounced between urban and rural residence; 82% of urban women and only 43% of rural women in the intervention group delivered with skilled birth attendance. The intervention produced a significant increase in skilled delivery attendance amongst urban women (odds ratio, 5.73; 95% confidence interval, 1.51–21.81), but did not reach their rural counterparts (Lund, Hemed, Nielsen, Said, Said, Makungu & Rascha 2012:1260).

2.10 CONCLUSION

This chapter presented information based on relevant reviewed literature with regard to skilled birth attendance globally, regionally and according to the local context. Detailed

discussions were presented according to the theoretical framework of the study. The components of the theoretical framework; the HBM Model, were described. The theoretical concept of skilled birth attendance was also discussed. The global, regional and country level progress towards MDG 5 was described in detail. The determinants of the utilisation of skilled birth attendance were thoroughly elaborated. Pertinent literature was also reviewed and presented on the reasons for not utilising skilled birth attendance. The effects of skilled birth attendance on maternal and neonatal health outcomes were also explicitly explained. Finally, relevant literature the on strategies to improve the utilisation of skilled birth attendance were also reviewed and described.

The next chapter (chapter 3) presents the research design and methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The research design and methodology employed to conduct the study "*developing strategies to improve the utilisation of skilled birth attendance in West Gojjam zone, Ethiopia"* is stated. The chapter reasserts the foundation of the research, explains the study design, study population, sampling and sampling designs, research tools, data collection procedures and data analysis. Trustworthiness and ethical considerations relevant to the study are also presented.

3.2 RESEARCH DESIGN

The research design used in a particular research largely determines the reliability of the research results and this comprises of the firm foundation of the entire structure of the research work. It is imperative to have a well thought out blueprint of the research plan for the smooth implementation of research operations as this would make the research as efficient as possible, yielding ample information with minimal expenditure of resources (Kothari 2009:32).

Kothari (2009:31) states that a research design is a conceptual structure within which a research is carried out and consists of the blueprint for data collection, measurement and analysis. Research designs are logical blueprints that link the research question, the data to be collected and strategies for data analysis with the ultimate goal of addressing the intended research questions (Yin 2010:75-76). Saunders et al (2009:136) also define a research design as an overall general plan of how the researcher will proceed to answer the research questions.

According to Creswell (2009:3), research designs are plans and procedures for research that range from broader assumptions to finer methods of data collection and analysis. The plan involves decision on which research design to be used to address a particular study topic. The selection of a research design depends on the nature of the

research problem or issues being addressed, personal experiences of the researcher and the audience for the study.

The qualitative paradigm is concerned with describing and understanding human experiences of a particular phenomenon from the perspectives of the people who had or having the experience (Ellis 2010:10). Creswell (2009:4) also indicates that qualitative research is a means for exploring and understanding the meanings that individuals or groups ascribe to social or human problems. Therefore, a qualitative research paradigm was employed in this study to describe, understand and explore individuals and community perceptions and experiences regarding the utilisation of skilled birth attendance services and reasons for not utilising skilled birth attendance services. The following section presents the various aspects of the research design.

3.2.1 Qualitative aspect of design

According to Saldaña (2011:3-4), qualitative research is a broad term for a wide range of approaches and methods applied to study natural social life. Primarily, the nature of information or the data collected and analysed is non-numeric and comprises of textual materials such as interview transcripts, field notes, documents, visual materials, and these account for human experiences in social life. Qualitative research explores in-depth opinions from study participants' attitudes, behaviours and experiences using interviews, focus group discussions and observations (Dawson 2007:15). Green and Thorogood (2004:5) contend that it makes sense to characterise qualitative research by the overall aims of the research not by the type of data collected and/or method employed to generate the data. The most basic features of qualitative research is that the aims are intended to address the 'why',' how' or 'what' of the phenomenon being investigated rather than research questions about the 'how many' or 'how much' (Green & Thorogood 2004:5; Pope & Mays 2006:3). Therefore, it was reasonable and appropriate to employ qualitative research in the current study as this research aimed at exploring and describing the perceptions and experiences of the individual and the community in the utilisation of skilled birth attendance service.

According to Pope and Mays (2006:4), qualitative research has different distinguishing features. The first distinguishing feature is its interpretative nature; the meaning the people give to their experiences in the social world and how they understand and

interpret the social phenomena. The other characteristics are that qualitative studies are invariably conducted in the people's natural settings and employ different qualitative research methods to study important questions about social phenomena. Yin (2010:8-9) also describes the five basic features of qualitative research as follows:

- It deals with researching the meanings of people's lives in real life settings;
- It captures the views and perspectives of the study participants but not the values;
- Preconceptions and meanings held by the investigator;
- It covers the contextual issues in which the study participants actually reside;
- It helps to contribute new insights into the extant or emerging concepts; and
- It employs multiple sources of data.

Furthermore, qualitative research is best suited as a stand-alone design for research questions that cannot be addressed or are unfolded by quantitative research (Bowling & Ebrahim 2005:216; Pope & Mays 2006:5-6).

In this study, the qualitative aspect of the research design was used to explore and describe the individual and community perceptions and experiences of the utilisation of skilled birth attendance. Understanding the perceptions and experiences of the community on the utilisation of skilled birth attendance and reasons for not utilising skilled birth attendance was used to develop strategies to improve the utilisation of skilled birth attendance.

3.2.2 Descriptive aspect of the design

According to Polit and Beck (2010:21-22), the most important purpose of quantitative and qualitative research is the description of phenomena. The main purpose of descriptive studies is to "describe, observe, and document aspects of a situation" (Polit & Beck 2010:236). Descriptive research studies are studies concerned with portraying accurately, the characteristics of an individual or, of a group (Kothari 2009:37). Ruane (2005:12) also submits that descriptive research confers a detailed picture or account of some social phenomena, setting, experience, and group.

The purpose of social research may be categorised into three groups based on what the researcher is striving to accomplish and these include exploratory, descriptive and explanatory. Many social researches are descriptive in nature. Descriptive research depicts a picture of the specific details of a situation, social setting, or relationship; it focuses on how and who questions such as How did it happen? Who is involved? (Neuman 2007:16). Punch (2000:38) also states that to describe is to draw a picture of what happened, or of how things are proceeding, or of what a situation or person or event is (or was) like, or means, or of how things are related to each other. A descriptive study is designed to collect data, organise, analyse and present information about the issues being researched. It is also concerned with disentangling complicated issues into easily understandable and summarising of information into pragmatic generalisations or summarising details of situations.

Hence, in the current study, the descriptive aspect of the design was utilised by the researcher with respect to:

- individual and community perceptions of the utilisation of skilled birth attendance;
- individual and community experiences of the utilisation of skilled birth attendance;
- the experiences of offering skilled birth attendance by the health system; and
- the strategies formulated in this study to improve the utilisation of skilled birth attendance.

3.2.3 Explorative aspect of the design

Exploratory research instigates with the phenomenon of interest and studies the in-depth nature of the phenomenon, including its manifestation and other factors associated with it. Qualitative methods are well suited for investigating the full nature of little studied or known phenomena. Exploratory qualitative research is useful to explore the manner in which a phenomenon is manifested and the underlying processes (Polit & Beck 2010:22; Wood & Ross-Kerr 2011:121). Kothari (2009:2) indicates that a researcher conducts exploratory studies in order to be familiar with the phenomenon and get new insights of it. Exploratory research is carried out with the intention of getting insights with the research topic, or to be familiar with a phenomenon and for in-depth exploration of new or little studied matters. Exploratory research virtually generates data of a qualitative nature (Ruane 2005:12).

According to Saunders et al (2009:139-140), an exploratory study is an avenue to discern what is happening; to seek new insights; to ask questions and to asses phenomena in a new light. It is very helpful to understand the detailed nature of a problem. The flexibility and adaptability to change features of exploratory research makes researchers to change direction when new results emerge and new insights appear to the researcher (Wood & Ross-Kerr 2011:121). Saunders et al (2009:140) also pointed out three principal mechanisms of conducting exploratory studies which are conducting a literature review, expertise interviewing and focus group discussions.

In the current study, individual interviews and focus group discussions were employed to explore the individual and community experiences of the utilisation of skilled birth attendance, experience of offering skilled birth attendance by the health system and reasons for not utilising skilled birth attendance. A thorough exploration of these phenomena helped the researcher in the development of strategies to improve the utilisation of skilled birth attendance.

3.3 THE RESEARCH METHOD

According to Dawson (2009:37), Dawson (2007:28) and Ellis (2010:13), research methods are tools used to collect data for the inquiry. The research method to be used in the study is guided by the choice of research paradigm and subsequent research methodology. Greener (2008:10) also defines research methods as specific activities devised to generate data.

Dawson (2009:34-35) indicates that the budget, time and human resources as well as the purpose of the research need to be taken into account to determine the research method(s) to use in the research. In this study, the methods used to explore and describe personal and community perceptions and experiences of the utilisation of skilled birth attendance, and to explore reasons for not utilising skilled birth attendance are discussed in detail below, starting with the population for the study.

The research was done in two phases, which are interdependent. The phases were planned and conducted for compilation of evidence in preparation for and development of strategies.

3.4 PHASE 1

Phase 1 was collection, analysis and interpretation of empirical data for this study. The purpose of this phase was to explore and describe the individual and community perceptions and experiences of the utilisation of skilled delivery care in order to develop strategies to improve the utilisation of skilled birth attendance.

3.4.1 Population and sampling

3.4.1.1 Population

According to Treiman (2009:3), a population is any definable collection of things with common characteristics. The study population refers to all individuals on whom the study is going to be conducted (Smith, Francis & Schafheutle 2008:83). Gray, Williamson, Karp and Dalphin (2007:103) also indicate that a population encompasses all the possible cases of the research interest. The population of interest is dependent on the purpose of the research. Prior to formulating the sampling strategy, it is critical to agree on the definition of the study population, including the details of the inclusion and exclusion criteria as this is helpful for the researchers to assess the validity and reliability with which eligible study participants will be identified by any sampling strategy (Smith et al 2008:83). In this study, the study population were pregnant women, women who gave birth within one year, health extension workers, primary health care unit directors, midwives working on labour and delivery units, traditional birth attendants, district maternal health and youth reproductive health officers and heads of district health offices.

The target population is all the elements, individuals or members that meet certain criteria for inclusion in the study (Polit & Beck 2010:569). As stated earlier, the target population consisted of:

- women who were pregnant at the time and had previously given birth at least once;
- women who gave birth within one year;

- health extension workers who were working in health posts at the time and have at least two years of experience;
- director of the selected primary health care units;
- district health office maternal and youth reproductive health technical officers of the selected districts;
- heads of district health office; and
- traditional birth attendants who were functioning or had functioned as traditional birth attendants.

3.4.1.2 Sample and sampling technique

A sample is a specified number of study participants selected from the study population. A sample is studied to make a valid inference about the entire population without studying every element in that population. The main reason for selecting a sample rather than studying the entire population is to make an accurate conclusion about the whole study population in a more cost-effective and efficient way (Lyons & Doueck 2010:111; Maltby, Williams, McGarry & Day 2010:126; Polit & Beck 2010:307). A sample was selected from a large population of pregnant women, women who gave birth recently, health extension workers, primary health care unit directors, midwives working on labour and delivery units, traditional birth attendants, district maternal health and youth reproductive health officers and heads of district health offices.

Sampling is a process of selecting study participants to represent the study population (Brannen & Halcomb 2009:78; Polit & Beck 2010:307; Singh 2007:89). A sampling technique is a process of selection of study respondents to represent the entire population that would enable to estimate the population parameters. It also refers to procedures or techniques that researchers would employ to obtain samples from the total population (Kothari 2009:55); and it includes non-probability (non-random) sampling techniques (Saunders et al 2009:213). A non-probability sampling, namely purposive sampling, refers to the chance of each study subject being selected from the total population (Saunders et al 2009:213). A non-probability sampling method was used in this study. Sample size is the number of study subjects in the sample and is affected by the research approached applied, for instance, quantitative versus qualitative (Polit & Beck 2010:316).

Sampling or eligibility criteria are the characteristics that delimit the population of interest. It further indicates that a study may have inclusion or exclusion sampling criteria (or both). The inclusion sampling criteria are those characteristics that a subject must possess to be part of the target group whilst the exclusion sampling criteria are those characteristics that can cause a person or subject to be excluded from the target population (Polit & Beck 2010:306). The researcher included women who were pregnant at the time of data collection and had given birth atleast once and women who gave birth within one year, and willing to provide informed written consent for the FGD. Furthermore, HEW who have worked atleast for two years in the selected health post, head of the PHCU, head of the district health office, maternal, reproductive, and youth health technical officers, and TBA who had functioned or currently functioning at the time of data collection, and willing to provide informed written consent included for the individual in-depth interview. Those who failed to meet the afformentioned inclusion criteria were excluded from the study.

3.4.1.2.1 Sampling of study sites

The non-probability sampling technique is useful when researchers cannot make sure that every unit in the population has an equal chance of being selected or do not need a sampling frame. Purposive sampling involves the selection of study subjects based on the researchers' predefined selection criteria (Balnaves & Caputi 2001:95). In a purposive sampling, study participants are selected based on predefined criteria that are relevant to address specific research questions (Mack, Woodsong, Macqueen, Guest & Namey 2005:5). Therefore, a purposive sampling technique was used to select study sites in this study.

A multistage purposive sampling technique was used to select study sites in this research. Primarily, the Amhara regional state administration was purposively selected for this study because the skilled delivery coverage rate was very low (10.3%) in the region as it was reported in a 2014 mini Ethiopian demographic and health survey (Central Statistical Agency 2014:46). Then, West Gojjam zone was purposively selected because it is one among the eleven zones under the direct supervision of Amhara regional state administration and are among the zones with the lowest skilled delivery coverage in the region. Thereafter, Burie zuria and Womberema districts were also purposively selected because they are among the districts under the supervision of

West Gojjam zone health department and are among the districts consisting of good and poor performing primary health care units (PHCUs) with respect to skilled birth attendance services.

Furthermore, Burie zuria district health office comprises of four PHCUs under its supervision namely; Tiatia, Kuche, Alefa and Dereqwua PHCUs and all of them were included in this study. Womberema district health office also consists of four PHCUs and three of them viz.; Shendi, Koki and Wogedade PHCUs were represented in the current study. Finally, one health post and one health centre was selected from each of the PHCUs. As a result, a total of seven health posts and seven health centres were included in this study. The details of the sampling of the study sites are portrayed in the following diagram (Figure 3.1).

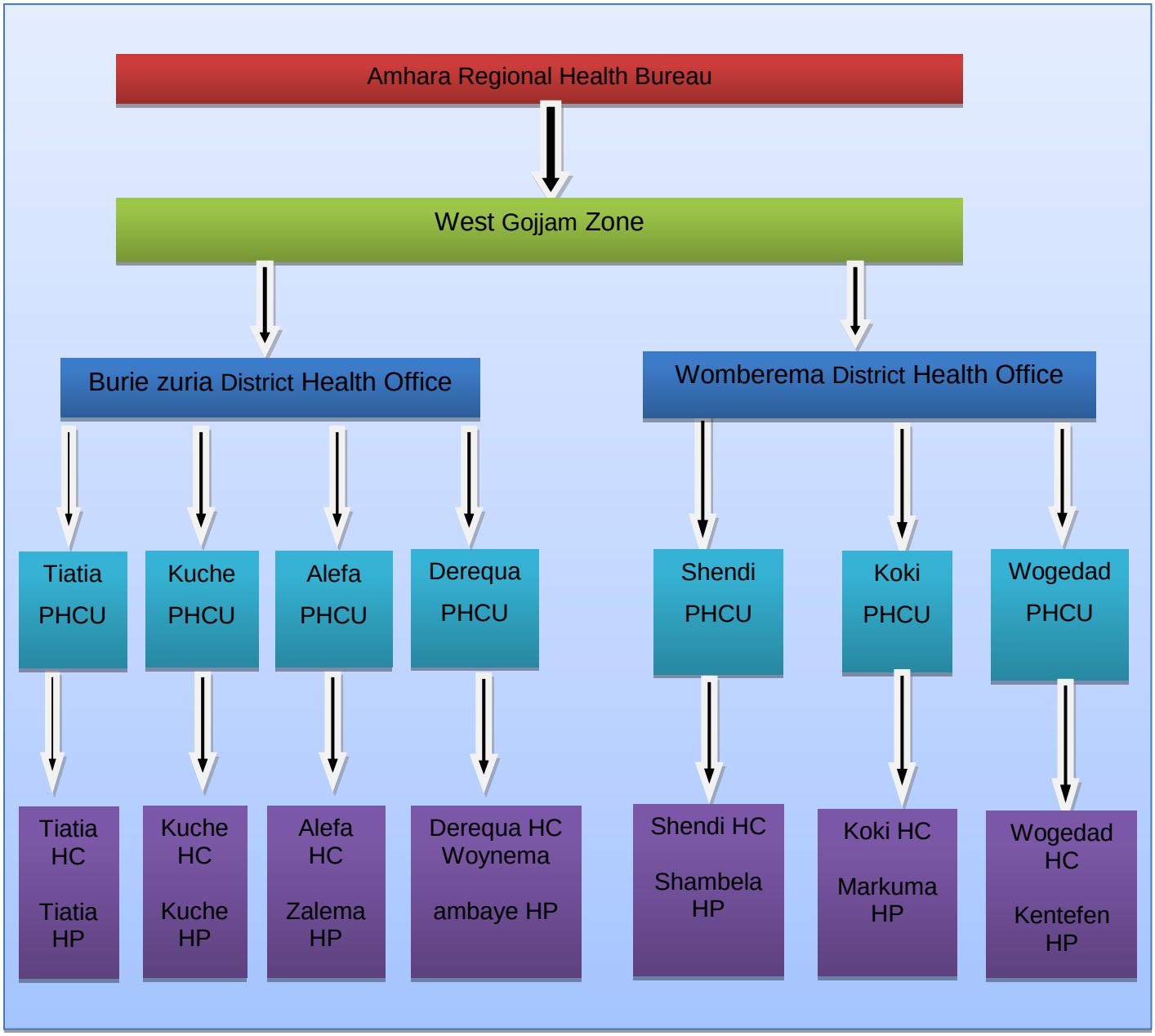

Figure 3.1 Diagram showing the multistage sampling of study sites

3.4.1.2.2 Sampling of study subjects

Purposive sampling was used to select the study participants in this study. The study participants were composed of as follows:

- Pregnant women;
- Women who gave birth within one year;
- Health extension workers (HEWs);

- Primary health care unit directors;
- Midwives who were working in the maternity unit at the time;
- District health office maternal and youth reproductive health technical officers;
- Head of district health office; and
- Traditional birth attendants.

Purposive sampling is the main strategy for sampling in qualitative research and is defined as selection of study subjects to meet the needs of the study. These study subjects may be individuals who have knowledge of or experience with the research topic of interest or other sources of data that would help the researchers to comprehensively understand the area of interest (Waltz, Strickland & Lenz 2005:221). The women who were pregnant at the time and had previously given birth at least once were purposively selected because they had the experience of giving birth either at home, in a health facility or both.

The researcher selected the majority of women who gave birth within one year were also included because these women had the experience of giving birth at health facilities or at home, which enabled the researcher to comprehensively understand their perceptions and experiences.

Health extension workers who were working in the selected health posts at the time and have at least two years of experience in that specific health post were selected because they had adequate knowledge on the topic of research or had experience of referring or linking and monitoring women for skilled birth attendance.

The researcher selected primary health care unit directors because they were knowledgeable or had the experience of offering skilled birth attendance services for the catchment population. Besides, midwives who were providing skilled birth attendance services and heads of the maternity unit in the respective health centres were selected as they were responsible for providing skilled birth attendance services and overall management of the maternity unit.

The district health office's maternal and youth reproductive health technical officers were selected because they were the technical lead, coordinate and manage with

regard to the skilled birth attendance services in the district. As a result, they have the knowledge and experiences to address the topic of interest of the researcher.

The heads of district health office were purposively selected for the current study. Presumably, they were responsible for the overall management, coordination and leadership of the district health office, both technical and administrative activities so that they became key sources of information to address the research questions.

Traditional birth attendants who were functioning or had functioned as traditional birth attendants were also purposively selected because they had the awareness and experience regarding the utilisation of skilled birth attendance in the community.

3.4.1.2.3 Sample size

According to Marvasti (2004:10) and Polit and Beck (2010:316), the sample size is the number of study participants in the sample. In qualitative research, there are no hard and fast rules for sample size. The size participants in a study is determined by the information needs of the research and guided by the principles of data saturation in which the investigator stops sampling when no new information is emerging or redundancy is achieved (Polit & Beck 2010:321). Smith et al (2008:90) further indicate that a saturation sampling technique is an approach often employed in qualitative studies. In this approach, the researcher will keep on sampling the study subjects until no new idea is generated in the data. This works well in exploratory studies where the purpose of the research is to explore the perspectives and concerns on the topics of the research from the study participants' point of view. Hence, the current study employed this approach as it is utilising an exploratory study design to address the research questions.

The optimum sample size required to reach data saturation depends on a number of factors. The scope of the research questions, data quality, characteristics of participants (ability to reflect and effectively communicate their experiences), longitudinal data collection, type of sampling strategy employed and type of qualitative inquiry to determine the size of study subjects are needed to measure data saturation (Polit & Beck 2010:321). Therefore, the sample size for the different study participants was determined by the saturation of information during data collection and the number of

individual interviews and FGDs conducted with various study participants is depicted in table 3.1.

Table 3.1 Number of individual interviews and FGDs conducted with different study participants

No	Data collection methods	Study subjects	Number
1	Individual interviews	Health extension workers	7
		PHCU directors	7
		Midwives	7
		District health office maternal and youth reproductive health technical officers	2
		Head of district health office	2
		Traditional birth attendants	2
		Total individual interviewes	27
2	Focus group discussion (FGD)	Pregnant women	7 FGDs
		Women who gave birth recently	7 FGDs
		Total FGDs	14

3.4.2 Pilot study

Polit and Beck (2010:563) define a pilot study as "a small-scale version or trial run, done in preparation for a major study." The main purpose of undertaking a pilot study is to fine-tune the data collection tools and as a result, study participants will have no problems in responding to questions and there will be no problems in recording the data. Furthermore, it enables the researcher to evaluate the validity of the questions and the likelihood of reliability of the data that will be collected (Saunders et al 2009:394). Willig (2013:162) argues that a pilot study enables the researcher to refine the research questions and provides useful information about the potential difficulties or challenges the researcher may encounter during the actual study. A pilot study ensures the examination of the acceptability and feasibility of study procedures and allows the researcher to check whether the data collected will address the research objectives (Smith et al 2008:16).

In this study, the researcher conducted a pilot study in one district health office, one health centre and two health posts that were not among the selected study sites for the actual research. The pregnant women, women who had recently given birth, health extension workers, PHCU directors, midwives, district health office heads and maternal and youth reproductive health technical officers were selected from the respective health posts, health centres and district health offices. This exercise helped in estimating the time required to conduct the interviews and FGDs, to improve the interview guides and questions, to check for appropriateness of data collection procedures and to familiarise the researcher with the data recording materials such as the audiotape recorder.

3.4.3 Data collection

3.4.3.1 Data collection approaches, methods and processes

Lyons and Doueck (2010:134) define data collection as the gathering of data from various data sources. Fitzpatrick & Wallace (2006:125) indicate that data collection is collecting a piece of information to address the research objectives. Yin (2010:130) refers to data collection as a collection of organized information, usually the result of experience, observation, experiment etc. and may consist of numbers, words, or images, particularly measurements or observations of a set of variables. According to Willig (2013:91), the objective of data collection in qualitative research is to create a comprehensive record of participants' words and actions.

The choice of a method of data collection depends on the research questions and the nature of the problem or setting (Berg 2001:182; Wood & Ross-Kerr 2011:171-172). The qualitative data collection methods of in-depth interviews and group discussions are useful to generate rich, detailed data through the expression of participants' own perceptions and experiences (Ulin, Robinson & Tolley 2005:71). The current study aimed to address the research questions related to the perceptions and experiences of the community regarding the utilisation of skilled birth attendance services. In this study, in order to answer the research questions in detail, individual in-depth interviews and focus group discussions were used.

3.4.3.1.1 Individual in-depth interviews

An in-depth interview is a structured encounter between the researcher and the research participants with the aim of generating information. Interviews relatively provide a practical, flexible and economical way of gathering research data (Carter & Henderson 2005:215). Ulin et al (2005:81-82) define in-depth interviews as an exchange between one researcher and one respondent to generate empirical data by enabling participants to talk freely about their lives. For this study, the conversation was between the researcher and study participants (HEWs, PHCU directors, district health office heads and technical officers, and traditional birth attendants) to describe and explore the perceptions and experiences of the community with regard to the utilisation of skilled birth attendance services. The purpose of interviewing participants is to generate and document information, in their own words, individuals' or groups' perspectives, feelings, opinions, values, attitudes and beliefs about their personal experiences and social world, in addition to the factual information about their lives (Saldaña 2011:32).

The researcher conducted individual in-depth interviews with health extension workers, PHCU directors, midwives, district health office head and maternal, youth reproductive health technical officers, and traditional birth attendants. In this respect, the study participants were interviewed to provide information about their perceptions and experiences of the community with regard to the utilisation of skilled birth attendance services.

3.4.3.1.2 Focus group discussion

According to Ulin et al (2005:89), a focus group is the use of group interaction to produce data and insights that would be less accessible without the interaction found in a group. A focus group is also defined as a qualitative data collection method in which researchers and groups of participants meet to discuss a given research topic. It helps researchers to learn the social norms of a community as well as the range of perspectives that prevail in the community (Mack et al 2005:51). In this study, the researchers, pregnant women and women who recently gave birth met as a group to

discuss personal and community perceptions and experiences on the utilisation of skilled birth attendance services.

The researcher conducted focus group discussions with pregnant women and women who recently gave birth.

3.4.3.2 Development, testing and characteristics of the interview guides

Semi-structured interviews are used when researchers have a list of topics or broad questions that must be addressed in an interview. Researchers use a written topic guide or interview guide in order to ensure all the questions are covered in the interview (Polit & Beck 2010:341). In this study, an indepth individual interview was used to collect the data. The general topics were identified from the objectives of the study, central research question and information obtained from the literature review to develop the semi-structured interview guides and enhance the conversation with participants during data collection. Open-ended questions were used to encourage participants to interpret questions themselves. The researcher followed a flexible pattern of three kinds of questions that is; the main question, follow-up questions and probing questions in order to cover the topic in sufficient depth to make most of the rich information that the participants could offer (Ulin et al 2005:82).

The semi-structured interview guides were prepared in English and translated to Amharic, which is the national language in Ethiopia, and spoken well in the Amhara region. The main question posed to the HEWs, PHCU directors, district health office head and maternal and youth reproductive health officers was describe the experiences of offering skilled delivery service in this region? The main question asked for traditional birth attendants was describe your perceptions and experiences about women's utilisation of skilled delivery services in your community. These open-ended questions initiated the discussion. Then probing questions helped to explore the perceptions and experiences of offering skilled delivery services and their utilisation by the communities.

According to Morgan and Guevara (2008:40), audio recording involves the use of either analogue or digital recording equipment to capture conversations, interactions, and interviews. It provides an accurate summary of what was said by the participants and particularly useful for in-depth interviews and focus group discussions. In this study, the

researcher used audiotape recorders to capture the interviews and to ensure that the researcher captured most of the data during data collection. The researcher gave an explanation to the participants for using the audiotape recorders and sought verbal consent prior to the commencement of the interviews. The researcher carried two audiotape recorders, one as a backup in the event that the other recorder failed.

Pretesting was done in the current study to streamline the interview guides and to ensure that the research questions and the method used in asking would bring forth the required information. The pretesting was done a few days ahead of the actual data collection. The researcher conducted in-depth interviews with two HEWs, one PHCU director, one midwife, one district health office head, one district maternal and youth reproductive health technical officer and one traditional birth attendant. This helped to streamline the interview guide by rephrasing and rewording some of the questions, re-ordering the sequence of questions and introducing probes to the semi-structured interview guides.

The semi-structured interview guide for HEWs, PHCU directors, midwives, district health office heads and maternal and youth reproductive health technical officers comprised of two sections which are described below.

Section 1 built rapport between the researcher and the participants. It included information about the objective of the study and information to obtain written informed consent. It also consisted of a demographic intake sheet to collect information on the participant's code, age, sex, profession, position held in the institution and the number of service years.

Section 2 included all the research questions and sub-questions. The questions were open ended, provoked discussion and engaged participants in the discussion. The main question posed to the participants was describe the experiences of offering skilled delivery services in the region. This was accompanied by follow-up and probing questions.

The semi-structured interview guide for traditional birth attendants consisted of two sections, which are elaborated below.

Section 1 helped the researcher to create a conducive environment and smooth communication with the participants. The purpose and objectives of the research introduced and explained for the participants to obtain written informed consent. It also included the participant's demographic intake sheet to collect information on participant's code, age, religion, employment status, educational status, number of years worked as TBAs and whether the TBA is currently working as TBA or not.

Section 2 consisted of all the interview guide questions, which were open-ended and engaged the participants in active discussion. The main question asked to the participants was describe your perceptions and experiences about women's utilisation of skilled delivery services in your community. This was followed by follow-up and probing questions.

3.4.3.3 Development, testing and characteristics of the focus group guide

A semi-structured focus group guide was used to collect data in the current study. The researcher developed a written focus group guide in advance and the guide was very specific to the research questions with carefully worded open-ended questions (Ayres 2008a:810). The topics of the focus group guide were derived from the literature review, theoretical orientation of the study and the main research questions of the current study (Saunders et al 2009:329). The focus group guide was composed of open-ended questions that enabled the researcher to know the participant's orientation on the research topic. The participant constructed their description and highlighted the topics that were meaningful to them and provided an elaboration of self-selected aspects of the topics of the guide (Roulston 2008:582). According to Ulin et al (2005:84), the open-ended questions in the guide were sequenced flexibly in a pattern of the main question, follow-up questions and probing questions. The researcher posed the main question to the participants to clarify the idea of the topic or guide the direction the researcher wanted the question to take. The main question posed to the FGD participants in the current study was describe your perception and experiences with regard to the utilisation of skilled delivery service. Follow-up questions were asked to take the discussion to a deeper level by asking for more details and these were accompanied by further probing questions to move the discussions to still a deeper territory with or without being specific to the topic of discussion.

The focus group guide was prepared in English, translated to Amharic, which is the national working language in Ethiopia, and spoken well in the Amhara region. The main question posed to FGD participants was describe your perceptions and experiences with regard to the utilisation of skilled delivery services. This was an open-ended question that initiated the discussion, and open enough to encourage spontaneity but specific enough to keep the conversation focused on the topic. The probing questions helped to explore the perceptions and experiences of the community regarding the utilisation of skilled birth attendance.

The focus group discussions were audio taped and supplemented with notes taken during the discussion. This enabled the researcher to devote his full attention to listening to the discussion and probing in-depth information. The audiotape recording provided an accurate, verbatim record of the discussion and captured the language used by the participants in more detail. The researcher sought the informed consent of the participants prior to using the audiotape recording by providing a clear, logical explanation about its use, reassurance about its confidentiality and explained what would happen to the tapes and transcripts (Legard, Keegan & Ward 2003:167). The researchers utilised two audiotape recorders, one was used as a backup in case the other audio tape recorder failed.

The researcher tested the scope of the FGD guide, carried out initial tests of the fieldwork and piloted the FGD guide, as it was a critical part of the research (Arthur & Nazroo 2003:134).The pilot testing was conducted a few days ahead of the actual data collection commencement in two health posts. The researcher conducted two FGDs with pregnant women, and two with women who recently gave birth to pilot test the scope of the guide, fieldwork strategies and the FGD guide. This enabled the researcher to refine the fieldwork strategies and fine tune the topic guide by arranging the questions in a logical order, adding or removing minor follow-up questions and estimating the duration of focus group discussions. The FGD guide consisted of two sections, which are described below.

Section 1 began with building rapport between the researcher and FGD participants. It included introducing the purpose of the research to the participants and securing written informed consent from all of them. The demographic information of the participants such

as age, religion, marital status, employment status, educational status, gravidity, parity and place of delivery of last pregnancy was also collected in this section.

Section 2 comprised one main and nine follow-up and probing open-ended questions. The main question posed to the FGD participants was describe your perceptions and experiences with regard to the utilisation of skilled delivery services. This was followed by further follow-up and probing questions for in-depth exploration of information. The FGD guide annexed in the current study was followed by probing questions.

3.4.3.4 Data collection process

The data collection process commenced with developing the interview guides, finding research assistants with previous experience of qualitative data collection, organising refresher training on qualitative data collection, obtaining letters of support (from UNISA, Amhara regional health bureau research and laboratory department, zonal health department and district health office) and availing the necessary logistics for the research team including audio tape recorders.

The data collection team was composed of the researcher and two research assistants. They were graduates in the fields of health science and sociology, with previous experience of qualitative data collection. The researcher organised refresher training on interview skills, data transcription and management prior to the actual data collection.

The heads of Buriezuria and Wombrema district health offices granted the researcher access to the purposively selected study sites after offering the letters of support for the research and explicitly explaining the purpose of the current study.

The research team members were introduced to the heads of district health offices, PHCU directors, midwives and HEWs. The researcher purposively selected heads of district health offices, PHCU directors, midwives and one HEW from each health post (head of the health post). Furthermore, the traditional birth attendants were identified and contacted by the HEWs for the individual in-depth interviews. The HEWs managed to identify and select the pregnant women and women who gave birth within one year for the FGDs. The researcher introduced himself to the study participants, explained the purpose of the research and obtained a written informed consent from each of the

participants before initiating the actual data collection. Semi structured individual in-depth interviews were conducted in the Amharic language which is a national working language and well-spoken in the study sites. Semi structured interview guides were used to collect the data. The interviews were conducted in the participants' own offices except for traditional birth attendants who were brought and interviewed in the health posts and the interviews took between 20-40 minutes on average. After each interview session, the note taker expanded the notes and shared among research team members. The researcher ceased the data collection after realising that new information or ideas stopped to emerge, which indicated the achievement of data saturation.

The pregnant women and women who gave birth within one year and eligible for the FGDs were identified by the HEWs and the researcher corroborated whether they fulfilled the inclusion criteria or not. The researchers introduced themselves to the participants, explained the purpose of the research and obtained a written informed consent from each participant before the commencement of the actual data collection. Focus group discussions were conducted in Amharic, which is the official working language of Ethiopia and well-spoken in the region. A focus group guide was used to collect data. The focus group discussions were conducted in the health posts that were easily accessible to the study participants and the FGDs lasted at least sixty to ninety minutes. According to Kitzinger (2006:24), researchers recommend to have homogeneity within each group to capitalise on the participant's shared experiences. In this study, the groups were homogenous with respect to pregnant women and women who gave birth within one year, as a result, FGDs with pregnant women and those with women who gave birth within one year were conducted separately to make the most out of their shared experiences. To determine the number of participants in a group, the researcher consulted different literature and the different literature suggested a different number of participants for the focus group discussions. Ellis (2010:51) recommends that 6-12 people were adequate for the FGD in health and social care research. Green and Thorogood (2004:111) also indicated that six to 12 participants were adequate for the FGD. Mack et al (2005:56) indicated that 8-12 participants sufficed for the FGD. In the current study, the researcher used seven to 12 study participants for each FGD. The note taker expanded the notes after each focus group discussion session and shared among the research team members. The researcher recognised that no new idea or insight emerged after conducting five FGDs with pregnant women and five with women who gave birth within one year, which revealed data saturation. An additional two FGDs

with pregnant women and two with women who gave birth within one year were conducted in order to ensure that data saturation was reached and further data collection stopped at this point.

Ultimately, the researchers thanked all the study participants, PHCU directors, heads of health posts and heads of district health offices that facilitated the successful hosting of the data collection.

3.4.4 Data analysis

The process of data analysis involved preparing the raw data for analysis, conducting different analysis, getting deeper into understanding the data, representing the data, and making interpretations of the bigger meaning of the data (Creswell 2009:183). The goal of the qualitative data analysis was to organise, provide structure to, and elicit meaning from the data (Polit & Beck 2010:463). It is intended to reveal to others through fresh insights what we have observed and discovered about the human condition (Saldaña 2011:89). In the current study, data analysis describes how the researcher identified relevant themes, derived understanding and created meaning out of the data.

According to Garnham (2008:192), qualitative data are the product of data sources (participants, documents, organisations, electronic media and events) and include quotations, transcripts, observations, field notes, and excerpts from documents such as images and newspaper articles. In this study, the qualitative data were transcripts and expanded field notes sourced from human participants. The analysis of the data was initiated on the field before the completion of data collection (Saldaña 2011:90; Ulin et al 2005:139). The researcher listened to the audio files and read the expanded field notes and transcripts after the end of each interview and FGD session and the transcripts were ready to use. This helped the researcher to make the necessary revisions and refinements in the subsequent interviews and FGD sessions. In the current study, the qualitative data generated and used for analysis were expanded field notes, audio recorded files and their transcripts. The audiotape records of the semi-structured in-depth interviews and FGDs were transcribed and the research assistants to prepare the interview transcripts for analysis expanded the field notes. Hence, the interview transcripts were generated from both the transcription of the audiotape records and expanded field notes. The researcher translated the Amharic transcripts directly in to

English. The researcher's colleague who fluently speaks both English and Amharic checked the consistency between the Amharic transcripts and its English version. The engagement of the researcher in the translation and partly in the transcription of the interviews familiarised and acquainted with the concepts as the researcher read the Amharic transcripts and its English version iteratively in the process.

The current study adopted an inductive thematic analysis approach, where themes that emerged in this analysis were firmly grounded in the data. Thematic analysis is a data reduction and analysis strategy by which qualitative data are coded, categorised, summarised and reconstructed to capture the basic concepts in the data. The thematic analysis facilitated the search for patterns of experiences within the qualitative data and described those patterns and the overarching design that linked them (Ayres 2008b:867). In an inductive approach to thematic analysis, the researcher works from the bottom up and approaches the data without preconceived theoretical coding frame and the resultant themes are firmly embedded within the data (Willig 2013:184).The researcher analysed the available data and collected more, where necessary, to get new insights from the study. It involved discovering patterns, categories and themes throughout the researcher's interaction with the data.

The researcher utilised computer assisted qualitative data analysis software (CAQDAS) to efficiently store, organise, manage and reconfigure the data to enable human analytic reflection (Saldaña 2009:22).

Qualitative data analysis was conducted using the Atlas ti version 7 qualitative data analysis software. The rationale for choosing the Atlas ti, as opposed to other qualitative data analysis software like Open code, was the fact that Atlas ti is a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data and the software was provided free by UNISA. The software was accessed from UNISA Akaki Regional Learning Centre.

Steps in qualitative data analysis

The basic steps in qualitative data analysis are reading, coding, displaying, reducing and interpreting (Ulin et al 2005:144). The current study adhered to these steps for the data management and analysis.

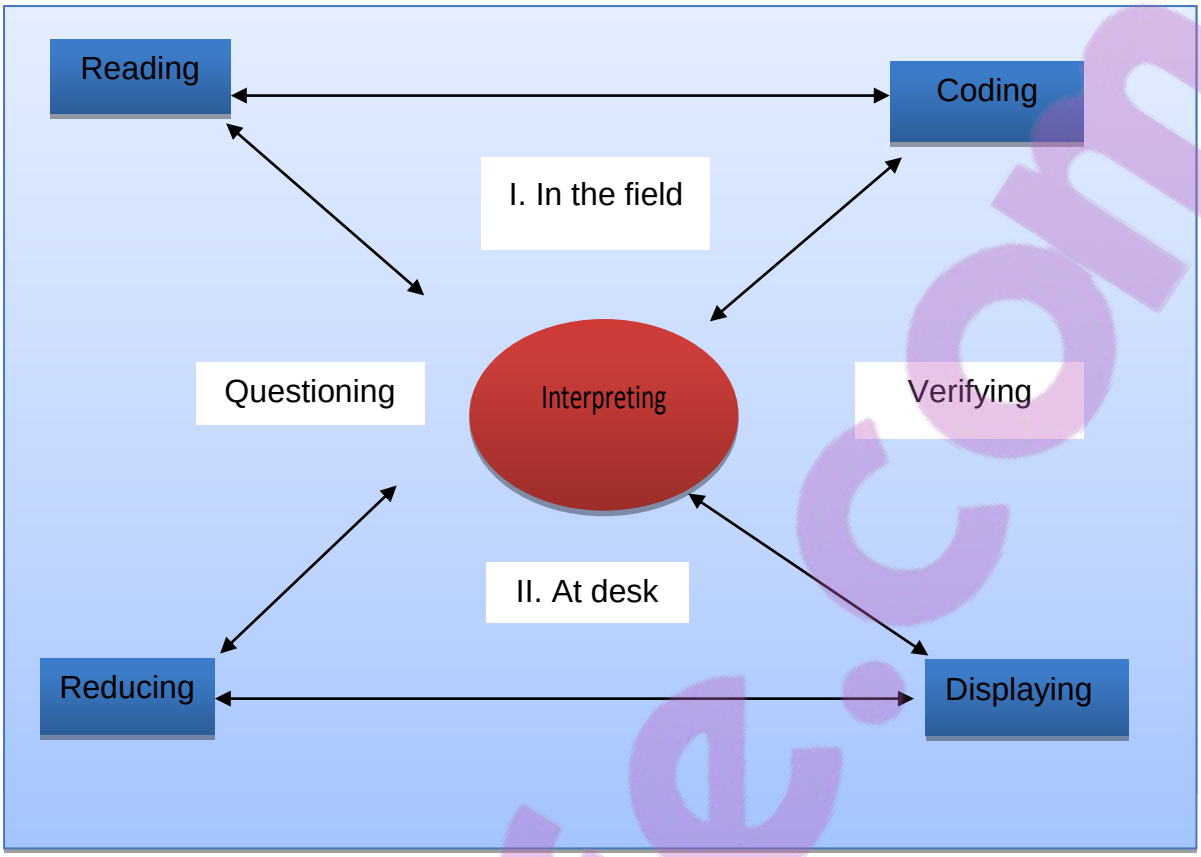

Figure 3.2 Qualitative data analysis: Step-by-step

(Adapted from Ulin et al 2005:144)

Reading/immersion: Developing an intimate relationship with the data

Qualitative data analysis began with reading and re-reading texts and reviewing notes and transcripts until the researcher is well acquainted with the content (Ulin et al 2005:144). The researcher began familiarising himself with the field notes and transcripts during data collection. The research team transcribed each interview and FGD immediately after each interview and FGD sessions and before conducting the next interview and FGD sessions. The researcher checked the transcription against the audio records every day of the data collection process. The researcher read all the Amharic transcripts and translated them into English transcriptions. This familiarised the researcher with the collected qualitative data. The researcher became very familiar with the transcripts by reviewing the qualitative data generated in the field, checking the transcripts against the audiotape records, verifying the proper translation of the transcripts from Amharic to English.

Coding: Identifying the emerging themes

After reading and re-reading the data, themes started to emerge and the researcher began to attach labels or codes to chunks of texts that represented those themes (Ulin et al 2005:144).

A code in qualitative inquiry is a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data (Saldaña 2009:3). Coding is heuristic to the meanings of individual sections of the data (Saldaña 2011:95). Creswell (2009:186) also defines coding as a process of organising the transcripts into chunks or segments of data before ascribing meaning to the information. In the current study, the coding served as a way of patterning, classifying, and later reorganising each datum into emergent categories and themes for further analysis.

Transcripts of the interviews and FGDs were prepared in the MS Word document format. The transcripts were imported to the Atlas ti qualitative data analysis software as a primary document, using the assign command in the main menu of the Atlas ti. The researcher labelled the coded texts with the words that sense the text description. The techniques employed for coding were open coding, quick coding and coding by list. The researcher used the open coding command for coding for the first time. Coding by list was used to assign existing codes to a selection and quick coding was used to assign currently selected codes to consecutive text segments.

Displaying data: Distinguishing nuances of a topic

This was the step where a theme was examined carefully and closely after information about a theme was extracted and collated in the coding sort. The researcher addressed the data display phase by developing detailed memos with respect to each main code in a coding scheme. According to Ulin et al (2005:157), displaying data means laying out or taking an inventory of what you know related to a theme; capturing the variation, or richness of each theme; separating qualitative and quantitative aspects; and noting differences between individuals or among subgroups. The first step taken in the data displaying was to identify the principal sub themes that emerged from the data. The second step involved returning to the data and examining the evidence that supported

each theme qualitatively (Ulin et al 2005:157). Once the researcher had identified the themes and sub themes, the researcher focused on one theme at a time. The researcher sought evidence from data that supported each theme.

Data reduction: Getting the bigger picture

Data reduction is the process of distilling information to make the most essential concepts and relationships visible. The goal is to get an overall idea of the data, differentiate central and secondary themes and a process of separating the essential from the non-essential (Ulin et al 2005:160).

Interpretation

Interpreting is considered as the act of giving your own meaning to the reassembled data and data array (Yin 2010:207). Ulin et al (2005:144) also state that interpreting is the act of identifying and explaining the core meanings of the thoughts, feelings and behaviours described in the text. This final step provided the overall interpretation of the findings of the study, indicated the relationships between thematic areas; how the research questions were addressed through the network of concepts that emerged, and the implication of the current study findings beyond the specific context of this study. In the present study, the meaning attached to texts in the transcripts was extracted and linkages between the different thematic areas were identified. The network view in the Atlas ti was used to identify the relationship between thematic areas. This helped to explain how the network of concepts responded to the original study questions and showed how the thematic areas related to each other. The inductive thematic analysis results were compared and variations were sorted out. Deviating ideas or concepts were accounted and represented as such, revealing rival explanations.

3.5 PHASE II

Phase II entailed the development of strategies to improve the utilisation of skilled birth attendance. The development process of the strategies was based on the empirical data collected and analysed during phase I. It resulted from the analysis and synthesis of the findings of the phase I study to come up with the ultimate goal of the current

study, which was developing strategies to improve the utilisation of skilled birth attendance. The strategies will be discussed in detail in chapter 6.

The perceptions and experiences in relation to the utilisation of skilled birth attendance, strategies currently being implemented and proposed strategies to improve skilled delivery care utilisation explored in phase I consisted of a range of suggestions and recommendations, which were eventually categorised in to themes. This enabled the researcher to determine and clarify the scope and objectives of the strategies. Draft strategies were developed from the themes identified in this study. Strategy statements were formulated, provided with a rationale to support their existence, and presented as draft strategies.

The draft strategies were summarised, operationalised and developed into interim strategies, which were presented to a group of health professionals and managers for analysis and validation. Expert health professionals and managers validated the interim strategies before they were finalised. The researcher presented the strategies to some of the initial participants in Phase I and other experts. Final strategies were developed following recommendations on the validated interim strategies.

3.6 ESTABLISHING TRUSTWORTHINESS

Different frameworks and guidelines are available about achieving rigor in qualitative research. According to Holloway (2005:296), trustworthiness is the credibility of the findings in a piece of qualitative research and the extent to which readers can have trust in the research and its findings. The rigor of the qualitative research is described by its trustworthiness, which ensures the extent to which the study findings can be valued. To ensure trustworthiness, the researcher employed Lincoln and Guba's framework (Lincoln & Guba 1985 in Polit & Beck 2010:492; Shenton 2004:64) of trustworthiness in qualitative research. The research ensured trustworthiness of the findings through ensuring the credibility, dependability, confirmability and transferability in the research, which are criteria for trustworthiness (Given & Saumure 2008:895; Polit & Beck 2010:492; Shenton 2004:64).

3.6.1 Credibility

Credibility refers to the confidence in the truth of the data collected and its interpretation, including a correct understanding of the context (Polit & Beck 2010:492; Ulin et al 2005:25). Shenton (2004:64) argues that credibility deals with how the findings of the study are closely related with reality. Jensen (2008b:138) also defines credibility as the methodological procedures and sources employed to establish harmonisation between participants' expression of the phenomenon being studied and the researcher's interpretation of them. The credibility was achieved through prolonged engagement, triangulation, peer debriefing and member check (Jensen 2008b:139; Shenton 2004:64).

- **Prolonged engagement**

Prolonged engagement includes establishing enough contact with the participants and the context in order to get the information the researcher needs (Jensen 2008b:139). This enabled the researcher to get an adequate understanding of the context and to establish a relationship of trust with the participants (Shenton 2004:65). In the current study, the researcher spent adequate period in the study area with the study participants undertaking interviews and focus group discussions.

- **Triangulation**

According to Polit and Beck (2010:497), triangulation refers to the use of multiple referents to draw conclusions about what constitutes truth. Creswell (2009:191) contends that collecting and examining multiple sources of data is useful to ensure the credibility of a study. There are four types of triangulation (data, investigator, method and theory) identified to ensure the credibility of a study (Polit & Beck 2010:497). In the current study, the researcher used data, method and theory triangulation methods. Data triangulation involves the use of multiple data sources (Polit & Beck 2010:497; Shenton 2004:66). In this study, the researcher collected data from different sources such as pregnant women, women who gave birth recently, HEWs, PHCU directors, heads and maternal and youth reproductive health officers of district health offices, midwives and traditional birth attendants to conduct data triangulation. Furthermore, the current study utilised in-depth interviews and focus group discussions to gather data about the same

phenomenon being investigated as methodological triangulation (Polit & Beck 2010:498; Shenton 2004:65). As part of the theory triangulation, the study consulted different literature.

- **Peer debriefing**

According to Leech and Onwuegbuzie (2008:200), in peer debriefing, the researcher discusses the study with trusted and knowledgeable colleagues in the subject matter to help the researcher to explore aspects of the study that have remained hidden. The peer debriefing enabled the researcher to keep his bias out of the study, motivated the researcher to get deeper into the data to capture a full understanding of the participant's perspectives and resolve methodological issues. Creswell (2009:192) also contends that involving a peer debriefer to review and ask questions about the study enhances the accuracy and validity of the account. In the current study, the researcher had a discussion with colleagues from Universities, who were experienced in qualitative research and presented the findings and interpretations of the data to colleagues who are experts in the field of study in order to avoid bias and misinterpretation of the data, and unfolded aspects of the study that remained covert.

- **Member check**

Member check is a strategy utilised to optimise the validity of a qualitative study and study participants are asked to validate whether the researcher accurately rendered their experiences, whether they fully understood the meaning of their experiences, and whether the final interpretation accounts of their experiences do justice to them or not (Sandelowski 2008:501). Polit and Beck (2010:499) also indicated that the researcher asked the participants to give their reactions about the emerging interpretations. The study participants were given an opportunity to validate whether the researcher's interpretations were a good representation of the participants' realities. The researcher asked the participants to elaborate on or clarify what they have said during the interviews or group discussions. When the researcher summed up the data collection sessions, the researcher also shared with the participants, data from the field notes to verify or comment on the information collected during the interviews or group discussions. This was done to confirm that the information captured and the meanings

that the participants intended to ascribe regarding their perceptions and experiences in the utilisation of skilled birth attendance were indeed accurate.

3.6.2 Transferability

Transferability in a qualitative study has a meaning equivalent to external validity in a quantitative study (Shenton 2004:64). External validity is concerned with the extent to which the findings of a study apply to other settings or groups in the population (Holloway, 2005:292). Transferability in qualitative study is the extent to which findings or conclusions can be transferred to other settings or situations beyond the scope of the study context (Jensen 2008d:886; Polit & Beck 2010:511; Ulin et al 2005:27).

To increase the transferability of the study, according to Jensen (2008d: 886), the researcher considered two key points: how closely the study participants were linked with the context being studied, and the contextual boundaries of the findings. In this study, the pregnant women, women who gave birth recently, HEWs, PHCU directors, Head and maternal and youth reproductive health officers of district health offices, midwives and traditional birth attendants were included and closely linked with the context being studied. Furthermore, the researcher described the study context in detail in Chapter 1.

In transferability, it is the responsibility of the researcher to provide a complete picture of the study context and then it is up to the reader to determine if the work is transferable to their context (Jensen 2008d:886). In the current study, as cited in Jensen (2008d:886) and Shenton (2004:70), the researcher employed two strategies to enhance the transferability of the study through thick description and purposeful sampling. The study contexts, participants and research designs were described in detail in the preceding sections and chapter to enable the readers to determine transferability. The study participants and sites were selected using purposive sampling as it was described in detail in section 3.4.1 of chapter 3.

3.6.3 Dependability

According to Polit and Beck (2010:492), dependability refers to the stability of data over time and over conditions. Holloway (2005:143) indicates that the decision trail, which

shows how decisions were reached during data collection, analysis and the relationship between methodology and methods used in the qualitative research, are helpful towards ensuring dependability. Dependability can be achieved by the description of the exact methods of gathering, analysing and interpreting data in order to provide information on how repeatable the study might be (Jensen 2008c:209; Waltz et al 2005:219). In this study, keeping notes on any of the decisions made during data collection and analysis, keeping raw data for interested researchers to crosscheck or verifying and making effective interpretations ensured dependability. Independent checks by colleagues helped to ensure the dependability of data.

