International Journal of Art & Humanity Science (IJAHS)
www.ijahs.com Volume 4, Issue 1, (May-June, 2017), PP. 01-25

Women's Experiences and Reasons for Preferences to Home Delivery: A Phenomenological Qualitative Study in Tembaro District, Southern Nations, Nationalities and People's Region (SNNPR), Ethiopia.

[1] **Getachew Shamebo (BSc, MPH in HE/HP),** [2] **LAKEW ABEBE (MPH, Ass. Professor)**
[3] **MORANKAR SUDHAKAR (PhD**
gechsham1977@gmail.com
+251916840619

Abstract

Background: Homebirth is defined as women giving birth to a baby in their place of residence but worldwide women who experience childbirth at home are at high risk of approximately 60% of death, illness and delivery associated health squeal. Tembaro district is one of the districts in SNNPR, Ethiopia where in 2012/13 the majority (67%) childbirths were reported at home.

The objective of this study was to explore women's childbirth experiences and reasons for preference to home delivery from women delivered at home in Tembaro district.

Methods: a descriptive phenomenological approach qualitative study was employed by using an in-depth open-ended unstructured interview to examine women's home delivery experiences. Using combined maximum variation and stratified purposive sampling 22 women who delivered at home during January 2013 to February 2014 were recruited from 9 villages in Tembaro District, Ethiopia from March 2014 to April/2014. The interviews digitally recorded in local language (Tembaregna) was translated and transcribed verbatim into written English by the researcher. The transcripts were analyzed using Colaizzi's (1978) phenomenological method. The trustworthiness was checked by 4 women from the 22 participants and they approved that all the findings were reflecting participants' information.

Result: Seven cluster themes were identified: 1) Impacts of home delivery, 2) Beliefs and traditional practices, 3) Assistance of unskilled attendants, 4) Logistic related factors,5) Experientialelated factors, 6) Cultural or personal related factors, and 7) Trust to home birth. A woman might have more than two experiences and reasons for having a home delivery.

Conclusion and Recommendations: this study identified two emerged themes: **First, experience of women's** delivered at home, which have negative implications on both mothers and the newborns health and wellbeing; and the **second, reasons to having home delivery** were found driving women to give child birth at home. Further investigation is required for some of findings connected to unskilled attendants manipulations such as adjusting the positioning of the newborn, cutting cord with 'sorghum', using 'Woger' for obstructed labor, to expel placenta waist tighten with rope and moving ups and down were found not clearly described by participants.

Background

Homebirth is defined as giving birth to a baby in their place of residence and which can be planned or unplanned, attended by a midwife, physician or others such as family members or emergency medical technicians (2). Although, health facility delivery in Ethiopia is free and the benefits have been publicized uptake the majority of women expressed a preference for home deliveries (10).

Worldwide women who experience labor and delivery alone, with a family members, traditional birth attendants, community health workers, or other unskilled birth attendance occur at home and are at high risk of approximately 60% of death, illness and delivery associated health squeal (11). However, the amount of risk related to childbirth among developed countries compared to developing is very low (2%). For example in the US, about 98.7% of births were delivered in hospitals and only 1.3% of births that were delivered out of hospitals. The majority (98%) of childbirth risk is found in developing countries, where every year an estimated 60 million women give birth outside health facilities, mainly at home, and 52 million births occur without a skilled birth attendant (SBA) (12). Among these, the proportion of the poorest women reporting home delivery is highest in Sub-Saharan Africa(SSA), which is also the region with world's highest rates of maternal and child mortality (13).

Ethiopia is one of SSA countries where majority(90%) childbirth were reported still at home and assisted by non health professionals(TBA, relatives or alone) and only(10%) by skilled health professionals (14).

EDHS 2011 report shows that in the SNNRP region the proportion of births assisted by a skilled provider were only 6.3 percent and 93.5% delivery service were given at home (14).

Tembaro is one of the districts in SNNPR, Ethiopia where in 2012/13 the majority (67%) childbirths reported were not assisted by skilled birth attendants (15).

This study tried to attempt women's experiences and reasons for preference of homebirth issues in detail in Tembaro district

1.2 Problem Statement

Maternal mortality is unacceptably high and about 800 women die from preventable causes related to pregnancy- or childbirth-related complications around the world every day. Out of which 99%, all maternal deaths occur in developing countries and more than half of these deaths occur in sub-Saharan Africa. Maternal mortality is higher in women living in rural areas and among poorer communities where most of women childbirths are at home and they are attended by unskilled health professionals. Most childbirth at home are related to the complication like severe bleeding after birth that can kill a healthy woman within two hours if she is unattended (16).

Thus, to reduce these problems currently WHO recommended all delivery services to be attended at health facility by skilled birth attendants. However, almost 60 percent of African women give birth without a skilled attendant and 18 million a year at home during last 10 years (17).

Similarly, in a study conducted in Nepal indicates among 94.7 percent delivered at home with no trained assistance, 114 women were brought to the hospital after home delivery, majority of the women (72.8%) were brought with retained placenta or excessive bleeding. Whereas, manipulations at home by unskilled attendants include abdominal pressure, pulling the cord, tying heavy objects in the cord for traction etc. were done (18).

Recent study in Ethiopia by Shiferaw et al. (2013) showed that only 16% of deliveries were assisted by health professionals, while a significant majority (78%) was attended by traditional birth attendants (19). Hence, most of home deliveries may be exposed for complications related to childbirth due to some reasons like lack of skilled manpower and inconducive home environment. This was indicated by study in Gondar, Ethiopia by Worku (2013) that experiences of complications among 1,668 eligible women about 476 (28.5%) of women were reported that they have some kind of complication related to childbirth. The most common reported complications were excessive bleeding (58.4%), and prolonged labor (23.7%). Thus, this shows that nearly half of the women who faced complications are reported outside health facilities at the time of obstetric complications (20). Therefore, it seems in Ethiopia maternal and newborn health are questionable especially at the time of delivery because home births are high (90%) (21).

The Federal Ministry of Health in Ethiopia (FMoH) aims for 40% of deliveries to be attended by a skilled attendant by 2015 (21) and currently required zero home delivery; which is very far to accomplish with this similar conditions.

In the Tembaro district, the delivery services out of skilled birth attendants supported in 2012/13 was around 67% (15). This indicates that still some women are at risk of complications related to childbirth. Due to the lack of studies on women's views and the reasons why women prefer home for childbirth was not addressed so far. Perhaps, it seems home delivery remained the normal place of option. Despite, both trained and untrained TBAs are assisting at delivery services in home level in the study area, which may have its own impact to influence

women's decision of delivery place and it has its own side effects due to lack of any delivery care materials for TBAs at hand and their inadequate skill to manage. Hence, the risk of untrained birth attendants' assistances may be higher due to their unskilled support in addition to their lack of delivery materials and inconducive home environments. Evidences showed that many of women delivering at health facility after delay at home by the TBAs and may be exposed to some complications related to childbirth. If they brought to health facility immediately after first initiation of labor, it can be preventable and manageable through assistance of skilled birth attendants. Here, TBAs may be more expected to assist laboring mothers in referring on time to facility and giving information to go all deliveries to facility to be assisted by skilled attendants. In developing countries especially in rural communities it is known that home is not safe place for delivery and not accessible for care of mothers and newborn. Since, women's childbirth experiences and reasons for preference to home were not addressed in the study area previously. This study uses as the baseline source for other studies on home delivery practices and experiences of women delivered at home in Tembaro District. Some of the ongoing interventions /strategies regarding maternal and child morbidity and mortality in the health service delivery system at National, Regional and district level like free delivery service at facility, provision of Ambulance to solve transportation shortages, construction of emergency medical obstructed labor care facility like District Hospital, training of emergency surgery health professionals, and upgrading of HEW to community midwifery are on the way of implementation. These helped to reduce some of childbirth related complications but this study indicated that still some women with normal delivery cases preferring homebirth due to some factors such as harmful traditional beliefs and practices, cultural or personal and preference of TBAs and home level family supports. Hence, despite the above strategies implemented and under the way this study contributed to investigate women's childbirth experiences and reasons for preference to home delivery will help for the application of appropriate interventions and solutions on delivery services on the study area.

