Anatomy & Physiology: Current Research

Mesele, Anat Physiol 2018, 8:3
DOI: 10.4172/2161-0940.1000302

Research Article Open Access

The Socio Economic Factors that Promote Maternal Health Seeking Behavior among Ethiopian Rural Women: The Case of Raya Alamata District

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Received date: June 26, 2017; **Accepted date:** July 23, 2018; **Published date:** July 30, 2018

Abstract

Maternal health is the physical wellbeing of a mother during pregnancy, childbirth and postpartum. It reflects the level of social justice and the degree of respect for women's rights in a society. Therefore, aim of this study is to identify the socioeconomic factors that promote Maternal Health Seeking Behavior (MHSB) among rural women of Raya Alamata districts. To conduct this study, the researcher used qualitative research design. Hence, Focus Group Discussion (FGD), key informant and in-depth interview were conducted with purposively selected participants from the three Tabias. Thematic analysis method was used to analyze and interpreted the qualitative data. Finally, the influence of media, the deployment of Health Extension Workers (HEWs), the contribution of social network and social capital, the provision of Maternity Waiting Rooms (MWRs) for birthing women, pregnant women conference, the establishment of women Health Development Army (HDA) and one to five groups were the major factors that promote MHSB of rural women of the study area. Moreover, the availability of ambulances, fear of HIV infection and punishment (fine) are factors which facilitates women to have birth in modern health institutions.

Keywords: Media; Social network; Maternal health; Health care

Abbreviations: MHSB: Maternal Health Seeking Behavior; FGD: Focus Group Discussion; HEW: Health Extension Worker; HDA: Health Development Army; FP: Family Planning; HEP: Health Extension Program; ANC: Antenatal Care, PNC: Postnatal Care; DC: Delivery Care; MWR: Maternity Waiting Room; EDB: Expected Date of Birth.

Introduction

According to World Health Organization (WHO), maternal health is the physical wellbeing of a mother during pregnancy, childbirth and postpartum [1]. Maternal health reflects the level of social justice and the degree of respect for women's rights in a society. Women's right to receive good-quality health services is guaranteed when their basic human rights to education, nutrition, to a safe environment, to economic resources and to participation in decision-making are met. In the broader context of reproductive health, safe motherhood is a critical component of the efforts to help women realize their full potential not only as mothers, but also as contributing members of society.

Maternal health is a vital component of healthy societies, economies and nations. The future of nations depends upon healthy women and mothers. Women are the sole income-earners in one-third of households globally, and comprise 70% of agricultural workers in Sub-Saharan Africa. Women's unpaid work, including farming, managing homes and caring for family members equals approximately one-third of the world's Gross National Product (GNP) [2].

Along with this, studies shows that an investment in maternal health is an investment in health systems in general. These investments help to improve the health of pregnant women, as well as the health of the general population. Healthy mothers lead to healthy families and societies, strong health systems, and healthy economies. As one step towards achieving these results, there are proven cost-effective interventions that can dramatically improve maternal care in Sub-Saharan Africa's health systems. Investing in maternal health is urgent: not only because giving life should not result in death, but also because women are important economic drivers and their health is critical to long-term, sustainable economic development in Africa. Furthermore, investing in maternal health is a way to improve health systems overall, which benefits the entire population of a country [2].

However, women in developing countries get the smallest benefits from societal and family resources. This is particularly evident in developing countries where women are most marginalized and bear the consequences of poverty, underdevelopment, and traditional and cultural sanctions [3]. Besides, African countries face a variety of obstacles to improved maternal health [2] thus includes biological (sex), social determinants such as gender, the physical environment, socio-cultural and the economic determinants including access and utilization of health services [4]. Moreover, there are also other common barriers that contribute to the low utilization of health services specifically maternal health includes lack of compliance of services with defined standards, the shortage of supplies, infrastructure problems, deficiency in detection and management of complications or emergency cases, and poor client-provider interaction. Furthermore, services are also underutilized when they are perceived to be disrespectful of women's rights and needs, or are not adapted to the cultural contexts.

Concomitantly, there are also cultural barriers that affect women's health. One of the cultural barriers to health care is relating to lack of autonomy and decision-making power; often constrain women's access

to health care. In some areas, for example, women are not allowed to leave home unaccompanied, while in others, women are not permitted to be attended by male health care providers. Sometimes, the fear of not having her cultural values respected inhibits a woman from accessing the services she needs. Besides, in many parts of Africa, women must seek permission from their husband or family to visit a clinic for care. Even when permission is nominally given, women's lack of autonomy in their families can still prevent them from seeking care [2].

