

Lack of autonomy in facility-based births makes women become absentees of maternity services in Somaliland fragile contexts - a qualitative study

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Abstract

Objective

Somaliland has high levels of both maternal and infant mortality. This has been attributed, in part, to the fact that nearly 80% of births in the country take place at home, with women assisted by Traditional Birth Attendants (TBA) who have limited medical knowledge when it comes to obstetric complications. In this study we aim to capture multipara women's decision-making when choosing the place of birth, illuminated by their experiences of maternity services in Somaliland

Design

An explorative qualitative approach using individual interviews conducted in Somaliland with 25 multiparous women who had experience of both a home and facility-based birth within the last three years.

Findings

The main finding of this study was the description of how valuable autonomy and respectful care were for Somaliland women. Respectful care and the cost of maternity services were vital parts of women's autonomous decision-making when choosing a place of birth. Disrespectful care in maternity services made low-risk pregnancy women chose homebirth instead of a health facility birth. Women who had previous high-risk pregnancies that suggested they should be returnees to facility-based antenatal care, were still planning for a homebirth as their first choice.

Key conclusion

This qualitative study was conducted in the fragile context of Somaliland and suggest a need to transform maternal and child health clinics into midwifery-led birthing centers that promote natural birth. It is further important to create new roles and responsibilities for TBAs that link them to the formal health system assuring timely health care seeking during pregnancy and in relation to delivery. There is a need to conduct a country-wide study on the availability and distribution of healthcare providers and to construct a long-term sustainable plan to assure quality and equal access to maternal health care in the country.

Introduction

It is well established that it can be difficult for women in fragile contexts to access adequate maternal healthcare. The idea that maternal mortality could be lowered if women had better access to maternal health services is one that has not been properly examined [1, 2]. The WHO has estimated that 830 women die every day because of preventable obstetric complications. Ninety-nine per cent of these deaths occur in low and middle-income countries of which more than half take place in sub-Saharan Africa [3]. To achieve a reduction in maternal mortality, women need to be able to access healthcare

facilities run by trained healthcare professionals that deliver evidence-based practice and uphold quality and respect in every aspect of the care provision (WHO, 2018).

A healthcare professional in this article is defined as an accredited and skilled birth attendant with the potential to make a positive intervention of an emergency in the birth process. This includes midwives, nurses, or physicians who have been educated and trained in contrast to Traditional Birth Attendants (TBAs). Skilled Birth Attendants (SBAs) have proficiency in the skills needed to manage both normal and complicated pregnancies, births and follow-ups through the identification, management and timely referral of women and newborns for specialist treatment [4–7].

Home-based birth is common around the world [8–12]. In low- and middle-income countries the homebirth rate is often more than 50 percent whilst in high income countries the homebirth rate is no more than 1–3 percent. In low- and middle-income countries homebirths are often assisted by Traditional Birth Attendants (TBAs), whilst in high-income countries they are supported by midwives [13–15].

The Lancet's series midwifery framework (2014) focused on women's right to be provided with quality maternal and newborn care services. Healthcare professionals were to be encouraged to work together to provide quality maternity care [16]. Studies have shown that midwives working in interdisciplinary teams, and with skills in complicated midwifery care, have the potential to avert 83 percent of all maternal deaths globally [17]. Evidence further shows that women who receive continuity models of midwife-led care are less likely to experience intervention and more likely to be satisfied with their care compared with women who receive other models of care [18]. In Somaliland, however, midwives are based in health facilities and do not carry out antenatal or postnatal visits. Thus, there is no link between the community and the maternity services [19]. At present, untrained TBAs conduct homebirths. Their involvement can delay the referral of complicated cases and thus, by extension, can contribute to high maternal morbidity. TBAs act in contravention of the recommendations of the Somaliland health authorities and UN agencies [19, 20]. The Somaliland government has invested in educating midwives [19, 21]. Despite these efforts the mortality rate is still high, with 396 maternal deaths per 100,000 live births [3, 21]. This figure is largely attributable to the shortage of midwives, equipment and transport infrastructure within the maternity services when complications occur [21, 22]. Innovative ways are required to save the lives of women and newborns, educating healthcare professionals, particularly midwives, and strengthening their capacity [23, 24]. The first step in addressing this challenge is to understand women's decision-making when choosing a place of birth in a subsequent pregnancy. In this study we aim to capture multipara women's decision-making when choosing the place of birth, illuminated by their experiences of maternity services in Somaliland as their decisions can then tell us about women's perceptions of the different birthing options available to them and why they might continue to prefer home births.

