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Introduction

Improving maternal health is recognised in the Millennium- and Sustainable-Development Goals as a key cornerstone in global efforts to improve public health care capacity and contribute to social and economic development (Agyei-Mensah et al., 2015; Likwa, 2015). Of the 1,500 daily maternal deaths due to complications with childbirth or pregnancy, 99 per cent occur in rural and impoverished communities in the global South (World Bank 2007; WHO 2008). Interventions such as the Safe Motherhood Initiative have produced some improvements in maternal health indicators in sub-Saharan Africa, contributing to a fall in global maternal mortality from 380/100,000 live births in 1990 to 210/100,000 in 2013 (Rijsbergen and D'exelle, 2013; Spangler and Bloom, 2010: 760; United Nations, 2015).

Investment in obstetric care provision has led to the proportion of births around the world being attended by a skilled health practitioner increasing from 59 per cent in 1990 to 71 per cent in 2014 (United Nations, 2010). In the global South, the rise has been from 53 per cent in 1990 to 63 per cent in 2008 (Spangler and Bloom, 2010; Weil and Fernandez, 1999). However, sub-Saharan Africa lags behind, with only 52 per cent of births being attended in 2014 (United Nations, 2015). Worryingly, these figures hide further inequalities: in East Africa 81 per cent of urban births are attended, but only 40 per cent in rural areas (United Nations, 2015). Maternal health outcomes are thus compromised: unattended homebirths contribute over 50 per cent of neonatal mortality and regions with the lowest percentage of skilled birth attendance have the highest incidence of maternal deaths (Lawn et al., 2005; Mrisho et al., 2007; Rijsbergen and D'exelle, 2013).

A range of factors promote and hinder uptake of institutional obstetric services. Key influences include marital status and gender (in)equality, levels of maternal education, cost of services (user fees, tips, purchasing consumables), access to services (distance, transport availability, cost), personal preference, socio-cultural factors, and previous personal experience (Mrisho et al., 2007; Moyer and Mustafa, 2013; Moyer et al., 2014; Rijsbergen and D'exelle, 2013; Spangler and Bloom 2010; Say and Raine, 2007). Given this range of influences and the heterogeneity of contexts within which birthing decisions are made it is important to develop nuanced understandings of women's access to and uptake of obstetric services (Spangler and Bloom 2010; Spangler 2012).

This article develops a contextual understanding of attitudes and behaviours towards obstetric care in Ghona village and Kiterini sub-village, Moshi Rural District, northern Tanzania.[1] The majority of recent literature on maternal health care and mortality in Tanzania relates to rural contexts (see for instance Danforth, 2009; Kowalewski et al.,2000; Mpembeni et al., 2007; Spangler and Bloom, 2010; Spangler, 2012). However, there is a dearth of literature relating to maternal health in the Moshi and Kilimanjaro regions of Tanzania (see Armstrong et al., 2015 for an overview). This paper thus focuses on maternal health experiences in Moshi rural district.

Based on qualitative data from interviews with villagers we explore how socio-cultural and material factors frame women's decision-making and health-seeking

[1] Villages are a key administrative element of Tanzania's political structure and typically contain 2,000 – 4,000 residents. Sub-villages are smaller communities, typically containing roughly 100 households. A collection of sub-villages comprise the administrative village unit.

behaviours surrounding maternal health and childbirth. From an initial overview of maternal health and birthing practices in the global South, the article develops contextually-rooted understandings of the logistical, financial, educational, experiential and socio-cultural influences on obstetric care practices. In particular, we note reported attitudinal and behavioural changes in relation to efforts to overcome material barriers to care, changing community attitudes and increasing practices of collective support to ensure expectant mothers can access institutional care.

