

An Exploratory Qualitative Study of Socio-cultural determinants of maternal health care services in Ethiopia

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Abstract

Background: The high rate of maternal mortality reported in The Ethiopia is due to complications of pregnancy and delivery. In Ethiopia, the maternal mortality ratio had been 353/100,000 live births in 2015. The socio-cultural contexts under which these pregnancies and deliveries occur are the factors that pave the way for these complications and mortality. Therefore, this study was conducted to examine, and describe the socio-cultural determinants of maternal health care in Ethiopia.

Methods: This study was based on a qualitative, exploratory research design and used focus group discussions and in-depth interviews as its primary data collection techniques. Focus group discussions and in-depth interviews conducted in three districts (Haramaya, Grawa and Meta) in the Ethiopia. The study population consisted of 24 focus group discussants and 152 respondents homogeneous group. The data resulting from the discussion was transcribed verbatim and investigated using a qualitative thematic analysis based on ATLAS.ti.8.2.

Results: The result of this study showed that relatives support, preferences, planned use of MHS, knowledge, family living arrangements, women's expectation, previous history, privacy and confidentiality and parity were community and social level factors affect maternal health care services. Gender of health care providers, behavior of health care providers, ethnicity, and autonomy of household, gender and cultural and traditional beliefs were interpersonal and family level factors affecting maternal healthcare services.

Conclusions: Our findings suggest that despite women's multiple roles in the household, their positions are quite unfavorable. The high maternal morbidity and mortality rate is related to socio-cultural factors in the communities. More emphasis should be placed on devising ways that can educate the women and discourage them from resorting to the traditional socio-cultural practices to reduce the high maternal mortality rates.

Keywords: Ethiopia, Maternal mortality, Maternal Health Care, Sociocultural Determinant.

Background

Use of quality maternal health services (MHS) is central to the achievement of the Sustainable Development Goals Summit of 2015, representatives of most countries agreed to reach seventeen sustainable development goals (SDGs) by 2030, specifically among those goals 3 SDGs on the first agenda reducing maternal mortality ratio less than 70 per 10,000 live births (United Nations Statistics Division, 2015a). These goals have not been met in low-resource regions, especially in Sub-Saharan Africa, where the maternal mortality ratio declined by 45% between 1990 and 2015 (Alkema et al., 2015).

Studies done by Geneti (2015), maternal health has emerged as global priority because of great gap in the status of mother's well-being between positive and fulfilling the rich and the poor countries. In connection with this, for many women in poor countries is associated with suffering, ill health and even death and complications during pregnancy and childbirth. Complications of pregnancy and childbirth are the leading causes of maternal morbidities and mortalities for women of reproductive age (15–49 years) in these countries (Geneti, 2015). Regional disparities in MMR persist in the developing region which is roughly 20 times larger than that of developed region (WHO, UNICEF, UNFPA Group, World Bank and UNPD, 2015). In connection with this, it is projected that approximately 303, 000 maternal deaths occurred globally in 2015 from pregnancy-related causes (WHO, UNICEF, UNFPA Group, World Bank and UNPD, 2015). While the overall global decline in maternal mortality ratio between 1990 and 2015 was 44 per cent, the annual decline was less than 2.3 per cent which in turn was quite less than the planned 5.5% (WHO, 2015b).

Maternal mortality situation was noted to be worse in the sub-Saharan Africa where the decline was 45 per cent (WHO, UNICEF, UNFPA Group, World Bank and UNPD, 2015). In Ethiopia, a sub-Saharan country, maternal mortality is noticeably higher (Tessema *et al.*, 2017). According to the United Nations' agency WHO (2015:b) report, 11,000 maternal deaths occurred and the maternal mortality ratio was 353 deaths per 100,000 live births. In other words, for every 1,000 live births, about three or four women (3 or 4) died during pregnancy, childbirth, or within two months of childbirth in Ethiopia (Birmeta *et al.*, 2013). Consequently, the chance of an Ethiopian woman dying from reproductive health disorders and complications was put at 1 in 25 in 2005, 1 in 39 in 2010, and 1 in 64 in 2015, placing her at far greater risk than her counterparts in the developed world, where the risk was estimated to be 1 in 23,700 and 1 in 22,100 in countries such as Greece and Poland, respectively (WHO, 2016a).

Studies have shown that despite the differences in maternal mortality ratio between developed and developing nations, the pattern of maternal mortality and morbidity has not changed over the decades. The reasons that are adduced for this are the persistent tradition of deliveries in domiciliary settings in unsafe and unhygienic conditions by untrained or poorly trained birth attendants (WHO, 2016).

Although maternal deaths in Ethiopia are mainly due to complications of pregnancy and delivery, it is the socio-cultural context under which these pregnancies and deliveries occur

that pave the way for these complications and mortality. Therefore, understanding the socio-cultural contexts under which these pregnancies and deliveries occur is very crucial for solving these complications and mortality relate with MHC services. Despite the importance of socio-cultural factors for solving maternal health care service complications and mortality, previous studies have mostly focused on other determinants of MHC services without giving attention to the socio-cultural contexts under which these pregnancies and deliveries occur. Hence, this study was conducted to examine, and describe the socio-cultural determinants of maternal health care in Eastern Ethiopia

Materials and Methods

Study design and Setting

This study was based on a qualitative, exploratory research design and used focus group discussions and in-depth interviews as its primary data collection techniques. We conducted focus group discussions and in-depth interviews in three districts (Haramaya, Grawa and Meta) in the East Hararghe Zone of Oromia National Regional State, Ethiopia. The study areas were selected purposively as they represent the areas with major health intervention (Belina *et al.*, 2018). The study was conducted from September to December, 2017. The study population consisted of 24 focus group discussants and 152 respondents homogeneous group (i.e., 24-community health workers, 48-reproductive aged women, 24-husbands, 24-religious leaders and 24-community representatives). Eight relatives who were involved in decisions about the birthing process, i.e. five mothers-in-law, two sisters and a father-in-law, were also interviewed (Baral *et al.*, 2012).