Another study also revealed the effects of socio-cultural beliefs and practices on MHSB. These beliefs and practices had carried out during the pregnancy, delivery and postnatal periods. For instance, abdominal massage, the ritual practices of Mejilis and Dubarti; and food taboos are commonly held during the prenatal periods. Therefore, beliefs and practice like Zarr spirit, custom of coffee ceremony, the demand of social gathering, customary tasting practice, religious beliefs and fear of disclosing to the external things and high desire of confinement as well as the utilization of herbs are carried out during the periods of delivery and postnatal periods. These traditional beliefs and practices have negative consequences on the utilization of maternal health services. As a result of these beliefs and practices, many rural women were exposing to excessive bleeding, uterine rupture and incomplete placental separation. It also plays a pivotal role in delaying women from visiting modern health facilities. Thus leads to maternal morbidity and mortality [5].

Literature shows that education is another important social determinant of health [6] in general and women's health in particular. Thus determines individual opportunities, attitudes, and economic and social status. The educational attainment of women has a strong effect on reproductive behavior, fertility, infant and child mortality and morbidity, and attitudes and awareness related to family health, use of Family Planning (FP), and sanitation [7]. It is an important issue in a woman's life because it helps her to lead to a better life. Through education, she can also acquire knowledge regarding health care seeking behavior for safe motherhood [8]. The higher the level of education of a woman, the more knowledgeable she is about the use of health facilities, FP methods, and the health of her children [9]. In contrary, low level of education is associated with poor health status [10] that affects the health seeking behavior of women. Besides, research finding in Nigeria also shows that lack of education was seen as a major socio-cultural factor that contributes to maternal mortality [11].

Moreover, the poor economic circumstances affect health throughout life [12]. People in the lowest socioeconomic groups consistently have the poorest health status [10]. The problems related to direct medical costs, loss of income potentially put the family in economic distress [13] because there is persistent correlation world-wide between low income and poor health [10]. The poorest women are generally least likely to use health-care services [14]. Furthermore, poor women spend more time and energy for cooking food or preparing for food. Usually they are unskilled and uneducated, so they are obliged to accept whatever work they can get. As a result, their health and families are severely affected [15].Thus makes maternal morbidity almost always higher among the poor and disadvantaged than among the wealthy, and this is also true of maternal mortality [16].

Reducing maternal mortality requires co-ordinate, long-term efforts at the household and community levels as well as at the level of national legislation and policy formation, especially in the health sector. Long-term political commitment is essential for reviewing national laws and policies in the area of FP and adolescent health ensuring availability of skilled attendants at birth, regulation of health practices, and the organization of health services.

Therefore, in response to the country's health problem the government of Ethiopia introduces the Health Extension Program (HEP) [17]. HEP is a flagship program of the government of Ethiopia [18]. This new health policy focuses mainly on providing quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children [17].Through this package, the necessary conditions will be met for mothers to receive full information and education about their health without going far away from their places. The HEW who can discuss their health and health related problems will be close to them [19]. In addition to this, HEWs provide Antenatal Care (ANC), delivery, immunization, growth monitoring, nutritional advice, and FP and referral services to the general population of the kebele [17]. As a result, there have been positive outcomes in improving maternal and child health in the community [20].

Concomitantly with the aim to promote community mobilization and adoption of healthy lifestyles, a major initiative undertaken by the Ethiopian Government is the implementation of the HDA in order to promote behavioral change as well as to ensure the implementation of all health extension packages in the communities so that they can produce and sustain their own health, including maternal health [21]. This is basically designed to improve the implementation capacity of the health sector by engaging communities to identify local challenges and corresponding strategies. It is also designed for scaling up best practices from one part of the country to another [18]; and come up with feasible strategies to address the problems that affect the health of the general population. It also designed to implement the strategies as well as to evaluate their activities [22].

Besides, studies showed that the improvement in ambulance services and the making of maternal care including ambulance free of charge is believed to be motivating for women especially their husbands to decide to choose health facility for birth. The improved service delivery in health facilities is expected to mitigate delay in health facilities. Scaling up in FP services in rural communities is taken as a strategy to reduce MMR, too [19]. All these put together in practice would radically reduce MMR, enabling the country to meet MDG targets in health [23]. Moreover, improved access to health facilities with maternal health services and improvement in availability of equipment, supplies, and skilled health care workers has been commonly documented to decrease maternal mortality. More importantly, Birth Preparedness and Complication Readiness (BPCR) is an important measure to improve utilization of maternal health services by planning for normal birth and predicting actions needed in case of emergency. It encourages women, family, and communities to make arrangements [24].

