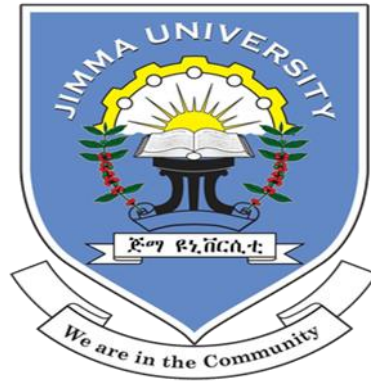


**EXPLORING THE BARRIERS AND FACILITATORS TO INSTITUTIONAL
CHILDBIRTH IN RURAL JIMMA ZONE, OROMIA ETHIOPIA, 2021**



BY; FIKIRTE LAKEW (BSC)

**A THESIS TO BE SUBMITTED TO JIMMA UNIVERSITY INSTITUTE OF
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,BEHAVIOR AND SOCIETY IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH IN
HEALTH PROMOTION AND HEALTH BEHAVIOR**

**DECEMBER, 2022
JIMMA, ETHIOPIA**

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DECEMBER, 2021

JIMMA, ETHIOPIA

Abstract

Background: *Based on world health organization 2017 data globally nearly 295,000 women died during pregnancy and childbirth of which 196,000 deaths are reported in sub Saharan countries and 13,000 maternal deaths occurred in Ethiopia. So, the aim of this study was to explore the barriers and facilitators of community health actors and health professionals for making use of institutional childbirth during pregnancy, delivery and post-natal from the community and healthcare provider's perspective in three districts Woreda's of Jimma zone.*

Methods: *An exploratory qualitative case study was conducted. The study was done in rural Jimma zone, Oromia Ethiopia. The data were collected 12 focus group discussions (FGDs) and 24 in-depth interviews with purposely selected community members (Women, women development army (WDA), Religious leaders (RL), Health extension workers (HEW), Midwifery nurse, as well as primary health unit directors (PHCUDs) and MCH unit directors at PHCU. were conducted using local language Afanoromo and Amharic by using interview guide. The interviews were transcribed and translated in to English, and the data were analyzed using qualitative data management software (ATLAS.ti version 7.5.7. Thematic analysis was done.*

Results: *From the analysis of Focus group discussions and in-depth interview data. knowledge; beliefs on pregnancy and delivery, poor access to health care services, poor quality of health services, lack of community's involvement and access to childbirth facilities. These themes were identified as rich and detailed accounts of the perspectives of institutional childbirth and the persistent home delivery from different perspectives [healthcare directors, health professionals, and from community leaders] in rural Jimma Zone, oromia Ethiopia.*

Conclusions and recommendation: *The study reveals the barriers and facilitators to institutional childbirth service. It explored by five major themes cited by study participants which was knowledge; beliefs on pregnancy and delivery, poor access to health care services, poor quality of health care services, lack of community involvement and access to childbirth facilities. Regular monitoring and follow up is crucial to improve institutional child health delivery, as well as work collaboratively with multidisciplinary approach is increase the intention to use institutional child birth. The concern government body should avail different logistic services like transportation and different basic supplies.*

Keywords: Health institutional, childbirth, maternal health, qualitative study, Ethiopia

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Acronyms and Abbreviations

ANC	Antenatal care
BSc	Bachelor of Science
EDHS	Ethiopian Demographic Health Survey
FGDs	Focus Group Discussions
FP	Family Planning
HCPs	Health Care Providers HEW
HEW	Health Extension Worker
IDI	In-depth Interview
JZHO	Jimma Zone Health Office
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MPH	Master of Public Health
MHCs	Maternal health care service
MNCH	Maternal neonatal and child health
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SBA	Skill Birth Attendant
TBA	Traditional Birth Attendant
WHO	World Health Organization

1. Introduction

1.1 Background information

Institutional childbirth is the delivery that takes place at any medical facility staffed by skilled delivery assistant. Delivery attended by skill professionals is known to contribute to the better outcome of pregnancy and child birth for early detection and management of complications in the ANC period, during delivery and postnatal period (1). Institutional childbirth grants safe birth outcomes through the provisions of supportive facilities, clean delivery services with skilled experts, and early detection and management of maternal and neonatal complications (1).

Institutional childbirth is one of the key indicators to reflecting progress towards the Sustainable Development Goal (SDG) of improving maternal health. The World Health Organization (WHO) recommends institutional childbirth as a key strategy for reducing maternal and neonatal mortality (2). Although institutional childbirth are a key strategy for reducing pregnancy and birth risks, many women in developing countries give birth at home (3)

Inadequate utilization of institutional childbirth services in Sub-Saharan Africa is a major hindrance to efforts aimed at improving the health of women, especially during delivery. The exposure of women to crude means of delivery at home and by untrained Traditional Birth Attendants (TBAs), poses a great danger to the health of women and yet it is

estimated that in Sub-Saharan Africa about 45 million births occur at home without the assistance of skilled attendants. (4).

The Federal Ministry of Health of Ethiopia launched the national maternal death response system in May 2013 as a tool to improve the quality of maternal health care, particularly during pregnancy, childbirth and the postpartum periods. The government of Ethiopian has re-affirmed its commitment in reducing Maternal Mortality Ratio (MMR) from 420 to 199 per 100,000 live births by 2020 (5).So, the aim of this study will be to explore the barriers behind truncated institutional childbirth from both community and health care provider's perspectives in the study setting.

1.2. Statement of the problem

Globally 295,000 women died during pregnancy and childbirth in 2017(6). Almost all maternal deaths (95%) occurred in low-income and lower-middle-income countries, in 2019 it is reported

(65%) maternal deaths occurred in African Region (7). The maternal mortality ratio in the least developed countries is as high as 415 per 100 000 births versus 12 per 100 000 in Europe and Northern America and 7 in Australia and New Zealand. According to WHO about 75% of maternal deaths occur due to avoidable causes including severe bleeding, sepsis, pre-eclampsia, unsafe abortion and complications in childbirth (8).

According to EDHS, 2019report, Institutional childbirth has increased from 5% in 2000 to 10% in 2011, 26% in 2016 and 47.5% in 2019. This is different from region to region and the proportion of Institutional childbirth in 2016 was 94.8% in Addis Ababa followed by Tigray region which is 72.4%, but it's much lower than in pastoralist and semi-pastoralist regions like Somali and afar which was the proportion was 23.3% and 28.3% respectively. In the same way the proportion of institutional delivery in 2019 in Oromia region was 40.9% (9).

There was a lot of existed literatures conducted in Ethiopia to quantify the percentage of mothers visited the institutional childbirth and to examine the factors contributing to the low institutional maternal care service. However, a more comprehensive understanding of the problem, which takes into account the perspectives of study participants involved with the decision regarding the place of delivery and associated care, is much needed by exploring through qualitative study. So the present study will be attempts to explore deeper insights into the barriers and facilitators of institutional childbirth and the persistent home delivery from different perspectives [healthcare directors, health professionals, and from community health actors] in rural Jimma Zone, Oromia Ethiopia.

2. Literature review

2.1. Individual, Social and health system factors to maternal and child health care

A study conducted in Bangladesh noted that, Barriers to accessing MHC services included low levels of understanding about the importance of MHC services, concerns about service costs, limited transport and fears of intrusive practices. Experiences within health services that deterred women from accessing future MHC services included demands for unofficial payments and abusive treatment by public facility staff (10).

A similar study conducted in Chitwan district, Nepal the identified Barriers and facilitators to institutional delivery was classified by three main themes which are socio-cultural norms and values; access to birthing facilities; and perceptions regarding the quality of health services. This study also identified factors encouraging an institutional delivery included complications during labour, supportive husbands and mothers-in-law, the availability of an ambulance, having birthing centers nearby, locally sufficient financial incentives and/or material incentives, the 24-h availability of midwives and friendly health service providers. Socio-cultural barriers to institutional deliveries were deeply held beliefs about childbirth being a normal life event, the wish to be cared for by family members, greater freedom of movement at home, a warm environment, the possibility to obtain appropriate “hot” foods, and shyness of young women and their position in the family hierarchy. Accessibility and quality of health services also presented barriers, including lack of road and transportation, insufficient financial incentives, poor infrastructure and equipment at birthing centers and the young age and perceived incompetence of midwives. Women across all regions of the world were likely to consider giving birth as a natural process which did not need any medical intervention or support unless there were obvious complications (11). Medical care was often considered only as a last resort. Traditional practices and traditional birth attendants (TBAs) were also strongly preferred by some women, due to their willingness to attend women at home, and the possibility to develop a strong, personal bond (11). TBAs were most of the time seen across the literature as trustworthy and respectful of cultural preferences, making them a first choice for many women. These poor services result in a lack of trust in healthcare providers, and sometimes fear and shame, which powerfully discourage women from seeking formal healthcare (12).

A systematic review on barriers of accessing maternal care in low and middle income countries, Africa revealed that the most important barriers to maternal health are transportation barriers to health facilities, economic factors, and cultural beliefs, in addition to lack of family support and poor quality of care (13). According a study conducted among pregnant adolescents in South Africa revealed that barriers to adolescents seeking ANC often centered on a discourse of adolescent pregnancy being deviant, irresponsible, and shameful. Pregnant adolescents often absorbed these beliefs and were fearful of other's reaction within their family, the community, at school, and within the ANC facilities (14).