3.6.4 Confirmability

Confirmability refers to the objectivity or neutrality of the data and interpretations (Polit & Beck 2010:550). It also ensures that the findings and interpretations match the data (Given & Saumure 2008:896). Confirmability can also be achieved through an audit trail in which an independent reviewer is invited to verify the research process and interpretation of data as inconsistent with the literature and methodological levels (Jensen 2008a:112). Ulin et al (2005:168) indicate that an audit trail is a "record that enables you and others to track the process that has led to your conclusions". The records were produced from notes and other field materials collected and stored along the process. In this study, data collection approaches, decisions on what data to collect, raw data, analysis notes and interpretation of data were documented to ensure confirmability.

3.7 ETHICAL CONSIDERATIONS

Ethics in qualitative research involves complying with ethical guidelines and gaining ethical approval from professional or academic bodies before commencing with the actual data collection (Birch, Miller, Mauthner & Jessop 2002:1). Neuman (2007:48) asserts that ethics includes the concerns, dilemmas and conflicts that arise from the proper way to conduct research. It also helps to define what is or is not legitimate to do, what moral research procedures involve.

In the present research, the ethical principles were adhered to and protected during the research process. The rights of both the participants and the institutions were protected.

3.7.1 Permission to conduct the study

Ethical clearance was obtained from UNISA Department of Health Studies Higher Degrees Committee and Amhara Regional Health Bureau Research and Laboratory Department to conduct the current study (see anexures 1 and 4). The UNISA Akaki Regional Learning Centre wrote a letter of support to the Amhara regional health bureau to conduct the study (see annexure 2). The Amhara regional health bureau wrote a letter of support to West Gojjam zonal health department. Then, the West Gojjam zonal health department wrote a letter of support and granted access to the selected district health offices. Finally, the district health office heads, PHCU directors and head of health posts allowed the study to be conducted in the selected district health offices, health centres and health posts. The ethical clearance certificates and letters of support have been annexed in the current study.

3.7.2 Informed consent

According to Israel and Hay (2008:431), researchers must provide participants with information about the purpose, methods, demands, risks, inconveniences and discomforts, possible outcomes of the research and dissemination plan of the findings. Neuman (2007:54) contends that informed consent is “agreement by participants stating they are willing to be in a study and they know something about what the research procedure will involve”.

Full information was provided for the research participants to take an informed decision. Accurate and complete information about the research was provided to enable the participants to take voluntary and thoroughly reasoned decisions to participate in the study. The research participants were fully informed about any potential impact of the investigations and written informed consent was obtained. In the present study, clients were informed about the purpose of the study, estimated duration of the interview, and their rights to participate or withdraw from the study. Informed verbal consents were also obtained from the participants to use audiotape recorders after fully explaining the purpose. The participants were also informed that they could withdraw at any point of the interview or not answer any question they felt uncomfortable answering. Only research participants who gave their written consent were allowed to participate in the

study. Written informed consent was taken from participants who could read and write whereas, fingerprints were used to obtain signed informed consent from participants who were unable to read and write. Hence, this study protected the self-determination or autonomy of the participants.

3.7.3 Privacy and confidentiality

The privacy of participants, as stated in Neuman (2007:57), would be protected from being public through anonymity and confidentiality. Anonymity means the participant's identity and responses cannot be identified (Ogden 2008:17). The other issue is ensuring confidentiality. Ogden (2008:111) asserts that the information shared with the researcher will not be publicised in a manner that can identify a participant or source.

In this study, confidentiality was ensured by removing all names and addresses of participants from the data collecting tools. The information that the participants provided was kept confidential and used only for the purpose of the research. Only codes were used to identify participants, along with audiotape recorders. Anonymity was ensured through the use of codes, thus making it difficult to attribute responses to particular participants. Data collected were kept in the strictest confidence; they were not made public to other people. Audiocassette tapes were also erased after the completion of the study. Only aggregate demographic information was reported to maintain anonymity.

3.7.4 Protection from harm

Lyons and Doueck (2010:83) indicate that the researcher is required to ascertain that the research participants are protected from any risk of physical or psychological harm. In this study, the researcher ensured the protection of participants by addressing issues such as the freedom of withdrawal from the study at any time and assuring them that no harm will be caused to them.

3.8 CONCLUSION

This chapter described the research design, methods of data collection, data analysis, trustworthiness, and ethical considerations of the study. The explorative and descriptive qualitative research design was used to explore and describe personal and community

perceptions and experiences regarding the utilisation of skilled birth attendance. The study was conducted among pregnant women, women who gave birth recently, HEWs, PHCU directors, midwives, district health office maternal and youth reproductive health technical officers and heads of district health offices. Semi structured in-depth interviews and focus group discussions were used to collect the data. The inductive thematic analysis approach was used to analyse data, using the qualitative data analysis software, Atlas ti version 7.0. The chapter also described the ethical requirements of the study and steps taken to ensure trustworthiness of the study. The presention, andalysis, and description of the study findings will be presented in the next chapter.

CHAPTER 4

PRESENTATION, ANALYSIS, AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The previous chapter described the research design and methodology that was used to conduct the study. This chapter focuses on data analysis, presentation, and description of the research findings on individual and community perceptions and experiences on the utilisation of skilled birth attendance services.

4.2 DATA MANAGEMENT AND ANALYSIS

The current study adopted the inductive thematic analysis approach where themes that emerged from this analysis were firmly grounded in the data. This approach was applied to explore and describe the perceptions and experiences of the community on the utilisation of skilled birth attendance services. The thematic analysis facilitated the search for patterns of experiences within the qualitative data and described those patterns and the overarching design that linked them. The researcher worked from the bottom up and approached the data without preconceived theoretical coding frame and the resultant themes were firmly embedded within the data.

The steps followed in data analysis were reading, coding, displaying, reducing and interpreting. The researcher familiarised himself with the data as he read expanded notes, transcribed the notes and translated the Amharic transcripts into English transcripts. Qualitative data analysis was conducted using Atlas ti version 7 qualitative data analysis software. The network view of the Atlas ti eased the explanation on how the networks of concepts responded to the original study questions and showed how thematic areas related to each other.

4.3 BIOGRAPHICAL PROFILE OF THE PARTICIPANTS

The profile of the FGDs and individual interviews of the study participants were described in detail.

4.3.1 Biographical profile of the FGD participants

The participants for the FGD section were seventy-one women who gave birth within one year or a few women who gave birth within two years and sixty-two pregnant women who had previously given birth at least once. The participants' profiles for the FGD section including age, marital status, religion, employment status, educational status, gravidity, parity, and place of delivery in the last pregnancy were described.

Table 4.1 Age distribution of women who gave birth within one year (n=71)

Age range	Frequency	Percentage
15-19	3	4.2
20-24	20	28.2
25-29	27	38.0
30-34	16	22.5
35-39	4	5.6
40-44	1	1.4
Total	**71**	**100.0**

Up to 38% of the participants were in the age range of between 25 and 29 years.

Table 4.2 Religion of women who gave birth within one year (n=71)

Religion	Frequency	Percentage
Orthodox Christian	71	100.0
Total	**71**	**100.0**

All (100%) of the participants were orthodox Christians.

Table 4.3 Marital status of women who gave birth within one year (n=71)

Marital status	Frequency	Percentage
Divorced	3	4.2
Married	68	95.7
Total	**71**	**100.0**

Up to 95.7% of the participants were married.

Table 4.4 Employment status of women who gave birth within one year (n=71)

Employment status	Frequency	Percentage
Government employee	1	1.4
Farmer	61	85.9
House wife	1	1.4
Merchant	7	9.9
Unemployment	1	1.4
Total	**71**	**100.0**

Up to 85.9% of the participants were farmer by occupation.

Table 4.5 Educational level of women who gave birth within one year (n=71)

Educational level	Frequency	Percentage
No education	46	64.8
Primary (1-6)	10	14.1
Secondary (7-8)	7	9.9
High school (9-12)	7	9.9
Higher education	1	1.4
Total	**71**	**100.0**

Up to 64.8% of the participants had no education.

Table 4.6 Gravidity of women who gave birth within one year (n=71)

Gravidity	Frequency	Percentage
1	18	25.4
2	9	12.7
3	8	11.3
4	20	28.2
5	7	9.9
6	4	5.6
7	3	4.2
9	1	1.4
10	1	1.4
Total	**71**	**100.0**

Up to 28.2% of the participants were pregnant for the fourth time while 25.4% were pregnant for the first time.

Table 4.7 Parity of women who gave birth within one year (n=71)

Parity	Frequency	Percentage
1	19	26.8
2	10	14.1
3	12	16.9
4	16	22.5
5	7	9.6
6	4	5.6
7	2	2.8
9	1	1.4
Total	**71**	**100.0**

Up to 26.8% of the participants had given birth for the first time while 22.5% had given birth for the fourth time.

Table 4.8 Place of delivery of women who gave birth within one year (n=71)

Place of delivery	Frequency	Percentage
Home	27	38.0
Health centre	38	53.5
Hospital	3	4.2
Health post	3	4.2
Total	**71**	**100.0**

Up to 53.5% of the participants gave birth in a health centre during their last pregnancies.

Table 4.9 Age of pregnant women (n=62)

Age range	Frequency	Percentage
15-19	1	1.6
20-24	16	25.8
25-29	22	35.5
30-34	17	27.4
35-39	5	8.1
40-44	1	1.6
Total	**62**	**100.0**

Up to 35.5% of the participants were in the age range of between 25 and 29 years.

Table 4.10 Religion of pregnant women (n=62)

Religion	Frequency	Percentage
Orthodox Christian	62	100.0
Total	**62**	**100.0**

All (100%) of the participants were orthodox Christians.

Table 4.11 Marital status of pregnant women (n=62)

Marital status	Frequency	Percentage
Married	62	100.0
Total	**62**	**100.0**

All (100%) of the participants were married.

Table 4.12 Employment status of pregnant women (n=62)

Employment status	Frequency	Percentage
Government employee	1	1.6
Farmer	55	88.7
House wife	3	4.8
Merchant	3	4.8
Total	**62**	**100.0**

Up to 88.7% of the participants were farmers by occupation.

Table 4.13 Educational status of pregnant women (n=62)

Educational status	Frequency	Percentage
No education	40	64.5
Primary education (1-6)	7	11.3
Secondary education (7-8)	7	11.3
High school (9-12)	8	12.9
Total	**62**	**100.0**

Up to 64.5% of the participants had no education.

Table 4.14 Gravidity of pregnant women (n=62)

Gravidy	Frequency	Percentage
1	6	9.7
2	13	21.0
3	12	19.4
4	11	17.7
5	8	12.9
6	9	14.5
7	2	3.2
8	1	1.6
Total	**62**	**100.0**

Up to 21% of the participants were pregnant for the second time while 19.4% and 17.7% were pregnant for the third and fourth time respectively.

Table 4.15 Parity of pregnant women (n=62)

Parity	Frequency	Percentage
0	8	12.9
1	14	22.6
2	14	22.6
3	11	17.7
4	6	9.7
5	6	9.7
6	2	3.2
7	1	1.6
Total	**62**	**100.0**

Up to 22.6% of the participants had given birth once and twice while 17.7% had given birth for the third time.

Table 4.16 Place of delivery of pregnant women during the last pregnancy (n=62)

Place of delivery	Frequency	Percentage
Never gave birth	8	12.9
Home	41	66.1
Health centre	10	16.1
Hospital	2	3.2
Health post	1	1.6
Total	**62**	**100.0**

Up to 66.1% of the participants gave birth at home while 16.1% and 3.2% gave birth in the health centre and hospital, respectively.

4.3.2 Biographical profiles of participants of the individual interview

The participants for the individual interviews were twenty-four health professionals who had the experience of offering skilled birth attendance services and had adequate knowledge on the topic of interest. The individual interviews captured the participants' profile such as age, sex, profession, position held in the health facility, and number of years of service.

Table 4.17 Age of participants (n=24)

Age range	Frequency	Percentage
20-24	8	33.3
25-29	13	54.2
30-34	1	4.2
35-39	1	4.2
40-44	1	4.2
Total	**24**	**100.0**

Up to 54.2% of the participants were in the age range of between 25 and 29 years while 33.3% were in the age range of 20-24 years.

Table 4.18 Sex of participants (n=24)

Sex	Frequency	Percentage
Female	13	54.2
Male	11	45.8
Total	**24**	**100.0**

Up to 54.2% of the participants were female while 45.8% were male.

Table 4.19 Profession of participants (n=24)

Profession	Frequency	Percentage
BSC	1	4.2
Diploma clinical nurse	4	16.7
Health officer	4	16.7
HEW	7	29.2
Midwife	7	29.2
Non-health	1	4.2
Total	**24**	**100.0**

Up to 29.2% of the participants were midwives and HEWs while 16.7% were health officers and diploma clinical nurses by profession.

Table 4.20 Position held by the participants in the institution (n=24)

Position	Frequency	Percentage
Maternity unit head	6	25.0
Health centre director	6	25.0
Head of WerHO	1	4,2
HEW	8	33.3
Maternal, reproductive and youth district technical officer	2	8.3
Maternity unit worker	1	4.2
Total	**24**	**100.0**

Up to 33.3% of the participants were health extension worker (HEW) while a quarter was maternity unit head and health centre director.

Table 4.21 Number of years of service (n=24)

Number of years	Frequency	Percentage
0-3	10	41.7
3-6	4	16.7
6-9	9	37.5
>9	1	4.2
Total	**24**	**100.0**

Up to 41.7% of the participants had 0-3 years of service provision while 37.5% had 6-9 years of service provision in district health offices, health centres and health posts.

With regard to traditional birth attendants, individual interviews were also conducted with three traditional birth attendants who are currently functioning or had been functioning as traditional birth attendants. The current study collected profiles of traditional birth attendants with regard to age, religion, employment status, number of year worked as TBA, and whether they were still functioning as TBAs at the time of this research or not. The mean age of the participants was 46 years; all of them were orthodox Christians, farmers and had no formal education; mean years of working as a TBA was 14 $\pm$ 11 years and all of them ceased to work as TBAs at the time of data collection.

4.4 ANALYSIS OF DATA OBTAINED FROM THE PARTICIPANTS

A total of 62 pregnant women and 72 women who gave birth within one year participated in the FGDs. Besides, individual in-depth interviews were conducted with 24 HEWs, midwives, health centre heads, district health office heads and technical experts. Consequently, nine major themes emerged from the analysis of the data obtained from FGDs and individual interviews. Of these, the first seven themes emerged from the FGDs conducted with pregnant women and women who gave birth within one year. They include: skilled birth attendance services that created good experiences for women, causes of disappointment of women with the utilisation of SBA services, reasons for not utilising skilled birth attendance services, factors influencing the utilisation of skilled birth attendance services, factors motivating women to utilise skilled birth attendance services in the future, perceived benefits of skilled birth attendance services, and community support for women to utilise skilled birth attendance services. The remaining two themes embracing challenges of offering skilled birth attendance services and strategies being implemented to improve the utilisation of skilled birth attendance services emanated from the analysis of the individual interviews. Each theme is presented below with categories, sub categories and meaning of units.

Table 4.22 Schematic presentation of themes and categories

THEME	CATEGORY
Skilled birth attendance (SBA) services that created good experiences for women	• Supportive and ethical health workers • Interpersonal care • Experience of receiving good services as perceived by women • Availability of basic and life-saving interventions • Women friendly service
Causes of disappointment of women with utilisation of skilled birth attendance (SBA) service	• Staff-related causes of disappointment • Delay in care and service provision • Individual related experience of SBA service use • Reverberation of poor service provision on future service provision and use • Experience of poor service provision in health facilities

THEME	CATEGORY
Reasons for non-utilisation of SBA services	• Health facility related reasons • Reasons related to health worker • Socio-cultural factors • Fear • HIV/AIDS-related issues • Individual factors • Low early care seeking behaviour • Distance and transportation service related problems
Factors influencing the utilisation of SBA services	• Availability of services • Fear of occurrence and experience of danger signs and complications • Services received
Factors that motivate women to utilise SBA services in the current and/or future pregnancies	• Good interpersonal care • Availability of services • Prior experience of health problems and/or complications in home delivery • Use of skilled birth attendance service in previous childbirth • Preventive and treatment services • Fear of obstetric danger signs and complications
Perceived benefits of SBA services	• Information and advice on maternal and newborn health • Good newborn care practice • Ensure health of woman and newborn • Disease prevention and treatment service • Prevention and management of obstetric and neonatal danger signs and/or complications
Community support for women to utilise SBA service	• Facilitation • Support related to household activities • Transportation service support • Advice and encouragement
Challenges of offering of SBA services in health facilities	• Barriers to transportation service • Health facility infrastructure related • Shortage of equipment, supplies and drugs • Effect of gap in health facility infrastructures and equipment on SBA utilisation • Staff related challenges • Culturally insensitive service
Strategies being implemented to improve utilisation of SBA service	• Awareness creation • Incentive and repercussion • Early pregnancy identification and follow-up • Use of community structures • Transcending transportation barriers using local solution • Labour notification system • Exploration of reasons for home delivery for action

4.4.1 Themes revealed by the analysis of FGD data (pregnant women and women who gave birth within one year)

Seven themes were identified from the FGD with pregnant women and women who gave birth within one year. They include: skilled birth attendance services that created good experiences for women, causes of disappointment of women with the utilisation of SBA services, reasons for not utilising skilled birth attendance services, factors influencing the utilisation of skilled birth attendance services, factors motivating women to utilise skilled birth attendance services in the future, perceived benefits of skilled birth attendance services, and community support for women to utilise skilled birth attendance services. Each theme is discussed in detail below.

4.4.1.1 Theme 1: Skilled birth attendance (SBA) services that created good experience for women

This theme dealt with skilled birth attendance services received by women that created good experiences for them. The presence of supportive and ethical health workers**,** interpersonal care, receiving good services as perceived by women, availability of basic and life-saving interventions/services, and women friendly services created good experiences for women.

4.4.1.1.1 Category 1: Supportive and ethical health workers

The findings in the current study indicated that women received skilled birth attendance services from disciplined and ethical health care providers. It was indicated that all staff of the health facilities were caring and cooperative for labouring women. Furthermore, the skilled birth attendants were present in the labour and delivery room all the time starting from the start of labour until childbirth. The FGD participants mentioned the following statements:

> "Starting from the health centre guard, they are very good and cooperative especially for labouring women. Starting from the guard, the secretary, midwives the word "excellent" could not describe them and their support. The health workers' discipline and ethics were very comfortable to us."

- **Caring and cooperative staffs**

The participants in the current study claimed that the health workers were caring and supportive for pregnant and labouring women. The health care providers provided good advice, regularly followed women, and properly attended their deliveries. In addition to this, administrative and technical staffs were cooperative for pregnant and labouring women any time they showed up in the health facilities. The following excerpts from the women corroborated this:

> "…But, what I saw in the health centre was; the health care providers are very caring and supportive, give good advice, regularly follow us and deliver mothers appropriately and properly."

> "I say that it is nice. Starting from the guard whether we came at night or in the afternoon or at 4:00, they serve us without any reluctance particularly if she is a pregnant woman their cooperation could not be described with the word 'excellent'. It is very nice."

> "Starting from the HC guard they are very good and cooperative especially for labouring women."

- **Ethical and disciplined health workers**

It was indicated that the participant women appreciated; they were comfortable with the ethics and discipline of the health workers who provided skilled birth attendance services. This was verbalised by the FGD participants:

> "The health workers discipline and ethics is very comfortable to us."

- **Presence of health workers all the time during labour and delivery**

The health workers stayed with the labouring women throughout the entire process of labour and delivery even they did not go away for a while. In conjunction with this, women received close follow-up, good advice, encouragement and care from health workers. The presence of health workers with labouring women all the time along all the way of labour and delivery could enable them to closely follow the progress of labour,

detect and manage unforeseen problems and complications timely, and even encourage women to utilise SBA services in the future. The following statements of the participants evidenced this:

> "Their follow-up is special. When they noticed that a labouring woman visits the health centre, everybody starts to run. They properly and closely follow labouring mothers. Thus, I want to give birth there for the future, too. Their follow-up is very nice. They advise us to do this and not to do that because the foetus may get hurt. We also comply with their advices. They stay together with us. They follow us there and they do not go away anywhere."

> "Since the start of my labour until I gave birth and during the late stage of my labour, they stayed with me based on their shifts; they did not go away. They went away after I gave birth."

> "The two nurses stood on my left and right sides and they encouraged me and even they did not go away for a while."

4.4.1.1.2 Category 2: Interpersonal care

Interpersonal care is the care between provider and client. It encompasses emotional support, ethical and respectful service, friendly and compassionate service, information and advice on the woman and newborn health, and respecting privacy. Interpersonal care created good experiences for women and has a great potential of influencing the utilisation of skilled birth attendance services.

- **Emotional support**

The findings revealed that emotional support created good experiences for women, with the utilisation of skilled birth attendance services. It was noted that health workers provided encouragement for women during labour and delivery. It made them not to get distressed, averted any form of fear and boosted the confidence of the women. The following statements of the FGD participants supported this:

> "...they encourage me and they say you are going to give birth now. Now this is the progress; now you have reached this; now this is your progress but they do

not say that your labour is not progressing or we do not know the progress of your labour or something else; they do not let us to be distressed or they do not make us to fear or they do not say such things. They said to me that it is simple, now you will give birth; now it is time for labouring when they say like that I feel confident."

"The two nurses stood on my left and right sides and they encouraged me and even they did not go away for a second."

"...I entered to the HC and got examined laying on a big bed and she informed me that everything is okay, she said to me the cervical dilation is good and the foetus is also descending in good way and she also encouraged me."

- **Ethical and respectful service**

It was indicated that the provision of ethical and respectful skilled birth attendance services created good experiences for women. The FGD participants reported that they received ethical services and were treated with respect. Ethical and respectful skilled birth attendance services have a huge potential to affect satisfaction of women on the services and subsequent use of skilled birth attendance services. The following quotes reaffirmed this:

"Everything, their reception, ethics made me very happy and they treated me with respect and discipline. I say I am very much happy with it, nothing else to say."

"They provided me the services with ethics and respect."

- **Friendly and compassionate service**

Women experienced a welcoming and friendly approach from health workers and good service provision, sympathetic, and respectful care and treatment. The provision of compassionate service maintains the quality of skilled birth attendance services and improves the utilisation of skilled birth attendance services. The following statements indicated this:

"...even your own sister do not care like this."

"The care, respect, treatment was very good; I considered it like my father's and mother's home."

"The service provision is very good. They are just like a father and a mother. "

"Their approach was very good and friendly."

"They provided me the service with ethics and respect."

- **Information and advice on woman and newborn health**

The participants in the current study explained that information and advice were provided to women on the importance of skilled birth attendance services, health problems and complications resulting from home delivery, what ought to be done in case of health problems and complications, conditions that entail re-visiting health facilities and proper newborn practices. Thus, this was essential to improve skilled birth attendance services seeking behaviour of women. The participants mentioned the following statements:

"...They are educating us not to give birth at home…and they are educating us about encountering complications if we give birth at home."

"Any ways, I am telling you their follow-up starting from ANC up to PNC and they are very good. They give priority for pregnant women and labouring mothers; they give us priority. I was pleased with their follow-up. They give us counselling."
"...They also inform us to get back to the HC if something wrong happens to us; as soon as the HEWs call to us and the ambulance will come to you; in case if you have bleeding."

"...She advised me not to wash my baby before 24 hours. I gave birth in the HC on Sunday at 10:00 and I bathed my baby on Monday at 10:00."

- **Respecting privacy**

Respecting the privacy of labouring women created good experiences for them with the utilisation of skilled birth attendance services. It was reported that only companions were allowed to enter and nobody else was allowed to get into the labour and delivery room. This relieved the women from experiencing distress and feelings of shame. The participants indicated this:

> "...Only labouring mothers and companions allowed to enter in the labour and delivery room; nobody else is allowed to in, as a result, there was no any shame and distress. So, I say that it is very good and suggest continuing with this service."

4.4.1.1.3 Category 3: Experience of receiving good services as perceived by women

The focus group discussants perceived that keeping their cleanliness, good newborn care practices, good quality of skilled birth attendance services, home visits form health workers, getting priority in service provision, and regular and close follow-up from health workers created good experiences for women with the utilisation of skilled birth attendance services.

- **Cleanliness**

In the current study, the participant women claimed that the health workers kept their newborn babies and their bodies clean when they utilised skilled birth attendance services in the health facilities. Hence, it made them to interact with other people without any reservations and unease. The FGD participants reaffirmed this:

> "They gave me the child after properly cleaning the newborn. Not only the newborn but also they cleaned me before I went out of the health facility."

> "Moreover, the cleanliness of my body, the people came closer and kissed me; I kissed the people without any reservation and refrain despite I stayed the whole day in health centre for childbirth..."

"The cleanliness is good. They had a container to receive our blood and we did not have contact with our blood."

- **Good newborn care practice as perceived by women**

It was purported that good newborn care practices created good experiences for women with the utilisation of skilled birth attendance services. The FGD participants reported that newborns received proper care, including vaccination services, thermal protection and care for hypothermia, proper cord care, and harmful traditional practices were averted. The provision of essential newborn care at childbirth and immediately after delivery was very instrumental in reducing neonatal morbidity and mortality. The following excerpts corroborated this:

"I was very happy because first of all they gave me the child with very proper care."

"In addition, they changed my cloths and properly made up bed of my newborn. They properly wrapped up the newborn with clothes and put aside to me."

"...I delivered keeping the health of both my baby and mine; they cleaned and wrapped my baby with a clean white towel."

"The service quality is good...The newborn also received something in his mouth. That is an immunization. So, the service is good..."

"...the midwife told us to bath the baby girl after 24 hours. We bathed her after 24 hour."

"The newborn was put in to heater because they said that the newborn is exposed for cold and they also provided me proper care."

"Previously, when I used to give birth at home, they cut the cord very close to the stomach and put cow dung and butter on the cord so that the cord did not get dried in the right time. But now, the cord tied with a cord and dried just within a week period so that giving birth in health facility has benefits.

- **Good quality of skilled birth attendance service as perceived by women**

Women perceived that they received quality skilled birth attendance services. In addition to this, the perceived quality of skilled birth attendance services had a significant impact on the preference and utilisation of skilled birth attendance services. Women indicated that they were provided with injections to prevent excessive bleeding and post-partum abdominal cramps, received regular and close follow-ups, and indicated the experiences of getting good skilled birth attendance services in contrast to prior home delivery experiences. The FGD participants mentioned the following verbatim quotes:

> *"*They cared me with quality services and checked for any bleeding at the end."
>
> The service quality is good. Health workers gave us an injection to prevent us from excessive bleeding...So, the service is good..."
>
> "During morning, they provided me proper care and check me for any bleeding before discharge."
>
> "There was no any cold or wind in the health facility; in addition, the delivery room is also comfortable. I gave birth in a very relaxed environment. The bleeding stopped immediately when I received the injection. I had no any abdominal cramp. I told you before the placenta also did not cause any trouble. Nothing happened to me. But, when I gave birth at home, I suffered a lot and I was slept on the wood nearly for two hours being exposed for cold and wind. There was no any wind there and the doctor stayed palpating my abdomen and immediately the baby delivered safely."

- **Home visits**

The FGD participants indicated that the health workers made home visits after the women gave birth in the health facilities in order to ensure the health of the women and their newborn babies. Undertaking of follow-up visits immediately after childbirth was very critical to avert maternal and neonatal morbidity and mortality as it was a critical time in which maternal and neonatal morbidity and mortality could occur. The FGD participants mentioned the following statements:

> "Leave alone in the health centre even after we gave birth and went back to our home. They came to our home and asked us; what we are feeling? What is it? For me it is very good up to now."

> "They closely follow us and are providing services even by coming to our home."

- **Promptness of care**

It was noted that health workers gave preference to pregnant and labouring women in the provision of services over other clients who visited the health facilities for other services. In addition to this, the participants perceived that they received the attention of health facilities staffs' and this further encouraged them to utilise skilled birth attendance services. The FGD participants mentioned the following statements:

> "...When they noticed that a labouring woman visits health facility, everybody starts to run. They properly and closely follow labouring mothers. Thus, I want to give birth there for the future, also. There follow-up is very nice. They advise us to do this and not to do that because the foetus may get hurt. We also comply with their advice. They stay together with us. They follow us there and they do not go away anywhere."

> "When I came to the HC accompanying someone, they just give us priority to get in and receive the service; they give precedence for labouring women in service provision over the other persons who came for other service."

- **Regular and close follow-up**

Regular and close follow-up in between and after labour and delivery created good experiences for women with the utilisation of skilled birth attendance services. Regular and close follow-up of labouring women helped to ensure smooth progress of the labour, early detection of health problems and complications, and action was taken to ensure the health of the women and their newborn babies. The FGD participants mentioned the following statements:

> "In between, the health workers regularly visited me to check for any bleeding, breastfeeding of the newborn, encouraged me and cleaned me, even your own sister do not care like this. Finally, health workers assessed me for bleeding for the second time gave me a bath and discharged me."

> "I gave birth in this health centre. At that time, I received a proper follow-up after giving birth. I had encountered some bleeding after delivery and they immediately gave me an injection and immediately got improved. I gave birth safely and I received proper follow-up."

> "They cared us. After we gave birth and moved to the waiting room, the health workers frequently visited us and closely followed us; they asked us whether we had bleeding or not. They closely follow us; they check whether the newborn is breastfeeding well or not. Then, they discharge us at the right time."

4.4.1.1.4 Category 4: Availability of basic and life-saving interventions

The availability and utilisation of ambulance services, referral services, timely care and services, life-saving interventions, the use of drugs and supplies to avert obstetric complications, and the provision of detergents and clothes for newborns created good experiences for women with the utilisation of skilled birth attendance services.

- **Availability of ambulance service**

The availability of ambulance services helped to avert delays in seeking skilled birth attendance services in relation to transportation barriers and facilitated the transportation of women from their residences to the health facilities and referral service to higher health facilities. The FGD participant mentioned the following statement:

> "...first, we do not look for a rental vehicle and since recently, ambulance service is available in the district. If there is a referred woman, she will be transported with ambulance..."

- **Life-saving interventions**

The availability and utilisation of life-saving interventions in the health facilities created good experiences for women with skilled birth attendance services. Some of the FGD participants reported that they had developed obstetric complications and received life-saving interventions such as treatment for excessive bleeding. Life-saving interventions were critical in the management of obstetric complications and, in return, averted maternal morbidity and mortality. The following statements corroborated this:

> "I gave birth here in this health centre. I had excessive bleeding after I gave birth. I got improved when they gave me an injection on the right and left thigh. They told me to stay in the health centre until the bleeding stopped and then I went to my home after the bleeding stopped."

> "I gave birth at home. After I delivered my baby, my placenta retained in the womb and then they brought me to the health centre and the retained placenta removed and I went back to home."

- **Provision of detergent and cloth for newborns**

The findings revealed that detergents and clothes were provided for the newborns for those women who gave birth in the health facilities. The provision of incentives for women who utilised skilled birth attendance services encouraged them to give birth in health facilities in the future, and influence other women in the community to utilise skilled birth attendance services. FGD participants mention the following statements:

> "I received towel, cap and two soaps for my newborn from the health centre."

> "They are providing services timely when a labouring woman comes to the health facility. After that, nobody gets contaminated with blood; the health workers themselves suffered a lot to provide good service for us; they also provide cloths and soap for the newborn."

- **Referral service**

Women received referral services for labour that could not be managed at the first level health facilities, obstetric complications, and neonatal complication. Availability of referral services to higher health facilities is very important to manage maternal and newborn health problems and complications that could not be managed at the first level health facilities. This has created good experiences for women with skilled birth attendance services. The following statements evidenced this:

> "My labour started at 4:00 at night and I came to the health centre...my labour stopped and I started to have vomiting. When I started to have vomiting, they called for ambulance and referred me to Fenot selam Hospital."

> "...I had excessive bleeding; they could not manage it and they were unable to manage it. Then they referred me and they brought an ambulance and sent me to Fenot selam Hospital."

> "My baby did not breastfeed until 1:00 and they referred me to Fenot selam Hospital. I went to Fenot selam and I stayed there. IV glucose and NG tube secured to my newborn and then she started to breastfeed..."

- **Timely service and care provision**

Timely service and care from health workers created good experiences for women with the utilisation of skilled birth attendance services. It was reported that the participant women had received prompt care and services from health workers when they visited health facilities for skilled birth attendance services. The following excerpts were taken from the FGD participants:

> "...After recognising that I am pregnant mother, the health workers took me to their room whereby I received prompt care and examination. Then, they offered me a bed to sleep; IV line with glucose secured and delivered my baby. They discharged us the next day morning at 8:00. No problem at all and nothing wrong happened to me. Nothing made me upset. I was very happy."

> "They are providing services timely when a labouring woman comes to the health facility..."

- **Use of drugs and supplies to avert obstetric complications**

The FGD participants claimed that they had received medical drugs and supplies to avert the occurrence of obstetric complications. The availability of drugs and supplies for the prevention and management of obstetric complications in health facilities created good experience for women with utilisation of skilled birth attendance service. The FGD participants mention the following verbatim statements:

> "...the injections that we received in order to prevent women from bleeding and to expel the placenta."

> "...They provided me medicines, which are tablets to be swallowed or oral suspensions; I brought it to my house."

> "There is an injection and they give us an injection to prevent us from bleeding after we gave birth."

4.4.1.1.5 Category 5: Women friendly service

Women friendly service is very important and critical as it ensures optimum utilisation and impact of maternal and neonatal services provided. It encompasses addressing the cultural needs of the community in order to utilise skilled birth attendance services optimally.

- **Practice of cultural ceremonies in health facilities**

As it was purported by the FGD participants, labouring women and their companions were allowed to undergo cultural ceremonies in health facilities, which were practiced in the households of labouring women. Even health facilities made the necessary arrangements for them to practice the cultural ceremonies, including availing equipment and materials, coffee beans, flour, and sources of energy. The FGD participants mention the following statements:

"Like they said, coffee ceremony and porridge also prepared for me."

"For me, I think it is very nice. Because I gave birth during daytime; I delivered my baby at day time it is very fine. I gave birth there; it is clean. Then they provided us coffee beans and equipment to prepare the coffee; we did not miss our cultural ceremonies. For me, it is very nice. I did not see any problem."

4.4.1.2 Theme 2: Causes of disappointment of women with utilisation of SBA service

This theme dealt with the causes of disappointment for women with the utilisation of skilled birth attendance services. This theme is divided into five categories; namely, staff related causes of disappointment, delays in care and service provision, individual related experiences, reverberation of poor service provision on service provision and use; and poor service provision.

4.4.1.2.1 Category 1: Staff-related causes of disappointment

Lack of cooperation among staffs, negligent health workers, and refusal of health workers to offer services out of working hours caused disappointment of women with the utilisation of skilled birth attendance services.

- **Lack of cooperation among staff**

It was indicated that there was no cooperation and collaboration among staffs when they gave birth in the health facilities. The health workers who were assigned in the labour and delivery rooms were completely responsible for managing the deliveries and the other health workers thought that it was the sole responsibility of the person assigned in the maternity unit. Furthermore, the women suggested the need for cooperation among staffs in order to provide quality services and avoid staff burn out. The following statements evidenced this:

"...Attending delivery of a woman should not be the responsibility of one health worker. For instance, I gave birth at night time; they left everything for one health

worker who was in charge at that time and they thought that the health worker who was in charge was responsible to handle my delivery."

"My husband knocked the door of the night duty room to call for somebody for assistance and somebody came and assisted her to deliver my baby. That is to mean that it should not be taken as the responsibility of one person. For example, when she had contact with my blood, somebody must be there to give her gloves and other."

"I think there should be such type of cooperation. It should be corrected. My opinion is it should not be the responsibility of one person. After delivery of a woman, the place where the woman delivered should be cleaned soon. These things need improvement."

- **Negligent health workers**

The presence of inactive and negligent health workers caused disappointment for women with the utilisation of skilled birth attendance services. The FGD participants claimed that notwithstanding, they visited health facilities seeking for skilled birth attendance services, the health workers were inactive and negligent. The FGD participants mention the following statements:

"...the health care providers were inactive and negligent."

"Like what my sister said, even if we went to the health centre, there was negligence there."

Refusal of health workers to offer services out of working hours

The findings of the current study showed that women experienced refusal by health workers to offer them services out of the regular working hour. This had an impact on the interests of women to utilise skilled birth attendance services. The FGD participants indicate the following statements:

"...I spent the night labouring and in the next day morning my father took me to the HC. It was Sunday and my father told the health worker that my daughter is

having labour and asked the health worker to get in to the HC and give me services. The health workers said that today is my off duty date and I do not get in to the HC. My father reacted with anger why you are so cruel on labouring mother and he quarrelled with him. Then, when my father was trying to take me to the other HC, that HW got in to the HC and I immediately gave birth there when the HW came in. Since then, I was not interested to go to the HC because I believed that they can do nothing if I go there."

"Here, in the drug dispensing room, one pharmacy professional is supposed to stay in his/her unit and provide services up to 12:00, but here in this area they came when they are called like somebody is serving tea and coffee. I went to the pharmacy to bring my drugs and gave them my prescription; they told me to go home and return after a while but I returned to the pharmacy and my prescription paper was lost. The pharmacy professionals were not available in their place."

4.4.1.2.2 Category 2: Delay in care and service provision

Delays in care and service provision in health facilities also caused disappointments for women with the utilisation of skilled birth attendance services. Delays in care and service provision in health facilities are among the factors that contribute to maternal and neonatal morbidity and mortality.

Delays in the referral of women

The FGD participants claimed that they had experienced delays in receiving referral services from the first level health facilities to referral level facilities. Delays in the referral of women could let them develop obstetric complications and ramify the maternal and newborn health outcomes. The following excerpts from FGD participants corroborated this:

"When I reached Fenote selam Hospital and they examined me; they said that why the health centre delayed you so far."

"One thing, when a woman faced problems/complications, they do not notify for anybody. It is only for the sake of reporting and to say that we have served this much women. But, they do not send women to higher health facilities as soon as

a woman encountered problems/ complications so that it is better a woman to die at home rather than going to a health facility."

Delays in the provision of services

It was indicated that participants experienced delays in receiving maternal health care services from health facilities due to long waiting time in the medical record department and the unavailability of health workers to provide the services. This has also caused disappointment for women with the utilisation of skilled birth attendance services. Participant women mentioned the following statements:

> "Probably, there may be a delay in situations where there are many clients waiting in the card room."

> "No one was coming to the health centre even when their children got sick they took them to the private clinic but no one was coming to the health centre. They did not receive timely care and service and went back to their home. Nobody was providing service even if a patient was on the verge of death."

4.4.1.2.3 Category 3: Individual related experiences of SBA service use

The participant women purported that personal experiences of not utilising ambulance services, dissatisfaction with the services provided, abandonment of women in the maternity rooms, and the loss of the newborns created disappointment for them with the utilisation of skilled birth attendance services.

Failure to make available ambulance services

Failure to provide an ambulance, following a call from the community and the unavailability of ambulance services affected the utilisation of ambulance services by women. This has caused disappointment for women with the utilisation of skilled birth attendance services and has affected the utilisation of skilled birth attendance services. The FGD participants also described this:

> "The community gathered and waited for the ambulance to come but the ambulance did not show up, the time went on and spent the night at home..."

> “There was shortage of transport vehicle and there was no ambulance as well. Then, I went to Burie HC with a public transport vehicle.”

Dissatisfaction with the service provision

Dissatisfaction with the services received was also another cause of disappointment for women with the utilisation of skilled birth attendance services. The FGD participants mention the following statements:

> “We give birth there with stress and unease and come back to our home because we have already gone to health facility once.”

> “I lost my child when I gave birth in HC last year during this time because of the problem of the HC. Just they have problem when they assist the delivery in the couch. They do not properly attend our delivery.”

> “When I saw this HC...I considered it like a tea house but, I did not want to say this is a health facility. I did not want to see it again.”

> “During that time, when I gave birth in Kuche HC that is before two years...I encountered a very disappointing condition.”

Abandonment of women alone in labour and delivery room

Women were abandoned in the labour and delivery rooms. In addition to this, they revealed that the lives of the mothers and newborns were endangered and de-emphasised the importance of the utilisation of skilled birth attendance services. The following excerpts are extricated from the FGD discussion:

> “They slept me on the bed and they did not think about and look after me in the delivery room that I can give birth at any time. Because I had been doing my household chores at home, I was exhausted and unable to push down (labour) so that they injected me a drug to augment the labour. After they gave me the injection, they went out of the room and they left me alone. After they went out of the room, I gave birth immediately and I waited grabbing the baby with my own cloth and he could have fallen down on the floor.”

> "They do not care about for anybody. They go out from the delivery room and leave us alone; they are not concerned about whether the baby is on the verge of delivery or whatever."

> "I gave birth there only once. There problem is they go out from the delivery room and leave us alone. No other problem. The only thing we need is the ANC check-up; otherwise, we give birth at home. Since they went out of the delivery room and left us alone, they did not closely follow and care us. Except for ANC check-up, the delivery is better at home."

Loss of newborn due to perceived health workers' error

Women perceived that they lost their newborns due to inadvertent errors from health workers and this has caused disappointments for women with the utilisation of skilled birth attendance services.

> "I gave birth in health facility. When I delivered the child, the baby was fine during the first examination; the doctor himself killed the baby inside my womb."

> "...the health worker overstretched the umbilical cord and killed the baby. I had taken the newborn to health facility. ...They told me that the problem was related to the umbilical cord and the umbilical cord was overstretched. The newborn died at home after I returned from HC."

> "...I lost my child when I gave birth in health centre last year during this time because of the problem of the HC. Just they have problem when they assist the delivery in the couch. They do not properly attend our delivery.

4.4.1.2.4 Category 4: Reverberation of poor service provision on future service provision and use

The provision of poor services from health facilities had an impact on maternal and newborn health, cost of care, intention of seeking health care from those facilities and future use of skilled birth attendance services. This category is further sub-categorised into six; viz. effects of the delay in the referral of women on their health and their newborn babies; poor interpersonal care on future SBA service utilisation; the effects of

lack of cooperation among staffs on care and service provision; poor service provision to seeking care from other health facilities; poor service provision on cost of care and future use of skilled birth attendance services.

Effects of delay in referral on health of woman and newborn

Delays in referral of women cost the life of newborns and resulted in long-term obstetric complications. This has created a big disappointment for women with the utilisation of skilled birth attendance services. The following verbatim notes evidenced this:

> “For instance, I accompanied a primi gravid labouring mother to the health centre...Then, she stayed the whole day without any progress up to 6:00. I talked to the health officer about the possibility of referring women to higher facilities if she is not making any progress...But, this woman should have been referred but he did not do that. Unfortunately, the newborn died in the health centre and even the life of the woman saved at Bahir Dar city because she had developed fistula. There is such kind of problem.”

> “Sometimes, there is a delay when women should be referred urgently. There was a woman who gave birth in the health centre last year and she had laboured for three days, finally, the newborn died because of asphyxia... the newborn could have been saved if the woman was referred to the hospital...The newborn was died after delivery and there was a delay while the woman should have been referred urgently to the hospital. She should not stay for three days because there is a better quality of care in the hospital than health centre...”

Effects of poor interpersonal care on future skilled birth attendance service use

Poor interpersonal care from health workers influenced the decision of women not to utilise skilled birth attendance services in their future pregnancy. Due to the poor interpersonal care, the participant women decided henceforth to give birth at home rather than utilising skilled birth attendance services. The FGD participants mention the following statements:

> “After he gave me the injection, he told me to push down (labour) and went out of the room. As soon as he left the room, I delivered the baby. There was no

anything to support the baby from the bottom so that I caught him with my cloth because the baby was going down...I waited catching the baby and dragging with my cloth until they wore their gloves. Because of this, it is better to give birth at home."

"If we go to health facility, they do not closely follow us; they do not closely follow us being with us...They do not care that the mother and the baby can be injured and they simply move here and there. I think I prefer to give birth at home; I prefer to give birth at home rather than giving birth in the HC."

Lack of cooperation among staffs on care and service provision

The lack of cooperation among staffs had negatively affected the process of care and service provision. One of the participant women indicated that the skilled birth attendant was exhausted and the place where she gave birth was not cleaned immediately after immediately attending her delivery because of lack of collaboration from other technical and administrative staffs. The FGD participants mentioned the following statements:

"...support, somebody else to support the health worker, meaning; there is lack of sleep, being exhausted; she spent the night with me standing; at that time there may be negligence. As far as I am concerned, it must not be taken as a responsibility of one person. After I gave birth, the nurse was very exhausted."

"After I gave birth at 4:00, immediately another woman came for delivery. The area where I gave birth that was contaminated with my blood was not cleaned up immediately. The nurse went to the janitor room and argued with them why they did not clean the area immediately and she was very upset."

- **Effect of poor service provision to seeking care from other health facilities**

The provision poor service from health facilities compelled women to seek care and treatment from other private and public health facilities. The FGD participants describe the following verbatim notes:

"...I started visiting a private clinic daily to check up my blood pressure...I had been buying and taking drugs from Saint George hospital."

> "... Then, I went to Burie HC with a public transport vehicle and somebody accompanied me to look after my newborn..."

Effect of poor service provision on cost of care

Poor service provision exposed women to unnecessary financial expenses as they bought drugs and sought quality care from private health facilities. The following statements reaffirmed this:

> "...I started visiting a private clinic daily to check up my blood pressure and I had been paying 2 birr daily for measuring my blood pressure. I had been buying and taking drugs from Saint George hospital."

Effect of poor service provision on future use of skilled birth attendance service

The experience of receiving poor service from health facilities deterred women from utilising skilled birth attendance services in their future pregnancies. The participant women said that they did not receive any support from health facilities for problems they encountered during labour and delivery; some experienced a loss of a newborn and some were abandoned in the maternity room. In addition to this, they would prefer to give birth at home rather than at health facilities if they get pregnant in future. The FGD participants mention the following statements:

> "First of all, when one woman is labouring and suffering, for instance, when the wife of Priest 'X' was in problem/hurt, they just kept her with them without doing anything. So that, it is better to give birth at home rather than going to health facilities. One thing, when a woman faced problems/complications, they do not notify for anybody. It is only for the sake of reporting and to say that we have served this much women. But, they do not send women to higher health facilities as soon as a woman encountered problems/ complications so that it is better a woman to die at home rather than going to a health facility."

> "Later, the main doctor came and examined me with ultrasound. When he saw it, he told me that the foetus is already dead. They killed the foetus inside my womb in Fenot selam Hospital and the foetus died inside my womb. The foetus was fine

and I think they killed it...There is a problem whenever we give birth in health facility. We safely deliver our child at home. We should not give birth in health facility."

"I gave birth there only once. There problem is they go out from the delivery room and leave us alone. No other problem. The only thing we need is the ANC check-up; otherwise, we give birth at home. Since they went out of the delivery room and left us alone, they did not closely follow and care us. Except for ANC check-up, the delivery is better at home."

4.4.1.2.5 Category 5: Experience of poor service provision in health facilities

Poor service provision, lack of food provision, lack of close follow-up, lack of compassionate care, misdiagnosis and mismanagement of obstetric complications emerged as causes of disappointment for women with skilled birth attendance services.

Poor service provision

Women perceived that they had received poor skilled birth attendance services and this in turn caused disappointment for them with the service received. The following statements supported this:

"When I gave birth in the HF in my previous delivery; there was no any proper service in the HFs."

"...they informed me that my placenta completely expelled and they discharged me to go to home. When I was on the way to my home, I sat to pass out my urine and at that specific moment, some portion of the placenta expelled from my birth canal and I realised that my placenta was not completely expelled by the health professionals. I did not go back to them and my companions covered the expelled placenta with soil. This was because they discharged me in hurry without making sure its complete expulsion."

"No one was coming to the HC even when their children got sick they took them to the private clinic but no one was coming to the HC. They did not receive timely care and service and went back to their home. Nobody was providing service even if a patient was on the verge of death."

Lack of food provision in health facilities

The participant women complained that they were not served with semi-solid and/or solid foodstuffs while they were utilising skilled birth attendance services. Furthermore, they suggested that health facilities should provide food for mothers who gave birth in health facilities. The following statements corroborated this:

> "I gave birth at 11:00 at night in the health centre; I spent the whole night without having any semi-liquid and solid food in my mouth. My families are illiterate; they did not bring money to buy foods for me and I spent the night suffering from hunger and I am really hurt."

> "I do have opinion to say it would be good if health facilities cater food for mothers who delivered in health facilities."

Lack of close follow-up during labour and delivery

Women claimed that they did not receive close follow-up during labour and delivery. Lack of close follow-up during labour and delivery put the health of the women and their newborn at stake. The FGD participants mention the following statements:

> "If we go to HF, they do not closely follow us; they do not closely follow us being with us. They did not follow me; I waited catching the baby with my hand so as not to let the baby fall down."

> "I gave birth there only once. There problem is they go out from the delivery room and leave us alone. No other problem. The only thing we need is the ANC check-up; otherwise we give birth at home. Since they went out of the delivery room and left us alone, they did not closely follow and care us. Except for ANC check-up, the delivery is better at home."

Lack of compassionate care

Women experienced non-compassionate care from health workers and this created disappointment for them with the utilisation of skilled birth attendance services. The

excerpt below reaffirmed health workers did not show any sympathy for labouring women.

> "They simply move here and there and they did not give any attention or bother for the community. What we are saying that they do not care for us. They did not care for us and they did not think for us. They just simply move here and there. Once we left that HF, nobody never go back to the HF. They do not worry and concern for us; they move here and there but they do not worry or bother when labouring woman visits the HF."

Misdiagnosis and mismanagement of obstetric complication

Misdiagnosis and mismanagement of obstetric complications put the lives of the participant women in danger and forced them to seek care from other private health facilities and this in turn exposed them to financial expenses. The following verbatim quote from the FGD participant evidenced this:

> "...I told them I am feeling heavy headed; my neck get strained and experiencing headache. The health workers said that this is caused by the labour you had and they provided me a chloroquine even they did not give me drug for my headache and went to my home. However, it got worse and in the afternoon I visited a private clinic and I diagnosed with hypertension; it was found to be hypertension and they told me it was a sever hypertension."

4.4.1.3 Theme 3: Reasons for not utilising SBA services

The reasons for not utilising skilled birth attendance services were explored in the current study. This theme discussed the reasons for not utilising skilled birth attendance services and further categorised them into eight categories; namely, 1) Health facility related reasons; 2) Health worker related reasons; 3) Socio-cultural factors; 4) Fear, 5) HIV/AIDS-related issues; 6) Individual factors; 7) Low early care seeking behaviour; 8) Distance and transportation service related problems.

4.4.1.3.1 Category 1: Health facility related reasons

The experience of receiving poor services from health facilities, bad reputation of health facilities, abandonment of women in labour and delivery rooms, and the inhibition of

women from doing things they wanted in health facilities were the health facility related reasons mentioned by women for not utilising skilled birth attendance services.

Inhibition of movement in health facilities

Inhibition of women to make movements during labour deterred them from utilising skilled birth attendance services. The FGD participants mentioned the following statements:

> “We are disallowed to move as we want...”

> “They are thinking that if they go to the HC, they may not be allowed to rotate their body as they want...so that they prefer to give birth at home.”

> “The women complained that they inhibited her to make a movement here and there until the labour progress to the final stage.”

Experience of receiving poor service from health facilities

The experience of receiving poor skilled birth attendance services from health facilities in previous deliveries was also one of the reasons for not utilising skilled birth attendance services. Those women who experienced the reception of poor services from health facilities in previous deliveries assumed that the same thing could happen to them in the subsequent pregnancies, too. Thus, they were not interested in utilising skilled birth attendance services.

> “In my previous first pregnancy, my labour started at dusk time...I spent the night labouring and in the next day morning my father took me to the HC. The day was Sunday and my father told the HW my daughter is having labour and asked the health worker to get in to the HC and give me services. The health workers said that today is my off duty day and I do not get in to the HC. My father reacted with anger why you are so cruel on labouring mother and he quarrelled with him...Since then, I was not interested to go to the HC because I believed that they can do nothing if I go there.”

> “The HC do not serve us properly; they do not serve us properly.”

> “What prevented them to use skilled birth attendance previously; even if we came to the HC for skilled delivery, nobody was here to treat and care us.”

Abandonment of women alone in labour and delivery room

The current study found that disallowing companions to enter the labour and delivery rooms, and abandoning women deterred them from utilising skilled birth attendance services. The following statements supported this:

> “Since companions are not allowed to enter in the labour and delivery room, they get distressed.”

> “They said that nobody is allowed to enter in the labour and delivery room. I heard that they make us to undress and expose our bare body. Nobody is there to catch or support us. In addition to that, we do have also feeling of shame.”

> “They do not allow companions to enter in the delivery room. Thus, it is better to give birth at home rather than going to the HC.”

> “One individual should be allowed to enter in the delivery room and the labouring woman should not get suffer alone. Otherwise, the HWs should have stayed in the delivery room and attended our delivery but the HWs went out of the room.”

Bad reputation of health facilities

The bad reputation about health facilities’ service provision that prevailed in the communities prevented women from utilising skilled birth attendance services. The participant women thought that the skilled birth attendance service provision in the health facilities was the same as what it used to be previously. The FGD participants mentioned the following verbatim quotas:

> “...I thought that giving birth in the HC is a very bad thing.”

> “...giving birth in the HC was bad.”

> "A few of the women this day also think the HC the same as it used to be and they do not go to the HC because they did not receive education...the women think the HC is the same as it was."