Data collection

The data collection involved representative community members residing in the three districts (Haramaya, Grawa and Meta). Participants in the study were recruited from representative community groups existing in the study communities. The study population consisted of 24 focus group discussants and 152 respondents homogeneous group (i.e., 24-community health workers, 48-reproductive aged women, 24-husbands, 24-religious leaders and 24-community representatives). Eight relatives who were involved in decisions about the birthing process, i.e. five mothers-in-law, two sisters and a father-in-law, were also interviewed (Baral *et al.*, 2012). They were contacted by researcher and data collectors, who briefed them about the objective of the study and requested for their assistance in identifying potential subjects.

Focus group discussion was limited to ten participants at a time for ease of management and was held in either the village health post or community development center to avoid noise and distraction. Following the introduction and informed consent routines, participants were asked to discuss the difficulties they face in keeping themselves healthy and health-related problems they had experienced during pregnancy and delivery. Based on the issues they raised, the researcher prompted them to describe their situations, how relevant decisions were made within their households, and how they managed to cope with difficulties. This

discussion was supplemented by interactive questions about such topics as obtaining prenatal care, travel arrangements at the time of delivery and division of labor when they were pregnant.

An interview guide developed was used to facilitate the discussion. The interview guide was developed based on literature review of previous studies on women's perceptions of maternal health issues [38], and on social and cultural barriers of maternity care [39, 40]. The interview guide was pilot tested with participants that have similar inclusion criteria as those that participated in the study and was ethically approved long before primary data was being collected and no change was made following ethical approval. In-depth interviews (IDIs) were also conducted to obtain in-depth information about maternal health issues in their communities. The rationale for the use of these qualitative methods was to draw upon participants' experiences and reactions in a way which would not be feasible using other methods [43]. The data collection process for both the FGDs and IDIs was based on the principle of saturation [44, 45] and was conducted during August and September 2017, with 16 female data collectors recording all the discussions. The data collectors were a female who had a minimum of secondary level education and had experience in data collection. They had three days of training for the purposes of data collection. The data collection process was closely supervised by field supervisors and the research team.

Data analysis

For the more rigorous part of the data analysis, all sound recording files from the FGDs were uploaded to a computer and password protected; they were then translated from the vernacular language into English and transcribed verbatim. Researcher played and listened to the audio recorder several times in full before transcription began. After transcription, familiarity with the data was developed through many readings of the entire transcripts; to obtain a sense of totality; significant statements were highlighted and extracted. Meanings of significant statements and sentences that bear similar attributes were then labeled and coded. Open coding with paper and pen was used at this stage, in which different parts of the text that contained significant statements were marked with appropriate labels and coded for further analysis.

Coding and analysis of all recordings were subjected to manual thematic analysis (Braun and Clarke, 2006). During analysis of the data, the study used common properties to group descriptions of similar situations or ideas into key concepts. Concepts with common properties were then classified based on the study objective and the data collected. The strategy used for coding was constructed code, which uses either coded data from in vivo codes or from academic terms. We created our own codes based on the study objective and question guide.

After coding the data, a table was created. Researcher copied and pasted the coded data into the table in order to group the themes to ensure that no code has been missed and that the described and named themes provide a clear picture of what each theme was about (Braun and Clarke, 2006). The themes comprised at least two quotes followed by summary accounts or comments from the TBAs. We cross-examined the interviews with the observations of the

TBAs to determine whether the experiences reported by the participants were also observed by the TBAs. Particular attention was paid to how many participants shared a certain idea in some of the quotations (using expressions such as “the majority”, “a few” and “several participants”). We also added more “context” around some of the verbatim data, using additional data regarding the participant's profile. Participants’ quotes were reported directly as they were spoken, without editing the grammar, to avoid losing meaning (Kululanga *et al.*, 2012). The data resulting from the discussion was transcribed verbatim and investigated using a qualitative thematic analysis based on ATLAS.ti.8.2.

Ethics

The study was approved by The UNISA Research Ethics Committee and the study also obtained ethical approval from Ethiopian Scientific and Ethics Committee. The survey commenced after written consent obtained from East Harargee health bureau and district offices. Informed verbal consent was requested from each study subjects. Each respondent were informed about the objectives of the study and assurance of confidentiality. Before the start of any discussion participants were informed about the purpose of the study and all what was required of them as respondents, such as the reason for them to stay to the end of the discussion. They were told that they reserve all the rights to participate and not to participate. The main data collectors informed them that all the discussion will be recorded on an audiocassette for his own use, to which all the participants consented to.

Results

The thematic analysis of the qualitative data was undertaken based on ATLAS.ti.8.2 to understand basic issues raised by participants in focus group discussion regarding socio-cultural determinants of maternal health care. Based on the qualitative data, two main themes emerged from the socio-cultural determinants of maternal health care services. The themes are: community and social level and interpersonal or family level factors. Important sub-themes were also identified in the analysis.

Community and social level factors

Figure 1 presents the community and social level factors affect maternal health care services. Relatives support, preferences, planned use of MHS, knowledge, family living arrangements, women’s expectation, previous history, privacy and confidentiality and parity are social level factors affect maternal healthcare services.

When asked about the community and social level factors affect maternal health care services, the participants agreeably reported that their preferences were among the factors affecting maternal health care services. The older women, particularly mothers-in-law, believed that pregnancy and childbirth were normal processes not requiring special care. These women had neither an experience of professional care nor a tradition of going to the hospital for delivery of babies. One mother-in-law stated:

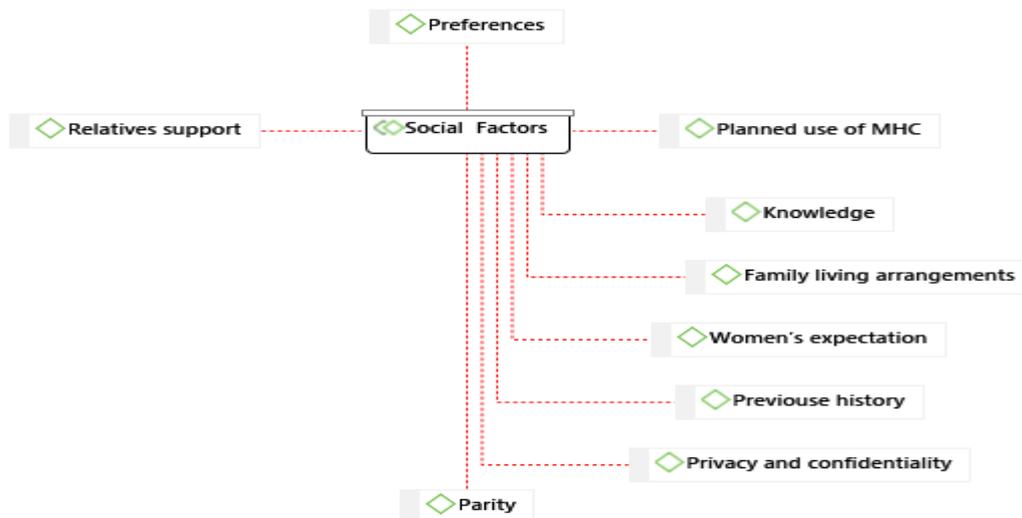


Figure 2: Social factors

“There was no tradition of going to the hospital for delivery in our time..... Women delivered all their children at home without anyone’s help. We did not even know what a doctor or nurse was but these days’ women are prepared to go to the hospital when labour starts ... We were working all day and delivering babies at night without anyone’s help. Some of the women delivered the baby in the jungle while collecting firewood and grass for cattle.” (Grawa, community leade-16)

Reliance on traditional birth attendant (TBA) care in the community is one of the client related factors identified as a reason for not seeking health facility delivery. On expectant mothers’ reliance on TBAs, a husband notes this:

“Pregnant women hope that the traditional birth attendants are with them to assist during labor and delivery. Women also depend on them.” (Haramaya, husband-10).

The information given during pregnancy when women went for antenatal care service was limited. They did not have any information regarding advantage of health facility delivery and birth preparedness plan. One of the women participants’ states:

“I have three children and delivered all of them at home.... No one asked/told me where I want to/have to deliver. Health providers told me as I finished my ANC follow up that I don’t need to go again because I have finished my follow up. Then I stayed at home and when labor started I called TBA and delivered at home.” (Chelenko, women-1)

Women who had delivered more than three times and/or were aged over 30 years reported that they were less likely to use. However, one woman gave safety due to her “old” age and the number of deliveries she had had as the reasons for using SBA services. She stated that:

“I went to the hospital for safety reasons. I was 38 years old during the last delivery..... It was my sixth pregnancy, and my age was not ideal for birth. I felt weak due to my age and number of pregnancies so my husband made me go to the hospital for safety.” (Haramaya, woman-4)

Other women reported that they preferred to go to the hospital believing that there was more safety in hospital in cases of complications. They frequently mentioned fear of different

traditional birth practices and high risk at home, as there was no maternal and modern health facility at home if they were needed. One of the women stated:

“I prefer going to hospital for delivery. There were no trained professionals for delivery at home in the village..... Different women came to our home and suggested different practices for delivery based on their experience. I really do not like that. If you go to the hospital; you are safer than at home..... There are health facilities like health professionals and equipment for treatment but nothing in the village. There was high risk in delivering at home.” (Grawa, woman-2)

One FGD participant women state that age of women has a great impact on the health of maternal health care services. One teenage participant state that:

“I was desperate to go to hospital. I was too young to give my first birth at the age of 18.... I knew it is not the ideal age for delivery as a result I asked my husband to take me to hospital for delivery. There might be high risk associated with my age during delivery.” (Grawa, woman-8)

Similarly, women participants of the study area state that:

“We wanted to deliver at health center.... But when we called the ambulance it came very late so that we were enforced to give birth at home.” (Grawa, woman-4)

Women’s expectation about the quality maternal health care services is another factor.

Women had a positive expectation about quality of maternal care services before they actually received any of these services. Women expressed their desire to have health facility staff with positive attitudes. These include giving reassurance and encouragement during labour and delivery, providing a faster service, with co-operative and polite behaviour from the SBAs. However, they found things different in reality. One of the maternal health services user a husband, reported:

“I had hoped for faster services in the hospital. I had thought that the health personnel would behave nicely and politely.... But I found the reverse of what I hoped for. I found most of them were impolite and rude. You can get more treatment in hospital than at home in case of complications but they did not care about women in a normal situation.... Some of the doctors and nurses were not experienced.”(Grawa, husband-9)

Similarly, a woman reported her expectations about maternal health service use:

“There was a long queue of women in the hospital when I went for an antenatal check-up.... I found it was different from what I had hoped before going to hospital for service use. There were no female doctors.... The male doctors were there to do check-ups. The doctors pressed my tummy hard and I had pain due to that.” (Haramaya, woman-5)

Planned use is another factor affecting the maternal health care services. Timely access to services was a problem even if women had planned SBA use during delivery. One husband reported that:

“My wife and I had planned to go to the hospital for delivery but the baby was born four weeks earlier than the expected due date. Suddenly, labour occurred in the

evening and she started bleeding then we rushed to the hospital.” (Haramaya, husband-9)

Relatives influence is also another factor affecting maternal health care services. Some women, though they were young and first-time-mothers, mentioned their different reasons for not using the services, even if they had intended to. For example, a woman described her reason for not using SBA services as follows:

‘It was my first time though no one helped me during the delivery. All of my family members were at work on that day and they did help to take me to hospital later.... I was walking here and there due to labor pains; the baby was born in the cowshed on the way to the toilet.’ (Chelenko, woman-7)

Participants, irrespective of their socio-economic circumstances and living conditions, reported that mothers-in-law had a big influence on SBA use during pregnancy and delivery of babies. Women reported that mothers-in-law are experienced so they can discuss pregnancy related problems with their daughters-in-law. Mothers-in-law mostly arranged household duties while men work outside the home. A woman stated that:

‘In our society we live an extended family system where household affairs are not decided over by the couple alone.... Even the head of a household (the husband’s) decision making role does not go beyond allocation of money and other issues.... Whereas, it is the mother-in-law who has full control over the matters of pregnancy, delivery, and post-delivery care and support’ (Chelenko, woman-4)

A senior woman who was usually a mother-in-law had a good relationship with her husband and her son and this can be helpful in guiding and controlling her daughter-in-law and other junior family members. Relationships between mother-in-law and daughter-in-law, including mother-in-law’s own delivery experience, all influence the use of maternal health services during labour and delivery. In this regard, a woman said:

‘I am always influenced by my mother-in-law who badly needs me to give her grandchildren though we had planned to delay birth for couple of years.... However, the ever-increasing pressure from the mother-in-laws made us to change our mind and planned to have a baby soon at this early age.’ (Grawa, woman-5)

