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ARTICLE

Perceived socio economic barriers to maternal health seeking behavior among rural women:
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Hayelom Abadi Mesele

Full Length Research Paper

Perceived socio economic barriers to maternal health seeking behavior among rural women: The case of Raya-Alamata District, Southern Tigray, Ethiopia

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Maternal health care service utilization is one of the components of the reproductive and child health interventions package with the aim of improving both maternal and child health. It is the health of the women during pregnancy, childbirth and postpartum period. Thus, the overall objective of this study is to investigate the perceived socio economic barriers to maternal health seeking behavior of rural women in Raya Alamata District. In doing so, the researcher employed qualitative methods substantiated by the quantitative data. In doing so, a sample of 359 HH units was selected from three 'Tabias' by using simple random sampling techniques. The qualitative data analyzed using thematic analysis whereas the quantitative data analyzed using descriptive statistics. According to the findings of the study, perceived social barriers such as shortage of qualified health workers, ill behavior of health workers, student's internship and poor quality of maternal health services influence the health seeking behavior of the rural women of the study area. On the other hand, the perceived economic barriers such as access to resources, working conditions and cost of transportation and medical treatment also influence maternal health seeking behavior of the women of the study area.

Key words: Antenatal care, delivery care, maternal health, maternal health seeking behavior, postnatal care.

INTRODUCTION

Maternal health care is the health of the women during pregnancy, childbirth and postpartum period which are crucial for the wellbeing of a mother and new born baby (WHO, 2008). It is one of the components of the national package of essential reproductive and child health interventions package focusing on improving quality of life of women and adolescent mothers (Tanzania Ministry of Health and Social Welfare, 2011). Moreover, health seeking behavior is any activity undertaken by individuals and they perceive themselves to have a health problem

or to be ill for the purpose of finding an appropriate remedy (Ward et al., 1997). It is situated within the broader concept of health behavior, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a state of good health (WHO., 1995). Besides, health seeking behavior involves identification of pathways to the formal health care system, often commencing with home care and traditional healers and extending to the formal system, pathways differing according to the

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presenting condition (MacKian, 2003). Along with this, maternal health-seeking behavior is the process and intention of consulting a physician during the prenatal, delivery and postnatal period, especially when disease symptoms are apparent (Caldwell, 1983).

Recent studies show that knowledge about health seeking behavior is essential for the provision of need based health care delivery to any population (Rahman et al., 2011). For example, planning for health care services provision depends on the health needs and health seeking behavior of the population. Thus, determining the health seeking behavior is essential to provide need based health care services to the population (Chauhan et al., 2015). The existing literature on maternal health seeking behavior can be categorized into two; those who studied the issue from an economic point of view and those studied from socio-cultural viewpoints. The first category focuses on economic factors such as income, insurance, cost and availability of medical care (Stekelenburg, 2005).

Besides, lack of money for treatment, costs of transport; formal and informal payments (Ajaegbu, 2013; Reuben Mahiti et al., 2015); and large family size, jobless, unnecessary expenditure on health services; and insecurity, lack of food at home and health facilities, poverty were identified as economic barrier (Lama and Krishna, 2014; Wilunda et al., 2014). These studies showed that poor economic circumstances affect health throughout life (Wilkinson and Marmot, 2003). Therefore, poorest women are generally least likely to use maternal health-care services (WHO, 2009) because of their inability to cover cost of treatment, transport, and other out-of pocket expenses (Yalem, 2013).

On the other hand, the second category focuses on the socio-cultural factors and traditions that affect maternal health seeking behavior. These studies indicate that in the developing countries like Ethiopia, the problem of cultural interference on maternal health has become a catastrophic problem, especially in rural areas (Shole, 2015) and often leads to self-care, home remedies and consultation with traditional healers in rural communities (Nyamongo, 2002). Likewise, Zenebe (2016) found that different cultural malpractices during pregnancy and childbirth affect the maternal health seeking behavior of mothers in Ethiopia.

The issue of maternal health seeking behavior has attracted the interest of some researchers in Ethiopia. Yet the amount of researches and the knowledge obtained from those researches do not suffice to explain the perceived socio economic barriers to maternal health seeking behavior. Furthermore, a critical look at the findings in Ethiopia showed that they mainly concerned with identifying biological aspects that affect maternal health care service utilization. On the other hand, investigating the traditional maternal health beliefs and practices in inclusive manner has been given little emphasis. Moreover, health care seeking behavior as

many studies indicate are cultural systems-they are culturally constructed and can only be understood in the context of the wider culture of which they are part.

On top of that, methodologically, the aforementioned studies gave a huge emphasis on quantitative method in the understanding of maternal health care service utilization, for the sake of describing socio-economic and demographic characteristics of study participants' vis-à-vis maternal health. On the contrary, in the present study attempt has been made to incorporate qualitative method intensively due to the fact that perceived socio economic barriers which affect maternal health seeking behavior are more understandable through a detailed and rich data that could be collected by giving more attention to qualitative method.