Unable to express emotions during labour in health facilities

Women claimed that they were not allowed to move in a way they wanted and received reprimands from health workers for shouting during labour. Inhibition of women to express their emotions during labour was also among the health facility related reasons for not utilising the skilled birth attendance services. The following excerpts from the participant women reaffirmed this:

> "... they say that do not shout to me during labour."

> "They have thinking that if they go to the HC, they may not be allowed to rotate their body as they want; they cannot shout as they want and give birth so that they prefer to give birth at home."

4.4.1.3.2 Category 2: Reasons related to health worker

Perceived misinformation on EDD (expected date of delivery) from health workers and negative reputation of health workers also emerged as reasons for non-utilising skilled birth attendance service.

Negative reputation of health workers

The prevailing negative reputation of health workers in the community was also detrimental for the utilisation of skilled birth attendance services. Women reported that they were not interested in utilising skilled birth attendance services because the health workers in the health facilities did not have any concern for them and the negative attitude towards health workers by the community. The FGD participants mentioned the following statements:

> "...HC staffs, they just move here and there and they did not support us. Thus, we only visit HFs for ANC check-up, but we give birth at home because they did not benefit us in any way."

> "The reasons for not to give birth in HFs...Second, the HWs did not have any concern for anybody "sew keguday aytefum" previously when we went to HFs."

> "...all patients who had visited the HC said that they just kept on playing a volley ball and they had no any job to do; they spent the day stretching their legs and they did not have any concern towards patients."

Perceived misinformation on EDD from health workers

Women perceived misinformation on their EDD from health workers and their failure to explain the meaning of EDD to them made them not to utilise skilled birth attendance services. The following verbatim note corroborated this:

> "Only thing I gave birth at home but I think they mistaken me. M: What? I came here at 9 months. I have been regularly visiting the HC on monthly basis. They informed me today is my 9 months of gestation but they told me that I may give birth within 9 months & 10 days and 10 months so that to come to the HC. However, I gave birth just at 9 months during night time. Meaning I did not have any pain and they also said to me my delivery date will stay."

4.4.1.3.3 Category 3: Socio-cultural factors

A myriad of socio-cultural factors stemmed from the current study as reasons for not utilising skilled birth attendance services. These factors were further sub-categorised into four; namely, old traditions, presence of families and relatives in home delivery, influence of older families and relatives, and household cultural beliefs and practices as causes of delay.

Old traditions

The influence and practice of old traditions was also one of the socio-cultural factors for not utilising skilled birth attendance services. Women tended to adhere to practicing the old traditions, previous trends and thinking, and a result they gave birth at home. The following statements evidenced this:

*"*They just keep on practicing the old traditions. Previously, there was no health facility. The women gave birth at home. Just they give birth at home, then coffee gets cooked and porridge gets prepared...They do not get the porridge here. Porridge is not available here; why should they come here? It is a tradition. This is:

> "It is because of their previous practices. They just keep on the old tradition..."

> "...It may be the old traditions. It is because of the old traditions and trends they refused to go to the HC."

> "It is a tradition. There are old traditions which are not avoided so far. The traditions are baking injera and roasting of coffee beans several times until we give birth."

Presence of families and relatives in home delivery

The presence of families and relatives during labour and delivery and the emotional support they got from them was also the reason for not utilising skilled birth attendance services. The following verbatim quote corroborated this:

> "It is customary like the old days to give birth at home. When we started to have labour; we call for and gather families and relatives and we give birth at home. So that we do not go to HFs."

Influence of old families and relatives

The elder families and relatives influenced women not to utilise skilled birth attendance services and they encouraged them to give birth at home. Besides, they caused delays for women to seek skilled birth attendance services. The women were nevertheless

interested in utilising skilled birth attendance services. The FGD participants mentioned the following verbatim notes:

> "The elders (mother, father, mother in law...) said that you should give birth at home and only saint marry help you. They do not say you should go to the HF. They say that we saw nothing when we give birth at home."

> "Particularly, mother and father in laws', husbands and the community make the women to wait for a while and try to give birth by themselves at home and cause delaying for the women to visit HFs even if the labouring women are interested to go to the HC."

Household cultural beliefs and ceremonies as a cause of delay

The cultural beliefs and ceremonies that were practiced in the households of labouring women caused a delay for women to seek skilled birth attendance services and exposed them to give birth at home. Women claimed that there were cultural ceremonies such as repeated cooking of coffee and baking of "injera" being practised iteratively in the home of labouring women until the women gave birth. The FGD participants mentioned the following statements:

> "...There are old traditions which are not avoided so far. The traditions are baking injera and roasting of coffee beans several times until we give birth."

> "...at home, there is coffee ceremony for those women who have experience of coffee during labour; there are women who have the experience of having "Abesh" during labour; there are women who have the experience of having linseed during labour. We are doing all these things at home and they say that you give birth here at home. We are doing all these and they say that why you go to the HF and get distressed in a narrow room and they inhibit them from visiting the HFs. The women do not like it much when we say them to go to the HF for skilled birth attendance."

4.4.1.3.4 Category 4: Fear

Fear of childbirth in health facilities, fear of medical procedures and fear of death in health facilities were also deterrent factors for the utilisation of skilled birth attendance services.

Fear of childbirth in health facilities

Fear of giving birth in a health facility was also the reason for not utilising skilled birth attendance services. The participant women stated that the insertion of hands into the birth canal, exposing their bare bodies and surgical operations were some of the sources of fear for women not to utilise skilled birth attendance services. The following statements evidenced this:

> "It is said that they insert their hands in the birth canal so that women fear to go to the HF."

> "...nobody is allowed to enter in the labour and delivery room. I heard that they make us to undress and expose our bare body. Nobody is there to catch or support us. In addition to that, we do have also feeling of shame."

> "Women give birth at home. Previously I delivered my baby at home because it is fear, we fear."

> "We are very suspicious and fearful because we thought that they might operate us."

- **Fear of medical procedures**

Fear of medical procedures in health facilities deterred women from utilising skilled birth attendance services. The participants said that they feared the physical vaginal examinations and surgical operation procedures in the health facilities. In conjunction with this, women were not utilising skilled birth attendance services.

> "When we go to the health facility, we think that they may suddenly operate us and they may insert many things in our vagina and uterus."

> "...the health worker told me that they are going to examine me to check for whether my cervix is opened or not, however, I rebuffed their request; preferred to die at my home and went back to my home."

> "...it is nothing it is just a fear. I personally feared and came back to home on Tuesday when the HCP worn gloves and asked me to examine for openness of my cervix. I thought that he was going to insert his arm up to the elbow."

4.4.1.3.5 Category 5: HIV/AIDS related issues

Communities' perception of the HIV status of women often visiting health facilities and fear of disclosure of HIV status by health workers were also identified as reasons for non-utilisation of skilled birth attendance services.

- **Fear of disclosure of HIV status by health workers**

Women indicated that fear of disclosure of HIV status by health workers deterred them from utilising skilled birth attendance services. One of the FGD participants mentioned the following statement:

> "...they do not know their status early, they just perceive it remains covert...Because of this, I know many people non-utilising skilled birth attendance...I, myself perceive that if I am tested; the health worker who tested me will go and disclose my results."

- **Women often visiting health facilities perceived HIV positive by the community**

The FGD participants reported that the community perceived women often visiting health facilities to be HIV positive and this was also identified to be a reason for not utilising skilled birth attendance services. The FGD participant mentioned the following verbatim quote:

> "For instance, when I was regularly visiting to the HC for monthly ANC follow-up and I had been attending meetings in the HC, too. What the community was

> talking about me was; as if I am infected with HIV because I was regularly attending meetings in the hospital; they are regularly watching me in the HC...I heard this from the people who are residing with me in the same compound and they told me not to go the HC."

4.4.1.3.6 Category 6: Individual factors

The current study found a myriad of individual factors as reasons for not utilising skilled birth attendance services. This category was further divided into seven sub-categories, namely: (a) Precipitated labour as perceived by women; (b) Rumour and misconception about health facility delivery;(c) Timing of initiation of labour; (d) Lack of ANC follow-up during pregnancy; (e) Refusal of women to expose bare bodies; (f) Experience of prior place of delivery; and (g) Low awareness or knowledge on the importance of skilled birth attendance services.

- **Precipitated labour as perceived by women**

The majority of FGD participants claimed that precipitated labour was the main reason for not utilising skilled birth attendance services. The participant women said that labour is said to be precipitated if it stays only for one and a half to two hours since initiation of labour up to childbirth. The FGD participants mentioned the following statements:

> "I delivered at home while I was trying to go to the health centre. I would have given birth in the HC but "Saint Marry" came to me quickly. The labour was fast; precipitated and gave birth immediately. I would have been delivered in the HC but the labour was so fast and given birth immediately and quickly, even we did not have time to call for ambulance."

> "It is just a fast and precipitous labour. "Saint Marry" came to me quickly; even she did not stay until the roasted coffee bean prepared and drunk up to 'Bereka'."

> "We say that the labour is fast if it stays only for 1:30-2:00 hours since initiation of birth up to delivery."

- **Rumours and misconceptions about health facility delivery**

Negative rumours and misconceptions about health facility delivery deterred women from utilising skilled birth attendance services. Some of the rumours and misconceptions with regard to health facility delivery were that the women indicated that giving birth in health facilities caused injury to the birth canal and uterus. Besides, the participant women had misconceptions about the physical examination done during labour and delivery. The participant women discussed the following excerpts:

> "In our village, yesterday, one woman was labouring and I told her families to take her to the HC and give birth in the HC. But, her families hated me; they negatively reacted and said to me that your uterus/vagina already damaged/injured by giving birth in the HC and you wanted the same thing to happen to her because they think that the health workers touch the labouring mother's uterus/vagina."

> "A few individuals said to me that they do something bad to you; you may be troubled to walk and control your urine; it cannot be stopped."

> "Insert their hands in to uterus; then again insert their hands and examine if it stays for a while; they cause trouble to us."

- **Timing of initiation of labour**

The participant women indicated that the reason they were not giving birth in health facilities was that their labour started at night and it was inconvenient to arrange transportation services. The following quote from the FGD participants affirmed this:

> "I was giving birth at home because my labour started at night; my labour started at night. I do not have other problem...It was night time when I was trying to come to the HC."

- **Lack of ANC follow-up during pregnancy**

The current research revealed that lack of ANC follow-up during pregnancy was also identified as a reason for not utilising skilled birth attendance services. Those women

who had no ANC follow-up during pregnancy did not know their gestational age and their expected date of delivery. Furthermore, they did not receive health education with regard to the importance of skilled birth attendance services. The following statements corroborated this:

> "The problem women do not give birth in the HC is; they do not have ANC follow-up. Thus, they do not know their gestational age and EDD; they give birth at home when their labour starts. If they had ANC follow-up, they would have given birth in the HC. Other it is just like that."

> "Probably, they do not go to the HC for delivery because they do not have follow-up for vaccination and they do not attend health education sessions."

- **Refusal of women to expose their bare bodies**

Women refused to get undressed and expose their bare bodies for health care providers during labour and delivery. Because of this, they refrained from utilising skilled birth attendance services. The FGD participants described this:

> "The thing that prevented them from coming to the HC; for instance, last time I came to the HC accompanying a labouring woman, the woman refused to show her bare body. Fortunately, the health worker was here, he called me to enter in to the labour and delivery room and he told me that she is refusing to show her body; he requested me to give her some advices. Then, he got out from the room and I discussed with her why she is behaving like that."

> "They said that nobody is allowed to enter in the labour and delivery room. I heard that they make us to undress and expose our bare body. Nobody is there to catch or support us. In addition to that, we do have also feeling of shame."

- **Experience of prior place of delivery**

The findings of the current study showed that previous places of childbirth influenced the utilisation of skilled birth attendance services in the subsequent pregnancies. Women who had no prior experience of giving birth in health facilities and those who

had been given birth at home did not use skilled birth attendance services. The following statements described the participant women's responses:

> "I think they do not have the experience of giving birth in the HC and also their previous experience of giving birth at home."

> "It is because of their previous practice. It has no any problem. Since they did not experience (adapt) giving birth in the HF before they get distressed."

- **Lack of knowledge on the importance of skilled birth attendance services**

Lack of knowledge or awareness on the importance of skilled birth attendance services was also identified as a reason for not utilising skilled birth attendance services. The following statements supported this:

> "This is the problem of lack of knowledge. But, it is good to give birth in the HC. They give birth at home because they are not educated and they do not have the knowledge otherwise it is good to give birth in HF."

> "Because there was lack of knowledge and the community was not educated. I told you before I have given birth at home previously because nobody knew about it; nobody knew about it."

4.4.1.3.7 Category 7: Low early care seeking behaviour

Low early care seeking behaviour of the community was identified as a reason for not utilising skilled birth attendance services in the current study. This was manifested by the failure of women to seek skilled birth attendance services unless they encountered health problems and/or complications and delays to take labouring women to health facilities.

- **Inexperience of danger signs and complications during labour and delivery**

Women believed that they had to seek skilled birth attendance services only when they encountered health problems and/or complications otherwise they should give birth at home. The participant women reported that they would have sought skilled birth

attendance services if they faced health problems and/or complications during labour and delivery. The following excerpts from the FGD participants corroborated this:

> "We could have sought for skilled birth attendance from health facilities if the labour persisted and we did not give birth after a repetitive coffee cook and drinking."

> "I would have gone to HF if my labour stayed for long."

> "They used to go to the HF when they had complications and stresses otherwise they say that you should give birth at home."

- **Delays to take labouring women to health facilities**

The findings of the current study also revealed that delays to take labouring women to health facilities was one of the reasons for not utilising skilled birth attendance services. The FGD participant mentioned the following statement:

> "The reason we do not give birth in HF is they do not take us to HF immediately, but they take us to HFs when we ill seriously/ get complicated. We do not go to HF as soon as the labour started."

4.4.1.3.8 Category 8: Distance and transportation service related problems

Problems related to distance to health facilities and transportation services were the reasons for not utilising skilled birth attendance services. Long distances to health facilities, unavailability of ambulance services and late arrival of ambulances were the barriers for the utilisation of skilled birth attendance service.

- **Distance and transportation service related problems**

The participant women explained that long distances to health facilities, unavailability of ambulance services and late arrival of ambulances were also identified as barriers for the utilisation of skilled birth attendance services. The FGD participants mentioned the following statements:

"I gave birth at home. I was experiencing the labour pain and we called for HEW and she came to our home. The HEW called for the ambulance and at that time the ambulance was in another kebele to provide service. When the ambulance was coming to take me, in the mean time I gave birth at home. The HEW attended my delivery."

"In our village, everybody is coming to the HC and giving birth here except women from the distant villages."

"I gave birth at home. The ambulance was non-functional at that time, as a result another vehicle from the woreda administrator assigned instead to transport me to the HC but the vehicle did not come as soon as we called for them unlike the ambulance. Thus, I gave birth at home because of the delay of the assigned vehicle."

4.4.1.4 Theme 4: Factors that influenced the utilisation of SBA services

This theme dealt with the factors that influenced women to utilise skilled birth attendance services in previous deliveries. The availability of services, fear of occurrence and experience of obstetric danger signs and complications, and services received by women emerged as categories under this theme.

4.4.1.4.1 Category 1: Availability of services

The availability of basic and essential services such as ambulance services, PMTCT services, referral services and life-saving interventions influenced women to utilise skilled birth attendance services in their previous deliveries. Below is a detailed discussion of each sub-category.

- **Availability of ambulance services**

The availability of ambulance services to transport labouring women from their homes to health facilities influenced them to utilise skilled birth attendance services in their preceding deliveries. The participant women mentioned the following statements:

> "The first thing is the presence of ambulance; the second thing is the education we are receiving from HEWs influenced us to use skilled birth attendance."

> "The availability of the ambulance service is an educational tool for us and an educational material for us...On top of the HEWs health education, the presence of the ambulance was very attractive for the community to give birth in HFs."

- **Availability of PMTCT service**

The participant women claimed that the availability of prevention of mother to child HIV transmission services in health facilities influenced women to utilise skilled birth attendance services in their previous deliveries. Because of the presence of PMTCT services, women sought skilled birth attendance services for childbirth whether they contracted HIV infection or not. The following quote corroborated this:

> "In case we have HIV infection in order to prevent its transmission to the child we give birth in the HF. Because of these, I had a follow-up visit in the HF from the beginning. I decided to go to the HF whether I had a disease or not. Then, I came to the HF when I gave birth."

- **Availability of referral service**

The availability of referral services in health facilities influenced women to utilise skilled birth attendance services in their previous deliveries. The participant women reported that they gave birth in health facilities owing to the fact that they could have received referral services if they faced health problems and/or complications. The following verbatim quotes evidenced this:

> "If I got sick and got worse, they would refer me to other HF. They said that if you get sick and get worse, we will refer you to higher HF."

> "They will assist us to deliver our child if they can; otherwise they will refer us to the higher health facilities."

- **Availability of life-saving interventions**

The participant women reported that the availability of essential life-saving interventions in health facilities influenced them to utilise skilled birth attendance services in their previous deliveries. The following statements corroborated this:

> "...If I had excessive bleeding, there is an injection. That is why I came to the HC."

> "If we face post-partum hemorrhage, there is an injection. So, we came here."

> "IV glucose will be administered whether I have hypertension or anaemia. Anti-hypertensive drugs will be administered intravenously if I have hypertension; that is why I utilised skilled birth attendance."

4.4.1.4.2 Category 2: Fear of occurrence and experience of danger signs and complications during delivery

The current study found that experiencing obstetric complications in previous deliveries, encountering obstetric complications during labour and delivery, and fear of the occurrence of obstetric complications and health problems emanated as factors that influenced women to utilise skilled birth attendance services.

- **Experiencing obstetric complications in previous deliveries**

The current study established that the experience of encountering obstetric problems and complications in previous childbirths influenced women to utilise skilled birth attendance services during childbirth in their following pregnancies. The following verbatim quotes affirmed this:

> "I went to HF because I had bleeding during my first childbirth, but my families advised me not to go to HFs. Thus, I insisted to them to take me to HC because I must go to HC."

> "I had faced many problems at home. When I gave birth [to] my three children, I had been spending the whole night and day, stretching and flexing the whole

night to give birth. I had never given birth quickly. Since I have seen these before, I had monthly ANC visits to the HC and they told me to come to the HC during delivery. I came to the HC for skilled delivery since I saw all these problems previously. That was which brought me to the HC. I came to the HC and they attended my delivery immediately and I did not encounter any problems unlike my previous deliveries."

- **Experiencing obstetric danger signs and/or complications during pregnancy and childbirth**

The participant women claimed that they sought skilled birth attendance services because they had experienced obstetric danger signs and complications during pregnancy and childbirth. To this end, many participant women reported that they went for skilled birth attendance services when their labour had prolonged at home. The FGD participants mentioned the following statements:

> "I had hypertension at that time. They told me that since I have hypertension I should not give birth at home; it can cause many problems; I should give birth here because it is good both for the newborn and you. They told me that I must come here as soon as you started to have a labour pain. As I told you before, I had hypertension and I feared that I can bleed."

> "I went to the HC because I had a prolonged labour. I could not give a birth despite my families' roasted coffee bean and prepared coffee, and baked "injera", and then they took me to the HC. I gave birth in the HC and came back to home."

- **Fear of health problems and obstetric complications**

The findings of the current study revealed that women utilised skilled birth attendance services because of fear of the occurrence of unanticipated health problems and obstetric complications resulting from home delivery and the sequel of many years of using injectable contraceptives. The FGD participants mentioned the following verbatim notes:

> "We had used Injectable contraceptives for many years and this may create constriction of the birth canal; then this may expose us for obstetric

complications. So, we fear the complications and visit HF for skilled birth attendance."

"If we give birth at home, we may get complicated due to hypertension; we may bleed. Previously, many women died of these complications."

4.4.1.4.3 Category 3: Services received

This category deals with the different types of services received by women that influenced them to utilise skilled birth attendance services. This category is sub-categorised into four, namely, information and advice, having ANC follow-up, ensuring the health of women and the newborn, and detection and management of unforeseen obstetric complications.

- **Information and advice**

The participant women claimed that the information and advice they were receiving from health care providers regarding the importance of utilising skilled birth attendance services, the various types of services rendered during health facility deliveries, and about the risks associated with home delivery, influenced them to utilise skilled birth attendance services. The following quotes evidenced this:

"During regular monthly ANC follow-up visit, HWs advised me to delivery my baby in the HC and they told me not to give birth at home. I said okay. I accepted their advice when they told me that the reason why I should not give birth at home."

"The issues that influenced us to utilise skilled birth attendance service are; firstly, the HEWs provided us health education with close follow-up."

- **Having ANC follow-up**

The women reported that having regular antenatal care follow-up during pregnancy influenced them to utilise skilled birth attendance services during childbirth. They said that they had received information and advice on maternal and newborn health, different preventive and treatment services during ANC care which in turn made them to seek

skilled birth attendance services. The FGD participant women mentioned the following statements:

> "Since we were pregnant they said to us that come and have examination; we came and got examined. When we had a monthly ANC check-up they told us to visit the HF when our EDD approached."

> "For instance, we had regular monthly follow-up visits in the HC and HP. The HWs were providing counselling service by gathering pregnant women about the risks of giving birth at home and advise us not to give birth at home; they provided us health education. After that, the HWs closely followed us even by visiting to our home. It is because of their education the community is utilising skilled delivery service..."

- **Ensuring the health of the woman and newborn**

Ensuring the health of the woman and the newborn was also identified as a factor that influenced women to utilise skilled birth attendance services. The following statements corroborated this:

> "The HWs immediately follow us and they encourage us in everything. Nothing bad happen[s] to us and we give birth safely; in addition, our newborns will be fine and receive close follow-up; we go back to our home safely so that giving birth in HC is very good."

> "The health of the newborn and mine will be kept and my problems and disease conditions will be detected and examined."

- **Detection and management of unforeseen obstetric complications**

The current study found that the women thought that services received with regard to detection and management of unforeseen obstetric complications influenced them to utilise skilled birth attendance services. The participant women discussed the following excerpts:

> "…To prevent us from getting any obstetric complications."

"Not to get hurt; to be protected from bleeding; everything get serious and complicated in home delivery."

"Now nobody dies of due to pregnancy and delivery because we are giving birth in HC. Thus, we do not face any complications like hypertension; bleeding and we give birth in HC and we go back to our home."

4.4.1.5 Theme 5: Factors that motivate women to utilise SBA services in the current and future pregnancies

This theme dealt with factors that would motivate women to utilise skilled birth attendance services in future pregnancies. Under this theme, six categories were identified as factors that would motivate women to utilise skilled birth attendance services in future pregnancies; viz., good interpersonal care, availability of services, previous encounter of health problems and complications in home delivery, previous use of SBA services, preventive and treatment services, and fear of obstetric danger signs and complications. Each of the categories and sub-categories will be discussed in detail below.

4.4.1.5.1 Category 1: Good interpersonal care

Good interpersonal care and receiving information and advice from health care providers were identified as factors that would motivate women to utilise skilled birth attendance services in future pregnancies.

- **Information and advice on maternal and newborn health**

The participant women reported that the information and advice on maternal and newborn health they were receiving from health care providers would motivate them to utilise skilled birth attendance services in future pregnancies. The FGD participants mentioned the following statements:

> "If I get pregnant in the future I will give birth in the HC. What encourages me to deliver in the HC; their advice; their advice during my monthly follow-up; their advice is enough for me..."

> "They will advise us about the newborn care. Previously, butter was given for the newborn to swallow and put on the cord. Thus, they will advise us not to practice such things. In order to know these things, we should give birth in HF."

- **Interpersonal care**

Good interpersonal care from health care providers motivated the women to utilise skilled birth attendance services in their future pregnancies. The participants indicated that a friendlily service and close follow-up from health workers encouraged them to utilise skilled birth attendance services. The following verbatim quotes corroborated this:

> "I would like to utilise skilled birth attendance service because we receive education. Firstly, even our father and mother do not care us like that and we give birth there. There is coffee ceremony and porridge preparation; besides, they also provide clothes. We feel like as if we did not have any labour pain."

4.4.1.5.2 Category 2: Availability of services

The current study found that the availability of ambulance services, referral services, and women friendlily services motivated women to utilise skilled birth attendance services in their future pregnancies.

- **Availability of ambulance service**

The availability of ambulance services for labouring women would motivate women to utilise skilled birth attendance services in their future pregnancies. FGD participants mentioned the following statements:

> "I am planning to give birth in the HF. I have received the phone number of the ambulance."

> "We can call for the ambulance service and the ambulance will come to us."

- **Availability of referral service**

The participant women said that the availability of referral services would encourage women to utilise skilled birth attendance services in their future pregnancies. They claimed that they could use referral services in circumstances in which they faced health problems and obstetric complications. The following statement evidenced this:

> "I will give birth in the HC...In case the placenta might come out ahead of the foetus I would like to take referral from this HC to other HF..."

- **Availability of women friendlily service**

The participant women said that the availability of cultural and ceremonial practices such as coffee and porridge preparation and the provision of clothes for the newborn in health facilities motivated them to utilise skilled birth attendance services in their current and future pregnancies. Furthermore, the provision of client friendlily services would also encourage women to utilise skilled birth attendance services in the current and future pregnancies. The FGD participants mentioned the following statements:

> "I want to give birth in HC because...there is coffee ceremony; and they are also providing cloths for newborns. I heard that they encourage women through coffee ceremony; they also provide cloth for newborns..."

> "I would like to utilise skilled birth attendance service because...Firstly, even our father and mother do not care us like that and we give birth there. There is coffee ceremony and porridge preparation; besides, they also provide clothes..."

4.4.1.5.3 Category 3: Prior experience of health problems and complications during home delivery

The current study established that experiencing health problems and obstetric complications in previous deliveries were identified as motivating factors for women to utilise skilled birth attendance services in the current and future pregnancies.

- **Experienced health problems and difficulties in previous home deliveries**

The findings of the current study revealed that experiencing health problems and childbirth related difficulties in previous home deliveries would motivate women to utilise skilled birth attendance services in their current and future pregnancies. The following verbatim quote corroborated this:

> "Now, I am thinking that I will go to the HC and give birth there as soon as my labour starts. Previously, I gave birth at home...I had suffered a lot and my labour persisted for more than 12 hours. In addition, non-experienced individuals attended my delivery as a result they over stretched the umbilical cord and her umbilicus is still bulged. Hereafter, I will inform the HEW as soon as my labour starts and the HEW will call to the ambulance and transport me to the HF."

4.4.1.5.4 Category 4: Use of skilled birth attendance service in previous childbirth

The use of skilled birth attendance services in previous deliveries emerged as a motivating factor to utilise skilled birth attendance services in the current and future pregnancies.

- **Use of skilled birth attendance service in previous delivery**

The utilisation of skilled birth attendance services in previous deliveries would motivate women to use the same services in their current and future pregnancies. The FGD participants mentioned the following verbatim quotes:

> "I would like to give birth in the HC. Because I gave birth safely in the HC in my previous delivery and now we think it would be the same us the previous delivery so that I would like to utilise skilled birth attendance."
> "Since I gave birth in HF previously, I am thinking to come and give birth here in the HC."

4.4.1.5.5 Category 5: Preventive and treatment services

Under this category, disease prevention and treatment services, proper care for the women and newborn, ensuring the health of the women and newborn, and detection

and management of obstetric complications emerged as motivating factors to utilise skilled birth attendance services in the current and future pregnancies.

- **Prevention and treatment of diseases**

The participant women claimed that they would utilise skilled birth attendance services in the current and future pregnancies in order to get prevention and treatment services for disease conditions. The participant women mentioned the following statements:

> "I will give birth in the HF. Why? They will prevent us from diseases..."

> "For instance, if there is a woman who is infected with HIV, when the woman gives birth, HIV can be transmitted from the mother to child during delivery. The drug is being provided in the HC and if the woman does not receive the drug in the HC, the newborn also might get infected."

- **Proper care for women and the newborn**

In order to get proper care for newborns and women from health facilities, the majority of FGD participants said that they were intending to utilise skilled birth attendance services in their current and future pregnancies. The following statements corroborated this:

> "The newborn will be put on heater to protect the baby from cold and the cord will be cut using a clean material."

> "I would like to give birth in the HC. I just want to receive a proper care. It is better here."

> "I will give birth in the HF. Because they would help us. They care for both the newborn and mine. I will give birth safely and go back to my home."

- **Ensuring health of woman and newborn**

The participant women claimed that they intended to utilise skilled birth attendance services in the current and future pregnancies to ensure the health of the mother and the newborn. The following statements evidenced this:

> "I would like to give birth in health facility because I do not get bleed and the newborn will be healthy. I am planning to give birth in health facility in the future."

> "I will give birth in HF. Because, I will not have excessive bleeding; not to have excessive bleeding. The health of my baby and mine will be okay. I will give birth in health facility because I do not want to die and health facility is very good."

- **Detection and management of obstetric health problems and/or complications**

The participant women reported that the availability of early detection and management of obstetric health problems and complications services in the health facilities could motivate them to utilise skilled birth attendance services in the current and future pregnancies. The FGD participants mention the following statements:

> "What motivate us to utilise skilled birth attendance service...in case the woman encounters bleeding she will be given injections..."

> "I will give birth in the HC. To avert many problems; to tackle problems from bleeding, anaemia, post-partum haemorrhage; the newborn and I will have a safe and clean delivery."

> "We are thinking to give birth in the HC because not to get excessive bleeding, to receive injections and not to have a prolonged labour..."

4.4.1.5.6 Category 6: Fear of obstetric danger signs and complications

The current study identified fear of obstetric danger signs and complications as a motivating factor to utilise skilled birth attendance services in the current and future pregnancies.

- **Fear of obstetric danger signs and complications**

Fear of the occurrence of obstetric danger signs and complications could motivate women to utilise skilled birth attendance services in the current and future pregnancies. The participant women said that they would like to give birth in health facilities in the current and future pregnancies since they had been using modern family planning methods for a long time; thus they perceived that their birth canal might get constricted and, as a result, they feared they could develop obstetric danger signs and/or complications. The following statements corroborated this:

> "Since I had been using Injectable contraceptives I expect that I might encounter narrowing of the birth canal and it is better here. The injection here; and the newborn will get proper care."

> "I would like to give birth here. Because I had been using Injectable contraceptives for long time I expect that my labour might get prolonged."

> I am thinking to give birth in HF. It has been long since I gave birth and I had been using FP methods so I am planning to go to HF and see there..."

4.4.1.6 Theme 6: Perceived benefits of SBA services

Women's perceived benefits of skilled birth attendance services emerged as one theme in the data analysis. The major issues that emerged from the data regarding perceived benefits of skilled birth attendance services were: advice and information, disease prevention and treatment, ensuring the health of the woman and the newborn, good newborn care practices, and prevention and management of obstetric and neonatal danger signs and complications.

4.4.1.6.1 Category 1: Information and advice on maternal and newborn health

The participants indicated that receiving information and advice on maternal and newborn health could be the benefits of skilled birth attendance service.

- **Information and advice on maternal and newborn health**

The findings of the current study indicated that women believed that skilled birth attendance services could enable them to have information and advice on maternal and newborn health. This, in turn, enhanced women's knowledge on the benefits of skilled birth attendance services and the risks associated with not utilising skilled birth attendances services during childbirth. The FGD participants mentioned the following:

> *"*They advised us a lot of things such as to take a better balanced diet to have a healthy fetus, help us during labour and ensure the health of the foetus."

> "They also provide good service and advice."

4.4.1.6.2 Category 2: Good newborn care practice

Good newborn care practises and averting harmful traditional practices to the newborn emerged as perceived benefits of skilled birth attendance services.

- **Good newborn care practice**

The findings of the current study noted that good newborn care practices were the perceived benefits of skilled birth attendance services. The participants claimed that newborns could receive proper thermal care, cord care, and vaccinations if women utilised skilled birth attendance service. The following FGD participants indicated these:

> "In the HC, they support and help us to bath the newborn in the next day at the same time of delivery. For instance, if the baby is delivered at 11:00 AM or 12:00 Am tonight, it will be bathed in the next day at the same time."

> "The cord of the newborn will be properly cared; to prevent the cord from bleeding when it is stretched."

> "My newborn also received a vaccine. My newborn could have missed the vaccine, if she was a home delivery."

Furthermore, the study also found that skilled birth attendance service could avert the harmful traditional practices practiced on newborn babies. The participant women reported that newborn babies could be protected from harmful traditional practices such as swallowing of butter and expression of colostrum using skilled birth attendance services. The following statements evidenced these:

> "The newborn will be protected from harmful traditional practices..."

> "Tonsillitis may occur to the newborn if it is home delivery. Thus, the newborn provided with butter mixed with ash to avert the tonsillitis. Now, giving birth in HFs is very useful to avert such problems."

4.4.1.6.3 Category 3: Ensuring the health of women and the newborn

The study reported that ensuring the health of the women and the newborn was identified as a benefit of skilled birth attendance services.

- **Ensure the health of women and the newborn**

The findings of the study revealed that ensuring the health of the women and the newborn indicated a benefit of skilled birth attendance services. The FGD participants indicated the following:

> "Both the mother and newborn will not be hurt. The other thing, the woman will give birth safely. Both the mother and newborn will be healthy."

> "It benefits us by preventing us from getting ill; the mother and the newborn will be healthy. In case we have excessive bleeding, we may die. But, both the mother and newborn will be healthy in HF delivery."

4.4.1.6.4 Category 4: Disease prevention and treatment services

Disease prevention and treatment services for the women and newborn emerged as a benefit of skilled birth attendance services from the analysis of the data.

- **Disease prevention and treatment service**

The findings indicated that one of the perceived benefits of skilled birth attendance services was disease prevention and treatment services for the mother and newborn. The study noted that women and newborns could be prevented and treated from diseases such as tetanus and HIV/AIDS. The FGD participants explained the following:

> "Giving birth in the HF is useful to prevent us from diseases. It prevents us from tetanus and other diseases."

> "It has benefits. For instance, if the woman is infected with HIV, they prevent the transmission of the virus from the mother to the child. They can make the newborn uninfected."

4.4.1.6.5 Category 5: Prevention and management of obstetric and neonatal danger signs and complications

This study found that prevention, early detection and management of obstetric and neonatal danger signs and complications are critical benefits of skilled birth attendance services.

Prevention and management of obstetric and neonatal danger signs and complications

The findings asserted that prevention, early detection, and management of obstetric and neonatal danger signs and complications were purported as women's perceived benefit of skilled birth attendance services. The majority of the participants indicated that skilled birth attendance services benefit women and newborn through prevention, early detection, and management of post-partum haemorrhage, prolonged labour, hypertension, and neonatal asphyxia. The FGD participants revealed the following:

> It prevents us from hypertension, haemorrhage, PPH and many other things."

> "The newborn could aspirate the amniotic fluid even within one hour of labouring; let alone the labour that stayed for five to six hours, like me. Giving birth in the HC is useful to prevent newborns from aspirating the amniotic fluid."

4.4.1.7 Theme 7: Community support for women to utilise SBA services

This theme explored the support that community members provide for women to utilise skilled birth attendance services. The community members have been providing various types of support for women to utilise skilled birth attendance services. This support includes facilitation, support related to household activities, transportation services, support, advice and encouragement.

4.4.1.7.1 Category 1: Facilitation

The community played a facilitative role for labouring women by calling for ambulance services and informing HEWs about them.

- **Call for ambulance services**

The study indicated that the community called for ambulance services when women started to have labour pains in their neighbour or locality. The FGD participants indicated the following:

> "The community is supporting us, for instance, if there is no one at home and I start to have a labour pain. Everybody in the community has the phone number of the ambulance driver. Thus, they will call to the ambulance driver and inform them a woman is experiencing labour."

> "The community call for ambulance service to take her to the HF in case if the husband is not available."

- **Informing HEWs about labouring women**

The study established that the community members have been notifying to HEWs about labouring women in their neighbourhood or locality. The community immediately informed HEWs, particularly, when women started to have labour pains in circumstances where no one was available in the household. The FGD participants discussed the following:

> "Everybody has the phone number of the HEWs and they will call for them..."

> "The community is providing support; first, the community inform for the HEW if it is nearby when the woman starts to have labour..."

> "If there is no one in the labouring woman home, the neighbours/ community members will immediately inform the HEWs..."

4.4.1.7.2 Category 2: Support related to household activities

The findings of the current study noted that the communities provided support to the women with regard to household chores by taking care of the other children, managing household assets and activities, and preparing food and other cultural ceremonies.

- **Looking after the other children at home**

The findings of the current study revealed that the communities took care of the other remaining children at home when the women went for skilled birth attendance services in health facilities. Furthermore, the community members and neighbours took care of the women at home after they gave birth. The participants revealed that:

> "...the community is providing support by protecting the household assets and the other children at home when the family went to the HC."

> "They will take care of the children..."

> "Women who live in the neighbourhood also care for the mother. The neighbours take care of the woman who gave birth came back to her home by serving food and other."

- **Managing household assets and activities**

The FGD participants indicated that the communities managed and protected the household assets such as cattle and other resources while the women visited the health facilities for skilled birth attendance services. The study also noted that the neighbours

took responsibility to manage the household activities. The FGD participants indicated the following statements:

> "They also take care of the properties of the household such as cattle, crop. They also care for the children."

> "They clean the house of the women while she was giving birth in the HF. They also cook coffee and the porridge."

> "They take care of the children remaining at home and the assets of the household including cattle."

- **Preparation of food and other cultural ceremonies**

The FGD participants revealed that the communities supported the women to utilise skilled birth attendance services preparing of food and other cultural ceremonies in their households. Furthermore, they provided food for the delivered women and the companions who accompanied them. The FGD participants mentioned the following statements:

> "...They also prepare coffee and the porridge."

> "The neighbours and other village residents bring and provide us milk and "Injera" both in the HFs and when we get back to home after delivery...In addition to the food, they support us by cooking coffee in our home."

> "The other support is the communities prepare food for those individuals who carried and transported the labouring women to HFs."

4.4.1.7.3 Category 3: Transportation service support

The communities provided transportation support for the women to utilise skilled birth attendance services.

- **Transportation of women to and from health facilities**

The findings of the current study indicated that the communities transported the women to health facilities and back to their homes, particularly in circumstances when there was no access to ambulance services. The FGD participants verbalised this:

> "They help us through carrying and transporting to the health facility."

> "We go to the HFs through ambulance; but we came back to our home after delivery through carrying."

> "The community transport labouring women to HFs through carrying."

4.4.1.7.4 Category 4: Advice and encouragement

The participants revealed that the community member provided advice and encouraged the women with regard to the importance and utilisation of skilled birth attendance services.

- **Advice and encouragement**

The participants claimed that they received advice from the communities on the benefits and utilisation of skilled birth attendance services. Moreover, they also indicated that the communities encouraged the women to utilise skilled birth attendance service. The following statements supported this:

> "The community advises us to give birth in the HF and not to give birth at home. In addition, they tell us to have ANC follow-up during pregnancy."

> "...the community encourages us to give birth in HFs."

> "They encourage us to go to the HC for ANC follow-up...They encourage us to utilise skilled birth attendance..."

4.4.2 Themes revealed by the analysis of individual in-depth interviews data

Theme eight and nine were emerged from the analysis of individual interviews with HEWs, Midwives, heads of PHCUs and district health office, and maternal, reproductive, and youth health technical officers. The two themes identified in this category are challenges of offering skilled birth attendance services and strategies being implemented to improve the utilisation of skilled birth attendance services. Each theme is dealt in detail below.

4.4.2.1 Theme 8: Challenges of offering SBA services in health facilities

This theme dealt with the challenges of offering skilled birth attendance services in health facilities. This theme consists of seven categories, namely; barriers to transportation services, health facilities related infrastructure, shortage of equipment, supplies and drugs, effects of health facility infrastructure, equipment barriers on the utilisation of skilled birth attendance services, staff related barriers, culturally insensitive services, and community related barriers. Each category will be discussed in detail below.

4.4.2.1.1 Category 1: Barriers to transportation services

The study identified bad terrains, the inaccessibility of roads, the distance to health facilities, the problem of ambulance services, and lack of transportation services to return women home after delivery, to be barriers to offering skilled birth attendance services.

- **Bad terrain and road inaccessibility**

The study reported bad terrains and road inaccessibility as some of the challenges related to transportation services to offer skilled birth attendance services. The participants indicated that there were areas where women could not be transported to health facilities using ambulance services due to bad terrains and road inaccessibility. The participants indicated the following statements:

> “The challenge that we have is the topography of the area. Even it is difficult to use traditional ambulance to transport labouring women...There are areas where woman cannot be transported using traditional ambulance let alone ambulance vehicle.”

> “There are remote kebeles...the two remote kebeles so that it is very difficult to travel from these kebeles to the HC and they are inaccessible for ambulance, too.

- **Distance to health facilities**

The findings of the study revealed that distance to health facilities was one of the challenges to offer skilled birth attendance services. The study further noted that women who resided in remote areas did not utilise skilled birth attendance services. The following statements affirmed this:

> “Distance is determinant factor for utilising skilled birth attendance.”

> “There are remote kebeles...the two remote kebeles so that it is very difficult to travel from these kebeles to the HC and they are inaccessible for ambulance, too.”

Problem of transportation services

The study identified problems related to transportation services to be a challenge to offering skilled birth attendance services. The unavailability of transportation services and shortage of ambulance services also hindered the provision of skilled birth attendance services. The participants mentioned the following statements:

> “The problem that currently exists is problem of transportation. There is only one ambulance service in the woreda.”

> “There is also a problem of vehicle. There is a problem of ambulance.”

> “The challenge that we have now is the problem of the ambulance service.”

4.4.2.1.2 Category 2: Health facility related infrastructure

The shortage of beds, rooms, lack of electricity and water supply, and the unavailability of maternity waiting homes emerged as challenges to offer skilled birth attendance services.

- **Shortage of beds**

The study identified the shortage of beds as a challenge to offer skilled birth attendance services. Women were forced to lie down and rest on the delivery couches and chairs after they gave birth in the health facilities due to the shortage of beds. Furthermore, women who stayed closer to the health facilities were told to go and stay in their homes until the progress of labour reached an advanced stage and consequently, some women reported giving birth at home. The following statements evidenced this:

> "The HC has no bed where women can rest after giving birth the women take a rest in the couch where they delivered."

> "We do not have beds; additional beds for example for women to take a rest during labour and in the second stage of labour before they move to the delivery couch."

- **Shortage of rooms**

The study revealed that the shortage of rooms emerged as a challenge to offer skilled birth attendance services in the health facilities. The following statements indicated this:

> "There were 5 labouring mothers in the HC at a time last month and one of the women was referred from our kebele. At that time, they let one of the women to sleep on the chairs after she gave birth there. There is a shortage of beds and rooms in the HC."

> "There is shortage of rooms in the HC so that this is one reason for the low uptake of the service."

- **Lack of electric power and water supply**

Lack of electric power and water supply in health facilities was a challenge to offer skilled birth attendance services. The participants indicated that lack of electric power supply caused a problem to offer skilled birth attendance services and a broad range of other services, particularly at night. The following verbatim quotes corroborated this:

> "The facility lacks water and electric supply."

> "There is a problem of electric power to offer complete services. We are using solar lamp when women give birth at night. One of the HW assigned assist by catching the solar light while the other attends the delivery."

- **Unavailability of maternity waiting homes**

The study reported the unavailability of maternity waiting homes as one of the challenges to offer skilled birth attendance services. There was no maternity waiting homes for women who visited the health facilities in advance to stay there before the start of their labour. The participants affirmed this:

> "Firstly, the issue we identified as a problem in our HF is unavailability of maternity waiting room."

4.4.2.1.3 Category 3: Shortage of equipment and supplies

Under this category, the unavailability of vacuum extractors, shortage of delivery couches, and incomplete personal protective infection prevention materials emerged as challenges to offer skilled birth attendance services in health facilities.

- **Unavailability of vacuum extractor**

The findings revealed that the unavailability of vacuum extractors was one of the challenges to offer skilled birth attendance services. The participants reported that the unavailability of vacuum extractors in health facilities was a challenge to offering vacuum assisted delivery. The following statements indicated this:

> "We have a gap in equipment such as vacuum extractor and most women need vacuum assisted deliveries."

> "The second challenge is unavailability of vacuum extractor."

- **Shortage of delivery couches**

Data from the current study showed that the shortage of couches was also a challenge to offering skilled birth attendance services in health facilities, particularly when two or more women visited the health facilities for skilled birth attendance service at a time. The participants verbalised this:

> "There is shortage of couch. For your surprise, there is only one couch in this HC... There is no couch if two or three labouring women come to the HC to attend their labour. Either you let her sleep and may attend her delivery on the examination couch or on the couch where ANC care is being provided. And, there is a problem of couch."

- **Incomplete personal protective infection prevention material**

Some participants in the current study indicated that they experienced shortages of personal protective infection prevention materials such as aprons, eye goggles, mouth masks, and heavy-duty gloves to offer skilled birth attendance services. The following statement affirmed this:

> "We do not have apron...The HC already bought us safety boot. But, we do not have eye goggle, mouth mask, cape and high duty glove. For example, if a woman presented with retained placenta, we use the usual surgical glove to remove the retained placenta. However, it could have been easy to remove the retained placenta, if we had heavy-duty glove. We have such shortages."

4.4.2.1.4 Category 4: Effect of gaps in health facility infrastructures and equipment on the utilisation of SBA

The current study found that the unavailability of basic infrastructure and equipment in health facilities negatively affected the provision of basic services for women and the utilisation of skilled birth attendance services. In addition, women were prone to unnecessary referrals due to the unavailability of vacuum assisted delivery services in the health centres.

- **Effect of unavailability of vacuum assisted delivery on referral service**

The study noted that women were referred to other health facilities where vacuum extractor equipment was available in circumstances where the women needed vacuum assisted delivery services. The women were prone to unnecessary referrals to other similar facilities or higher health facilities due to the unavailability of functional vacuum extractors. Consequently, women lost confidence and trust in the provision of services by health facilities. The following verbatim quotes corroborated thus:

> "Since there is no vacuum instrument, we are referring to other HFs where the equipment is available when women in need of vacuum assisted deliveries."

> "Now, even they are losing trust in our service because we referred five labouring women to Fenot selam Hospital today and five of them were normal vaginal deliveries. Their trust in our service and other things they have about us is now declining. Think of what information these women will disseminate when they come back."

- **Effect of unavailability of electric power supply on service provision**

The study reported that women did not receive basic laboratory investigation services and the health workers failed to provide skilled birth attendance services at night due to the unavailability of electric power supply. Furthermore, the communities established that health facilities did not provide good skilled birth attendance services, particularly at night. The participants mentioned this:

> "One of the challenges to offer skilled birth attendance service is electric power problem. If there is electric power, it will be possible to offer many services including different laboratory services. Since there is no electric power, we are not providing laboratory service for women."

> "First, with regard to the unavailability of electric supply, the community may perceive as if the HC does not provide any skilled birth attendance service and in particular, the community perceive that the HC doesn't provide good services at night."

- **Effect of unavailability of maternity waiting home on utilisation of skilled birth attendance service**

The findings showed that the unavailability of maternity homes was one of the challenges to offer skilled birth attendance services. Women were did not utilise skilled birth attendance services due to the fact that health facilities did not have maternity waiting homes where women visited health facilities in advance to give birth. Some participants commented as follows:

> "The pregnant woman visit HF today and we examine her; then we send her back to home and she gives birth at home. We do not make the woman to stay here for two to three days."

> "If two or three labouring women came at a time...In case, the women are residing in the nearby areas and tell them better to go and stay home because of the unavailability of bed, the women might not come back. In case she faced fast labour and she will not come back. If this woman gets a room in the HC to stay for one or two days, there will not be any problem. You can let her stay for three days because it is near so they can bring food for her."

- **Effect of lack of returning transportation service to home after delivery on utilisation of skilled birth attendance service**

The participants in the current study asserted that women walked back to their homes or did not receive transportation services after giving birth in the health facilities. As a result, the women were disappointed about it and complained that they were bleeding

and hurt. They questioned the benefits of utilising skilled birth attendance services if they did not receive transportation services after childbirth. One participant commented as follows:

> "Women come to the HC with ambulance and they go back to their home on feet after delivery...The women get very upset and they say that why we came here to give birth and we are bleeding when we go back to our home on feet. The midwives visit each kebeles once per month and the women are complaining about this. They say that why the ambulance should take us back to home we are bleeding; what importance does it have giving birth there because we are getting hurt when we go back to our home on feet."

4.4.2.1.5 Category 5: Staff related challenges

The presence of basic emergency obstetric and newborn care (BEmONC) untrained staffs emerged as a challenge to offer skilled birth attendance services.

- **Presence of BEmONC untrained staffs**

In the current study, some of the participants claimed that the midwives in their health facilities did not receive training on basic emergency obstetric and newborn care (BEmONC) to offer quality skilled birth attendance services. Some of the participants mentioned this:

> "The midwives never received trainings. For instance, a woman may encounter pre-eclampsia or eclampsia during delivery or after delivery; in this case magnesium sulphate need to be administered for the treatment and this drug must be administered with a BEmONC trained health professional and nobody is trained here to do it."

4.4.2.1.6 Category 6: Culturally insensitive service

The study identified the absence of cultural ceremony practices in health facilities as a challenge to offer skilled birth attendance services.

- **Absence of cultural ceremony practices in health facilities**

The study identified the absence of the practice of cultural ceremonies in health facilities such as porridge preparation and coffee ceremonies as challenges to offer skilled birth attendance services. This, according to the respondents, contributed to the low skilled delivery coverage. Furthermore, the study indicated that there was no resting placed organised for companions and family members who brought the women to the health facilities; some of them were even barred from entry into the health facility compound.

> "There is no preparation of porridge in this HC even the coffee ceremony is interrupted."

> "There are no maternity waiting rooms for women to stay and rest when pregnant women come early before their labour starts; after the women came to the HC to utilise skilled birth attendance they do not get the things they want in relation to their culture. These have contributed for the low skilled delivery coverage."

> "Two or three individuals who accompany the woman. There are also individuals who carry the woman to the HC when there is ambulance service. There is no place to rest for them particularly when they bring a woman at night. There is no place to go for the companions during that time and even the guards also do not permit them to enter to the HC. They do not permit to enter more than two or three individuals so that there is no place to rest for them."

4.4.2.2 Theme 9: Strategies implemented to improve the utilisation of SBA services

The findings of the current study revealed that various strategies were implemented to improve the utilisation of skilled birth attendance services. The strategies under this theme were categorised into eight; namely, awareness creation, incentives and repercussions, early identification of pregnancy and follow-up, use of community structures, transcending transportation barriers using local solutions, labour notification systems, collaboration with influential stakeholders, and exploration of reasons for home delivery for action. Each of the categories and sub-categories is discussed in detail below.

4.4.2.2.1 Category 1: Awareness creation

Various strategies and approaches were implemented to raise the awareness of the communities regarding the different aspects of skilled birth attendance services. In addition to this, health education and advice, family conversations, pregnant women conferences, and social mobilisation and advocacy were the strategies implemented in this regard.

- **Health education and provision of advice**

The participants reported that health education and provision of advice undertaken using various circumstances and opportunities by health workers, political leaders, religious groups, and other stakeholders. The issues addressed during health education and provision of advice sessions included but not exhausted the importance of skilled birth attendance services, risks and consequences of home deliveries, and birth preparedness and complication readiness. The participants indicated the following:

> "For instance, when we teach a woman about utilising skilled birth attendance, we tell her the risks and consequences of giving birth at home."

> "Women get advised about birth preparedness and complication readiness since 8 months of gestation and close follow-up is also needed because they may give birth at home."

- **Family conversations**

The findings indicated that family conversations were identified as a strategy to raise the awareness of key family members, neighbours and other community groups with regard to pregnancy care, birth preparedness and complication readiness, skilled birth attendance services, and newborn care. The study also indicated that family conversations were conducted, involving pregnant women, husbands, mothers-in-law, fathers-in-law, one to five network leaders, TBAs, and neighbours. The key issues discussed during family conversations were the care the pregnant woman should get, birth preparedness and complication readiness, planning for the place of delivery, identifying skilled birth attendants, and newborn care. Health workers and women's

health development team-leaders facilitated this forum. The following statements evidenced this:

> "We go to the house of pregnant women to conduct family conversation using the guide. Family conversation is the conversation carried out in the presence of the pregnant woman, her husband, mother/father-in-law, neighbour, 1 to 5 network and women development team leaders about the health of the pregnant woman and birth preparedness and complication readiness so that harmful traditional practices to the pregnant woman get averted and the pregnant women give birth in the HC..."

> "The HEWs and HDAs team leaders are conducting family conversation for pregnant women with the involvement of key family members and other stakes."

- **Pregnant women's conference**

The participants revealed that the pregnant women's conference was one of the strategies employed to improve the awareness of the communities on the utilisation of skilled birth attendance services. The findings indicated that the pregnant women's conference was conducted in most of the kebeles once per month. It was moderated by health workers, specifically midwives and health extension workers. The activities that were performed during the pregnant women's conference were the provision of health education; out-reach ANC, and PMTCT services. The participants explained the following:

> "We are also conducting pregnant women conference in all kebeles in the catchment."

> "Pregnant women conference is being done for pregnant mothers in all "kebeles" and the conferences are led by health professionals specifically midwife and education will be given for pregnant women to utilise skilled birth attendance during childbirth."