Maternal health and birthing practices in Tanzania

Prioritising maternal mortality and health concerns within international and domestic health care policies recognises the detrimental impacts of poor maternal health outcomes on family life, childhood mortality, and lost productivity at household and national levels (Stekelenburg et al., 2004). Integral to efforts to improve maternal health are endeavours to increase the proportion of births attended by a skilled health practitioner, institutionalise birthing practices, modernise health provision and improve accessibility of health services (Giacaman et al., 2005). The Tanzanian government has demonstrated sustained political commitment to, and some success in, tackling maternal and neonatal mortality (Armstrong et al., 2015): abolishing maternal and child health user fees, expanding health service provision and supporting institutional deliveries, has reduced maternal mortality rates from 770 to 410 (per 100,000 live births) between 2000 and 2013 (World Bank, 2014). However, many births in Tanzania still occur in non-institutional settings and without skilled supervision, contributing to slow reductions in a very high maternal mortality rate

(table 1; see also Amooti-Kaguna and Nuwaha, 2000; Armstrong et al., 2015; Mrisho et al., 2007; World Bank 2014, 2015).

INSERT TABLE 1 AROUND HERE

Tanzanian government programmes, including the National Road Map Strategic Plan to Accelerate Reduction of Maternal and New Born Mortality (2008-2015), have sought to increase the availability and uptake of obstetric care (Spangler, 2012). While increased provision of health care services meant that 72 per cent of Tanzanians lived within 5km of a health clinic (90 per cent within 10km) in 2007, it was reported that only 47 per cent of births occurred in institutional settings (Mpembeni et al., 2007). Exploring the reasons behind this low uptake of services, researchers have identified distance to facilities and lack of transport as contributing to 84 per cent of rural homebirths in Tanzania, with the number of antenatal visits, knowledge of risk indicators and health worker advice as additional influences (Mrisho et al., 2007; Mpembeni et al., 2007). The uptake of modern maternal health services varies across Tanzania, informed by the provision and accessibility of services, socio-demographic and socio-cultural factors with rural areas suffering poorer maternal health indicators due to cultural attitudes and shortcomings in provision and affordability (Armstrong et al., 2015).

The challenges identified by research on maternal health in Tanzania resonate with Thaddeus and Maine's (1994) three-delay model. Based on a multidisciplinary literature review on maternal health in the global South, Thaddeus and Maine (1994) argue that the majority of maternal deaths arising from direct obstetric causes were

readily preventable with timely access to medical treatment. Preventing or hindering this access, they suggest, were three phases of delays: delays in deciding to seek care (Phase I), delays in reaching adequate health care facilities (Phase II), and delays in receiving care at the facility (Phase III). Informing these three phases of delay, they argue, are three main sets of factors; socio-economic/cultural factors, accessibility of facilities, and quality of care (encompassing both actual and perceived accessibility and quality of care). Thaddeus and Maine (1994) argue that socioeconomic/cultural factors, accessibility and quality of care inform the decision to seek care, while accessibility and quality of care influence delays in reaching medical services, and quality of care is the sole contributor to Phase III delays. Key challenges or barriers, they note, include distance, cost, quality of care, recognition and understanding of illness, economic status, the status of women, educational status, distribution of facilities and transport and infrastructure to reach these, the level of staffing and equipping of facilities, and previous experience of care (Thaddeus and Maine, 1994).

These interactions are evident in research from rural areas within Tanzania and beyond, (see Amooti-Kaguna and Nuwaha 2000; Moyer et al 2014; Stekelenburg et al., 2004). Perception of the quality of care is a key concern, particularly for poor women who fear being stigmatised and discriminated against, as highlighted in the Kilombero Valley and Mtwara District (Kowaleski et al., 2000; Kowaleski et al., 2002; Spangler and Bloom 2010; Spangler 2011). Various studies have noted poor women's complaints that they are seen as inferior and unworthy of care during encounters with institutional birthing, and left in degrading positions by indifferent or hostile health care workers (Kowaleski et al., 2002; Spangler and Bloom 2010). Such negative experiences undermine both individual and societal attitudes towards

institutional birthing, an influence compounded by stories from new mothers of being expected to provide 'fees' for free maternal health care or being asked to source the consumables used during procedures (Kruk et al., 2008; Spangler and Bloom, 2010). These encounters themselves directly produce Phase III delays but also contribute to future Phase I delays by deterring women from using Western facilities.

The influence of cultural expectation and tradition has also been identified in several regions within Tanzania as key influences on whether women seek Western maternal health care (Mrisho et al., 2007). Research has noted how increased levels of education contribute to changing individual and collective attitudes, shifting perceptions away from the importance of traditional birthing as a passage to 'womanhood' to recognising institutional birthing as a safer option (Kyomuhendo, 2003; Spangler and Bloom, 2010).