Another woman reported that the relationship between mother-in-law and daughter-in-law was helpful to her regarding maternal health care services use:

‘I got every help from my mother-in-law. She was always happy even if I delivered up to six times.... I gave birth to five daughters continuously but she did not complain, misbehave, or say bad words to me. She always supports me in work, cares for me well, and gives me good food and rest during pregnancy and after delivery.’ (Grawa, woman-6)

Again, parity of women affects maternal healthcare services. Most of women have not information or knowledge about maternal health care services. One women state that:

‘I have three children and delivered all of them at home.... No one asked/told me where I want/have to deliver. Health providers told me as I finished my ANC follow up that I don’t need to go again because I have finished my follow up. Then I

stayed at home and when labor started I called TBA and delivered at home.”
(Chelenko, woman-1)

Women aged over 30 years reported that they were less likely to use maternal health services. However, woman went to the health facility for safety reasons due to her “old” age and the number of deliveries she had had as the reason for using maternal health services. She stated that:

“I went to the hospital for safety reasons. I was 38 years old during the last delivery..... It was my sixth pregnancy, and my age was not ideal for birth. I felt weak due to my age and number of pregnancies so my husband made me go to the hospital for safety.” (Haramaya, woman-4)

However, one mother-in-law commented on her perception of maternal health care use and said that pregnancy was a natural process with no need for special care during that period.

“I delivered nine children at home without anyone’s help. I never saw doctors for delivering a baby in my lifetime. Nowadays, women already know about the sex of the baby in the womb whether it is boy or girl.... Today’s women consider birthing a baby is very difficult but it is a natural phenomenon so there is no need to worry.”
(Haramaya, woman-7)

Again, Women’s (pregnancy) history and maternal health care services are factors affecting maternal health care services. Women had not planned go to the hospital for delivery if everything remained normal. A woman stated:

“I had not planned go to the hospital for delivery if everything remained normal. I felt unwell as the delivery date came nearer and nearer then I decided go the hospital for delivery.... I think my age and number of children caused weakness this time. I did not feel like this for previous births.” (Chelenko, women-3)

Privacy and confidentiality matters on maternal health care services also affect maternal health care services. Women reported that the difficulty of maintaining privacy and confidentiality was another barrier to maternal health care use. A woman described it thus:

“The male doctor inserted his fingers into my vagina and other nurses were standing looking at that, Pause for a while. Maybe they were in training. I feel bad seeing that group of people looking at me.... There were no curtains and no private room so this made it difficult to change my clothes and breastfeed the baby after delivery. We can see each other and other people (visitors) can see us easily.... One bed for each woman after birth of the baby and private rooms or curtains around the bed to avoid seeing others would be more comfortable for all women.”(Haramaya, woman-3)

Furthermore, family living arrangements affect maternal healthcare services. In the study area the society was patriarchal, and the husband was at the center of the household. A final decision of the family issue was decided beforehand. A member of community leaders states that:

“Father has greater role in making final decisions over family issues even if we discuss on them beforehand. We are living in an extended family system..... When it comes to deciding over delivery matters, mothers-in-law have significant role.

Support from family members, financial situations, time of the day when the labor starts, and availability of transportation service are factors that determines one's ability to go to hospital.'' (Chelenko, community leader-16)

Mothers-in-law mostly arrange household duties while men work outside the home. In line with this, a woman stated:

'In our society we live an extended family system where household affairs are not decided over by the couple alone.... Even household's head (the husband's) decision making role does not go beyond allocation of money and other issues.... Whereas, it is the mother-in-law who has full control over the matters of pregnancy, delivery, and post-delivery care and support'' (Chelenko, woman-4)

Knowledge about the maternal health care services is also another factor affecting maternal healthcare services. Women in the study area were both culturally and traditionally dominated in the community. Most women had no access to education, information and knowledge. A community leader said that:

''The literacy rate among women is poor in this village and girls are married at a younger age than the boys. Women lack information especially for first births. They have difficulty sharing ideas due to shyness, lack of knowledge and teenage pregnancy.'' (Haramaya, community leader-14)

Unlike women, men in the study area were socially dominant, and women had less involvement in social activities, and therefore some women had less chance to communicate about different issues both within and outside the home. A husband stated that:

''Women are less involved in communications and outside movements in our community. They have less knowledge about the maternity services of the country.... Especially women lack information about the safer maternity services for the first-time birth. In addition, they feel embarrassed during pregnancy; it makes it difficult to discuss what kind of maternity services they need.'' (Haramaya, husbsnd-9)

It is common knowledge that the society in the study area gave little emphasis to women's education. Due to lack of education and knowledge about maternal health services, teenage pregnancies were rampant in the area. One husband who participated in the discussion commented the following in this regard:

''The fact that little emphasis has been given to educating girls as well as girls' marriage at younger age, literacy rate among women is very low in this village.....Teenage pregnancy of girls with lack of knowledge and who can hardly share birth related ideas among themselves due to shyness face difficulties handling first birth.'' (Grawa, husbsnd-9)

As a result of lack of knowledge about pregnancy and other social factors, women did not exactly know when and where to deliver in their first pregnancy. Hence, women needed help from relatives during the first delivery. A woman relates her first experience of delivery as stated next:

'It was my first time but no one helped me during the delivery. All of my family members were at work on that day and they did help to take me to hospital later.... I

was walking here and there due to labor pains; the baby was born in the cowshed on the way to the toilet.’’ (Haramaya, woman-7)

It has been found that many women, especially less educated ones, first-time and young mothers considered that being pregnant was shameful. These women reported that they had less knowledge about safer pregnancy. They could not discuss pregnancy related matters with family members due to shyness or lack of knowledge. Some women felt embarrassed when they knew they were pregnant for the first time rather than being happy. Some of the traditions affected the women’s timely access to services, for example, due to shame about the pregnancy; some women even kept it secret from others until their pregnant belly grew. A woman relates her first pregnancy experience as young woman in the following lines:

“I was young the first time I was pregnant at the age of 16. I had no specific ideas about pregnancy and safe delivery.... It was embarrassing when my stomach started to grow. What should I do to tackle the embarrassment about what has already happened. uha.... I used to wear big and loose clothes and did not want to go anywhere outside home and chat to other people due to shyness.’’ (Grawa, woman-4)

Interpersonal or family level factors

Cultural and traditional level factors affecting maternal health consist of gender of health care providers, behavior of health care providers, ethnicity, and autonomy of household, gender and cultural and traditional beliefs. Graphically presented in the figure below are these cultural and traditional factors.