Therefore, the most important aim of this study is to identify the major socio economic factors that promote MHSB during pregnancy, labor and delivery in Raya Alamata district. It is also hoped that the results of the study is essential to policy makers to disseminate and expand the most excellent experience and practices on perceived facilitators to MHSB; and it also serve as a foundation for any possible intervention aimed at improving the low utilization of maternity care services in the study area.

Research Methods

Study area

Raya Alamata is located at 600 km north of the capital city Addis Ababa and about 180 km south of the capital city of Tigray Regional State, Mekelle. It is the south most administrative district of Tigray Regional State bordered in the south with the Amhara Regional State in the east with Afar regional State in the North East with Raya Azebo woreda and in the North with Ofla woreda. Alamata woreda has 15 tabias (peasant associations) and 2 town dwellers associations. The number of agricultural households of the woreda is approximately 17,597 (IPMS, 2005). The total population of the woreda was 128,872 in 2003/04 [25]. Its population was estimated to be 141,695 based on census 2007. Rural Raya Alamata woreda health office shows the availability of health infrastructure. Therefore, the district had one district hospital, six health centers and 13 health posts [26].

Research design

Research design refers to the steps that researchers follow to complete their study from start to finish [27]. It is the plan or proposal to conduct research which involves the intersection of philosophy, strategies of inquiry and specific methods [28]. There is differences in philosophical perspectives in each paradigm combined with the aims of a study, to a large extent, determine the focus, approach and mode of enquiry which, in turn, determine the structural aspects of a study design. Therefore, the researcher employed qualitative research design in order to achieve the desired objective of this study. The main focus of qualitative research is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of a group of people [29]. Along with, qualitative research has specific designs. One of the specific designs that were applied for this study was phenomenology. Phenomenology refers to the way in which we as humans make sense of the world around us. A phenomenological study describes the lived experiences of individuals about a phenomenon as described by participants. This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon [30]. This study design is the most appropriate method to describe and understand the socio economic factors that promotes the utilization of maternal health services in general and MHSB in particular.

Methods of data collection

Research methods involve the forms of data collection, analysis, and interpretation that researchers propose for their studies [28]. To conduct this research, three kinds of data collection methods were used. These are FGDs, key informant interviews and in-depth interviews were employed. The selected participants were model women, males/husbands, leaders of one to five groups, HEWs, District health experts, model women and community leaders.

Focus Group Discussion (FGD)

Focus groups are a qualitative data collection method. It is an effective method because it helps researchers to learn the social norms of a community or sub group, as well as the range of perspectives that exist within that community or subgroup. Focus groups are especially effective for capturing information about social norms and the variety of opinions or views within a population [31]. Moreover, it is one of the data gathering tools that were used in the field to gather and dig out qualitative data pertaining to the research topic. During the FGDs, the researcher was moderated the discussion and ensure some individuals do not try to dominate the discussion at the expense of shy participants. Finally, the researcher has conducted three FGDs consisting of 24 participants. The three FGD were model women, males/husbands and leaders of one to five groups (female) respectively. All the participants of the FGD were selected purposively.

Key informant interview

The interview method of collecting data involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses [32]. A key informant interview is one of the methods that involve interviewing a selected group of individuals who are likely to provide needed information, ideas, and insights on a particular subject [33]. Therefore, the researcher used key informant interview because information comes directly from knowledgeable people, key informant interviews often provide data and insight that cannot be obtained with other methods. Key informants may offer confidential information that would not be recalled in other settings. They may tell of incidents, local happenings, or conditions that explain implementation problems. Besides, provide flexibility to explore new ideas and issues that had not been anticipated in planning the study but that are relevant to its purpose. Furthermore, it is essentially qualitative interviews which are conducted using interview guides [33].

The interviews were conducted with purposively selected informants. The informants consists of 6 model women, 6 health workers (3 district health experts and 3 HEW); and three community leaders. To collect the necessary data, the researcher also employed interview guide and checklist. The interview guide has different questions related to factors that promote MHSB. The interviewer develops and outlines the semi structure questions before the course of the actual interviews but the interviewer subtly probes informants to elicit more information and takes elaborate notes, which are developed later [33].