Educational status is recognised as important for illness recognition and awareness of potential health risks from childbirth, and for improving women's status and ability to exert influence over health-seeking behaviour including for antenatal support and births (Amooti-Kaguna and Nuwaha, 2000; Mrisho et al., 2007). Work in low resource communities in Kasulu District, Tanzania has identified the benefits of involving and engaging male partners in education around maternal health and gender equality to further encourage the use of maternal health care services (Danforth et al., 2009). However, the effectiveness of such interventions is diminished in situations where antenatal clinics unintentionally discourage women from using institutional facilities after they are informed of the healthy condition of their unborn child (Amooti-Kaguna and Nuwaha, 2000; Myer and Harrison, 2003). Interventions aimed

at minimising Phase I delays therefore both adapt to and complement certain socioeconomic and cultural factors while seeking to influence and change others in order to reduce delays and improve service uptake.

In contexts where Phase I or II delays prevent women from seeking Western maternal health care, traditional birth attendants often provide essential psychological and physical support (Amooti-Kaguna and Nuwaha, 2000; Izugbara et al., 2009). Since the 1970s, efforts in Tanzania to improve the training of traditional birth attendants to promote safe and hygienic deliveries and post-natal care have resulted in mixed outcomes for improvements in maternal mortality rates (Kruske and Barclay, 2004; WHO, 2005). Notably, those interventions with the most positive outcomes have been the more contextually-sensitive programmes (Ray and Salihu, 2004) which recognise and respond appropriately to the causes of Phase I and II delays by working with traditional beliefs and socio-cultural factors.

Efforts to reduce maternal and infant mortality have often focussed on improving health care coverage. Tanzania's government has invested heavily in expanding maternal health service coverage (Mpembeni et al., 2007; Spangler, 2012)), with mixed outcomes (Straneo et al., 2014). While they have brought facilities closer to many rural communities, issues relating to the lack of availability of suitable transport (particularly in wet seasons), the costs associated with using transport (particularly in an emergency), and control over the finances and decision-making to use transport remain.

Thaddeus and Maine's (1994) use of the phrase 'adequate health care facility' is useful here, encompassing not only the services offered at a facility but also the staffing levels, expertise and competence of staff present, and provision of equipment and disposable supplies. Recent years have witnessed targeted efforts within Tanzania (and beyond) to expand the provision of facilities and services across rural areas. However this increased coverage does not necessarily equate to improved intervention and treatment: Straneo et al. (2014) make the provocative argument that reducing the number of health care delivery sites in rural Tanzania would actually improve the quality and equity of care. Pregnant women in Tanzania can expect to receive assistance with childbirth at dispensaries, health centres and hospitals, minimising Phase II delays. However, many of these sites are understaffed (both staff numbers and staff with relevant experience and expertise) resulting in a de facto Phase II delay as the patient is transferred elsewhere or an extended Phase III delay while awaiting the arrival of suitable qualified staff and required resources.

Increasing awareness of service provision and experience of institutional childbirth can further encourage utilization of these services, provided expectant mothers' experiences are positive (Stephenson et al., 2006). Previous experience of complications during homebirths can also bolster uptake of institutional delivery services through heightening individual and collective awareness of obstetric health risks (Rijsbergen and D'Exelle, 2013). However, negative experiences of poor treatment and lack of respect from health care professionals, failures to ensure privacy or to provide for preferences for birthing position or gender of health worker can reduce satisfaction and utilization of services (Amooti-Kaguna and Nuwaha, 2000; Mrisho et al., 2007; Some et al., 2011).

Obstetric care decisions are the result of individuals' negotiations of these multiple and often contested influences. Maternal health service provision must, therefore, be contextually specific and culturally sensitive (Griffiths and Stephenson, 2001), meaning it is necessary to develop nuanced, contextually-rooted understandings of how women make decisions around obstetric care practices. This article explores these decision making processes and practices in Ghona village and Kiterini sub-village, Tanzania, and makes contextually sensitive policy-related suggestions, with specific attention to how access to health care facilities, cultural norms and perception of better and safer deliveries in hospitals inform individual and collective maternal health behaviours.