Methods

5.1 Study Area and Period

The study was conducted in Tembaro district, Southern Nations, Nationalities and People's Region (SNNPR), Ethiopia from March to April 2014. Out of the four health centers under Tembaro district, the catchment area of all health centers was included. Tembaro district is one of the eight districts in Kembata Tembaro zone, which is located in SNNPR. It is one of the districts in which a total of 129,421 population lives and its main town is Mudulla. It is far from Addis Ababa, Hawassa and Durame 400km, 185kms, and 60kms respectively. It is bordered: by North Hadiya zone, West Omo river, East Hadero Tunto Zuria District, South Wolaita zone. In Tembaro district there are a total land area of 27,917 Hectare, 20 rural and 3 semi-urban kebeles; 20 health posts, 04 health centers and 04 Private health facilities are found. The overall potential health coverage of the district is 80%.

5.2 Study Design

Qualitative study design, using descriptive phenomenology, was employed to explore and investigate women's childbirth experiences and reasons of women delivered at home. It was preferred for data collection in that it gives the ability to collect accurate data and provide a clear picture of the phenomenon under study. Hence, once a Husserlian descriptive phenomenological philosophy was followed as a basis for a phenomenological theory of science, in order to achieve rigor both the data collection and the data analysis was followed the same approach (49,53).

5.2.1 Appropriateness of Phenomenological Approach

Phenomenology focus on an individual experiences, beliefs, and perceptions; and text used as a proxy for human experiences. It also focuses on the processes and experiences one goes through the study of phenomena or the things we experience and the ways we experience such things. Experience is a complex concept and not directly observable by an external observable. It may be difficult to study such a complex experiences in a concrete way because it is subjective. However, inter-subjectivity is often used as a mechanism for understanding how people give meaning or interpret their experiences. In addition to, choice of an appropriate phenomenological research method underlying philosophical tenets of Husserl's descriptive phenomenology is found vital to the credibility of the nurse interested to understand how nurses make meaning of their experience of being in nurse patient interactions, nursing and health sciences. Hence, phenomenologists are interested in how people put together the phenomena they experience in such a way as to make sense of the world and develop a worldview. They assume commonality in human experience and focus on meaning making as the essence of human experience. In general phenomenology is a highly appropriate approach to researching human experience; and as a research method, it is a rigorous, critical and systematic investigation of phenomena (53).

5.3 Study population and recruitment

The researcher recruited 26 participants consisted of the population of women who delivered child at home from the four health center catchments in Tembaro district once they agreed to participate, before one week of the interview to prepare them for the actual meeting and to answer any preliminary questions. The researcher conducted the recruitment process after discussing with the HEW and leaders on the eligibles selection criteria in each of the selected kebeles.

5.4 Inclusion and Exclusion Criteria

5.4.1 Inclusion Criteria

The criteria for inclusion were women:

-who delivered at home from January 2013 to February 2014 period

-residing in Tembaro district for at least 6 months and

-Age between 15year to 49years (childbearing age groups) was included.

5.4.2 Exclusion Criteria

Eligible participants in the inclusion criteria, who were very sick or not in condition to give interviews were excluded.

5.5 Sample size determination, Sampling Technique and Procedures

5.5.1 Sample size determination

In this research the adequacy of the sample was attained when sufficient data had been collected so that saturation occurs and variation is both accounted for and understood. According to Polkinghorne (1989) for phenomenological studies saturation means that no new or relevant data seem to emerge regarding a category, the category development is dense and the relationships between the categories are well established (54). Among the 26 recruited participants 22 of them were sampled when

saturation was achieved. The saturation of data was identified because both the data collection and analysis were done simultaneously. After each data collection, there was transcription and read and re-read to extract significant statement. Therefore, this process enabled to get data saturation easily.

5.5.2 Sampling Technique

A combination of stratified purposeful and maximum variation sampling technique was used. Stratified Purposeful Sampling was used in order to obtain the eligibles from different health center catchments, for dividing the district into four health center catchments stratification; then purposefully kebeles were selected from each catchment and eligible participants selected using maximum variation sampling from each selected kebele. Such both sampling techniques aimed to include those eligible participant women from different geographical location, high number of delivery at home, age variation, etc. within the district. Therefore, inclusion of participants from different health center catchment kebeles was used to enhance the essence of the phenomenon (home delivery) that occurs within the District. This was according to Patton (52), a maximum variation sampling technique together with stratified purposeful sampling techniques was used to obtain diverse participants and identifying important common patterns among diverse participants on home delivery.

5.5.3 Sampling Procedure

Before participant selection and data collection ethical clearance was obtained by consulting, discussing and seeking advice from woreda focal persons like woreda council office and health office. Sampling frame indicated in table 3, was used for the selection of kebeles and based on it 09 kebeles were selected from the four catchments. At kebele level, the issue was discussed together with health extension workers and leaders of kebele for participant women selection based on some criteria (distance from nearby health facility, number of having home delivery, eligible group and in condition to explore rich information) were taken into consideration. Then, eligibles participants, who were willing to participate and getting consent, two to three from each kebele were selected purposefully and used for data collection. Women selected from the nine kebeles were interviewed in their home. This enabled women to freely describe their history of experiences and reasons for preference to home delivery.

5.6 Data Collection Method and Process

The data collection process was done using an in-depth interview guide with open-ended questions. The in-depth interview was done after receiving approval and getting individual consent. The researcher was engaged with participants posing questions in a neutral manner, listening attentively to participants' responses and asking follow up and probes questions based on participants' response. The interview was conducted face to face and was involved one interview with one participant at a time. The place of interview was in their home which was decided with participant's interest in order to obtain rich data on the way of safe environment. Initially data collector-participant communication was open in order to gain access to the participants' reality and for encouraging participants to tell their story of experience. The eligible women were interviewed what they experienced and the reasons for preference to home delivery. They were preferred because first person reports of life experiences are what makes phenomenological research valid and experiences cannot be felt to be known in advance or felt to be known by other person rather than experienced. For each participant the interviews were conducted at the range of 30 to 45 minutes. All interviews were digitally recorded and transcribed verbatim by the researcher in English. The interviews were conducted by researcher in translating

to local language, Tembaregna, using the English version open-ended interview guide. Permission was obtained from participants for audio-recording of interview guide. In addition to, short field notes were used for non-verbal (facial, head nodding, etc.) expressions as a means of data collection through active interaction with researcher-participants (57–59).

5.6.3 Data Collection Tools: In-depth interview guide

Open-ended questions were preferred because it will supply a frame of reference for the participants' answers. Based on the research question probes and follow up questions were used to gain an in-depth understanding on the topic of the study. Streubert Speziale and Carpenter stated that a descriptive method in data collection of a qualitative research is central to open-ended unstructured interview investigations (53).

The following four major and probing questions were used:

1. Would you describe your history of delivery experience in as much detail as you can?

-What were your specific examples of childbirth experience?

-Would you tell me about a time you first experienced childbirth?

-Would you tell me some community practices applied during delivery?

2. Can you tell me your decision making for delivery place during delivery?

-Can you tell me specific examples in your decision for delivery place?

-Would you share me your family support during decision of delivery place?

3. Would you tell me about the services provided by the birth attendants during delivery at or facility?

-Can you tell me some activities performed by birth attendant services?

-What are the obstacles you faced in using birth attendant services?

4. Would you tell me your justifications for preferring to home delivery?

-Would you tell me your preference to home for delivery services?

-Would you tell me the obstacles you thought in preventing facility based delivery services?

5.6.4 Pre -test

A Pr -test was conducted with two mothers separately to refine the question. The question was asked to two mothers (who were delivered at home and residing in neighboring district (HaderoTunto zuria)) to reduce information contamination and the interview was conducted as planned. The reason was to see whether the question was clear to the mothers and whether the interview developed as planned. The mothers understood the question and the interview went well, so no changes were made to the question and interview procedure.

