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Perceptions of Home Delivery Risk and Associated Factors among Pregnant Mothers in North Achefer District, Amhara Region of Ethiopia: The Health Belief Model Perspective

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BACKGROUND

Maternal mortality is a sensitive indicator of maternal health and well-being in all countries. The World Health Organization (WHO) has defined maternal mortality as "the death of a pregnant woman or within 42 days of the termination of pregnancy, regardless of the duration and place of pregnancy, for any cause linked or aggravated by pregnancy or its management but no accidental and fortuitous causes ". Globally, an estimated 10.7 million people died in the 25 years between 1990 and 2015 due to maternal causes. Although substantial progress has been made in reducing maternal mortality, the World Health Organization (WHO) has estimated that in 2015, 303,000 women died from potentially preventable problems during pregnancy or childbirth in the world [2]. In comparison to other African countries, Ethiopia has one of the highest maternal mortality rates. Progress in reducing maternal mortality has stalled since 2005, when the country successfully reduced the maternal mortality ratio (MMR) to 676 per 100,000 births in 2010/11, from 871 in 2000/01. In Ethiopia, the percentage of births attended by skilled birth attendants was only 20.4% in 2011/12, far below skilled birth by 74% and 44% respectively for urban and rural communities in the region from southern and eastern Africa. To strengthen the components of maternal health, Ethiopia has adapted the current global development program (SDG), which has 17 objectives, objective 3 focusing on health (ensuring healthy life and promoting the well-being of all at all ages). In many low-income countries, including Ethiopia, Nepal, pregnancy and childbirth are often seen as normal life events without justification for seeking professional help. In fact, need factors can be driven by pregnancy-related factors such as perception. Women who perceive the need for professional help and recognize the risk of pregnancy and childbirth, should perform antenatal care and prepare and organize childbirth. Although home births are chosen or occur for a variety of reasons, they have been associated with adverse outcomes for the infant and mother.

Extant research has pointed to some possible explanation. A range of factors such as knowledge of pregnancy and health risks, importance given to pregnancy, earlier health facility use, pre-birth visits and pregnancy complications, can affect whether a woman perceives the need for institutional delivery. Some studies reported that multiparity was perceived as a significant risk factor for a home delivery and associated with use of postnatal care. The other main reasons for low utilization of health care services was due to lack of response by health professionals to the perceived risk of the women.

Culture plays a major role in how a woman perceives and prepares for her childbirth experience. If caregivers know different ideas, rituals and behavioral restrictions and prohibitions, and communicate with the women they care for, women in rural areas will have a choice. Local myths and misconceptions about pregnancy and childbirth have been noted as deterrents to seeking health care. More specifically, some authors maintain that the search for care during pregnancy is strongly influenced by the perception of the unfavorable results resulting from witchcraft. On the other hand, several previous studies have examined the factors contributing to poor maternal and child health outcomes and access to care in Ethiopia. A positive perception of the added value of childbirth in an institution is generally the motivating factor for women and families to seek maternity care. On the other hand, since pregnancy and childbirth are often considered as normal events, if this value is not perceived, it is unlikely that professional care will be sought. According to the behavioral model proposed by Andersen, need factors are essential to health care seeking behavior. For the use of service delivery services, this means that the pregnant woman and her family must perceive pregnancy and childbirth as abnormal events, where life-threatening situations can arise without any prediction. There is extensive literature on the factors that influence the delivery of facilities. The majority of studies have focused on demand, for example, the characteristics of women and their families. Few studies have attempted the complex task of assessing the perceived need of women for the delivery of health services. But has not been comprehensively evaluated in Ethiopia against the health belief model developed by Hochbaum, Rosen stock and Becker. Many studies have not linked mothers' perceptions to the risks of home birth. Therefore, this study assesses perceptions of the risk of home birth and associated factors among pregnant women in the regional state of Amhara, Ethiopia.

REVIEW OF HBM CONSTRUCTS

The HBM has been used extensively in the study of health screening behaviors ranging from influenza inoculations, seatbelt use, nutrition, chronic illness, smoking, breast cancer screening-both self-examination and mammography, to health beliefs and AIDS-related health behaviors; however, it has been seldom used in home delivery-related behaviors. Perceived Susceptibility and Perceived Severity Threat perception is highlighted in this model as an important step in recognizing the value in taking a recommended action to reduce the threat. Earlier versions of the model, in fact, combined perceived

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susceptibility and perceived severity and labeled the component as perceived threat. Perceptions of susceptibility and severity are highly subjective (Figure 1). Where some people will see a particular health problem as imminent and life-threatening, and are prepared to take preventive action, others will see themselves as immune and preventive measures are unnecessary. If the perception of severity is low, then " there might be no subsequent consideration of susceptibility, " but when the perception of severity reaches a certain point, then susceptibility becomes more real and preventive measures are considered [19-21,35-37].

METHODS

Study design A cross-sectional community-based study was employed in January2015. The study was conducted in North Achefer district, which is located 110 km far away from Bahir Dar, to the Southeast direction of Ethiopia. The total population of the district is estimated to be 215,723 of which 50.3% are males and 49.7% are females (according to 2015 population estimation of the district) [23]. There are 27 Kebeles (sub districts). Concerning to the health service facilities, there are 7 health centres, two higher clinics, 24 health posts, 1 district hospital, 14 private health institutions. The lowest level of referral system in Ethiopia is the primary health care unit, which is composed of five satellite health posts, one health center and one primary hospital [24]. The study subjects were pregnant women who were in their third trimester of pregnancy and who gave birth in the last two years prior to the survey.

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