Local research context and methods

Ghona village and Kiterini sub-village (an adjoining smaller and more rural hamlet linked with Ghona) are located in a rural part of the Moshi district of Tanzania. The region is characterised by high levels of poverty: local livelihoods are predominantly subsistence farming and livestock, with some diversification into crafts and weaving; in Ghona and Kiterini, farming remained the main source of livelihoods but with some mat and basket weaving in Ghona. Maternal mortality rates are also high (790/100,000 live births) compared with the national average (460/100,000) (UNICEF 2011; World Bank, 2015).

Broader development indicators in Ghona and Kiterini reflect not only the enduring poverty of the area, but the notable differences in infrastructure, wealth and service provision between the two settlements. Primary education is almost universal in Ghona but not in Kiterini. Local infrastructure and housing are basic: Ghona is accessed by a sealed road, with sub-villages connected by unpaved roads vulnerable to damage during rainy seasons. Residents in Kiterini receive lower incomes, and housing tends to be more basic than in Ghona. It was also noticed that people in Kiterini are more superstitious and more likely to utilize the services provided by traditional healers than residents in Ghona. Health care services are provided by public and private providers, with most maternal health care through public institutions. The closest primary health centre is a public dispensary 5km from Ghona (further from Kiterini) along an unsealed road which provides antenatal support but no delivery services. Delivery services are provided either by local traditional birth attendants or Mawenzi Government Hospital in Moshi, 30kms from Ghona. Maternity services, including prenatal check-ups and delivery services, are provided free of charge although women are expected to provide vifaa – the consumables used during birthing procedures (see Spangler and Bloom, 2010).

Research was conducted in Ghona and Kiterini in July 2011. A cross-section of the community were engaged through 30 in-depth semi-structured interviews supplemented by observational notes, was used to explore trends and beliefs about birthing practices and delivery choices. Contextual information and observations were recorded in a field diary. A gatekeeper from KEDA assisted in the identification and recruitment of a purposive sample of 19 mothers between the ages of 18-48 years who had previously given birth either at home and/or a local health facility (see table 2 for

background information). Recruitment of mothers continued until data saturation was reached. Other key informants, including village chiefs and elders (3), health workers (3), traditional birth attendants (3), and males in households (2), were purposively recruited and interviewed to gather broader impressions on birthing practices and relevant socio-cultural factors.

INSERT TABLE 2 AROUND HERE

Semi-structured interviews provided contextual, descriptive and process-oriented information while providing flexibility to explore emergent key issues. The interviews were conducted in participants' homes to ensure a sense of comfort and security for the participants, while seeking to minimize disturbance and ensuring the interviewees felt valued.Interviews explored the factors informing birthing and maternal health seeking decisions, experiences of home and/or institutional deliveries, barriers to accessing obstetric care services, community perceptions towards birthing practices and identification of those involved in decision making processes. As none of the participants spoke English, a local Swahili-speaking translator with previous research experience assisted Singh in all interviews, each of which lasted 45-55 minutes. In order to minimise the risk of misinterpretation and misunderstanding, translators were thoroughly briefed about the research prior to the project and follow-up questions and clarifications were sought from participants during interviews. These follow up questions were also intended to mitigate against any bias among respondents towards giving the 'correct' or 'expected' answer in relation to use of modern health care. Singh's positionality (in terms of status (a postgraduate student at a UK institution) and national background and race (Indian) undoubtedly informed

the data collected (see Richards and Emslie, 2000) and efforts were thus made where possible to verify information given through follow-up questions and observational data.

Interviews were audio recorded and translated content transcribed by the researcher. Analysis was based upon an inductive approach: emergent themes from the data formed the basis for the coding framework. Transcripts were coded and further cross-cutting themes and categories identified and recorded. This iterative process ensured themes emerged from the data rather than being imposed from an external theoretical frame. Nine key themes were identified which have been consolidated into three key strands for discussion here, namely access, cultural norms and care provision.