Methodology

Design

This study employed an exploratory qualitative approach using individual interviews to illuminate women's decision-making when choosing a place of birth [25]. Ethical approval was obtained from the Somaliland MOHD and the research ethics committee at the University of Hargeisa. Dr: CS/41105/18.

Setting

This study interviewed women living in the Ahmed Dhagah district, a part of Hargeisa, the capital city of Somaliland. The district contains eight small villages with an estimated population of 23,000 inhabitants. Healthcare is managed from one large hospital and four health facilities where, at the latter, the care is free of charge. Since the civil war in the 1990s many Somalis have been forced to flee their homes. Many of these 'internally displaced people' (IDP), largely Somali speakers and drawn from the Maroodi Jeex region and other parts of rural Somaliland, now live in one of the 18 IDP camps in the Ahmed Dhagah district. These camps now represent over 15,000 families, all of whom are eligible for the same free antenatal, birth and postnatal maternity services as the rest of the community.

Participants

Eligible multipara women from Ahmed Dhagah and the IDP camps with experience of delivery at both a health facility and at home were identified as meeting the inclusion criteria for participation in this study. Twenty-six women voluntarily agreed to take part in the study. One woman was excluded when she refused to be audio recorded. Individual in-depth interviews were conducted with 25 women between January 2015 and September 2019. For the socio-demographic details of the participants see Table 1.

Data collection

Using a purposeful sampling approach, midwives employed at district health facilities and local TBAs working in the area identified and approached women they felt met the study criteria. These women were invited to take part in the study and were provided with verbal and written information. Participation was voluntary and they could withdraw without explanation. After giving their informed consent, participants signed a consent form with a signature or thumbprint. Then an appointment for an interview to be held in the woman's home was arranged.

The interviews were conducted by the first authors using an interview guide. The questions focused on the aims of the study, to collect data on women's decision-making when choosing a place of birth and to explore their experiences of both home and facility-based births. The questions were developed in English and then translated into Somali. They were then pilot tested on two of the participants which resulted in some minor clarifications to the guide before being used for the rest of the study. The questions included: Please tell me about your pregnancy and birth experiences. Please tell me why you decided on a home birth. How was your experience of antenatal care? Why did you decide on a facility birth? How was your experience of your home birth? How was your experience of your facility-based birth? Who delivered your baby at home? Who delivered your baby at the facility-based birth? The questions enabled the interviewees to speak freely about their experiences and the prompt to "please tell me more" was used to

encourage the informant to continue to tell their stories. The interviews were held in Somali, took about 45-60 minutes, were audio recorded and transcribed verbatim into Somali and then translated into English.

Analysis

A phased inductive process was carried out that included a preparation, organization and reporting phase. In the *preparation phase* the unit of analysis was the 25 transcribed interviews. The transcripts were read and re-read to make sense of the data as a whole. Thereafter a sheet of open coding was developed. In the *organization phase* text parts (sentences or small paragraphs) with the same meaning were grouped into categories (see Table 2). In the *reporting phase* the text was reconstructed into a running text close to the participants' words. The authors used the coding sheet to analyze the original 123 pages of data individually and then, through a series of discussions, agreed on the content of the main and the generic categories [26].

Findings

The main category to emerge from this study is "Somaliland women value autonomous choices". Somaliland women make decisions about their place of birth based on what they perceive to be the best quality care given their circumstances and with some consideration of the financial implications of their decision. The interlinked generic categories are; "Clinical knowledge and cultural competence", "Strengthening women's capacities" and "Optimizing natural processes", "Providing respectful women-centered care and cultural understanding" and "Preventing complications through education and health promotion and maternal autonomy".