Similar study conducted in Nigeria also revealed that, the study concludes that; costs of treatment, distance and time, income level, sat attitude and women's autonomy were mentioned as barriers for utilization of maternity care services (15). The obstacles affecting the quality and appropriateness of maternal and neonatal health services in the rural communities and the Nadowli District Hospital, Ghana, were inadequate medical equipment and essential medicines, infrastructural challenges, shortage of skilled staff, high informal costs of essential medicines and general limited capacities to provide care (16).

In the same way a research conducted in Garissa sub-county, Kenya revealed that the persistent barriers to the use of maternal, newborn and child health services were gender of service provider, insecurity, poverty, lack of transport, distance from health facilities, lack of information, absence of staff especially at night-time and quality of maternity care (17). According to study conducted in rural Malawi showed that, onset of labor at night, rainy season, rapid labor, socio-cultural factors and health workers' attitudes were related to the women delivering at home (18).

A study conduct in Addis Ababa, Ethiopia why some women who attend focused antenatal care fail to deliver in health facilities perceived benefits of home delivery, knowledge deficit about health facility-based delivery, poor access to healthcare facilities and inadequate (demand side) resources (19). A similar study conduct in Sidama, Ethiopia exploring barriers to the use of formal maternal health services and priority areas was revealed that Lack of knowledge on danger signs and benefits of maternal health services; cultural and traditional beliefs, lack of decision making power of women, previous negative experiences with health facilities; fear of going to an unfamiliar setting; lack of privacy and perceived costs of maternal health services and lack of transportation were the main factors causing the first delay in deciding to seek care (20).

According to study conducted in Somali region, Ethiopia to explore barriers to reproductive, maternal, child and neonatal (RMNCH) health-seeking behaviors major barriers for health seeking behaviors are low socio-demographic and economic status, poor exposure to health information or mass media, detrimental preferences of breast feeding methods and short acting family planning (FP) methods were identified barriers at the individual level. Male dominance in decision making, the influence of the husband and society and the role of word of mouth were identified barriers at the interpersonal level and lack of acceptance, fear of modern health practices, unclean health facility environment, lack of well-equipped facilities shortage of trained staffs and barriers relating to distance and transportation were barriers identified at organizational and policy level (21).

A study conducted in Hadiya Ethiopia entitled as “why do some Ethiopian women give birth at home after receiving Antenatal Care (ANC)” revealed that poor counseling during antenatal care service, traditions, early pregnancy symptoms, and lack of planning in advance for childbirth were the identified barriers from women’s description (22).

According to study conducted in Jimma zone, Ethiopia regarding to the roles of community health actors to promote maternal health service, the commonly identified roles included promotion of health care services; provision of continuous support during pregnancy, labour and postnatal care; and serving as a link between the community and the health system. Participants also felt unable to fully engage in their identified roles, describing several challenges existing within both the health system and the community (23). In the same way a research conducted in Jimma zone rural areas, Ethiopia on promoting and delivering ANC to understand the perception of midwives revealed that HEWs had a larger role in promoting ANC services in the community, midwives functioned in a supervisory capacity and provided more clinical aspects of care. Midwives’ ability to work with HEWs was hindered by shortages in human, material and financial resources, as well as infrastructure and training deficits. Nevertheless, midwives felt that closer collaboration with HEWs was worthwhile to enhance service provision. Improved communication channels, more professional training opportunities and better-defined roles and responsibilities were identified as ways to strengthen midwives’ working relationships with HEWs (24).

2.2. Significant of the study

The aim of study is to explore the barriers and facilitators of institutional childbirth from different study participant's perspective. It gives base-line information for policy makers and health planners like federal minster of health, regional health office, zonal health office, district health office and stakeholder's so as to increased institutional childbirth. Additionally, this study can help as a base line data in the study area for next researches

3. Objectives

3.1. General objectives

- To explore the barriers and facilitators of institutional childbirth from health care providers and community health actors in rural Jimma zone, oromia Ethiopia, 2021.

3.2. Specific objectives

- To explore the barriers of institutional childbirth services utilization in rural Jimma, oromia Ethiopia
- To explore the facilitators of institutional childbirth services utilization in rural Jimma, Oromia Ethiopia

4. Methods and materials

4.1 Study area and study period

The study was conducted in Jimma Zone. It is one of the biggest zone of Oromia Regional state, located 356 km from the capital city Addis Ababa to the Southwest Ethiopia. Jimma Zone comprises 23 districts, and 42 urban and 513 rural kebeles. The total population of Jimma zone is estimated to be 3.2 million the majority of the population resided in rural areas (25). Jimma zone is providing institutional childbirth service using 05 hospitals and 120 health centers or Primary Health Care Units. Data were collected from three rural districts (Gomma, Kersa, and SekaChokorsa) with in 24 PHCUs in Jimma Zone there are 112 kebeles in the study area (41 in Gomma, 32 in Kersa and 38 in Seka Chekorsa).

Gamma is one of the districts in the Jimma Zone of Oromia Region of Ethiopia. Located at a distance of 403 km from Addis Ababa in the southern part of Ethiopia, according to the 2007 national census report a total population for this district were 213,023 (26). Institutional child birth in Gamma districts is 71%.

Kersa is one of the districts in the Jimma Zone of the Oromia Region of Ethiopia. Located at a distance of 345 km from Addis Ababa in the southern part of Ethiopia, according to the 2007 national census reported total populations for this woreda of 165,391. There are 8 health centers and there are 32 health posts in the district (27). Institutional child birth in kersa is 33%.

Sekachekorsa is one of the districts in the Jimma Zone of Oromia Region of Ethiopia. Located at a distance of 479.9 km from Addis Ababa in the southern part of Ethiopia, according to the 2007 national census reported a total population for this woreda of 208,096. Institutional child birth in sekachekorsa is 50%.

The selection of the districts and health facility was done purposefully by considering of high population low health service utilization, as well as the number of health centers, health posts, HEWs and Health development army leaders in the selected three districts than other districts. The study was conducted from May-Novembers 2021.

4.2 Study Design

An exploratory qualitative case study was conducted to explore barriers and facilitators of low institutional childbirth service. It also help to investigate and understanding the underlined contexts from different perspectives.

4.3 Population

4.3.1 Population

Women's, midwives, health extension workers, primary health care unit heads, religious leaders, and women health development from the study districts.

4.3.2 Study populations

Purposely selected study population from the above six categories study participants was included.

4.4 Sample size and sampling technique

The sample size was conducted a total of (N-34) from FGDs and IDIs.16 Focus group discussions (FGDs) with women's, women development army and primary health care unit director/MCH and 18 In-depth interview with Religious leaders, HEWs and midwives nurses. Sample size was used by considering saturation. Purposive sampling was used by considering selecting participants who are accepted in the society and actively participated as well as share particular characteristics and has the potential to provide rich, relevant and diverse data pertinent to the research question, but I also included participants from remotest and closest villages from their respective PHCUs.

Table 1: Overview of sampling for focused group discussions (FGD) and In-depth Interviews in Jimma zone three districts, September 2021

Method	Types of participant	No. per districts	Across three districts
FGDs	Women's	2	6
	WDA	2	6
	PHCUDs	3	3
	MCH heads	1	1
	Total	8	16
In-depth interview	MWN	2	6
	HEW	2	6
	RL	2	6
	Total	6	18
Total FGDs and IDIs interview			34

4.5 Participant recruitment

The recruitment of participants was employed by using criterion sampling, plus discussion with zonal and district health offices were considered to get people with the information we want to explore. So, for this study the participants could be women's, women health development army primary health care unit heads, midwives, religious leaders and health extension workers,

4.6 Data Collection procedures

The data were collected using in-depth interview technique with semi structured interview guide and FGD guides were developed by researcher. The guides was first developed in English, translated into local languages (Afan Oromo or Amharic).The interview guide was include open-ended questions regarding to Knowledge, Beliefs practices and access about institutional childbirth from women's, women developmental army, primary health care unit directors, religious leader, midwifery nurse and health extension workers. Probing questions was also asked, as needed to get a more in-depth understanding of the participants' feelings and their experience with the situation and more particularly in health facility delivery areas. Strategies used for the Mobilization of participants and facilitation of the interviews and focus group discussions as follows: Prior on face to face communication with the PHCU directors and HEWs at each PHCUs, Prior on site visit by the supervisors to meet responsible persons who can mobilize participants at the PHCUs and Abrupt visit to the PHCUs was also made especially when the participants are people in the health system like PHCU directors, HEWs and Midwives. Procedures to conduct Focus group discussion select topic of discussion, Prepare focus group guide (questions) with prove follow, prepared materials like not taking, recording (Use voice recorder), and watch. Prepare one leader (moderator), one assistant (or co-moderator), Recruit and schedule participants, introduce themselves, get consent and start the discussion. IDIs and FGDs interview was conducted by investigator and trained data collector. The data collector who has MPH degree, and has a research experience and there was audio being recorded, the length of the interview's ranges between 1:15 and 1:30-2:00 hours and also field notes are taken to capture verbal and nonverbal All FGDs and IDIs was audio recorded and transcribed into English by the assigned data collectors. A sample of transcript was randomly checked against the recordings by bilingual researcher. Daily debriefing sessions with the researchers and all data collectors was held to discuss key

findings, refine the IDI and FGD guides, identify saturation of themes, and refine lines of inquiry. To document their experiences and impressions, data collectors and researchers will keep field notes. The duration of data collection for most FGD and IDI could be 1 hour and 2 hours respectively.