Hence, it could be said there is a place to conduct a study that assess the issue of maternal health seeking behavior and its socio economic barriers. Thus, the purpose of this study is to identify the major perceived socio economic barriers that affect maternal health utilization and maternal health seeking behavior during pregnancy, labor and delivery in Raya Alamata District. It is also hoped that the results of the study is essential to policy makers to understand the perceived socio economic barriers to maternal health seeking behavior and serve as a groundwork for any possible intervention aimed at improving the low utilization of maternity care services in the study area.

MATERIALS AND METHODS

Description of the study area

Raya Alamata is located at 600 km north of the capital city Addis Ababa and about 180 km south of the capital city of Tigray Regional State, Mekelle. It is the south most administrative district of Tigray Region State bordered in the south with the Amhara Regional State in the east with Afar regional State in the North East with Raya Azebaworeda and in the North with Ofla woreda. Alamataworeda has 15 tabias (peasant associations) and 2 town dwellers associations. The number of agricultural households of the woreda is approximately 17,597. The total population of the woreda was 128,872 in 2003/2004 (IPMS, 2005). Regarding the health infrastructure, the district had one hospital, six health centers and 13 health posts (Rural Raya Alamata district health office, 2004).

Research design

The study is intended to explore the perceived socio economic barriers that affect maternal health seeking behavior among rural women in Raya Alamata District, southern Tigray. In doing so, a cross-sectional study design is employed. Furthermore, the objective of the study requires the integration of both quantitative and qualitative data to best answer questions that cannot be answered by either of the two approaches alone. Therefore, the study employs both data and methodological triangulation.

Study population and sample size determination

The target populations of the study are all women in the

reproductive age group (15-49 years) in Raya Alamata District. Particularly, the study focuses on 5467 households of the study area. Out of this, the researchers selected 359 samples of women from Raya Alamata District based on simple random sampling technique. To do this, Kothari (2004) sample size determination formula would be used as follows:

$$n = \frac{Z^2 \cdot p \cdot q \cdot N}{e^2(N-1) + Z^2 \cdot p \cdot q} n = 359$$

Inclusion and exclusion criteria

Inclusion criteria

- (1) Women who were mentally and physically capable of being interviewed are included in the study.
- (2) Women, who were permanently, reside in the study area.
- (3) The elder woman is only selected for the interview (key informant, FGD and in-depth interview) from members of the household.
- (4) Women under the age of 15 and above 49 were not included in the survey

Exclusion criteria

- (1) Women who are mentally and physically incapable of being interviewed.
- (2) Mothers who stayed for less than six month in the study area.
- (3) Women, who critically ill, could not talk or listen, were excluded from the study.

Methods of data collection

Four main methods of data collection were employed. These included survey, focus group discussions (FGDs), key informant interviews and in-depth interviews.

Household survey

Survey method is one of the most widely used primary data gathering methods in social research. This method enables researchers to study a given population by relaying only in the portion of that population which is called samples. Thus, it saves time and economy, again access accurate information. Accordingly, in this study the researchers selected 359 samples of women from Raya Alamata district. In order to get a reliable data from respondents, the data collected by using structured questionnaire. The researcher prepared questionnaire in accordance with the research objectives. The entire questionnaire prepared in English for the first time afterward it will be translated in to Tigrigna language in the intention that the majority of the informants are Tigrigna speakers. In addition to, the preparation of the questionnaire, the survey administered by three enumerators for the reason that all women may not read and write. Then, the researcher given one day training for three enumerators to perform their job well and to have clear understanding about the questions put in the schedule. The training includes how the enumerator conducted the survey and the way filling the questions. Besides, it includes further explanation and discussion on the questions to make clear to the enumerators. Finally, the enumerators administered the questionnaires under the supervision of the

researcher. Once the data are gathered from informants, the process of editing, coding, data entry, data cleaning and consistency checking done. The final step was analyzing and interpreting the results.

Focus Group Discussion (FGD)

Focus groups are a form of strategy in qualitative research in which attitudes, opinions or perceptions towards an issue, product, service or programme are explored through a free and open discussion between members of a group and the researcher (Kumar, 2011). It is useful data collection method which helps to generate qualitative data from the discussion by making group interaction between members of the target population. The FGD helps to capture more deeper and comprehensive information from respondents such as model women and males. The researcher conducted three Focus Group Discussions consists of twenty four purposively selected participants. The participants of the FGD were selected from model women, non model women's and husbands/males respectively. The discussion with the participants of the FGD was based on discussion guide that were structured around the key themes by using local Tigrigna language to avoid misunderstandings. Besides, the moderator was sensitive to local norms and customs during discussion. Before the commencement of the discussion, the moderator specified the objective of the focus group discussion and guides the discussion accordingly.