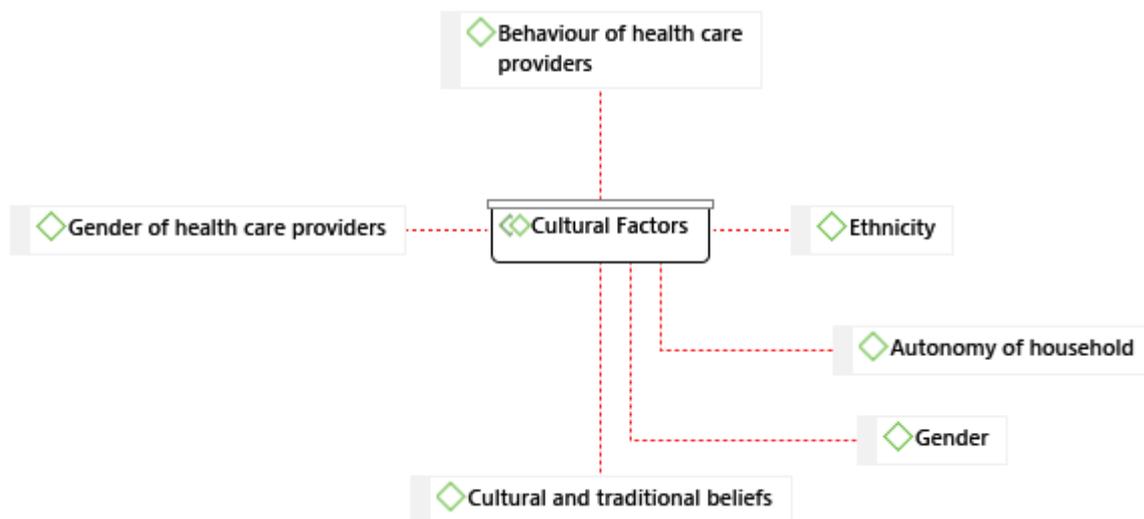


Figure 3: Cultural factors

Gender of health care providers affects maternal health care services. As this study already indicated, utilization of maternal health care services in the study area was influenced, among others, by the gender of the service user. In addition to this, it has been found that the gender of health care providers also affected the utilization of the services. How the gender of the health worker affected service utilization is described as follows by one of the husbands who participated in the study:

“There was a big issue of gender of the health service providers.... Most of the male doctors helping women during delivery make women uneasy especially first-time mothers from the village.” (Grawa, husband-10)

As has been pointed out above, women’s utilization of maternal health care services was affected by the gender of the health professional. While gender affects use of maternal care services, there were no female doctors in the facilities in the study area; it was only male doctors were there to provide maternal services to users. That made women be shy and prefer home delivery. One woman said:

“There was a long queue of women in the hospital when I went for an antenatal check-up.... I found it was different from what I had hoped for before going to hospital for service use. There were no female doctors..... The male doctors were there to do check-ups. The doctors pressed my tummy hard and I had pain due to that.” (Haramaya, woman-5)

In relation to how a health professional’s gender affects beneficiaries of maternal health care services, a participant of the discussion group complained that all the times she had to confront male doctors for her check-ups which were difficult for her to freely discuss the situation of her pregnancy and was unable to ask about any concerns, and she said:

“Throughout my pregnancy, I had four antenatal check-ups. All the times I had to confront male doctors for my check-ups which were difficult for me to freely discuss the situation of my pregnancy.... I was unable to ask about any concernsHad I been served by female doctors during antenatal check-ups, I would have been comfortable to share any of my concerns regarding my pregnancy.” (Grawa, woman-5)

Behaviors of health care providers also affect maternal healthcare services. It was reported that in a health facility, health care providers were described as not being so much compassionate towards maternal health care service users. Due to the misbehavior of health care providers, women prefer home delivery. A community leader describes how a laboring woman was treated at a health center and the reaction it caused in the following manner.

“A woman suffering in labor is not adequately managed or handled. As a result, we become angry and prefer home delivery with the help of local birth attendants.” (Haramaya, community leader-13)

Where health professionals work at, i.e., their work both at public and private health facilities, was found to be another factor that made mother to prefer home delivery to hospital delivery. The mothers pointed out that medical staff who worked in such a manner discriminate their treatment on the basis of whether they were working at a publicly- or privately-owned health facilities. The doctors who worked in both hospitals told women to go to the private health facility for better and faster services than in the public hospital. Some of these women reported that what the doctors did practiced was discriminatory. For example, one of the women stated that:

“Some doctors are working in a private hospital and a government hospital, too; I did not find good behavior from them.... They ordered me go to the private hospital for better and faster services instead of helping me in public hospital..... They did not

care for the women. They did not even talk politely if you asked some questions.”
(Chelenko, woman-4)

Moreover, what an FGD discussant who witnessed a woman in labor getting no help from health care providers stated below could further illustrate how medical personnel working in a public hospital affected mothers' utilization of maternal care services at public health facilities. This woman said that:

“One day while I was in hospital with my sister, a woman in labor arrived with a baby coming out. Meanwhile someone shouted....she is giving birth.... I see the baby!” But none of the nurses showed up to take care of. Eventually, the baby was delivered with the help of women accompanying the mother.” (Haramaya, woman-7)

Ethnicity also affects maternal health care services. Almost all of the focus group discussion participants were Muslims. Their religion it was learned affected the use of maternal health care services as utilization of maternal health care services was low among them. With regard to the relation between religion and use of maternal health care, a religious leader said:

“The Muslim women feel that they can only be touched and seen by their husbands. That is why they do not want to be attended by male midwives.” (Chelenko, religious-19)

Again, Autonomy of household affects maternal health care services. It has been found out that who decides the use of maternal care services depended on the degree of autonomy of women had in the household. A participant husband who was a community leader, for instance, declared that labour and delivery was a “women's matter”, so mothers-in-law had a significant role in decision making for service use. However, men also had a major say in deciding whether women should deliver at home or hospital. One community leader elaborated it as follows:

“Labor and delivery are a women's matter, so mothers-in-law can play an important role in making it easier.... However, in our patriarchal society men are powerful voices in the family. The men have more value than the women in this society in many ways.... Most families have a male-headed household, so he has a vital role in decision making for health seeking behavior and many more matters such as education, travel, and work.” (Chelenko, community leader-14)

This study indicates that women sometimes could decide whether to deliver at home or not regardless of their economic status. This decision, however, could be overruled by mothers-in-law if the woman did not have a nuclear family. Regarding the use of maternal health service, a service-user woman living in a nuclear family reported what is next.