Accessibility of care

The accessibility of modern health care facilities remains a key concern for maternal health care provision and uptake amongst women in Ghona and Kiterini. The closest public hospital providing recognised maternity services is Mawenzi Hospital in Moshi, a 30km journey away from Ghona. Travel to the hospital is problematic due to a paucity of transport options, journey time, and the cost of transport. The lack of reliable public transport or private vehicles in Ghona and Kiterini presented a barrier to access, one that was exacerbated by heightened perceptions of inaccessibility. For expectant mothers, such as one 26-year old pregnant woman, these concerns were particularly acute in relation to potential emergencies or the onset of labour during the night,

> I am currently very worried as I may go into labour anytime and with the closest hospital being 30 km away I might not be able to make it… There are no means of transport available especially at night and therefore if I get pains at night I will have no option but to deliver at home. (Respondent no 3)

Compounding these concerns were stories from mothers in both Ghona and Kiterini who had been unable to access the hospital due to either the rapid onset of labour or the lack of readily-available, suitable transport. In one instance, this led to a 30 year old woman with previous positive experience of giving birth at the hospital delivering at home without any medical assistance,

> I have four children, three were delivered at the main hospital in Mawenzi and the youngest one at home. My force of labour came so suddenly that I had not time to go to the hospital and I literally delivered outside my house on my own, without any help. (Respondent no. 5)

For a twenty year old mother, the delay in being able to reach the hospital meant she delivered her child on a dala-dala (minibus) en route to the hospital,

> My pains started in the afternoon and with much difficulty I managed to get on a dala-dala. Midway into the journey I realised that the legs of my baby were already out. It was extremely uncomfortable and embarrassing as I had to deliver in the bus in front of everyone. (Respondent no 10)

The challenges posed by barriers to access (Phase II delays in Thaddeus and Maine's (1994) model) due to the distance, time, and lack of suitable transport options available to reach a hospital are noted elsewhere (see for instance Magadi et al., 2000; Seljeskog et al., 2006). These challenges were more pronounced for women in the poorer Kiterini sub-village than in Ghona due to the extra distance to Mawenzi hospital, poor road conditions in Kiterini, more limited access to public transport vehicles and the comparatively higher financial burden. These limitations were particularly acute when there was a sudden onset or rapid progression of labour which often necessitated attendance by a traditional birth attendant due to an inability to rapidly access institutional facilities (Spangler and Bloom, 2010; Mrisho et al., 2007; Amooti-Kaguna and Nuwaha, 2000).

In both communities, the issue of cost remained a barrier to the poorest accessing institutional maternal health care. While maternity services are free in Tanzania, the costs of transport plus consumables used during the procedure imposed a significant, and at times insurmountable, burden particularly for those in Kiterini. In such situations, women who wanted to deliver at hospital were unable to do so,

> I only had a limited amount of money, just enough to pay for transport but then in the hospital I had to buy gloves, cotton and other things including my food. So what is free at the health centre? I want to deliver at the hospital but if I have no money what can I do? Delivering at home is the only choice left. So for my last two births I delivered at home as I did not have enough money. (Female, 45 years old, Respondent no 12)

While the spread of maternal health care services in Tanzania has reduced the distance, cost and time taken for many women in rural areas to access these services, it appears that for the poorest women in Ghona and particularly Kiterini, the continued costs incurred for consumables and sundries are a significant enough burden to prevent them from accessing these services. While this finding resonates with Straneo et al.'s (2014) findings, it does not support their conclusions for rolling-back maternal health provision to fewer sites as the increased transport costs would further marginalise the poorest women in these communities from maternal health care services. Rather, the contrasting findings from Ghona and Kiterini suggest that in a situation of improved education and community awareness of positive experiences of institutional birthing, attitudinal and socio-cultural changes follow. These changes witnessed in Ghona indicate that where educational and attitudinal changes are occurring, both individuals and communities seek ways to ensure expectant mothers can access hospital services by reducing delays in deciding to seek care through increased awareness not only of health concerns, symptoms and risks but also the availability of care (Phase I delays) as well as providing collective support to ensure expectant mothers are able to travel to the hospital (Phase II delays).