Clinical knowledge and cultural competence

In general, the women in this study felt that the healthcare professionals at health facilities were good at obstetric emergencies but not at providing respectful care. One woman who had experienced a complicated delivery in a health facility said she felt medically safe but had felt verbally abused:

I was in a very serious condition when I gave birth in the health facility and the young healthcare professional spoke to me in bad words. The elderly woman that welcomed me and hoped to deliver me already her shift finished. That elderly woman made prayer and asked Allah to facilitate my birth. I was very happy to get support from that woman, but the younger health care professional, she assisted my birth, and I hated that (Case 4).

Experiences at health facilities similar to this were an important factor when choosing a subsequent place of birth. Several women described their experiences of disrespectful behavior from healthcare professionals had led them to decide to give birth at home rather than at a facility. One participant explained:

When I was in labor the healthcare professional at the health facility was not helpful, they were asleep. Another time, I did not have any health problems, but still, I went to the health facility to give birth, but the healthcare professional slapped me (Case 3).

During the interviews the women talked at length about the importance they placed on respect and privacy during labor. Even though they knew they might encounter disrespectful and abusive behavior from health facility staff, they knew that a health facility birth was the safest option for them. One woman explained her experience of a facility-based birth:

Every time I tried to talk while I was in very painful labor pains, they kept asking me to be quiet. I felt very restricted while I felt like needing to scream. I missed my freedom and privacy, they never examined me when I needed them to do it as the night shift was asleep. I arrived at 3 am and I delivered at 11. I was not satisfied with the position that I had my baby in, every time I tried to ask for something, they told me to be quiet and they answered me with rude comments (Case 1).

From the interviews it is clear that many of the healthcare professionals at the health facilities were young and lacked the professional experience and social skills displayed by older staff who had worked in maternity services for a longer period. The interviewees did not trust these professionals and spoke about them with less respect, especially in comparison to their generally positive comments about older healthcare workers or TBAs. They suggested that the maternity services should be comprised of mixed teams of younger and older healthcare professionals.

Strengthening women's capabilities optimizing natural processes

The women in this study shared a generally positive experience of homebirth. This was because they said their TBA made them feel relaxed and empowered and did not rush or force the birthing process. This was in contrast to their experience of a health facility birth, where the healthcare professionals dealing with them needed to care for other women at the same time. From their descriptions, TBAs were able to practice 'expectant management' during home births. TBAs were present, but in the background, watching the labor process but allowing it to proceed on its own terms. According to the interviewees, TBAs supported them emotionally throughout their labor. They valued this support a great deal and it motivated them to choose a homebirth. One of the study participants recalled:

My TBA was always my supporter and although I delivered at home, she has always been available to me every minute of the delivery she was with me. She never left my side and always asked me what I needed. She read something and stayed by my bedside all night. I felt her efforts to care for me the best she could (Case 10).

The participants stated that during their home birth the TBAs encouraged them to listen and trust their body and used interventions only when necessary. This made the women feel empowered and in control of the events during their labor. They knew that interventions that they did not want to happen would not

take place. They also appreciated being at home and able to take care of their other children while giving birth. This greatly reduced their anxiety levels. One woman explained:

Xalimo [her TBA] was very caring for me and my children. She checked on me regularly and encouraged me to listen to my body and to let her know how I feel whenever I needed something (Case 1).

Providing respectful women-centered care and cultural understanding

The participants felt that their TBAs shared the same values as they did and thus recognized the importance of dignity and understanding during the birthing process. They understood that they were a guest in the woman's own home and that above all else their care needed to reflect her needs. One participant said:

Home and hospital birth are completely different. Women search for normality, someone that assists you, who is kind and keeps your dignity intact (Case 4).

One factor for women when deciding on a birth location was their previous experience of the health facility and the financial implications of using the maternity services. One woman said:

I and other women choose home birth because of financial reasons. I spent only two hours in a private hospital, and we had to pay them \$52 (Case 1).

TBAs also expected to be paid for their services although their fee was lower than a health facility's and often took the woman's financial situation into account. Another women pointed out that The TBA took a lower price for the birth than at the health care facility. The hospitals have a fixed price (Case 6).