4.7 Data management process

The most important part of data management process is for researchers and participants. The collected data was used only for the purpose agreed with the participant and not shared with others the data collected were taken by field note, audio recordings after data collection they stored electronically as to use as a form of backup and the transcriptions as well as notes were stored as Microsoft (MS) word files and different backup materials by using key password - protected to ensure confidentiality.

4.8 Data Analysis

For data analysis, the recorded materials was transcribed verbatim in the local language by researcher and then translated into English. Coding was carried out through reading and re-reading the compiled transcripts using qualitative data management software ATLAS.ti version. Before the actual coding began, the transcripts were independently read by the researcher and then a code book was developed. Codes were organized to create categories and themes. The data was analyzed thematic analysis. Finally, result was presented using major themes and categories supported by quotes to describe an overall essence of the experience. An inductive approach was implemented to identify themes and category.

4.9 Trustworthiness

To assure dependability the chosen methodology, selection and recruitment of participants, data collection methods and the analysis process was detailed described. Detailed chronology of research activities and processes, data collection and analysis, emerging themes, categories or quotations was audited by advisors, colleagues and examined by other person who has experience on conducting qualitative research to assure dependability and conformability audit. To assure credibility researcher and data collector were set aside personal experiences and presumptions to illustrate the true picture of participant's accounts (Bracketing mind). The investigator and research assistant was take adequate time with participants. The interviews were open ended and the respondent was discussed about the questions in an uninhibited manner while being guided to remain focused to the topic of interest. Appropriate probes were used to obtain detail information on responses. Member checking was done at

the time of the conversation and at the end of each data collection; the participants were given a summary of what they have said in order for them to confirm that it is what they wanted to say. To assure transferability the different method of data collection was used and different category study participants were participated. Furthermore, thick description of all the inquire process and findings was made. Key findings and saturation of data were confirmed by discussion with data collector.

4.10 Ethical consideration

Ethical clearance was obtained from the institutional review board (IRB) of Jimma University Faculty of public health Institute, then by explaining the aim and its significance, a support letter to conduct this research was obtained from Zonal health office and district level. After explaining the purpose of the study informed consent was obtained from all participants before their participation. Informed consent was obtained from the participants. Confidentiality of the participants was secured about the identity and personal information of all interviewees. The collected data was used only for the purpose agreed with the participant and not shared with others the data collected were stored electronically as audio recordings to use as a form of backup and the transcriptions as well as notes were stored as Microsoft (MS) word files. The MS word files were password-protected to ensure confidentiality. In addition to the above mentioned activities respondents was accessed COVID-19 personal protective equipment's like face mask, hand sanitizer and also they was keep physical distance at least for two meters distance.

4.11 Dissemination plan

The findings of this study were presented to Jimma university department of health behavior and society. Recommendation based on the findings was forwarded to the study district health and administrative offices and also zone health office as well as feedback was given to the health centers. The findings may also be presented in different seminars, meetings and was tried to publish in a peer-reviewed scientific journal.

5. RESULT

5.1. Participant's socio-demographics

In this study, HEWs, women, WDAs, Religious leader, Midwifery nurses and PHCU directors was participated. All health extension workers were female with the average age of the respondent was 26 years. The average of years' service was 6 years. In this study the average years of WDA was around 36 years old with minimum and maximum age of 19 and 50 years old respectively. The average years of experiences of WDA were 5.7 years with minimum and maximum age of 1 and 10 years respectively. In this study all religious leaders were males, the average age of religious leaders were 43.0 years. Regarding to service year of religious leader the average years of provided service was around 11 years. This study revealed that the average years of midwives were 26 years and the working experiences working as midwife was around 5 years. Additionally, among six midwives participated in this study two of them were males and four out of six was had diploma holder on their level of education.

Table 2 : socio demographic characteristics of the study participant

Study participants	Average age in years	Average RL experience year	Level of education	Average family size
Religious Leaders	43	11	5	5
Women	35		4	6
Health extension worker	26	6	13	2
WDAs	36	5.7	3	7
Midwifery nurse	26	5	14	3
PHCU director	28	4	15	4

5.2. Descriptions of participant response themes and categories

This study revealed that barriers and facilitators of institutional childbirth from health care providers and **community leaders** were categorized as five main themes, **twelve** categories and **five** sub- categories emerged from the thematic analysis. The main themes were Knowledge and beliefs on pregnancy and delivery, Poor access to health care services, Poor quality of health services, **Lack of community involvements** and access to childbirth facility. Under Knowledge and beliefs on pregnancy and delivery there was three categories were reported which are **lack of knowledge, religious beliefs and women trust**. Similarly the categories for poor access to health care services are two which are transportation and health

insurance. Under poor quality of health services there were three categories and three sub-categories which are **lack of work commitment, health workers behaviors, and in adequate resource: in adequate medicines, shortage of man power, and lack of food, water, cloth and electricity**. Additionally, under the main theme of Lack of community involvements there were two categories and two sub-categories identified which is **Lack of community involvements: weak WDA and HEW activity, lack of husband, family and community support. Lacks of religious reader promotions in the same way, Access to child birth facility were the main theme identified by thematic analysis in this study with two categories which were social support and health care providers support. Each sub- theme was reported in detail as follows.**

5.2.1. Main theme 1 Knowledge and beliefs on pregnancy and delivery

The first theme that emerged from data analysis was the Knowledge and beliefs on pregnancy and delivery. Within the theme, three categories: Lack of knowledge, Religious beliefs and Women trust emerged.

5.2.1.1. Lack of Knowledge

All people don't have equal knowledge regarding to the benefits of childbirth at health institution. The reasons mentioned are multi-faceted. These are like lack of attention by audience though the benefits of childbirth at health facility messages are delivered by different media outlets, particularly through TV and Radio. At local level awareness raising mechanism is also low. Often health providers also miss to give health information immediately after a woman gives birth and before discharge what benefits she received through counseling or proper advice. A woman development army spoke as of the following:

“Factors related to these issues are lack of attention or low awareness of the community. Because at this time different information's are transmitted through television and radio, therefore as to me every woman is can learn. But the main problems of them are lack of attention and lack of awareness” (WDA from Gomma P#6)

A female study participant stated the following:

“The reason behind low childbirth at health facility is due to low awareness raising activities. Even if doctors attend many deliveries often miss advising mothers while discharging delivered mothers.” (Female from Kersa).

Again the PHCU director mention the following statement about low awareness of mothers

“ mothers don’t come to health institution to get childbirth service due to lack of awareness. (PHCU director from district of Jimma Zone).

A religious leader spoke about the barriers of using institutional childbirth as follows

“As sharia [Religion] we are talking about the implication of hygiene and health. The health facilities are also talking about it [hygiene and health]. Those who know about it, apart from imparting information, good attitudes are important. Still there are women who do not use childbirth service due to knowledge gap; not having knowledge to identify what is good and bad and fail to identify whom to hear, and those not admitted advice are many”(RL from seka chkorsa)

5.2.1.2. Religious beliefs

This study was revealed that study participants had different perspectives of beliefs on childbirth at health institution. There are multiple dimensions of beliefs, religion and cultural norms; and these dimensions are overlapping each other. For example, many of the study participants believe that a woman who gives childbirth at health institution encounters devil or evil spirits or entities while she returns within a day or so on the way to home. As a result most of them claim they resort to traditional or spiritual healer is rampant yet; and the trust to health institution service provision seems denuded. Others also stated their tradition do not allow male health providers for woman. They need to be served by female health workers while wearing “niqab” or face wear not by male workers

A midwifery nurse (MWN) from the different district also spoke about the Religious beliefs is as a barrier of institutional child birth.

“Right now, even if I do not know this community’s (people) culture well, most of times their culture related to religion. They do not need men health workers both during delivery and anytime during other services. Some of them cover their faces [wear niqab] and their culture mean women should attend women during delivery or other services” (MWN from Gomma)

A Woman from kersa district stated the following:

“When a woman, who gave birth at health facility, becomes sick after return to home due to devil or evil or other like entities, a great deal of them were taken to the spiritual healers (Tebela or Holy water or religious person),, (MWN from Kersa)

5.2.1.3. Women trust

Women trust about institutional childbirth is still a problem this is mainly due to inappropriate approach by health extension workers which the community may assume it is just nagging by health providers for nothing. The other main reasons on women’s lack of trust are lack of support while they stay at MWAs as if they stay at home.

A woman development army underscored the following one:

“There are some women who do not trust on what health extension workers teach. Health extension workers who do not treat community well, nag people when they come to get services” (WDA from Gomma)

Focus group discussant MCH heads from three districts spoke about the women trust using institutional childbirth.

“Mothers have no interest to come and to stay at maternal waiting area. Her home is than maternal waiting areas. She also overlook her child at her home and she feels hope at home. Imagine that when she separated from her child and families no one can support or treat her like the one at her home. This can impose a psychological trauma which may need lifelong treatment for her. As a result, she is comfortable with her own warm house and feels that relaxed with her usual environment” (MCH heads from three districts)

Midwifery nurse also described women trust as a barrier of institutional child birth.

A HEW from the same district also spoke about the barriers of using institutional childbirth as community.