Key informant interview

Key informant interview is used to collect qualitative data from informants that have knowledge and experience on the issue of maternal health. This enabled to get in-depth information from informants. Interview guide with loosely structured conversation is used to collect data. This allows the interviewee to respond flexibly and the interviewer to manage the core issues of the study. In this study, nine model women, six health workers including health extension workers, six religious leaders, three community leaders, were selected purposively and interviewed.

In-depth interview

In-depth interviewing is the most commonly used data collection approach in qualitative research. In-depth interviews are those interviews that are designed to discover underlying motives and desires. Such interviews are held to explore needs, desires and feelings of respondents (Kothari, 2004). This method enabled the researcher to generate highly detailed information and to have better understanding on the perceived socio economic barriers to maternal health seeking behavior. In doing so, in-depth interview is conducted with twelve women with the help of interview guide check lists.

Methods of data analysis

The data obtained from various sources is analyzed using both quantitative and qualitative data analysis methods. The qualitative data was collected from respondent using focus group discussion, key informant and in depth interview. Qualitative data analysis is conducted concurrently with gathering data, making interpretations, and writing reports (Creswell and Creswell, 2017). The researcher listen all audio taped and read the field notes step by step to jot down all the information. After that the audio taped from FGDs, key informant interview and in depth interview it has transcribed verbatim, and translate from Tigrigna to English. Then, the

translated data is organized, prepared, and broken up into sections based on their themes. Then a technique of thematic analysis is used to interpret and make sense of the organized data. On the other hand, the quantitative data was processed as an important part of the whole survey operation. It includes editing, coding, data entry, data cleaning and consistency checking. A Statistical Package for Social Sciences (SPSS, version 20) was used to analyze the data. The researcher used descriptive statistical tools to analyze the quantitative data. Descriptive tools such as frequency, percentages, and graphs are employed to present the results. Finally, the quantitative findings are used to substantiate the qualitative findings.

Ethical consideration

In the progress of research, researchers need to respect the participants and the sites for research (Creswell and Creswell, 2017). Thus, due respect was given to the participants during the data collection process. Besides, an informed consent was received from participants before the commencement of the interviews to ensure that participation in research was voluntary. Respondents were informed that they have the right to participate voluntarily and withdraw from the research at any time. Anonymity of respondents and confidentiality of their responses were ensured throughout the research process. Information that was provided by informants would not be transferred to a third party or would not be used for any other purpose.

RESULTS AND DISCUSSION

In this part, the major findings of the study, based on the data obtained through household survey; in-depth and key informant interview and FGD are presented and discussed, in a descriptive rhetoric. Theories relevant to the underlying themes and related literatures are used to interpret the primary data.

Socio-demographic characteristics of respondents

The quantitative data is collected and analyzed on demographic and social characteristics of sample respondents. As indicated in the Table 1, the socio demographic characteristics in this study include age, marital status, ethnic identity, religious affiliation, educational background and income of the respondents.

In this study, a total of 359 rural women aged 15-49 years were included. Out of 359 respondents, the majority 113(31%) of women were found between the age category of 25-34 years. With regard to marital status, the majority of the respondents 314(87.5%) were married followed by divorced consists of 24(6.7%). According to participant's marital status of the respondents has an association with maternal health seeking behavior. Being and becoming divorced and widowed affect maternal health seeking behavior of rural women. Accordingly divorced and widowed women were at risk, lack financial resources, lack emotional, psychological and physical support; and are less likely to receive maternal health care services than the married

ones. Moreover, women FGD participants also revealed that most divorced and widowed women were female headed households who have different duties that restrained women from visiting health facilities.

Furthermore, almost all respondents 336(93.6%) belongs to Tigran ethnic groups followed by 23(6.4%) Amhara ethnic groups. With regard to religious affiliation, the majority of respondents 257(71.6%) are followers of orthodox Christian followed by Muslim 98(27.3%). In relation to educational level of respondents, 218(60.7%) are illiterate, 94(26.18%) are educated up to grade eight, 31(8.63%) are educated up to grade twelve; and the rest 16(4.5%) of the respondents are simply able to read and write. Another important indicator for understanding the socio-economic status is the monthly income of the respondents in the household. Out of 359 respondents, 159(44.7%) of them earn an average monthly income of 501-1000 birr, whereas 132(37.1) of the respondents earn less than 500 birr per month.

Perceived social barriers to maternal health seeking behavior

There are varied perceived social barriers to maternal health seeking behavior in rural areas of Raya Alamata. Among the many perceived social barriers: lack of professional personnel, lack of confidence in the professional competency of health workers, less privacy and confidentiality on health care providers, ill behavior of health workers and poor quality of maternal health services are the major problems of the study area. Each of these perceived social barriers to maternal health seeking behavior has been shown to have strong effects upon the health of rural women of the study area.