According to the women in this study, facility-based deliveries disrupt their family life because it forces them to be away from the supportive and familiar environment of their home and away from their children. Homebirths make all of these concerns easy to manage:

It was my home and not a hospital. I slept in my warm bed at home but in the health facility, it is possible you feel cold and moist after childbirth. I slept with my baby, I got relaxed, and I had all the other children with me in my home (Case 4).

Preventing complications through education and health promotion

The women described how healthcare professionals working at the health facility provided them with general health messages, explained some dietary requirements, encouraged them to take medicine that would protect their health. The participants, however, also expressed disappointment with the quality of the health education and information they received from the healthcare professionals at the health facility. For example, within the sample of women interviewed here, pre-eclampsia was a prominent condition which many of them knew was one of the leading causes of maternal deaths. Participants found it very careless of the facility-based staff to simply diagnose high blood pressure and then fail to explain the effects pre-eclampsia could have on labor if left untreated:

The healthcare professionals did not give me any health education or advice on how to manage my high blood pressure, but they measured my blood pressure and prescribed medication, and I bought my medication and used it regularly (Case 3).

The women with experience of home-based and facility-based births said that the healthcare professionals provided them with an assessment, a screening service and care planning but failed to talk about birth planning, so the woman was left to decide on her birth location on her own:

I attended antenatal care and they told me that I am normal and that my blood is fine...So, I thought if the baby is in a normal position and I did not have any complication and the TBA was ready to transfer me to the health facility if something went wrong, I could have the baby at home. That was why I decided to give birth at home (Case 18).

TBAs were eager to avoid the complications associated with a "high risk pregnancy". For women who had complicated pregnancies, they reported their TBAs constantly advising them to seek facility-based care so they would not blamed if complications arose further down the line. One participant recalled:

The TBA encouraged me to go to the health facility and consult with the healthcare professionals. Whenever she visits us, she kept asking me if I went to the health facility this morning, if I check my blood pressure level. So, when I say yes, she always says all right, do not stop going to the health facility. Also, later I developed high blood pressure that is why I was very pleased that I was going to the health facility regularly' (Case 3).

Maternal autonomy

The women in this study were aware of their local maternity services and appreciated the difference in competency and capabilities between the health care professional and the TBA. If they experienced abnormalities or emergencies, they autonomously decided to utilize the maternity services at the health facility. One participant said:

The healthcare facility is better when you face complications. There are trained health care professionals who manage your condition. There is care available that you cannot get at home (Case 5).

TBAs were described as a first choice. They were accessible, provided individualized care and lived nearby, often on the same street or in the same village. Sometimes, however, TBAs were busy or away when the woman went into labor and were not easily accessible. This meant that the woman might have to quickly change her plan from a home to a facility-based birth. The first choice for a healthy woman was, according to the participants, a homebirth; a facility-based birth was only a second choice:

I delivered in the health facility. I started labor pains one day when I was alone, so I tried to seek a TBA as the first choice for a home birth, but she was not present at that time so as a second choice I saw a taxi driver that I knew and I went to the health facility to give birth and soon after I arrived at the health facility I gave birth. All my family came to the health facility later on (Case 5).

Discussion

When discussing the lack of quality care as identified in this study, it is important to highlight a poorly functioning health system and a heavy workload for trained staff with only adequate pay. Together these create a culture and environment which is not always able to support a positive attitude towards women and their babies [27, 28]. In this study, women simultaneously acknowledged the important work health care professionals did when treating maternal emergencies at the health facility, yet consistently stated their preference for the caring values of a TBA for a normal labor and birth. As suggested by the maternal and newborn care framework, engaging TBAs in a midwife-led continuity of care is an important element of an ideal care philosophy [16].

For this philosophy to be realized, the number of midwives educated to global standards with the ability to provide holistic care within the community needs to be increased [29]. The findings from Somaliland are supported by the literature that describes TBAs as a link between the women in the community and the healthcare professionals in the maternity services [30]. The WHO has also emphasized the importance of creating new roles and responsibilities for TBAs that link them to the formal health system [31].