> "The pregnant women conference is being conducted by midwives in those kebeles. It is being conducted once per month in each kebele."

- **Social mobilisation and advocacy**

Social mobilisation and advocacy emerged as a strategy in the analysis of the data to raise the awareness of the communities with regard to the utilisation of skilled birth attendance services. The participants indicated that they were using case presentations, cases of women who gave birth at home and encountered health problems and complications, for community mobilisation. One participant explained the following:

> "We present cases to them as an example those women who had given birth at home and encountered complications as a result of it and this also influences the women to utilise skilled birth attendance service."

The study reported that maternal deaths that occurred in the districts have also been used as advocacy and community mobilisation tools to mobilise the community to utilise skilled birth attendance services. The following statement corroborated this:

> "We also use unfortunate maternal deaths as advocacy tool."

Furthermore, the promotion of ambulance services to the communities has been one community mobilisation strategy to improve the utilisation of skilled birth attendance services. One participant explained the following:

> "Using the ambulance service as one means of mobilisation by informing them the ambulance will pick them up from their home and take to the HC and this is also one mobilisation system."

One PHCU director accounted that women who gave birth in their health centre were considered ambassadors of the health centre. They disseminated information to their families and communities in general regarding the skilled birth attendance services they received from the health centre. Therefore, the health centre was striving to provide the highest attainable quality of skilled birth attendance services. The PHCU director explained the following:

> "We begin that women who gave birth in our HC are our ambassadors. If that is the case, we are highly exerting our efforts to make women satisfied with the service provision. We are striving to satisfy women with our service because we think that those women will talk to their mothers, aunts and to the community in general about the services they received."

4.4.2.2.2 Category 2: Incentives and repercussions

Monetary fines and the provision of non-monetary incentives emerged from the data analysis, as strategies implemented to improve the utilisation of skilled birth attendance services.

- **Monetary fines**

The participants revealed that monetary fines were identified as one strategy to improve the utilisation of skilled birth attendance services. They also indicated that the communities agreed and proposed monetary fines for husbands and family members who let their wives give birth at home. The following verbatim notes evidenced this:

> "A husband who let his wife to give birth at home to pay 100 birr. Women should give birth in the HF; women who give birth at home must be fined 100 birr."

- **Provision of non-monetary incentive**

The study reported that the provision of non-monetary incentives was implemented to improve the utilisation of skilled birth attendance services. The participants claimed that women who completed ANC follow-up and gave birth in health facilities were given certificates of recognition, mama kits and soap as incentives. The participants mentioned the following statements:

> "We also provide certificates for those who gave birth in the HC."

> "Soap is also provided for the newborn..."

4.4.2.2.3 Category 3: Early pregnancy identification and follow-up

The findings revealed that early pregnancy identification and follow-up emerged as one of the strategies implemented to improve utilisation of skilled birth attendance service.

- **Early pregnancy identification and follow-up**

The participants indicated that the early identification of pregnancy was very critical for the determination of the pregnant women's expected dates of delivery and following the pregnant women until childbirth. It also enabled pregnant women to have basic health and counselling services as per the recommended ANC visit schedules. The participants indicated the following statements:

> "What we are currently implementing to improve utilisation of skilled birth attendance; if you do not identify and register a pregnant woman, you will not know her EDD. Similarly, if you do not know the EDD of a pregnant woman, the woman will not give birth in the HC."

> "...early identification of pregnant women to improve utilisation of skilled birth attendance."

4.4.2.2.4 Category 4: Use of community structures

The women's health development teams were found to be an important community structure to improve the utilisation of skilled birth attendance services.

- **Use of women health development army teams**

The participants highlighted that one to five networks and women's health development team-leaders played a significant role in improving the utilisation of skilled birth attendance services. The women's health development teams interacted with pregnant women, transmitted key health messages, identified pregnant women early and reported to the HEWs, mobilised pregnant women for conferences and other interventions, notified labour to the HEWs and called ambulance services. The following excerpts supported the findings:

> "There are women development teams established in the kebele. There are also 1 to 30 (women development team leaders) and 1 to 5 network leaders who are under the supervision of HEWs...Both 1 to 30 and 1 to 5 network team leaders know the EDD of the pregnant women."

> "Women are now giving birth in the HF better than the previous time is that the HDAs teams have a very good knowledge so that they can early identify and register the pregnant women. The HEWs cannot reach to all villages and households. The HDAs team identify how many pregnant women are under their catchment. We meet with them monthly and give us the list and number of pregnant women."

4.4.2.2.5 Category 5: Transcending transportation barriers using local solutions

The use of locally made stretchers (traditional ambulances) emerged as a strategy to surmount transportation barriers that often hampered women from utilising skilled birth attendance services.

- **Use of locally made stretchers (traditional ambulances)**

The study reported that the community prepared and used locally made stretchers (traditional ambulances) in situations where there were problems of transportation services and road accessibility. The locally made stretcher (traditional ambulance) was used to transport women in labour from their villages to transportation access points or health facilities and returned them to their homes after childbirth. Each of the women development teams were supposed to prepare their own locally made stretchers (traditional ambulances). The following statements evidenced this:

> "In our kebele, there is a remote gotte and it takes one hour on feet. What we are doing there, there is traditional ambulance. As soon as, women start to have labour, we send the traditional ambulance and bring them to the HP first. Then, we attend the deliveries here in the HP if the labour comes so fast; otherwise, we call for ambulance to take them to the HC."

> "First, particularly for kebeles located far away from the HC each women development teams prepare traditional ambulance and transport women to the HF when their labour starts and we are creating awareness for each women development teams to prepare traditional ambulance."

4.4.2.2.6 Category 6: Labour notification system

The findings showed that telephone communication was an avenue to notify the initiation of labour to midwives, HEWs and women's health development teams.

- **Telephone communication as an avenue to labour notification**

The participants indicated that women and families were using telephone communication to notify labour for midwives, HEWs and women's health development teams. The midwives and HEWs provided their telephone numbers and ambulance driver's telephone numbers to the pregnant women. The pregnant women or their families could call either of them for labour notification. The participants verbalised this:

> "We provide our mobile phone number to the pregnant women and when they call to us even we go to their home and bring them to the HC."

> "We also provide them telephone number and we write the telephone number of the ambulance driver and we also provide the telephone number of ours and then the families will call to us."

4.4.2.2.7 Category 7: Exploration of reasons for home delivery for action

An investigation of the reasons for home delivery and taking corrective actions was another strategy to improve the utilisation of skilled birth attendance services.

- **Exploration of reasons for home delivery for action**

The participants reported that finding reasons for not utilising skilled birth attendance services and rectifying the identified problems was also one of the strategies to improve the utilisation of skilled birth attendance services. In cases where a woman gave birth at

home, either midwives or HEWs visited the home of the mother to find out the reasons for not utilising skilled birth attendance services and make a follow-up on corrective actions. The participants indicated the following:

> "The other, when women give birth at home, we find out the reasons for non-utilising skilled birth attendance and we tackle the identified problems so that women will not deter utilising skilled birth attendance with the same reasons."

4.5 CONCLUSION

This chapter presented and described the study's findings. The themes that emerged from the data were skilled birth attendance services (SBA) that created good experiences, causes of disappointment for women with the utilisation of SBA services, reasons for not utilising SBA services, factors that influenced the utilisation of SBA services, factors that motivated women to utilise SBA services in the future, perceived benefits of SBA services, community support for women to utilise SBA services, challenges of offering of SBA services, and strategies to improve the utilisation of SBA services.

The next chapter will present the discussion and development of strategies to improve the utilisation of SBA services.

CHAPTER 5

DISCUSSION OF THE STUDY FINDINGS

5.1 INTRODUCTION

The previous chapter outlined the data analysis and research findings. This Chapter presents the discussion of the findings, followed by the development of strategies for the implementation of Phase II in chapter 6. Phase II will be guided by the findings from Phase I and the background literature, based on the conceptual framework and the management process. Strategies will be developed based on the findings of this study and presented to expert health professionals for review and validation.

5.1.1 Overview of the research discussion

This study adopted an inductive thematic data analysis strategy to explore and describe community perceptions and experiences of skilled birth attendance utilisation in North West Ethiopia.

Nine themes emerged from the study that include:

- **THEME 1**: SBA service that created good experiences for women;
- **THEME 2**: Causes of disappointment for women with the utilisation of SBA services;
- **THEME 3**: Reasons for not utilising SBA services;
- **THEME 4**: Factors influencing the utilisation of SBA services;
- **THEME 5**: Factors motivating women to utilise SBA services in the future;
- **THEME 6**: Perceived benefits of SBA services;
- **THEME 7**: Community support for women to utilise SBA services;
- **THEME 8**: challenges of offering SBA services; and
- **THEME 9**: strategies implemented to improve the utilisation of SBA services

The themes, categories, and sub-categories that emerged from the study were interpreted and discussed using literature sources and in line with the health belief model and objectives of the study.

5.2 BIOGRAPHICAL PROFILE OF THE PARTICIPANTS

Of all FGD participants in this study, 64% were in the age group of 20-29 years whilst about 100% were married and Orthodox Christians. The majority of the participants (87%) were farmers by occupation and 64% of them never went to school. Furthermore, about half of the participants were pregnant at least four times while a similar proportion had given birth at least three times. A literature review on the determinants of the utilisation of skilled delivery in Gabrysch and Campbell (2009:4) revealed that age had no effect or a higher utilisation of skilled birth attendance among older mothers as compared to younger mothers. Older women were possibly more confident and influential in household decision making as compared to younger women. In addition, older women were advised to deliver in health facilities since old age is a biological risk factor. On the contrary, Moyer and Mustafa (2013:5) indicated that younger women were found to be more likely to deliver in health facilities or use skilled birth attendance services. Hence, maternal age is a determinant factor to utilise skilled birth attendance services. According to Gabrysch and Campbell (2009:5), Kebede et al (2013:82) and Moyer and Mustafa (2013:4), higher maternal education and lower parity were significantly associated with increased likelihood of the utilisation of skilled birth attendance services. Besides, studies conducted in Ethiopia, Eretria, Ghana, Kenya, Nigeria, and Zimbabwe revealed that maternal employment was positively associated with the utilisation of skilled birth attendance services (Moyer & Mustafa 2013:4). However, women who were farmers by occupation were less likely to utilise skilled birth attendance service (Gabrysch & Campbell 2009:6). The current study was exploratory and descriptive; therefore, it did not identify the determinants of the utilisation of skilled birth attendance service. Rather, descriptions of women's perceptions and experiences regarding skilled birth attendance services were obtained from women who were in their twenties; less educated, unemployed, and had given birth at least three times in their lifetime.

5.3 SKILLED BIRTH ATTENDANCE (SBA) SERVICES THAT CREATED GOOD EXPERIENCES FOR WOMEN

This theme dealt with skilled birth attendance service received by women that created good experiences for them. Presence of supportive and ethical health workers**,** interpersonal care, receiving good services as perceived by women, availability of basic and life-saving interventions/services, and women friendly service created good experience for women.

5.3.1 Supportive and ethical health workers

5.3.1.1 Caring and cooperative staffs

In the current study, the study participants reported that health workers were caring and supportive for pregnant and labouring women. The health care providers provided good advice, regularly followed the women, and attended their deliveries. In addition to this, administrative and technical staffs were cooperative towards pregnant and labouring women any time they showed up in the health facilities. A systematic review of attitudes and behaviours of maternal health care providers in their interaction with clients revealed that maternal health care providers were described as caring when the women sought ANC, were in labour, or having an abortion. The existence of respectful, caring, friendly, helpful and sympathetic maternal health care providers was a salient factor in encouraging the demand for maternal health care. Women experiencing positive attitudes and behaviours were more likely to decide to return to a facility than those experiencing negative ones (Mannava, Durrant, Fisher, Chersich & Luchters 2015:5). Therefore, women who experienced caring and cooperative health workers were likely to utilise skilled birth attendance services in future pregnancies.

5.3.1.2 Ethical and disciplined health workers

The participant women experienced the reception of skilled birth attendance services from ethical and disciplined health workers. This finding was corroborated by Mannava et al (2015:5) that women who had delivered in health facilities commended the midwives for good personal treatment of maternity clients. Hence, women with such experiences were more likely to be satisfied with the quality of care and feel positive

emotions. As cited in Sword, Heaman, Brooks, Tough, Janssen, Young, Kingston, Helewa, Akhtar-Danesh and Hutton (2012:6), staffs who were pleasant, efficient and greeted patients by name, had a positive impact on how women viewed their care. Hence, women who received skilled birth attendance services from ethical and disciplined health workers were more satisfied with the quality of care.

5.3.1.3 Presence of health workers all the time during labour and delivery

The health workers stayed with labouring women throughout the entire process of labour and delivery; they did not go away even for a while. In addition to this, the women received close follow-up, good advice, encouragement and care from the health workers. The presence of health workers with labouring women all the time and throughout the process of labour and delivery enabled them to closely follow the progress of labour, detect and manage unforeseen problems and complications, and even encourage the women to utilise SBA services in the future. Akum (2013:7) contends that women need constant and continuous support and motivation until the delivery of the child.

5.3.2 Interpersonal care

Interpersonal care is the care between the provider and the client. It encompasses emotional support, ethical and respectful service, friendly and compassionate service, information and advice on woman and newborn health, and respect for privacy. Interpersonal care created good experiences for women and had a great potential of influencing the utilisation of skilled birth attendance services.

5.3.2.1 Emotional support

The findings revealed that emotional support created good experiences for the women with the utilisation of skilled birth attendance services. The study noted that health workers provided encouragement for the women during labour and delivery. It made them not to be stressed, averted any form of fear and boosted the confidence of the women. The review of literature on the relationship between social and emotional support on health revealed a relationship in which social and emotional support could be protective for health (Reblin & Uchino 2008:201). This was affirmed by Srivastava,

Avan, Rajbangshi and Bhattacharyya (2015:7) in their review of literature from developing countries that emotional support provided by a companion of the parturient during labour and delivery has a positive effect on the women's satisfaction with the overall birth experience. There was evidence of the benefits of emotional support were in terms of shorter labour, lesser need for pain relief and greater birth satisfaction among women with birth companions during labour. According to Hulton, Matthews and Stones (2007:2090), effective psychosocial support reduces medical interventions such as the use of forceps, analgesics and caesarean sections. In addition, emotional support from friends, relatives and health facility staffs during labour speeded up recovery, favoured early bonding between mother and child, decreased anxiety and depression during the postpartum period and reduced the time spent in labour. Therefore, skilled birth attendants needed to be equipped not only with medical skills but also with supportive skills, both of which needed to be performed with sensitivity and competence.

5.3.2.2 Ethical and respectful service

The findings of the current study indicated that the provision of ethical and respectful skilled birth attendance services created good experiences for women. The participants reported that they received ethical services and were treated with respect by the staffs of the health facilities. Ethical and respectful skilled birth attendance services have a huge potential to affect satisfaction of women on the services and subsequent utilisation of skilled birth attendance service.

It was internationally ascertained that every woman has the right to be treated with dignity and respect in seeking and receiving maternity care before, during, and after childbirth (White Ribbon Alliance 2005:3). Therefore, respecting this right during labour and delivery would satisfy the women on the service utilisation and encourage subsequent utilisation of SBA services. According to Baral, Lyons, Skinner and Van Teijlingen (2010:327), positive staff attitude towards women during labour and delivery, including giving reassurance, encouragement and politeness, encouraged the utilisation of SBA services. A systematic review of attitudes and behaviours of maternity care providers in interaction with clients revealed that women reported respect and good treatment by providers (Mannava et al 2015:5).

Furthermore, the community members often considered the interpersonal skills of providers as key indicators of quality of care than clinical dimensions of care. The behaviours and attitudes of the healthcare providers affected the women's decisions with regard to where to seek care and utilisation of available health services (Akum 2013:3; Family Care International 2005:6).

5.3.2.3 Friendly and compassionate service

The women experienced a welcoming and friendly approach from health workers and good service provision, sympathetic care, and respectful care and treatment. The provision of compassionate service maintained the quality of skilled birth attendance services and improved the utilisation of skilled birth attendance services. A cross-sectional study of respectful maternity care in health facilities Ethiopia, Kenya, Madagascar, Rwanda, and the United Republic of Tanzania revealed that women overall, were treated with dignity and in a supportive manner by health providers (Rosen, Lynam, Carr, Reis, Ricca, Bazant & Bartlett 2015:8). Mannava et al (2015:5) also reported that maternity care providers were reported as being friendly, kind, sympathetic, polite, welcoming, informative, helpful, and attentive. These experiences meant that the implicated clients were more likely to be satisfied with the quality of care and returned to the health facilities for skilled birth attendance services. According to Sword et al (2012:11), women desired care providers to be non-judgmental, easy to talk, listen and address their concerns, respectful and value the clients all the time, and offer culturally sensitive services.

5.3.2.4 Information and advice on women and newborn health

The participants in the current study indicated that they have recieved information and advice regarding importance and benefits of skilled birth attendance services, health problems and complications associated with home delivery, what need to be done in case of health problems and complications, conditions that require re-visiting of health facilities, and proper newborn care practices. Therefore, enhancing the knowledge of women on maternal and newborn health is very critical to improve SBA service seeking behaviour and use. A qualitative study in rural Tanzania revealed that women received advice from heath workers on how to use routine services, danger signs, and on the importance of delivering at health facilities (Mahiti et al 2015:5). Sword et al (2012:6-7)

submit that women recognised the importance of health promotion advice to encourage a healthy life style. However, a study conducted in Ethiopia revealed that the participant women claimed that the only reason a woman I labour visited a health facility was for complicated labour. They did not have information about the importance of health facility delivery and birth preparedness. Therefore, the provision of information and advice for women on maternal and newborn health is very important to encourage the utilisation of skilled birth attendance services.

5.3.2.5 Respecting privacy

Respecting the privacy of women in labour created good experiences for them with the utilisation of skilled birth attendance services. The research reported that only companions and nobody else was allowed to get into the labour and delivery room. This relieved the women from experiencing distress and feelings of shame. According to Srivastava et al (2015:6), privacy is a key requirement of women utilising maternal care services for physical examinations, labour and the delivery process. Maintenance of privacy via a separate room or the use of a screen was a significant determinant of satisfaction with maternal health services.

5.3.3 Reception of good quality of service as perceived by women

The participants in the current study indicated that keeping their cleanliness, good newborn care practices, good quality of skilled birth attendance services, home visit from health workers, getting priority in service provision, and regular and close follow-up from health workers created good experiences for women with the utilisation of skilled birth attendance services.

The quality of care that a health service provided influenced the use of health services in many ways. Studies have shown that the quality of care provided in health facilities and users' perceptions and experiences of the quality of care could affect the decision to seek care, choice of health facility, health seeking behaviour, and timing of presentation to a health facility (Hulton, Matthews & Stones 2000:6).

5.3.3.1 Cleanliness

In the current study, the participant women claimed that the health workers ensured the cleanliness of the newborns and their bodies when they gave birth in health facilities. Hence, it made them to interact with other people without any reservations and unease. Bhattacharyya, Srivastava and Avan (2013:5) corroborated the fact that the health workers cleaned the delivery place, the mother, and newborn after attending deliveries. The women perceived this as an advantage of health facility delivery and a good delivery care. According to Srivastava et al (2015:6), cleanliness, good housekeeping services and maintenance of hygiene emerged as a determinant of service satisfaction. Therefore, maintenance of the hygiene of the mother and the newborn after delivery could affect the satisfaction of women on the service.

5.3.3.2 Good newborn care practice as perceived by women

The FGD participants reported that their newborns received proper newborn care, including vaccination services, thermal protection and care for hypothermia, proper cord care and averting harmful traditional practices. The provision of essential newborn care at childbirth and immediately after delivery was very instrumental to reduce neonatal morbidity and mortality. The recommendation of the WHO on postnatal care for mother and newborn indicated that newborns should be assessed for danger signs and care is sought from health facilities. If any of the danger signs was identified, counselling and the provision of support for exclusive breast feeding, proper cord care, thermal care, and immunization should be initiated. The provision of this care for newborns could considerably reduce the neonatal morbidity and mortality (WHO 2013:3-4).

5.3.3.3 Good quality of skilled birth attendance service as perceived by women

Women perceived that they have received good quality of skilled birth attendance services. In this regard, the perceived quality of skilled birth attendance services has a significant potential to influence the preference and utilisation of skilled birth attendance services. Women submitted that they were provided with injections to prevent excessive bleeding and post-partum abdominal cramps, received regular and close follow-ups,

and indicated the experience of receiving good skilled birth attendance services in contrast to prior home delivery experiences.

Larson, Hermosilla, Kimweri, Mbaruku Kruk (2014:5) corroborated this in their study when they indicated that the participants rated the overall quality of care received during childbirth as excellent. The women's expectations and their prior and current experiences of SBA services swayed the perception of the quality of care they received. A systematic review of evidence to examine the relationship between maternal and child health quality improvement strategies and its effect on health outcomes revealed that clients' better perceived quality of service tended to lead improved utilisation of services (Dettrick, Firth & Soto, 2013:5). According to Srivastava, Bhattacharyya, Clar and Avan (2014:36), an improvement in clinical and public health services in maternal and child health led to increased utilisation, client satisfaction, and improved health outcomes. Therefore, women's perceived quality of SBA services was associated with increased utilisation and improved outcomes.

5.3.3.4 Home visit

The participants in the current study indicated that the health workers made home visits after the women gave birth in health facilities. The purpose of these visits was to ensure the health of the women and their newborn. Undertaking of follow-up visits immediately after childbirth was very critical to avert maternal, neonatal, morbidity and mortality as it was a critical time in which these could occur. The WHO also recommended home visits in the first week after birth to provide care for the mother and the newborn (WHO 2013:3). Furthermore, studies showed that home visits by health workers were highly valued by mothers and they felt that they were cared for. This contributes to the reduction of maternal and neonatal morbidity and mortality (Cargill & Martel 2007:358).

5.3.3.5 Promptness of care

The research established that health workers gave precedence for pregnant and labouring women in the provision of services over the other clients who visited the health facilities for other services. In the same strength, the participants perceived that they enjoyed the attention of health facility staffs and this further encouraged them to utilise skilled birth attendance services.

Srivastava et al (2015:6) opine that promptness of care is a significant determinant for maternal satisfaction. Another qualitative study conducted in India further corroborated that promptness of care is a key criteria of perceived good delivery care. Virtually all women were satisfied with the promptness of services as they were cared for soon after the initiation of labour (Bhattacharyya et al 2013:5). Moyer and Mustafa (2013:8) also reaffirm that the perception of the promptness of care was linked to the utilisation of skilled birth attendance services.

5.3.3.6 Regular and close follow-up

Regular and close follow-ups in-between and after labour and delivery created good experiences for women with the utilisation of skilled birth attendance services. Regular and close follow-ups of labouring women helped to ensure progress of the labour, early detection of health problems and complications, and took timely action to ensure the health of the woman and the newborn.

According to Larkin, Begley and Devane (2009:55), intra-partum support found has dozens of benefits for the mothers and newborns, with a pivotal influence on the childbirth experience. This was further corroborated by Lavender, Walkinshaw and Walton (1999:42) who submitted that the participant women considered the support of midwives as very crucial to fulfilling a good childbirth experience. Quality midwifery practices during childbirth and after delivery contributed to the decrease of maternal and infant morbidity and mortality rates and are a measurement of healthcare delivery (Mensah, Mogale & Richter 2014:[3]).

5.3.4 Availability of basic and life-saving services

This category comprised of the availability and utilisation of ambulance services, referral services, timely care and services, life-saving interventions, the use of drugs and supplies to avert obstetric complications, and the provision of detergents and clothes for newborns.

5.3.4.1 Availability of ambulance services

The availability of ambulance services helped to avert delays in seeking skilled birth attendance services in relation to transportation barriers and facilitated the transportation of women from their residence to health facilities and referral services to higher health facilities. Dhakal et al (2011:375) corroborated this in their study that the participant women suggested the availability of ambulance services to improve the utilisation of skilled delivery care. The study also recommended an increase in the number of ambulances for referral of women with obstetric complications to the nearby health facilities that provided comprehensive emergency obstetric and newborn care (Tadese & Ali 2014:8). Belda and Gebremariam (2016:8) revealed that knowledge of the availability of free ambulance services was significantly associated with the place of delivery. Therefore, it was highly recommended to promote the availability of free ambulance services for the communities. A study conducted in Ethiopia revealed that the majority of women who gave birth in health facilities used ambulance as a transport service (Limenih, Deyesa & Berhane 2016:4).

5.3.4.2 Life-saving interventions

The participant women reported that they had developed obstetric complications and received life-saving interventions such as treatment for excessive bleeding. Life-saving interventions were critical in the management of obstetric complications and, in return, averted maternal morbidity and mortality.

A synthesis of qualitative evidence in low and middle-income countries revealed that the participant women highly recognized health facilities in case of complicated births (Alemayehu & Mekonnen 2015:4; Bohren et al 2014:4). According to Chakraborty et al (2003:336), women who have had a life-threatening condition are more likely to seek care from a doctor or nurse to treat their maternal morbidities.

5.3.4.3 Provision of detergent and clothes for newborns

The findings revealed that those women who gave birth in the health facilities received detergents and clothes for the newborns. The provision of incentives for women who utilised skilled birth attendance services would encourage them to give birth in health

facilities in the subsequent childbirths and influence other women in the communities to do the same. A study conducted in a pastoralist setting in Ethiopia found that the use of non-monetary incentives for pregnant women increased antenatal care attendance (Khogali, Zachariah, Reid, Alipon, Zimble, Gbane, Etienne, Veerman, Hassan & Harries 2014:13). Anastasi, Borchert, Campbell, Sondorp, Kaducu, Hill, Okeng, Odong and Lange (2015:12) noted that the provision of incentives for women enabled them to utilise skilled birth attendance services.

5.3.4.4 Referral service

Women received referral services for labour that could not be managed at the first level health facilities and these included obstetric and neonatal complications. The availability of referral services to higher health facilities was very important to manage maternal and newborn health problems and complications that could not be managed at first level health facilities and this created good experiences for women with skilled birth attendance services.

An efficient referral system was essential in antenatal care and childbirth for providing access to EmOC at higher levels of care and for supporting antenatal and delivery care in the primary level of care facilities (Pembe, 2010:14). It is noteworthy that maternal and neonatal health outcomes could be improved considerably if emergency obstetric and neonatal care was in place, particularly in resource-limited settings. A well-established and functional referral system was very critical to ensure access to EmONC (Chaturvedi, Randive, Diwan & De Costa 2014:5).

5.3.4.5 Timely service and care

Timely service and care from health workers created good experiences for women with utilisation of skilled birth attendance services. The research reported that the participant women received prompt care and service from health workers when they visited health facilities for skilled birth attendance services. Thaddeus and Maine (1994:1092) and Hulton et al (2000:3) supported the fact that the majority of maternal and neonatal deaths could have been averted by the provision of timely and appropriate medical treatment and care. A literature review from developing countries showed that the

satisfaction of women on maternity care relied on the timely and good quality of care received (Srivastava et al 2015:8).

5.3.4.6 Use of drugs and supplies to avert obstetric complications

The FGD participants claimed that they received medical drugs and supplies for the prevention and management of obstetric complications from the health facilities. Gebrehiwot et al (2012:7), contended the women appreciated the availability of drugs, especially injections. Mahiti et al (2015:7) also indicated that the women were provided with drugs during pregnancy as well as at referral health facilities in case of complications.

The study recommended that health facilities needed to be equipped with essential drugs and equipment to manage specific situations and qualified staffs who were trained to detect, manage, and refer these conditions (Hulton et al 2000:35).

5.3.5 Women friendly services

Women friendly services are very important and critical as they ensure optimum utilisation and impact of maternal and neonatal services provided. They encompass addressing the cultural needs of the community in order to utilise skilled birth attendance services. According to Sword et al (2012:7), women centred care emanated as a salient feature of quality prenatal care. The main notion of women-centred care is that it puts the care in the women's life context, recognises the social determinants of health, and position women as active partners of their care rather than passive recipients. The women cherished a high level of personalized care. They wanted the health care providers not only to focus on the pregnancy but also on the psychosocial aspects of their lives. Cultural sensitivity by health workers and permitting cultural practices in service delivery could attract women to deliver in health facilities (Wilunda et al 2014:9).

5.3.5.1 Practice of cultural ceremonies in health facilities

The findings of the current study indicated that labouring women and their companions were allowed to practice cultural ceremonies in health facilities, which were practiced in

the household of labouring women. Health facilities made the necessary arrangements for them to practice the cultural ceremonies, including availing equipment and materials, coffee beans, flour, and sources of energy. The provision of culturally sensitive care is imperative to improve utilisation of skilled birth attendance services in developing countries (Srivastava et al 2015:10). According to Anastasi et al (2015:11), allowing women to perform traditional rituals and other practices in the health facilities could make health facilities more women-friendly and respectful of individual women and their socio-cultural beliefs and traditions. Hulton et al (2000:43) opine that recognising cultural practices in health facilities would substantially enhance women's experiences of care and may even be beneficial.

5.4 CAUSES OF DISAPPOINTMENT OF WOMEN WITH THE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICES

This theme dealt with the causes of disappointment of women with the utilisation of skilled birth attendance services. This theme embraced staff related causes of disappointment; delay in care and service provision, individual related experiences, reverberation of poor service provision on service provision and use, and poor service provision.

Larkin et al (2009:56) note that the consequences of childbirth could lead to increased self-confidence, acquisition of knowledge and skills, and could result in feelings of guilt and dismay. Negative birth experiences have resulted in women shunning future pregnancies, choosing to terminate pregnancies and demanding caesarean sections. Previous birth experiences of parturient women in health facilities may be a facilitator or deterrent of facility delivery in future pregnancies. To this end, negative childbirth experiences with facility delivery could deter women utilising skilled birth attendance services in future pregnancies (Bohren et al 2014:8).

5.4.1 Staff related causes of disappointment

Lack of cooperation among staffs, negligent health workers and refusal of health workers to offer services during odd hours engendered disappointment for women with the utilisation of skilled birth attendance services.

5.4.1.1 Lack of cooperation among staffs

The data in the current study showed that there was no cooperation and collaboration among staffs when they gave birth in the health facilities. The health worker who was assigned in the labour and delivery room was completely responsible for managing the deliveries and the other health workers thought that it was the sole responsibility of the person assigned in the maternity unit. Furthermore, the women posited the need for cooperation among staffs in order to provide quality service and avoid staff burnout.

Baker, Day and Salas (2006:1579) and Mosadeghrad (2014:84) purport that cooperation and teamwork are an important component of high quality health care services. They support the provision of efficient and effective health care services and promote shared responsibility for patient care. However, lack of cooperation among health care providers contributed to clients' underutilisation of health services (Moore, Armbruster, Graeff & Copeland 2002:4).

5.4.1.2 Negligent health workers

The presence of inactive and negligent health workers caused disappointment for the women with the utilisation of skilled birth attendance services. Notwithstanding the participant women visited health facilities seeking for skilled birth attendance services, the health workers were inactive and negligent.

According to Mselle, Kohi, Mvungi, Evjen-Olsen and Moland (2011:10), the participant women claimed that the perceived provision of substandard care in health facilities stemmed from negligence on the part of health care providers. In a study conducted in Northern Ghana, negligence of health care providers, particularly those in ANC clinics, labour and delivery wards pointed out as a prominent theme. The demeanour of nurses sleeping throughout the night while on duty or relying on the patient's call for help was an exhibit for this. (Akum 2013:6). Rodamo, Salgedo and Nebeb (2015:74) submitted that the participant women did not want to deliver in health facilities because of the negligence of health professionals in attending mothers during labour and delivery.

5.4.1.3 Refusal of health workers to offer service out of working hour

The findings of the current study showed that women experienced refusal of health workers to offer them services during odd hours. This has negatively affected the interest of women to utilise skilled birth attendance services.

Mselle et al (2013:6) revealed that the participant women did not find health care providers when they went to health facilities for check-up and even if available, they did not attend the to their satisfaction. The unavailability of health care providers during odd hours deterred parturient women from giving birth in health facilities (Shiferaw et al 2013:5).

5.4.2 Delay in care and service provision

Under this category, delays in the referral of women and service provision caused disappointment for women with the utilisation of skilled birth attendance services.

5.4.2.1 Delay in referral of women

The data in the current study showed that women had experienced delays in receiving referral services from first level health facilities to referral level facilities. Delays in the referral of women caused them to develop obstetric complications and ramified the maternal and newborn health outcomes. Mselle et al (2011:11) corroborated this in their study in which the findings illustrated how referral delays happened and were experienced at each phase of the childbirth process, and how these referral delays were critical in determining the maternal and newborn health outcomes. Referral delays occurred in the birth process because of lack of close monitoring and support, carelessness, lack of capacity to foresee difficult labour, lack of communication mechanisms, absence of health care providers to endorse referrals, and unavailability of ambulance services. Poor referral procedures were identified as an impediment to accessing emergency obstetric care. Therefore, the quality of referral system was very crucial to prevent maternal death (Hulton 2000:21).

5.4.2.2 Delay in service provision

The research established that participants experienced delays in receiving maternal health care services from health facilities because of long waiting time in the medical record department and the unavailability of health workers to offer the services.

According to Kumbani et al (2013:[4]), the participant women pointed out delays in service provision as their concern. They disliked the long waiting time until the clinic opened late and delays in receiving the attention of the health care providers when they went to health facilities. A qualitative study conducted in rural Gambia revealed that women experienced delays in receiving prompt and adequate obstetric care at the hospital level. Lack of blood transfusion, basic medical supplies, and poor management of staff availability accounted for this (Cham et al 2005:5). Many studies revealed that there was a positive association between delays in the provision of obstetric care and the severity of maternal outcomes (Pacagnella, Cecatti, Parpinelli, Sousa, Haddad, Costa, Souza & Pattinson 2014:5).

5.4.3 Individual related experience

The participant women reported that personal experiences of not utilising ambulance services, dissatisfaction with the service provision, abandonment of women alone in maternity rooms, and loss of their newborn created disappointment for them with the utilisation of skilled birth attendance services.

5.4.3.1 Failure to make available ambulance services

Failure to provide an ambulance following a call from the community and the unavailability of ambulance services affected their utilisation by the women. This has caused disappointment for the women with the utilisation of skilled birth attendance services and had a potential to influence the utilisation of skilled birth attendance services.

Alabi, O'Mahony, Wright and Ntsaba (2015:4) affirmed this in their study that poor response time by the public emergency medical services and the ambulance services accounted for births occurring before arrival to the health facilities. The delay in

ambulance services was attributed to perceived shortages of ambulances and drivers and the drivers' challenge to locate the women's houses in rural areas. Non-utilisation of ambulance services was substantially associated with pregnancy related deaths (Godefay, Kinsman, Admasu & Byass 2016:170). The uptake of freely available transport in relation to the women's obstetric needs was associated with the substantially reduced pregnancy–related morbidity and mortality (Bhopal, Halpin & Gerein 2012:6; Godefay et al 2016:171).

5.4.3.2 Dissatisfaction with the service provided

Dissatisfaction with the services received was also another cause of disappointment for the women with the utilisation of skilled birth attendance services. Maternal satisfaction on maternity care was affected by a multitude of factors and this could influence future use of care. The determinants of maternal satisfaction were summarised based on the Donabedian framework of structure (physical structure, cleanliness, availability and adequacy of human resource, availability of medicines, supplies), process (promptness of care, interpersonal behaviour, privacy, perception of good care or provider competence, cognitive support, emotional support, and preference for female providers), outcome (delivery outcome), socio-economic determinants and access (Srivastava et al 2015:5-7). According to Tayelgn, Zegeye and Kebede (2011:3), health facility related factors and health care providers' characteristics were the predictors of maternal satisfaction. In this study, wanted status of the pregnancy, immediate maternal condition after delivery, waiting time before attendance by a health worker, perceptions about the waiting area for mothers and relatives, occurrence of complications, health professionals' measure taken to assure privacy during maternal examinations, and the cost of the service were found to be the determinants of mothers' satisfaction on the skilled delivery services. The breach of privacy and the costs incurred for services were associated with mothers' dissatisfaction. Moreover, poor information sharing, lack of health promotion, and long waiting time to be seen by a health care provider were blamed for maternal dissatisfaction with public maternity services (Shabila, Ahmed & Yasin 2014:7). Staff discipline, facility cleanliness, meal quality, inadequate pain control, sub-optimal client-provider communication, and loss of privacy had a great impact on the clients' satisfaction in labour and delivery services in maternity referral hospital in Ethiopia (Melese, Gebrehiwot, Bisetegne & Habte 2014:3-4).

5.4.3.3 Abandonment of women in labour and delivery rooms

Women were abandoned in labour and delivery rooms. In addition to this, they revealed that the lives of the mothers and newborns were put in danger and de-emphasised the importance of the utilisation of skilled birth attendance services.

Bohren, Vogel, Hunter, Lutsiv, Makh, Souza, Aguiar, Coneglian, Diniz,Tunçalp, Javadi, Oladapo, Khosla, Hindin and Gülmezoglu (2015:17) evidenced this in their systematic review on the mistreatment of women during childbirth in health facilities. The women reported feeling alone, ignored, and abandoned during their stay at the health facilities. This has engendered physical risks to the women during labour and delivery. These experiences of neglect and abandonment by health workers in facilities were direct barriers to seeking future deliveries in the facilities. Kumbani et al (2013:8) revealed that some women were left and delivered alone in health facilities. McMahon, George, Chebet, Mosha, Mpembeni and Winch (2014:4) also indicated that several women experienced feeling ignored or neglected in health facility childbirth.

5.4.3.4 Loss of newborn due to perceived health workers' error

The women believed that they lost their newborns due to inadvertent errors from health workers and this caused disappointment for them with the utilisation of skilled birth attendance services. Maternal and newborn outcomes, in terms of survival and health of mothers and newborns, affected the satisfaction of the women with regard to the care they received (Srivastava et al 2015:7). D'Ambruoso, Abbey and Hussein (2005:8) submitted that positive outcomes of labour and delivery for mother and child were highly important. Poor outcomes of previous pregnancy, such as fresh stillbirth and perceptions of poor quality of care deterred women from choosing certain facilities for delivery. This was especially true where mothers had the perception that the outcomes could have been positive because of the care she received. Previous negative experiences with facility births may deter women from delivering at a facility during a future birth (Bohren et al 2014:8).

5.4.4 Reverberation of poor service provision on future service provision and use

The reception of poor service from health facilities had an impact on maternal and newborn health, cost of care, intention to seek health care from that facility and future use of skilled birth attendance services.

According to Bohren et al (2014:8), previous negative experiences with facility births could deter women from delivering at a health facility during a future birth. Olayinka, Achi, Amos and Chiedu (2014:14) also reveal that the previous experiences of mothers about the care received influenced the utilisation of maternal health services.

5.4.4.1 Effect of delays in referral on the health of women and newborn

Delay in the referral of women cost the lives of newborns and resulted in long-term obstetric complications. This created disappointment for the women with the utilisation of skilled birth attendance services.

According to Mselle et al (2011:9), the majority of women who experienced delays in referral to higher health facilities lost their newborns and only a few of the babies delivered were healthy and alive. Studies conducted in many hospitals on maternal mortality revealed that 10% or more deaths occurred within one hour of arrival and 30-50% within 24 hours because of late or lack of referral to essential obstetric care.

5.4.4.2 Effects of poor interpersonal care on the future utilisation of SBA services

Poor interpersonal care from health workers influenced the decision of women not to utilise skilled birth attendance services in their future pregnancies. Due to the poor interpersonal care, the participant women decided to give birth at home rather than utilising skilled birth attendance services.

Sword et al (2012:15) corroborated this in their study that poor interpersonal care might affect the willingness of clients to comply with advice and deterred them from seeking

care in the future. Anastasi et al (2015:15) and Bohren et al (2014:11) revealed that women's fear or experiences of poor interpersonal care from health workers was a primary barrier to delivery in health facilities.

5.4.4.3 Lack of cooperation among staffs on care and service provision

The lack of cooperation among staffs had negatively affected the process of care and service provision. One participant woman indicated that the skilled birth attendant was exhausted and the place where she gave birth was not cleaned immediately after attending her delivery because of lack of collaboration from other technical and administrative staffs. Mosadeghrad (2014:84-85) supported the view that the lack of collaboration between health care organisations or health care providers influenced service quality. The health care providers' ability to effectively communicate and collaborate with other health professionals or institutions was deemed intrinsic to the delivery of high quality health services.

5.4.4.4 Effect of poor service provision to seeking care from other health facilities

The provision of poor services by health facilities compelled women to seek care and treatment from other private and public health facilities.

Women have alternative places to seek health care. The options of delivery places mentioned were home, public health facilities, or private health facilities. Home or private maternity clinics are alternative places that women prefer. The preference for alternative services was influenced by the quality of service (Akum 2013:4). Lack of adequate resources, including shortage of staff, drugs, and equipment compelled women to seek care from other sources (Roro et al 2014:5). Studies conducted in Cambodia, Ghana, and South Africa indicated that women and significant others opted to seek care from private facilities despite the cost of services, or at facilities that were located distant, because providers were reported to be friendly and caring (Mannava et al 2015:12). The inability to provide comprehensive obstetrical services compelled peripheral level health facilities to refer all women needing such services to higher-level health facilities (Cham et al 2005:5).

5.4.4.5 Effect of poor service provision on cost of care

Poor service provision predisposed women to unnecessary costs of care as they bought drugs and sought quality care from private health facilities. Mahiti et al (2015:7) corroborated that women reported that the drugs in the health facilities were meagre and are advised by health workers to buy drugs from other private drug stores. A study conducted in Gambia also revealed that the families of women were unable to buy all the prescribed drugs, which were unavailable in the hospitals because of the high cost of drugs in privately owned pharmacies. A few of the women afforded the costs of some of the prescribed drugs (Cham et al 2009:5). Srivastava et al (2015:8) indicated that a strong association was found between the cost of care, maternal satisfaction and the utilisation of maternity care.

5.4.4.6 Effect of poor service provision on future use of skilled birth attendance services

The experience of receiving poor services from health facilities deterred women from utilising skilled birth attendance services in their future pregnancies. The participant women said that they did not receive any support from health facilities for problems they encountered during labour and delivery. They experienced loss of their newborn and were abandoned in the maternity rooms. In concert with this, they preferred to give birth at home rather than health facilities in the future if they happened to fall pregnant.

The women's experiences of receiving (perceived or real), poor quality of care could deter them from returning for subsequent deliveries or led to rumours to the same effect to the wider community (Hulton et al 2000:38). D'Ambruoso et al (2005:5) opine that poor outcomes of previous pregnancies and perceptions of poor quality of care deterred women from choosing certain health facilities for delivery. The women's experiences with poor quality of care influenced their future behaviours. Complications that resulted after receiving care from some health facilities have deterred them from seeking future care at health facilities (Lubbock & Stephenson 2008:80).

5.4.5 Experience of reception of poor service from health facilities

5.4.5.1 Poor service provision

Women perceived that they received poor skilled birth attendance services and this in turn caused disappointment for them with the services received. Roro et al (2014:5) accounted that women did not receive proper care during labour and delivery. Those women who previously gave birth in health facilities did not advice others to go there. According to Akum (2013:6), the experience of the reception of poor services had a considerable influence on the acceptability and utilisation of the services. Srivastava et al (2015:7) revealed that perceived neglect in care, delays in the provision of care, not involving clients in care, poor handling during labour and mistakes in test results adversely affected the satisfaction with maternal services.

5.4.5.2 Lack of food provision in health facilities

The participant women claimed that they were not served with semi-solid and solid foodstuffs while they were utilising skilled birth attendance services. Furthermore, they suggested that health facilities should provide food for mothers who gave birth there. Morgan et al (2014:4) corroborated this in their study that the health facilities did not provide any food for mothers after delivery. Lack of food at health facilities was identified as a barrier to the utilisation of skilled birth attendance services (Wilunda et al 2014:8).

5.4.5.3 Lack of close follow-up during labour and delivery

The women claimed that they did not receive close follow-up during labour and delivery. Lack of close follow-up during labour and delivery exposed the health of the women and newborn. According to Nilsson, Thorsell, Wahn and Ekström (2013:4), inadequate support from the midwives during labour and delivery could lead to negative birth experiences. Women experienced a feeling of inadequate support when midwives were not present and did not help during labour and delivery.

5.4.5.4 Lack of compassionate care

The women experienced non-compassionate care from health workers and this created disappointment for them with the utilisation of skilled birth attendance services. According to Bohren et al (2015:18), women felt that they were “technically processed” and did not receive humanized or compassionate care. A study conducted in Ethiopia revealed that the overall prevalence of disrespect and abuse during childbirth was high (78.6%) (Asefa & Bekele, 2015:6). Ouédraogo, Kiemtoré, Zamané, Bonané, Akotiongaa and Lankoande (2014:S42) revealed that the study found several non-compassionate behaviours, including lack of respect for privacy, lack of intimacy, lack of information on the services offered, verbal violence and lack of informed consent.

5.4.5.5 Perceived misdiagnosis and mismanagement of obstetric complications

Misdiagnosis and mismanagement of obstetric complications put the lives of the participant women in danger and forced them to seek care from other private health facilities and this in turn predisposed them to unnecessary financial expenses.

Shimkhada, Solon and Peabody (2015:102) opine that the prevalence of obstetric complication misdiagnosis was substantially high and it could exacerbate the prognosis of the condition into significant morbidity and probably mortality. A study conducted in Tanzania noted that many substandard care factors were identified for the deceased women. Mismanagement of obstetric cases was one of the substandard care factors on the part of the medical service factors (Pembe, Paulo, D’mello & Roosmalen 2014:6). Mismanagement of obstetric patients was the most profound delay that occurred in health facilities and was associated with the severity of maternal outcomes (Pacagnella et al 2014:6).

5.5 REASONS FOR NOT UTILISING SKILLED BIRTH ATTENDANCE SERVICES

This theme dealt with the intricacy of the reasons for not utilising skilled birth attendance services. It discussed the reasons for not utilising skilled birth attendance services and further identified eight categories; namely, (1) Health facility related reasons; (2) Health worker related reasons; (3) Socio-cultural factors; (4) Fear, (5) HIV/AIDS-related issues;

(6) Individual factors; (7) Low early care seeking behaviour; 8) Distance and transportation services related problems.

5.5.1 Health facility related reasons

The experience of receiving poor services from health facilities, bad reputation of health facilities, the abandonment of women in labour and delivery rooms, and inhibition of women from doing things they wanted in health facilities were health facility related reasons mentioned by women for not utilising skilled birth attendance services.

Health facility and staff related factors were identified as influential for the low utilisation of health facilities for delivery (Roro et al 2014:6). Past experiences of women with health facilities such as interaction with health care providers, examinations, long waiting time and other issues had a substantial sway on the acceptability and utilisation of skilled birth attendance services (Akum 2013:6; Olayinka et al 2014:6).

5.5.1.1 Inhibition of mobility in health facilities

Inhibition of parturient mobility during labour deterred them from utilising skilled birth attendance services. According to Lugina, Mlay and Smith (2004:4), the mobility of parturient women during labour was not ubiquitously practiced in the study hospitals. More women were mobile at home after initiation of labour than in the labour wards of the study hospitals. Inhibition of women's movement may have adverse birth outcomes and may decrease women's satisfaction with their birth experiences (Storton 2007:25S). Conversely speaking, freedom of movement in labour appears to facilitate the progress of labour and enhances satisfaction of women with childbirth experiences (Shilling, Romano & DiFranco 2007:22; Storton 2007:25S).

5.5.1.2 Experience of receiving poor service from health facilities

The experience of receiving poor skilled birth attendance services from health facilities in previous deliveries was also one of the reasons for not utilising skilled birth attendance services. The women who experienced poor services from health facilities in previous deliveries thought the same thing could happen to them in health facilities. Hence, they were not interested in utilising skilled birth attendance services.

Okeshola and Sadiq (2013:81) submitted that the quality of services provided in the last delivery determined the place of delivery. Previous negative experiences at the health facilities were a reason for the women and their families' choosing not to deliver there. The women's or their families' perception of poor services at the health facilities discouraged them from giving birth in health facilities (Sychareun et al 2012:7).

5.5.1.3 Abandonment of women alone in labour and delivery room

The current study revealed that disallowing companions access to labour and delivery rooms and abandoning women deterred them from utilising skilled birth attendance services. Roro et al (2014:4) corroborated that the FGD participants discussed disallowing the presence of companions with labouring mothers at the heath facilities as one reason for home deliveries. According to Akum (2013:5), support, care, and companionship were highly cherished and valued by the participants. However, these were not always available in health facilities. The provision of support by companions of the women's choice during labour and delivery had positive effects on the women's satisfaction with the overall birth experience (Srivastava et al 2015:7).

5.5.1.4 Negative reputation of health facilities

The negative reputation about health facilities' service provision that prevailed in the communities prevented women from utilising skilled birth attendance services. The participant women thought that the provision of skilled birth attendance services in the health facilities was the same as what it used to be previously.

Studies conducted in low and middle-income countries revealed that previous experiences and perceptions of mistreatment, low expectations of the care provided at facilities, and poor reputations of health facilities in the communities have dwindled women's trust in the health system and negatively influenced the decision to bear a child in health facilities in the future (Bohren et al 2015:21). Mselle et al (2013:1) affirmed this in their conclusion that previous bad childbirth experiences in health facilities diminished the reputation of the health system, low community expectations of facility birth, and sustained high rates of home deliveries. Evidence suggested that the reputation was very important in healthcare decision making even in resource-

constrained settings. Thus, there was a need to redress the issues of quality and responsiveness to increase access to and utilisation of health services (Jacobsen, Ansumana, Abdirahman, Bockarie, Bangura, Meehan, Jimmy, Malanoski, Sundufu & Stenger 2012:307).

5.5.1.5 Unable to express emotions during labour in health facilities

The women claimed that they were not allowed to move in a way they wanted and received reprimands from health workers for shouting during labour. Inhibition of women to express their emotions during labour was also among the health facility related reasons for not utilising skilled birth attendance services.

Studies conducted in Bangladesh, Benin, Ghana, Nigeria, Tanzania and South Africa noted that maternity care providers ignored, dismissed or ridiculed the opinions of women when they expressed their needs or voiced their opinions (Mannava et al 2015:7). According to Bohren et al (2015:15), women's treatment by health workers was contingent on their ability or inability to remain silent throughout labour and delivery, or they were poorly treated in the maternity unit because of disobedience.

5.5.2 Health worker related reasons

5.5.2.1 Negative reputation of health workers

The prevailing negative reputation of health workers in the communities was also detrimental in the utilisation of skilled birth attendance services. The women reported that they were not interested in utilising skilled birth attendance services because of health workers who were unconcerned about the clients and the negative reputation of health workers in the communities.

Sialubanje, Massar, Hamer and Ruite (2015:7) recounted that the women who gave birth at home had a negative attitude towards nurses and health care providers because of mistreatment during prior maternity care. In a study conducted in Tanzania, women were chagrined with the attitude of maternity care providers and experienced feelings of neglect when they failed to receive attention and support from them. The husbands who had accompanied their wives to the health facilities during delivery resonated the

women's experiences of lack of support from health care providers during labour and delivery and blamed them for the negative birth outcomes. This concern was also shared by other community members (Mselle et al 2013:5-6).

5.5.2.2 Perceived misinformation on EDD from health workers

Women perceived misinformation on their EDD from health workers and failure to enlighten the meaning of EDD caused them not to utilise skilled birth attendance services. According to Alabi et al (2015:7), the miscalculation of EDD was cited as a reason for home delivery. Health care providers' failure to inform the women the meaning of expected date of delivery emerged as a barrier to access skilled delivery care. Women who started to have labour before the expected date of delivery often ended up giving birth at home, though they intended to deliver in health facilities (Magoma et al 2010:6). Women delivered at home or on the way to a health facility due to lack of knowledge on the expected date of delivery, or they could not prepare for health facility delivery because they were unable to predict the expected date of delivery (Onta et al 2014:6).

5.5.3 Socio-cultural factors

A myriad of socio-cultural factors were identified from the current study as reasons for not utilising skilled birth attendance services.

Gabrysch and Campbell (2009:3) in their literature review on the determinants of the utilisation of skilled delivery recounted that socio-cultural factors influenced women's health care decision-making. Cultural practices such as perpetuation of older generation practices were pinpointed as a reason for giving birth at home (Munjial, Kaushik & Agnihotri 2009:135).

5.5.3.1 Old traditions

The influence and practice of old traditions were also some of the socio-cultural factors for not utilising skilled birth attendance. Women tended to adhere to practicing the old traditions, previous trends and thinking; subsequently, they gave birth at home.

According to Sarker, Rahman, Hossain, Reichenbach and Mitra (2016:8), the participant women claimed that giving birth at home was a tradition. In another study conducted in Punjab, traditional attitudes were echoed as the most common reason for home delivery (Garg, Shyamsunder, Singh & Singh 2010:26). Home delivery was a traditional practice and custom and women would not go to health facilities for delivery unless they encountered problems (Roro et al 2014:4). Cultural factors strongly influenced women to perpetuate the tradition of home delivery (Gebrehiwot et al 2012:5).