Shortage of qualified health workers

As table two showed that more than half 200(55.7%) of the respondent proved the absence of qualified professional personnel in the health institutions whereas the rest 159 (44.3%) of the respondents proved the presence of adequate health professionals. This finding is lower than the findings of study conducted in Southern part of Ethiopia in Duna district in which (62.3%) of women were perceived the availability of health professional personnel as low (Abaychew, 2015). On the other hand, the qualitative data from respondents proved the absence of qualified health workers (physician) in the rural area of the study area. To do this, the quantity of health workers assigned in each health centers and their skill to treat people was taken as a measurement to evaluate their skill. Therefore, in substantiating this idea, A 44 years of old health expert at Raya Alamata District health office described the condition as follows:

There were shortages of skilled and qualified health

Table 1. Demographic and socioeconomic characteristics of respondents (n=359).

Variable	Category	Frequency	Percentage
Age range	15-27	106	30
	25-34	113	31
	35-44	100	28
	45-49	40	11
	Total	359	100
Marital status	Single	14	3.9
	Married	314	87.5
	Widowed	7	1.9
	Divorced	24	6.7
	Total	359	100
Ethnicity	Tigray	336	93.6
	Amhara	23	6.4
	Total	359	100
Religion	Orthodox	257	71.6
	Muslim	98	27.3
	Others	4	1.2
	Total	359	100
Education	Illiterate	218	60.7
	Read and write	16	4.5
	1-8 grades	94	26.2
	9-12 grades	31	8.6
	Total	359	100
Monthly income	Below 500 birr	132	37.1
	501-1000 birr	159	44.7
	1001-1500 birr	43	12.1
	1501-2000 birr	16	4.5
	2001 and above	6	1.7
	Total	356	100

Source: Own survey, 2016.

professionals especially laboratory technician, pharmacy and environmental health expert which are unavailable in the market. Moreover, there are health centers in the district with no laboratory equipments at all. So it is difficult to say we were given adequate maternal health services in the absence of such health personnel's and equipments in the health institutions.

As the narratives of the health worker of the district, indicate that rural women were restrained from getting adequate health personnel particularly laboratory technician, pharmacy and environmental health experts. The health centers are dysfunctional in the absence of those professionals and the necessary equipments. So it is unthinkable to give full fledged maternal health services for rural women like pregnancy checkup, urine

test, hemoglobin and blood pressure. It also difficult to give adequate delivery and postnatal care services in the absence of qualified health personnel. The absence of qualified health professional in the rural area compelled women to bypass and travel long distance to get better services. This is one of the causes to delay to get maternal health services and contributes to incur additional cost. Besides, they have compelled to search alternatives medications from traditional healers at home. In support of this, one of the FGD participants noted the shortage of health workers as follows:

There is lack of quick and adequate services given to the clients particularly women due to shortage of health professionals in the health centers. Besides, the health workers assigned to the rural areas were unqualified and

Table 2. Respondents opinion on the availabilities of qualified health workers at health institutions (n=359).

Variable	Alternatives	Frequency	Percentage
Availabilities of professional personnel	Yes	159	44.3
	No	200	55.7
	Total	359	100

Source: Own survey, 2016.

Table 3. Respondents opinion on privacy and trust of health care providers (n=359).

Variable	Alternatives	Frequency	Percentage
The presence of privacy and confidentiality	Yes	167	46.5
	No	192	53.5
	Total	359	100

Source: Own survey, 2016.

they are with inadequate skill to treat severe maternal health problems. They also disclose that most of the rural women often forced to sidestep for further medication in search of better physicians. However, this costs us additional money and which makes us vulnerable to the already burden that we have due to poverty [53 years old participant].

The shortage of skilled health professionals in the health centers has negatively affected the overall health of the community in general and women in particular at the rural areas. It contributes rural women to wait long hours to get maternal health services. Moreover, as a result of shortage of skilled health professionals in the health centers many rural mothers were referring to the district hospital for further medication; and laboratory examination for screening of diseases such as anemia, STIs, Hemoglobin and HIV infection. These conditions restrained rural women of the study area from getting timely treatment and exposes for further complications, pain and extra cost. This condition is very awful for women especially during the period of delivery. Sometimes women delivered before they have reached health facilities. Others died before they have arrived at the district hospital (Table 2).

Lack of privacy and confidentiality

As Table 3 indicates 167(46.5%) of the respondents ensured the presence of privacy and confidentiality while 192(53.5%) of the respondents were not comfortable with privacy and confidentiality. This finding is consistent with the study done in southern Ethiopia among non-user of ANC (55.7%) were proved of the absence of privacy and confidentiality of the service (Abaychew, 2015). Similar studies in Africa also revealed that lack of privacy in health facilities was also mentioned as a contributing