5.7 Data Management and Analysis Procedure

Each interview (tape records) including field notes was translated in to written form texts and transcribed.

Schools of Phenomenology have developed different approaches to data analysis. Three frequently used methods of data analysis for descriptive phenomenology are the methods of Colaizzi's (1978), Giorgi (1978), and Van Kaam (1966). Colaizzi’s method was applied in this study because it allows the researcher to use a structured approach to data analysis and to expand their understanding of the meaning within the participants' responses. In addition, Colaizzi’s analysis strategy is a well established and proven method that has been used extensively in qualitative research literature (60). The rigorous analysis of the descriptive

phenomenological investigation by Colaizzi's method of data analysis was preferred to be an appropriate method for this study with its focus on finding the essence and expanding meaning of the experience of women's in home delivery. This method consists of six steps: dwelling with the data, extracting significant statements, formulating meanings into clusters or themes, creating an exhaustive description of the phenomenon, and reducing the description to a statement of the fundamental structure of the phenomenon (61).

Based on the Colaizzi's method of qualitative data analysis processes, the seven steps followed were: Each participant's transcript was read by the researcher to achieve a deep understanding of the description and make sense of it; Each individual transcript was reread by the researcher and 87 statements that directly relate to the phenomenon under investigation were extracted; 87 Formulated meanings of each significant statement were created; The researcher repeated these steps for each transcript and then aggregated formulated meanings into clusters of themes, 7 themes were identified and an exhaustive description was developed, (6) The essential structure of the description of the experience was identified. Finally, the essential structure was validated by the 4 women participants selected purposefully from 4 health center.

5.8 Strategies for Maintaining Trustworthiness

By its nature, a phenomenological study is associated with description and verbatim quotes utilized in reports of the findings to further enhance credibility. The participants of this study were included because of their home delivery experiences. In order to attempt the required high quality of the study findings maximum efforts were made to improve trustworthiness (62).

To enhance trustworthiness of this study the following points were maintained: Interview responses were checked by the members of the study to ensure truthfulness of the study findings from the participants' point of view to enhance credibility; Understandings were compared with similar studies done before to check its applicability; All participants were seen equally by using a similar guide and approaches. Oral recorded and the transcribed texts were compared to ensure their consistency that the way and their interpretation were actual, similar and not fabricated; Blind reading of the interview texts was done by Medical doctor working at Mudulla health center, which is in Tembaro district (who have no connection to the study setting where the research occurs) to be free of biases. This was done to enhance neutrality

In addition, the researcher bracketed consciously previous concepts and understandings in order to understand, in terms of the perspectives of the participants interviewed regarding the topic of interest in this study (1).

Validation of the findings was done in order to ensure whether the findings reflect the study of interest from the point of participants view. It was done through the method of Colaizzi's data analysis strategy, which is the only phenomenological analysis that calls for the validation of results by returning to participants ascertain their answers to any questions needed to be rectified, and ensured that the researcher has not misinterpreted the data (61).

For the validation process, 4 participant women selected purposefully from twenty-two participants reconfirmation from them obtained and the final themes and their aggregated respective issues translated to local language (Tembarigna) verbally by the researcher for making clarity of written English text (which may be difficult to understand easily for them) were read by the author to the 4 women to verify the findings may reflect the participants point of view or not. They approved all findings and included no additional points were to the study findings.

5.9 Ethical Consideration

After approval of thesis proposal, ethical clearance was obtained from Research Ethics Committee of Jimma University, College of Public Health and Medical Sciences; and support letter was obtained from relevant respective bodies SNNP Government States Regional Health Bureau, Kembata Tembaro Zone Health Desk and Tembaro District Health office accordingly. Written consent was obtained from participants and a copy of signed was given after they were informed about the study and their right to withdraw from the study any time they wished too. Anonymity and confidentiality ensured by not using the real names of the participants, in order to prevent emotional harm. Permission for audio recording was obtained from the participants. Field notes and tape recordings will be kept under lock and key for three years and more in the Department of Health Education and Behavioral Sciences, College of public Health and Medical Sciences, Jimma University.

5.10 Dissemination of the Study Findings

The study findings will be presented, communicated and approved in the Department of Health Education and Behavioral Sciences, College of Public Health and Medical Sciences, Jimma University. Then, it will be disseminated to the relevant organization that can make use of these findings, including the Regional Health Bureaus, Zonal Health Desk, and Districts Health Offices, Health institutions, Community leaders & relevant non-government organizations. Finally, the study will be published in the International Public Health Journal.

5.11 Researcher's positionality, reflexivity and Roles

5.11.1 Researcher's positionality and reflexivity

Researcher's positionality includes attention to assumptions researchers have about the topic, their relationships to the topic, and reflexivity about their own identities and/or feelings connected to the topic. Our attention to issues of power and positionality in order to address the silencing of underrepresented groups. Such work reminds us that the ways in which we represent the participants of our studies and ourselves as researchers within our studies, matters (63).

Researcher's epistemological position regarding this study, he placed himself in an interpretivist paradigm, while ontologically he would say he was a relativist. Here, in this study his perceived identity as a university researcher, not as a district health office staff, was appeared to make participants feel safe to express their views. In the information sheet, however, the researcher's background as a health professional was fully disclosed and therefore there was no deception. Since in most qualitative research, health professionals conduct research as a means to understanding a health, as well as for developing their profession and improving health care. Researcher believed that his background as a health professional enables him the conduct of this study on women's home delivery experiences through qualitative health research; and helped him to gain knowledge working with women, their knowledge and perspective expand from health professional closeness and care provider role (53).

5.11.2 Role of the Researcher

As being the researcher of this study, researcher's background was BSc in Environmental health. The aim of current study was to explore women's childbirth experiences and reasons for their preference to home delivery. He believed and appreciated that lessons obtained from the study memorized my awareness, knowledge, and sensitivity to the issues being addressed and assist me in working with the participants of this study. He recognized and made open the need to the thoughts and opinions of participants and set

aside my experiences in order to understand and not to interfere preconceptions to those of the participants in the study (1). Therefore, the researcher as being human instrument an iterative and active communication were made through the data collection period in order to obtain rich data on the topic of this study.

Results

The analysis is presented under the two headings: (1) Demographic Characteristics of the Participants and (2) Analysis of the verbatim of Participants

6.1 Demographic Characteristics of the Participants

Twenty two women, who delivered at home in Tembaro District, were interviewed. They were aged between 24 and 36 years (mean age 29). All of them were not employed. Among all the current occupation of all of them was house wives and only three of them were participated with small additional trading activities. Among all women participated, eighteen women had given birth only at home and four both at home and health facility. The average time length of the interview was from 30 minutes to 45 minutes. Table 1: Shows a summary of the Characteristics of the study population gathered during the interviews.

6.2 Analysis of the verbatim of Participants

The Themes were identified from the data collected using in-depth interviews on women's delivered at home and analysis done by Colaizzi's Method of analysis Strategy. The data collected regarding home delivery care services in nine kebeles of Tembaro District.

Two major themes were emerged: 1) Experiences of home delivery and 2) Reasons for having a home delivery. Subcategories for the experiences of home delivery: 1) Impacts of home delivery, 2) Beliefs and traditional practices, 3) Assistance of unskilled attendants; and another subcategories under theme of reasons for having a home delivery: 1) Logistic related factors, 2) Experiential related factors, 3) Cultural or personal related factors, 4) Trust to home birth. A woman might have more than two experiences and reasons for having a home delivery. Figure 3, illustrates the summary of these themes, their categories and subcategories.

6.2.1 Women's home delivery experiences

This study showed that there were three sub themes emerged which are related to home delivered women's experiences: Impacts of home delivery, Beliefs and traditional practices and Assistance of unskilled birth attendants.