Whereas other studies have noted the cost of transport as a significant barrier to accessing institutional health services, this was less of an issue according to women in Ghona. While the cost of transport was mentioned as a burden, these generally are not enough to dissuade women from utilising institutional services: rather, the benefits of accessing these services are viewed as outweighing the financial costs incurred (see also Griffiths and Stephenson, 2001). For women in Kiterini perceptions and realities of barriers to access in terms of financial and other resources are an important factor,

although the dominant influencing factor on deciding to seek care remain sociocultural factors.

Sociocultural factors, quality of care and behaviour change

Sociocultural influences are central to the possibility of, and delays in, expectant mothers seeking maternal health care (Thaddeus and Maine, 1994), with clear differences evident between Ghona and Kiterini. Discussions with mothers in Kiterini sub-village highlighted how cultural traditions and expectations remained influential: women who delivered at home were seen as stronger and having undergone a rite of passage, leading to higher social status than those women opting for institutional deliveries (see also Kyomuhendo, 2003). As one key informant in Kiterini explained, traditional beliefs remained powerful and determined the health care choices made during labour,

> It is believed that when a woman is having a prolonged labour and is unable to deliver, she may be bewitched and needs to be taken to a witch doctor. The witch doctor will then perform some sacrifices to help the woman deliver fast. As these cannot be practiced at hospitals, some women prefer to deliver at home with the traditional birth attendant. (Male, 57 years old, Respondent no 15)

Low levels of education and limited exposure to institutional health facilities amongst women in Kiterini contributed to the continued prevalence of such beliefs and distrust of modern health care provision (see Stephenson et al 2006). These attitudes and community pressures differed notably from Ghona, where residents had greater access

to formal education and increased engagement with modern health care facilities as well as access to ante-natal classes at the local dispensary. Here, health practitioners also counselled women on the benefits of institutional birthing, contributing to the increasing uptake of this option by women in Ghona,

> I did not have enough money to go to the hospital during my pregnancy and had decided that I will deliver at home. But when I went for an antenatal check-up the nurse convinced me and told me about the risks I can expose my baby to if I delivered at home. This made me change my mind and I started to save money to go to the hospital. Also the nurses gave me iron capsules during my visit and checked me and my baby thoroughly for any problems. I found that to be very reassuring (Female 45 years old, Respondent no 11)

The reassurance provided by health care practitioners as well as growing awareness of the enhanced technical skills, equipment and hygienic conditions improved perceptions not only of the quality but also the importance of deciding to and reaching care facilities in a timely manner. These concerns were outlined by several women in Ghona who noted how increased awareness of potential complications and satisfaction with treatment and outcomes increased their predisposition to seeking hospital care for future births, and encouraging others to do the same,

> I delivered en route and was bleeding heavily. When I finally reached the hospital the nurses had to give me an injection to stop me from bleeding. If it had happened at home with a traditional birth attendant I would have definitely

> died. That's when I promised myself that I will always go to the hospital to deliver. (Female, 30 years old, Respondent no 18)
>
> I have delivered all my children at the hospital, so even for this one I will go back to the health facility as I had a good experience during my last deliveries and also feel safer there. (Female, 36 years old, Respondent 22)

The feedback generated through such experiences – experiences that highlight both the dangers posed in delaying seeking care and reaching medical facilities, as exemplified by the second quote above – influence both individual and collective attitudes. As increasing numbers of women in Ghona have positive maternal health experiences at Mawenzi Hospital, trust increases and local sociocultural attitudes begin to shift, reducing Phase I delays in deciding to seek care (Thaddeus and Maine, 1994).

However, a number of negative stories and experiences of hospital births by women in Ghona highlighted how issues such as maltreatment of patients or the seeking of bribes for treatment could undermine the reputation of the treatment centre and reduce utilisation of these services. Two of the stories relayed illustrate continued challenges in ensuring the uptake of maternal health care services. The first set of concerns raised illustrate how additional hidden costs of treatment in the form of vifaa or bribes to ensure treatment is provided may result in Phase III delays (receiving adequate and appropriate treatment) for those unwilling or unable to pay (see also Spangler and Bloom, 2010). As a young woman explained.