“There are some community members who have lack of awareness about institutional childbirth. For example during our home to home health service visits, some mothers ask about the benefit of child birth at health institution. Sometime they were angry on us because during their journey to health post or health center they couldn’t get the service as they expected because the facility may be closed. So they were not willing to take any advice from us” (HEW from Kersa).

Another HEW explained the following points

“People think that if the women deliver at health facility, health professionals cut her organ (episiotomy) and the women also fears. This is why they are most of the time didn’t seek health care for delivery” (HEW from seka chkorsa)

5.2.2. Poor access to health care services

The second theme that emerged from data analysis was Poor access to health care service. Within the theme, two categories: Transportation and Health insurance emerged.

5.2.2.1. Transportation

Having access for transportation is one of the pillars to childbirth at health institution. But this study revealed that they have lack of ambulance after childbirth to return to home again. This is due to two main reasons one is that even if ambulance is available it is only to take the mother to health center or hospital; second, most of rural community’s area living outside of road access for transportation and when emergency happens no means to get to childbirth services at health facility. So, the only option is either to try at home or get carried by humans which in turn may not be possible if it is at night.

This was evident in the sample resonant of PHCU head;

“... For us, those at walking distance they are not more than 5%. So ambulance with road access is needed by more than 95%. Much of the landscape is not conducive for transport as well” (PHCUD from Jimma district p#4)

A religious leader spoke about the shortage of transport to access health facility

“There is no road connecting these kebeles. In emergency situation such as labour, we carry the women by preparing local stretcher from the wood; but often we reach to health center after many hours travel” (RL from kersa)

WDA describe the main challenge of ambulance services

“The ambulance services is only for taking women to health center or hospital if referred and there is no service to return home after childbirth” (WDA from Gomma P#9)‘

5.2.2.2. Health insurance

The government implemented health insurance at the level of health facilities to improve health care deliveries. However, there are multiple complaints by the users including women who need childbirth services at health facility. One aspect is that, though they paid health

insurance, medical supplies and drugs are not available in most of government health centers. Community members who have health insurance scheme expect to get the needed health services but often time they don't get it. As a result, community members prefer not to have health insurance so that they better prepare by their own to pay rather than losing both.

A WDA and a female community member describe that the health insurance didn't benefit to community

“Health insurance does not benefit the community. Its objective is to help and support poor peoples like laboring mothers. But they are often forced to buy medicines from private or outside pharmacy. As a result, though one has health insurance, one is forced to pay 200 birr up to 500birr. Thus, our community is in a big problem” (WDA from kersa)

“We have what they call health insurance and when our children get sick we will go to health facilities. Sometime health professionals get angry by us and they will darken their face and we may return to our home without getting the medication. The same is true for laboring mothers to” (a female from kersa)

“Mothers who do not prepare for delivery by assume having health insurance do not cope up if insurance scheme doesn't work. Therefore, this is not only due to less awareness or knowledge but also there are other barriers which prevent them from going to health facilities for delivery due to demotivation of uncovered insurance as well as lack of paying out of pocket or poor economic status” (MWN from kersa)

5.2.3. Poor quality of health services

The third theme that emerged from data analysis was poor quality of health services. Within the theme, three categories and three sub-categories which is Lack of work commitment, Health workers behaviors and inadequate resource: Shortages of manpower, inadequate medicines and medical supplies and Lack of food, water, cloth and electricity were emerged.

5.2.3.1. Lack of work commitment

This study was revealed that lack of work commitment had implication on the utilization of childbirth services at health institution. This is evidenced that many participants cited as health care provider was not punctual and doesn't give appropriate care, service users feel lack of respect and trust as well. A WDA and a health extension worker don't give appropriate information regarding to institutional child birth delivery and they gave false

reported as they worked properly. In many occasions, capable and committed individuals are not assigned to the rural health center. On top of this, though community representatives are not committed to carry their responsibility due to the existing gap between the service provision and the health needs of childbirth giving mothers.

A maternal and child unit head (MCH head) underscored as of the following:

“There is low commitment starting from the PCUs or health center director still now that is the reason to bring change on maternal health. Hence the next measures we want to take is, assigning an appropriate person at appropriate position, even at a sector level, so that people’s commitment, should start from the director of PCUs, and next to him/her, the next team level’s which are below the director have a commitment to implement it. The director can manage either onion & oil is purchased or not, but if the director has no commitment for this, no one who is below him/her has no concern for it” (MCH heads from three districts)

A WDA spoke about the lack of work commitment is of the disadvantage to increase childbirth at health facility

“To be hones all people are orally speaking the positive parts and about the achieved changes, which is practically false and even I can say things are going from bad to worst. In remote areas women developmental army is not working, which means many children are not getting vaccination properly. In these remote areas children are discontinued vaccination after two or three rounds, and even there are children who didn’t receive vaccination at all. All these problems and gaps are due to the weakness of WDA which is causing problems and harming our children” (WDA from seka chekorsa kersa)

5.2.3.2. Health workers behaviors

According to this study health workers behavior is a challenge to use health institution childbirth service. Health workers claimed each other towards their on negligent approach to childbirth woman service handling. Due to this fact, women not have interest to deliver at health institution.

A female community participant underscored:

“I heard pregnant women complaints regarding the Service they get at health facilities, health professionals were not observing them well” (A females from kersa P#8)

PHCU directors also spoke about the inappropriate health worker behaviors is the main challenges to use institutional child delivery

“The way our service providers welcome women, particularly midwives is not good. As you know, welcoming face has to do with service utilization. So, these are again the challenge I need to mention about our health center” (PHCU director)

5.2.3.3. Inadequate resource

5.2.3.3.1. Shortages of manpower

One aspect mentioned is shortage of man power leads to decrease in childbirth at health institution. Health care provider may have faced assault due to having workload at health institution. Over stretching workload may create irritability and impose less responsiveness to the need of the health service seekers. Another aspect is also High professional turnover also the other causing agent for shortage of man power due to unfavorable environment like shortage of subsidized housing, lack of transportation and being remote areas. In addition to the general presence of low manpower resources, there is no uniform distribution at each level of the health institution.

A midwifery nurse stated:

“No, according to civil service man power standard, one HC needs around 40-60 staffs including supportive but practically we have only nine staffs , therefore, Zonal health department and wared health office should consider this problem and assign additional staffs” (MWN from seka chekorsa)

A WDA also describe shortage of manpower is one of the barrier to use institutional child birth

“There is scarce in human power (health care providers) and disrespecting of the patient at health facility. In our health center, there assault, disrespect and arrogance from the health care providers to patient/attendants” (WDA from kersa P#4)

PHCUD also spoke about shortage of manpower's

“We have problem of inadequacy of human resource everywhere and lack of a facilitator is a problem” (PHCUD from districts)

5.2.3.3.2. Inadequate medicines and medical supplies

5.2.3.3.3. Lack of food, water, cloth and electricity

Lack of resources like lack of medicines, medical supplies, water supply, and electricity in health institution is one of the main challenges of childbirth at health institution. Another challenge is electric generator is going to start at 4 local time or night 10:00PM. Other complaint is that there is still lack of equally distributed health post.

A health extension worker stated:

“Lack of health post is the major challenge and there is a huge challenge at Serbo Health Center. For example, if there is no light, the HC generator never opened before evening 10:00 PM Ethiopian time. So, at this time the woman must oblige to go to Jimma hospital for delivery. I heard that a woman's husband buy a battery for a midwifery nurse and she managed the delivery” (HEW from kersa)

AWDA and RL are describe about the inadequate resource is one of the challenge to institutional child delivery

“All needed drugs are not found or available in the health center; therefore, we have to buy from Private pharmacy” (WDA from seka chkorsa).

“There is problem in regard to get drug at health facility. Currently the only problem we face is lack of drug” (RL from Gomma)

5.2.4. Lack of Community Involvement

The fourth theme that emerged from data analysis was poor involvements of health actors. Within the theme, two categories: **Poor involvements of community's** and Lack of religious leader promotion emerged.

5.2.4.1. Lack of community's involvements

This study was identified as lack of health actor's involvement of husband, family, neighbor and community's is still the remaining challenge for utilization of institutional child birth delivery in the study setting. Some of the participant responses present as the following;

PHCU director and MCH head describe about the poor involvements of community's which is one of the barriers to use institutional child delivery service

“There is a lack of consistent and uniform community engagement in contributing resources across PHCU on improving MWAs quality and service. In addition health insurance scheme varies across PHCUs and districts” (PHCU director)

“There is no neighbor, so that she doesn't feel a confidence in a health center. Since counseling is not given properly while staying at MWA, mothers may not understanding what is going on eventhough they get the services. Hence if we counsel her and convince her, she might come to PCUs but the above mentioned issues are some of the bottle-necked, that hinder utilization of maternal waiting area” (MCH head from three districts)

5.2.4.2. Lack of religious leader promotion

This study revealed that there is lack of promotion by religious leaders on childbirth at health institution. Often times, RLs promote regarding to religion aspect than maternal and child health care. Some Muslim religion followers (sharia) don't want to use the modern reproductive health services; they think as that it contradicts with the will of the Allah. It supports by the following participant responses;

“Frankly speaking it is now around thirty years since I engaged in the committee as religious leader and I haven't seen any one preaching about pregnancy, health of mother and children at all in the church. Church is a place for preaching about religion and soul, not for other issues like health” (RL from Gomma)

HEW and a females spoken about luck of religious promotions one of circular challenge to use institutional child birth service

“The challenges are related to religious view. Means that some Muslim religion followers (sharia) don't want to use the modern reproductive health services we are providing. They think that it contradicts with the will of the Allah. There was real

story that ‘once upon a time one women refused to come to health post. First, I send her one to five leaders, she refused to come. Then I went her home, at that time her husband responded me she is not present at home’ (HEW from seka chekorsa)

‘Regarding religious leaders, they didn’t involve in such kinds of activities, and didn’t oppose activities related with pregnancy and delivery.’ (a female community member from kersa)

5.2.5. Access to childbirth facility

The five themes that emerged from data analysis were access to childbirth facility. Within the theme, two categories: social support and health care providers supports were emerged.