Theme 1: Impacts of home delivery

Some impacts of home delivery such as exposed for unskilled attendants, delivery alone, prolonged labor, placenta prolonged to expel, high bleeding, and abdominal pain more than a week, and unhygienic environment were mentioned by participants.

Women may give birth at home but there were no any health care supports that give immediate relieve. Hence, a woman has no option to be assisted delivery instead anyone who may be unskilled birth attendants can help her.

"But in my latest childbirth I delivered at home alone and later my sister (she has no training of how to help delivering mother) came and cut cord with new blade."

(A 30 years illiterate woman from Durgi Kebele)

Participants indicated that most of time after home delivery high bleeding and abdominal pain exceed a week.

"High bleeding continued up to a week and abdominal pain present throughout that week."

(A 25 years woman not completed grade from Belella Kebele)

Sometime at home delivery labor prolonged more than a week and placenta also may be prolonged additional days to expel or after childbirth normally placenta may be left long time to be expelled out. Due to such cases, women suffer a challengeable life times that can be immediately managed at facility level.

"Yes, I can tell you the truth. In my former childbirth I delivered at home but after the newborn come out, the placenta left long time to expel and later I was then taken to health facility."

(A 25 years illiterate woman from Durgi Kebele)

Sometimes home delivery impacts are very worst because it causes to lose the life of both newborn and mother's. For example, one woman wept due to reminding her bad experience and loss of child at home birth and expressed her emotional feeling.

"The newborn was died as well as I was sick and my thigh deformed when delivering child at home."

(A 30 years illiterate woman from Durgi Kebele)

According to some women delivery at home sometimes is in a poor hygienic condition of the home environment. This may be caused due to lack of timely preparation for delivery services and some inconveniences at home.

"Of course, no one helped me when delivering this child and just I laid down the sacks on the floor and the child was born there."

(A 27 years woman not completed grade from Ferzano Kebele

Theme 2: Beliefs and Traditional Practices at home delivery

As described by the participants some of beliefs and traditional practices such as preference to male child, birthing near to fire, delayed mothers bathing, delay to clean bedding, traditional practice to expel placenta, removal of colostrums and protecting some foods such as milk for delivering mothers were connected to practices after home delivery.

Woman described that they were giving birth at home in the place which was adopted to live and considered better to get desired option. For instance a woman reminded her previous traditional way of food preference after birth at home and assumed changing that trend may cause as abdominal pain.

"I followed my previous first child delivery trend of eating first time food types after delivery, I had trend of drinking muki (type of soft food made from cereals and fed after delivery) and hot coffee so I utilized it. If this was changed it causes abdominal pain for me."

(A 26 years woman not completed grade from Samen Ambukuna Kebele)

Some mothers responded that although their bedding material were temporarily prepared and have during delivery believed to be exchanged only after 'Wobatta' (mother celebrating day which is dependent on the sex of newborn that means if the newborn was male fourth day and females third day celebrated). Thus, they were considering their traditional practices but not about the hygiene of bedding which were believed to exchange only after their ceremony. Depending on their beliefs and traditional practices women were comparing the advantages of home birth as overweighting of the facility birthing such as at home person assisting them is familiar, desired food obtained, no same bed problem and wishing family support were seen traditionally accepted.

"Firstly, starting at the date of delivery 'bulae genfo or muki' should be used until three days. Then after 'adja or gebs genfo or muki' should be eaten up to five days. Enjera or other cereal foods can be started after fifth or sixth day of the delivery. This is just to thinking of blood clotting for delivered mothers. If the mother started just on the day

of delivery thought that she may be exposed to diarrhea."

(A 32 years woman not completed grade from Belella Kebele)

Woman experience in delivering at home is also accepted in spiritually that as it will help them without going to health facility. They believe in what they experienced before and what heard from their grandmothers. The study participants' described their preference to give birth at home due to their traditional practices of eating locally accepted trend. They noted that even though, they seem perceived threats of home births, did mostly what they believed and practiced in their previous way. Some of respondents indicated that still women delivered at home practice as traditionally such as they remove the colostrums part of breast milk.

"Laughed! After we drunk the coffee within a short hour the baby fed breast milk after removing the first part of breast milk because it causes newborns to be abdominal pain."

(A 27 years woman not completed grade from Ferzano Kebele)

"When we were delivering at health facility many health workers can touch the laboring mother, and any foods necessary for enhancing labor can't be provided. This is not good for me; I heard it from other women who delivered at health facility. Also a woman told me that they can lay us without any clothes at bed in which many other mothers delivered on it. So I don't want to be lonely during the labor at health facility."

(A 25 years woman not completed grade from Belella Kebele)

Theme 3: Assistances of Unskilled Birth Attendants related to home birth

Participant women revealed that experiences of most women delivered at home were assisted by any person who was present during laboring (Even if the person may be skilled has no care materials and unhygienic environment). Unskilled birth attendants may not know what to help and how to help laboring mother (it has double problem).

Some women described that their experiences at home by unskilled birth attendants made on them was worst. They complained that some traditionally experienced persons used such as forceful manual technique, rubbing abdomen and using butter during delivering. Hence, due to this malpractices some newborn was died, and mother were exposed for deformity. Yet some of women living in rural areas with low economic status were using 'Woger' for obstructed laboring mother which was very life threatening assistance on delivery services by traditionally accepted people who have no scientific knowledge.

"Worried! Hui it was very bad to memorize again! In my previous birth I faced a problem. In that case, there were ... faced birthing problem and also I ...with local traditional assistant using forceful manual technique.... He used forcefully by piercing the newborn head with local farm instrument "Woger' (Ethiopian plough instrument used for farming) that means the child was died, and I was exposed to temporary thigh deformity but ...healed. Because when I gave childbirth at home ... TBA helped me by rubbing my abdomen and using butter for lubricating ... easily."

(A 30 years illiterate woman from Durgi Kebele)

According to some respondents, in home delivery, sometimes labor prolonged to expel more than three days at home after the newborn was delivered. Hence, traditional birth assistant applied his mal-technique for enhancing placenta expel such as tightening waist with rope, other people nearby move the delivered woman up and down frequently, where no one certain whether the placenta expel or not but the client become weak and relieved near to expire.

"Okay, in my former childbirth, the labor stayed three days and then after much challenge the child was delivered. Also the

placenta took long hours and after then just to enhance it my waist tighten with rope and people were lying down and up me frequently. In that time the placenta dried and removed after a long time. I was exposed to high risk and only few minutes left for me to expire."
(A 36 years illiterate woman from Gaecha Kebele)

Participant women described that still traditional birth attendants during labor at home were doing beyond their capacity such as adjusting the position of the newborn in the womb, rubbing abdomen, make to delay at home and applying some kind of lotion. They also suggested that placental cord cut was practiced with local material like stem of sorghum used, which was adopted from the elder women's.

"My husband mother cut the cord with what is known in our community with stem of sorghum outer cover 'beshinki ageda' because we learnt such trend has no any risk. Hence, I got such local material for cutting prior to my laboring put in the box to take it as the newborn was born."

(A 32 years woman not completed grade from Belella Kebele)

6.2.2 Reasons for preferences to home delivery

Theme 4: Logistic related factors

Participants described that their preference to home birth were related logistics issues such as people carry cost, perceived threat, weak delivery management, lack of access, low awareness, bad topography, difficult road, lack of facility delivery practice, fear operation, HEW not ready, lack of delivery bed, low economic, lack of health education were categorized to either facility side or community side related.

Logistic related factors affecting delivery services from facility side such as bad health workers approach, bed problem, etc. were mentioned by the participants.

Sometimes health workers missed diagnoses mentioned as one of the reasons to prefer homebirth. For instance, a woman returned back to her home when health workers ordered to come back after a week but she gave birth as she arrive her home within same day. Due to such cases that created those not to be satisfied by the delivery services provided by health workers instead fix their decision not to go facility again for delivery services utilization.

"At health center, health workers laid me down on the examination table and examined and said that as the time is not arrived and yet it may take too many days..... but after reaching home in the morning of that night just at 10:00AM the child was born in my home normally."