factor for home delivery (Mirsho et al., 2007). Another study in Gambia also shows that limited choice for seeking care was one of the reasons for heavy reliance on TBAs, who are considered to be more secretive and friendly than professional healthcare workers (Nyanzi et al., 2007). In line with this, the qualitative data from the majority of the respondents revealed that health workers did not respect their professional ethics why because they were not keeping the privacy of clients. Along this, there are also problems of privacy during the labour and delivery process. According to the statement of the FGD participants, in the district hospital privacy of the birthing woman was not kept. The hospital hosted many apprenticeship students from different colleges and universities of the two adjacent regional states, as a practical attachment fieldwork. The students entered into the delivery room during labour and delivery practice. As a result, birthing women are embarrassed by the crowd for they will be exposed naked in front of them. Some of them refused to deliver at the hospital due to embracement caused by the presence of many individuals in the delivery room. They prefer to deliver at home with the help of elders or TBAs. A 30 year old interviewee from 'Selam Bekalsi' stated that "*I know one woman refuses to deliver and she returns to her home due to this trouble*". Concomitantly, frequent entry of many health workers to attend the labour woman once at delivery room disrupts the psychology of the birthing woman and raises the issues of privacy. Such incidents erode the confidence of birthing women. Another FGD participant also reported that if you delivered at health facility you would be treated as a doll everyone come and observe the birthing woman. In line with this argument, another 40 years old female key informant reported the condition as follows; "Many rural women do not have interest to deliver at health facilities due to problems related to delivery in the health facilities. During labour the sexual organ (uterus) of the birthing women had



Figure 1. Respondents opinion regarding the behavior of health workers (n=359).
Source: own Survey, 2016.

injured. This bad lived experience of women in the health facilities deter them from delivering at health institution”.

Behavior of health workers

As Figure 1 indicates that the majority 219(61%) of the respondents reported that health workers have bad behavior's. This ill behavior of health workers deterred rural women from using modern maternal health services at the earliest time. Similarly, studies showed that the attitude of the health care provider and previous experience of the mothers about the care received influence utilization of maternal health services (Olayinka et al., 2014). Studies in Uganda also revealed that bad staff attitude towards clients was mentioned as a reason for low utilization of health services in general and maternity services in particular (Wilunda et al., 2014). Furthermore, studies in Gondar, north Ethiopia revealed that bad experiences and unwelcome attitude towards health facilities hinder the use of maternal care services (Abebaw et al., 2013). In consistent this, the qualitative data from FGD participants also revealed that health workers have not positive attitude towards rural women. Rural women are being discriminated based on their dressing style and hygiene situations. In strengthening this, one of the FGD participants from 'Tabia' 'Timuga' reported the behavior of health workers as follows:

Some health workers at the district hospital are cruel, impatient and unsympathetic for rural women. The health workers insulting and mistreating women who attend maternal health [A 40 years model woman].

Another FGD participant from 'Tabia' 'Selam Bekalsi' forwarded similar ideas regarding the behavior of health workers as follows:

During labour and delivery rural women entered the health facilities for delivery purpose however, the health workers did not give much attention. They give better attention and follow up for those who have a close acquaintance with the health workers than other patients

who are awaiting the health service. Women who do not have someone inside the health facilities do not get the necessary follow up and checkups about the progress of labor. When complication became severe they call them but they abuse us in bad words particularly at night time. They did not like to wake up from their sleep. They were saying wait until the labor is push. This affected our psychology and sometimes we decide not to come again to the health facilities [A 45 year model woman].

As the narratives from FGD participants revealed that the negative attitude and behavior of health workers affect maternal health seeking behavior of rural women. It has discouraged rural women to attend and visit health facilities during pregnancy, delivery and postnatal care services. In addition to this, key informants from Raya Alamata District health office also assured the problems of health workers related to misbehaving and bad working conditions particularly at district hospital. These kind of problems occurred at maternity, OPD and card rooms. The other problem that has taken place at Raya Alamata District hospital is related to discrimination and bias. In substantiating this idea, key informant from 'Tabia' 'Selam Bekalsi' noted that:

Health workers are discriminatory at the district hospital. They are given better services to women who are well dressed and well groomed. On the other hand, those who came from rural areas dressed according to their traditional norms and values were undervalued and mistreated by health workers in the hospital. Moreso, they were treated below the required standard for patients [A 40 years old model woman].

The discriminatory behaviors of health workers inside the hospital affect health seeking behavior of rural women. The health workers provide prompt services for those who have known previously. Besides, those who have relatives in the health facilities get better admiration and care than others specifically at the district hospital. As result of this, rural women preferred to use home based treatment as an alternative of modern health care services. Along with, rural women seek treatment from

Table 4. Respondents opinion on the quality of maternal health services.

Variable	Alternatives	Frequency	Percentage
Quality of maternal health services	Low	201	56.1
	Medium	116	32.4
	High	41	11.5
	Total	358	100

Source: Own survey, 2016.

TBAs, herbalist and other relatives during the time of pregnancy and delivery at Raya Alamata District.