5.5.3.2 Presence of families and relatives in home delivery

The presence of families and relatives during home delivery and the emotional support they got from them was also the reason for non-utilising skilled birth attendance service.

Roro et al (2014:4) opine that gathered to support, encourage, and pray for the parturient women wishing for safe childbirth in home delivery. Women in labour received physical and psychological support when they gave birth at home. Close relatives, other families and neighbours could easily visit women giving birth at home but giving birth in health facilities made this impossible (Sychareun et al 2012:5).

5.5.3.3 Ascendancy of old families and relatives

The older families and relatives influenced women not to utilise skilled birth attendance services and encouraged them to give birth at home. Besides, they created delays for the women to seek skilled birth attendance services notwithstanding women were interested in utilising skilled birth attendance services.

Gebrehiwot et al (2012:5) corroborated this in their study that the participant women explained that the decisions regarding where to give birth, whom to call, when and where to seek care in case of complications were influenced by elderly family members in the household. Women's dependence on their husbands for financial support and decision-making was reported as the main reason for the non-utilisation of skilled birth attendance services (Sialubanje et al 2015:5). The women's significant others, who had delivered at home, could influence their decision and would advise their daughters or daughters-in-law to give birth at home (Sychareun, Phengsavanh, Hansana, Somphet & Menorah 2009:22).

5.5.3.4 Household cultural beliefs and ceremonies as a cause of delay

The cultural beliefs and ceremonies that were practiced in the households of labouring women caused a delay for women to seek skilled birth attendance services and made them to give birth at home. Women claimed that there were cultural ceremonies such as repeated cooking of coffee and baking of “injera” being practised iteratively in the home of labouring women until the women gave birth. Some cultural and religious practices prevented women from accessing and utilising essential health care services (Baral et al 2010:329).

A qualitative study was conducted in Northern Ghana to explore the factors contributing to low institutional delivery coverage. The findings revealed that many cultural beliefs were practiced in the houses of parturient women and most women adhered to it. These beliefs were practised first even in situations where the women were encountering problems and if it ended up in vain, they turned to health facilities which in most cases was late (Akum 2013:5).

5.5.4 Fear

Fear of childbirth in health facilities, fear of medical procedures, and fear of death in health facilities were also deterrent factors for the utilisation of skilled birth attendance services.

5.5.4.1 Fear of childbirth in health facility

Fear of giving birth in a health facility was also the reason for not utilising skilled birth attendance services. The insertion of hands in the birth canal, exposing bare body, surgical operation, being left alone in the labour and delivery room, fear of death in health facilities, and feeling of shame were believed to be the source of fear for women not utilising skilled birth attendance services.

According to Devasenapathy, George, Jerath, Singh, Negandhi, Alagh, Shankar and Zodpey (2014:6), fear and embarrassment in relation to health facility childbirth were discerned to be the main reason for giving birth at home. The feeling of dread stemmed from being alone in odd surroundings and fear of surgical interventions. In addition, the

parturient women felt embarrassed and uncomfortable in the presence of strangers in the labour and delivery room. The provision of poor quality of care in public health facilities engendered fear of death, embarrassment, and lack of confidence (Otis & Brett 2008:49). According to Anastasi et al (2015:8), women indignantly accounted fear, shame, and maltreatment from health workers as barriers to health facility delivery. Furthermore, women also feared the unfamiliar and undesirable birth practices such as delivery positions and repeated vaginal examinations and mistreatment from health workers for relinquishing ANC cards (Bohren et al 2014:6).

5.5.4.2 Fear of medical procedures

Fear of medical procedures in health facilities deterred women from utilising skilled birth attendance services. The research noted that women feared repeated vaginal examination and surgical operation procedures in health facilities. Mahdi & Habib (2010:876) corroborated that fear of interventions and repeated examinations at hospitals were the main concern of women who preferred to give birth at home. Fear of cutting procedures such as episiotomy, caesarean section, and abdominal or perineal incision emerged as a deterrent to health facility delivery. This was due to perceived longer hospital stays, higher costs, perceived unjustified operations, social stigma, and potential problems with future sexual relations (Bohren et al 2014:7; Moyer & Mustafa, 2013:6; Sarker et al 2016:14; Sychareun et al 2012:6).

5.5.5 HIV/AIDS-related issues

5.5.5.1 Fear of disclosure of HIV status by health workers

The women perceived that fear of disclosure of HIV status by health facilities deterred them from utilising skilled birth attendance services. According to Bohren et al (2014:11), women's fear of the disclosure of their HIV status by health facilities was found to be a barrier for health facility childbirth which could result in social, psychological, physical, and economic consequences.

5.5.5.2 Women often visiting health facilities perceived HIV positive by the community

The FGD participants reported that the communities held the perception that women who often visited health facilities were HIV positive and this was identified to be a reason for not utilising skilled birth attendance services. Turan, Hatcher, Medema-Wijnveen, Onono, Miller, Bukusi, Turan and Cohen (2012:8) corroborated this in their findings that HIV-related stigma played a role for low skilled childbirth coverage. Moreover, the qualitative data unfolded the extent of strong community perceptions that childbirth in a health facility was apt to women with health problems such as HIV. This may have strengthened the perceptions of the communities that women who delivered in health facilities were more likely to be HIV positive.

5.5.6 Individual factors

5.5.6.1 Precipitated labour as perceived by women

The overwhelming FGD participants claimed that precipitated labour was the main reason for not utilising skilled birth attendance services. This finding was in congruence with studies conducted in Malawi, Nigeria, and Nepal (Kumbani 2013:5; Shehu, Ibrahim, Oche & Nwobodo 2016:98; Tuladhar, Khanal, Kayastha, Shrestha & Giri 2009:168).

5.5.6.2 Rumours and misconceptions about health facility delivery

Unfounded rumours and misconceptions about health facility delivery deterred women from utilising skilled birth attendance services. Some of the rumours and misconceptions with respect to health facility delivery were the women who indicated that giving birth in health facilities causes injuries to the birth canal and uterus. Besides, the participant women had misconceptions about the physical examination done during labour and delivery.

Roro et al (2014:3) reported that the study participants believed that every woman who gave birth in a health facility would undergo minor or major operations such as genital cutting, episiotomy, or caesarean section. Thus, women were deterred from giving birth in health facilities. Besides, women perceived that once a part of the genitalia was cut, it

would remain open and the problem would exist forever. Sarker et al (2016:14) also revealed that few of the study participants expressed their concern that if the visited the health facilities, the doctors would conduct caesarean delivery rather than trying the normal vaginal delivery. They also indicated that the surgery would cause physical harm to the women and for that reason, many women preferred home delivery.

5.5.6.3 Timing of initiation of labour

The participant women also indicated that the reason they were not giving birth in health facilities was that their labour started at night and it was inconvenient to arrange transportation services. Kumbani et al (2013:5), Sychareun et al (2012:6), and Sychareun et al (2009:25) corroborated in their studies that the labour started at night and families either did not want to travel to health facilities and gave birth at home or started off a journey to the health facility and gave birth in transit.

5.5.6.4 Lack of ANC follow-up during pregnancy

The current research established that lack of ANC follow-up during pregnancy was identified as a reason for not utilising skilled birth attendance services. Those women who had no ANC follow-up during pregnancy did not know their gestational age and their expected date of delivery. Furthermore, they did not receive health education concerning the importance of skilled birth attendance services.

Bohren et al (2014:6) submitted that women's lack of ANC attendance inhibits health facility childbirth. Some women may not feel at ease to give birth in health facilities if they have not attended ANC. Bayu, Fisseha, Mulat, Yitayih and Wolday (2015:6) revealed that lack of ANC attendance was an important predictor of home delivery. Mothers who had no ANC during the index pregnancy were twice as likely to deliver at home compared to those who attended ANC. However, having antenatal care check-up during pregnancy was identified to be a strong determinant of utilisation of skilled birth attendance services (Alemayehu & Mekonnen, 2015:4; Karkee, Lee & Binns, 2013:139; Worku et al 2013:6). The study reported that there was a strong association between ANC advice to deliver in health facilities and the subsequent delivery in a health facility. Women who reported having received this advice during their last pregnancies had

nearly three times the likelihood of delivering at a health facility, compared to those who reported not having received such advice during ANC (Anastasi et al 2015:8).

5.5.6.5 Refusal of women to expose bare body

Women refused to undress and expose their bare bodies for health care providers during labour and delivery. In addition to this, they refrained from utilising skilled birth attendance services. Roro et al (2014:5) and Sychareun et al (2012:7) affirmed in their studies that women were not comfortable and felt embarrassed when they were naked and exposed their genitals for examination by health care providers. The presence of a high number of health professionals coupled with the coyness of the women at being naked during delivery made them to prefer and opt for home delivery.

5.5.6.6 Experience of prior place of delivery

The findings of the current study showed that the previous place of childbirth influenced the utilisation of skilled birth attendance services in the subsequent pregnancies. Women who had no prior experience of giving birth in health facilities and those who had been giving birth at home did not use skilled birth attendance services.

The previous place of delivery was considered when selecting the place of delivery for subsequent births. Previous positive experiences with home delivery were the common reason to give birth at home. The participant women reported that they had some experiences of delivering at home in their previous deliveries. If the previous place of delivery was good, it was more likely that the same place of delivery could be used for their next births (Ntozi & Katusiime-Kabazeyo 2016:2872; Simfukwe 2011:20; Sychareun et al 2012:7).

5.5.6.7 Lack of knowledge on the importance of skilled birth attendance services

Lack of knowledge or awareness on the importance of skilled birth attendance services was also identified as a reason for not utilising skilled birth attendance services. The knowledge of women regarding the importance of skilled birth attendance services could influence whether the women perceived the need for health facility delivery. The

women did not have appropriate knowledge regarding the importance of maternal health services and the demerits of home delivery leading to home delivery (Karkee et al 2013:139; Sarker et al 2016:7; Shiferaw et al 2013:6).

5.5.7 Low early care seeking behaviour

5.5.7.1 Inexperience of danger signs and complications during labour and delivery

Women believed that they would seek skilled birth attendance services only when they encountered health problems and complications; otherwise, they would give birth at home. The participant women noted that they would have sought skilled birth attendance services if they faced health problems and complications during labour and delivery. Onta et al (2014:4) and Otis and Brett (2008:49) corroborated that women and their families did not think it was necessary to go to a health facility for normal delivery until and unless they experienced serious health problems. Thus, lack of biomedical understanding of the risks of obstetric emergency influences women's decision to give birth at home.

5.5.7.2 Delay to take labouring women to health facilities

The findings of the current study established that delay to take labouring women to health facilities was one of the reasons for not utilising skilled birth attendance services. According to Thaddeus and Maine (1994:1092), factors that affect the decision to seek health care embrace different actors involved in the decision making process, women's status, illness characteristic, distance from health facility, financial and opportunity costs, previous experiences with the health care system, and perceived quality of care. A qualitative study conducted in rural Gambia on the access to emergency obstetric care revealed that underestimation of the severity of complication, cultural beliefs, and previous deplorable experiences with the health care system emerged as reasons for delay in deciding to seek care (Cham et al 2009:4).

5.5.8 Distance and transportation service related problems

5.5.8.1 Distance and transportation service related problems

The participant women believed that far distances to health facilities, the unavailability of ambulance services, and late arrival of ambulances were also barriers to the utilisation of skilled birth attendance services. Gebrehiwot et al (2012:7), Onta et al (2014:4), Thaddeus and Maine (1994:1094), and Wilunda et al (2014:8) corroborated this finding in their studies that distance, poor road conditions, inadequate or inappropriate transport, and the unavailability of ambulance services made it difficult for the women to reach the health facilities.

5.6 FACTORS THAT INFLUENCED THE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICES

This theme dealt with the factors that influenced women to utilise skilled birth attendance services in previous deliveries. The availability of services, fear of occurrence and experiences of obstetric danger signs and complications, and services received by the women emerged as categories under this theme.

5.6.1 Availability of services

The availability of basic and essential services such as ambulance services, PMTCT services, referral services, and life-saving interventions influenced the women to utilise skilled birth attendance services in their previous deliveries.

5.6.1.1 Availability of ambulance services

The presence of ambulance services to transport labouring women from their homes to health facilities influenced them to utilise skilled birth attendance services in their preceding deliveries. According to Akum (2013:5), Baral et al (2010:327), Bhattacharyya et al (2013:4), and Karkee et al (2013:139), the availability of transportation services was found to be an important factor for the utilisation of maternal health services. Access to a vehicle as a mode of transport to the place of delivery was strongly associated with an increased likelihood of delivery with a skilled birth attendant (Kimani

et al 2015:3). Furthermore, women who knew the presence of free ambulance transportation services for the parturient were more likely to deliver in health institutions than women who did not know the availability of the services (Belda & Gebremariam 2016:8).

5.6.1.2 Availability of PMTCT service

The data showed that the availability of prevention of mother to child HIV transmission services in health facilities influenced women to utilise skilled birth attendance services in their previous deliveries. Owing to the availability of PMTCT services, the women sought skilled birth attendance services for childbirth whether they contracted HIV infections or not.

According to Hardon, Vernooij, Bongololo-Mbera, Cherutich, Desclaux, Kyaddondo, Ky-Zerbo, Neuman, Wanyenze and Obermeyer (2012:6), women were satisfied with the PMTCT services and valued its benefit because it helped to protect the health of the foetus and provided a gateway to treatment.

5.6.1.3 Availability of referral services

The availability of referral services in health facilities influenced the women to utilise skilled birth attendance services in their previous deliveries. The participant women reported that they gave birth in health facilities due because they could have received referral services if they faced health problems and complications. Akum (2013:6) supported the finding that women indicated referral service as an important aspect of quality maternal care.

5.6.1.4 Availability of life-saving interventions

The participant women noted that the availability of essential life-saving interventions in health facilities influenced them to utilise skilled birth attendance services in their previous deliveries. Gebrehiwot et al (2012:7) corroborated this in their findings that women appreciated the role of health facilities in dealing with delivery related complications and acknowledged the various medical services as life-saving interventions. Women also claimed that health facilities were better prepared to deal

with labour and delivery related complications than home deliveries (Mahiti et al 2015:5). Bhattacharyya et al (2013:5) revealed that the availability of health care providers and appropriate medical care in case of complications were valued as critical aspects of care and an important reason for preferring institutional delivery.

5.6.2 Fear of occurrence and experience of danger signs and complications

5.6.2.1 Experience of obstetric complications in previous deliveries

The current study found that the experiences of encountering obstetric problems and complications in previous childbirths influenced women to utilise skilled birth attendance service in their follow on pregnancies. According to Amoakoh-Coleman et al (2015:4), previous pregnancies and delivery complications were found to be significant predictors of the utilisation of skilled birth attendance services. Women were more likely to give birth in health facilities if they had previous obstetric complications (Bohren et al 2014:5).

5.6.2.2 Experience of obstetric danger signs and complications during pregnancy and childbirth

The findings of the current study showed that the women sought skilled birth attendance services because they experienced obstetric danger signs and complications during pregnancy and childbirth. To this end, many participant women reported that they went for skilled birth attendance services when their labour had prolonged at home. According to Sychareun et al (2012:5), the only reason the women gave for giving birth in health facilities were the medical knowledge and skills of trained skilled birth attendants and their ability to assist them in case of the occurrence of obstetric complications. The odds of the utilisation of skilled birth attendance services among mothers who did encounter complications were more likely to deliver with the assistance of skilled birth attendants than women who did not encounter obstetric complications (Alemayehu & Mekonnen 2015:5; Moyer & Mustafa 2013:6).

5.6.2.3 Fear of health problems and obstetric complications

The study revealed that women utilised skilled birth attendance services because of fear of the occurrence of unanticipated health problems and obstetric complications resulting from home delivery and the sequel of many years of using injectable contraceptives. Mengesha et al (2013:4) indicated that family planning users were more likely to utilise skilled birth attendance services as compared to those who did not. According to Bhattacharyya et al (2013:4), women who had previously given birth at home would prefer to have institutional delivery for the next child, as doctors and nurses were in a better position to assess the condition of the child and mother. The women felt more secure at the facilities as there was the assurance of appropriate medical care in case of any emergency.

5.6.3 Services received

This section dealt with the various types of services received by women that influenced them to utilise skilled birth attendance services.

5.6.3.1 Information and advice

The data indicated that the information and advice provided by health care providers regarding the importance of utilising skilled birth attendance services, the various types of service rendered during health facility deliveries, and about the risks associated with home deliveries influenced them to utilise skilled birth attendance services. The women received advice to deliver in health facilities during ANC and this was associated with the likelihood of health facility delivery (Moyer & Mustafa 2013:8). Women also valued the information received from health workers with regard to the health of the women and newborns (Gebrehiwot et al 2012:7). Mahiti et al (2015:5) reveal that women received advice from health workers on how to use routine services, on the danger signs and on the importance of delivering in health facilities.

5.6.3.2 Having ANC follow-up

The women reported that having regular antenatal care follow-up during pregnancy influenced them to utilise skilled birth attendance services during childbirth. They said

that they received information and advice on maternal and newborn health, different preventive and treatment services during ANC care which in turn, made them to seek skilled birth attendance services. This was corroborated by Mengesha et al (2013:4); Kawakatsu et al (2014:6) and Tsegay et al (2013:5) corroborated this in their studies that receiving antenatal care visits was significantly associated with health facility delivery.

5.6.3.3 Ensuring the health of the women and newborn

Ensuring the health of the women and the newborn was also identified as a factor that influenced women to utilise skilled birth attendance services. This finding was supported by Mahiti et al (2015:5) supported the finding that women recognised the benefits of maternal health services as they provided different investigations and treatment services to ensure the health of the women and newborns. Furthermore, the women felt safe and secure when assisted by skilled birth attendants at health facilities during delivery (Gebrehiwot et al 2012:7).

5.6.3.4 Detection and management of unforeseen obstetric complications

The current study revealed that the interventions received to detect and manage unforeseen obstetric complications influenced the utilisation of skilled birth attendance services. According to Gebrehiwot et al (2012:4), women considered health facilities better organized to deal with obstetric complications when they occurred because there was nothing or little that could be done at home. The presence and availability of detection and management of obstetric complications served as a critical component of good delivery care and an imperative reason to opt for health facility delivery (Bhattacharyya et al 2013:4).

5.7 FACTORS THAT MOTIVATE WOMEN TO UTILISE SKILLED BIRTH ATTENDANCE SERVICES IN THE CURRENT AND FUTURE PREGNANCIES

This theme dealt with factors that would motivate women to utilise skilled birth attendance services in future pregnancies.

5.7.1 Good interpersonal care

Good interpersonal care and receiving information and advice from health care providers were identified as factors that would motivate women to utilise skilled birth attendance services in future pregnancies.

5.7.1.1 Information and advice on maternal and newborn health

The study reported that the information and advice on maternal and newborn health they received from health care providers would motivate them to utilise skilled birth attendance services in future pregnancies. According to Sword et al (2012:6), women and health care providers commended the importance of health promotion advice to encourage and practice healthy behaviours. Besides, receiving health information during prenatal check-up was found to be associated with the utilisation of skilled birth attendance services (Tsegay et al 2013:5).

5.7.1.2 Interpersonal care

Good interpersonal care from health care providers would motivate the women to utilise skilled birth attendance services in their future pregnancies. It was indicated that a friendlily service and close follow-up from health workers would encourage them to utilise skilled birth attendance services. To this end, the presence of health care providers who are respectful, caring, friendly, helpful and sympathetic was an important factor in encouraging the demand for maternal health care (Mannava et al 2015:7). According to Akum (2013:5), women expressed their interest to have staff with a positive attitude in order to utilise skilled birth attendance services. Bhattacharyya et al (2013:4) also revealed that good interpersonal care was a critical component of good delivery care.

5.7.2 Availability of services

The current study established that the availability of ambulance services, referral services, and women friendlily services would motivate women to utilise skilled birth attendance services in their future pregnancies.

5.7.2.1 Availability of ambulance service

The availability of ambulance services for labouring women would motivate women to utilise skilled birth attendance services in future pregnancies. Ssebunya and Matovu (2016:8) supported this in their findings that the community members appreciated the availability and use of motorcycle ambulances to transport pregnant women to health facilities. Women who knew the availability of free ambulance services were more likely to deliver in health facilities than those who did not know (Belda & Gebremariam 2016:8).

5.7.2.2 Availability of referral services

The participant women indicated that the availability of referral services would encourage women to utilise skilled birth attendance services in their future pregnancies. They claimed that they could use referral services in circumstances where they faced health problems and obstetric complications. Hulton et al (2000:21) indicated that an effective and efficient referral system was very crucial to prevent maternal and newborn morbidity and mortality.

5.7.2.3 Availability of women friendlily services

The participant women indicated that the availability of cultural ceremonial practices such as coffee and porridge preparation and provision of clothes for newborn in health facilities would motivate women to utilise skilled birth attendance services in the current and future pregnancies. Furthermore, the provision of client friendlily services would also encourage women to utilise skilled birth attendance services in the current and future pregnancies. Bruce, Blanchard, Gurav, Roy, Jayanna, Mohan, Ramesh, Blanchard, Moses and Avery (2015:4-5) corroborated that social and cultural acceptability of health facilities was a key aspect of quality care and influenced their choice of the place of delivery. In addition, women would prefer to give birth in delivery places where incentive schemes were available.

5.7.3 Health problems and complications in previous delivery

5.7.3.1 Experienced health problems and difficulties in previous home deliveries

The findings of the current study revealed that experiencing health problems and childbirth related difficulties in previous home deliveries would motivate women to utilise skilled birth attendance services in the current and future pregnancies. Gebrehiwot et al (2012:7) indicated that previous negative home delivery experiences when women faced life threatening complications, made them to recognise medical services in their next pregnancies and childbirth. Bohren et al (2014:5) claimed that previous delivery experiences or birth outcomes would inform their future delivery location. A woman is more likely to give birth in a health facility if she had negative previous delivery experiences or birth outcomes.

5.7.4 Use of skilled birth attendance services in previous childbirth

5.7.4.1 Use of skilled birth attendance services in previous delivery

The utilisation of skilled birth attendance services in previous deliveries would motivate women to use skilled birth attendance services in the current and future pregnancies. According to Moyer and Mustafa (2013:5), previous delivery location predicted subsequent delivery location. Women who previously delivered with a skilled attendant would become more familiar with the medical setting, which would make them more likely to use it again (Gabrysch & Campbell 2009:10). History of hospital childbirth was found to be associated with the utilisation of skilled birth attendance service during (Adewemimo et al 2014:e10).

5.7.5 Preventive and treatment services

Under this category, the prevention of diseases and treatment services, proper care for the women and newborn and ensuring their health, detection and management of obstetric complications emanated as motivating factors to utilise skilled birth attendance services in the current and future pregnancies.

5.7.5.1 Prevention and treatment of diseases

The participant women claimed that they would utilise skilled birth attendance services in the current and future pregnancies in order to get preventive and treatment services for disease conditions. Mahiti et al (2015:5) recounted that the women recognised the importance of skilled birth attendance services as they provided various investigations and treatment of diseases such as malaria and HIV. The study also noted that one importance of skilled birth attendance services was to attend pre-existing health conditions (Sword et al 2012:7).

5.7.5.2 Proper care for woman and newborn

In order to get proper care for the newborns and women from health facilities, the women would utilise skilled birth attendance services in the current and future pregnancies. Gebrehiwot et al (2012:7) revealed that women appreciated the various interventions provided by health care providers in health facilities during pregnancy and delivery such as abdominal examination, checking blood pressure and checking the foetal heartbeat.

5.7.5.3 Ensuring the health of women and newborn

The women claimed that they were intending to utilise skilled birth attendance service in the current and future pregnancies in order to ensure the health of the mother and the newborn. Bhattacharyya et al (2013:7) corroborated this in their findings that women would prefer to give birth in health facilities for the next child because the health care providers were in a better position to asses and ensure the health of the mother and children. Furthermore, they felt more secured in health facilities, as there was assurance of appropriate medical care in case of any emergency.

5.7.5.4 Detection and management of obstetric health problems and complications

The participant women reported that the availability of early detection and management of obstetric health problems and complications in the health facilities could motivate them to utilise skilled birth attendance services in the current and future pregnancies.

According to Bhattacharyya et al (2013:7), the availability of trained health workers and medicines to detect and manage obstetric complications was a critical aspect of care and an important reason to utilise skilled birth attendance services in the next childbirth. Sychareun et al (2012:7) indicated that the skill and medical knowledge of trained health care providers in health facilities and their ability to assist women in case of obstetric complications was a reason to utilise skilled birth attendance services in future pregnancies.

5.7.6 Fear of obstetric danger signs and complications

5.7.6.1 Fear of obstetric danger signs and complications

Fear of occurrence of obstetric danger signs and complications could motivate women to utilise skilled birth attendance services in the current and future pregnancies. The participant women indicated that they would like to give birth in health facilities in the current and future pregnancies since they had been using modern family planning methods for a long time. Therefore, they perceived that their birth canal might get constricted and, as a result, they feared they could develop obstetric danger signs and complications. Bohren et al (2014:8) and Gabrysch and Campbell (2009:10) reaffirmed that women who had a higher perceived risk may desire facility delivery in the subsequent pregnancies.

5.8 COMMUNITY SUPPORT FOR WOMEN TO UTILISE SKILLED BIRTH ATTENDANCE SERVICE

This section discussed the support that community members were providing for the women to utilise skilled birth attendance services. The community members have been providing various types of support for the women to utilise skilled birth attendance services. The support included facilitation, support related to household activities, transportation service support, advice and encouragement. Marston, Renedo, McGowan and Portela (2013:3) defined community participation as a strategy that provided people with a sense that they could solve their problems through careful reflection and collective action. It has many social and health benefits and it facilitates many positive outcomes.

5.8.1 Facilitation

The communities played a facilitative role for labouring women by calling for ambulance services and informing health extension workers about labouring women.

5.8.1.1 Call for ambulance service

The study established that the communities called the ambulance services when women started to be in labour in their neighbourhood or locality. Jackson, Tesfay, Godefay and Gebrehiwot (2016:10) corroborated this in their findings that the community called the HEWs either in person or through telephone so that they called an ambulance to transport the parturient women to health facilities.

5.8.1.2 Informing HEWs about labouring women

The study noted that the community members have been notifying the HEWs about labouring women in their neighbourhood or locality. The communities immediately informed the HEWs, particularly when the women started to have labour in circumstances where no one was available in the household of the labouring women. Jackson et al (2016:9) recounted that the community members, particularly women development groups, notified the HEWs when women started to have labour.

5.8.2 Support related to household chores

The findings of the current study showed that the communities provided support for the women with regard to household chores by taking care of the other children at home, managing household assets and activities, and preparation of food and other cultural ceremonies.

5.8.2.1 Looking after other children at home

The findings revealed that the community took care of the other remaining children at home when the women went for skilled birth attendance services in the health facilities. Furthermore, the community members and neighbours took care of the women at home after they gave birth and back to their homes. Magoma et al (2010:6) supported this

finding in their study that the children who remained at home were looked after by relatives or neighbours in the absence of their mothers.

5.8.2.2 Managing household assets and activities

The FGD participants indicated that the community was managing and protecting the household assets such as cattle and other resources while the women visited health facilities for skilled birth attendance services. The study also noted that the neighbours were responsible for managing the household activities. No article was identified to support this finding.

5.8.2.3 Preparation of food and other cultural ceremonies

The FGD participants revealed that the community supported the women to utilise skilled birth attendance services through the preparation of food and other cultural ceremonies in their households. Besides, they provided food for the delivered women and for companions who accompanied the labouring women. No article was identified to support this finding.

5.8.3 Transportation service support

5.8.3.1 Transportation of women to and from health facilities through carrying

The study indicated that the community transported the women to the health facilities and back to their homes through carrying in circumstances when there was no access to ambulance services. Onta et al (2014:4) revealed that community groups helped to arrange transportation for pregnant women to reach health facilities. A study conducted in rural Ghana, found that the community members transported, referred, and accompanied pregnant women to health facilities for skilled birth attendance services (Evelyn, Lois, Judith, Henry, Kojo & Samuel 2014:4-5). The husbands of the women also organised a group of women to carry the women on a stretcher to the main road where the ambulance or transportation vehicle could be accessed (Jackson et al 2016:10).

5.8.4 Advice and encouragement

The data revealed that the community members provided advice and encouragement for the women regarding the importance and utilisation of skilled birth attendance services.

5.8.4.1 Advice and encouragement

The participants claimed that they have received advice from the community on the benefits and utilisation of skilled birth attendance services. Moreover, the study also indicated that the community members encouraged the women to utilise skilled birth attendance services. Jackson et al (2016:9) and Kok, Kea, Datiko, Broerse, Dieleman, Taegtmeyer and Tulloch (2015:4) reported that women development groups provided information for pregnant women about ANC and the need to give birth at health facilities.

5.9 PERCEIVED BENEFITS OF SKILLED BIRTH ATTENDANCE SERVICE

The major issues that emerged from the data regarding the perceived benefits of skilled birth attendance services were advice and information, disease prevention and treatment, ensuring the health of the women and newborn, good newborn care practices, prevention and management of obstetric and neonatal danger signs and complications.

5.9.1 Information and advice on maternal and newborn health

5.9.1.1 Information and advice on maternal and newborn health

The findings of the current study indicated that women believed that skilled birth attendance services could enable them to have information and advice on maternal and newborn health. This, in turn, enhanced the women's knowledge of the benefits of skilled birth attendance services and the risks associated with not utilising skilled birth attendances services during childbirth. Contact with skilled birth attendants could increase the knowledge of women on childbirth through health education. Therefore, specific knowledge about the risks of childbirth and the benefits of skilled attendance

could increase preventive care seeking, while recognition of danger signs and knowledge about available life-saving interventions increased care seeking for complications (Gabrysch & Campbell 2009:8). Mahiti et al (2015:5) accounted that women perceived maternal health services as beneficial as they received health education on reproductive, nutrition, danger signs, and the importance of skilled birth attendance services.

5.9.2 Good newborn care practices

5.9.2.1 Good newborn care practices

The findings of the current study noted that good newborn care practises were also perceived benefits of skilled birth attendance services. The participants indicated that newborns could receive proper thermal care, cord care, protected from harmful traditional practises, and vaccinations if women utilised skilled birth attendance services. Kumbani et al (2013:4) rated care as being good when the delivery process went well and had healthy children.

5.9.3 Ensure health of women and newborn

5.9.3.1 Ensure the health of women and newborn

The findings of the study revealed that ensuring the health of the women and newborn was a benefit for skilled birth attendance services. Bhattacharyya et al (2013:4) indicated that women would utilise skilled birth attendance services in future pregnancies to ensure the health of the women and the newborn.

5.9.4 Disease prevention and treatment services

5.9.4.1 Disease prevention and treatment services

The findings indicated that one of the perceived benefits of skilled birth attendance services was disease prevention and treatment services for the mother and newborn. The study noted that women and newborns could be protected from diseases such as tetanus, HIV/AIDS, and so on. Mahiti et al (2015:5) recounted that women were

recognised as beneficiaries as they received various preventive and treatment interventions.

5.9.5 Prevention and management of obstetric and neonatal danger signs and/or complications

5.9.5.1 Prevention and management of obstetric and neonatal danger signs and complications

The findings indicated that prevention, early detection, and management of obstetric and neonatal danger signs and complications were purported as some of the women's perceived benefits from skilled birth attendance services. To this end, the majority of the participants revealed that skilled birth attendance services benefit women and newborn through prevention, early detection and management of post-partum haemorrhage, prolonged labour, hypertension, and neonatal asphyxia. Bhattacharyya et al (2013:4) and Gebrehiwot et al (2012:7) corroborated this in their findings that skilled birth attendance services enabled the women to receive life-saving interventions whenever obstetric and neonatal complications arouse.

5.10 STRATEGIES IMPLEMENTED TO IMPROVE THE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICES

The findings of the current study revealed that various strategies have been implemented to improve the utilisation of skilled birth attendance services. Each strategy is discussed in detail below.

5.10.1 Creating awareness

Various strategies and approaches have been implemented to raise the awareness of the communities regarding the different aspects of skilled birth attendance services. In concert with this, health education and advice, family conversations, pregnant women's conferences, social mobilisation and advocacy are the strategies that were implemented in this regard.

5.10.1.1 Health education and the provision of advice

The health workers reported that health workers, political leaders, religious groups, and other stakeholders have undertaken health education and the provision of advice at various circumstances and opportunities. Gitimu, Herr, Oruko, Karijo, Gichuki, Ofware, Lakati and Nyagero (2015:7) posited that health education and behavioural change communication strategies needed to be enhanced to increase the demand for skilled delivery. Anastasi et al (2015:7) submitted that strengthening health education and sensitisation among women, families, and communities could improve the utilisation of skilled birth attendance services. Strengthening health promotion and education programmes were recommended to improve the awareness of the community about skilled birth attendance and rectify cultural barriers (Onta et al 2014:5).

5.10.1.2 Family conversations

The findings indicated that family conversations were viewed as a strategy to raise the awareness of key family members, neighbours and other community groups with regard to pregnancy care, birth preparedness and complication readiness, skilled birth attendance services, and newborn care. The study further indicated that family conversations were conducted, involving pregnant women, husbands, mothers-in-law, fathers-in-law, 1 to 5 network leaders, TBAs, and neighbours. The key issues discussed during family conversations included the care that the pregnant women should get, birth preparedness and complication readiness, planning for a place of delivery, identifying skilled birth attendants, and newborn care. This forum was facilitated by health workers and women's health development team leaders. The Last Ten Kilometres Project (2015:30) confirmed that family conversations were conducted by HEWs or health development armies or both, with key decision makers of the household of the pregnant women to reinforce birth preparedness, improve utilisation of skilled delivery, and essential newborn care.

5.10.1.3 Pregnant women's forum

The pregnant women's forum was one of the strategies employed to improve the awareness of the community on the utilisation of skilled birth attendance services. The findings revealed that pregnant women's conferences were conducted in most of the

kebeles once per month. Health workers, specifically midwives and health extension workers moderated them. The activities, which were conducted during the pregnant women's conferences were the provision of health education, out-reach ANC, and PMTCT services. According to Elmusharaf, Byrne and Donovan (2015:7), community participation and community based health interventions were crucial for the universal access to health care and for improving maternal and newborn health. One approach to do this was female health workers, who organised group sessions at the community level to promote antenatal care, use of clean kits at delivery, institutional delivery, newborn care, danger signs identification and promotion of health-seeking behaviour. Community based interventions positively impacted maternal and neonatal health (Marston et al 2013:3-4).

5.10.1.4 Social mobilisation and advocacy

Social mobilisation and advocacy emerged as a strategy in the analysis of the data to raise awareness of the community regarding the utilisation of skilled birth attendance services. The findings of the study noted that case presentations, maternal deaths that occurred in the locality, promotion of ambulance services, and provision of quality services were used as social mobilisation and advocacy tools. Roro et al (2014:6) corroborated this in their conclusions that strengthening social mobilisation and the creation of community awareness about the importance of skilled birth attendance service was imperative to improve the utilisation of skilled birth attendance services.

Morrison,Thapa,Hartley,Osrin,Manandhar,Tumbahangphe,Neupane,Budhathoki,Sen,Pace, Manandhar and Costello (2010:31-32) reported that women's group members shared key health information during their interactions with friends, neighbours and community meetings and raised the awareness of the community on maternal and newborn health. Kebele administrators, religious leaders, and elders were involved to support the maternal health advocacy and communication with the community (Kok et al 2015:6).

5.10.2 Incentives and repercussions

5.10.2.1 Monetary fine

Monetary fine emerged as a strategy to improve the utilisation of skilled birth attendance services. The communities agreed and proposed monetary fine for husbands and family members who let their wives give birth at home. Jackson et al (2016:10) revealed that disincentives have been put in place to hold husbands responsible if they disallowed their wives to go to health facilities for delivery.

5.10.2.2 Provision of non-monetary incentives

The research reported that the provision of non-monetary incentives was implemented to improve the utilisation of skilled birth attendance services. The participants claimed that the women who completed ANC follow-up and gave birth in health facilities received incentives in the form of certificates of recognition, mama kits and soap. Ediau, Wanyenze, Machingaidze, Otim, Olwedo, Iriso and Tumwesigye (2013:7) corroborated this finding that there was a considerable increase in the number of pregnant women delivering in the health facilities with the provision of mama-kits during childbirth.

5.10.3 Early pregnancy identification and follow-up

5.10.3.1 Early pregnancy identification and follow-up

Early identification of pregnancy was very critical to determine the pregnant women's expected date of delivery and closely follow them until childbirth. It enabled pregnant women to have basic health and counselling services as per the recommended ANC visit schedules. Jackson et al (2016:9) opine that early identification and follow-up of pregnant women through health extension workers and women development groups facilitated the utilisation of skilled birth attendance services.

5.10.4 Use of community development groups

5.10.4.1 Use of women health development army teams

One to five social networks and the team-leaders of the women's health development team played a significant role in improving the utilisation of skilled birth attendance services. The women's health development teams interacted with pregnant women and conveyed key health messages, early identification of pregnant women and referral to the HEWs, mobilising pregnant women for conferences and other interventions, notifying labour to the HEWs and calling for ambulance services. Women development groups provided information to the communities about ANC and the need to give birth in health facilities (Jackson et al 2016:9). Mushi, Mpembeni and Jahn (2010:8) concluded that the utilisation of community volunteers to follow-up pregnant women could substantially improve the utilization of skilled attendance at delivery. Hence, women's groups practising participatory learning and action approach enhanced the demand for ANC and skilled birth attendance services and improved birth outcomes (Elmusharaf et al 2015:6).

5.10.5 Transcending transportation barriers using local solution

The use of locally made stretchers (traditional ambulances) emerged as a strategy to surmount transportation barriers that often hampered the women from utilising skilled birth attendance services.

5.10.5.1 Use of locally made stretchers (traditional ambulance)

It was reported that the communities prepared and used locally made stretchers (traditional ambulances) in situations where there was a problem of transportation services and road accessibility. The locally made stretchers (traditional ambulances) were used to transport labouring women from villages to transportation access points and health facilities, and returned them to their homes after childbirth. In order to overcome the geographical inaccessibility and improve accessibility of health facilities, Onta et al (2014:5) recommended the utilisation of stretchers. Jackson et al (2016:9) also noted that the community members used stretchers to carry the pregnant women to the main road.

5.10.6 Labour notification system

5.10.6.1 Telephone communication as an avenue to labour notification

Women and families used telephone communication to notify labour for midwives, HEWs, and the women's health development army teams. The midwives and HEWs provided their telephone numbers and ambulance driver's telephone numbers to the pregnant women. The pregnant women or their families could call to either of them for labour notification. Jackson et al (2016:9) corroborated that families of pregnant women made a telephone call to notify labour. Lund et al (2012:1260) revealed that mobile phone intervention as a health communication tool was associated with an increase in skilled delivery attendance.

5.10.7 Exploration of reasons for home delivery for action

5.10.7.1 Exploration of reasons for home delivery for action

The participants reported that finding reasons for not utilising skilled birth attendance services and rectifying identified problems was one of the strategies to improve the utilisation of skilled birth attendance services. In cases where a woman gave birth at home, either midwives or HEWs visited the home of the woman to find the reasons for not utilising skilled birth attendance services. No article was identified to support this finding.

5.11 CHALLENGES OF OFFERING SKILLED BIRTH ATTENDANCE SERVICES IN HEALTH FACILITIES

This theme dealt with the challenges of offering skilled birth attendance services in health facilities.

5.11.1 Barriers to transportation service

Bad terrains, road inaccessibility, distance to health facilities, problem of ambulance services, and lack of transportation services to return women home after delivery were identified as barriers to offer skilled birth attendance services.

5.11.1.1 Bad terrain and road inaccessibility

Bad terrain and road inaccessibility were reported as some of the challenges related to transportation services to offer skilled birth attendance services. The participants indicated that there were areas where the women could not be transported to health facilities using ambulance services due to bad terrains and road the inaccessibility of the roads. This finding was supported by Roro et al 2014:4), Onta et al (2014:4) and Otis and Brett (2008:49).

5.11.1.2 Distance to health facility

The distance to health facilities was a challenge to offering skilled birth attendance services. The study noted that women residing in remote areas were not utilising skilled birth attendance services. Okeshola and Sadiq (2013:83), Sychareun et al (2012:6) and Shehu et al (2016:99) corroborated this in their findings that distance to health facilities was an obstacle to health facility delivery.

5.11.1.3 Problem of transportation service

Problems related to transportation services were identified to be a challenge to offer skilled birth attendance services. The research indicated that the unavailability of transportation services and shortage of ambulance services caused a problem to offer skilled birth attendance services. Lerberg et al (2014:38), Munjial et al (2009:137), Sarker et al (2016:13) and Sychareun et al (2012:6) supported this finding that lack of transportation services was a barrier to delivering at health facilities.

5.11.2 Health facility infrastructure related barrier

Shortage of beds and rooms, lack of electricity and water supply, and the unavailability of maternity waiting homes emerged as challenges to offer skilled birth attendance services. Inadequate health infrastructure and logistics engendered serious challenges to provide skilled birth attendance services (Onta et al 2014:5).

5.11.2.1 Shortage of beds

The shortage of beds was identified as a challenge to offer skilled birth attendance services. Women were forced to lie down and rest on the delivery couches and chairs after they gave birth in health facilities due to shortage of beds. Furthermore, women who stayed close to the health facilities, were told to go and stay in their homes until the progress of labour had advance and some women were reported giving birth at home. Onta et al (2014:5) revealed that the lack of beds resulted in the immediate discharge of women and their babies following delivery. Inadequate beds compelled mothers and children to sleep on the floor. The availability of single beds caused problems in case more than one mother was to be attended at a time (Wilunda et al 2014:6).

5.11.2.2 Shortage of rooms

Shortage of rooms emerged as a challenge to offer skilled birth attendance services in health facilities. Onta et al (2014:5) indicated that the room and the waiting areas in the health facilities were inadequate to provide skilled birth attendance services and this resulted in the immediate discharge of mothers and newborns following delivery. Women, who presented with labour and their cervix not yet dilated, were sent back to home because of the small maternity rooms and the lack of space to accommodate everyone (Akum 2013:6).

5.11.2.3 Lack of electric power and water supply

Lack of electric power and water supply in health facilities was a challenge to offer skilled birth attendance services. The participants indicated that lack of electric power supply caused a problem to offer skilled birth attendance services particularly at night and a broad range of other services. Wilunda et al (2014:6) corroborated that the lack of

light at night and water supply were the reasons for the women not utilising health facilities and the quality of care was perceived to be poor in these facilities.

5.11.2.4 Unavailability of maternity waiting homes

The unavailability of maternity waiting homes was reported as one of the challenges to offer skilled birth attendance services. There was no maternity waiting homes for women who visited the health facilities in advance and stayed there before their labour initiates. The absence of maternity waiting homes in health facilities was a main barrier to give birth in health facilities (Sialubanje et al 2015:7).

5.11.3 Shortage of equipment and supplies

5.11.3.1 Unavailability of vacuum extractors

The participants reported that the unavailability of vacuum extractors in health facilities was a challenge to offer vacuum assisted delivery. According to Kreyberg and Helsingen (2010:16), the majority of health workers reported a shortage of essential materials such as vacuum extractors and this made it difficult for them to do their job satisfactorily. According to Essendi, Johnson, Madise, Matthews, Falkingham, Bahaj, James and Blunden (2015:7), the shortage of basic supplies and equipment impaired the provision of basic maternal and newborn care services.

5.11.3.2 Shortage of delivery couches

Data from the current study showed that the shortage of couches was also a challenge to offer skilled birth attendance services in health facilities, particularly when two or more labouring women visited health facilities for skilled birth attendance services at a time. Lack of delivery beds and bed sheets were a problem in the peak seasons of deliveries (Kreyberg & Helsingen 2010:16).

5.11.3.3 Incomplete personal protective infection prevention material

Some participants in the current study indicated that they experienced shortages of personal protective infection prevention materials such as aprons, eye goggles, mouth

masks, and heavy-duty gloves to offer skilled birth attendance services. Wasswa, Nalwadda, Buregyeya, Gitta, Anguzu and Nuwaha (2015:5) corroborated this in their findings that health facilities often experienced shortage of supplies essential for infection prevention and control.

5.11.4 Effects of poor health facility infrastructures and the shortage of essential equipment on the utilisation of skilled birth attendance

5.11.4.1 Effects of the unavailability of vacuum assisted delivery on referral services

The study reported that women were referred to other health facilities where vacuum extractor equipment was available in circumstances where the women needed vacuum assisted delivery services. Women were prone to unnecessary referrals to other similar capacity or higher health facilities due to the unavailability of functional vacuum extractors. As a result, the confidence and trust of the women on health facilities dwindled. Kreyberg and Helsingen (2010:26) supported that the unavailability of essential equipment such as vacuum extractors in health facilities could result in inappropriate treatment, delay, unnecessary referrals or life threatening situations. Poorly equipped health facilities were unable to manage obstetric complications; hence, women experiencing complications were referred to other health facilities (Essendi, Mills & Fotso 2010:S364).

5.11.4.2 Effects of the unavailability of electric power supply on service provision

The unavailability of electric power supply resulted in health facilities not undertaking basic laboratory investigations; and the health workers had difficulties providing skilled birth attendance services at night. Furthermore, the communities perceived that health facilities did not provide good skilled birth attendance services particularly at night. The lack of electricity impeded the provision of any of the nine CEmONC signal functions. To this end, intravenously administered drugs including uterotonics, were not available at the facilities since they were required to be stored in refrigeration that required electricity. Furthermore, resuscitation and assisted delivery could not be performed at

the facilities due to the lack of oxygen masks and suction machines, which also required electricity to function (Essendi et al 2015:7).

5.11.4.3 Effects of the unavailability of maternity waiting homes on the utilisation of skilled birth attendance services

The unavailability of maternity homes was one of the challenges to offer skilled birth attendance services. The women did not utilise skilled birth attendance services because health facilities did not have maternity waiting homes where women visited health facilities in advance to give birth there. Sialubanje, Massar, Hamer & Ruite (2015:7) affirmed that the absence of maternity waiting homes was one of the main barriers for not giving birth at health facilities.

5.11.4.4 Effect of lack of drop back transportation services on the utilisation of skilled birth attendance services

The participants in the current study asserted that the women did not receive returning transportation services after giving birth in health facilities. As a result, the women resented it and complained that they were bleeding and hurt. They became sceptical of the benefits of utilising skilled birth attendance services if they did not receive return transportation services after childbirth. No literature was identified to support this finding.

5.11.5 Staff related challenges

5.11.5.1 Presence of BEmONC untrained staffs

In the current study, some of the participants claimed that the midwives in their health facilities did not receive training on basic emergency obstetric and newborn care (BEmONC) to offer quality skilled birth attendance services. Kreyberg and Helsingen (2010:27) revealed that most of the interviewed staff expressed the need for additional in-service training for proper and effective detection, management, and referral of critical emergency obstetric situations.

5.11.6 Culturally insensitive services

The absence of cultural ceremony practices in health facilities was identified as a challenge to offer skilled birth attendance services.

5.11.6.1 Absence of cultural practices in health facilities

The findings revealed that the absence of cultural ceremony practices in health facilities such as porridge preparation and coffee ceremonies caused a challenge in the offering of skilled birth attendance services and this contributed to the low skilled delivery coverage. Furthermore, it the study indicated that there was no organised place to rest for companions who brought the labouring women to the health facilities; some of them were barred from entry into the health facility compounds. Alemayehu and Mekonnen (2015:1) opine that the inability to perform cultural practices in health facilities was a barrier to delivering in health facilities.

5.12 CONCLUSION

This chapter presented and discussed the perceptions and experiences of the communities in the utilisation of skilled birth attendance services. This section brought a plethora of issues regarding the perceptions and experiences of the utilisation of skilled birth attendance services that needed to be addressed. These issues include the discussion of the following: skilled birth attendance services (SBA) that created good experiences, causes of disappointment of women with the utilisation of SBA services, reasons for not utilising SBA services, factors that influenced the utilisation of SBA services, factors that would motivated women to utilise SBA services in the future, perceived benefits of SBA services, community support for women to utilise SBA services, challenges of offering of SBA services, and strategies for the improvement of the utilisation of SBA service.

The next chapter will present strategies to improve the utilisation of skilled birth attendance services in Ethiopia.

CHAPTER 6

STRATEGIES TO IMPROVE THE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICES

6.1 INTRODUCTION

This chapter presents the development of strategies to improve the utilisation of skilled birth attendance services in Ethiopia. The strategies were informed by the findings of the current study, relevant aspects of reviewed literature, the theoretical framework of the study and the researcher's insights informed the development of the strategies. The themes from the study were categorised under the adapted health belief model. Strategies and activities were proposed for each theme arising from relevant literature and insights from the researcher. Finally, the chapter describes the validation process of the strategies and the dissemination plan.

6.1.1 Process of strategies development

The notion for developing these strategies stemmed from the problem of the utilisation of low-level skilled birth attendance services in Ethiopia and the need to address challenges and improve utilisation of these services. The development of the strategies was informed by findings of the study in chapter four and extensive literature review. A group of public health professionals validated the draft strategies to build consensus on the content and to ascertain their feasibility in the Ethiopian context. The development of the strategies was finalised after incorporating the recommendations of the public health professionals. Figure 6.1 illustrates schematic presentation of the methodology followed to develop the strategies.

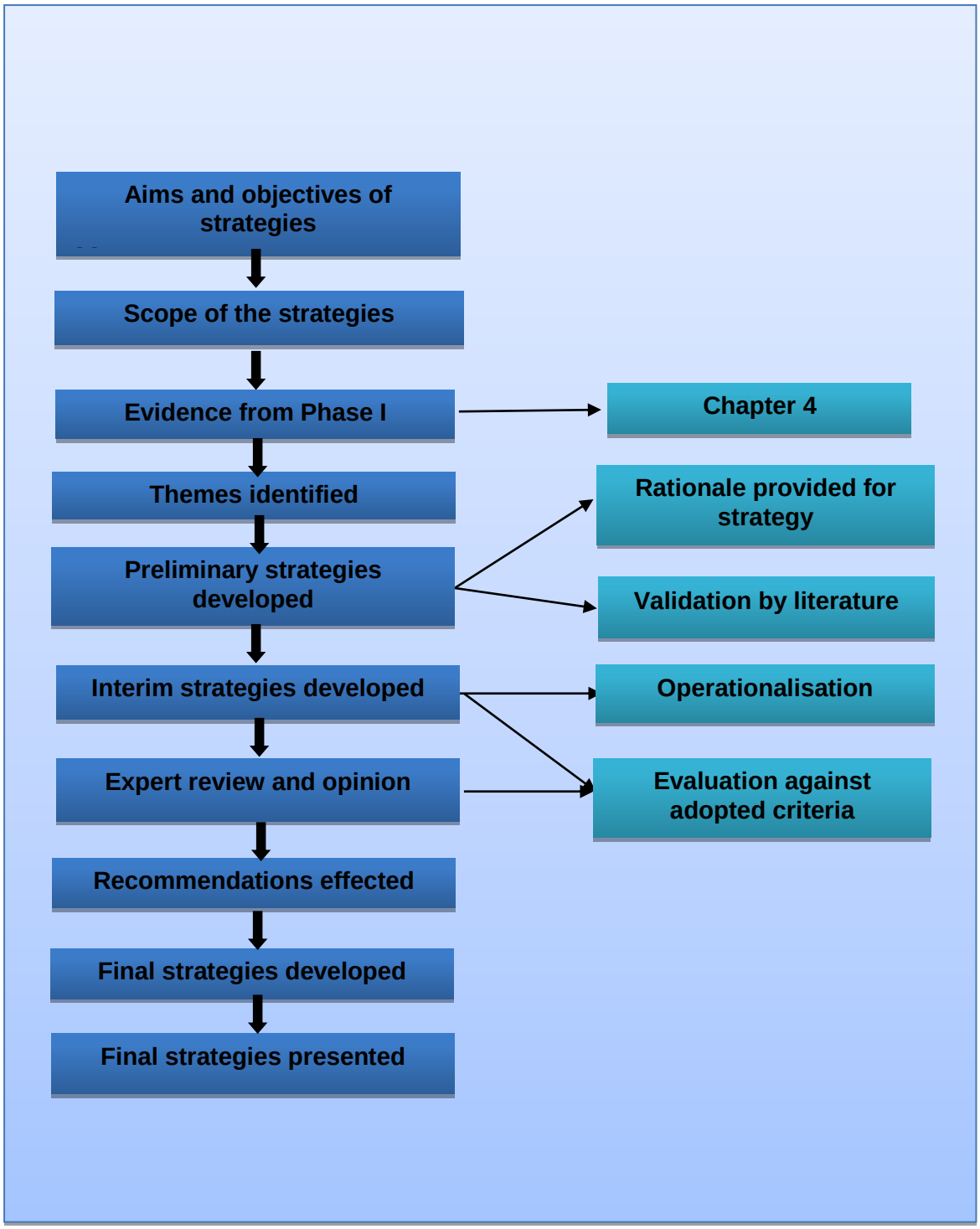

Figure 6.1 Methodology for development of strategies

6.1.2 The scope of the proposed strategies

The proposed strategies are to be applied in the communities, primary health care units, district health offices, zonal health department, regional health bureau, and Federal

Ministry of Health. They were designed to support the planning, implementation, monitoring and evaluation of skilled birth attendance services. The target groups for the proposed strategies are health works, health managers, and health policy makers.