(A 36 years illiterate woman from Gaecha Kebele)

Also from facility side such as health extension workers didn't stay at health post at night, no delivery service started at health post and lack of regular health education program were some of reasons to prefer home birth.

"Because health workers serving at our kebele didn't arrange the place of delivery well and saying only we will arrange the delivering bed and we can be here even at night. Therefore, they were not at health post during my laboring time and then after God helped me to deliver well at home; and HEWs didn't give health education on delivery services except one day."

(A 30 years illiterate woman from Ha-Zembara Kebele)

Logistic related factors affecting delivery services from community side such as bad road condition, bad geographic location, lack of awareness, lack of access, low economic status, etc.

Low economic status of the society affects the choices of delivery services strongly. A woman described low economic condition as being made her decision for delivery

services to be at home even if she was referred to hospital for delivery complications to be delivered through operation. She justified her low economic status as influencing the decision of delivery service to be delivered at home.

"But my economic status was very low and my worry is if I made operation my children and husband fall to poverty so I don't do like this. Then, I decided to return back to my home to pray God and not to be made operation and then later I delivered at home normally."

(A 35 years illiterate woman from Bada Kebele)

Home place far from health facility was one of the reasons that cause women to prefer homebirth and decided to be assisted with community birth attendants. Also most women were interested when birth attendants assisted them at their home.

"Since, it is difficult to get health workers as we need to call our home and since our home was far from facility. Hence, community birth attendants are good for us."

(32 years illiterate woman from Farsuma Kebele)

According to some women, lack of facility delivery trend in the community and low economic status even women who were interested to go for facility delivery services will not be accepted by their community due to this unless there is difficulty in laboring they didn't intend to go health facility.

"I followed the experience of previous women in my neighbor where there was no trend of delivery to go health facility unless it becomes difficult. I was in fear of rumoring for normal delivery. Lack of income even if there was no payment for delivery service at health facility; money was required for people carrying to health facility."

(A 36 years illiterate woman from Bada Kebele)

Theme 5: Experiential related Factors

Experiential factors include factors related to previous facility or home delivery practices perceived on own or from others as a reason, reminding it to decide for the next birth.

Experiential related factors described in this study such as good previous experiences at home, sudden labor initiation, normal labor and position, labor at night, lack of HEW at night, health workers working behavior and so on were related as causes of preference to home delivery than facility.

Women when delivered at home having good previous practices don't feel fright and be confident to deliver again at home. For this reason they may not think to consider any risks related to delivery at home.

"Okay, as god helped me I delivered well at home. I have had thought to go health facility if labor stayed for long time but fortunately it was not become hard hence it ended for me at home level."

(A25 year's illiterate woman from Durgi Kebele)

"Okay, I will tell you the truth; I have similar experience in the previous childbirths. I didn't face any problems during and after my all childbirths at home."

(A 27 years woman not completed grade from Ferzano Kebele)

Similarly those women whose labor initiated and delivered within sudden condition, normal delivery and position also expected similar condition in their later deliveries and decide based on such situation condition to give birth at home.

"I preferred to deliver at home because laboring was not long and not difficult, labor started at night time; health extension workers didn't stay at night in the health post and lack of awareness."

(A 30 years illiterate woman from Ha-Zembara Kebele)

Some women perceived some conditions which may contradict facility delivery such as labor at night, lack of HEW at night, dislike health workers working behavior in their previous own delivery or from others may complain not to go for the next delivery services. In addition, women who hate some of health workers working behavior such as moving laboring mother within delivery room, despise to catch their body, beat laboring mothers and lack of responsibility at health facility were mentioned as causes for preferring home delivery.

"As labor started I ... but from the neighbor previously one mother went to there for delivery as labor started, for she it was the fifth child, health workers when supporting beat her and made very Silly approach, she returned ... cried after recalling back what was made on her and her body beaten was changed to wound. So thinking what was made on her, I felt fear and decided not to go health facility. I prayed for Allah. Just immediately after I prayed Allah helped and I delivered normally. At health facility there were no responsible bodies which make follow mothers on laboring."

(A 35 illiterate woman from Bada Kebele)

Theme 6: Cultural or Personal related Factors

Participants responded that many of cultural or personal related factors such as earlier delivery experience, uncertain of labor timing, decision left to husband, money required for carrying woman, lack of privacy at facility and public exposure at many beds in a room, ease of tension with family member, etc. were most of influencing women's decision of delivery place.

Some health facility related cultural or personal factors such as the presence of many delivery beds within one room, lack of privacy, lack of responsible person and lack of hot cooked food in health facility were mentioned as factors influencing decision of women for delivery place option.

Women are interested in their culture to protect privacy but in some health facilities it was not in such way. Hence, the presence of many delivery tables in one room and the presence of many people entrance to delivery room as a cause of disliking facility delivery. In addition, at health facility, due to hating of delivery tables and fear of support in hot cooked food were also justification for preferring home birth.

"Many beds within the same room in which People came for others' looks the whole other mothers' humanity and it were like big hall within one room six to seven beds were present."

(A 35 illiterate woman from Bada Kebele)

"Our humanity is protected well when we are delivering at home. This is not possible in health facilities because any person entering the room watches our humanity which is not good for me."

(A 36 years illiterate woman from Gaecha Kebele)

"Okay, I think all laboring mothers were laid down at the same delivery table which is very bad; and if labor stay long hours giving hot cooked food are not possible."

(A 28 years illiterate woman from Farsuma Kebele)

Participants described that community related cultural or personal factors such as lack of practices in the in going to facility for normal delivery services, hating of delivery bed, low economic status, work load at home, uncertainty to true labor and lack of family support, only husband has power of decision and so on were mentioned.

Due to the lack of normal delivery practices trend in going to facility even those women who had interest to facility fear of rumor influenced women's delivery choice delivery place.

" If home delivery would become difficult as the previous labor and childbirth, what will I do was my threat because I have fear of rumor from the society as I go on timely to health facility. Fortunately god helped me and I delivered in my home well without any problem."

(A 25 years illiterate woman from Durgi Kebele)

Due to their low economic status some women complained that even though delivery services at health facilities were free of charges fear of cost of tea/coffee for people carrying laboring mother to health facility or for those brought to health facility by Ambulance to return to home. Thus, they preferred to deliver at home.

"In fact, our low economic status was one the major contributor to decide delivery place. At facility level no payment requested for delivery services but cost for people carrying to health facility and for TBA during delivery services only 10ETB given for washing their hands, so it was little cost."

(A 30 years illiterate woman from Durgi Kebele)

In the study community some women perceived that as only husband has power of decision for all things in their home. Hence, women could not able to decide delivery place to be facility despite some complication and delay at home and will of husband's.

" Aheau! Not at all, my neighbors were not supporting me because my husband is not voluntary to take into health facility. Thus, I have no any power to decide. I cannot decide but only the husband has the chance and power to decide all things." (A 30 years illiterate woman from Durgi Kebele)

Other woman was justified for home birth as a main reason was her work load at home and time of labor started influenced decision of delivery place. Hence, their fear was if labor stays at facility what we could be.

"Of course, I had my own reasons to prefer home for delivery: the starting time of labor was not suitable for calling people to carry out to health facility; I had no potential to go health facility during the time of labor started; and I had work load and no one was present at home if I go there together." (A 32 years illiterate woman from Le-Zembara Kebele)

Theme 7: Trust to Home birth related Factors

Trust to home birth related factor includes those issues which have been believed most interesting by women's for giving birth at home.

Participants of this study described those factors related to trust for having birth at home such as good previous home birth practices, advantages in saving further expenditures related to childbirth, home birth as good for protecting privacy, support from TBAs' assistance and families supply desired food, wishing relatives, husband and religious members pray and so on were mentioned.

Due to good previous home birth practices in delivering at home in which our community accepts were very interested. Hence, having previous good birth experiences, women formed trusted in homebirth.