5.2.5.1. Social support

Social support is important to promote childbirth at health institution through conducting community mobilization for fund raising, arrange necessary equipment, by preparing food, washing clothes and promoting to keep personal hygiene. The community also supports the women while there is no availability of ambulance by caring the women up to health institution. This idea is supported by the following participant’s response;

“Yes, there is a change. For example if her mother or mother in-law is living far from her, they may come and stay with her until she gives birth and they can prepare different foods and cloths which is used after delivery” (MWN from seka chkorsa)

A female also spoke about the role of community health actor importance of supporting pregnant women

“Religious leaders were support their wife’s very well. On the first they kept them at home, they get ready fire wood, water and different types of foods, they prepare such like things, they recruited house maid and their wife’s were not performed, she might perform indoor activities but not activities at outside” (a females from Gomma P#10)

PHCU directors also described the importance of community health actors

“The neighbor plays a major role in looking after children left at home and that family’s house. Thus, the family plays a major role in sending women to MWH”
(PHCU director)

5.2.5.2. Health care providers support

Provided information about pregnancy, birth preparedness and childbirth, Provide counseling about to keep self-hygiene, nutrition, take rest and stop work load and facilitating logistics like ambulance for women is the major support which helps to promote institutional childbirth. It’s supported by the following participant responses;

“There is HEWs in the Kebele who knows which mother is pregnant at which site, they registered them and mobilize them to have ANC2 and ANC3. If the mother unable to come, they go to home to home to counsel them and the time when she should take vaccination” **(PHCU directors)**

A MWN describe the health care providers support is the best influential reduction of maternal and child mortality

*“I am playing on the reduction of maternal and child death through providing delivery services, provision of health education and counseling for pregnant mothers at static and Outreach area to use ANC service”***(MWN from Gomma)**

A female and WDA rise supportive ideas about role of health care providers; health care providers assist women as needed and HEW advise pregnant women

“Regarding health professionals, they need to solve or treat what they see as problem of that woman. If it is labor, health care providers should assist the women as well as if it is other problems due to disease, they also need to care the women, up to their knowledge” **(female from kersa)**

“Health extension workers are advising pregnant women to save money and to help each other in the community” **(WDA from seka chkorsa)**

6. Discussion

This study was tried to exploring the barriers and facilitators to institutional childbirth in rural Jimma zone, oromia Ethiopia. The result of this study revealed that barriers and facilitators institutional childbirth from health care providers and community health actors were categorized as five main themes which was knowledge; beliefs on pregnancy and delivery, poor access to healthcare services, poor quality of health care services, lack of health actors involvement and access to institutional childbirth emerged from the thematic analysis.

According to this finding, the women who participated in this study responded that the main barriers why women didn't seek institutional child birth were due to lack of knowledge, being lack of attention and lack of awareness about institutional child birth delivery. This study is consistent with study conducted in Bangladesh (10).Noted that low level of understanding about the importance of MCH service was the barrier to access MCH service, this study also consistent with study conducted in (19, 20).Lack of knowledge about facility based delivery influenced their decision to give birth at home and lack of knowledge regarding to benefits of MCH makes complex decision making process about institutional child birth delivery respectively. This implies that having knowledge about the importance of institutional child birth delivery and understanding the risks of home child delivery is a crucial to enhance institutional child health delivery in all aspects.

The result of this study was revealed that religious leaders had lack of knowledge regarding to institutional childbirth, this finding is consistent with a study conducted in (20).This showed that religious leaders thought that God will help pregnant women during laborand it appeared to encourage women to deliver at home. According to this study some of women participants' belief that health extension workers not have provided equal services regarding to MCH services because of lack of infrastructures like poor road and lack of transportation to access or reach to the community. This implies that basic infrastructure like roads and other utility service (water, electric city) is important to facilitate the utilization of institutional child delivery through giving quality of services.

This study was revealed that some of the participants agreed that institutional childbirth makes unfavorable situation than home delivery according to their perception while women who gave delivery at home they supported by husbands, neighbors, and other relatives. This indicates that they have lack of understanding about the risk of problems after delivery. The possible justification is that there is still have a gab regarding to maternal and child health in

the community; so awareness creation is not only crucial but also mandatory to improve the utilization of institutional childbirth.

Based on the finding of study, poor access to health care service played an important role in influencing women's place of delivery. This finding indicates that the participants who took part in the study reported that lack of ambulance service, lack infrastructure like roads and poor proximity and access to facility was the barriers to institutional child birth delivery. Similar previous findings were supported this study like a study conducted in local study (11, 15). Another study also consistent with study conducted in Addis Ababa also indicated that women who took part in the study failed to reach the healthcare facilities because of the difficulty of getting transport to the health facility at night, long distance to travel to the health facilities, poor conditions of the roads to health facilities and financial constraints.(19). A study conducted in South Africa also supported this study which was indicated that among study participants revealed that barriers to seeking ANC being deviant, irresponsible, shameful and often absorbed these beliefs and were fearful of other's reaction within their family, the community and within the ANC facilities (14). The finding of this study revealed that health insurance users were reported as having extra payment for drugs and laboratory investigations, this is the main fear of why women did not seek MCH services even if they want to use the service. This implies that unavailable of ambulance services might be leads decrease the utilization of institutional child birth delivery because of fear of payment for transportation.

This finding revealed that having inadequate health facility staffing or man power with lack of infrastructure is a key finding affecting the utilization of institutional child birth delivery among the study participants. This finding is supported with a study conducted in Garissa sub-county, Kenya revealed that the persistent barriers to the use of maternal, newborn and child health service was absence of staff especially at night-time (17). This finding also consistent with the previous study conducted in Nadowli district Hospital, Ghana which was revealed that quality and appropriateness of maternal and neonatal health services influenced by shortage of skilled staff (16). Similar study also supported this study conducted in local study Somali, Ethiopia which was showed that among barriers affecting institutional child birth delivery shortage of trained staff was cited by the study participants (21).Skilled and trained man power is an important for once country growth and development in all aspects and lack of skilled ma power might be decrease the desire of institutional child birth delivery.

This study showed that health provider behavior like be angry and darken his/her face and providers negligence were the enabling factors that women didn't seek health institutional child birth delivery. This finding is comparable with study conducted in Bangladesh, based on this study demands for unofficial payments and abusive treatment by public facility staffs were barriers for institutional child birth delivery (10). In the same way another study conducted in Nigeria pointed out that staff attitude on women's autonomy were mentioned as barriers for utilization of maternity care services (15). This implies that women who come for delivery needs a companionate and holistic approach from health care providers, so they attend women without irritation.

According to this study in adequate resources like Shortage of drugs and lack of necessary equipment's for delivery, lack of water supply, lack of food and not access to electricity were the main factors affecting the utilization of institutional child birth delivery mentioned by respondents in the study setting. This finding was in line with a study conducted in Ghana, these study was showed that inadequate medical equipment and essential medicines, infrastructural challenges were the identified factors cited by the study participants the reason why women didn't prefer institutional child birth delivery (16). Another similar study conducted in Nepal was consistent with this study; women who took part in the study mentioned that among the indicated barriers was poor infrastructure and equipment at birthing centers (11). In the same way this study was comparable with a local study conducted in Addis Ababa which revealed that women did not choose facility-based delivery because of the perceived incompetence and negative attitudes of health professionals, as well as poor service at health facilities (19). Availability of basic supplies and equipment's are crucial to encourage institutional child birth delivery, so as much as possible such things are always being accessible in order to increase the intention of women to use maternal and child health services.

This study revealed that there was poor involvement towards the level of understanding about institutional childbirth between different stakeholders like WDAs, religious leaders and community at large. This makes information gap about the utilization of institutional child birth delivery in the study setting. This finding is somewhat consistent with study conducted in Somali, Ethiopia, showed that poor exposure to health information or mass media and male dominance in decision making were factors affecting utilization of Maternal and Child Health services (21). Maternal and child services required involvement of many stakeholders like

religious leaders, WDAs, governmental and non-governmental organizations; they work collaboratively through sharing information the benefits of institutional delivery and risks of home delivery.

This study was showed that the access to institutional childbirth as cited by the participants were promote the women to keep personal hygiene, conduct community mobilization for fund raising to help the women, arrange necessary equipment for birth preparedness and Preparation of food and washing clothes were the enabling factors to use institutional child birth delivery in the study setting. This study was consisted by a study conducted in Jimma zone, the main identified factors to promote maternal health services were promotion of health care services; provision of continuous support during pregnancy, labour and postnatal care; and serving as a link between the community and the health system (23). This implies that each community health actors should know what they work regarding to maternal and child health services in order to improve maternal and child health.