In-depth interview

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation [34]. It is also designed to elicit a vivid picture of the participant's perspective on the research topic. This is also an effective qualitative method for getting people to talk about their personal feelings, opinions, and experiences [31]. In-depth interviews are useful when you want detailed information about a person's thoughts and behaviors or want to explore new issues in depth. It also helps to understand the perceptions, feelings and knowledge of people in a way ordinary life affords them. They allow and provide an opportunity for the researcher to yield rich, detailed information about an issue or experience [35]. To conduct this research, in-depth interview was employed as important data collection instrument. Therefore, the researcher employed this method in order to explore the thoughts and memories of participant's. It also was employed to share their experience through the eyes of those who experience it with respect to factors that promote MHSB. Finally, to accomplish this research, in-depth interview was conducted with ten women with the help of interview guideline. Through in-depth interview the researcher was uncovered the detailed information regarding the socio economic factors that promote MHSB; and the

subjective experience of rural women of the study area. The interview was held in the living places of women.

Data analysis methods

Data analysis is making sense of massive amount of collected data, reducing the volume of information, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal and, hence, producing findings [28].

Initially, the collected data reviewed through reading and listening of the note taken by the researcher and audio recorder respectively which served as data collection equipment. The audio recorded data/output directly transcribed into local Tigrigna language and, afterward, translated into English. Direct quoting was also used to make a comprehensive understanding on the issues of maternal health. The overall collected data of the study subject/issue organized by using different codes in accordance with the respective themes. Those themes were arranged by taking each specific objective as a base and reducing/breaking it into more specific sub themes by using manageable units. Then different data that have been arranged in their respective sub themes and/or objectives were synthesized to give meaningful finding and, after that, the synthesized information was given a pattern to be able to make it coherent and understandable enough. Therefore, the transcription and analysis of qualitative data were commenced during data collection process. Finally, the qualitative data collected from FGD, key informant interview and in-depth interview was analyzed using thematic analysis methods.

Ethical consideration

While studying groups of a particular community having its own normative connotation, research ethics, as key issues in any research, need to be strictly maintained. Taking this into consideration, maximum effort would be exerted to safeguard the rights of all research participants; by keeping their confidentiality, respecting each of them and acknowledging their values, norms and government laws in the whole process of carrying out this study.

Before the commencement of data collection, the researcher was presented supportive letters from University of Gondar department of sociology in order to obtained legal permission from the respective concerned bodies of the woreda and study participants. Subsequent to that at the inauguration of data collection, the necessary supportive letter was provided to all of the study participants along with open communication of the study objectives. Study participants were also kindly requested to have freedom from asking questions, including the identity (address) of the researchers and refusing to participate at any stage of data collection. Consent of each participant were obtained to participate in the study and to be able to audio record by the researcher. With the exception of study participants who have been included in the acknowledgement, to the rest informants, pseudonym was given and/or used to each of them that will help the researcher keep their confidentiality.

Results and Discussion

There are a number of factors that promote MHSB in study area of Raya Alamata district. The major contributing factors are media, availability of HEW, the existence of social network and social capital, the provision of MWRs, pregnant women conference, availability of HDA and one to five groups. Moreover, the availability of ambulances, fear of HIV infection and punishment (fine) also helps women to have birth in modern health institutions.

The role of mass media in improving MHSB

Media has a great contribution on disseminating health related information; in line with this it play great role on the improvement of health outcome [36]. Besides, having access to information through modern media could influence women's knowledge about availability of services [37]. For instance, a radio or a television can bring household members information and new ideas. Furthermore, interpersonal communications were also used as source of information regarding maternal health. More recently, the availability of phones has considerably increased the exposure, particularly of rural households, to communication and information [7].

The findings of this study also affirmed that media has immense contribution in improving health in general and MHSB in particular. It has also play a great role on disseminating and imparting maternal health related information from source to the communities. Mass media as a means of communication has the capacity to promote the smooth exchange of information to understand maternal health care. The development and advancement of electronic and print media have a dominant impact on the society in general and women of the study area in particular in changing and improving their health seeking behavior. Moreover, media had also enabled rural women to change their perception about their overall health utilization. The influences of media also promote women level of knowledge, understanding and consciousness regarding maternal health [5]. Accordingly, rural women started to change their unhealthy life style to healthy life style and motivating women to promote healthy behavior due to the influence of media.