> They (nurses) always expect some additional money to look after us better. This time when I was admitted I saw a nurse beat a pregnant woman, as she was not following her orders. (Female, 32 years old, Respondent no 23)

The use of physical violence against a patient further undermines the reputation of the hospital and satisfaction with service. This concern is raised in other studies where – particularly very poor – pregnant women are subject to maltreatment and treated as 'inferior' by hospital staff (Kowalewski et al., 2000). On a less directly violent level, but invoking a form of emotional violence through maltreatment, the refusal of staff to adequately attend to another woman during her labour resulted in her delivering in the ward without adequate privacy and medical support, causing emotional distress,

> I kept on telling the nurse that I am ready to deliver but she insisted that I should wait. After sometime I could not control and delivered on my bed in the ward in front of everyone. It was the most embarrassing and humiliating moment of my life. (Female, 45 years old, Respondent no 27)

Failure to provide adequate emotional support during and after childbirth was not confined to such extreme incidents as outlined above. The lack of attendance to the emotional wellbeing of pregnant women and new mothers was identified by many as a key failing of existing maternal health provision. For several women from Ghona, the hospital's policy to bar friends and relatives led to a sense of isolation as well as increasing burdens associated with procuring food and other basics,

> It would have been better if any of my family members was allowed to be with me during my stay as I was physically and mentally weak that time and wanted help and support. I even had to get my own food. (Female, 45 years old, Respondent no. 11)

Giving birth in an unfamiliar environment, with unknown caregivers, caused stress and anxiety amongst women, echoing findings that demonstrate how hospitalization is perceived as providing 'physical' safety but not 'emotional' security (Seljeskog et al., 2006). The desire expressed by women in Ghona and Kiterini that a family member or friend be allowed to accompany them during institutional birthing would increase their emotional security (Bonaro and Mary, 2004; Hadjigeorgiou et al., 2001), while also providing a deterrent to mistreatment or abusive behaviour by nurses (Kowalewski et al., 2000; Mrisho et al., 2007; Moyer et al., 2014; Spangler and Bloom, 2010). While there is extensive literature on issues of physical and emotional violence before and after childbirth, there is very limited engagement with the issue of emotional security during childbirth. Not only can degrading encounters lead to individuals deciding against institutional childbirth in the future, but this may also contribute to collective antipathy towards maternal health care provision, with negative outcomes for maternal mortality and other indicators.

Despite such negative experiences and concerns over the lack of emotional care provided, the general perception remained that the benefits outweighed the costs of hospital deliveries, as outlined by one mother,

> Even though there are problems regarding the attitudes of the staff, I would still go back to the hospital to deliver as I want skilled people to help me during childbirth and make sure that my baby and I are safe. (Female, 45 years old, Respondent no 27)

While such positive perceptions and greater understandings of the health benefits of seeking medical care have assisted in the increased uptake of institutional birthing services, other factors have also been important in Ghona and Kiterini. Notably, the relative autonomy of women – primarily in Ghona – to make decisions pertaining to family matters and resource utilisation, coupled with positive engagement and integration of husbands into maternal health education practices, have improved maternal health service access (Adjiwanou and LeGrand, 2014). Effective engagement of multiple stakeholders – pregnant women, husbands, elders, traditional birth attendants – has increased awareness of and support for maternal health service uptake.

These educational engagements and increasing experience of modern health services are contributing to both individual and collective attitudinal change and practices. It is evident that there is a gradual shift in the dominant sociocultural frame away from suspicion of Western health care, stigmatization of women using these services, and valorizing of homebirths as a rite of passage into womanhood. Instead, with increased awareness of the potential dangers and complications of childbirth, community expectation and pressure was for expectant mothers to access institutional maternal health care – an expectation that translated not only into pressure on expectant

mothers to save money to meet hospital costs but also into communal savings practices to assist impoverished women in accessing hospital care.