6.1.3 Purpose of the strategies

The purpose of the strategies is to provide guidance based on evidence to improve the utilisation of skilled birth attendance services in Ethiopia.

6.1.3 Objective of the proposed strategies

The objective is to describe the strategies that would help the health system to overcome the problems and challenges of utilising and offering skilled birth attendance services and the improvement of the utilisation of skilled birth attendance services.

6.2 PRELIMINARY STRATEGIES

The themes for the strategy development were health worker related factors, health facility related factors, individual and community perceptions and experiences, essential equipment and supplies, health facility infrastructure related, and geographic inaccessibility and transportation services. Figure 6.2 illustrates the framework of themes for preliminary strategy development.

The preliminary strategies were developed from the identified themes. Themes 1 to 6 were tabulated and the categories from each theme were identified and presented with each strategy and rationale provided for the strategy. Tables 6.1 to 6.6 present the preliminary strategies and their rationale.

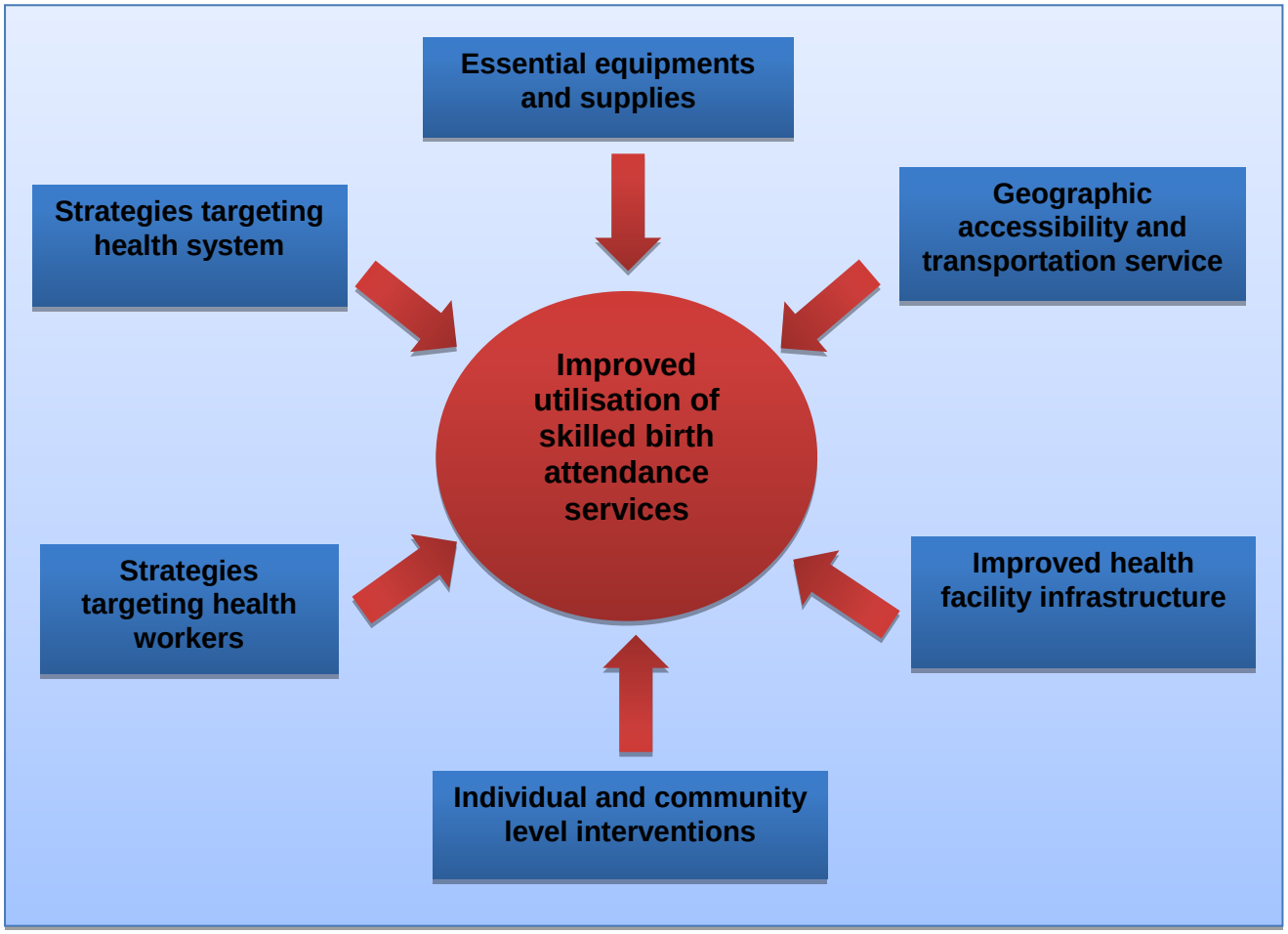

Figure 6.2 Framework of themes for strategy development

6.2.1 Strategy towards health care providers

"*Skilled, supported, and motivated people as the indispensable cement needed to construct a cohesive, well-functioning health system"* (Management Sciences for Health 2010:10). In order for the health system to operate effectively and efficiently, health facilities need to be equipped with skilled, supported, and motivated health workers. It is very crucial to have motivated staff, multi-disciplinary collaboration and team work, and availability of midwives around-the-clock to improve the utilisation of skilled birth attendance services.

Table 6.1 Strategy for health care providers

Strategy	Rationale and 0perationalisation
Multidisciplinary collaboration and team work among staffs: Develop an orientation and on-job training programme for health workers and support staffs.	 To emphasise the importance of both technical and support staff contribution to the success of the health facilities by providing orientation and on-job training on their responsibilities and expectations.

- **Multidisciplinary collaboration and team work among staffs**

Teamwork is critical for the delivery of quality health care and health care providers must coordinate their activities to deliver safe and efficient patient care (Baker et al 2006:1578). Health workers' collaboration and communication with other health workers is essential to deliver high quality care (Mosadeghrad 2014:84).

Therefore, the health workers and administrative staffs should collaborate and work in a team to provide high quality skilled birth attendance services. To this end, maternity care providers and support staffs should be oriented and trained together on the shared goals and visions of the health facility. Hence, each member of the team could anticipate the needs of others, adjust to each other's action, and have a shared understanding of how a procedure should happen.

6.2.2 Strategy targeting the health system

The health system should understand and get insight regarding the women's perceptions about the system and experiences of care reception from health facilities. Thus, the health system needs to be responsive to the perceptions, experiences, and health needs of the communities. In concert with this, strategies that could address promptness of care, timely referral services, quality of care, humanisation of care, in-service training, availability of Midwives around-the-clock, enhancing and promoting the reputation of health facilities, and women centred care were formulated.

Table 6.2 Strategy targeting the health system

Strategy	Rationale and operationalisation
Promptness of care: Develop a policy to give priority to pregnant and labouring women in all service delivery units. Ensure the availability of maternity care providers around-the-clock.	 To make sure pregnant and labouring women were attended to soon after their arrival in health facilities. To provide timely maternity care for women any time they visited to health facilities
Provision of quality care: Develop and implement continuous quality improvement interventions based on the provision of care and experience model. Ensuring that maternity care providers are present on the bedside of parturient women all the time on the process of labour and delivery.	 To provide quality clinical care that also meets or exceeds the expectations and experiences of the women. To provide timely clinical care to ensure the health of the women and the newborn. Moreover, to provide emotional and physical support to the women
Women centred care: Provide food services for parturient women and companions. Allow cultural ceremonial practises in health facilities.	 To provide food services for labouring women to make them feel at home. To address the cultural needs of women and their families which are often practised during home delivery.
Timely referral services: Develop referral protocols, service directories, and adherence to these protocols and procedures.	 The health workers adhered to these referral standards, operating procedures and timely referred women in need of referral services.

Strategy	Rationale and operationalisation
Develop or use existing referral job aids.	The maternity care providers used the job aids and provided timely referral service.
Make sure of the availability of midwives around-the-clock: Assign midwives in health facilities for twenty-four hours, seven days a week	 To ensure that pregnant and labouring women receive skilled birth attendance services in health facilities both during working and odd hours.
Respectful, caring, and compassionate maternity care providers: Develop an orientation and in-service training programme for maternity care providers on how to provide respectful, caring, and compassionate care. Design motivation mechanisms and incentive schemes for maternity care providers. Create a supportive environment to implement respectful, caring, and compassionate care.	 To improve the knowledge and skills of maternity care providers on respectful, caring, and compassionate maternity care. To enhance the performance of maternity care providers and keep them motivated. To buy-in and foster ubiquitous recognition and support from all health workers for respectful, caring, and compassionate care.
In-service training: Organise BEmONC in-service training for maternity care providers.	 To enhance the knowledge and skills of maternity care providers to provide quality skilled birth attendance services.
Humanisation of delivery care: Allow companions in the labour and delivery rooms. Allow mobility of labouring women and express their emotions in labour and delivery rooms	 To provide emotional and physical support for parturient women. To make labouring women feel at home and expedite the labour process and for better birth outcomes.

Strategy	Rationale and operationalisation
Improve and promote reputation of health facilities:	
Develop mechanisms to asses and understand the prevailing perceptions about health facilities in the communities.	To understand the prevailing perceptions about health facilities in the communities.
Design a system to asses clients' satisfaction on the services received and take corrective measures.	To know the experiences of women's reception of care from health facilities and take timely corrective action.
Organise a forum with different community groups and use existing platforms to address the negatively perceived reputation about health facilities.	To address negatively perceived reputation about health facilities.

- **Make sure midwives are available in health facilities around-the-clock**

Midwives needed to be assigned to provide maternity care in health facilities for twenty-four hours a day and seven days a week. The other health professionals could replace and provide skilled birth attendance services for the women whenever midwives are not around due to various reasons. No woman should be denied the service anytime she shows up in the health facilities.

- **Respectful, caring, and compassionate maternity care providers**

Maternity care providers' attitudes and behaviours towards clients weighed heavily on the women's decisions to seek facility-based delivery care or to opt for alternative sources of care. Moreover, due to the difficulties experienced by lay people to evaluate clinical dimensions of care, the providers' interpersonal skills were often seen by community members as key indicators of the quality of care. Therefore, there was a need to develop training programmes for maternity care providers to equip them with maternity care skills. Besides, an enabling environment should be created to enlist commitment from all staffs in the implementation of respectful, caring, and compassionate care. Designing staffs' motivation mechanisms and incentive schemes was indispensable to enhance the performance of maternity care providers and keep them motivated. Furthermore, health systems must be accountable for respectful caring and treatment of women during childbirth, ensuring clear policies on rights and ethical standards are developed and implemented. Health care providers at all levels require support and training to ensure that childbearing women are treated with compassion and dignity. It is also recommended to noteworthy interpersonal skills in the basic training curriculm of health workers to improve respectful care attitude of health care providers. Teamwork and interproffessional collaboration between different staff members working in the delivery room must be a platform of buy-in to respectful maternity care.

- **Promptness of care**

There should be minimum waiting time between the women's arrival to the health facilities, their admission, and monitoring by the maternity care providers. The promptness of care satisfied the women and was a key criterion for the perceived good

care (Bhattacharyya et al 2013:5). To this end, there was a need to develop a policy to give priority to service provision for pregnant and labouring women in all service delivery units. Moreover, ensuring the availability of maternity care providers around-the-clock was indispensable to provide prompt care for the pregnant and labouring women after their arrival in the facilities.

- **Timely referral services**

The timeliness of referral services could be detrimental to the outcomes of labour for both the mother and the child (Mselle et al 2011:11). Referral protocols, service directories, and referral job aids should be developed and properly utilised to provide timely referral services.

- **Provision of quality care**

The quality of the provision of care and women's actual experiences of care in health facilities is very crucial to ensuring the effectiveness of care and for good maternity outcomes (Hulton et al 2007:2084). Therefore, it was realised that developing and implementing continuous quality improvement interventions based on the provision of care and experience of care model is very crucial to improve the quality of care and ensure effectiveness of care. Besides, it is advisable to make sure that the maternity care providers are present on the bedside of the labouring women in the process of labour and delivery for timely care provision and emotional support.

- **Humanisation of delivery care**

Hodnett, Gates, Hofmeyr and Sakala (2013:2) concluded that continuous support during labour had clinically sound benefits for women and infants and all women should have support throughout labour and delivery. Hence, health facilities should allow companions in the labour and delivery rooms to provide continuous emotional and physical support for labouring women. In addition, labouring women in the labour and delivery rooms should be allowed to move around and express their emotions.

- **Women centred care**

Women centeredness is one of the salient attributes of quality maternity care. Key principles of women-centred care are that it situates care within women's life contexts, acknowledges the social determinants of health, and positions women as active partners in their care rather than as passive recipients (Sword et al 2012:9-10). Health facilities need to be organised in a way that provides women centred care. It became evident that an enabling environment should be set up in health facilities to allow parturient women and their families or relatives to practise cultural ceremonies. Furthermore, the necessary arrangements need to be made to cater food services for labouring women and their families or relatives.

- **Improve and promote the reputation of health facilities**

The prevailing perceptions in the communities about the provision of care by health facilities could be detrimental to the utilisation of health services from health facilities. Thus, the study recommended the design of a system to explore issues that could be sources of dissatisfaction and potentially damage the reputation of the health facilities and redress these issues with the communities. Therefore, designing mechanisms to track and understand the prevailing perceptions of the communities about health facilities could pave the way to address issues negatively affecting the utilisation of health care services. Furthermore, it is advisable to put in place a system to asses women's satisfaction level on the care received from health facilities and implement corrective measures. It would be also good to organise and undertake regular forum with different community groups or use extant platforms to resort negative perceptions possessed by the community.

- **In-service training**

According to Mosadeghrad (2014:85), the quality of health care could improve through the provision of education and training. Hence, BEmONC in-service training should be provided for maternity care providers to enhance their knowledge and skills in the management of normal labour, detection, treatment and timely referral of obstetric complications.

6.2.3 Strategy targeting the community

The perceptions and knowledge of communities regarding the importance of skilled birth attendance services and the services provided in health facilities influenced the health care seeking behaviour and utilisation of skilled birth attendance services. Therefore, devising strategies to address the perceptions and knowledge of communities regarding the importance of skilled delivery services could improve the health care seeking behaviour and utilisation of skilled birth attendance services.

Table 6.3 Strategy targeting the community

Strategy	Rationale and operationalization
Improve community's perceptions and knowledge regarding skilled birth attendance service:	
Develop social behavioural change communication (SBCC) interventions, provide health education, and undertake advocacy and social mobilisation.	To improve the perceptions and knowledge of the community on the importance of maternity care.
Design interventions that engage older families and relatives and significant others in order to improve their knowledge on importance of skilled birth attendance service.	To improve the perceptions and knowledge of older families and relatives regarding the importance of skilled delivery care and acquire their support in order for the women to utilise skilled birth attendance services.
Advocate maternity care services and support provided in health facilities:	
Promote permissibility of companions in labour and delivery rooms to the community.	To inform the community about the permissibility of companions in labour and delivery wards and the availability of cultural ceremonial practices in health facilities. Hence, those women, who have been deterred from using skilled birth attendance services due to these reasons, could use the services.
Promote the presence of cultural ceremonial practises in health facilities to the community.	
Adequately informing the maternity care procedures and succinctly explain when to have surgical procedures.	To familiarise women with the maternity care procedures and actual indications of surgical procedures, and get relief from their fear of childbirth in health facilities

Strategy	Rationale and operationalization
Ensure pregnant women undertake a walk through visit to maternity ward.	To make women become familiar with the maternity ward and get accustomed with the procedures.

- **Improve community's perception and knowledge regarding skilled birth attendance service**

Studies conducted in low and middle income countries recommended that improving communities' perceptions and knowledge about the importance of skilled birth attendance services could sway health care seeking behaviour and utilisation of skilled birth attendance service (Bohren et al 2014:15). Hence, designing social behavioural change communication interventions, provision of health education, and undertaking of advocacy and social mobilisation was the mainstay to improve communities' perceptions and awareness regarding skilled birth attendance services. Furthermore, the influence of older family members and significant others on the utilisation of maternity care was a well know and established factor. However, its negative effects still perpetuated the utilisation of skilled delivery services. Therefore, it called for strategies to be in place to redress the problems associated with it.

- **Advocate maternity care services and support provided in health facilities**

Cognisance and familiarisation of the maternity care services and social support provided in health facilities could purge some of the barriers that were related to the misconception of services provided in health facilities. The researcher found that support from families and significant others in home delivery, household cultural beliefs and practices as a cause of delay, and misconceptions about services provided in health facilities were barriers to giving birth in health facilities. To address these barriers, there was a need to advocate the maternity care services and social support provided in health facilities. To this end, promoting permissibility of companions in labour and delivery rooms, promoting the presence of cultural practices in health facilities, adequately informing the maternity care procedures and succinctly explain when to have surgical procedures, and making the pregnant women to visit maternity wards before labour started were the proposed strategies to address the aforementioned barriers.

6.2.4 Strategy for improving health facility infrastructure

It is evident that poor infrastructure; including lack of electricity, lack of water supply, and inadequate number of beds and rooms adversely impacted the provision of life-saving maternal and newborn health services, perceived and actual quality of care and clients' satisfaction (Essendi et al 2015:6 and Hulton et al 2007:2087). The health facilities' infrastructure needed to be improved to enable the implementation of the recommended strategies in view of their economic implications.

Table 6.4 Strategy for improving health facility infrastructure

Strategy	Rationale and operationalisation
Improve health facility infrastructure: Ensure the availability of an adequate number of rooms committed for the provision of maternity care and maternity waiting homes through the construction of new rooms and renovation of existing rooms. Mobilise the community to make financial and material contributions. Equip the health facilities to have adequate number of beds through purchase, request support from partners or from the health system. Ensure that health facilities have regular supply of electricity and water by communicating with the respective government offices. Make alternative sources of electricity and water available.	To make maternity waiting homes available in the health facilities so that expectant mothers could come in advance before labour starts and stay there until childbirth. To provide the best quality of care and life-saving interventions.

- **Improve health facility infrastructure**

Good physical environment and infrastructure with water supply, electricity, beds and cleanliness, adequate room space, seating arrangement and waiting areas were significant in the women's positive assessment of the health facilities and maternal care services (Srivastava et al 2015:5). In order to provide the best quality of care and life-saving interventions and improve utilisation of skilled birth attendance service, it was

indispensable to ensure that health facilities have adequate rooms and was equipped with adequate number of beds. Besides, health facilities needed to have a regular supply of electricity and water.

6.2.5 Strategy for essential equipment and supplies

The availability of essential equipment and supplies is a significant predictor of satisfaction with care, perceived and actual quality of care, and the utilisation of skilled birth attendance services (Onta et al 2014:5 and Srivastava et al 2015:6). The current study discerned the unavailability of vacuum extractors to provide assisted delivery, shortage of delivery beds, and incomplete infection prevention personal protective materials. Addressing the availability of these essential equipment and supplies could improve women's satisfaction in maternity care, provision of quality care, and improvement of the utilisation of skilled birth attendance services.

Table 6.5 Strategy for essential equipment and supplies

Strategy	Rationale and operationalisation
Avail essential equipment and supplies: Equip health facilities with functional vacuum extractors, adequate number of delivery couches, and infection prevention personal protective materials. Strengthen the supply chain management system in the health facilities.	To ensure that health facilities are equipped with essential equipment and supplies to provide quality maternity care.

- **Essential equipment and supplies**

Health facilities should be equipped with functional vacuum extractors, adequate number of delivery beds, and continuous supply of infection prevention personal protective materials. A strong supply chain management system should be in place to ensure continuous availability of infection prevention personal protective materials.

6.2.6 Strategy for improving physical accessibility and transportation service

The current study established that bad terrain and the inaccessibility of roads, distance to health facilities, and problems related to transportation services impeded the utilisation of skilled birth attendance services. Strategies that surmounted these challenges were instrumental in improving the utilisation of skilled birth attendance services.

Table 6.6 Strategy for improving physical accessibility and transportation service

Strategy	Rationale and 0perationalisation
Improve physical accessibility and transportation service: Use locally prepared stretchers. Make maternity waiting homes available Make ambulance transportation services available around-the-clock. Provide drop back transportation services for women who gave birth in health facilities. Develop communication mechanisms to ensure timely arrival of ambulances and transport the women to health facilities. Road construction and maintenance.	To ensure that women are transported and timely arrive at the health facilities and utilise skilled birth attendance services.

- **Improve physical accessibility and transportation service**

Improving access to health facilities and availing transportation services is very instrumental to improve the utilisation of skilled birth attendance services. Strategies that improve physical accessibility of health facilities include the utilisation of locally made stretchers, maternity waiting homes, road construction and maintenance. Besides, the provision of ambulance services is indispensable to improve the transportation service related problems. Designing communication mechanisms between the communities, health facilities, and ambulance drivers could improve the

timely arrival of ambulances and transportation of women to health facilities. Furthermore, availing drop back transportation service for women who gave birth in health facilities would encourage women to utilise skilled birth attendance services in subsequent childbirth.

6.3 INTERIM STRATEGIES

The purpose of developing the interim strategies was to decide on the most critical issues to be the objects of review and opinion by health professionals in order to develop the final strategies. Focus was on making the interim strategies as operational as possible. It is important to note that to get to the strategies as outlined, was still the work of the researcher before presenting the strategies to the experts for validation. A set of criteria, based on Thompson and Dowding's (2002:150) work, was adopted to evaluate the strategies. The criteria for the development of the interim strategies were as follows:

- **Clarity and presentation:** each strategy is precise, simple and easily understandable.
- **Specificity:** specific and focused on improving the utilisation of skilled birth attendance services.
- **Reliability**: based on the evidence that led to the development, the strategy could be used by other health facilities and health workers in similar circumstances.
- **Clinical flexibility or adaptability:** exceptions were identified, as were differently capacitated and set up for the health facilities.
- **Effectiveness:** the strategy was able to address the needs and overcome the challenges in the utilisation of skilled birth attendance services.
- **Validity:** based on evidence from correctly analysed and interpreted data as described in Chapter 4 of this study.
- **Relevance: the** strategy was appropriate for improving the utilisation of skilled birth attendance services.
- **Applicability:** the target users were clearly defined as described in the scope of the strategies in this study.

- **Acceptability:** realistic and ambitious, in line with the existing maternal health strategies.
- **Achievability:** could be done by the target group as described in this study.
- **Utilisation review:** indications of ways in which adherence may be monitored, were explained as operationalisation of the strategies.

Ten (10) interim strategies were developed. Following each identified strategy, operationalisation was done with the information obtained from the preliminary strategies. The section that follows outlines the interim strategies. These strategies were submitted to expert health professionals for review and validation.

Strategy 1: Develop and equip health facilities with skilled, motivated, respectful, caring, and compassionate health care providers

- Ensure the availability of skilled, respectful, caring, and compassionate maternity care providers in health facilities around-the-clock. It is indispensable to make sure that women receive maternity care any time they show up to the health facility.
- Develop an orientation and in-service training program for health care providers to equip them with respectful, caring, and compassionate care knowledge and skills. The training can be integrated in to a broader training program aimed at upgrading maternal and newborn knowledge and skills of health care providers.
- Undertake continuous mentorship, supportive supervision, and monitoring to improve the performance of health care providers. Besides, provide in-service BEmONC training to enhance the knowledge and skills of health care providers.
- Create an enabling environment to implement respectful, caring, and compassionate care. In order to foster broad-based recognition and support for respectful, caring, and compassionate care, there is a need to introduce health facility level initiatives such as continuous quality improvement approaches.
- Design motivation mechanisms and incentive schemes for maternity care providers to improve their performance and keep them motivated. To this end, the provision of respectful, caring, and compassionate care could be integrated as one performance review criterion in the health workers' performance appraisal.

- Ensure the availability of a code of conduct for treating clients with the necessary disciplinary measures included.

Strategy 2: Establish mechanisms for multidisciplinary collaboration and team work among staffs

- Develop orientation and training programs for staff to have a clear understanding of the shared goals and vision of the health facilities and the system, enable each member of the team to anticipate the needs of others, adjust to each other's action, and have a shared understanding of how a procedure should happen.
- Establish strong leadership that outlines a clear direction and vision for the team and capable of listening to the needs of the teams and provide support and supervision to the teams.
- Develop communication strategies that facilitate intra-team and inter-team communication, collaborative decision-making and effective team processes.
- Develop standard operating procedures in all service delivery units that foster interdependence and multidisciplinary collaboration among staff. Besides, the staff should have clearly defined roles in a way that promotes multidisciplinary collaboration and teamwork.
- Cultivate a set of values and cultures that promote interdisciplinary collaboration and teamwork, and pave the way for the teams' service provision.

Strategy 3: Develop and implement continuous quality improvement interventions based on the provision of care and experience of care model

- Adapt and implement the national quality improvement strategy, taking into account the provision of care and experience of care model.
- Organise orientation and training programmes for all staff on the process of continuous quality improvement.
- Undertake situational assessment of the supply and demand side to understand the extant situation, identify quality gaps, and develop action plans.
- Establish holistic quality improvement teams, composed of all service delivery units. The team has the responsibility to conduct continuous quality assessment, support and monitor the implementation of the action plans developed.

- Develop a policy that promotes promptness of care for pregnant and labouring women any time they show up to the facilities.
- Ensure availability of maternity care providers in health facilities for 24 hours. Besides, ensure the presence of maternity care providers in the labour and delivery rooms of parturient women all the time for the process of labour and delivery.
- Develop and implement a well-functioning referral system that ensures timely referral of pregnant and labouring women to the next referral facility. To this end, it is very instrumental to develop referral protocols, service directories, referral job aids, and make sure that adherence to these protocols and procedures is observed.

Strategy 4: Re-orienting the health system to provide humanised and women centred skilled birth attendance services

Based on the findings of the current research, the following strategies were posited:

- Allow companions in the labour and delivery rooms. The health facilities should allow companions in labour and delivery rooms to provide physical and emotional support.
- Allow mobility of labouring women and express their emotions in labour and delivery rooms. The mobility of the women should not be restricted unless the progress of labour is advanced. Furthermore, the labouring women should not be reprimanded or ridiculed for shouting or making dissonant noise associated with the labour pain.
- Provide food for parturient women and their companions. The health facilities should make the necessary arrangements to cater for both the parturient women and their companions.
- Allow cultural ceremonial practises in the health facilities. The labouring women and their families or significant others should be allowed to practise cultural ceremonial practises in the health facilities. The health system needs to develop a mechanism to provide the necessary materials and resources needed for the cultural ceremonial practises.

Strategy 5: Improve and promote the reputation of health facilities

- Develop mechanisms to asses, and understand the prevailing perceptions about health facilities in the community and take steps to improve areas of weakness.
- Design a system to assess clients' perceptions and satisfaction levels on the services received and take corrective measures.
- Develop key messages and orientate staff about the messages to be delivered to the community to constantly build and maintain a positive reputation of the health facilities.
- Organise a regular forum with different community groups and use existing platforms to redress negatively perceptions about the health facilities.

Strategy 6: Develop health promotion and education strategies to improve the communities' perceptions and knowledge about skilled birth attendance services

- Implement community based, multi-media, and interpersonal communication approaches to improve communities' perceptions and knowledge about skilled birth attendance services.
- Develop and use existing social behavioural communication change tools to communicate key messages, targeting the importance of skilled birth attendance services, benefits of adopting early care seeking behaviour, and socio-cultural beliefs and barriers.
- Develop key messages that target the importance of skilled birth attendance services, socio-cultural beliefs and barriers, early care seeking, importance of having ANC, danger signs, birth preparedness and complication readiness, and medicalisation of childbirth.
- Design interventions that engage older families, relatives and significant others in order to improve their knowledge on the importance of skilled birth attendance services and buy-in their support to improve the utilisation of skilled birth attendance services in the communities. In this regard, conducting family dialogues and conversations, regarding skilled birth attendance services with the involvement of older families and significant others, pregnant women, neighbours, social network leaders and others could be one intervention.

- Engage community leaders, religious leaders, and kebele leaders (smallest government administration unit) to undertake advocacy and social mobilisation activities regarding skilled birth attendance services.
- Engage women development groups, women's health development team-leaders to convey key health messages in health education, advocacy and social mobilisation regarding maternal and newborn health. Besides, women's health development team-leaders are instrumental for early identification of pregnant women and referral to the health facilities.
- Develop messages targeting HIV/AIDS related stigma and discrimination that hinder the utilisation of skilled birth attendance services. The messages should address the community perception that women often visiting health facilities are not HIV positive. Moreover, the messages should also reassure women's fear of disclosure of HIV status in health facilities.

Strategy 7: Advocate maternity care services and support provided in health facilities

- Promote the permissibility of companions in labour and delivery rooms to the community.
- Promote the presence of cultural ceremonial practises in health facilities to the community.
- Adequately inform women about the maternity care procedures during childbirth and succinctly explain when to have surgical procedures. This could address the unfounded rumours and misperceptions of health facility childbirth and fear of medical and surgical interventions.
- Ensure pregnant women to take a walk through to visit the maternity ward during a visit to health facilities. This could help pregnant women to become familiar with the environment and be attuned to the care process.

Strategy 8: Improve health facility infrastructure

- Ensure the availability of adequate number of rooms committed for maternity care provision and maternity waiting homes through construction of new rooms and renovation of existing ones.

- Mobilise the community to make financial and material contributions to build new or renovate maternity rooms.
- Equip health facilities to have adequate numbers of beds through purchase, request support from the health system or development partners.
- Ensure that health facilities have a regular supply of electricity and water by communicating with the respective government offices.
- Make available alternative sources of electricity and water.

Strategy 9: Ensure availability of essential equipment and supplies

- Equip health facilities with functional vacuum extractors, adequate number of delivery couches, and infection prevention personal protective materials.
- Strengthen the supply chain management system in the health facilities.

Strategy 10: Develop interventions to improve physical accessibility and transportation services

- Use locally made stretchers. Locally made stretchers can be used to transport labouring women to the main road where it can be accessed by ambulance services. This is more practicable to bad terrain areas.
- Construct and make available, maternity waiting homes. Pregnant women from geographically inaccessible areas can go to health facilities in advance, often two weeks before the expected due date and stay there until childbirth.
- Make available ambulance transportation services around-the-clock.
- Provide drop back transportation services for women who gave birth in health facilities. Develop a mechanism to provide drop back transportation services for women after giving birth in health facilities.
- Develop communication mechanisms to ensure timely arrival of ambulances to transport the women to health facilities.
- Road construction and maintenance. This intervention may not be implemented immediately because of its financial implications and could be considered as a long-term plan.

6.4 VALIDATION OF THE STRATEGIES

The purpose of validation of the strategies was to ensure that the strategies were of acceptable and achievable quality. The interim strategies as discussed in section 6.3 were sent to a group of health professionals for external review and validation. The validation group was purposefully selected to involve experts in the subject. The respondents who were involved in the validation of the strategies were one district health office maternal health expert who was involved in Phase I, step 1 of this study, two district based reproductive, maternal, neonatal, and child health project coordinators, and three maternal and child health project managers who were experienced and experts in the subject. The strategies were sent via e-mail to these experts for external review. The supervisors of this study who are experts in research, maternal and newborn health, and health services management were also involved in the external review and validation of the interim strategies.

The process of strategy validation assisted to improve the validity of the strategies. The six knowledgeable and experienced health professionals were requested to evaluate the strategies and to rate them according to criteria provided. The abstract for the study was sent to the evaluators, which included the topic, problem statement, objectives of the study, significance and the methodology applied. Table 6.7 outlines the description of the expert evaluators' biographic information.

Table 6.7 Expert evaluators' information

No	Qualification	Occupation	Professional experience
1	MPH	Cervical cancer project manager	10+
2	MPH	Maternal and child health program coordinator	10+
3	MPH	RMNCH project coordinator	10+
4	MPH	Maternal and newborn health technical officer	10+
5	BSC	District health office maternal technical expert	10+
6	BSC	District RMNCH technical officer	10+

A Likert scale was used, which had four assessment alternatives, starting with strongly disagree, disagree, agree and strongly agree. The evaluators were requested to use the key to evaluate, score and indicate if each of the strategies met the adopted criteria set

to achieve each strategy. Where necessary, the evaluators were requested to provide a written comment and feedback to give their opinions about each strategy. The key to the scale was as follows:

Key to evaluation:

1: Strongly disagree; 2: Disagree; 3: Agree; 4: Strongly agree

Table 6.8 presents the criteria and scoring that was sent to the health professionals to evaluate the interim strategies, before they were finalised.

Table 6.8 Criteria for evaluation of the interim strategies

Criteria/Score	Strongly disagree	Disagree	Agree	Strongly agree
Clarity and presentation Strategy is precise, simple and easily understandable				
Specificity Specific and focused on improving the utilisation of skilled birth attendance services				
Reliability Based on the evidence that led to the development, the strategy can be used consistently by other health facilities and health workers in similar circumstances.				
Clinical Flexibility Exceptions are identified, as in the case of capacitated and set up of health facilities				
Effectiveness The strategy is able to meet the needs and overcome the challenges of the utilisation of skilled birth attendance services.				
Validity Based on evidence from correctly analysed and interpreted data as described in chapter four of this study				
Relevance Strategy is appropriate for improving the utilisation of skilled birth attendance services.				
Applicability The target users are clearly defined, as described in the scope of the strategies.				

Criteria/Score	Strongly disagree	Disagree	Agree	Strongly agree
Acceptability Realistic and ambitious, in line with the existing national strategies.				
Achievability Can be done by the target group as described in this study.				
Utilisation review Indication of ways in which adherence may be monitored is explained as operationalisation of the strategies				

All the evaluators provided feedback. There were consistent scores and some discrepancies in the scoring of the strategies by the individual evaluators. The total score for each strategy was 44. The researcher considered that a strategy that scored 33 and more points was regarded as acceptable to improve the utilisation of skilled birth attendance services, as it represented a 75% acceptance level. None of the strategies was scored less than 33 points score. Following the scoring, specific comments were made by the evaluators for the areas in which they considered needs improvement. Table 6.9 shows the scoring of each strategy by the six individual evaluators as well as the mean scores for each strategy.

Table 6.9 Description of the scores from the validation group

Strategy/evaluator Total score	Evaluator 1	Evaluator 2	Evaluator 3	Evaluator 4	Evaluator 5	Evaluator 6	Mean score
Strategy 1	38	43	42	41	37	41	40.3
Strategy 2	35	44	38	38	38	38	38.5
Strategy 3	41	44	42	39	43	38	41.2
Strategy 4	42	44	44	39	39	38	41.0
Strategy 5	39	44	40	39	42	38	40.3
Strategy 6	44	44	44	40	37	41	41.7
Strategy 7	44	44	43	41	38	40	41.7
Strategy 8	40	44	44	38	40	39	40.8
Strategy 9	44	44	39	43	37	38	40.8
Strategy 10	44	44	41	38	40	39	41.0

The evaluators provided comments and remarks on strategies 1, 2, 3 and 10. The following comments were made in relation to the mentioned strategies:

Strategy 1

The evaluators commented on the effectiveness of the strategy. They advised that pre-service training programmes are an ideal opportunity to create caring, respectful, and compassionate health care providers and needed to have a system to ensure these attitudes and behaviours were reflected in the service providers. Moreover, they also commended that the presence of a strong and committed leadership was imperative to implement staff motivation and incentive schemes, based on continuous assessment of staff performance.

Strategy 2

With regard to the achievability of strategy 2, the evaluators were of the opinion that it may be difficult to establish a strong leadership unless some criteria or leaders selection mechanism was in place.

Strategy 3

The evaluators remarked that the relevance of strategy 3 could be better achieved by taking into account the perspectives and experiences of clients in an endeavour to improve the quality of care.

Strategy 10

They indicated that strategy 10 had challenges with the effectiveness of the provision of drop back transportation services for clients who gave birth in health facilities. One of the evaluators became sceptical about the applicability of the provision of drop back transportation service for women.

6.5 FINAL STRATEGIES

The following are the final strategies that were developed following the validation and adaptation of the interim strategies:

- Strategy 1: Develop and equip health facilities with skilled, motivated, respectful, caring, and compassionate health care providers.
- Strategy 2: Establish mechanisms for multidisciplinary collaboration and teamwork among staffs.
- Strategy 3: Develop and implement continuous quality improvement interventions based on the provision of care and experience of care model.
- Strategy 4: Re-orienting the health system to provide humanised and women centred skilled birth attendance services.
- Strategy 5: Improve and promote the reputation of health facilities.
- Strategy 6: Develop health promotion and education strategies to improve communities' perception and knowledge about skilled birth attendance services.
- Strategy 7: Advocate maternity care services and support provided in health facilities.
- Strategy 8: Improve health facility infrastructure.
- Strategy 9: Ensure the availability of essential equipment and supplies.
- Strategy10: Develop interventions to improve physical accessibility and transportation services.

6.6 CONCLUSION

This chapter explained in detail the implementation of Phase II, which was the development of strategies to improve the utilisation of skilled birth attendance services. A preliminary strategy was developed for each of the re-categorised themes as problem areas to utilise and offer skilled birth attendance services. Thereafter, ten interim strategies were developed from the six preliminary strategies, which were validated by experts and experienced health professionals. The final strategies were developed, following the validation and adoption of the interim strategies. The following chapter discusses the conclusion and recommendations of this research and presents the final strategies.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS OF THE STUDY

7.1 INTRODUCTION

The purpose of this thesis was to determine factors influencing the utilisation of skilled delivery services in order to develop strategies to improve the utilisation of skilled birth attendance services in North Western Ethiopia. It also set out to develop strategies that would help to improve the utilisation of skilled birth attendance services. The study embraced pregnant women, women who gave birth recently, health extension workers, midwives, heads of health centres, heads of district health offices, and technical experts in order to have a comprehensive view of the perceptions and experiences. The study used a descriptive, exploratory, and qualitative research design to obtain information. Chapter 4 and 5 presented the findings and discussion of the study while chapter 6 presented strategy development to improve the utilisation of skilled birth attendance. This chapter presents the conclusion of the study, the limitations, and recommendations.

7.2 CONCLUSION

This research was conducted to determine the factors influencing the utilisation of skilled delivery services in order to develop strategies to improve the utilisation of skilled birth attendance services in North Western Ethiopia. In the current study, nine themes emerged from the analysis of the data. The themes dealt with individual and community perceptions, experiences, and the health care providers experience of the provision of skilled birth attendance services that could be facilitators and deterrents of the utilisation of skilled birth attendance services.

Theme 1 dealt with the experiences of skilled delivery care, which were highly cherished by women. In concert with this view, the study found that the presence of supportive and caring health workers in health facilities**,** good interpersonal care**,** perceived good skilled birth attendance services, the availability of basic and life-saving interventions, and the provision of women friendly services, created good experiences for women

utilising skilled birth attendance services. This implies that the efforts aimed at improving the utilisation of skilled delivery care should pay more attention to these domains of services. However, as explained in theme 2, the women experienced shortcomings in some aspects of care and this has resulted in feelings of resentment and dissatisfaction by the women with the services received. To this end, problems related to health workers, delays in the provision of care in health facilities, and perceived poor quality of care emerged as causes of disappointment and dissatisfaction on the experiences of care. The study also explored the reasons for the non-utilisation of skilled birth attendance services. Previous bad experiences of giving birth in health facilities, experiences of dehumanised care, bad reputation of health facilities and health workers, and ambulance service related problems were identified as supply side deterrents of health facility childbirth. Whereas, the demand side barriers for health facility childbirth or reasons for home delivery were fear of medical and surgical interventions, socio-cultural factors, perceived HIV/AIDS stigma and discrimination, low early care seeking behaviour, and lack of knowledge about the importance of skilled birth attendance services. Physical inaccessibility of health facilities and transportation service related problems were also identified to be the main barriers to the utilisation of skilled birth attendance services. Therefore, it is not surprising that most of the proposed strategies were geared up towards addressing these issues.

The study also established that the availability of referral services, ambulance and life-saving interventions, previous experiences or fear of obstetric danger signs and complications; reception of information and advice, ensuring the health of women and their newborn, having ANC services, and detection and management of obstetric complications; previous use of skilled birth attendance service; and good interpersonal care emerged as the factors that influenced the previous utilisation of skilled birth attendance services. These experiences would motivate the utilisation of skilled birth attendance services in subsequent childbirth. Furthermore, the study noted that the perceived benefits of skilled birth attendance services were the reception of advice and information, disease prevention and treatment, ensuring the health of the women and the newborn, good newborn care practices, and prevention and management of obstetric and neonatal danger signs and complications.

The community members provided support for women to utilise skilled birth attendance services. Calling for ambulances, notifying labour to HEWs and health workers,

household chores support, transporting women to and from health facilities, advice and encouragement were among the supports provided by the community members to the women.

The in-depth interviews with health extension workers, midwives, heads of health centres, district health office heads and technical experts found that various strategies have been implemented to improve the utilisation of skilled birth attendance services. In concert with this, awareness creation strategies, provision of non-monetary incentives, monetary fine as a disincentive, early pregnancy identification and follow-up, labour notification systems, exploring reasons for home delivery and taking apt measures are the strategies which were identified and implemented in the health system to improve the utilisation of skilled delivery care. The study also revealed that barriers to transportation services, poor health facility infrastructures, shortage of equipment and supplies, untrained staffs, and culturally insensitive care were the challenges to offer skilled birth attendance services. Hence, the proposed strategies would address these challenges to provide good quality care and improve the utilisation of skilled birth attendance services.

7.3 RECOMMENDATIONS

Based on the findings of the study, the following recommendations were posited:

7.3.1 Health workers' education and training

Ongoing learning to update the knowledge and skills of health workers is imperative to provide good quality of care and for improved utilisation of care by clients. The findings of the current study provide evidence to this view. The attitude and behaviour of maternity care providers are detrimental in the utilisation of skilled delivery care. Therefore, in-service interpersonal care training should be provided for health workers to equip them with compassionate, respectful, and caring skills. Interpersonal care should be incorporated as one component and an intrinsic part of health related training. The pre-service training curriculum content needs to be evaluated for inclusion and adequacy of interpersonal care and possible updating. Besides, in-service BEmONC training should be provided for maternity care providers.

7.3.2 Provision of humanised and women centred care

The women's utilisation of maternity care depends not only on the quality of clinical care but also on the provision of services that address the social determinants. Hence, health facilities need to be re-oriented to provide humanised and women centred care. The type of socio-cultural beliefs and practises provided or allowed to be practised in health facilities should be tailored to the context or be contextually defined. In the current study, it was evident that health facilities should allow companions in the labour and delivery rooms, allow cultural ceremonial practises, and provide food for parturient women and their companions. In general, it is noteworthy for the health facilities to pay equal attention to humanisation and women centeredness of clinical care.

7.3.3 Continuous quality improvement

The current study found that perceived poor quality of care or and reception of poor service emerged as causes of dissatisfaction and reason for non-utilisation of skilled birth attendance services. This calls for a development and implementation of holistic continuous quality improvement interventions both at health facility and at community level. The design of quality improvement interventions should take into account the provision of quality care and women's perceived and actual experiences of care.

7.3.4 Health promotion and education

The current study demonstrated that reception of information and advice from health workers influenced or would motivate women to utilise skilled birth attendance services in the previous delivery or in the subsequent childbirths.

Therefore, it is indispensable to implement health promotion and education interventions to improve the perceptions and knowledge of the communities regarding skilled birth attendance services. The health promotion and education messages need to address socio-cultural beliefs and practises, early care seeking behaviours, importance of ANC and skilled birth attendance services, and maternal and neonatal danger signs. Furthermore, perceived HIV/AIDS related stigmas and discriminations that impede the utilisation of skilled delivery care should be addressed in the health

promotion and education messages. Women need to be clearly appraised about their expected date of delivery during the course of pregnancy.

Interpersonal, community based, and multi-media communication approaches should be used to effectively deliver and reinforce the health promotion and education messages. Besides, social behavioural communication change tools should be developed or existing tools be used to convey key health messages.

It is also commendable to develop interventions to improve the perceptions and knowledge of older family members and significant others regarding the importance of skilled birth attendance services and buy-in their support for the women to utilise skilled delivery care. Furthermore, engage different community groups such as community leaders, women's development groups (health development team-leaders), religious leaders, and kebele administrators in the advocacy and social mobilisation of maternal and newborn health.

7.3.5 Community participation

The study also established that, the community has provided various supports for women to utilise skilled birth attendance services. This has to continue in a strengthened and sustained manner. The engagement of women's health development groups and community volunteers in early identification and referral of pregnant women, conveying key health messages, advocacy and social mobilisation of health issues, should be further enhanced and capitalised on to improve the community's knowledge and utilisation of maternity care.

7.3.6 Health facility infrastructure

Many concerns were raised about the status of the health facility infrastructures. Inadequate rooms, shortage of beds, lack of electricity and water supply, and the unavailability of waiting rooms substantially affected the utilisation and quality of maternity care. Attention must be paid to improving the availability of adequate rooms and beds. Furthermore, it is imperative to ensure the availability of continuous supply of electricity and water.

7.3.7 Essential equipment and supplies

The unavailability of vacuum extractors, delivery beds, and inadequate infection prevention personal protective materials negatively affected the provision and utilisation of quality skilled delivery care. The health system needs to make sure that health facilities are equipped with adequate and functional equipment and supplies. One way to do this is through strengthening the supply chain management system.

7.3.8 Access to health facility and transportation service

It was evident that geographic inaccessibility and transportation services related problems emerged as barriers to the utilisation of skilled birth attendance services. Therefore, it is crucial to develop interventions that surmount these geographic barriers and transportation services related problems. The community can use locally made stretchers to transport women to the points where they can access an ambulance or any vehicle. The other intervention could be the construction and availability of maternity waiting homes so that women residing in bad terrain areas may go to health facilities in advance, usually two weeks before labour starts and stay there until childbirth. Most of the challenges could be solved through availability and proper use of ambulance services. Notwithstanding, it may not be implemented immediately because of its economical implication, road construction and maintenance could be a mainstay to transcend geographic inaccessibility.

The study also found that the unavailability of drop back transportation s for women who delivered in health facilities could be a deterrent for subsequent childbirths. Therefore, a mechanism should be put in place to provide drop back transportation services for women who gave birth in health facilities.

7.3.9 Implementation of the proposed strategies

As presented in chapter 6, the ultimate aim of the study was to develop strategies to improve the utilisation of skilled delivery care. The strategies were developed based on the problems areas identified in the study. Therefore, it is highly recommended to implement the proposed strategies to address the problems and challenges that stemmed from the study.

7.4 FURTHER RESEARCH

The results from this study provide several opportunities for future research. Further research could explore the community perceptions and experiences of skilled delivery care in other regions to provide more understanding of skilled delivery care and provide data for comparison. In the current study, a qualitative study design was used to obtain information. Therefore, quantitative studies on the community's perceptions and experiences regarding skilled delivery care could be conducted to explore factors associated with good and poor experiences of skilled birth attendance services.

Studies that focus on quality of care and women's actual experiences of this care could be beneficial to improve the process of care provision and utilisation of maternity care. Furthermore, researches that explore the provision and experiences of respectful, caring, and compassionate care are also recommended and could contribute significantly to improve the quality of care and the utilisation of skilled care. In addition, it would be good to examine the effects of the re-orientation of the health system to provide humanised and women centred care on the provision and utilisation of skilled delivery care. It is also imperative that the implementation of the proposed strategies to improve the utilisation of skilled birth attendance services be supplemented with operational researches.

7.5 CONTRIBUTION OF THE STUDY

Some of the findings of the study are not new findings and well established issues. However, these problems and challenges continue to exist. Therefore, the current study calls for efforts and interventions to target these challenges and problems. Moreover, numerous quantitative studies were conducted in Ethiopia on this subject but a limited number of exclusive qualitative researches have been conducted for in-depth exploration of communities' perceptions and experiences regarding skilled birth attendance services. Thus, the current study has contributed substantially towards gaining insights and in-depth understandings of good and poor experiences of skilled delivery care, reasons for home delivery, perceived influencers and motivators, perceived benefits of skilled birth attendance, community support, health systems related challenges to offer skilled delivery care, and existing strategies to improve the utilisation of skilled birth attendance services. Ultimately, the proposed strategies that

emanated from the findings of the study would help the health system to improve the utilisation of skilled birth attendance services.

7.6 LIMITATIONS

The following are limitations of the study:

- One limitation is that data were collected through FGD and in-depth interviews. A structured interview questionnaire could have revealed different results to enrich the findings of the study.
- Criticisms surface in qualitative research in general, often pertaining to issues of small sample, interpretation and bias. The researcher is of the view that the rich description of the sample, data collection methods and the process of analysis demonstrated the transparent nature of the research.
- The findings may not be generalisable because the study was conducted in only two districts of the 15 districts of West Gojjam zone but they may be transferable to other settings of similar characteristics.

LIST OF REFERENCES

Abebe, F., Berhane, Y. & Girma, B. 2012. Factors associated with home delivery in Bahirdar, Ethiopia: A case control study. *BMC Research Notes* 5:[1-6].

Adegoke, A., Utz, B., Msuya, S.E. & Van den Broek, N. 2012. Skilled birth attendants: who is who? A descriptive study of definitions and roles from nine sub-Saharan African countries. *PLoS ONE* 7(7):[1-10].

Adegoke, A. & Van den Broek, N. 2009. Skilled birth attendance-lessons learnt. *British Journal of Obstetrics and Gynaecology* 116 (Suppl. 1):33-40.

Adewemimo, A. Msuya, S. Olaniyan, C. & Adegoke, A. 2014. Utilisation of skilled birth attendance in Northern Nigeria: A cross-sectional survey. *Midwifery* 30:e7-e13.

Afulani, P.A. & Moyer, C. 2016. Explaining disparities in use of skilled birth attendants in developing countries: a conceptual framework. *PLoS ONE* 11(4):[1-16].

Agha, S. & Carton, T.W. 2011. Determinants of institutional delivery in rural Jhang, Pakistan.*International Journal for Equity in Health* 10:[1-12].

Ajaegbu, O.O. 2013. Perceived challenges of using maternal healthcare services in Nigeria. *Arts and Social Sciences Journal*: ASSJ-65:[1-7].

Akum, F.A. 2013. A qualitative study on factors contributing to low institutional child delivery rates in Northern Ghana: The Case of Bawku Municipality. *Journal of Community Medicine Health Education* 3(6):[1-9].

Alabi, A.A., O'Mahony, D., Wright, G. & Ntsaba, M.J. 2015. Why are babies born before arrival at health facilities in King Sabata Dalindyebo Local Municipality, Eastern Cape, South Africa? A qualitative study. *African Journal Primary Health Care Familiy Medicine* 7(1):[1-9].

Alemayehu, M. & Mekonnen, W. 2015. The prevalence of skilled birth attendant utilization and its correlates in North West Ethiopia. *BioMed Research International*:[1-9].

Amoakoh-Coleman, M., Ansah, E.K., Agyepong, I.A., Grobbee, D.E., Kayode, G.A. & Klipstein-Grobusch, K. 2015. Predictors of skilled attendance at delivery among antenatal clinic attendants in Ghana: A cross-sectional study of population data. *BMJ Open* 5:[1-10].

Anastasi, E., Borchert, M., Campbell, O.M., Sondorp, E., Kaducu, F., Hill, O., Okeng, D., Odong, V.N. & Lange, I.L. 2015. Losing women along the path to safe motherhood: Why is there such a gap between women's use of antenatal care and skilled birth attendance? A mixed methods study in Northern Uganda. *BMC Pregnancy and Childbirth* 15:[1-15].

Anyait, A., Mukanga, D., Oundo, G.B. & Nuwaha, F. 2012. Predictors for health facility delivery in Busia district of Uganda: A cross sectional study. *BMC Pregnancy and Childbirth* 12:[1-9].

Arthur, S. & Nazroo, J. 2003. Designing *fieldwork* strategies and materials. In J. Ritchie & J. Lewis (ed.). *The Qualitative research practice: A guide for social science students and researchers*. London: SAGE: 09-137.

Asefa, A. & Bekele, D. 2015. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. *Reproductive Health* 12(33):[1-9].

Ayres, L. 2008a. Semi-structured interview, in *The SAGE Encyclopedia of qualitative research methods,* edited by LM Given. Volume 1 & 2. California: SAGE:810-811.

Ayres, L. 2008b. Thematic coding and analysis, in *The SAGE Encyclopedia of qualitative research methods,* edited by L.M. Given. Volume 1 & 2. California: SAGE:867-868.

Babalola, S. & Fatusi, A. 2009. Determinants of use of maternal health services in Nigeria – looking beyond individual and household factors. *BMC Pregnancy and Childbirth* 9:[1-13].

Baker, D.P., Day, R. & Salas, E. 2006. Teamwork as an essential component of high-reliability organizations. *Health Services Research* 41(4):1576-1598.

Ban Ki-moon. 2010. *Global strategy for women's and children health*. Geneva: UN.

Baral, Y.R., Lyons, K., Skinner, J. & Van Teijlingen, E.R. 2010. Determinants of skilled birthattendants for delivery in Nepal. *Kathmandu University Medical Journal* 8(3):325-332.

Barber, S. 2006.Does the quality of prenatal care matter in promoting skilled institutional delivery? A study in rural Mexico. *Maternal Child Health Journal* 10:419-425.