"Since I didn't face any problem at home, delivering at home was my best interest and I don't have any uncertainty with it." (27 years woman not completed grade from Ferzano Kebele)

Some women preferring home birth because of its advantages in saving further expenditures related to childbirth in health facility.

"As God helped me, no one delivers by force at any place so delivering at home saved: time, cost, and wastage of power expenditure of voyage on health HF for delivery."

(A 27 years woman not completed grade from Le-Zembara Kebele)

Most women described that delivery at health facility as not protected privacy well and due to this home birth were more trusted to protect our privacy. Also in home birth TBA assisted me well.

"Okay! When I was assisted by TBA in many of my delivering child in good condition which is very interesting for me. Because in health facility our privacy is not protected and any health professionals get enter and observe us. This is not good for me. Of course, I preferred TBAs during my delivering child because they are helping me in my laboring times by arranging newborns position, rubbing my abdomen, promoting me with creating conducive environment with my families, keeping boiled water for washing and so on."

(A 25 years illiterate woman from Ferzano Kebele)

Some of women justified as a reason for preferring home birth was due to preferring of support from TBAs' assistance and families supply desired food.

"Some of TBAs know how to manage and other doesn't know well. At home, family support by catching the laboring mother, hot foods can be cooked and given to facilitate labor... delivering in my home looks very interesting for me; better to get any interested food or support and family will be happier as I had been delivered at home."

(A28 year's woman not completed grade from Farsuma Kebele)

Some women described their trust to deliver at home because in home birth relatives, husband and religious members help by pray.

"When I was delivering at home, my relatives as well as husband support me. Religious group members pray for god to enhance my psychology strengths."

(A36 year's illiterate woman from Gaecha Kebele)

Discussion

Women's choices of delivery places were not merely limited by themselves. Despite, there are different factors influencing women's preference of delivery places and they have their own experiences through which they have been passed.

This study revealed that women delivered at home were mostly exposed to some impacts following delivery such as prolonged placenta expulsion, high bleeding and abdominal pain for more than a week, death of newborn, sickness and physical damages of mothers body, exposing mothers for unskilled birth attendants, delivery alone and delivery on unhygienic place. This study findings has conformity with other studies indicating that home delivery health risks associated with pregnancy and childbirth especially prevalent in the least developed and lowest-income countries, and among less affluent and marginalized families and communities everywhere (18,25)

According to this study most of deliveries at home were tied with some harmful beliefs and traditional practices such as delay on keeping hygiene of bedding (for both newborn and mother), birthing place on temporarily made near to fire (for both newborn and mother), and practices of discharging of colostrums' (for the newborn) are among all may have negative implication. Some of the findings are align to the previous studies conducted with similar settings (24,26,27,29)

Findings also revealed that most of women delivered at home were assisted by community birth attendants especially unskilled attendants were applying manual techniques for delivery services such as forceful using local material 'Woger' piercing the heads of newborn to deliver obstructed laboring mother; for delayed placenta expulsion tightening mothers waist with rope and moving delivered mother

upside and down; trying for arranging fetus position, rubbing abdomen and lubricating with butter; cutting placental cord with local material such as stem of Sorghum in Amharic Mashila ageda. These activities beyond the capacity of TBAs in that it may be threat for the life of both mothers and newborns. It needs further investigation for better understanding these practices. This idea is also supposed by the WHO in 1975 that TBAs found in rural areas of many developing countries are mostly elderly and illiterate due to this their assistance in delivery service follows traditional procedures (64). It is also supported by other previous findings (10,30,32)

In this study, the findings revealed that the major logistic related factors affecting delivery services are found both from community and health facility side such as from community side low economic status, lack of trend in facility delivery service in the community, and difficulty in geographical location as well as from health facility side:-some health workers' incorrect diagnosis for pregnant women advice to return back to her` home, some HEWs not staying at night at health post regularly, delivery bed destroyed and lack of regular health education in some villages. It has found similar support from the studies (14,19,25,35,36)

Study findings also suggested that some of women's reasons for preference based from experiential related practices and perceptions attained from their community they live. For instance, lack of awareness, fear of economic status, and hating health workers working behavior are found the major justifications for giving birth at home. These study findings are also supported in other studies (19,24,40,41)

In the community there are different cultural or personal practices which affect women's health. This study indicates that many cultural or personal factors are affecting women's delivery services utilization. Among all husband's and family influence, fear of cost for tea/coffee for people carrying, lack of privacy at facility level and lack of information related to delivery service payment are found the most frequently mentioned reasons. Some of these findings are also supported in the studies (19,42–46)

Childbirth is a natural occurrence in which most women need to give birth in their natural environment. This study indicates that women are trusted to give birth at their home due to many issues surrounding them. Among those, easy home birth experiences, liking support from TBAs at home level, wishing support from relatives, husband and family are some of points mentioned by the participants. This findings have also gain support from the previous studies (19,41,46,47)

CONCLUSSION

This study highlighted experiences and reasons surrounding women from those who delivered at home in Tembaro District.

This study revealed that the experiences of women delivered at home were mostly: exposed to some impacts of delivery at home such as prolonged placenta expulsion, high bleeding and abdominal pain for more than a week, death of newborn, delivery alone and delivery on unhygienic place; some of harmful beliefs and traditional practices were connected to home delivery due to this many women followed previous elder women unskilled way of practices both after and before birth at home; and women delivered at home were assisted by any person present during laboring or alone. In addition, some unskilled birth attendants are still doing beyond their capacity such as trying to adjust the positioning of the newborn in the womb, cutting cord with local materials like use of 'sorghum', using 'Woger' for obstructed labor, to expel placenta waist tighten with rope and also moving ups and down which were found negative implications on both newborns and mothers health.

This study also show that most of women delivered at home revealed that their preference to home birth was related to logistics factors both from the institutional and community related factors For example, health workers skill problem in diagnoses found reason to return back home and then give birth at home. The other finding of the study was that experiential related factors were the main factors that riding women to give birth at home. Thus, some of women justified their previous home delivery practice at home as a reason, looking it to decide for the next birth. On the other hand, cultural practices surrounding home delivery are found the main influencing factors for the decision of delivery place. For instance, most of cultural or personal factors for preferring to home birth such as husband's and family influence, fear of cost for tea/coffee for people carrying, lack of privacy at facility level and lack of information related to delivery service payment are found the major factors. The study findings also indicate that most women were trusted to give birth at home due to easy home birth experiences, liking support from TBAs at home level, wishing support from relatives, husband and family are also found reasons for preference to home delivery.

In conclusion, this study identified two emerged themes: First, experience of women's delivered at home such as impacts of home birth, beliefs and traditional practices and assistance of unskilled birth attendants; which have negative implications on both mothers and the newborns health and wellbeing; and second, reasons to home delivery such as logistic related factors, experiential related factors, cultural or personal factors and trust to home birth related factors; which are mentioned by the participants usually driving them to give child birth at home. Therefore, the findings provided new knowledge and understanding on women's homebirth experiences and reasons for preference to home delivery in a Tembaro district.

Abbreviations and Definitions of some terms used in this study

ANC -Ante-Natal Care

Bracketing is a means of demonstrating the validity of the data collection and analysis process through researchers putting aside their previous knowledge, beliefs, values and experiences in order to accurately describe participants' life experiences (1).

EDHS-Ethiopian Demographic and Health Survey

FMoH-Federal Ministry of Health

HE/HP-Health Education and Health Promotion

HEW-Health Extension Worker

Home birth is as giving birth to a baby in their place of residence and which can be planned or unplanned, attended by a midwife, physician or others such as family members or emergency medical technicians; it is considered risky place for childbirth related complications(2).

Home delivery assumed similar to home birth.

ID-Identification

Inter-subjectivity is the process of several, or many people, coming to know a common phenomenon, each through his or her subjective experience(3).

MDGs-Millennium Developmental Goals

MPH-Master of Public Health

Natural settings is the ordinary settings in which people live and work, and/or uses interviews that are designed to approximate to ordinary conversations in key respects(4).