“I did not work outside the home for money.... I did not earn any money.... Therefore, I have to depend on my husband for everything though my husband consults me before doing something. Both of us discuss and decide what is best to do.”
(Haramaya, woman-3)

Gender plays an important role in decision-making in the society where men are considered as more important than women socially and culturally. Participants reported that male family

members had more influence in decision-making than females. On the role of gender in decision making in maternity service use, a non-maternal health care user woman reported:

“As per the socially constructed gender roles, husbands are the breadwinners and the decision makers over big household issues while women are seen as dependents and as responsible for household chores.... As a result, men’s voices are easily heard than women’s..... A woman in labor and delivery who has an adult male in her family can get more help as compared to the one who has no adult male member in her family.... The entire community trusts a male borrower in need of money rather than a woman borrower. Women who have male members in their family feel more secure in such a male-dominated society.” (Haramaya, community leader-14)

Again, Gender affects maternal health care services. As has been just described in the preceding paragraph, gender played an important role in decision-making in society where men are considered socially and culturally as more important than women. Participants in general reported that male family members had more influence in decision-making than females, as the following lines show.

“Men have higher social position in our society so do husbands in the family. Whereas a decision made by a man is influenced by his job, level of income, and education....Hence men with better education and economically better-off are capable of being acceptable in their decision not only in their respective families but also in the community” (Chelenko, husband-11)

Cultural and traditional beliefs also affect maternal healthcare services. In the study area, cultural and traditional beliefs often influenced women’s use maternal care services. These cultural and traditional issues positioned men to have more power than women in the society. The position that men had in the society generally enabled them to make a final decision on matters pertaining to women’s personal, social and economic lives What a community leader from one of the localities in the study area said can represent how cultural and traditional beliefs affected women’s use of maternal care services.

“Labor and delivery are a women’s matter, so mothers-in-law can play an important role in making it easier.... However, in our patriarchal society men are powerful voices in the family. The men have more value than the women in this society in many ways.... Most families have a male-headed household, so he has a vital role in decision making for health seeking behavior and many more matters such as education, travel, and work.” (Chelenko, community leader-14)

It was learned that mothers-in-law had more power than their daughters-in-law because of cultural and traditional beliefs in the past. As a result of this power differential, women’s use of maternal care services used to be easily determined by their mothers-in-law. However, there had been changes regarding the care of pregnant women and the availability of maternity services in recent years. In the past, the community in general and pregnant women in particular used to have no access to modern services; as a result, women had no options except to follow the traditional practices related to pregnancy and delivery. Below a

community leader compared how access to health facility changed in the study area over time and how the influence of cultural and traditional beliefs were gradually waning.

“Cultural and traditional beliefs were high in our time. I had a problem with expelling the placenta for my fifth birth. It did not come out for three days..... At that time people gave me healing water to drink. I tied a trowel over placenta, tried to vomit by putting hair into my mouth, and tied a rail ticket to my back but all those did not work..... There were no doctors at that time so these were common practices during delivery of the baby, but nowadays women go to hospital if they have such problems.” (Chelenko, community leader-16)

As a result of the expansion of health facilities in the research area, women reported that the availability of maternal health care services at local level increased SBA use by reducing the time taken to travel long distances to a facility. They also mentioned that access to reliable transportation services could help timely access to a service. If there were trained health personnel in the facilities, women could also take advice from them if complications arose during delivery. In connection with this, one community leader stated that:

“It would be good if there was a Health Post with qualified nurses in this village.... If the facility is near it is easier to go. If there were some trained nurses or midwives in the village women could ask them for advice about safe delivery.....After I delivered the baby, I hung the trowel for two hours to bring the placenta out. If there were qualified health people, they would stop such kind of harmful practices.” (Grawa, community leader-15)

From group discussions with participants, it was found that women particularly older women believed that pregnancy and childbirth was a normal process not requiring special care. These women neither received professional care nor had a tradition of going to the hospital for delivery. A community leader, for instance, stated the following in this regard:

“There was no tradition of going to the hospital for delivery in our time.... Women delivered all their children at home without anyone’s help. We did not even know what a doctor or nurse was like but these days women are prepared to go to the hospital when labor starts.....We were working all day and delivering babies at night without anyone’s help. Some of the women delivered the baby in the jungle while collecting firewood and fodder for cattle.” (Grawa, community leader-16)

This study indicates that some mothers would prefer getting maternal health services at health posts. During the interviews, the participants emphasised the need for a functioning HP with trained health professionals in the village. Participants suggested that if the services were easily available in the local area, it would help to increase maternal health service use during delivery of the baby. One woman thus said the following:

“I prefer going to hospital for delivery. There were no trained professionals for delivery at home in the village.... Different women came to our home and suggested different practices for delivery based on their experience. I really do not like that. If you go to the hospital; you are safer than at home.... There are health facilities like

health professionals and equipment for treatment but nothing in the village. There was high risk in delivering at home.” (Grawa, woman-2).

In spite of some mothers or would-be mothers’ preferences, utilization of maternal health care services was always influenced by my mothers-in-law who badly needed their daughters-in-law to bear grandchildren, though the daughters-in-law had planned to delay birth for a couple of years. One of participant women said that:

“I am always influenced by my mother-in-law who badly needs me to give her grandchildren though we had planned to delay birth for couple of years.... However, the ever-increasing pressure from the mother-in-laws made us to change our mind and planned to have a baby soon at this early age.” (Grawa, woman-5)

Another woman reported that the relationship between mother-in-law and daughter-in-law was helpful to her regarding maternal health care uses:

“I got every help from my mother-in-law. She was always happy even if I delivered six times..... I gave birth to five daughters successively, but she did not complain, misbehave, or say bad words to me. She always supports me in work, cares for me well, and gives me good food and rest during pregnancy and after delivery.” (Grawa, woman-6)

Another finding that the current study revealed is that cultural and traditional practices of the society influenced the utilization of maternal health care services in the study area. How such practices influenced use of maternal health care services is described by a woman who participated in the discussion next.