Along with, media also served as a source of information for communities in general and women in particular on the topics of maternal health utilization (such as ANC, delivery and Postnatal Care (PNC)) services. Thus, It is possible to conclude that media has positive contribution to increase the awareness of women regarding maternal health care utilization. It has also a great role chiefly in inspiring rural women to make use of ANC services. The elevation in knowledge regarding maternal health enables women to check the condition of pregnancy. In addition to this, media also helps to promote women to take medical examination and to treat their diseases early. The interviewees' result showed that rural women exposure to media helps to increase their knowledge regarding the utilization of Delivery Care (DC) services. They had raised the level of knowledge on the benefit of institutional DC services. It has also contributed to the development of positive attitude towards institutional delivery.

As the FGD and key informant result showed that rural women were heard and knew about PNC services from media. So the knowledge and awareness of respondent's regarding the utilization of PNC services has improved. The knowledge and awareness of rural women on the issue of FP, culture of breast feeding and supplementary feeding had increased as a result of media and other associated factors. This enables children and mothers to be beneficiaries of vaccination services in their vicinity.

On the other hand, print media is considered as essential methods that back to teach people about maternal health however illiteracy becomes a barrier to use it. Some of the respondents were reading printed materials such as pamphlets, brochures and posters that were

received from Tabia HEW. The data from FGD participants showed that different published and non-published materials like pamphlets, leaflets, brochures, booklets and posters were used as gadget for transmitting the desired information to the community. These are the most important means of communication than the newspapers due to the content of the publications that has direct relation with maternal health issues. These printed materials presented by using pictures and diagrams thus made the message clear and precise. To conclude this, the print media has great contribution in transmitting and offering updated information as well as to educate the rural community regarding maternal health care and its components like antenatal, delivery, postnatal, child health care and FP services. Thus, this brought about the behavioral changes in the rural women regarding their maternal health and they were increasing their health seeking behavior.

The contribution of HEW in improving MHSB

The Health Extension Program (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. It is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom. This is the main vehicle for bringing key maternal, neonatal and child health interventions to the community [17].

HEWs provides women with intensive health education meetings. The focus of these meetings is to educate the women about ANC, PNC, delivery, child vaccination etc. [20]. Similarly, the finding of this study also showed that the commencements of the program in the study area under the management of two employed HEWs (in each Tabias) have brought attitudinal and behavioral changes in the community. They had also much contribution to prevent maternal and child health related problems that exist in all kebele of the study areas. Therefore, many women are becoming aware of the health issues that affect their lives. This has helped the women to make informed decisions on their health [20]. The data from HEWs also revealed that the number of vaccinated children and women has been boosted due to massive efforts of the HEWs and other stakeholders. One of the HEW from the informants said that the number of women and children who take the vaccine to prevent respiratory infections, diarrheal diseases, and measles has increased. Because of this, the number of children and mothers morbidity and mortality has declined at alarming rate in the Tabias's. In with this, study by Tilak [20] showed that maternal mortality has been decreasing especially compared to previous times.

HEWs create the awareness among the community women that every pregnancy has different characteristics and they educate the women to strictly follow their ANC checkups in the nearby health post and health center [20]. Correspondingly, the majority of HEWs said that mothers and children have been getting attention. Rural women are being learnt about health in general and maternal health in particular. As a result of frequent and continuous health education, they started to utilize antenatal and PNC services. The number of women who were visiting to ANC is increased. Other study conducted by Araya [38] revealed that the number of women who have utilized FP, ANC, and HIV testing was increased. Moreover, Tilak [20] in his study, found that the number of women started to visit health institutions for ANC, delivery and PNC services has increased as a result of health education that has been given by the HEW.

Concurrently, HEWs are engaged in educating people regarding nutrition and its values in practical and interactive ways during the outreach activities (home to home visits). Besides, the two HEWs who are deployed in each kebele also provided voluntary counseling and testing services to the local communities. During the period of house to house visits (out rich activities), they thought the local communities about mother to child transmission of HIV. The HEWs did these activities through advising women to have HIV test before marriage and during pregnancy; and advising women to use HIV prevention methods like condom. As a result of this tremendous effort of the HEWs, it could be improved the health seeking behavior of rural women in the study area. Therefore, HEWs have a critical role in counseling of pregnant women to take drugs that helps them to prevent mother to child HIV transmission. This endeavor helps rural women to deliver HIV free children.