Balnaves, M. & Caputi, P. 2001. *Introduction to quantitative research methods An investigative approach*. London: Sage.

Bayu, H., Fisseha, G., Mulat, A., Yitayih, G. & Wolday, M. 2015. Missed opportunities for institutional delivery and associated factors among urban resident pregnant women in South Tigray Zone, Ethiopia: a community-based follow-up study. *Global Health Action* 8:[1-8].

Belda, S.S. & Gebremariam, M.B. 2016. Birth preparedness, complication readiness and other determinants of place of delivery among mothers in Goba District, Bale Zone, South East Ethiopia. *BMC Pregnancy and Childbirth* 16(73):[1-8].

Berg, B.L. 2001. *Qualitative research methods for the social sciences*. 4th edition. Needham: Pearson Education.

Bhandari, G., Subedi, N., Thapa, J., Choulagai, B., Maskey, M. & Onta, S. 2014. A cluster randomized implementation trial to measure the effectiveness of an intervention package aiming to increase the utilization of skilled birth attendants by women for childbirth: study protocol. *BMC Pregnancy and Childbirth* 14(109):[1-9].

Bhattacharyya, S., Srivastava, A. & Avan, B.I. 2013. Delivery should happen soon and my pain will be reduced: understanding women's perception of good delivery care in India. *Global Health Action* 6:[1-7].

Bhopal, S.S., Halpin, S.J. & Gerein, N. 2012. Emergency obstetric referral in Rural Sierra Leone: What can motorbike ambulances contribute? A mixed-methods study. *Maternal Child Health Journal*:[1-7].

Birch, M., Miller, T., Mauthner, M. & Jessop, J. (Eds). 2002. *Ethics in qualitative research.* London: SAGE.

Birmeta, K., Dibaba, Y. & Woldeyohannes, D. 2013. Determinants of maternal health care utilization in Holeta town, central Ethiopia. *BMC Health Services Research* 13:[1-10].

Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K., Souza, J.P., Aguiar, C., Coneglian, F.S., Diniz, A.L.A., Tunçalp, Ö., Javadi, D., Oladapo, O.T., Khosla, R., Hindin, M.J. & Gülmezoglu, A.M. 2015.The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Medicine* 12(6):[1-32].

Bohren, M.A., Hunter, E.C., Munthe-Kaas, H.M., Souza, J.P., Vogel, J.P. & Gülmezoglu, A.M. 2014. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reproductive Health* 11:[1-17].

Bowling, A. & Ebrahim, S. (Eds.). 2005. *Handbook of health research methods: Investigation, measurement and analysis*. England: Open University Press.

Brannen, J. & Halcomb, E.J. 2009. Data collection in mixed methods research. In S. Andrew & E. Halcomb (Eds.). *Mixed methods research for nursing and the health sciences*. West Sussex: Blackwell:67-83.

Bruce, S.G., Blanchard, A.K., Gurav, K., Roy, A., Jayanna, K., Mohan, H.L., Ramesh, B.M., Blanchard, J.F., Moses, S. & Avery, L. 2015. Preferences for infant delivery site among pregnant women and new mothers in Northern Karnataka, India. *BMC Pregnancy and Childbirth* 15:[1-10].

Byrne, A. & Morgan, A. 2011. How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance*. International Journal of Gynaecology and Obstetrics* 115:127-134.

Canavan, A. 2009. *Review of global literature on maternal health interventions and outcomes related to skilled birth attendance.* KIT Working Papers Series H3. Amsterdam: KIT.

Cargill, Y. & Martel, M.J. 2007. Postpartum maternal and newborn discharge. *Journal of Obstetrics and Gynaecology Canada* 29(4):357-359.

Carlough, M. & McCall, M. 2005. Skilled birth attendance: What does it mean and how can it be measured? A clinical skills assessment of maternal and child health workers in Nepal. *International Journal of Gynecology and Obstetrics* 89(2):200-208.

Carter, S. & Henderson, L. 2005. Approaches to qualitative data collection in social science. In A. Bowling & S. Ebrahim.(Eds.). *The Handbook of health research methods: Investigation, measurement and analysis*. England: Open University Press:215-229

Central Statistical Agency [Ethiopia]. 2014. *Ethiopia mini demographic and health survey 2014*. Addis Ababa, Ethiopia.

Central Statistical Agency [Ethiopia] and ICF International. 2012. *Ethiopia demographic and health survey 2011*. Addis Ababa and Maryland: Central Statistical Agency and ICF International.

Chaibva, C.N., Roos, J.H. & Ehlers, V.J. 2009. Adolescent mothers' non-utilisation of antenatal care services in Bulawayo, Zimbabwe. *Curationis* 32(3):14-21.

Chakraborty, N., Islam, M.A., Chowdhury, R.I., Bari, W. & Akhter, H.H. 2003. Determinants of the use of maternal health services in rural Bangladesh. *Health Promotion International* 18(4):327-337.

Cham, M., Sundby, J. & Vangen, S. 2009. Availability and quality of emergency obstetric care in Gambia's main referral hospital: women-users' testimonies. *Reproductive Health* 6(5):1-8.

Cham, M., Sundby, J. & Vangen, S. 2005. Maternal mortality in the rural Gambia, a qualitative study on access to emergency obstetric care. *Reproductive Health* 2(3):1-8

Champion, V.L. & Skinner, C.S. 2008. The health belief model. In K. Glanz, B.K. Rimer, & K. Viswanath. *Health behavior and health education: theory, research, and practice.* 4th edition. San Francisco: Jossey-Bass:45-62.

Chaturvedi, S., Randive, B., Diwan, V. & De Costa, A.2 014. Quality of obstetric referral services in India's JSY cash transfer programme for institutional births: A Study from Madhya Pradesh Province. *PLoS ONE* 9(5):1-11.

Choulagai, B., Onta, S., Subedi, N., Mehata, S., Bhandari, G., Poudyal, A., Shrestha, B., Mathai, M., Petzold, M. & Krettek, A.2 013. Barriers to using skilled birth attendants' services in mid- and far-western Nepal: A cross-sectional study*. BMC International Health and Human Rights* 13(49):1-9.

Creswell, J.W. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches*. 3rd edition. London: SAGE.

Crissman, H., Engmann, C., Adanu, R., Nimako, D., Crespo, K. & Moyer, C. 2013. Shifting norms: pregnant women's perspectives on skilled birth attendance and facility–based delivery in rural Ghana*. African Journal of Reproductive Health* 17(1):15-26.

Crowe, S., Utley, M., Costello, A. & Pagel, C. 2012. How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015*? BMC Pregnancy and Childbirth* 12(4):1-9.

D'Ambruoso, L., Abbey, M. & Hussein, J. 2005. Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health* 5:[1-11].

Darmstadta, G., Leea, A., Cousensc, S., Sibleyd, L., Bhuttae, Z., Donnayb, F., Osrinf, D., Bangg, A., Kumara, V., Wallh, S., Baquia, A. & Lawnh, J. 2009. 60 million non-facility births: Who can deliver in community settings to reduce intrapartum-related deaths? *International Journal of Gynaecology and Obstetetrics* 107(Suppl 1):S89-S112.

Dawson, C. 2009. *Introduction to research methods: a practical guide to anyone undertaking a research project*. 4th edition. Oxford: How to Books.

Dawson, C. 2007. *A practical guide to research methods: a user- friendly manual for mastering research techniques and projects*. 3rd edition. Oxford: How to Books.

Dettrick, Z., Firth, S. & Soto, E.J. 2013. Do strategies to improve quality of maternal and child health care in lower and middle income countries lead to improved outcomes? A review of the evidence. *PLoS ONE* 8(12):1-9.

Devasenapathy, N., George, M.S., Jerath, S.G., Singh, A., Negandhi, H., Alagh, G., Shankar, A.H & Zodpey, S. 2014. Why women choose to give birth at home: a situational analysis from urban slums of Delhi. *BMJ Open* 4:[1-11].

Dhakal, S., Edwin, V.T., Raja, E.A. & Dhakal, K.B. 2011.Skilled care at birth among rural women in Nepal: Practice and challenges. *Journal of Health Population and Nutrition* 29(4):371-378.

Ediau, M., Wanyenze, R.K., Machingaidze, S. Otim, G., Olwedo, A., Iriso, R. & Tumwesigye, N.M. 2013.Trends in antenatal care attendance and health facility delivery following community and health facility systems strengthening interventions in Northern Uganda. *BMC Pregnancy and Childbirth* 13:[1-11].

Ellis, P. 2010. *Understanding research for nursing students*. Exeter: Learning Matters.

Elmusharaf, K., Byrne, E. & O'Donovan, D. 2015. Strategies to increase demand for maternal health services in resource-limited settings: challenges to be addressed. *BMC Public Health* 15:[1-10].

Essendi, H., Johnson, F.A., Madise, N., Matthews, Z., Falkingham, J., Bahaj, A.S., Patrick, J. P. & Blunden, L. 2015. Infrastructural challenges to better health in maternity facilities in rural Kenya: community and health worker perceptions. *Reproductive Health* 12:[1-11].

Essendi, H., Mills, S, & Fotso, J.C. 2010. Barriers to formal emergency obstetric care services' utilization. J*ournal of Urban Health: Bulletin of the New York Academy of Medicine* 88(2):S356-S369.

Evelyn, S., Lois, M., Judith, B., Henry, D., Kojo, Y. & Samuel, M. 2014. *Is there any role for community involvement in the community-based health planning and services skilled delivery program in rural Ghana? BMC Health Services Research* 14:[1-14].

Family Care International. 2005. *Compassionate maternity care: provider communication and counseling skills*. New York: Family Care International.

Fapohunda, B. & Orobaton, N. 2014. Factors influencing the selection of delivery with no one present in Northern Nigeria: implications for policy and programs. *International Journal of Women's Health* 6:171-183.

Fitzpatrick, J.J. & Wallace, M. (Eds). 2006. *Encyclopedia of nursing research*. 2nd edition. New York: Springer.

FMOH. 2013. *HSDP IV annual performance report:* EFY 2005(2012/2013). Addis Ababa: Ministry of Health.

FMOH. 2010*. Health sector development programme IV:* 2010/11–2014/15.Addis Ababa: Ministry of Health.

FMOH. 2006. *National reproductive health strategy: 2006–2015*. Addis Ababa: Department of Family Health.

Gabrysch, S. & Campbell, O. M. 2009. Still too far to walk Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth* (34):[1-18].

Gabrysch, S., Cousens, S., Cox, J. & Campbell, O. 2011. The influence of distance and level of care on delivery place in rural Zambia: A study of linked national data in a geographic information system. *PLoS Medicine* 8(1):[1-12].

Garg, R., Shyamsunder, D., Singh, T. & Singh, P.A. 2010. Study on delivery practices among women in rural Punjab*. Health and Population: Perspectives and Issues* 33(1):23-33.

Garnham, B. 2008. Data generation. In L.M. Given. *The SAGE Encyclopedia of qualitative research methods,* Volume 1 & 2. pp. 192-193California: SAGE:192-193.

Gebrehiwot, T. Goicolea, I., Edin, K. & Sebastian, M.S. 2012. Making pragmatic choices: women's experiences of delivery care in Northern Ethiopia. *BMC Pregnancy and Childbirth* 12:[1-11].

Gitimu, A., Herr, C., Oruko, H., Karijo, E., Gichuki, R., Ofware, P., Lakati, A. & Nyagero, J. 2015. Determinants of use of skilled birth attendant at delivery in Makueni, Kenya: A cross sectional study. *BMC Pregnancy and Childbirth* 15:[1-7].

Given, L.M. & Saumure, K. 2008. Trustworthiness. In L.M. Given (Ed.).*The SAGE Encyclopedia of qualitative research methods.* Volume 1 & 2. pp. 895-896. California: SAGE.

Glanz, K., Rimer, B.K. & Viswanath, K. (Eds). 2008. *Health behaviour and health education: theory, research and practice*. 4th edition. San Francisco: Jossey-Bass.

Godefay, H., Kinsman, J., Admasu, K. & Byass, P. 2016*. Can innovative ambulance transport avert pregnancy–related deaths? One-year operational assessment in Ethiopia*. *Journal of Global Health* 6(1):167-175.

Goo, L. & Harlow, S.D. 2012. Intimate partner violence affects skilled attendance at most recent delivery among women in Kenya. *Matern Child Health Journal* 16:1131–1137.

Graham, W., Bell, J. & Bullough, W. 2001. Can skilled attendance reduce maternal mortality in developing countries? *Stud HSO&P* 17:97-129.

Gray, P.S., Williamson, J.B., Karp, D.A. & Dalphin, J.R. 2007. *The research imagination: an introduction to qualitative and quantitative methods*. New York: Cambridge University Press.

Green, J. & Thorogood, N. 2004. *Qualitative methods for health research*.London: SAGE.

Greener, S. 2008. *Business research methods*. Ventus Publishing Aps.

Hardon, A., Vernooij, E., Bongololo-Mbera, G., Cherutich, P., Desclaux, A., Kyaddondo, D., Ky-Zerbo, O., Neuman, M., Wanyenze, R. & Obermeyer, C. 2012. Women's views on consent, counseling and confidentiality in PMTCT: A mixed-methods study in four African countries. *BMC Public Health* 12:[1-15].

Harvey, S.A., Blandón, Y.C.W., McCaw-Binns, A., Sandino, I., Urbina, L., Rodríguez, C., Gomez, I.A., Ayabaca, P. & Djibrina, S. 2007. Are skilled birth attendants skilled? A measurement method, some disturbing results and a potential way forward. *Bulletin of the World Health Organization* 85:783-790.

Hazarika, I. 2011. Factors that determine the use of skilled care during delivery in India: implications for achievement of MDG-5 targets. *Matern Child Health Journal* 15:1381-1388.

Hodnett, E.D., Gates, S., Hofmeyr, G.J. & Sakala, C. 2013. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 7:[1-118].

Holloway, I. 2005. *Qualitative research in health care.* Maidenhead: Open University Press.

Hounton, S., Chapman, G., Menten, J., Brouwere, V., Ensor, T., Sombie', I., Meda, N. & Ronsmans, C. 2008. Accessibility and utilisation of delivery care within a skilled care initiative in rural Burkina Faso. *Tropical Medicine and International Health* 13(Supplemental I):44-52.

Hounton, S., Menten, J., Ouedraogo, M., Dubourg, D., Meda, N., Ronsmans, C., Byass, P. & Brouwere, V. 2008. Effects of a skilled care initiative on pregnancy-related mortality in rural Burkina Faso. *Tropical Medicine and International Health* 13(Supplmental I):53-60.

Harvey, S.A., Ayabaca, P., Bucagu, M., Djibrina, S., Edson, W.N., Gbangbade, S., McCaw-Binns, A. & Burkhalter, B.R. 2004. Skilled birth attendant competence: an initial assessment in four countries, and implications for the Safe Motherhood movement. *International Journal of Gynecology and Obstetrics* 87(2):203-210.

Hulton, L.A., Matthews, Z. & Stones, R.W. 2007. Applying a framework for assessing the quality of maternal health services in urban India. *Social Science and Medicine* 64:2083-2095.

Hulton, L.A., Matthews, Z. & Stones, R.W. 2000. *A framework for evaluation of quality of care in maternity services*. University of Southampton: Southampton.

Ir, P., Horemans, D., Souk, N. & Van Damme, W. 2010. Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia. *BMC Pregnancy and Childbirth* 10(1):1-11.

Islam, M. & Yoshida, S. 2009. MDG 5: How close are we to success? *British Journal of Gynaecology and Obstetrics* 116:2-5.

Israel, M. & Hay, I. 2008. Informed consent. In L.M. Given (Ed.). *The SAGE Encyclopedia of qualitative research methods.*Volume 1 & 2. California: SAGE:431-432.

Ith, P., Dawson, A., Homer, C. & Whelan, A.K. 2013. Practices of skilled birth attendants during labour, birth and the immediate postpartum period in Cambodia. *Midwifery* 29:300-307.

Ith, P., Dawson, A. & Homer, C. 2012. Quality of maternity care practices of skilled birth attendants in Cambodia. *International Journal of Evidence-based Health Care* 10:60-67.

Jacobsen, K.H., Ansumana, R., Abdirahman, H.A., Bockarie, A.S., Bangura, U., Meehan, K.A., Jimmy, D.H., Malanoski, A.P., Sundufu, A.J. & Stenger, A. 2012. Considerations in the selection of healthcare providers for mothers and children in Bo, Sierra Leone: reputation, cost and location. *International Health* 4(4):307-313.

Jackson, R., Tesfay, F.H., Godefay, H. & Gebrehiwot, T.G. 2016. Health extension workers' and mothers' attitudes to maternal health service utilization and acceptance in Adwa woreda, Tigray region, Ethiopia. *PLoS ONE* 11(3):[1-15].

Jensen, D. 2008a. Confirmablity. In L.M. Given (Ed.). *The SAGE Encyclopedia of qualitative research methods.* pp. 112. Volume 1 & 2. California: SAGE:112.

Jensen, D. 2008b. Credibility, in *The SAGE Encyclopedia of qualitative research methods,* edited by LM Given. Volume 1 & 2. California: SAGE:138-139.

Jensen, D.2008c. Dependability, in *The SAGE Encyclopedia of qualitative research methods,* edited by LM Given. Volume 1 & 2. California: SAGE:208-209.

Jensen, D. 2008d. Transferability, in *The SAGE Encyclopedia of qualitative research methods,* edited by LM Given. Volume 1 & 2. California: SAGE:886.

Joharifard, S., Rulisa, S., Niyonkuru, F., Weinhold, A., Sayinzoga, F., Wilkinson, J., Ostermann, J. & Thielman, N. 2012. Prevalence and predictors of giving birth in health facilities in Bugesera District, Rwanda. *BMC Public Health* 12(1049):1-10.

Jones, L.C., Jensen, J.D., Scherr, C.L., Brown, N.R., Christy, K. & Weaver, J. 2015.The Health Belief Model as an explanatory framework in communication research: Exploring parallel, serial, and moderated mediation. *Health Communication* 30(6):566-576.

Julinawati, S.; Cawley, D.; Domegan, C.; Brenner, M. & Rowan, N.J. 2013. A review of the perceived barriers within the Health Belief Model on pap smear screening as a cervical cancer prevention measure.*Journal of Asian Scientific Research* 3(6):677-692.

Kabakyenga, J.K., Östergren, P., Eleanor, T. & Pettersson, K.O. 2012. Influence of birth Preparedness, decision-making on location of birth and assistance by skilled birth attendants among Women in South-Western Uganda. *PLoS ONE* 7(4):[1-8].

Kabakyenga, J.K., Östergren, P., Eleanor, T. & Pettersson, K.O. 2011. Knowledge of obstetric danger signs and birth preparedness practices among women in rural Uganda. *Reproductive Health* 8:[1-10].

Karkee, R., Lee, A.H. & Binns, C.W. 2013. Why women do not utilize maternity services in Nepal?: A literature review. *WHO South East Asia Journal of Public Health* 2(3-4):135-141.

Kawakatsu, Y., Sugishita, T., Oruenjo, K., Wakhule, S., Kibosia, K., Were, E. & Honda, S. 2014. Determinants of health facility utilization for childbirth in rural western Kenya: cross-sectional study. *BMC Pregnancy and Childbirth* 14(265):1-10.

Kebede, B., Gebeyehu, A. & Andargie, G.2013.Use of previous maternal health services has a limited role in reattendance for skilled institutional delivery: Cross-sectional survey in Northwest Ethiopia. *International Journal of Women's Health* 5:79-85.

Khan, K.S, Wojdyla, D., Say, L., Gülmezoglu, A.M. & Van Look, P.F.A. 2006. WHO analysis of causes of maternal death: a systematic review. *Lancet* 367:1066-1074.

Khogali, M., Zachariah, R., Reid, A.J., Alipon, S.C., Zimble, S., Gbane, M., Etienne, W., Veerman, R., Hassan, A. & Harries, AD. 2014. Do non-monetary incentives for pregnant women increase antenatal attendance among Ethiopian pastoralists? *Public Health Action* 4(1):12-14.

Kimani, H., Farquhar, C., Wanzala, P. & Ng'ang'a, Z. 2015. Determinants of delivery by skilled birth attendants among pregnant women in Makueni County, Kenya. *Public Health Research* 5(1):1-6.

Kitui, J., Lewis, S. & Davey, G. 2013. Factors influencing place of delivery for women in Kenya: an analysis of the Kenya demographic and health survey, 2008/2009. *BMC Pregnancy and Childbirth* 13(40):1-10.

Kitzinger, J. 2006. Focus groups, in *Qualitative research in health care,* edited by C Pope & N Mays. 3rd edition. Oxford: Blackwell:21-31.

Kok, M.C., Kea, A.Z., Datiko, D.G., Broerse, J.E.W., Dieleman, M., Taegtmeyer, M. & Tulloch, O. 2015. A qualitative assessment of health extension workers' relationships with the community and health sector in Ethiopia: Opportunities for enhancing maternal health performance. *Human Resources for Health* 13: 1-12.

Kothari, C.R. 2009. *Research methodology: Methods and techniques*. 2nd edition. New Delhi: New Age.

Kreyberg, I. & Helsingen, L.M. 2010. *Skilled attendance at delivery: How skilled are institutional birth attendants?* An explorative study on birth attendants at Bansang Hospital, Gambia. University of Oslo.

Kumbani, L., Bjune, G., Chirwa, E., Malata, A. & Odland, J. 2013. Why some women fail to give birth at health facilities: A qualitative study of women's perceptions of perinatal care from rural Southern Malawi. *Reproductive Health* 10:1-12.

Larkin, P., Begley, C.M. & Devane, D. 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery* 25:e49-e59.

Larson, E., Hermosilla, S., Kimweri, A., Mbaruku, G.M. & Kruk, M.E. 2014. Determinants of perceived quality of obstetric care in rural Tanzania: A cross-sectional study. *BMC Health Services Research* 14:1-9.

Lavender, T., Walkinshaw, S.A & Walton, I.1999. A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery* 15:40-46.

Leech, N.L. & Onwuegbuzie, A.J. 2008. Debriefing. In L.M. Given (Eds.). *The SAGE Encyclopedia of qualitative research methods.* Volume 1 & 2. California: SAGE:199-201.

Legard, R., Keegan, J. & Ward, K. 2003. In-depth interviews. In J. Ritchie & J. Lewis (Eds.).*Qualitative research practice: A guide for social science students and researchers* pp. 138-169. London: SAGE.

Lerberg, P.M, Sundby, J., Jammeh, A. & Fretheim, A. 2014. Barriers to skilled birth attendance: A survey among mothers in rural Gambia*. African Journal of Reproductive Health* 18(1):35-43.

Liambila, W. & Kuria, S. 2014. Birth attendance and magnitude of obstetric complications in Western Kenya: A retrospective case–control study. *BMC Pregnancy and Childbirth* 14(311):1-15.

Limenih, A., Deyesa, N. & Berhane, A. 2016. Assessing the magnitude of institutional delivery service utilization and associated factors among mothers in Debre Berhan, Ethiopia*. Journal of Pregnancy and Child Health* 3:1-7.

Lohela, T., Campbell, O. & Gabrysch, S. 2012. Distance to care, facility delivery and early neonatal mortality in Malawi and Zambia. *PLoS ONE* 7(12):[1-9].

Loke, A.Y., Davies, L. & Li, S. 2015. Factors influencing the decision that women make on their mode of delivery: the Health Belief Model. *BMC Health Services Research* 15:1-12.

Lori, J., Munro, M., Rominski, S., Williams, G., Dahn, B., Boyd, C., Moore, J. & Gwenegale, W. 2013. Maternity waiting homes and traditional midwives in rural Liberia. *International Journal of Gynecology and Obstetrics* 123:114-118.

Lubbock, L.A. & Stephenson, R.B. 2008. Utilization of maternal health care services in the department of Matagalpa, Nicaragua. *Pan American Journal of Public Health* 24(2):75-84.

Lugina, H., Mlay, R. & Smith, H. 2004. Mobility and maternal position during childbirth in Tanzania: an exploratory study at four government hospitals. *BMC Pregnancy and Childbirth* 4(3):1-10.

Lund, S., Hemed, M., Nielsen, B., Said, A., Said, K., Makungu, M. & Rascha, V. 2012. Mobile phones as a health communication tool to improve skilled attendance at delivery in Zanzibar: A cluster-randomised controlled trial. *British Journal of Gynacology and Obstetrics* 119:1256-1264.

Lyons, P. & Doueck, H.J. 2010. *The dissertation: From beginning to end*. New York: Oxford University Press.

Mack, N., Woodsong, C., Macqueen, K.M., Guest, G. & Namey, E. 2005. *Qualitative research methods: A data collector's field guide*. North Carolina: Family Health International.

Magoma, M., Requejo, J., Campbell, O.M., Cousens, S., Merialdi, M. & Filippi, V. 2013.The effectiveness of birth plans in increasing use of skilled care at delivery and postnatal care in rural Tanzania: a cluster randomised trial. *Tropical Medicine and International Health* 18(4):435-443.

Magoma, M., Requejo, J., Campbell, O.M., Cousens, S. & Filippi, V. 2010. High ANC coverage and low skilled attendance in a rural Tanzanian district: A case for implementing a birth plan intervention. *BMC Pregnancy and Childbirth* 10:[1-12].

Mahdi, S.S. & Habib, O.S. 2010. A study on preference and practices of women regarding place of delivery. *Eastern Mediterranean Health Journal* 16(8):874-878.

Mahiti, G.R., Mkoka, D.A., Kiwara, A.D., Mbekenga, C.K., Hurtig, A.K. & Goicolea, I. 2015. Women's perceptions of antenatal, delivery, and postpartum services in rural Tanzania. *Global Health Action* 5:1-9.

Maltby, J., Williams, G.A., McGarry, J. & Day, L. 2010. *Research methods for nursing and healthcare*. Harlow: Pearson Education.

Management Sciences for Health. 2010. *Health systems in action: An eHandbook for Leaders and Managers*. Cambridge, MA: Management Sciences for Health.

Mannah, M., Warren, C., Kuria, S. & Adegoke, A. 2014. Opportunities and challenges in implementing community based skilled birth attendance strategy in Kenya. *BMC Pregnancy and Childbirth* 14(279):1-12.

Mannava, P., Durrant, K., Fisher, J., Chersich, M. & Luchters, S. 2015. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalization and Health* 11(36):1-17.

Marston, C., Renedo, A., McGowan, C.R. & Portela, A. 2013. Effects of community participation on improving uptake of skilled care for maternal and newborn health: A systematic review. *PLoS ONE* 8(2):[1-9].

Marvasti, A.B. 2004. *An introduction to qualitative research in sociology*. London: SAGE.

McMahon, S.A., George, AS., Chebet, J.J., Mosha, I.H., Mpembeni, R.N.M. & Winch, P.J. 2014. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy and Childbirth* 14:[1-13].

Medema-Wijnveen, J., Onono, M., Bukusi, E., Miller, S., Cohen, C. & Turan, J. 2012. How perceptions of HIV-related stigma affect decision-making regarding childbirth in rural Kenya. *PLOS ONE* 7(12):[1-8].

Melese, T., Gebrehiwot, Y., Bisetegne, D. & Habte, D. 2014. Assessment of client satisfaction in labor and delivery services at a maternity referral hospital in Ethiopia. *Pan African Medical Journal* 17(76):[1-8].

Mengesha, Z., Biks, G., Ayele, T., Tessema, G. & Koye, D. 2013. Determinants of skilled attendance for delivery in Northwest Ethiopia: A community based nested case control study*. BMC Public Health* 13:[1-6].

Mensah, R.S., Mogale, R.S. & Richter, M.S. 2014. Birthing experiences of Ghanaian women in 37th Military Hospital, Accra, Ghana. *International Journal of Africa Nursing Sciences* 1:29-34.

Metcalfe, R. & Adegoke, A. 2013. Strategies to increase facility-based skilled birth attendance in South Asia: A literature review. *International Health* 5:96-105.

Montoya, A., Calvert, C. & Filippi, V. 2014. Explaining differences in maternal mortality levels in Sub-Saharan African hospitals: a systematic review and meta-analysis. *International Health* 6:12-22.

Moore, M., Armbruster, D., Graeff, J. & Copeland, R. 2002. *Assessing the "caring" behaviors of skilled maternity care providers during labor and delivery: Experience from Kenya and Bangladesh.* The change project: Washington.

Morgan, D.L. & Guevara, H. 2008. Audio recording. In L.M. Given (Ed.). *The SAGE Encyclopedia of qualitative research methods*. Volume 1 & 2. : 40-41. California: SAGE.

Morgan, A., Soto, E.J., Bhandari, G. & Kermode, M. 2014. Provider perspectives on the enabling environment required for skilled birth attendance: a qualitative study in western Nepal*. Tropical Medicine and International Health* 00(00):1-9.

Morrison, J., Thapa, R., Hartley, S., Osrin, D., Manandhar, M., Tumbahangphe, K., Neupane, R., Budhathoki, B., Sen, A., Pace, N., Manandhar, D.S. & Costello, A. 2010. Understanding how women's groups improve maternal and newborn health in Makwanpur, Nepal: A qualitative study. *International Health* 2:25-35.

Mosadeghrad, A.M. 2014. Factors influencing healthcare service quality. *International Journal of Health Policy Managment* 3(2):77-89.

Moyer, C., Dako-Gyeke, P. & Adanu, R. 2013. Facility-based delivery and maternal and early neonatal mortality in sub-Saharan Africa: a regional review of the literature. *African Journal of Reproductive Health* 17(3):30-43.

Moyer, C.A. & Mustafa, A. 2013. Drivers and deterrents of facility delivery in sub-Saharan Africa: a systematic review. *Reproductive Health* 10(40):1-14.

Mpembeni, R., Killewo, J.Z., Leshabari, M.T., Massawe, S.N., Jahn, A., Mushi, D. & Mwakipa, H. 2007. Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG-5 targets. *BMC Pregnancy and Childbirth* 7:[1-7].

Mrisho, M., Schellenberg, J., Mushi, A., Obrist, B., Mshinda, H., Tanner, M. & Schellenberg, J. 2007. Factors affecting home delivery in rural Tanzania. *Tropical Medicine and International Health* 12(7):862-872.

Mselle, L.T., Moland, K.M., Mvungi, A., Evjen-Olsen, B. & Kohi, T.W. 2013. Why give birth in health facility? Users and providers' accounts of poor quality of birth care in Tanzania. *BMC Health Services Research* 13:1-12.

Mselle, L.T., Kohi, T.W., Mvungi, A., Evjen-Olsen, B. & Moland, K.M. 2011. Waiting for attention and care: Birthing accounts of women in rural Tanzania who developed obstetric fistula as an outcome of labour. *BMC Pregnancy and Childbirth* 11:1-13.

Muller, M., Bezuidenhout, M.C. & Jooste, K. 2011. *Healthcare service management*. 2nd edition. Cape Town: Juta.

Munjial, M., Kaushik, P. & Agnihotri, S. 2009. A comparative analysis of institutional and non-institutional deliveries in a village of Punjab. *Health and population: Perspectives and Issues* 32(3):131-140.

Mushi, D., Mpembeni, R. & Jahn, A. 2010. Effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care. The case of Mtwara Rural District in Tanzania. *BMC Pregnancy and Childbirth* 10:1-9.

Nabudere, H., Asiimwe, D. & Amandua, J. 2013. Improving access to skilled attendance at delivery: A policy brief for Uganda*. International Journal of Technology Assessment in Health Care* 29(2):207-211.

Nathan, R. & Mwanyangala, M. 2012. Survival of neonates in rural Southern Tanzania: does place of delivery or continuum of care matter? *BMC Pregnancy and Childbirth* 12(18):1-7.

Neuman, W.L. 2007. *Basics of social research: Qualitative and quantitative approaches*. 2nd edition. Boston: Pearson.

Nilsson, L., Thorsell, T., Wahn, E.H. & Ekström, A. 2013. Factors influencing positive birth experiences of first-time mothers. *Nursing Research and Practice*:[1-6].

Ntozi, J. & Katusiime-Kabazeyo, F. 2016. Do cultural beliefs and practices influence place of delivery among women? A case of Ibanda district, Uganda? *African Population Studies* 30(2):2865-2875.

Ogden, R. 2008. Confidentiality. In L.M. Given (Ed.). *The SAGE Encyclopedia of qualitative research methods,*. Volume 1 & 2. California: SAGE:111.

Okeshola, F.B. & Sadiq, I.T. 2013. Determinants of home delivery among Hausa in Kaduna South Local Government Area of Kaduna State, Nigeria. *American International Journal of Contemporary Research*, 3(5):78-85.

Olayinka, O.A., Achi, O.T., Amos, A.O. & Chiedu, E.M. 2014. Awareness and barriers to utilization of maternal health care services among reproductive women in Amassoma community, Bayelsa State. *International Journal of Nursing and Midwifery* 6(1):10-15.

Onta, S., Choulagai, B., Shrestha, B., Subedi, N., Bhandari, G. & Krettek, A. 2014. Perceptions of users and providers on barriers to utilising skilled birth care in mid- and far-western Nepal: A qualitative study. *Global Health Action* 7:1-9.

Otis, K.E. & Brett, J.A. 2008. Barriers to hospital births: Why do many Bolivian women give birth at home? *Pan American Journal of Public Health* 24(1):46-53.

Ouédraogo, A., Kiemtoré, S., Zamané, H., Bonané, B.T., Akotiongaa, M. & Lankoande, J. 2014. Respectful maternity care in three health facilities in Burkina Faso: The experience of the Society of Gynaecologists and Obstetricians of Burkina Faso. *International Journal of Gynaecology and Obstetrics* 127:S40-S42.

Oxford Advanced Learner's Dictionary. 2010. Sv "content". 7th edition. Oxford University Press.

Oyerinde, K., Harding, Y., Amara, P., Garbrah-Aidoo, N., Kanu, R., Oulare, M., Shoo, R. & Daoh, K. 2013. A qualitative evaluation of the choice of traditional birth attendants for maternity care in 2008 Sierra Leone: implications for universal skilled attendance at delivery. *Journal of Maternal and Child Health* 17:862-868.

Pacagnella, R.C., Cecatti, J.G., Parpinelli, M.A., Sousa, M.H., Haddad, S.M., Costa, M.L., Souza, J.P. & Pattinson, R.C. 2014. Delays in receiving obstetric care and poor maternal outcomes: results from a national multicentre cross-sectional study. *BMC Pregnancy and Childbirth* 14:[1-15].

Pembe, A.B., Paulo, C., D'mello, B.S. & Roosmalen, J.V. 2014. Maternal mortality at muhimbili national hospital in Dar-es-Salaam, Tanzania in the year 2011. *BMC Pregnancy and Childbirth* 14:1-7.

Pembe, A.B. 2010. *Quality assessment and monitoring of maternal referrals in rural Tanzania.* Acta Universitatis Upsaliensis. Digital comprehensive summaries of Uppsala Dissertations from the Faculty of Medicine 552:1-58.

Pervin, J., Moran, A., Rahman, M., Razzaque, A., Sibley, L., Streatfield, PK., Reichenbach, L.J., Koblinsky, M., Hruschka, D. & Rahman, A. 2012. Association of antenatal care with facility delivery and perinatal survival– a population-based study in Bangladesh. *BMC Pregnancy and Childbirth* 12:[1-12].

Phiri, S., Fylkesnes, K., Ruano, A. & Moland, K. 2014. 'Born before arrival': user and provider perspectives on health facility childbirths in Kapiri Mposhi district, Zambia. *BMC Pregnancy and Childbirth* 14(323):1-10.

Phiri, S.N., Kiserud, T., Kvåle, G., Byskov, J., EvjenOlsen, B., Michelo, C., Echoka, E. & Fylkesnes, K. 2014. Factors associated with health facility childbirth in districts of Kenya, Tanzania and Zambia: A population based survey. *BMC Pregnancy and Childbirth* 14:[1-14].

Polit, D.F. & Beck, C.T. 2010. *Essentials of nursing research: Appraising evidence for nursing practice*. 7th edition. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Pope, C. & Mays, N. (Eds). 2006. *Qualitative research in health care*. 3rd edition. Oxford: Blackwell.

Punch, K.F. 2000. *Developing effective research proposals essential resources for social Research*. London: Sage.

Reblin, M. & Uchino, B.N. 2008. Social and emotional support and its implication for health. *Current Opinion in Psychiatry* 21(2):201-205.

Rodamo, K.M., Salgedo, W.B. & Nebeb, G.T. 2015. Magnitude and determinants of utilization of skilled birth attendance among women of child bearing age in Sidama Zone, Southeast Ethiopia. *Journal of Gynaecology and Obstetrics,* 3(4):69-76.

Roro, M., Hassen, E., Lemma, A., Gebreyesus, S. & Afework, M. 2014. Why do women not deliver in health facilities: a qualitative study of the community perspectives in south central Ethiopia? *BMC Research Notes* 7(556):1-7.

Rosen, H.E., Lynam, P.F., Carr, C., Reis, V., Ricca, J., Bazant, E.S. & Bartlett, L.A. 2015. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth* 15:1-11.

Roulston, K.J. 2008. Open-ended question. In L.M. Given. *The SAGE Encyclopedia of qualitative research methods.* Volume 1 & 2. California: SAGE:582.

Ruane, J.M. 2005. *Essentials of research methods: A guide to social science research*. Malden: Blackwell.

Sakeah, E., Doctor, H., McCloskey, L., Bernstein, J., Yeboah-Antwi, K. & Mills, S. 2014. Using the community-based health planning and services program to promote skilled delivery in rural *Ghana* socio-demographic factors that influence women utilization of skilled attendants at birth in Northern Ghana. *BMC Public Health* 14(344):1-9.

Saldaña, J. 2011.*Fundamentals of qualitative research: Understanding qualitative research*. New York: Oxford University Press.

Saldaña, J. 2009.The *coding manual for qualitative researchers*. London: SAGE.

Sandelowski, M. 2008. Member check. In L.M. Given (Ed.).*The SAGE Encyclopedia of qualitative research methods.* Volume 1 & 2. (pp.501-502).California: SAGE

Sarker, B.K., Rahman, M., Rahman, T., Hossain, J., Reichenbach, L. & Mitra, D.K. 2016. Reasons for preference of home delivery with traditional birth attendants (TBAs) in rural Bangladesh: A qualitative exploration. *PLoS ONE* 11(1):[1-19].

Saunders, M., Lewis, P. & Thornhill, A. 2009. *Research methods for business students*. 5th edition. Harlow: FT Prentice Hall.

Say, L. & Raine, R. 2007. A systematic review of inequalities in the use of maternal health care in developing countries: examining the scale of the problem and the importance of context*. Bulletin of the World Health Organization* 85(10):812-819.

Shabila, N.P., Ahmed, H.M. & Yasin, M.Y. 2014. Women's views and experiences of antenatal care in Iraq: A Q methodology study. *BMC Pregnancy and Childbirth* 14:[1-11].

Shah, N., Rohra, D., Shams, H. & Khan, N. 2010. Home deliveries: reasons and adverse outcomes in women presenting to a tertiary care hospital.*Journal of the Pakistan Medical Association* 60 (7):555-558.

Shehu, C.E., Ibrahim, M.T.O., Oche, M.O. & Nwobodo, E.I. 2016. Determinants of place of delivery: A comparison between an urban and a rural community in Nigeria. *Journal of Public Health and Epidemiology* 8(6):91-101.

Shenton, A.K. 2004. *Strategies for ensuring trustworthiness in qualitative research projects.* Education for information. City: IDS Press.

Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y. & Tekie, M. 2013. Why do women prefer home births in Ethiopia? *BMC Pregnancy and Childbirth* 13(5):1-10.

Shilling, T., Romano, A.M. & DiFranco, J.T. 2007. *Freedom of movement throughout Labor.* Journal of Perinatal Education 16(3):21-24.

Shimkhada, R., Solon, O. & Peabody, J.W. 2015. The health cost of misdiagnosis among obstetric providers in the Philippines*. Annals of Global Health* 81(1):102.

Sialubanje, C., Massar, K., Hamer, D.H. & Ruite, R.A.C. 2015. Reasons for home delivery and use of traditional birth attendants in rural Zambia: A qualitative study*. BMC Pregnancy and Childbirth* 15(216):[1-12].

Simfukwe, M.E. 2011*.* Factors contributing to home delivery in kongwa district, dodoma-September, 2008. *The Dar-es-salaam Medical Students' Journal*:13-22.

Singh, K., Brodish, P. & Suchindran, C. 2014. A regional multilevel analysis: can skilled birth attendants uniformly decrease neonatal mortality? *Journal of Maternal and Child Health* 18:242-249.

Singh, K. 2007. *Quantitative social research methods*. New Delhi: Sage.

Smith, F., Francis, S.A. & Schafheutle, E. 2008. *International research in health care*. London: Pharmaceutical Press.

Srivastava, A., Avan, B.I., Rajbangshi, P. & Bhattacharyya, S. 2015. Determinants of women's satisfaction with maternal health care: a review of literature from developing countries. *BMC Pregnancy and Childbirth* 15(97):[1-12].

Srivastava, A., Bhattacharyya, S., Clar, C. & Avan, B.I. 2014. Evolution of quality in maternal health in India: Lessons and priorities. *International Journal of Medicine and Public Health* 4(1):34-39.

Ssebunya, R. & Matovu, J.K.B. 2016. Factors associated with utilization of motorcycle ambulances by pregnant women in rural eastern Uganda: a cross-sectional study. *BMC Pregnancy and Childbirth* 16:1-16.

Storton, S. 2007. The Coalition for improving maternity services: Evidence basis for the ten steps of mother-friendly care. Step 4: Provides the birthing woman with freedom of movement to walk, move, and assume positions of her choice. *The Journal of Perinatal Education* 16(Supplmental 1):25S-27S.

Sword, W., Heaman, M.I., Brooks, S., Tough, S., Janssen, P.A., Young, D., Kingston, D., Helewa, M.E., Akhtar-Danesh, N. & Hutton, E. 2012.Women's and care providers' perspectives of quality prenatal care: a qualitative descriptive study. *BMC Pregnancy and Childbirth* 12(29):1-18.

Sychareun, V., Hansana, V., Somphet, V., Xayavong, S., Phengsavanh, A. & Popenoe, R. 2012. Reasons rural Laotians choose home deliveries over delivery at health facilities: a qualitative study. *BMC Pregnancy and Childbirth* 12(86):[1-10].

Sychareun, V., Phengsavanh, A., Hansana, V., Somphet, V. & Menorah, S. 2009. *Cultural beliefs and traditional rituals about child birth practices in Lao PDR. Kuala Lumpur, Malaysia*: The Asian-Pacific Resource & Research Centre for Women.

Tadese, F. & Ali, A. 2014. Determinants of use of skilled birth attendance among mothers who gave birth in the past 12 months in Raya Alamata District, North East Ethiopia. *Clinics Mother Child Health* 11:[1-9].

Tayelgn, A., Zegeye, D.T. & Kebede, Y. 2011. Mothers' satisfaction with referral hospital delivery service in Amhara Region, Ethiopia. *BMC Pregnancy and Childbirth* 11:[1-7].

Thaddeus, S & Maine, D. 1994. Too far to walk: maternal mortality in context. *Social Science Medicine* 38(8):1091-1110.

The Last Ten Kilometers Project (L10K). 2015. *Trends in reproductive, maternal, newborn and child health care practices in 115 L10K woredas: Analyses of three rounds of survey data*. JSI Research & Training Institute, Inc., Addis Ababa, Ethiopia.

Thompson, C. & Dowding, D. 2002. *Clinical decision-making and judgment in nursing*. London: Churchill Livingstone.

Titaley, C., Hunter, C., Dibley, M. & Heywood, P. 2010. Why do some women still prefer traditional birth attendants and home delivery? A qualitative study on delivery care services in West Java Province, Indonesia. *BMC Pregnancy and Childbirth* 10(43):1-14.

Tomedi, A., Tucker, K. & Mwanthi, M. 2013. A strategy to increase the number of deliveries with skilled birth attendants in Kenya. *International Journal of Gynecology and Obstetrics* 120:152-155.

Treiman, D.J. 2009. *Quantitative data analysis: doing social research to test ideas*. San Francisco: Jossey-Bass.

Tsegay, Y., Gebrehiwot, T., Goicolea, I., Edin, K., Lemma, H. & Sebastian, M.S. 2013. Determinants of antenatal and delivery care utilization in Tigray region, Ethiopia: a cross-sectional study. *International Journal for Equity in Health* 12:[1-10].

Tuladhar, H., Khanal, R., Kayastha, S., Shrestha, P. & Giri, A. 2009. Complications of home delivery: Our experience at Nepal Medical College Teaching Hospital. *Nepal Medical College Journal* 11(3):164-169.

Tura, G., Afework, M. & Yalew, A. 2014. The effect of birth preparedness and complication readiness on skilled care use: a prospective follow-up study in Southwest Ethiopia. *Reproductive Health* 11(60):[1-10].

Tura, G., Fantahun, M. & Worku, A. 2013. The effect of health facility delivery on neonatal mortality: systematic review and meta-analysis. *BMC Pregnancy and Childbirth* 13:[1-9].

Tura.n, J.M., Hatcher, A.H., Medema-Wijnveen, J., Onono, M., Miller, S., Bukusi, E.A, Turan, B. & Cohen, C.R. 2012. The role of HIV-related stigma in utilization of skilled childbirth services in rural Kenya: A prospective mixed methods study. *PLoS Medicine* 9(8):[1-12].

Ulin, P.R., Robinson, E.T. & Tolley, E.E. 2005. *Qualitative methods in public health: A field guide for applied research*.San Francisco: Jossey-Bass.

UN see United Nations.

UNISA see University of South Africa.

United Nations. 2014. *The Millennium Development Goals Report 2014*. New York: United Nations.

United Nations. 2010. *Human rights and the millennium development goals in practice: A review of country strategies and reporting*. New York: United Nations.

United Nations. 2003. *Indicators for monitoring the millennium development goals: Definitions, rationale, concepts and sources*. New York: United Nations.

Utz, B., Siddiqui, G., Adetoro, A., & Van Den Broek, N. 2013. Definitions and roles of a skilled birth attendant: A mapping exercise from four South-Asian countries. *Acta Obstetricia et Gynecologica Scandinavica* 92:1063-1069.

Vallières, F., Hansen, A., McAuliffe, E., Cassidy, E.L., Owora, P., Kappler, S. & Gathuru, E. 2013. Head of household education level as a factor influencing whether delivery takes place in the presence of a skilled birth attendant in Busia, Uganda: A cross-sectional household study. *BMC Pregnancy and Childbirth* 13:[1-8].

Waltz, C.F., Strickland, O.L. & Lenz, E.R. 2005. *Measurement in nursing and health research*. 3rd edition. New York: Springer.

Wasswa, P., Nalwadda, C.K., Buregyeya, E., Gitta, S.N., Anguzu, P. & Nuwaha, F. 2015. Implementation of infection control in health facilities in Arua district, Uganda: A cross-sectional study. *BMC Infectious Diseases* 15: [1-9].

White Ribbon Alliance. 2005. *Respectful maternity care: The universal rights of childbearing women*. White Ribbon Alliance: Washington.

WHO see World Health Organization.

Willig, C. 2013. *Introducing qualitative research in psychology*. 3rd edition. England: Open University Press.

Wilunda, C., Quaglio, G., Putoto, G., Takahashi, R., Calia, F., Abebe, D., Manenti, F., Riva, D.D., Betrán, A.P. & Atzori, A. 2015. Determinants of utilisation of antenatal care and skilled birth attendant at delivery in South West Shoa Zone, Ethiopia: A cross sectional study. *Reproductive Health* 12:1-12.

Wilunda, C., Quaglio, G., Putoto, G., Lochoro, P., Oglio, G., Manenti, F., Atzori, A., Lochiam, R., Takahashi, R., Mukundwa, A. & Oyerinde, K. 2014. A qualitative study on barriers to utilisation of institutional delivery services in Moroto and Napak districts, Uganda: implications for programming. *BMC Pregnancy and Childbirth* 14(259):1-12.

Wood, M.J. & Ross-Kerr, J.C. 2011. *Basic steps in planning nursing research: From question to proposal*. 7th edition. Massachusetts: Jones and Bartlet.

World Health Organization. 2014. *Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. Geneva: World Health Organization.

World Health Organization. 2013. *WHO recommendations on postnatal care of the mother and newborn*. Geneva: World Health Organization.

World Health Organization. 2012. *Trends in maternal mortality: 1990 to 2010. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. Geneva: World Health Organization.

World Health Organization. 2005a. Health *and the millennium development goals*. World Health Organization.

World Health Organization. 2005b.*The world health report 2005: Make every mother and child count*. Geneva: World Health Organization.

World Health Organization. 2004. *Making pregnancy safer: The critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO*. Geneva: Department of Reproductive Health and Research.

Worku, A., Yalew, A. & Afework, M. 2013. Factors affecting utilization of skilled maternal care in Northwest Ethiopia: a multilevel analysis. *BMC International Health and Human Rights* 13(20):1-11.

Yakoob, M., Ali, M., Ali, M., Imdad, A., Lawn, J.E., Broek, N. & Bhutta, Z. 2011.The effect of providing skilled birth attendance and emergency obstetric care in preventing stillbirths*. BMC Public Health* 11(Supplmental 3):[1-8].

Yanagisawa, S., Oum, S. & Wakai, S. 2006. Determinants of skilled birth attendance in rural Cambodia. *Tropical Medicine and International Health* 2(2):238-251.

Yin, R.K. 2010. *Qualitative research from start to finish*. New York: Guilford.

INTERNET SOURCE

http://www.oxforddictionaries.com (accessed on 31/12/2016).

ANNEXURES

ANNEXURE 1: ETHICAL CLEARANCE FROM UNISA

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/280/2013

Date:	10 December 2013	Student No:	5360-888-7
Project Title:	Factors influencing utilization of skilled delivery care in North West Ethiopia: Community based study.		
Researcher:	Biruhtesfa Bekele Shiferaw		
Degree:	D Litt et Phil	Code:	DPCHS04
Supervisor:	Prof LM Modiba		
Qualification:	D Cur		
Joint Supervisor:	-		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

For **Prof MM Moleki**
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

UNIVERSITEIT VAN SUID-AFRIKA
PRETORIA
UNIVERSITY OF SOUTH AFRICA

ANNEXURE 2: LETTER OF SUPPORT FROM UNISA REGIONAL LEARNING CENTER TO CONDUCT THE STUDY

UNISA university of south africa

16 JANUARY, 2014

UNISA-ET/KA/ST/29/16-01-14

AMHARA REGIONAL HEALTH BUREAU

BAHIR DAR

Dear **Madam/Sir,**

This is to confirm that Mr. Biruhtesfa Bekele Shiferaw (student number 53608887) is a PhD student in the Department of Health Studies at the University of South Africa (UNISA). Currently, he is at the stage of data collection on his Doctoral research entitled "***Factors Influencing Utilization of Skilled Delivery Care in North West Ethiopia: Community-based Study***."

This is therefore to kindly ask you to please assist the student to get ethical clearance from your Bureau that enables him to collect the necessary data. Attached, please find the copy of the Ethical Clearance he secured from the Department of Health Studies, UNISA.

UNISA REGIONAL LEARNING CENTRE
PO BOX 13836 ADDIS ABABA ETHIOPIA
TEL +251-114-350141
+251-114-350078
FAX +251-114-351243
MOBILE +251-912-191483

Sincerely,

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

UNISA – ETHIOPIA Centre of Graduate Studies

University of South Africa
Regional Learning Centre
PO Box 13836 ADDIS ABABA - Ethiopia
Telephone: +251 114 35 0141 / +251 114 35 0078
Facsimile: +251 114 35 1242/43/44
Mobile: +251 912 19 1483
www.unisa.ac.za

ANNEXURE 3: LETTER OF PERMISSION REQUEST TO AMHARA REGIONAL HEALTH BUREAU

Date: _____

To Amhara Regional Health Bureau

Bahir dar, Ethiopia

Subject: Request for permission to conduct a research in West Gojjam Zone

I am a Doctorate student (D Lit et Phil in Health Studies) with the University of South Africa (UNISA). The proposed research will look at factors influencing utilisation of skilled delivery services in West Gojjam zone, Amhara region with a view of coming up with strategies/interventions to improve utilisation of skilled delivery services.

The study proposal was duly reviewed and approved by UNISA, and subsequently reviewed and approved by Amhara Regional health bureau review committee. Please find attached letter of ethical clearance from both institutions.

Thus, I am kindly requesting you to grant me permission to conduct this proposed research in West Gojjam Zone, Amhara Region.

With Regards,

Biruhtesfa Bekele (BSC, MPH), DLitt et Phil (Candidate)

Tel:+251914681360

E-mail:53608887@mylife.unisa.ac.za or birbek@yahoo.com

ANNEXURE 4: LETTER OF PERMISSION FROM REGIONAL HEALTH BUREAU TO CONDUCT THE STUDY

በአማራ ብሔራዊ ክልላዊ መንግስት
Amhara National Regional State
ጤና ጥበቃ ቢሮ
Health Bureau

ቁጥር መ/ጥ/ቴ/ት/11/06
Ref.no.....
ቀን 11/07/06
Date.....