Phenomenology is a qualitative study design that represents an approach to enquiry that emphasizes the complexity of human experience and the need to

understand that experience holistically, as it is actually lived(5).

Saturation is the point at which no further themes are generated when data from more participants are included in the analysis(6).

Skilled Birth Attendant(SBA) is a qualified health professionals(midwife, doctor, nurse or health officer) who has the skills needed to manage normal (uncomplicated) childbirth and the identification, management and referral of complications in women(7).

SNNPR-Southern Nations, Nationalities and people's Regional Government

SSA- Sub-Saharan Africa

Subjectivities-is describe the interaction of the researcher's subject positions that informs her/his study (8).

Traditional Birth Attendant (TBA) is a person usually woman with or without training, who has no qualified skills(not licensed) to assist a mother in a childbirth(9).

WHO-World Health Organization

ACKNOWLEDGEMENT

I wish to express my sincere gratitude and appreciation to Jimma University, College of Public Health and Medical Sciences, Department of Health Education and Behavioral Sciences that gave me the chance and financial support for conducting this study.

I would like to sincerely thank my advisors Lakew Abebe (MPH, Assistant Professor) and Morankar Sudhakar (PhD) for their critical comments, guidance, patience, encouragement and support which made it possible to complete this study.

I also wish to thank the following most sincerely:

Tembaro district council office and health office that permit to undertake this study under their jurisdiction and sharing necessary background information to develop the study setting.

My wife Rawuda Ali who encouraged me by sharing constructive ideas and supported me to work hard on this study.

My children Sadik and Yekina for their support and patience for the duration of this study.

All participants, the women, who voluntarily agreed to be interviewed, who delivered at home for their sharing precious information's regarding the study.

References

1. Chan ZCY, Fung Y-ling, Chien W-tong. Bracketing in Phenomenology: Only Undertaken in the Data Collection and Analysis Process? The Qualitative Report [Internet]. 2013;18(Article 59):2,5,6. Available from: http://www.nova.edu/ssss/QR/QR18/chan59.pdf

2. Rebecca Dekker. What is Home Birth [Internet]. Giving Birth Based on Best Evidence. 2012 [cited 2014 Feb 17];:1–2. Available from: http://evidencebasedbirth.com/what-is-home-birth/

3. Phenomenology Glossary [Internet]. [cited 2014 Jan 27];:3. Available from: http://www.sonoma.edu/users/d/daniels/phenomenology.html

4. Defining qualitative research [Internet]. [cited 2014 Jan 27];:8. Available from: http://www.bloomsburyacademic.com/view/What-Is-Qualitative-Research/chapter-ba-9781849666084-chapter-001.xml

5. McMaster University. National Collaborating Centre for Methods and Tools [Internet]. NCCMT Workshops and events across Canada. 2013 [cited 2014 Jan 27];:22. Available from: http://www.nccmt.ca/glossary/all_terms-eng.html

6. Glossary in Qualitative Research [Internet]. [cited 2014 Feb 25];:1, 3. Available from: http://www.kcl.ac.uk/library/nhs/training/glossary.doc

7. WHO/UNICEF. Home visits for the newborn child: a strategy to improve survival [Internet]. 2008. Available from: http://www.unicef.org/health/files/WHO_FCH_CAH_09.02_eng.pdf

8. Kakali Bhattacharya. Introduction to Qualitative Methods A Student Workbook. 2007.

9. WHO. ALMA-ATA Primary Health Care. 1978.

10. Ngomane S, Cur BA, Cur MA, Mulaudzi FM, Cur MA, Zhao Y. Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo , South Africa. Midwifery [Internet]. 2010;:6,10. Available from: www.elsevier.com/midw Indigenous

11. Martin JA, Hamilton BE, Ventura SJ, Osterman MJK, Mathews TJ. Births: National vital statistics reports [Internet]. Statistics. 2010;57(7):10. Available from: http://www.mendeley.com/catalog/national-vital-statistics-reports-births-final-data 2007/

12. Darmstadt GL, Lee ACC, Cousens S, Sibley L, Bhutta ZA, Donnay F, et al. 60 Million non-facility births: who can deliver in community settings to reduce intrapartum-related deaths? International journal of gynaecology and obstetrics: 2009 Oct;107 Suppl (00207292):1.

13. Montagu D, Yamey G, Visconti A, Harding A, Yoong J. Where Do Poor Women in Developing Countries Give Birth? A Multi-Country Analysis of Demographic and Health Survey Data. PloS one. 2011;6(2):6–7.

14. Central Statistical Agency [Ethiopia] ICF International. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Agency and ICF International: 2012.

15. Tembaro ditrict health office. 2012/13 Annual Health Service Report.

16. China. WHO-Maternal mortality: Fact sheet N°348 [Internet]. WHO Media centre. 2012 [cited 2014 Feb 8];:1. Available from: http://www.who.int/mediacentre/factsheets/fs348/en/

17. Luwei Pearson, Margareta Larsson, Vincent Fauveau JS. Childbirth care [Internet]. 2006;:1. Available from: www.WHO.childbirth care.pdf

18. H Tuladhar, R Khanal, S Kayastha PS and AG. Complications of home delivery: Our experience at Nepal Medical College Teaching Hospital. Nepal Med Coll J. 2009;11(3):3, 4.

19. Shiferaw S, Spigt M, Godefrooij M, Melkamu Y, Tekie M. Why do women prefer home births in Ethiopia? BMC pregnancy and childbirth. 2013 Jan;13(1):1, 5.

20. Worku AG, Yalew AW, Afework MF. Maternal Complications and Women's Behavior in Seeking Care from Skilled Providers in North Gondar. PLoS ONE. 2013;8(3):2–4.

21. Kok M, Herschderfer K, Koning KD. Technical Consultation on the

role of Community Based Providers in improving Maternal and Newborn health Report. 2012.

22. Ryan F, Coughlan M, Cronin P. Step-by-step guide to critiquing research . Part 2 : qualitative research. British journal of Nursing. 2007;16(12):739–40.

23. Elan McAllister. Guide to a Healthy Birth. 5th ed. New York: Choices in Childbirth; 2012.

24. Some TD, Sombie I, Meda N. Women's perceptions of homebirths in two rural medical districts in Burkina Faso: a qualitative study. Reproductive Health [Internet]. 2011;8(3):2,3, 4, 6. Available from: http://www.reproductive-health-journal.com/content/8/1/3

25. Unicef. The State of the World's Children 2009 Maternal and Newborn Health. New York: Jaclyn Tierney; 2009.

26. Mwanakulya E. Simfukwe M4-I. FACTORS CONTRIBUTING TO HOME DELIVERY IN KONGWA DISTRICT, DODOMA-SEPTEMBER, 2008. The Dar-es-salaam Medical Students' Journal. 2011;:6, 8, 20.

27. Sibley LM, Hruschka D, Kalim N, Khan J, Paul M, Edmonds JK, et al. Cultural Theories of Postpartum Bleeding in Matlab , Bangladesh : Implications for Community Health Intervention. Journal of health, population and nutrition. 2009;27(3):4–5.

28. Shah N, Rohra DK, Shams H, Khan NH. Home deliveries: reasons and adverse outcomes in women presenting to a tertiary care hospital. Journal of Pak med Assoc. 2010;60(7):3.

29. China. Study on Traditional Beliefs and Practices regarding Maternal and Child Health in Yunnan, Guizhou, Qinghai and Tibet [Internet]. Minzu, China; 2010. Available from: www.un.org.cn/cms/p/jointprogrames/84/1047/content.html.

30. Tsinuel Girma HN. ORIGINAL ARTICLE TRADITIONAL NEWBORN CARE IN JIMMA TOWN, SOUTHWEST ETHIOPIA. Ethiopiop J Health Sci. 2008;18(3):80–4.

31. Master T, Program IH, Kr G, Supervised G, Peterhans B. A critical appraisal looking at traditional birth attendants: their potential impact on the health of mothers and newborns in developing countries and the policy on traditional birth. 2009.