The women in this study identified the advantage of including TBAs in the network of care. They emphasized the transfer of knowledge and the building of trust that would take place if healthcare professionals and TBAs worked together in networks that divided roles and responsibilities between them. This view is supported by a study that suggests TBAs could use their competence as a doula to provide cultural and psychosocial support during pregnancy and childbirth in Somaliland [32]. Another intervention improving quality of care would be to provide healthcare professionals with training in respectful maternity care. This has been suggested in a review reporting that healthcare professionals should communicate with women and their families while providing maternity care that allows for planning, that gives women the opportunity to choose, that encourages them to ask questions and is willing to disclose treatment results appropriately [33].

This study showed healthcare professionals could have provided better health education and information to women at their antenatal check-ups, better informed them of the risks involved in pregnancy and birth and offered them a better discussion of their birthing options. Such advice is especially important in fragile contexts like Somaliland, where women, like those in this study, are frequently left to make their own risk assessments and to decide for themselves, based on the results of their antenatal care assessments, the safest place to have their baby. Healthcare professionals in Somaliland could offer women the opportunity to have normal births in a more autonomous version of the health facility. Facilities that function as a midwife-led birth center staffed with midwives and TBAs looking to promote a birth experience that supports and reflects the woman's needs. Only women with complicated pregnancies and births would need to be transferred from these birthing centers to secondary- or tertiary-level hospitals. Only then will it be possible to form strong links between the maternity services and the local community. According to Yu et al., [29] well-functioning birthing centers resulted in significantly

lower intervention rates, greater maternal autonomy and lower health system costs than carrying out normal births in hospitals. Australia and Somaliland are obviously very different, but a similar study examining the specific circumstances of introducing birthing centers in Somaliland would be very suggestive.

Strength And Limitations Of This Study

The key strength of this study was the research process and the personal interviews in a unique setting that give voice to one of Somaliland's most vulnerable populations. It is the first study of its kind in the Somali region, providing vital insights into women's decision-making when choosing a place of birth. Despite the high credibility of its findings, this study has a series of limitations that affect its transferability. Multipara women might, because of their age and experience, be more autonomous in their decision-making than primipara women. This is evident in a health survey [34] that shows how the autonomy of women's decision-making with regards to their sexual and reproductive health seems to increase with age and the growing parity of knowledge. In addition, financial status of the women in this study may have influenced their decision-making [35]. Because women in our study were from a relatively poor socio-demographic background, they might have been more inclined to choose home birth due to financial considerations, regardless of its more supportive reputation. The findings outlined here, therefore, should not be transferred to primipara women or women from secure economic backgrounds when choosing private alternatives.

Conclusion And Clinical Applications

This study suggest a need to transform maternal and child health clinics into midwifery-led birthing centers.

To create new roles and responsibilities for TBAs linking them to the formal health system assuring timely health care seeking during pregnancy and in relation to delivery.

To provide health care professionals with a training package on respectful maternity care that would help to end the mistreatment of women in maternity services.

To develop a policy on quality maternity care for the Somaliland maternity services. This would encourage respectful women-centered care at existing health facilities.

To conduct a country-wide study on the availability and distribution of healthcare providers. To construct a long-term sustainable plan to assure quality and equal access to maternal health care in the country.

Declarations

Acknowledgements

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Conflict of Interest

The authors have no conflicts of interest to declare.

Ethical Approval

Ethical clearance to conduct the study was obtained first from the Somaliland Ministry of Health and Development and then the research ethics committee of the University of Hargeisa. Approval number Dr: CS/41105/18

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Clinical trial registry

Not applicable.

Credit authorship contribution statement

All authors have made substantial contributions to the conception and design of this study. All authors have participated in the work to such a degree as to be willing to be responsible and accountable for all aspects of the study and for ensuring that questions related to the accuracy of any part of the work are appropriately investigated and described.

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Tables

Table 1. Sociodemographic information

Participants Sociodemographic information	
Female Participants	N= 25
Age	22 – 38 (M = 31)
Marital status	
Married	24
Separated	1
Educational level	
Illiterate	12
Primary School	2
Intermediate	4
Lower Secondary	3
Quran School	4
Occupation	
Housewife	23
Employed	2

Table 2 not available with this version