“I had faced the difficulty of unremoved placenta for 2 hours after delivery.... The TBA asked me to hang a trowel over the placenta for 2 hours and inserted her hand into my vagina and took it out.” (Grawa, woman-6)

Moreover, what one community leader stated below illustrates how social and cultural beliefs and practices influenced use of maternal health care services.

“As per the socially constructed gender roles, husbands are the breadwinners and the decision makers over big household issues while women are dependents and responsible for household chores.....As a result, men’s voices are easily heard than women’s... A woman in labor and delivery who has an adult male in her family can get more help as compared to the one who has no adult male member in her family.... The entire community trusts a male borrower in need of money rather than a woman borrower. Women who have a male member in their family feel more secured in such a male dominated society.” (Haramaya, community leader-14)

It has been found that socially mothers-in-law had significant roles in their sons’ households. For example, they mostly managed their sons’ household duties while the men worked outside the home. As a result of their roles, as was stated by some FGD participants, mothers-in-law could even influence whether their daughter-in-law should get SBA’s services during pregnancy and delivery. What is more, religious leaders also reported that mothers-in-law were experienced, so they could discuss pregnancy related problems with their daughters-in-

law. The following quote illustrates how socially and culturally mothers-in-law were influential with regards to the use of maternal health care services.

‘In our society, concerning maternity services, such as antenatal check-ups or childbirth, mothers-in-law have big influence because they have more experience about pregnancy and delivery..... It is easier to share problems with a mother-in-law than with other members in the family. Husbands are mostly working outside the home, so they do not know much about pregnancy matters. Mothers-in-law can provide good food, rest and other care as they have more responsibility inside the house.’ (Chelenko, religious leader-17)

The study shows that education is one of the most important factors affecting use of maternal health services. Generally, women in the study area were less educated than men. Women who had dropped out of school at an early age tended to have less knowledge about safer pregnancy and delivery services. Other women also stated that educated mothers were more likely to use SBA services during delivery of a baby. One religious leader stated her views as follows:

‘Girls are less educated in our society than the boys.... Daughters are married at a younger age than the son in the family.... When the daughter enters into puberty and menstruates for the first-time, parents are more worried about getting her married rather than sending her to school.... Those who were married young and dropped out of school early do not have the knowledge about safe delivery.’ (Grawa, religious leader-20)

DISCUSSIONS

In many focus group discussions, gender of health care providers, behavior of health care providers, ethnicity, and autonomy of household, gender and cultural and traditional beliefs were interpersonal and family level factors associated with maternal healthcare services. The result of this study showed the presence of association between gender of the head of the household and healthcare providers with maternal health care services. This finding is consistent with the findings of similar studies conducted in Namibia, Kenya, and India (Press, 2012; Lowe *et al.*, 2016). In addition to the gender of healthcare providers, male family members influence females’ utilization of maternal healthcare services because the communities in the study area are patriarchal. This finding is similar to the study done by (Neil and Domingo, 2015).

How healthcare providers behave towards MHC users is also another factor that influences use of MHC services. In order to improve utilization of MHC services by women, health professionals should behave compassionately towards MHC service users. This finding is in agreement with a study by Mannava *et al.* (2015) that indicated the misbehavior of health professionals made women prefer a home delivery. In eastern part of Ethiopia, particularly where this research was done, almost all of the communities are Muslims whose use of MHC services was low. As a result, this study finds that religion is another socio-cultural factor that affects women’s utilization of MHC services. This finding consistent with the finding done in Ethiopia by Ayele *et al.* (2014); Kifle *et al.* (2017).

Our finding is in agreement with other studies showing that giving Women's preference and use of MHC services are determined by the autonomy they have in the household. As the communities in the research area have a patriarchal structure, most women do not have parity with men in making decisions concerning use of MHC services and decisions over family issues. This finding is consistent with the study done in Ghana and Nepal by (Lewis *et al.*, 2015; Craymah *et al.*, 2017). In addition, Women who have equal autonomy in their households were 2.85 times more likely to seek ANC services than their counterparts. The result of the present study is found to be similar with previous studies in Ethiopia (Birmeta *et al.*, 2013; Yaya *et al.*, 2017). "Husband's or partner's approval of ANC was most significantly related to antenatal care attendance." It is expected that having a husband who approves antenatal care significantly increases the likelihood that a woman used antenatal care, irrespective of the husband's background characteristics. Therefore, efforts to improve husband's or partner's attitude would probably increase utilization of health services by women. In this patriarchal society, cultural and traditional beliefs about labour and delivery and type of family affect women's use of MHC services. Consequently, "women's use of MHC services can be decided by husbands and mothers-in-law who have a powerful voice in the household." This finding is again consistent with the results of studies done by Roudsari *et al.* (2015); Ugwu and Kok (2015); Mesele (2018).

In many focus group discussions, relatives support, preferences, planned use of MHS, knowledge, family living arrangements, women's expectation, previous history, privacy and confidentiality and parity were community and social level factors associated with maternal health care services. Previous studies have also showed presence of association between preferences and MHC services (Kaphle *et al.*, 2013; Sialubanje *et al.*, 2015; Aziato and Omenyo, 2018). Women's traditional beliefs about pregnancy and childbirth are one of the social factors that determine mothers' choice and utilization of MHC services. That is to say mothers-in-law and traditional birth attendants believe that pregnancy and childbirth is a normal process not requiring special care. They had neither experience of professional care nor a tradition of going to a hospital for delivery. Therefore, mothers-in-law do not encourage their expectant daughters-in-law to go to hospital for maternal care services. This finding is similar to results of studies done in Ghana, Nepal and Zambia (Kaphle *et al.*, 2013; Sialubanje *et al.*, 2015; Aziato and Omenyo, 2018). Nevertheless, safety in case of complications during pregnancy and delivery is found to be a key reason for women to prefer MHC at health facilities. This finding is consistent with the results of studies conducted in Bangladesh, Malawi and Zambia (Kumbani *et al.*, 2013; Sialubanje *et al.*, 2015; Sarker *et al.*, 2016).