32. Falle TY, Mullany LC, Thatte N, Khatry SK, Leclerq SC, Darmstadt GL, et al. Potential Role of Traditional Birth Attendants in Neonatal Healthcare in Rural Southern Nepal. J Health Popul Nutr. 2009;27(1):55–7.

33. Boucher D, Bennett C, Mcfarlin B. Staying Home to Give Birth : Why Women in the United States Choose Home Birth. Journal of Midwifery & Women's Health. 2009;54(2):4.

34. Programme LL. Chapter 2 Logistics – Basic Concepts & Characteristics. 1996.

35. Crissman HP, Engmann CE, Adanu RM, Nimako D, Moyer CA. Shifting norms : pregnant women ' s perspectives on skilled birth attendance and facility – based delivery in rural Ghana. African Journal of Reproductive Health. 2013;17(1):1.5,6.

36. Alexandra Carter. Factors That Contribute to the Low Uptake of Skilled Care During Delivery in Malindi, Kenya. Independent Study Project (ISP) Collection [Internet].

2010;:18,19,21. Available from: digitalcollections.sit.edu/isp_collection/821

37. Rogers C. Experiential Learning [Internet]. Northern Illinois University, Faculty Development and Instructional Design Center; 2010. Available from: httpwww.niu.edufacdevresourcesguidestrategiesexperiential_learning.pdf

38. James Fieser. Experiential gnowledge [Internet]. From Great Issues in Philosophy. 2011 [cited 2014 Apr 27];:8. Available from: www.utm.edu/staff/jfieser/class/120/6-knowledge.htm

39. Vanphanom Sychareun, Alongkone Phengsavanh, Visanou Hansana, Vatsana Somphet SM. Cultural beliefs and traditional rituals about child birth practices in. 2009.

40. Annie M, Warren Charlotte. Taking Critical Services to the Home : Scaling-up Home-based Maternal and Postnatal Care , including Family Planning , through Community Midwifery in Kenya Frontiers in Reproductive Health , Population Council. 2008.

41. Titaley CR, Hunter CL, Dibley MJ, Heywood P. Why do some women still prefer traditional birth attendants and home delivery?: a qualitative study on delivery care services in West Java Province, Indonesia. BMC Pregnancy and Childbirth [Internet]. 2010;10(43):7–9. Available from: http://www.biomedcentral.com/1471-2393/10/43

42. V. Sychareun, A. Phengsavanh, V. Hansana, V. Somphet SM. Cultural beliefs and traditional rituals about child birth practices in Lao PDR. 2009;:24–7.

43. Sharma B, Giri G, Christensson K, Kv R, Johansson E. The transition of childbirth practices among tribal women in Gujarat , India - a grounded theory approach. BMC International Health and Human Rights [Internet]. 2013;13(1):1,6,7. Available from: http://www.biomedcentral.com/1472-698X/13/41

44. Chowdhury AH, Hasan M, Ahmed S, Darwin C, Hasan MS. Socio-demographic Factors Associated with Home Delivery Assisted by Untrained Traditional Birth Attendant in Rural Bangladesh. American Journal of Public Health Research [Internet]. 2013;1(8):1,2. Available from: http://pubs.sciepub.com/ajphr/1/8/6

45. Press D. Use of previous maternal health services has a limited role in reattendance for skilled institutional delivery : cross-sectional survey in Northwest Ethiopia. International Journal of Women's Health. 2013;5:1.

46. Mette Oxnevad. Perceptions and practices related to home based and facility based birth. A qualitative study from Agemssa, Ethiopia. 2011.

47. Marit TG JJ. Traditional and professional birth attendants' influence on women' s decisions of birth place and type of birth assistance: A qualitative study in Tanga District, Tanzania. 2010;(1):7.

48. Amol Bhattacherjee. Social Science Research: Principles, Methods, and Practices [Internet]. Book 3. USF Tampa Bay Open Access Textbooks Collection; 2012. Available from: http://scholarcommons.usf.edu/oa_textbooks/3

49. Reiners GM. Nursing and Care Understanding the Differences between Husserl's (Descriptive) and Heidegger's (Interpretive)

Phenomenological Research. Nursing Care. 2012;1(5):1–3.

50. Muhammad Farooq Joubish. Paradigms and Characteristics of good qualitative research.pdf. World Applied Sciences Journal. 2011;12(11):2.

51. Wahyuni D. The Research Design Maze: Understanding Paradigms, Cases, Methods and Methodologies. JAMAR. 2012;10(1):1–3, 4.

52. Interpretivist Paradigm [Internet]. [cited 2014 Jan 28];:1. Available from: http://www.qualres.org/HomeInte-3516.html

53. Magnus E. The Interview: Data Collection in Descriptive Phenomenological Human Scientific Research. Journal of Phenomenological Psychology [Internet]. 2012;43(1):3. Available from: http://www.mendeley.com/catalog/interview-data-collection-descriptive-phenomenological-human-scientific-research/

54. DW Brooks site. Chapter 3 Research design and methodology [Internet]. 2004. Available from: http://dwb4.unl.edu/Diss/Hardy/chapter3.pdf

55. Anthony J. Onwuegbuzie. A Call for Qualitative Power Analyses. Springer. 2007;41:9, 10.

56. Patton MQ. Qualitative evaluation and research methods (2nd edn.) [Internet]. Newbury Park, CA: Sage Publications. 1990 [cited 2014 Jan 24];:1. Available from: http://www.gifted.uconn.edu/siegle/research/samples/purposivesampling.htm

57. Al-busaidi ZQ. Qualitative Research and its Uses in Health Care. Sultan Qaboos Univesity Medical Journal. 2008;8(1):3,4,5.

58. Janice Morse. Qualitative Health Research: creating a new discipline. International Journal of Qualitative Methods. 2012;:28, 29.

59. Mottern R. Teacher-Student Relationships in Court-Mandated Adult Education : A Phenomenological Study. The Qualitative Report [Internet]. 2013;18(Art.13):7. Available from: http://www.nova.edu/ssss/QR/QR18/mottern13.pdf

60. Lockie BNM, Lanen RJV. Impact of the Supplemental Instruction Experience on Science SI Leaders. Journal of Developmental Education. 2008;31(3):2.

61. Gharibpoor M, Allameh SM, Abrishamkar MM. New Concept of Social Network Citizenship Behavior: Definition and Elements. Australian Journal of Basic and Applied Sciences [Internet]. 2012;6(9):6. Available from: http://www.ajbasweb.com/ajbas/2012/Sep%25202012/154-163.pdf

62. Mackenzie N. CLINICAL PAPER A phenomenological study of women who presented to a physiotherapy-led continence service with dyspareunia and were treated with trigger point massage. Journal of the Association of Chatered Physiotherapists in Women's Health. 2009;105:3.

63. Penny A P. Foundation of Qualitative Inquiry in Adult and Higher Education. 2012.

64. WHO. The Traditional Birth Attendant in Maternal and Child Health and Family Planning. Geneva: 1975.

SN	Type of HF available	# of HF
1	Health center	4
2	Health posts	20
3	Health posts under construction	06
4	Hospital under construction	01
5	Private health facilities	04
6	The overall Potential health coverage is	80%.
7	Health officer BSc in Nursing	09
8	Mid wife nurse	04
9	Rural HEWs	47
10	Urban HEWs	06
11	Health development army leaders	4174
12	Health development army followers	52614
13	TBA Trained	24
14	TBA not Trained	18
15	2012/13 Year total pop	129,421
16	Estimated pregnancy/3.6%	4,646
17	Estimated live birth/3.26%	4,219
18	Estimated deliveries	4,219
19	Women in reproductive age (15-49 years)	30,155

Table 1: Additional Background Information of the Study Area

ANC and delivery services Achievement in 2011/12		
1	Antenatal care first visits	129%
2	Antenatal care 4 time visits and above	77%
3	Delivery by SBA	33.4%
4	Delivery by TBA	30.1%
5	Delivery by HEW	36.5%