Poor quality of maternal health services

Availability of adequate health facilities determines quality of services provided to a population of a country (Jason, 2005). The quality of health services which has been given for the community also determines maternal health services. However, the quality of maternal health services from the survey indicates that more than half 201(56.1%) of the respondents ranked the quality of maternal health services as low whereas 116(32.4%), 41(11.5%) of respondents ranked it the quality of maternal health services as medium and high respectively.

Quality of care is a major factor for determining the utilization of maternal health services. High quality maternal health services attracted more women. In opposite to that low qualities of maternal health care thrust clients from the health facilities. This low quality of maternal health services causes women to be dissatisfied. Similarly, this finding is consistent with the study done in north Ethiopia which showed that providing incomplete (poor quality) maternal health service had damaging effect on health-seeking behavior of mothers (Abebaw et al., 2013). Besides, there is shortage of drugs and medical supplies, and qualified health professionals in the health facilities. The absence of such facilities in the health centers has negative impacts on the utilization of maternal health utilization as well as maternal health seeking behavior of the rural women of the study area. In view of fact that a key informant from 'Tumuga' health center reported that:

Antenatal care, delivery and postnatal care were given for women. These services were not good enough due to problems related to shortage of manpower and equipment. Now, there were many problems that take place in the health center [A 48 years of old midwife].

In line with this, the health workers stated that the majority rural health centers are not equipped with the necessary equipments, skill personnel and medicines to give quality maternal health services such as antenatal care, delivery and postnatal care services. Except few,

the majority health centers do not give quality maternal health services for pregnant women like urine test, hemoglobin, TTC, blood pressure and HIV testing. Additionally, the health centers also could not give quality maternal health services for birthing woman with the necessary and recommended procedures (Table 4).

Perceived economic barriers to maternal health seeking behavior

Perceived economic barriers like less access to resources, bad working conditions and cost of transportation and medical treatment affect maternal health seeking behavior of the rural women of the area under study.

Less access to resources

Women have no decision making power and smaller share of resources and benefits. They have less access to and control over productive resources, land and credit (Kalkidan, 2007). However, the husband/male has the power to own and control every resource. He is the only source of power in the household. On the other hand, women have less access to resources. They do not control and own properties like land, cattle and other products even though this resource are determinants for their health. In the study area women have unequal property right with their husbands. In line with this, a young interviewee from Garjale add that "I have no equal property right with my husband why because I am little girl". According to the view of the informant age gap in marriage is one of the causes to property inequality. This age gap between younger married girls and their spouses creates unequal power relations. The age gap creates favorable condition for the husbands to have a dominant role in the decision-making process of the household; however, it is troubled for the young girl to bargain with her husband and getting timely maternal health services.

Concurrently, another 40 years of old interviewee participant and mother of 6 children noted that:

I knew that the government gave equal property right with my husband but in our culture the husband has the sole

Table 4. Respondents opinion on the quality of maternal health services.

Variable	Alternatives	Frequency	Percentage
Quality of maternal health services	Low	201	56.1
	Medium	116	32.4
	High	41	11.5
	Total	358	100

Source: Own survey, 2016.

power to own and make decision regarding property. Everything was commanded by husband. He has the power to sell and buy any property. I always received money from my husband for purchasing of household consumption and other activities.

The government guaranteed the property rights of women however, some women did not benefit from their constitutional rights. They did not have equal decision making power in the common properties of the household. They lack power to control and own their common properties with their spouse. They are least likely to afford to pay for health service charges. This in turn causes to deter women from getting timely treatment until the husband permit and sold property to the market. The powerlessness of woman to make decisions regarding their communal property causes to suffer from maternal health problems and they are also often at greater risks of vulnerability. Lack of property rights also affects women's ability to make decision on their own health care, contraception use and reproductive health services.

Bad working conditions of women

All rural women were engaged in physical work during their pregnancy. This can be detrimental to their health and damaging for the unborn babies. This also has potential influence on maternal health (Idowu, 2013). Accordingly, the findings from the survey indicates that 282(78.6%) of the respondents have done any work within or outside the home while the rest 77(21.4%) of the respondents were not work within or outside the home. Out of the total women who said, "Yes" regarding the type of work, 179(63.5%) of the respondents executed difficult tasks, 62(22%) carried out moderate works and 41(14.5%) of the respondents carried out easy works. This finding is very low than the findings of study conducted in Bangladesh, 100% of the respondents were engaged in physical work during their pregnancy (Aktar, 2012). In most society's women are the ones who are mostly working at home in the maintenance of the household or very close to home, doing both household activities and small-scale production and trading

(Ethiopian societies of population, 2008). Other studies in Gambia by Lowe et al. (2016) shows that women's daily activities were too strenuous and could not get sufficient rest even as they approached their delivery date. In consistent with this, the findings from interviewee, FGD and key informant interview revealed that women are performing different indoor and outdoor activities. Most rural women do routine types of domestic activities from dawn up to the middle night without the assistance of their partner. In substantiate of this idea, a mother of 5 children and participant of the FGD described her lived work experience in the household as follows:

Most of the time, I spent my time doing different household activities. I do different activities like washing clothes, preparing foods, taking care of my children and other household activities. Sometimes, I fetch firewood from the field. Further, I also hauling water and going to the field to reach food to my husband in the farmland. I do not know the time to have rest in my life. My life always come with many ups and downs which enlarge my strain. I do not think so about my health and well being.