HEWs also played indispensable contributions to boost the number of women who were utilizing PNC services. Besides, community mobilization and education also generated smooth environment for children and mothers to grasp knowledge from the session provided by HEW. It also allowed to women to be beneficiaries of PNC services. To strength the above ideas, 24 years of old key informant reported the condition as follows;

"*I alert and mobilization the community during the out rich activities. At this time, I used partnership with community leaders, religious leaders, Tabia leaders and other concerned bodies. This joint movement helps to coach the mass about maternal health service utilization mainly PNC. I had thought the community; and created attitudinal change in all Tabia. As a result, everyone knows the advantage of PNC services like breast feeding and supplementary feeding, FP and immunization.*"

Another HEW from Timuga one of the study area said that "*Village based house to house visit can also increase the number of women who had attended PNC services*". During the out rich activities, HEWs vaccinated women specifically to those who delivered in their home. So the out rich activity made by HEWs helps women to accessible to PNC services. Moreover, the HEWs articulated that FP is one of the key components of health extension package that helps to educate communities to increase their awareness, knowledge and skills about FP. Because of this frequent and continuous counseling and health education, the number of women who utilized FP services was increased in the previous years. The interviewees said that the majority mothers who have been utilized different kinds of contraceptives had limited the number of pregnancies and children. Therefore, many of them were prevented from unwanted pregnancies and high risk of abortions that occurs before.

The role of social network and social capital in improving MHSB

The social network perspective stresses that people live their daily lives among a number of groups, organizations, and sets of friendship and family relations [39]. On the other hand, social support refers to those aspects of social relationships that provide a sense of self-worth and offer resources in tackling life's troubles [40]. The establishment of social networks helps people to strength their social relationships and interactions. These conditions enable to support each other during the time of ecstasy and trouble. Social networks are established across groups of individuals, neighbors, villages and at community level. The establishment of social networks helps people to strength their social relationships and interactions. These allowed people to support each other during the time of ecstasy and trouble. As the findings from FGD

and key informants revealed that a woman entails social support during pregnancy, delivery and post delivery period via their social networks. The social support which has given for women started at family level. As a member of the family, the husband/partner offered his own support to attend her maternal health care services. This is for the reason that the involvement of the husband/partner in maternal care can play a fundamental role in guaranteeing safe pregnancy, delivery and postpartum periods. Most of the respondents argued that their husbands/partners took them to health institutions while they were sick. Besides, the husbands/partners supported their wives by consulting the health problems of their wives to health professionals; and took to the health institutions for medication. They also took to the health institutions when women were in labour.

On the other hand, others reported that their husband/partners gave them constructive advice, moral and emotional support to maintain the wellbeing of the woman. Some of the respondents also said that the husbands or the partners were supported their partners/wives by providing financial resources for medical and transportation cost. In addition, they also supported their partners in terms of accomplishing household chores. They also went to the market and buy the necessary things to the household during the confinement period.

In the contrary, some of the respondents reported that husbands did not support their wives to utilize maternal health care services. Some husband/partners ignore the issue of maternal health since this is the concern of the wife only. Other respondents reported that husbands/partners did not support wives to attend maternal health services why because they were busy and preoccupied with agricultural work.

HDA and its role in improving MHSB

HDA refers to an organized movement of the community through participatory learning and action meetings. The health development teams is consists of 30 households residing in the same neighborhood thus further divided into smaller groups of 6 members commonly referred as one-to-five networks. The leaders of the health development teams and the one-to-five networks are selected by the team members. The main criteria for selection of the leaders are being a model family and trust by the members in mobilizing the community. The formation of the health development teams and the one-to-five networks is facilitated by HEWs and the Tabia administration. In line with the national programs, women-centered HDA were established in Tigray that lead the one-to-five networks [41]. Accordingly, the local government of the study area established different social networks in all Tabias to achieve their goals. By using these social networks, they have promoted healthy behavior mainly MHSB under the principles of HDA. Therefore, members of the women HDA in the study area have organized and mobilized the community to promote health behavior particularly maternal health care. By authenticating this idea, Key informant from district office reported that:

"Women development teams (Limat Gujile) were playing a pivotal role in maternal health issues. They were registering the total number of pregnant women in their groups which enables women to attend antenatal care, to have delivery at health institutions and to get PNC services. They also registered FP users and HIV positive people who belong to their women development teams. Besides, they had reported the emergence of epidemic disease either to the HEWs or to the district office; and enforced the government to take appropriate and timely measurement to undertake the problem early (A 44 years of health expert from the district health office)".