To: - Mr Biruhtesfa Bekele

Bahir Dar

Subject: Health Ethical Clearance

You have submitted a project proposal entitled with " **Factors Influencing Utilisation of Skilled Delivery Care in West Gojjam Zone"** to Regional Health Bureau Review Board for ethical approval.

The Regional Health Bureau Research Ethics Review Committee /RERC/ has reviewed the submitted project proposal critically. We are writing to advise you that the RERC has granted **Full approval**.

The project indicated above for a period of **One year**. All your more recently submitted documents have been approved for use in this study. The study should comply with the standard international and national scientific and ethical guideline. Any change to the approved protocol or consent material must be reviewed and approved through the amendment process prior to its implementation. In addition, any adverse or unanticipated events should be reported within 24-48 hours to RERC. Please insure that you submit progressive report prior the expiry date of project.

We, therefore, request your esteemed organization to ensure the commencement and conduct of the study accordingly and wish for the successful completion of the project.

With regards

Endalkachew Desalegn

D/Health Research and Technology Transfer Core Process Owner

Amhara National Regional State Health Bureau * Health Research and Technology Transfer Core Process *

C.C:-

- ARHB Health programs deputy head

✉ 495 Tell. 0582201698 0582220191 Fax. 0582266701 : 0582262396
Take care from AIDS

ANNEXURE 5: CONSENT LETTER FOR PARTICIPANTS

Study Title: Strategies to improve utilisation of skilled birth attendance service in North West Ethiopia

Researcher: Biruhtesfa Bekele Shiferaw

Biruhtesfa Bekele Shiferaw, a public health professional currently pursuing a Doctoral degree from the University of South Africa conducting a study as titled above in the fulfillment of the requirements for the degree of Doctor of Literature and Philosophy degree in Health Studies (DLitt et Phil). This study will be conducted in selected districts (woredas) and health facilities of West Gojjam Zone, Amhara Region.

The purpose of this study is to identify what factors are influencing skilled delivery service utilisation in West Gojjam Zone. The researcher intends to use the findings from this research to improve skilled delivery service utilisation in the region.

The Amhara regional health bureau ethical review committee has approved that the study can be conducted in the Region. Heads of the study districts and health facilities have been notified to this effect.

I , the undersigned individual being oriented about the relevance of this study in improving the skilled delivery service utilisation was well informed. I have been also informed that, there will be no risk or harm to my participation in this study. My participation in this study is crucial and all my information is to be kept confidential and will be used solely for this study. In addition, I have been well informed that my name will not be asked and unique identification is not required. I have the right not to discuss issues that I do not want to. If I want to withdraw from the study any time along the discussion process, I will not be obliged to continue or give reasons for doing so.

However, my agreement to participate in this study is with the assumption that, the information that I provide during the discussion will help greatly to understand the factors influencing skilled delivery utlisation that might help in improving the service provision.

In case you need any clarification, you can ask the research assistants discussing with you. Or you can contact the researcher with the following address. **Biruhtesfa Bekele; Tel: +251914681360; e-mail: 53608887@mylife.unisa.ac.za**

I have read this form and voluntarily consent to participate in this study.

Participant's Signature:_____ Date: _____

I have explained this to the above participant and have sought his/her understanding for informed consent.

Researcher/ research assistant's Signature:_____ Date:_____

ANNEXURE 6: CONSENT LETTER FOR PARTICIPANTS (AMHARIC)

የፈቃደኝነትመግለጫፎርም

መግቢያ

ጤናይስጥልኝ፡፡----------እባላለሁ፡፡

እኔየዚህጥናትቡድንአባልስሆንይህጥናትበደቡብአፍሪካዩንቨርስቲተማሪይጠናል፡፡

በዚህጥናትውስጥለሚያደርጉትተሣተፎበቅድሚያበጣምአመሰግናለሁ፡፡

ስለጥናቱአላማከዚህበታችእንደሚከተለውእገልፅሎታለሁ፡፡

የጥናቱአላማ

የዚህጥናትዓላማበዚህአካባቢበጤናድርጅት/በሰለጠነባለሙያወሊድአገልግሎትምንእንደሚመስልማወቅሲሆንከዚህበመነሳትወደፊትአገልግሎቱንለመሻሻልእናየአካባቢውንህብረተሰብየበለጠተጠቃሚማድረግነው፡፡

በጥናቱመሳተፍንበተመለከተ

ይህቃለመጠይቅበግምት60ደቂቃዎችያህልይወስዳልበዚህጥናትውስጥለመሳተፍየእርሶፈቃደኝነትአስፈላጊሲሆንያለመሳተፍሙሉመብትአለዎት፡፡ለመሳተፍፍቃደኛባይሆኑምበእርሶላይምንምየሚደርስነገርየለም፡

ፍቃደኛሆነውቃለመጠይቅከተጀመረበኋላምቢሆንለሚጠየቀውጥያቄመልስያለመስጠትወይምቃለመጠይቁንበፈለጉጊዜማስቆምይችላሉ፡፡

የምናደርገውቃለመጠይቅሚስጥራዊነቱየተጠበቀሲሆንየዚህጥናትአጥኚዎችእርሶየሚሰጡትመረጃስለእርሶየግልማንነትአንዳችየሚገልፅነገርእንዳይኖረውአስፈላጊውንጥንቃቄሁሉያደርጋሉ፡፡

የሰጡትመረጃሚስጥራዊነቱየተጠበቀሆኖእንዲቀርለዚህጥናትበተዘጋጀኮምፒተርተቆልፎየሚቀመጥሲሆንከጥናቱአጥኚዎችበስተቀርማንምሊያየውአይችልም፡፡የጥናቱየመጨረሻውጤትለጤናባለሙያዎች፤

ለፖሊሲአውጪዎችእንዲሁምበተለያዩኮነፈረንሶችበማቅረብበጤናድርጅት/በሰለጠነባለሙያወሊድንለማሻሻልጥረትይደረጋል፡

፡ይህጥናትበሰውላይምንምጉዳትእንደማያደርስከአማራከልልጤናቢሮምርምርናጥናትክፍልማረጋገጫተሰጥቶታል፡፡

እርሶበዚህጥናትበመሳተፍዎምክንያትበእርሶላይየሚደርስአንዳችጉዳትየለም፡፡

በእርግጥበጥናቱበመሳተፍዎየሚያገኙትየገንዘብምሆነሌላጥቅምየለም፡፡

ነገርግንየእርሶበዚህጥናትመሳተፍናለቃለመጠይቁየሚሰጡትመልስትልቅግምትየሚሰጠውናለጥናቱእጅግጠቃሚሲሆንየክልሉጤናቢሮለዚህአከባቢህብረተሰብየሚሰጠውንየጤናአገልግሎትለማሻሻልለሚያደርጉትጥረትመልካምግብዓትይሆናል፡፡

ጥያቄአለዎትት? አዎ--------የለኝም----------

ለመረጃሰብሳቢውማስታወሻ፡ጥያቄካለጥያቄውንከዚህበታችአስፍር፡፡

ተጨማሪጥያቄካለየጥናቱንአጥኝአቶብሩህተሰፋበቀለበስልክቁጥር 0914 681360 ደውለውመጠየቅይችላሉ፡፡

በጥናቱለመሳተፍፈቃደኛነዎት? አዎ--------አይደለሁም----------

(መረጃሰብሳቢ፡ፈቃደኛካልሆኑበማመስገንተሰናበት፡፡)

ስለጥናቱዓላማጉዳትናጥቅምእንዲሁምየሰጡትመረጃበሚስጥርስለመጠበቁበደንብተገልፆልኝ,ቃለመጠይቁንበፈቃዴ ስለመስጠቴበፊርማዬአረጋግጣለሁ፡፡

ፊርማ፡---------- ቀን፤ ----------

እኔምየጥናቱመረጃሰብሳቢስለጥናቱዓላማጉዳትናጥቅምእንዲሁምተሳታፊውየሚሰጡትመረጃበሚስጥርስለመጠበቁበደንብ ገለፃበማድረግቃለመጠይቁንስለማድረጌበፊርማዬአረጋግጣለሁ፡፡

ስም፡---------- ፊርማ፡---------- ቀን፤ ----------

ጥናቱየሚደረግበትቦታ:_____

የጥናቱመለያቁጥር:_____

ቃለመጠይቁየተካሄደበትቀን:_____

ANNEXURE 7: FOCUS GROUP DISCUSSION GUIDE FOR PREGNANT WOMEN AND WOMEN WHO GAVE BIRTH RECENTLY

I. Participant Demographic Intake Sheet Form for Focus Group Interview

Participant demographic intake sheet: This form should be filled before the FGD

A. For pregnant mothers and mothers gave birth within 6 months					
Participant code	____	_____	_____	_____	_____
Age					
Religion					
Marital status					
Are you employed? (Yes/No)					
Educational level					
Gravidity					
Parity					
Place of delivery in last pregnancy					

II. Focus group interview guide for pregnant mothers and mothers who gave birth within 6 months

Name of District (woreda):_____

Name of Kebele: _____

Name of moderator: _____

Name of note taker: _____

Date of discussion: _____

Start time: ____:_____ Adjourned: _____:_____

One question will be asked:

"Describe your perception and experiences with regard to utilisation of skilled delivery service"

Interview guide

1. What is your understanding of skilled delivery service provided in health facilities?
2. In your opinion what are reasons for pregnant women not to use skilled delivery services
3. Explain the factors that influenced you to utilise skilled delivery services?
4. How do you rate the quality of care you received from the skilled delivery services?
5. If you were to give birth in your next pregnancy, would you use skilled delivery services?
6. Explain factors that would motivate you to utilise skilled delivery service in your next pregnancy
7. Explain the support you get from the community to utilise skilled delivery service?
8. What are the benefits of skilled delivery services for women?

Thank you for your participation!!!

ANNEXURE 8: SAMPLE FGD TRANSCRIPT FROM WOMEN WHO GAVE BIRTH RECENTLY

Name of district- Burie zuria woreda
Kebele- Kuche town kebele
Date- Tir 6,2007 E.C

FGD with lactating mother

1. Please describe your experience of skilled birth attendance utilisation?

A. I gave birth in this HC. At that time, I received a proper follow-up after giving birth. I had encountered some bleeding after delivery and they immediately gave me an injection and immediately got improved. I gave birth safely and with proper follow-up. M: What did something wrong happened to you? There was nothing that I say it is bad. Previously, I gave birth at home and I faced many bad things but now I delivered my child in good way and nothing happened to me. M: What did happen to you when you give birth at home? I gave birth at that time in rural area and I had been labouring for two to three days. I was unconscious till a bed was made and transported me to the HC and gave birth in the HC. M: What was the problem? What made you to lose your consciousness? At that time I had excessive bleeding. The area is rural and I lost large volume of blood until I reached to the HC. Because of this, I had lost my consciousness and I went to the HC and gave birth there. I feared at that time because I thought that I will always encounter the same thing in my future pregnancies. But now, nothing occurred to me I gave birth safely.

B. I am also like she said. I gave birth here in this HC. I had excessive bleeding after giving birth. I got improved when they gave me an injection on the right and left. They told me to stay in the HC until the bleeding stopped and then I went to my home after the bleeding stopped. No other problem happened to me. It was my first child and everything was good. Nothing else. No other problem happened to me.

C. I had a follow-up visit here in this HC. While I was having a follow-up visit here, I was informed that I had low PTT and I had also follow-up visit in Bahirdar City at private clinic. I was told to give birth in hospital because I may have excessive bleeding during

delivery. I came back here in this HC from Burie and informed them about the results of the examination I had. I came to the HC one day before I gave birth around 4:00 PM and I had abdominal cramp at that time; they told me that my cervix was not opened; there is nothing that signals whether I gave birth today or tomorrow. I told them my fear of having excessive bleeding because of my low PTT and requested them to refer me to higher HF. They told me that I may be exposed for unnecessary expenses so that they said to me they follow me here and if something wrong happens they will call for ambulance and send me to higher HF and they advised me to stay here. And, I was told to go to home. When I was at home, I started to experience severe labour pain around 10:00 AM and I came back to the HC. The nurses stayed the whole night with me and I delivered my baby at 4:00 PM. My bleeding was not as it was feared. I received a proper follow-up and gave birth safely. For me, it is good and it was not like what I feared.

D. It was my first birth. I had a follow-up visit here. At that time I went to the HC for examination because I was not feeling well but it was not for skilled birth attendance service. When they examined me, it was a true labour and I was told that today is my date of delivery and then I gave birth after 30 minutes. I had no any bleeding; I received proper follow-up from HWs and I safely delivered my baby and went back to my home.

E. My labour started at 4:00 PM at night and I came to the HC. When I came to the HC, they told me that I will give birth at 8:00 AM; then they said from 8:00 AM to 11 AM, then from 11 AM to 1:00 AM. At 1:00 AM, my labour stopped and I started to have vomiting. When I started to have vomiting, they called for ambulance and referred me to Fenot selam hospital. When I reached Fenot selam hospital and they examined me; they said why the HC delayed me so far; then I received an injection and delivered my baby at 7:30 PM. I had no excessive bleeding and the next day, I went back to my home. Nothing happened wrong to me. Here, in the HC, they were unable to deliver my baby. They said that they cannot deliver my baby; the labour cannot be managed here. An injection for labour is available in the hospital but not available here. When I got exhausted, the HWs tried to help me; the first, the second doctors examined me and send me to the hospital. I reached their immediately; they examined me and I gave birth there.

F. It was very nice for me. I was having a regular ANC follow-up up to 9 months starting from the beginning. I came to the HC at 9 months. They informed me I may give birth at 9 months & 10 days or 10 months so they told me to prepare towels for the newborn. At that time I was aggressively doing household activities at 9 months. I did not feel anything. I gave birth during night time; I thought that I was defecating. It was during night time; it was in the toilet; I did not recognise it. I could have come to the HC. But, the HEWs mistaken me; they told me like that and I delivered my baby at that time. After that, I had a retained placenta so that I came to the HC and they also told us to bring the newborn and we brought it also to the HC. It was very nice. I did not feel any pain. After that, no problem occurred to me. Only thing I gave birth at home but I think they mistaken me. M: What? I came here at 9 months. I regularly visit the HC on monthly basis. They informed me today is my 9 months of gestation but they advised me I may give birth within 9 months & 10 days and 10 months so that to come to the HC. However, I gave birth just at 9 months during night time. Meaning I did not have any pain and they also said to me my delivery date will stay. I could have come to the HC. I did not come. I gave birth around toilet area; it was just like I was having defection; I did not realise that. I gave birth at home. After that, I came to the HC. No problem at all. I gave birth while I was trying to defect; unfortunately I was lonely at that time. Then after, other people came to my home; even my husband also came to home; I did not feel so much.

2. **Please describe your perceptions regarding skilled birth attendance utilisation?**

A. Having ANC follow-up in the HC and giving birth in the HC has many benefits. For me, it has provided me many benefits and knowledge. It has provided me many benefits and knowledge; how to breastfeed my baby; how to keep my cleanliness, when to bath my newborn and every what hour to provide care. Having given birth and they visited to our home and taught us many things about how to breastfeed? How to keep the hygiene of my baby? About family planning? Before this, I had no awareness on the above issues. Because of this, I taught that giving birth in the HC has many benefits for both the newborn and mine. I did not know anything about; how many times to breastfeed? What to breastfeed? According to the education I received, not to switch to other breast before completely breast feeding the one breast; how to breastfeed my child? I say that it is a very good thing.

B. For instance, when you give birth at home; we may face excessive bleeding and we go to the HC after losing very much blood. We get bleeding and we will die. When our delivery is attended by traditional birth attendants, we may be exposed for various diseases; the safety of the newborn is at risk and may have blood contact with the birth attendant. They were providing us education while we were pregnant and they call us to come to the HC every month. Where to give birth, the risks, how it is helpful for our life they regularly conducted follow-up for us before we gave birth. They called us to the HC every month. For the sake of our health and the growth of our newborn; it has many benefits for us; we came to the HC by immediately our labour starts. I thought that it has huge benefits.

C. I say that it is very nice. It causes many problems when we give birth at home. The problems that may be caused as a result of home deliver are; retained placenta and the newborn may be exposed to diseases. I thought that giving birth in the HC prevents the newborn from diseases and from excessive bleeding. I do not have anything else.

D. My perception regarding utilisation of skilled birth attendance. If I gave birth at home; first I may have excessive bleeding. The second thing, post partum haemorrhage may be caused in case. Thirdly, the newborn may not be properly cared. But, if we gave birth in the HC, the post partum haemorrhage can be prevented with an injections; the post partum abdominal cramp can also be prevented with an injection. The other thing the newborn can also be cared. Due to that, I say that giving birth in the HC is a very good thing.

E. It is good. There will not be any bleeding; it is good to give birth at the HF. There will not be also postpartum bleeding and it is also good for the children

3. What do you understand the skilled birth attendance service provided in the HFs?

A. I say that it is nice. Nice. With respect to what they can do, they deliver our baby if they can; if they cannot manage the delivery here, they refer us to higher HF.

B. I see that it is very nice. But, in cases when the labour gets prolonged and the woman does not have the power to push; first they do not have an injection for the labour; second, they are unable to do episiotomy and stitch to deliver us and they refer

us to higher HF. Except these, they can provide proper care for the newborn and they prevent us from excessive bleeding and from any illnesses. They are fine. But I myself, they say that we cannot manage deliveries doing these and these things; we cannot do episiotomy and stitch in case we get narrow birth canal. ... We do not have also an injection for labour and in such conditions we refer you to higher HFs.

C. I say that it is good. The main thing we say that it is good and we are living with full hope; first, we do not look for contract vehicle and since recently, ambulance service is available in the district. If there is a referred woman, she will be transported with ambulance and it is a good thing. Their reception is very good and they follow us beyond what they can. I say that it is good. For me it is very good. Leave alone in the HC even after we gave birth and went back to our home. They came to our home and asked us; did you feel unwell? What is it? For me it is very good up to now. I have nothing to say something is not good. Probably, there may be a delay in cases where there are many clients in the card room. During my pregnancy until 9 months I have nothing to say something happened to me. During childbirth also, I delivered my baby in a good way. What I saw in myself and other community members it is good; very good. It is fine. I have nothing to say something is bad. There follow-up is good; there follow-up is good during labour and delivery; they encourage me and they say you are going to give birth now. Now this progress; now you have reached this; now this is your progress but they do not say that your labour is not progressing or we do not know the progress of your labour or something else; they do not let us to be distressed or they do not make us to fear or they do not say such things. They said to me that it is simple, now you will give birth; now it is time for labouring when they say like that I feel confident. There follow-up is very good. The HWs were standing from 9:00 Am to 12:30 Am while I was labouring and until I gave birth. Before this, I thought that giving birth in the HC is a very bad thing. The two nurses stood on my left and right sides and they encouraged me and even they did not go away for a second; I delivered my baby safely so that there is nothing that I can say, it is bad. M: You said that giving birth in the HC is a bad thing? Why? I did not think that they had such follow-up for us. I did not think that they encouraged me like that; exerted efforts if something wrong happened to me and they saved my life. I thought that the only thing they can do is delivering our baby but I did not think that they encouraged us like that and they provided support. When I see for myself, they attended my delivery with proper care.

D. The service is very good. The service provided here is ...I before this... heard that giving birth in the HC was bad. Then, I said to them that did not take me to the HC but they took me to the HC. This fear is because something that we did not get taught and we did not know. They said that they insert their hands and they do something to our birth canal... Then, when I came to the HC, they did not touch me but, measuring the size & the dilation of the cervix and they did nothing to me. Then, I feared when I came to the HC. A few individuals said to me that they do something bad to you; you may be troubled to walk and control your urine; it cannot be stopped. But, I came to the HC and they told me to sleep and I slept. Then, they asked me. I stayed for sometime while they asked me. The amniotic fluid already ruptured when I was at home and I stayed for short time and I gave birth and no problem occurred to me.

E. I say that it is nice. Starting from the guard whether we came at night or in the afternoon or at 4:00 Am they serve as without any reluctance particularly if she is a pregnant woman their cooperation could not be described with the word excellent. It is very nice. What it had been talked previously; all patients who had visited the HC said that they just kept on playing a volley ball and they had no any job to do; they spent the day stretching their legs and they did not have any concern towards patients. Here, I work closely with them through NGO and when I follow and see them, they are very good for me. Starting from the HC guard they are very good and cooperative especially for labouring women. Starting from the guard, secretary, midwifery the word excellent could not describe them their support. It is very nice. Last time during the pregnant women conference, some individuals like you asked us what to be improved and we told them the things at least that need improvement. The pregnant women got very tired to reach the HC from their home, but the HWs cancelled the meetings. We told them to improve such things. Since the pregnant women are physically weaker than their pre pregnancy state; it is very difficult for them let alone to travel from their home to the HC and vice versa for the conference even they cannot stand up from their seats. We told them that they must not miss any appointment after arranging a conference with pregnant women and to treat them properly. These comments provided for them last time and now they are doing well and they are properly following up. They do not miss any appointment with pregnant women. They conduct the pregnant women conference and they also prepare tea and coffee programs if they have.

4. **Reasons for non-utilising skilled birth attendance?**

A. Nothing it is good to utilise skilled birth attendance. It is lack of awareness not to utlise skilled birth attendance. We say that it is good to give birth in HF. First, it is good to go to HC for skilled birth attendance. Previously, it is lack of awareness not to give birth in the HC. That is our judgment. Now, now at this time, nobody is giving birth at home; giving birth in the HF. Thus, it is good to give birth in the HF. M: What else? I think giving birth in the HF was considered as socially unacceptable (newer) according to old sayings. Giving birth in the HC is like a socially unacceptable act and very difficult thing. When it is said giving birth in the HC they expect that the uterus and birth canal is opened and they insert their hand and examine it. It seems for them that their uterus gets opened, insert their hands and see it not only during complications but also during normal delivery. It is lack of knowledge and experience but it creates no problem for them. I think they do not have the experience of giving birth in the HC and also their previous experience of giving birth at home. They said that. It causes no other thing. This is the say. Insert their hands in to uterus; then again insert their hands and examine if it stays for a while; they cause trouble to us; disallow us to move as we want; they say that do not shout to me during labour; they say like these. It seemed for me, personally and I believed these when I was giving birth at home. Now, there is nothing at all. Yes, there is nothing when I see it now. These enforce women to give birth at home. This is the big thing. They only take in to account giving birth with inserting their hands but they do not consider the care provided to attend their delivery.

B. The problem women do not give birth in the HC is; they do not have ANC follow-up. Thus, they do not know their gestational age and EDD; they give birth at home when their labour starts. If they had ANC follow-up, they would have given birth in the HC. Other it is just like that.

C. First, while they are focusing only on their household tasks and their labour gets precipitated and give birth. After the baby delivered, they say that they do not want anything and they remain at home. When the woman wants to go to the HC, her husband may say that I am busy doing my jobs.

D. The reason for women not to give birth in the HF; they depend on the old thinking. But now, everybody is civilised/educated. But, they depend on the old thinking; the HF

cannot do anything for us and always without the help of saint marry they cannot deliver our baby. They have thinking that if they go to the HC, they may not be allowed to rotate their body as they want; they cannot shout as they want and give birth so that they prefer to give birth at home. Thus, they have thinking to give birth at home. The HWs tell us to sleep on one side and not to sleep on supine position. Yes, they say that do not sleep on supine position; tell us to sleep on one lateral side and we cannot rotate to the other side. If they give birth at home, they can sleep either on supine position or lateral sides whatever they want and give birth. Here, in the HC, they are doing this to take care for them but they do not accept it.

5. **What influenced you to utilise skilled birth attendance in your previous delivery?**

A. When we came for ANC visits and they followed us. They told us to give birth in the HF and might face problems if we gave birth at home. We might have excessive bleeding; we might encounter problems and complications; the newborn might not be properly cared. We accepted their advice and we came here. We came here for examination when we got sick.

B. There close follow-up made us to utilise skilled birth attendance. When we came for ANC visits for the first time; they followed us very closely. They sent us with proper care and it would have been good if we gave birth in the HC when our EDD is reached. I gave birth at home, indeed, I did not realise that. I did not recognise that. I did not experience any pain; nothing happened to me; it was not known. It would be good if they have ANC visits in the HC from the beginning and give birth in the HC.

C. They attended our delivery properly. When I came for ANC follow u , they told me to give birth in the HC and I gave birth here.

D. What influenced us to utilise skilled birth attendance; there is what we call mother support group. There is a mother group; we had discussions on monthly basis and when we came to the HC; they provided us a lot of advice to utilise skilled birth attendance. Then, we made their advice practical and we gave birth in the HF. Secondly, they provided us advice how to keep the hygiene of our children. They told us in how many months we are supposed to bring our children for vaccination and they

also told us how to breastfeed our child, how to prepare soup and porridge for our children. Since we had been receiving such advices every month and we wanted to give birth in the HF.

E. Since my conception of the pregnancy I had epitaxsis (bleeding from the nose). Because of this, they said that you had no follow-up; they made me to fear. There, when I had gone to Bahir dar and Burie. Because I had that fear; I told them when I went to the HC for follow-up and then they followed me up. I gave birth in the HF because I had the fear. I had a monthly check up of my blood pressure. When I came to the HC for ANC follow-up, they told me the side effects of excessive bleeding and then I preferred the HC and came here. The other thing, the blood pressure check up brought me to the HC.

6. How do you see the quality of the skilled birth attendance service you received?

A. I have nothing to say on my side. The quality is good; it is clean. With respect to practising cultural ceremonies and knowledge of the HWs, it is very nice. I gave birth at 12:00 am and they told me that I will be discharged from the HC at 6:00 am. When I stayed in the HC until 6:00 am, first it was like our cultural practices. When my companions told them the cultural practices of preparing coffee, baking injera and other things after a woman has given birth and they provided them the necessary materials & equipments to prepare coffee. The companions prepared coffee and we enjoyed until 6:00 am. Then, my families asked me whether I can travel to my home on foot or not; I replied to them that I can do that. However, the HWs refused that and informed them that she must not travel on her foot because she may get bleed. They suggested that a stretcher is already available in the HC and informed them to find for other people to carry and transport to my home and they transported me to my home as per their suggestion. I say that it is good. It is very fine. They provided us care according to our culture and their knowledge. They denied us nothing.

B. It is very good. No problem at all. For me, it is good. When I got exhausted, they immediately referred me to higher HF.

C. I did not give birth here. I came here because I had excessive bleeding, excessive bleeding. When I was at home, I had excessive bleeding. They told them to bring me

here and they brought me to the HC; then I had excessive bleeding; they could not manage it and they were unable to manage it. Then they referred me and they brought an ambulance and sent me to Fenot selam hospital. I gave birth at Fenot selam. When I reached Fenot selam hospital, they received me properly, received me immediately and I took a bed there; they stayed with me; they did not go away from me. Thus, their quality of service is also very fine. Since initiation of my labour until I gave birth and during late stage of my labour, they stayed with me based on their shift; they did not go away. They properly went away from me after I gave birth.

D. What I say is; attending delivery of a woman should not be the responsibility of one HW. For instance, I gave birth at night time; they left everything for one HW who was in charge at that time and they thought that the HW who was in charge was responsible to handle my delivery. When I saw it. After I arrived the HC at 10:00 pm until I gave birth at 4:00 pm, only one nurse spent the night with me standing. Finally, my companions requested her to take me to the hospital because my amniotic fluid was ruptured at 12:00 am but I could not give birth. The companions told her I may face complications. The nurse responded to them my labour had been progressing to the final stage and no need to take me to hospital. My husband knocked the door of the night duty room to call for somebody for assistance and somebody came and assisted her to deliver my baby. That is to mean that it should not be taken as the responsibility of one person. For example, when she had contact with my blood, somebody must be there to give her gloves and other. I was so comfortable by her handling of my delivery; she allowed me to rest on my side. But, support, somebody else for the support of the HW, meaning; there is lack of sleep, being exhausted; she spent the night with me standing; at that time there may be negligence. As far as I am concerned, it must not be taken as a responsibility of one person. After I gave birth, the nurse was very exhausted. After I gave birth at 4:00 pm, immediately another woman came for delivery. The area where I gave birth that was contaminated with my blood was not cleaned up immediately. The nurse went to the janitor room and argued with them why they did not clean the area immediately and she was very upset. When she was talked like that; there was a nurse assigned for night duty that came in and assisted two of them. I think there should be such type of cooperation. It should be corrected. My opinion is it should not be the responsibility of one person. After delivery of a woman, the place where the woman delivered should be cleaned soon. These things need improvement.

E. For me, I think it is very nice. Because I gave birth during day time; I delivered my baby at day time it is very fine. I gave birth there; it is clean. Then they provided us coffee beans and equipments to prepare the coffee; we did not miss our cultural ceremonies. For me, it is very nice. I did not see any gap.

7. **If you get pregnant for the future, would you utilise skilled birth attendance service?**

A. We should come and give birth in the HC. Because they will attend our delivery with proper care. If we give birth at home, we will not keep our cleanliness.

B. In the HC. Our newborn will be properly cared; we will not encounter excessive bleeding. But, if we give birth at home, there will be many problems; we may have excessive bleeding and we may experience sever abdominal cramp after delivery. In the HC, they give us injection to prevent the post delivery abdominal cramp; we will not have excessive bleeding and we will also be clean.

C. It is HC. The motivating factors to utilise skilled birth attendance is; if I give birth at home, I may encounter problems and complications waiting for to give birth at home. I may die. Meaning, I may get exhausted; the foetus also may get hurt when I rotate here and there. In the HC, we are permitted to sleep on the left lateral side to give birth. But, at home, I sleep in every direction I want and my foetus may get distressed; I may get hurt. We are allowed to sleep in any direction we want until the labour gets serious. Then, after the labour becomes serious, we only sleep on our left lateral side because the foetus may become distressed.

D. For keeping our health; cleanliness and for my life; I want to give birth in the HC. The newborn also delivered in a very clean way and cared properly. If it is a home delivery; the cord of the newborn may get stretched; no glove; the newborn cared with her bare body; the newborn may face many problems. In the HC, we will be protected from everything and our delivery assisted with good health professional. It is a huge thing.

8. **What support do the community provide for pregnant women to utilise skilled birth attendance?**

A. Now everybody is aware; everybody wants to give birth in the HC; everybody wants to give birth in the HF. Many of my friends and neighbours asked me whether I have ANC visits or not; whether I am having vaccination or not; whether I have a regular check up or not while I was pregnant. Now, day to day, even when my facial expression is not good; my neighbours asked me; what happened to you today? Are you okay? Many of my neighbours tell me to go to the HC for check up. Now, all people are educated. I do not know! Nobody hates to give birth at HC.

B. They encourage us to go to the HC for ANC follow-up, vaccination and not to face problems like excessive bleeding, swelling of body and legs. They encourage us to utilise skilled birth attendance to protect us from any problem...

C. Our family encourage us but the community do not do so. In contrary, the community think an odd idea. For instance, when I was regularly coming to the HC for monthly vaccination and ANC follow-up and I had been attending meetings in the HC, too. What the community was talking about me was; the wife of Legesse might be infected with HIV because she is regularly attending meetings in the hospital; we are regularly watching her in the HC and what problem does she have. I heard these from the people who are residing with me in the same compound and they told me not to go the HC. I was visiting the HC because it is useful for me; what other people was taking was none of my business and I continued to have follow-up visit to the HC. But, as to me the community do not support us. Only the HWs and our family are supporting and follow us; but the community do not provide any support. They think as if we are having other problems when we go to the HC. This is very difficult.

D. First, the community is providing support through carrying and transporting the woman to the HC. Second, the community is providing support by protecting the household assets and the other children at home when the family went to the HC. The community discusses during meetings and suggest ITN to be provided for pregnant women.

E. It is good; they support us. They carry and transport us to the HC. In addition, they protect our house and household assets. Furthermore, they protect and care our children.

ANNEXURE 9: SAMPLE FGD TRANSCRIPT FROM PREGNANT WOMEN

Name of district- Wombrema woreda
Kebele- Kentefen kebele
Date- Tir 4, 2007 E.C

FGD with pregnant mother

Q1. Please tell me your experience regarding delivery?

A. What we know is giving birth at home. There is no other problem. Last year, only I delivered my youngest son at Wogedad HC; otherwise I used to give birth at home. I have never gone to HF before that. No other problem occurred to me.

B. Health facility...giving birth in HF is better than giving birth at home because we do not get bleed. In health facility, we receive injections; they give us medications but nothing is given at home. So that it is good to give birth in HF. My first child was born at home but the second child was born in hospital. When I gave birth my second child, I did not experience that much pain; I had no any bleeding; my delivery was assisted properly; I did not have any bleeding. But, I had bleeding when I delivered my first child and I perceive that I was hurt when I delivered my first child. In the second child, I did not hurt.

C. So far I am giving birth at home. I have never gone to HF. No problem. I did not encounter any problem. My families assisted my delivery and nothing happened to me.

D. My first child was born at home, but last year I gave birth in HC. The HC staffs do not properly attend our delivery and they have problem. That is to mean the HC. So I lost my child when I gave birth in HC last year during this time because of the problem of the HC. Just they have problem when they assist the delivery in the couch. They do not properly attend our delivery. When they assisted the delivery; after the baby came out the HW put the baby on a vessel. That is on a vessel. Thus, the HW overstretched the umbilical cord and killed the baby. I had taken the newborn to the HF. Though I had taken the newborn to HF, They told me that the problem was related to the umbilical

cord and the umbilical cord was over starched. The newborn died at home after I came back from HC.

E. I am giving birth at home. I have never gone to HF and I am giving birth at home. I have never faced any problem at home. I have never gone to HF and seen anything. I have never gone to HF and I do not know delivery practices there. Since I have never gone to HF, I do not know the experiences of HF delivery. We assist ourselves in home delivery and nobody is there to support us. But, if we go to the HF, the HWs assist us. No problem at all; it is cutting and tying of the cord after we gave birth and my father, mother, brother and sister assisted me.

F. I have been giving birth at home. I delivered four of my children at home. But, I delivered only one of my child in HC. Like she said, they slept me on the bed and they did not think and look after me in the delivery room that I can give birth at any time. Because I had been doing my routine tasks at home, I was exhausted and unable to push down (labour) so that they injected me a drug to facilitate the labour. After they gave me the injection, they went out of the room and they left me alone. After they went out of the room, I gave birth immediately and I waited grabbing the baby with my own cloth and he could have fallen down on the floor. And, giving birth in HF has many problems. But, I had no any problem by giving birth at home. We inform our families and they closely follow us when our date of delivery is approached and our labour starts. If we go to HF, they do not closely follow us; they do not closely follow us by sitting with us now you will give birth and now this will happen. This happened at Wogedad HC. They did not follow me; I waited catching the baby with my hand so as not to let the baby fall down. They do not care that the mother and the baby can be injured and they simply move here and there. I think I prefer to give birth at home; I prefer to give birth at home rather than giving birth in the HC. They do not care about for anybody. They go out from the delivery room and leave us alone; they are not concerned about whether the baby is on the verge of delivery or whatever. After he gave me the injection, he told me to push down (labour) and went out of the room. As soon as he left the room, I delivered the baby. There was no anything to support the baby from the bottom so that I caught him with my cloth because the baby was going down. Then, my husband called them from outside and I waited catching the baby and dragging with my cloth until they wore their gloves. Because of this, it is better to give birth at home. In addition, they did not allow our companions to enter in to delivery room rather they let them out.

G. There is nothing to be added; nothing to be added. At our home only. We need only to have ANC check up there and detect and manage if something is wrong with us. Otherwise, I think it is preferred to see our death or defeasibility (life) at home. The other thing, Wogedad HC staffs, they just move here and there and they did not benefit us. Thus, we only visit HFs for ANC check up, but we give birth at home because they did not benefit us in any way. There is no any benefit whether we go or not. Unless they help us, cut and tie the cord, and care us, we may get hurt. I say that giving birth at home is better. Except for the ANC check up, everything is better at home.

I. Please describe your experience regarding utilisation of skilled birth attendance service?

A. I gave birth there only once. There problem is they go out from the delivery room and leave us alone. No other problem. The only thing we need is the ANC check up; otherwise we give birth at home. Since they went out of the delivery room and left us alone, they did not closely follow and care us. Except for ANC check up, the delivery is better at home.

B. I gave birth in HF. When I delivered the child, the baby was fine during the first examination; the doctor himself killed the baby inside my uterus. Initially, he examined me for long time and he told me that the foetus is fine. They said to me that the foetus is fine and I also replied for them I wish also the foetus is to be fine as long as I reached to this level. Then, he examined me inserting his hand. It was at Fenot selam hospital. He called for the main doctor and he stayed being worried for two or three times. Later, the main doctor came and examined me with ultrasound. When he saw it, he told me that the foetus is already dead. They killed the foetus inside my womb in Fenot selam hospital and the foetus died inside my womb. The foetus was fine and I think they killed it. The good thing that I recognise was I did not bleed; otherwise they were not good at all. There is a problem or hurt whenever we give birth in HF. We properly deliver our child at home. We should not give birth in HF. When I was labouring, they said that why you are labouring and they did not allow me to labour at all in Fenot selam hospital. Rather they told me to labour (push down) after the foetus was dead. Initially, they were intended to operate me but later they told me not to labour (push down). It has many problems/trauma. It has also benefits. The benefits are we do not bleed; they give us injections.

C. What do you understand about the skilled birth attendance service being offered in HFs?

A. They simply move here and there and they did not give any attention/ bother for the community. What we are saying that they do not worry for us. They did not worry for us and they did not think for us. They just simply move here and there. Once we left that HF, nobody never go back to the HF. They do not worry and think for us; they move here and there but they do not worry/bother when labouring woman visits the HF. Thus, we give birth there with stress and without feeling ease and come back to our home because we have already gone to HF once.

I: Reasons for giving birth at home?

A. We do not have any problem. It is customary like the old days to give birth at home. When we started to have labour; we call for and gather families and relatives and we give birth at home. So that we do not go to HFs. Somebody go to HFs when they ill seriously and worried/stressed. So that, we give birth at home with our families. So, why we go the HF? People must go to the HF when they ill seriously/ face difficulties. The ambulance service becomes available very recently. Previously, women transported to HFs through carrying with a bed made up of wood and that was also a problem. That is why we give birth at home. Giving birth in HFs is good for everybody. We give birth at home because we are practicing the old traditions, but giving birth in HF is good and helpful for everybody.

B. The reason we do not give birth in HF is they do not take us to HF immediately, but they take us to HFs when we ill seriously/ get complicated. We do not go to HF as soon as the labour started. I am not willing to go to Fenot selam hospital rather I prefer to go to private health facilities. Because, they do not properly serve us.

C. I give birth at home and I have never known the HFs. I gave birth very fast as soon as my labour started. Because my labour does not get prolonged, there is no problem if I go to HFs. Women should give birth in HFs depending on their labour; if their labour stayed for long, they should go to HFs; otherwise they should give birth at home.

D. The HC do not serve us properly; they do not serve us properly. One individual should be allowed to enter in the delivery room and the labouring woman should not get suffer alone. Otherwise, the HWs should have stayed in the delivery room and attended our delivery but the HWs went out of the room. Secondly, they do not allow companions to enter in the delivery room. Thus, it is better to give birth at home rather than going to the HC.

E. My labour came so fast and gave birth immediately. I had no any pain. What I can do for it, our father's and mother's maintained this practice until now.

I: What influenced you to utilise skilled birth attendance service?

A. They treat us if we have problems. I went to the HC because I can get medicines if my labour gets prolonged. I do not have any problem. Of course, I went there only once; just only once. I did not go many times; only once.

B. I went to HF because I had bleeding during my first childbirth, but my families advised me not to go to HFs. Thus, I insisted to them to take me to HC because I must go to HC.

C. My labour got protracted and it stayed for one day. As per your advice, we went to HF but they did not properly serve us and it is only for the sake of talk. I did not see any solution from them. First of all, when one woman is labouring and suffering, for instance, when the wife of Priest Minable's foetus was in problem/hurt, they just kept her with them without doing anything. So that, it is better to give birth at home rather than going to HFs. One thing, when a woman faced problems/complications, they do not notify for anybody. It is only for the sake of reporting and to say that we have served this much women. But, they do not send women to higher health facilities as soon as a woman encountered problems/ complications so that it is better a woman to die at home rather than going to a HF. No other thing. There is nothing that they help us and benefit us. Thus, I say that it is better to give birth at home. It is my thinking.

I. Where are you planning to give birth?

A. It is at home. I will give birth at home.

B. Like the previous deliveries, if the labour comes fast, it is better to deliver at home. If I face a difficulty, whether they are good or bad, I must go to HF at least to save my life. At least to save my life, I told you before they do not care about and follow the newborn. I said that there was nobody in the delivery room to receive and care the newborn that was why I caught the baby with my cloth. Thus, I will give birth at home with my father and mother if my labour does not get prolonged; otherwise it may be compelled to go to the HF. Father and mother are not allowed to be with us and labouring mother will be alone. They do not monitor us. It is better to go to HF, whether the newborn alive or dead, at least they may save our life.

C. If the labor gets prolonged, it is a must to go to HF. Otherwise, it is better for us to deliver at home. Why we go to the HF unless they help us. Otherwise, it is better for us to be worried/ suffer with our family.

D. I am thinking to give birth in HF. It has been long since I gave birth and I had been using FP methods so I am planning to go to HF and see there. My families are also planning my delivery to be in HF.

E. I am planning to give birth in HF. I will go to HF as soon as my labour starts. I am planning to give birth in private health facilities because the private HFs deliver me safely; whereas the government HFs do not properly follow us so it is better to give birth in private HFs.

F. I am going to give birth at home. But, I will go to HFs if my labour gets prolonged/complicated. I am thinking to give birth at home. I gave birth all my children at home so I am not thinking to give birth in HFs.

G. I am planning to give birth at home. I will go to HFs if my labour gets prolonged/complicated; otherwise, I will give birth at home if my labour comes fast.

I: What would motivate you to utilise skilled birth attendance service?

A. We would like to utilise skilled birth attendance service if they properly provide the service and closely follow us. It is better for us to give birth at home with our mother and father if they leave us and go out of the delivery room by saying that it is not the right

time now like the previous times. Other than this, there is no problem to give birth in HFs if there is a better thing and they closely follow and monitor the mother and newborn so as to prevent from any problem; if they say that “how she is doing now” like father and mother do and if they are mother and father and closely follow and monitor us. But, if they do not follow us; they move here and there wearing their gown and call each other; leave us and go out of the delivery room by saying that it is not the time to give birth. It does also nothing for us now. If the newborn dies of falling down to the floor after we gave birth; if the newborn falls down before the cord is cut and tied. It has no any benefits. Otherwise, we can give birth at home with our father and mother. The doctors should closely follow and monitor us.

B. One person should be assigned to be with the mother in the delivery room; one person should be assigned. There must be one person assigned in the delivery room to follow the woman. If the HWs do not stay in the delivery room; one of her relatives should be with her to follow her.

C.I am planning to give birth in private HFs. They do every examination and investigation immediately for me, whereas in government HFs, they do things slowly and even they do not pay any attention. Because of this I preferred private HFs. It would have been good if the government HFs immediately examine the foetus with ultrasound whether it is alive or dead. It would be good if it is available in government HFs. But, you cannot get this in government HFs. Thus, you are required to visit private HFs. What motivates me to give birth in private HFs is they can identify everything and tell me. Thus, it is better for me to give birth in HFs. But, if I go to government HFs, they do not properly follow me and they keep on saying that it is not the time for you to give birth; even they do not properly do examinations and investigations. Thus, private HFs are better than public HFs. If these all things get fixed and ultrasound is available, public HFs will be preferred even in terms of cost.

D. They will treat us if health problems happen to us. In addition, we receive treatment and care in case we have other additional diseases.

I. **What support do the community provide for women to utlise skilled birth attendance service?**

A. They provide education for us.

B. They encourage us to give birth in HFs.

I. What are the benefits of skilled birth attendance service for the mother and newborn?

A. The woman does not bleed; they give us injections and medicines to prevent haemorrhage and they also give us drugs for post delivery abdominal cramp.

ANNEXURE 10: INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS, HEALTH EXTENSION WORKERS, HEALTH CENTER DIRECTORS, DISTRICT HEALTH OFFICE TECHNICAL OFFICERS AND HEADS

Name of District: _____

Name of Health Facility: _____

Name of Interviewer: _____

Date of Interview: _____

I. Participant demographic intake form

II.

Participant code	Age	Sex	Profession	Position held in the institution	# of service year

III. Interview guide questions for health professionals, woreda technical officers and heads

"Describe the experiences of offering skilled delivery service in this region"

Interview guide

1. What is the level/coverage of skilled delivery service utilisation in your community?
2. What do you think about the skilled delivery service being provided in health facilities?
3. What are the benefits of skilled delivery services for women?
4. What are challenges in offering skilled delivery service?
5. What intervention strategies you are currently implementing to improve skilled delivery service utilisation?
6. What intervention strategies do you suggest to be put in place to improve utilisation of skilled delivery service?

Thank you for your participation!!!

ANNEXURE 11: SAMPLE INTERVIEW TRANSCRIPT FROM HEALTH CARE PROVIDERS, HEALTH EXTENSION WORKERS, HEALTH CENTER DIRECTORS, DISTRICT HEALTH OFFICE TECHNICAL OFFICERS AND HEADS

Name of district- Wombrema woreda
PHCU- Shendi health center
Date- Tir 4, 2007 E.C

Interview with health center director

I. **Please describe the experience of offering of skilled birth attendance service?**

R: Skilled delivery service has been provided by HFs for long years and there are positive changes since recently though it is not up to the level of expectation. That is to mean that the number of women of giving birth in the HC have been increasing from year to year. For instance, I remember that during the 2002 E.C a total of 186 women utilised skilled delivery service; whereas at the end of 2006 E.C a total of 500 women gave birth in the HC. These improvements were documented because of the introduction of new processes and there have been improved things starting from the lower level, community, HP and up to the HC level. For example, when we begin from the community awareness level, the awareness of the community has improved from time to time. Particularly, because of the establishment of the structure of women health development teams. There are 1 to 5 networking at the kebele level. As a result of the opportunities created to meet among themselves and the health extension workers. Frankly speaking, since the commencement of the HEP up to the currently existing situation, the awareness of the community on health issues has been improving and this has been seen on women i.e. skilled delivery service. Thus, the effectiveness of the HEP, since recently the women health development teams and the ambulance service take the big share. Particularly roads, previously non-existent roads are now becoming available for service. It is now possible to bring women to the HFs through these roads. Beyond this, in general the health system, since the focus that has been given by the government for maternal health has elevated, the care being for women is good. It is impossible to find a woman disappointed with the maternal health service provision due to the focus given by the government. As a result of the focus given by the government, it is possible to say the community mobilisation is better. In contrary to this, there are

situations where we did not do as per our expectation. We are exerting efforts that no woman should give birth at home, but there are still women who are giving birth at home. We could achieve our plan. When we see it the reason for this, as I told you before the women health development team are good more or less, though there are differences among kebeles, gotte and woreda. Due to these differences, awareness creation was not done for all women so that there are women still giving birth at home. The other thing, yet there are gottes not easily accessible for transportation. Because of the low awareness level of the community, women say that we go to the HC when our labour is prolonged. We go to the HF when the labour is prolonged and they see it at home for a while and give birth at home. They came to the HC when it prolonged. Due to these reasons, we are not moving forward as per the expectation. It is also known that we did not achieve the plan set. Our achievement is not more than 50%. The plan was set based on the population conversion factor so that we do not expect to find the number of women stipulated in the plan. For example, the annual plan is 1000 but we expect to reach to the maximum 600.

Overall, when we see briefly the skilled delivery service provision in the HC. It is being closely followed and regularly monitored. A long journey has been made to fulfil the coffee ceremony and porridge preparation like the household practice. It is possible to say that the things we are doing to have clean beds, provision of standard skilled delivery service, presence of BEmONC trained HWs, neonatal care corner, and monitoring of the delivery room, are very good. Fortunately, two of the ambulance drivers are health professionals. So, we have good feedbacks about the women we refer to the higher HFs. The drivers can attend the deliveries in cases where women give birth on the way to the referred HFs. They ask and bring the problems from there like any HW. We have also a good learning mechanism; we share daily information. Why a woman is referred? How she was delivered? Though the hospital does not send feedback for the HC, our drivers provide us the information. The HC has also good HWs. The attitude of the staffs starting from the administrative staffs up to the guards is already solved. Regarding the HEWs, it is better than the previous time and maternal health is one of their top priority activities. We also ask them during our monthly meetings. What was there? Beyond that, there are newly initiated interventions. There is family conversation. We use new interventions every time. There are family conversations, pregnant women conference, and TBAs conference. These interventions are cumulatively bringing improvements. I have 5 years of experience and I can talk that

there is a big difference between what it was around 2002 E.C and what currently exists.

I. What are the challenges to offer skilled delivery service?

R: There is nothing in the HC. The following things are available to offer a complete skilled delivery service; HWs, necessary drugs and equipments are available, infrastructure, maternity waiting rooms are also available for women to rest before and after giving birth.

I: What are the challenges at the community level?

R: As I mentioned it earlier towards the challenges out of the HF. There is still a gap in the attitude of the community towards the HC. They do not think that a woman can give birth safely in the HC. Their confidence on the HC is now becoming better after we attended the delivery of many women safely. The women did not believe on the services offered in the HC; in the other way round, we observed lack of a complete reliance on the service. In addition to this, the community has low level of awareness. Since recently, there is also a complete dependence on the ambulance service when they can easily carry and transport them to the HC. The other, low awareness of the community. The awareness of other family members such as mother in laws, husband, mother and father is also very low and their influence is significant in this community. Beyond that, though I told you before many kebeles have access to roads, there are still many gottes and kebeles which have no access to roads. Even if the kebeles have access to roads, some of the kebeles are very wide and women are required to travel for more than one hour through carrying to access the roads.

I: How you are solving the problem of family influence and inaccessibility of roads?

R: In order to solve the influence of families, ADA/L10K introduced a tool called family conversation. As a PHCU, the HEWs are visiting pregnant women in their home starting from 8 months of gestation and at the same time, they hold discussion with the pregnant women and their families and put actionable solutions. We tried to do this. Other than this, there are villages and kebeles which are far from the kebele. So as to bring women

to the centre of the kebele or to the road through carrying, traditional ambulances are being prepared though there is a problem of utilisation. Most of the 1 to 5 teams have traditional ambulance but there is a problem of utilisation. We have tried to solve this problem this way.

I: What strategies you are implementing to improve utilisation of skilled birth attendance service?

R: We begin that women who gave birth in our HC are our ambassadors. If that is the case, we are highly exerting our efforts to make women satisfied with the service provision. We are striving to satisfy women with our service because we think that those women will talk to their mothers, aunts and to the community in general about the services they received. Thus, initially we are striving to satisfy women with our services. Starting from admission of the woman to the delivery room, there is a very close follow-up and support from the HWs and we give solutions immediately for every problem happening. There is a system where they can give suggestions. They are giving suggestions. So, we get feedbacks. Telephone numbers are posted in every room. There is a bath room in the HC where women can take a bath after they gave birth. We also provide certificates for those who gave birth in the HC. Besides, soap is also provided for the newborn and there is also coffee and porridge preparation ceremony. We are utilising a standard partograph even when we refer women to higher facilities because when the woman is giving birth if the newborn is died, the reputation of the HC can be damaged. The second thing is at the HP level. This one of the top activity of the HEWs. In case a woman gives birth at home, the HEWs visit to the home of the woman and conduct interview. There is a separate form prepared. When did the labour start? When did the woman give birth? Why the woman did not go to the HC? There is a separate form prepared so that they conduct the interview in their home. They send us the information collected. First, we thought that it could help us the reasons for home delivery; but, it was not as we expected it. Most of the time women tell us by shortening the duration of labour. They shorten the duration of labour when we ask them for how long the labour stayed. However, we thought that it could give us some data. The HEW also checks for the health status of the mother and newborn at the same time. The HEWs also conduct home visits to pregnant women starting from 8 months of gestation and they send it as a report. There is a form which asks for how many of the pregnant women visited in their home. How many of the visited women were 8 or 9 months of

gestation? The HEWs identify pregnant women with 9 months of gestation and report to the HC and they communicate with the HC midwives. The HC also identifies women with 9 months of gestation based on their EDD and post it in the labour and delivery room. We take also their medical records to the labour and delivery room. We are working to have the same recording system in the HPs and communicate with the HC. We post list of women disaggregated by kebele during pregnancy and after they gave birth. We give feedback for HEWs as soon as they give birth. We often provide feedback on Monday for HEWs and the midwives provide information for HEWs through telephone. Every Monday, the midwives give feedback for HEWs if a woman gives birth at home from that kebele. The whole feedback about the kebele will be given at the end of each month. There are TBAs and religious leaders' conferences that are being conducted.

ANNEXURE 12: EDITING AND PROOFREADING CERTIFICATE

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

27 January 2017

TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Mr Biruhtesfa Bekele Shiferaw's dissertation entitled: **"STRATEGIES TO IMPROVE UTILISATION OF SKILLED BIRTH ATTENDANCE SERVICE IN NORTH WEST ETHIOPIA".**

I found the work easy and enjoyable to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors Guild and also a Language Editor at Bureau of Market Research at the University of South Africa.

Hereunder are my particulars:

JM Chokwe

Jack Chokwe (Mr)

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Professional EDITORS Guild