The other participant added that most of the rural women had passed difficult time all over their life due to the influence of heavy workload. Womanhood by itself is a problem. Many rural women have accompanied with many life trajectories.

"For instance me, I do a lot of activities until five up to six o'clock at the nighttime; and I do not take rest until I sleep at the mid night". I do not get timely maternal health services because of lack of time. Accordingly, a day has created another day without getting timely medical treatment. This condition affects every rural woman not only me [38 years old Key informant].

In line with the above thought, the following vivid account of the informant will show the role of husbands during pregnancy time: The problem is with our husbands. Because they do not see pregnancy as a thing that needs attention rather they take it as a natural rite of passage that has to be accomplished. That is why during pregnancy my husband gives much attention to his agricultural work, friendship cheers in local alcohol

Table 5. Proportional distribution of respondents according to their working condition and the type of work.

Questions	Alternatives	Frequency	Percentage
Have you done any work within or outside the home? Frequency Percent	Yes	282	78.6
	No	77	21.4
	Total	359	100
What type of work they did?	Difficult	179	63.5
	Moderate	62	21.4
	Easy	41	14.5
	Total	282	100

Source: Own survey, 2016.

houses than me.

If I say something he will lash out to his physical measure that deems his skill to suppress at home. Thus, day in day out I have to silence my voice and pain even during pregnancy [35 years old Key informant].

As the story shows that rural women mostly spent their time in hard physical labour. Such backbreaking working condition in the home created heavy burden on women's health. Most of the rural women did not get timely treatment particularly maternal health services like ANC. Besides, the majority FGD participants reported that rural women are engaged in physical work during their pregnancy and in the post delivery periods. They participate in public work activities like water and soil conservation programs until six months of pregnancy. At this time they were forced to travel more 15 km in one trip every day for about forty days to participate in the public work. It is expected for these women to travel ups and downs in tough geographical area this affect the overall health and wellbeing of the woman. Sometimes rural women has exposed to miscarriage. It has also negatively affected unborn infant (Table 5).

Cost of transportation and medical treatment

Costs of seeking healthcare may include costs for transportation (Gabrysch and Campbell, 2009). However, as Table 6 demonstrated that the majority 232 (64.6%) of the respondents cannot afford the cost of transportation to get maternal health care services while the rest 127 (35.4%) of the respondents can afford the cost of travel to get maternal health services due to different reasons. The quantitative data shows that the majority of the respondents unable to pay their cost of transportation. In substantiating this idea, findings from FGD participants revealed that during the antenatal, delivery and postnatal care rural women traveled by using Bajaj on contract base and it costs up to 150 birr for one trip to reach the nearest health facilities in the absence of ambulances.

Another similar studies by Wilunda et al. (2014) in Uganda showed that the cost of the ambulance were (20,000 Ugandan shillings, about \$ 8). These were the most expensive one which is difficult to afford particularly for the poorest rural women. This situation affects rural women treatment seeking behavior. It deters women from utilizing antenatal, delivery and postnatal services. Cost of transportation also causes to delay to get maternal health services. In addition to this, findings from northern part of Ethiopia also showed that inability to cover the costs of transport or service is an important barrier to the utilization of skilled maternal care, especially at the time of complication (Abebaw, 2013).

Correspondingly, lack of money for transportation and other extra costs negatively affected rural women in the study area. This condition deterred rural women from using modern health facilities. It increases delay to diagnosis, put off treatment compliance and it has affected the maternal health seeking behavior of rural woman. The cost of transportation affects the ability of women access to maternal health services. Due to cost of transportation rural women cause to delay to visit health facilities until they get money. They did not go to health institutions at the right time. As the right time was postponed due to lack of money the state of sickness worsens and it affects the overall health of the mother. Besides, the informants argued that women have developed low self esteem and develop feeling of inferiority due to unable to cover the cost of travel. All of these factors affect maternal health seeking behavior of rural women of the study area.

On the contrary to the above narrative, some of the FGD participants and interview schedule respondents said that there was no payment for transportation due to proximity of the health facilities. Thus, they have gone on foot to get maternal health services especially to the health post and health centers. Besides, qualitative data from the majority of FGD participants revealed that rural women were not paid for transportation cost due to convenience of ambulances which were provided by the government during delivery and labour. The ambulance were given free transport services to rural women to ship

Table 6. Proportional distribution of respondents according to the ability to afford the cost of travel (n=359).