Another key informant from district office also reported that:

"Women have Iqub within their development teams. These women development teams have weekly meetings for the purpose of Iqub. During this meeting, members of the group save little amount of money. This money was used for hygiene and sanitation. Above and beyond, the main goal of the Iqub was to congregate women in the meeting to make discussion regarding maternal health problems (A 45 year's health expert from the district health office)".

The above narrative showed that traditional associations like Iqub in Ethiopia have its own contribution to support one another. For example, the existence of women Iqub within their development teams at Raya Alamata district enables women development teams to have weekly meetings thus aids members of the group to save money which is used for hygiene and sanitation. Moreover, the main goal of the Iqub was to congregate women in the meeting to make discussion regarding maternal health problems. The key informant from district health office stated that:

Women development teams along with one to five networks mobilize the surrounding people in order to collect money, cereals and flour to cover maternal care expenses. The Tabia committees were sold the cereals and flour and save the money. After that the committees take a seat and discuses to whom offer the collected money. Accordingly, the money would be given to poor women specifically pregnant and birthing women. The birthing woman was benefited from this support up to forty days after delivery (A 44 years health expert at Raya Alamata district health office interviewed on May 10/08/2008).

In line with this argument, 30 years of old HEW from Timuga said that "*All members of women development teams (Limat Gujile) along with one to five networks donated one birr per month to support mothers. The money would be given for extra expenses like transportation, medical and food expenses for the poor one.*"

Another 26 years of old HEW from Garjale added that "*women contribute one birr per month this money would be given for birthing woman used for food and transportation services*".

Pregnant women conference and its role in improving MHSB

Monthly conferences with all pregnant women in the village used to improve peer-to-peer support [18]; and that facilitate MHSB [5]. These conferences are conducted on monthly basis at kebele level. The celebration and preparation of mother's day along with coffee ceremony at the health post enables pregnant and breast feeding women to meet and discuss on the issue of maternal health thus helps to facilitate women to use antenatal, delivery and PNC services [5]. The facilitation role is given to the HEWs. Literature shows that the purpose of the pregnant women conference is basically to support the Women's Development Army (WDA) outreach and follow-up to pregnant women for early pregnancy identification and referral to ANC. Moreover, it has also key role in motivating members of the pregnant women conference to seek and receive care as well as to promote peer support amongst women to motivate each other to seek appropriate ANC, plan for delivery at a health facility, follow through with essential PNC, support exclusive breast-feeding, and FP options [42]. Similarly, this study also revealed that pregnant women conference can also promote women to deliver at health facilities. Besides, this helps women to plan how and where to deliver. Further, the organization and celebration of pregnant conference by rural women with the support from HEW also created awareness on DC

services. The pregnant women were gathered at nearby health centers and getting counseling about DC services from HEWs. During the session, the HEWs were advised the pregnant women to deliver at health facility. Subsequent to the pregnant women conference, a lot of rural women were decided to deliver at health facilities. According to Hailom [23] pregnant mothers' conferences which are conducted on monthly basis help women to ask questions and express their fear to providers including reporting about experiences of women who gave birth in health facility. Another study also revealed that variety of topics on pregnancy, delivery, post-natal care are raised and discussed in an open forum and participatory environment. During discussions women also share their experiences with their peers, learn from each other, and create an informal community network through which information and support is fostered. Moreover, studies conducted by Kesetebirhan [41] monthly conferences with all pregnant women in the village has played a critical role in commencing a monthly conference with all pregnant women facilitated by HEWs and midwives. The conferences are used to improve peer-to-peer support.

Fear of HIV/AIDS infection and its role in improving delivery utilization

The emergence of communicable disease like HIV has devastating effect on the social relationship of individuals, communities and even at societal level. It also creates fear and anxiety among people due to its incurable nature of the disease. In the recent days, neighbors and relatives were not interested to assist birthing woman at home since they fear HIV transmission and infection. Because neighbors and relatives were fear contamination of blood since HIV status of the birthing woman is unknown. Therefore, this unsafe condition forced women to go to health institutions to get delivery services under the assistance of skilled man power.