Similarly, the result of this study was revealed that the support of health care provider to promote institutional child birth delivery mentioned by the respondents were provide information about pregnancy, birth preparedness and child birth, provide counseling about to keep self-hygiene, nutrition, give advice take rest and stop work load while women become pregnant and facilitate logistics like ambulance services. This finding is consistent with another study previously conducted in Jimma zone rural areas which was revealed that HEWs had a larger role in promoting ANC services in the community, midwives functioned in a supervisory capacity and provided more clinical aspects of care (24). Health care providers should be give consistent and continuous information about maternal and child health services for women, WDAs and religious leaders at all time.

6.1. Strength and limitation of the study

The strength of this study was to use two different methods which is in-depth interview and focus group discussion. Similarly this study was used different groups of the study participants it helps to give more representative information. The limitation of this study social desirability bias

7. Conclusion and recommendations

7.1. Conclusion

This study was tried to explore the barriers and facilitators of institutional childbirth service in three districts of Jimma zone. The main barriers cited by majority of study participant categories were: lack of knowledge, wrong beliefs about institutional childbirth service use and cultural norms are one aspect. Poor access to health care service was identified the second major obstacles to use institutional childbirth service; in addition, poor quality of health care service is mentioned as other dimension of barriers towards using institutional childbirth service. Lack of health actors' involvement is also barriers to use this service.

As a facilitator, presence of social support by husband, family and neighbors as well as accessibility to health extension workers and health care providers were mentioned by many of them. Religious leaders also are mentioned as potential actors to facilitate and promote institutional childbirth delivery service.

7.2. Recommendation

Based on the finding of this study the following recommendations were given accordingly;

Jimma zonal health districts

- ✓ Should implement the way of regular monitoring and evaluation regarding institutional child health service provision
- ✓ Should be strengthen collaborative team work with PHCU directors and health care providers
- ✓ Should be conduct regular follow up of Health extension workers and other health care providers
- ✓ Should be facilitate end ensured the availability of transportation like ambulance service

MIDWIFEs, HEWs and WDAs

- ✓ Health offices at all levels need to build the capacity of Midwives, HEWs and WDAs so as to improve institutional childbirth delivery services.
- ✓ Midwives and HEWs shall work collaboratively with religious leaders and community actors to increase the level of understanding about the benefits of institutional child birth delivery

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 27. Strengthening the health system in Jimma zone (oromia region, Ethiopia) through performance based financing (2019-2023)

ANNEX

JIMMA UNIVERSITY, INSTITUTE OF HEALTH, FACULTY OF PUBLIC HEALTH, DEPARTMENT OF HEALTH, BEHAVIOR AND SOCIETY

Annex A: Participant Information Sheet and Consent Form for participants;

Hello, my name is _____. I am working as a data collector for the study being conducted in rural Jimma zone oromia ethiopia by Fikirte Lakew who is studying for her Master's degree in at faculty of public health, Jimma University, I kindly request you to lend me your attention to explain to you about the study and being selected as the study participant.

The study/project title: exploring the barriers and facilitators to institutional childbirth in rural jimma zone, oromia 2021

Purpose/aim of the study: The findings of this study can be a paramount importance for the three districts Worde's of Jimma zone and to plan intervention programs to increased institutional childbirth in the study area. Moreover, this study helps as thesis for the partial fulfillment of requirements for health, behavior and society for the principal investigator.

Procedure and duration: I will be interviewing you using FGD and IDI guideline, so that you will provide me with pertinent data that is helpful for the study. The interview and discussion will take about 1:30-2:00 hour. So, I kindly request you to spare me this time for the interview and discussion.

Benefits, Risk and Discomfort: Your participation will help us to find more about barriers and facilitators of institutional childbirth. So this will help to improve institutional childbirth service in the district and other parts of the zone. There is no risk or direct benefit in the participating in this research.

Incentive:

We will not pay you for taking part in this study.

Confidentiality:

The information that we collected in this study will be kept confidential by using codes instead of any personal identifiers and is meant only for the purpose of the study.

Right to refuse or withdrawal:

You have the full right to refuse and have the right to discontinue the interview at any time, and refusing to participate will not affect anything you want.

Consent form

My name _____ and I am collecting data for the research being conducted by Mrs. Fikirte Lakew, Masters Student from Jimma University. I am doing research on institutional childbirth services as the partial fulfillment for master's degree in Health behavior and society. You are selected to be one of the participants for the study. This interview probably takes few minutes/hours. I would like to assure you that all you tell during the interview will be strictly confidential and that information collected from you used only in scientific reports without any mentioning of personal information including your name. There is no harm or incentive for your participation. Information gathered from the study will be used to improve programs that promote institutional childbirth services. If you have any question about this study you may ask me and researcher; Mrs. Fikirte Lakew using his phone number +251910143002 or email fikirlakew12@gmail.com.

Do you agree to participate?

1. Yes-----
2. No----- No respect the decision and thanks her, if yes continue the interview

Interviewer name _____ sign _____ date _____

Annex B, interview guidelines

Focus Group Discussion and In-Depth Interview Guidelines

Midwifery nurse (IDI)

Thinking about pregnancy, childbirth and the time after a baby is born, what are some of the important issues that you are addressing at the PHCU?

What are the services providing during delivery?

What about services after delivery or during PNC?

Probe: what kinds of issues do people talk about or think about? Beliefs, practices, knowledge, behaviors? Are they talking about your service is good or bad? Are they utilizing the service currently

Did you receive any material or in-service training on this issue as a factor of progress?

What is needed to see further improvements?

How do you support health workers building capacity to promote maternal, newborn and child health?

What is the role of MWN during pregnancy, delivery and post natal care?

Religious leaders (IDI)

Thinking about pregnancy, childbirth and the time after a baby is born, what are some of the important topics that you are aware of in your community? Probe: what kinds of issues do people talk about or think about? Beliefs, practices, knowledge, behaviours

What do you see as improving over the last year or so with regards to these issues? Why?

Follow up: what is needed to see further improvements?

What has not improved? Why?

Follow up: what would be needed for this to improve?

How do you learn about health in pregnancy, childbirth and the time after the baby is born?

Follow up: has this changed over the past year or so?

In what ways do you, or other religious leaders that you know, promote the health of mothers and newborns in your communities?

Follow up: has this changed over the past year or so?

In what way is this engagement effective?

Follow up: How could it be more effective?

What is needed to ensure that your engagement has lasting impact?

Probe: additional training, resources, community mobilization efforts, support from others

Health Extension Workers (IDI)

Thinking about pregnancy, childbirth and the time after a baby is born, what are some of the important issues that you are working on in your kebele?

Probe: what kinds of issues do people talk about or think about? Beliefs, practices, knowledge, behaviours

What do you see as improving over the last year or so with regards to these issues? Why?

Follow up: what is needed to see further improvements?

What has not improved? Why?

Follow up: what would be needed for this to improve?

How do you learn about maternal, newborn and child health?

Follow up: has this changed over the past year or so?

What are your strategies for promoting maternal, newborn and child health in your community?

Follow up: has this changed over the past year or so?

What challenges do you face in promoting the health of mothers and newborns in your communities?

Follow up: What is needed to overcome these challenges?

What is needed to ensure that your engagement with the community has lasting impact?

Probe: additional training, resources, community mobilization efforts, support from others

Women (FGD)

What do you think about maternal health, healthy child birth in your opinion? Probe: pregnancy, delivery, postnatal period

During pregnancy some of pregnant women wear experienced problems while others were enjoyed healthy pregnancy time to your opinion what was the reason for this?

Where dose women's go when she were become start labors with whom they wear discussed?

Probe: Husband, HEW, Health professionals, family's

What factors do you think make women not to attend ANC in formal health facilities? Probe: resources, knowledge

What are the reasons why women deliver at home?

What factors do you think make the women not to deliver in health facilities even after attending ANC there?

What are the roles of community leaders, People who are part of health system to promote maternal health services? Probe: WDA,MDA, RL, HEW,HCP

Women Development Army (FGD)

What improvements have you seen in your community over the last year or so with respect to pregnancy and childbirth?

Probe: beliefs, knowledge, practices, service use

Follow up: why do you think those positive changes occurred?

What has not improved with respect to pregnancy and childbirth? Why?

Follow up: what would be needed for this to improve?

How important are MWAs for the health of women and babies?

Prompt: reasons for use or non-use

Have your opinions about MWAs changed?

Follow up: why or why not? Have you had any personal experiences with MWAs?

What changes, if any, have you noticed in MWA use over the past year or so?

Follow up: Please describe these changes and why they occurred.

Thinking about the health of the mother and newborn during the month following childbirth, what improvements have you seen in your community over the last year or so?

Probe: beliefs, knowledge, practices, service use

Follow up: why do you think those positive changes occurred?

What has not improved? Why?

Follow up: what would be needed for this to improve?

How do you work with others to promote the health of mothers and newborns in your community?

Follow up: has this changed over the past year or so?

Moving forward, what changes do you hope to see in your community?

How can the WDA support these improvements?

Primary Health Care Unit (FGD)

Thinking about pregnancy, childbirth and the time after a baby is born, what are some of the important issues that you are addressing at the PHCU?

Probe: what kinds of issues do people talk about or think about? Beliefs, practices, Knowledge, behaviours?

What do you see as improving over the last year or so with regards to these issues? Why?