Variable	Alternatives	Frequency	Percentage
Abilities to afford the cost of transportation	Yes	127	35.4
	No	232	64.6
	Total	359	100

Source: Own survey, 2016.

women to health institutions. But, there is one problem related to the ambulance services. The ambulances did not come back the birthing woman to her home after delivery this condition forced women to cost extra money for transportation.

Medical costs are expenses for drugs, diagnosis and treatment by the women to get maternal health services. Medical cost for maternal health care services like ANC, delivery and postnatal care become barriers to get timely and appropriate care from health facilities. Due to the presence of medical costs women received delayed treatment which affects the overall health seeking behavior of rural women. In consistent with this, studies in rural Tanzania supports the argument that high direct payments, together with the costs of unofficial payments, are acute barriers to the use of maternal services (Mubyazi et al., 2010) thus contributes to women's inability to access medical services for maternal health care (Lwelamira and Safari, 2012). Another studies in Ethiopia by Abaychew (2015) indicated that cost of medicine and other due costs were the major economic constraints for rural women to get adequate maternal health services.

In order to reduce the problems related to medical costs, the government of Ethiopia provided free maternal health care services for pregnant, delivered and PNC attendants. In line with this, the key informant from district health office said that the federal government of Ethiopia was permitted free medical services for pregnant women from the period of conception to 45 days after delivery. At this phase all pregnant and birthing women were given free medical services at all government health institutions. Then, in our district all the health institution would give free medical services for pregnant women and for birthing women until 45 days of delivery [A 44 year's key informant].

In substantiating to the above idea, one of the FGD participants said that maternal health services are given for free in every public health facilities. What is the problem here is if there is no availability of drugs, the clients referred to private drug stores. Another key informant added that as women went to health institutions there is shortage of medicine; and they did not get adequate medicine in public institutions. The physicians ordered to buy medicine from private clinics which is high in terms of cost and unaffordable especially for the rural

poor. The cost of medicine directly or indirectly affects women maternal health seeking behavior. Similar to this, other respondents add that we always expected free medication for mothers in public health institutions but the condition is not found as they expect why because the expose for extra costs urgently (Table 6).

Conclusion

This study has tried to assess the perceived socio economic barriers to maternal health seeking behavior among rural women in the case of Raya Alamata District, southern Tigray, Ethiopia. In doing so, the finding of this study give much emphasis into the perceived socio economic barriers to maternal health seeking behavior among rural women. Accordingly, the shortage of skilled health professionals in the health facilities restrained rural women from getting adequate health services like cheek ups, urine test, hemoglobin and blood pressure. It is also difficult to give adequate delivery and postnatal care services in the absence of qualified health personnel. It causes women to bypass and travel long distance to get better services. They have also compelled to search alternative treatments like traditional healers at home which cause to deter women from getting modern maternal health services. Due to these problems rural women were restrained from getting timely treatment and exposes for further complications, pain and extra cost.

The other problem is related to privacy. Lack of confidence and privacy in health facilities and health care providers were hindered in the use of maternal care services specifically during the labour and delivery process due to the gathering of apparent ship students and frequent entry of many health workers. This bad lived experience of women in the health facilities deter them from delivering at health institution and further debilitate their delivery care seeking behavior. Bad behavior of health workers, lack of respect and mistreatment, abuse and bad staff attitude towards clients are the main reasons for low utilization of maternal health services in the study area. This ill behavior of health workers plus discrimination and bias based on their status negatively affects the maternal health seeking behavior of rural women in the study area. It had discouraged women from seeking them again, discourage other potential users,

and possibly affect the degree of compliance with referrals. Availability of adequate health facilities determines the quality services however, the quality of maternal health services were very low in the study area. This low qualities of maternal health care thrust clients from the health facilities. The majority mother's are dissatisfied with maternal health services given in the health facilities due to unavailability of drugs, medical supplies and dearth of qualified health professionals. These poor quality maternal services had damaging effect on health-seeking behavior of mothers.

The study also showed that women have little decision making power and smaller share of resources and benefits. The majority of women in the study area are not capable to control and own property equally with their spouse. They are least likely to afford to pay health service charges; and they do not get timely treatment until the husband permit and sold property to the market. Due to power imbalance between the husband and the woman; women's ability to make decision on their own health care, contraception and reproductive health services were limited.

In addition to this, the indoor and outdoor activities performed by rural women affect their health seeking behavior. These stressed working condition in the home created heavy burden on women health. They did not able to get timely treatment particularly maternal health services such as ANC. The economic costs related to transportation and medical issues were another determinant factor to maternal health utilization. Lack of money for transportation and other extra costs negatively affected rural women in the study area. This condition deterred rural women from using modern maternal health facilities. It could increase delay to diagnosis, put off treatment compliance and it has affected the maternal health seeking behavior of rural woman. Therefore, all concerned government and non government organizations should address these perceived socio economic barriers in order to increase the health seeking behavior of rural women specifically maternal health seeking behavior.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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