Fine against TBA and its role in daunting home delivery

The other factors that promote MHSB were the punishment of traditional birth attendants via fine by the local government. Due to fear of fine, traditional birth attendants were restrained from assisting the birthing women at home. Accordingly one of the FGD participant said that the government discourage and condemn home delivery via penalty of traditional birth attendants with imprisonment and charge with money. The traditional birth attendants were charged up to one thousand Ethiopian birr when they assisted labour women at home. Another 40 years of old key informant added that TBA was abstained from giving assistance to the birthing woman because they were charged and sentenced. The punishment of TBAs with money and imprisonment restrained from assisting home delivery at the same time this encourages women to deliver at health facilities.

The provision of ambulances and its role in improving MHSB

The introduction of the ambulance service has created a new role for HEWs as they are now responsible for calling for ambulances to transport women either before their Expected Due Date (EDD) or during onset of labour at home. Depending on the situation, a child or the woman's husband will call the HEW in person or by telephone. If the husband is around, he may need to organize a group of men to carry the woman on a stretcher to the main road [43]. Other studies in Adwa district revealed that ambulance service available 24/7. Other sectors provide a vehicle if the ambulance is under repair [44]. Another study also affirmed that when women commenced the labour the husband or other relatives call to the women HDA leader to inform to the HEW. After that the HEW call to the driver of the ambulance to take the mother to the health center or to the hospital. The labour women were taken to the hospital with the help of women HDA leader and the HEW. Moreover, the improvement in ambulance services and the making of maternal care including ambulance free of charge is believed to be motivating for women especially their husbands to decide to choose health facility for birth [19]. In line with this, the majority of the respondents proved the existence of ambulances in the district. Specifically key informant from Raya Alamata district office confirmed the existence of three ambulances which are allotted to 15 Tabias to transport labour women to the health facilities. In the absence of ambulances, the government used sector cars to transport women to the health institutions. Other key informants else added that the provision of ambulances to rural settings increases the number of women to deliver at health facilities.

In addition to this, in the absence of ambulances due to different reasons the rural people used traditional ambulance (stretcher) in the study area helps to transport labour women to the health facilities. Similarly, studies in Tigray also showed that HDA came up with a locally made stretcher and had also organized the youth to carry a laboring mother to the nearby health facility or major road where the regular ambulance could be accessed [41]. To sum up, the provision of ambulance services enables rural women to get and make use of modern maternal health services from professionals.

The provision of MWR and its role to improve MHSB

MWR or house is the process of receiving and keeping pregnant mothers near to term or at term irrespective of length of stay in the MWR [45]. The maternity waiting homes are being expanded to accommodate women expecting birth who are coming from distant and inaccessible villages. Furthermore, the availability of maternity waiting home in health centers and hospitals is important to avoid carrying women for a long distance during complications. Many women who have had experience of complications and those who wanted to avoid risks associated with home birth travel before one or two weeks of Expected Date of Birth (EDB) to nearby health centers. They stay in waiting rooms; and if a maternity waiting home is available, they stay there till birth [23]. In Raya Alamata district, labour women were suffered from problems related to lack of temporary accommodations specifically before the establishment of maternity waiting homes by the government. In order to solve the problems of accommodation, the government was provided guest houses (MWR) for labour women. According to the saying of the key informants, the provision of guest houses by the government to birthing women at the nearby health facilities with necessary equipment helps women to join and deliver at health institutions. The provision of guest house has given significant contribution for pregnant women to stay until the time of delivery has been reached at health facilities particularly during the summer season. The availability of the waiting room during the summer season helps rural women to stay there till birth. In corroborating this, other studies in Ethiopia also shows the availability of maternity waiting home in health centers and hospitals in Amhara regional state which is important to avoid carrying women for a long distance during complications. According to him, many women who have had experience of complications and those who wanted to avoid risks associated with home birth travel before one or two weeks of EDB to nearby health centers [23,42].

Conclusion

The major purpose of this research paper has devoted to unveil the socio economic factors that promote MHSB in the study area. According to the findings of this study, it conclude that the influence of media, the deployment of HEW, the contribution of social network and social capital, the provision of maternity waiting homes for birthing women, pregnant women conference, the coming out of women HDA and one to five groups had a great contribution to the improvement of women health seeking behavior in the study area. In addition to this, other factors like fear of HIV contamination, fine against traditional birth attendants and provision of free ambulance services for labor women of the study area also promote the utilization of maternal health services in general and MHSB in particular.

Acknowledgement

I am very grateful to University of Gondar for the overall support to conduct this research. Furthermore, I would like give my appreciation to all study participants and respondents for their time, information and life stories with full interest during the research.

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