Follow up: what is needed to see further improvements?

What has not improved? Why?

Follow up: what would be needed for this to imp

How do you support health workers building capacity to promote maternal, newborn and child health?

Probe: midwives, HEWs and MDA/WDA

Follow up: has this changed over the past year or so?

How does the PHCU encourage community participation in maternal, newborn and child health activities and services?

Follow up: has this changed over the past year or so?

What challenges do you face in promoting the health of mothers and newborns in your community?

Follow up: What is needed to overcome these challenges?

What is needed to ensure that your engagement with health workers and with the community has lasting impact?

Probe: additional training, resources, community mobilization efforts, support from others

Annex C; Guano Affann Oromo

Qajeelfama Af-dubbii (IDI) fi Marii Gareerratti Hundaa`e (FGD)

Qabinsa Fayyaaisa Jalqabaa (IDI)

1. Waa`eeulfaa, dahumsaa fi

dahumsaboodaairratti wantootajoo isin Qabinsa fayyaaisa jalqabaairratti hojjetan maalfa`i?

Yaadachiisuuf: Namoonni waa`eeulfaa, dahumsaa fi dahumsaboodaairratti ilaalcha, amantaa/fudhannaa, gocha, beekumsa, amalaakkamii qabu?

2. Hojiilee barootadarban kana

irratti hojjetaman irratti wantoota fooyya`uu qabujetteeya addumaalfa`i? maaliif?

Fooyya`insaa ilmaan argamsiisuuf Maaltubarbaachisa?

3. Wantoonni hin fooyyofne hoo maalfa`i? maaliifi? Fooyya`insa kana

fiduuf maalfa`itu hojjetamuu qaba?

4. Fayyaahaadholii fi daa`immanii eegu irratti dandeetti ogeessota fayya akkamiindeeggarta?

Yaadachiisuuf: Deessitoota, Hojjetoota Exteenshinni fayyaa, Gamtaaguddin adubartootaa

Dhimmakan irratti isabarootadarbeerraawanti fooyya`ejira?

5. Hirmaanna uummataata jaja jilafayyaahaadholii fi

daa`immanii jajjabeessu keessatti gaheen qabinsa fayyaaisa jalqabaamaali?

Dhimmakan irratti isabarootadarbeerraawanti fooyya`ejira?

6. Fayyaahaadholii fi

daa`immanii uummatanaannoo kanaafeegu keessatti rakkooleensimudatan maalfa`i?

Rakkoo kana furuuf maaltubarbaachisa?

7. Dhiibbaa kana hir`isuuf hirmaannaankee, ogeessota fayyaa fi

uummata waliin mirkaneessuuf maalfa`atubarbaachisa?

Yaadachiisuuf: leenjiidabalataa, qabeenya, hirmaanna uummataa, deeggarsa biro

Hojjetoota Eksteenshinni Fayyaa

Waa`eeulfaa, dahumsaa fi

dahumsaboodaairratti wantootajoo gandakeessan keessatti hojjetan maalfa`i?

Yaadachiisuuf: Namoonni waa`eeulfaa, dahumsaa fi dahumsaboodaairratti ilaalcha, amantaa/fudhannaa, gocha, beekumsa, amalaakkamii qabu?

Hojiilee barootadarban hojjetaman irratti wantoota fooyya`uu qabujetteeya addumaalfa`i?

maaliif? Fooyya`insaa ilmaan argamsiisuuf Maaltubarbaachisa?

Waa`eefayyaahaadhooliiyerooulfaa, dahumsaa fi dahumsaboodaaakkamiinbaratta?

Kanbarootadarbaniirraajijjiiramnijirumaali?

Tootftaaleefayyaahaadhoolii fi

daa`immaniieeguufuummanninaannookanaafayyadamumaalfa`i?

Kanbarootadarbaniirraajijjiiramnijirumaali?

Fayyaahaadhoolii fi

daa`immaniiuummatanaannookanaaeeguukeessattirakkooleensimudatanmaalfa`i? Rakkoo

kana furuufmaaltubarbaachisa?

Dhiibbaa kana hambisuufhirmaannaankee, ogeessotafayyaa fi

uummatawaliinmirkaneeesuufmaalfa`atubarbaachisa?

Yaadachiisuuf: leenjiidabalataa, qabeenya, hirmaannaauummataa, deeggarsabiroo

GamtaaGuddinaaDhiirotaa (MariiGareerrattiHundaa`e)

Barootadarbankeessawaa`eeulfaa fi

dahumsaauummatanaannookanaakeessattifooyya`iinsijirumaali? ilaalcha, amantaa/

fudhannaa, gocha, beekumsa, tajaajilafayyadaman

Fayyaayerooulfaa fi dahumsaakeessattiwantoonnihinfooyyofnemaalfa`i? maaliifi?

Fooyya`insa kana fiduufmaalfa`ituhojjetamuuqaba?

Uummatanaannookanaakeessattifayyaahaadhoolii fi daa`immaniieeguufmaaltuhojjetamaajira?

Kanbarootadarbaniirraajijjiiramnijirumaali?

Jijjiiramniatiuummatanaannookanaairrattiarguuabdattumaalfa`a?

Gamtaanguddinadhiirotaajijjiirama kana akkamiindeggara?

GamtaaGuddinaDubartootaa (MariiGareerrattiHundaa`e)

Jijjiiramnifayyaahaadhoolii fi daa`immaniiirrattiummata kana keessattiargitemaalfa`i?

ilaalcha, amantaa/ fudhannaa, gocha, beekumsa, tajaajilafayyadaman

Jijjiiramnigaariikunmaaliifdhufesittifakkaata?

Fayyaayerooulfaa fi dahumsaakeessattiwantoonnihinfooyyofnemaalfa`i? maaliifi?

Fooyya`insa kana fiduufmaalfa`ituhojjetamuuqaba?

Gamtaaguddinadubartootaafayyaahaadhoolii fi

daa`immaniieegsisuukeessattigaheenisaaniimaali? Fayyadamuu fi

fayyadamuudhiisuufsababniisaaniimaali?

Waa`eegamtaaguddinadubartootaailaalchikeejijjiirameeraa?

Maalifijjiirameyknhinjijjiiramne?Muuxannoogamtaaguddinadubartootaawaliinqabdujira?

Barootadarbankeessattijijjiiramnifayyadamagamtaaguddinadubartootaakeessattiargitejira?
Jijjiirama kana maalif fi akkamiinakkauumamanibsi.

Waa`eefayyaahaadholii fi daa`immanii`ajalqabaatti,
fooyya`iinsiatiuummatakeekeessattiargitemaali? ilaalcha, amantaa/ fudhannaa, gocha,
beekumsa, tajaajilafayyadaman

Fayyaayerooulfaa fi dahumsaakeessattiwantoonnihinfooyyofnemaalfa`i? maaliifi?
Fooyya`insa kana fiduufmaalfa`ituhojjetamuuqaba?

Dhiibbaa kana hambisuufhirmaannaankee, ogeessotafayyaa fi
uummatawaliinmirkaneessuufmaalfa`atubarbaachisa?

Yaadachiisuuf: leenjiidabalataa, qabeenya, hirmaannaauummataa, deeggarsabiroo

Jijjiiramniatiuummatanaannookanaairrattiarguuabdattumaalfa`a?

Gamtaanguddinadubartootaajijjiirama kana akkamiindeggara?

HIRMAANNAA KEEF GALATOOMI!!

Annex D: Description of participants' response

Table 3 Major themes and categories of the study finding conducted at Jimma zone, oromia Ethiopia 2021.

Major themes	Categories
Knowledge and beliefs on pregnancy and delivery	lack of knowledge Religious beliefs Women trust
Poor access to health care services	Transportation Health insurance
Poor quality of health services	Shortages of manpower Lack of work commitment Health workers behaviors Inadequate resource
Lack of health actors involvements	Lack of health actors involvements [Weak WDA and HEWs activities as well as community support] Lack of religious leader promotion
Access to institutional childbirth	Social support (Family, husband, Neighbor's and women in -low) Health care provider support (HEW and HCP)

ANNEX E: codebook for exploring the barriers and facilitators to institutional childbirth

Codes	Definitions	Examples
Lack of knowledge	<p>All people don't have equal knowledge regarding to the benefits of childbirth at health institution. The reasons mentioned are multi-faceted. These are like lack of attention by audience though the benefits of childbirth at health facility messages are delivered by different media outlets, particularly through TV and Radio. At local level awareness raising mechanism is also low. Often health providers also miss to give health information immediately after a woman gives birth and before discharge what benefits she received through counseling or proper advice</p>	<p><i>“Factors related to these issues are lack of attention or low awareness of the community. Because at this time different information's are transmitted through television and radio, therefore as to me every woman is can learn. But the main problems of them are lack of attention and lack of awareness”</i></p> <p><i>“The reason behind low childbirth at health facility is due to low awareness raising activities. Even if doctors attend many deliveries often miss advising mothers while discharging delivered mothers.”</i></p>
Religious beliefs	<p>There are multiple dimensions of beliefs, religion and cultural norms; and these dimensions are overlapping each other. For example, many of the study participants believe that a woman who gives childbirth at health institution encounters devil or evil spirits or entities while she returns within a day or so on the way to home. As a result most of them claim they resort to traditional or spiritual healer is rampant yet; and the trust to health institution service provision seems denuded. Others also stated their tradition do not allow male health providers for woman. They need to be served by female health workers while wearing “niqab” or face wear not by male workers</p>	<p><i>“Right now, even if I do not know this community's (people) culture well, most of times their culture related to religion. They do not need men health workers both during delivery and anytime during other services. Some of them cover their faces [wear niqab] and their culture mean women should attend women during delivery or other services”</i></p> <p><i>“When a woman, who gave birth at health facility, becomes sick after return to home due to devil or evil or other like entities, a great deal of them were taken to the spiritual healers (Tebela or Holy water or religious person)”</i></p>
Women trust	<p>Women trust about institutional childbirth is still a problem this is mainly due to in appropriate approaches by health extension workers which the community may</p>	<p><i>“There are some women who do not trust on what health extension workers teach. Health extension</i></p>