Other studies have also found an association between religion and MHC services (Kifle *et al.*, 2017). Muslims were found to have low MHC service seeking behavior as compared to Christians. Christian women were 3.2 times more likely to seek postnatal care than Muslim women. The finding of this study also suggests that religion is associated with postnatal service seeking behaviors of women. This finding is consistent with studies done in Ethiopia (Kifle *et al.*, 2017). The possible explanation could be Muslim women in the study area believed that their naked body could only be seen by their husbands. This is also

demonstrated with the qualitative data in which religion was an influencing socio-cultural factor of MHC service seeking behavior. Generally, Muslim women prefer female traditional birth attendants than skilled healthcare providers (Kifle *et al.*, 2017).

In addition to women's religion, women's maternal health services utilization is also affected by the ethnicity to which they belonged. Oromo women, it was found, were 1.2 more times likely to get postnatal care. In contrast to this finding, another study's finding shows that there was no significant association between ethnicity and the use of postnatal care service (Shiferaw *et al.*, 2013). Women's expectations of the speed and quality services at health facilities and their expectations of behaviour of medical personnel are social determinants of preference and use of MHC services. Thus, women who have positive expectation of quality services at health facilities and of the behaviour of medical personnel prefer to deliver at a hospital. The finding is similar to the studies done in Kenya, Nigeria and South Sudan (Tsawe and Susuman, 2014; Lang and Mwanri, 2015; Okonofua *et al.*, 2017).

Planned use of maternal healthcare services also associated with maternal healthcare services. The study has indicated that timely access to services was a problem even if women had planned SBA's use during delivery. This finding is similar to the findings of studies done by Wilunda *et al.* (2015). *Furthermore, relatives influence on maternal healthcare services associated with maternal healthcare services.* Owing to social factors, pregnant women's non-use of MHC services has been influenced by the presence of extended family members, household affairs, mothers-in-law and daughters-in-law. This finding is similar to a finding of a study done in Malawi (Mokomane, 2012). This study has revealed that polygamy is a factor associated with women's PNC utilization. In connection with this, it was found that women who are not in polygamous marriage were 16% times more likely to seek PNC services than women in polygamous marriage. This finding shows that women need to work exceedingly hard to save money for their medical and other related expenses like transport fares which are unlikely to be provided by their polygamous husbands. Yet, other studies show that giving women decision-making powers by their spouses could raise the rates of delivery at healthcare facilities (Lowe *et al.*, 2016).

Use of postnatal care services is found to be significantly affected by social support provided to pregnant women by family members. Thus, women with husband's support were 6.18 times more likely to seek PNC services as opposed to their counterparts. The review of also revealed, women who are not supported by friends and family members are less likely to receive prenatal care services (Ramezani Tehrani *et al.*, 2016).

Parity also associated with MHC services. According to women who participated in FGD, they used maternal health services due to feeling of weakness even if they had no initial plan for SBA use. Women who have delivered two or more times prefer to deliver at home (Kjerulff *et al.*, 2013; Sarker *et al.*, 2016). However, one Haramaya women commented on her perception of maternal healthcare use and said that pregnancy is a natural process with no need for special care during that period. The finding consistent with the study done by Srivastava *et al.* (2015); Aborigo *et al.* (2018).

The present study finds that women's health status is another key factor that influences their use of MHC services. Accordingly, women do not plan to use SBA services if everything goes normal during pregnancy; nevertheless, they decide to go to a health facility if they feel unwell during pregnancy and when the baby due draws nearer and nearer. Thus, this finding is similar to the study done in southern Malawi (Kumbani *et al.*, 2013). Women's fear of their privacy invaded and their confidential information not kept are barriers to their use of maternal healthcare services. The finding of this study is consistent with this study by (Mannava *et al.*, 2015; Srivastava *et al.*, 2015). To increase women's regular use MHC services, relevant information about how their privacy is kept should be given to women by health workers and medical staff at health facilities.

Mothers' use of MHC services has also been found to be determined by family types. In other words, mothers in a nuclear family type and who have parity with their spouses can decide whether to they should use MHC services or not. Women in an extended family type and who do not parity with their spouses over household issues can hardly make decisions by themselves to use MHC services or not because in a patriarchal society decisions about family members are made by fathers. Similarly, pregnant women's use of MHC services is influenced by mothers-in-law as mothers-in-law have social power to make decisions for/against her daughter's-in-law preferences to use MHC. The finding of this study is consistent with the study done by (Shahnazaryan *et al.*, 2017). Women with knowledge about/of MHC services use them more often use MHC than women without information or knowledge of MHC as a result of their being culturally and traditionally dominated. This finding is consistent with findings of studies done in Ethiopia and Zimbabwe (Dodzo and Mhloyi, 2017; Mezmur *et al.*, 2017; Aborigo *et al.*, 2018).

CONCLUSION

In general, patriarchy still influences all aspects of social life and relationships particularly in seeking maternal health services by the women folks in Ethiopia. There are various socio-cultural underpinnings of the high maternal mortality in East Hararghe, Oromia, Ethiopia. The most important among which are maternal illiteracy, traditional belief systems and behavior about diseases, dominance of the patriarchal family system and the subsequent low status of women in the region. All these continue to add value to socio-cultural practices in maternal health and combined with early marriage and female genital mutilation contributes to the sustained high maternal death among the dominant Muslim women groups in East Hararghe. To confound the situation, growing poverty due to lack of access to employment opportunities beyond unpaid agricultural labor at family farms and limited roles in decision making about women's own healthcare encourage the utilization of traditional birth attendant in eastern part of Ethiopia. Hence, in order to reduce the high maternal mortality rates more emphasis should be placed on devising ways that can educate the women and discourage them from resorting to the traditional socio-cultural practices instead of increasing modern facilities that are grossly underutilized.

Finally, although the study has touched on some important factors affecting maternal health, the findings are by no means all the social and cultural factors that impact MHC services in

Ethiopia. Regarding future research, this study indicates the need for “micro-demographic studies” that incorporate anthropological perspectives to assess the wide range of factors that affect MHC services in societies with different subsistence practices and a specific gendered social organization.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

IM was responsible for the conception, design, data collection, data analysis, interpretation, and write-up and in the preparation of the draft manuscript. ON was involved in the design, data analysis, interpretation, write up and revision of the paper. All authors read the final manuscript.

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