	<p>assume it is just nagging by health providers for nothing. The other main reasons on women's lack of trust are lack of support while they stay at MWAs as if they stay at home.</p>	<p><i>workers who do not treat community well, nag people when they come to get services”</i></p> <p><i>“Mothers have no interest to come and to stay at maternal waiting area. Her home is than maternal waiting areas. She also overlook her child at her home and she feels hope at home. Imagine that when she separated from her child and families no one can support or treat her like the one at her home. This can impose a psychological trauma which may need lifelong treatment for her. As a result, she is comfortable with her own warm house and feels that relaxed with her usual environment”</i></p>
Transportation	<p>Having access for transportation is one of the pillars to childbirth at health facility. But this study revealed that they have lack of ambulance after childbirth to return to home again. This is due to two main reasons one is that even if ambulance is available it is only to take the mother t health center or hospital; second, most of rural community's area living outside of road access for transportation and when emergency happens no means to get to childbirth services at health facility. So, the only option is either to try at home or get carried by humans which in turn may not be possible if it is at night</p>	<p><i>“There is no road connecting these kebeles. In emergency situation such as lab our, we carry the women by preparing local stretcher from the wood; but often we reach to health center after many hours travel”</i></p> <p><i>“The ambulance services is only for taking women to health center or hospital if referred and there is no service to return home after childbirth”</i></p>
Health insurance	<p>The government implemented health insurance at the level of health facilities to improve health care deliveries. However, there are multiple complaints by the users including women who need childbirth services at health facility. One aspect is that, though they paid health insurance, medical supplies and drugs are not available in most of government health centers. Community members who have health insurance scheme expect to get the needed health services but often time they don't get it. As a result, community members prefer not to have health insurance so that they better prepare by their own to pay rather than losing both</p>	<p><i>“Mothers who do not prepare for delivery by assume having health insurance do not cope up if insurance scheme doesn't work. Therefore, this is not only due to less awareness or knowledge but also there are other barriers which prevent them from going to health facilities for delivery due to demotivation of uncovered insurance as well as lack of paying out of pocket or poor economic status”</i></p>

		<p><i>“Health insurance does not benefit the community. Its objective is to help and support poor peoples like laboring mothers. But they are often forced to buy medicines from private or outside pharmacy. As a result, though one has health insurance, one is forced to pay 200 birr up to 500birr. Thus, our community is in a big problem”</i></p>
Shortages of manpower	<p>Shortage of man power leads to decrease in childbirth at health facility. The health facilities may have faced assault due to having workload of health care provider. Over stretching workload may create irritability and impose less responsiveness to the need of the health service seekers. Another aspect is also High professional turnover also the other causing agent for shortage of man power due to unfavorable environment like shortage of subsidized housing, lack of transportation and being remote areas. In addition to the general presence of low manpower resources, there is no uniform distribution at each level of the health institution.</p>	<p><i>“There is scarce in human power (health care providers) and disrespecting of the patient at health facility. In our health center, there assault, disrespect and arrogance from the health care providers to patient/attendants”</i></p> <p><i>“No, according to civil service man power standard, one HC needs around 40-60 staffs including supportive but practically we have only nine staffs , therefore, Zonal health department and wared health office should consider this problem and assign additional staffs”</i></p>
Lack of work commitment	<p>Health care provider was not punctual and doesn't give appropriate care; service users feel lack of respect and trust as well. A WDA and a health extension worker don't give appropriate information regarding to institutional child birth delivery and they gave false reported as they worked properly. In many occasions, capable and committed individuals are not assigned to the rural health center. On top of this, though community representatives are not committed to carry their responsibility due to the existing gap between the service provision and the health needs of childbirth giving mothers.</p>	<p><i>“There is low commitment starting from the PCUs or health center director still now that is the reason to bring change on maternal health. Hence the next measures we want to take is, assigning an appropriate person at appropriate position, even at a sector level, so that people's commitment, should start from the director of PCUs, and next to him/her, the next team level's which are below the director have a commitment to implement it. The director can manage either onion & oil is purchased or not, but if the director has no commitment for this,</i></p>

		<i>no one who is below him/her has no concern for it”</i>
Health workers behaviors	Health workers behavior is a challenge to use health facility childbirth service. Health workers claimed each other towards their on negligent approach to childbirth woman service handling. Due to this fact, women not have interest to deliver at health institution.	<p><i>“I heard pregnant women complaints regarding the Service they get at health facilities, health professionals were not observing them well”</i></p> <p><i>“The way our service providers welcome women, particularly midwives is not good. As you know, welcoming face has to do with service utilization. So, these are again the challenge I need to mention about our health center”</i></p>
Inadequate resource	Lack of resources like lack of medicines, medical supplies, water supply, and electricity in health institution is one of the main challenges of childbirth at health institution. Another challenge is electric generator is going to start at 4 local time or night 10:00PM. Other complaint is that there is still lack of equally distributed health post	<p><i>“Lack of health post is the major challenge and there is a huge challenge at Serbo Health Center. For example, if there is no light, the HC generator never opened before evening 10:00 PM Ethiopian time. So, at this time the woman must oblige to go to Jimma hospital for delivery. I heard that a woman’s husband buy a battery for a midwifery nurse and she managed the delivery,,</i></p> <p><i>“All needed drugs are not found or available in the health center; therefore, we have to buy from Private pharmacy”</i></p>
Lack of health actor involvement	Lack of health actor’s involvement of husband, family, neighbor and community’s is still the remaining challenge for utilization of institutional child birth delivery in the study setting.	<p><i>“There is a lack of consistent and uniform community engagement in contributing resources across PHCU on improving MWAs quality and service. In addition health insurance scheme varies across PHCUs and districts”</i></p> <p><i>“There is no neighbor, so that she doesn’t feel a confidence in a health center. Since counseling is not given properly while staying at MWA,</i></p>

		<i>mothers may not understanding what is going on eventhough they get the services. Hence if we counsel her and convince her, she might come to PCUs but the above mentioned issues are some of the bottle-necked, that hinder utilization of maternal waiting area”</i>
Lack of religious leader promotion	Lack of promotion by religious leaders on childbirth at health facility. Often times, RLs promote regarding to religion aspect than maternal and child health care. Some Muslim religion followers (sharia) don’t want to use the modern reproductive health services; they think as that it contradicts with the will of the Allah	<i>“Frankly speaking it is now around thirty years since I engaged in the committee as religious leader and I haven’t seen any one preaching about pregnancy, health of mother and children at all in the church. Church is a place for preaching about religion and soul, not for other issues like health”</i> <i>“Regarding religious leaders, they didn’t involve in such kinds of activities, and didn’t oppose activities related with pregnancy and delivery”</i>
Social support (Family, husband, Neighbor’s and women in -low)	Social support is important to promote childbirth at health facility through conducting community mobilization for fund raising, arrange necessary equipment, by preparing food, washing clothes and promoting to keep personal hygiene. The community also supports the women while there is no availability of ambulance by caring the women up to health institution.	<i>“Yes, there is a change. For example if her mother or mother in-law is living far from her, they may come and stay with her until she gives birth and they can prepare different foods and cloths which is used after delivery”</i> <i>“The neighbor plays a major role in looking after children left at home and that family’s house. Thus, the family plays a major role in sending women to MWH”</i>
Health care provider support (HEW and HCP)	Provided information about pregnancy, birth preparedness and childbirth, Provide counseling about to keep self-hygiene, nutrition, take rest and stop work load and facilitating logistics like ambulance for women is the major support which helps to promote institutional childbirth.	<i>“I am playing on the reduction of maternal and child death through providing delivery services, provision of health education and counseling for pregnant mothers at static and Outreach area to use ANC</i>

		<p><i>service”</i></p> <p><i>“Regarding health professionals, they need to solve or treat what they see as problem of that woman. If it is labor, health care providers should assist the women as well as if it is other problems due to disease, they also need to care the women, up to their knowledge,,</i></p>
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ANNEX F: Code list

Code-Filter: All

Awareness- utilizing MNCHS

Belief-community

Belief-religion

C- Health insurance

C- Lack of resource

C-Lack of religious leader promotion

C-availability of drug

C-availability of equipment

C-bad health workers behavior

C-health care provider negligence

C-inaccessible services

C-lack of health center

C-Lack of husband/family/community support

C-lack of knowledge

C-lack of transportation

C-lack of water

C-Lack of work commitment

C-shortage of man power

C-women trust

Knowledge-delivery

Knowledge-pregnancy

S-family

S-health care providers

S-HEW

S-husband

S-neighbors

S-WDA

S-Religious leader