Educational interventions through public health information provision, coupled with growing experience of and trust in modern health care, meant that expectant mothers in Ghona increasingly prioritised the benefits of giving birth in Mawenzi Hospital over the significant financial expanse. The differences in responses between Kiterini and Ghona demonstrate the importance of women's perception of the benefits of receiving skilled, professional maternal health care, as well as the influence of local community expectation, were important in determining preferences for institutional or homebirth (Amooti-Kaguna and Nuwaha 2000; Hodgkin 1996). In Ghona, increasing familiarity with and trust in institutional obstetric care meant collective attitudes towards these services engendered self-reinforcing maternal health-seeking behaviours that prioritised utilisation of health facilities. Here, women opting for institutional births were viewed as modern and knowledgeable, while those having homebirths were stigmatized and deemed irresponsible (see also Spangler and Bloom, 2010). Increased presence of and engagement with health promotion programmes (aided, to an extent, by higher levels of literacy in Ghona as compared with Kiterini), increased engagement of and buy-in from elders and traditional birth attendants, enhancing the uptake of institutional birthing facilities.

Gaining local trust and support from elders and traditional birth attendants, as well as developing effective (in)formal education programmes, have encouraged gradual collective attitudinal and behavioural change (see also Mwewa and Michelo, 2012). This shift towards increasing preference for modern maternal health care has resulted

in collective strategies to provide emotional, financial and material support to enable mothers-to-be to access hospital care and reducing delays in deciding to seek and then reaching health care services. Changing collective socio-cultural views on childbirth have a clear emotional dynamic: the emotional work required to decide to and then undergo institutional birthing is reduced when there is collective support, reflected in emotions of trust, acceptance, sense of security and belonging, and the emotional comfort associated with reduced conflict and tension surrounding maternal health decisions and practices.

In Ghona, pregnant women were encouraged, through direct advice and mutual expectation, to save towards the costs associated with institutional births – a private investment for this 'private' good. In this situation, the sociocultural pressure is inverted: in Kiterini, pressure remains for women to give birth at home with traditional birth attendants as a rite of passage, whereas in Ghona, women who give birth at home believe they are viewed as 'backwards', poor and irresponsible,

> If I deliver at home then there will be gossip in the community and people will say that I did not have enough money to deliver at the hospital. They will look down at me and think that I am poor and I will certainly not like that. (Female, 19 years old, Respondent no 1)

This young, expectant mother's response highlights the changing sociocultural pressures in Ghona and the changing focus of stigmatisation. In Kiterini, women opting for or requiring hospital-based delivery were stigmatised as 'weak' or 'cursed', wheras in Ghona stigma is instead reserved for those who are viewed as being

careless or inconsiderate of the welfare of their baby through opting for homebirth or failing to plan financially to cover the costs of hospital-based labour,

> Women who deliver at home are careless, unaware of risks involved in homebirth and do not care much about their health or their child's health. They are conscious of their pregnancy from the start so they should plan properly and have enough money for institutional childbirth (Female, 39 years old, Respondent no. 24)

The two responses above implicitly reiterate the continued issue of cost and access as a Phase I and Phase II delay. The cost of transport, consumables and other expenses is a burden but one which in delaying the decision to seek care (Phase I) is overtaken by sociocultural expectation and pressure to seek care. With this shift, the barrier of the actual costs (Phase II delay) becomes a stronger issue, however, this is (at least partially) mitigated by pressure upon expectant mothers to plan ahead and make provision for these costs in the months before giving birth.

In Ghona, expectant mothers who had not saved enough money for an institutional birth were thought to be careless and irresponsible. While this led to a stigmatisation of such women, it did not lead to their marginalisation. Instead there was a move towards increasing community intervention through gifting or lending small sums of money to ensure access to institutionalised care and support – a collective or 'public' investment in a 'private' good. Such practices indicate a collective concern and moral dynamic associated with increased acceptance, and expectation, of institutional maternal care resulting in self-reinforcing maternal health-seeking behaviours that

prioritise access to and utilisation of health facilities. Simultaneously, they highlight how social capital and collective consensus are powerful influences over both individual and communal decision making and practices, including overcoming material, logistical and financial barriers to institutional care, and reducing delays in both deciding to use and then actually reaching modern health care facilities.

Conclusions

Multiple factors influence maternal health seeking behaviours and attitudes within Ghona and Kiterini, contributing to various delays across each of the three phases suggested by Thaddeus and Maine (1994). While distance and accessibility remain a key factor in limiting uptake of institutional birthing, shifting sociocultural influences and expectations are seen as driving a change in attitudes towards, and utilisation of, modern maternal health care services. Improvements in education levels and increased autonomy for women are implicated in increasing utilisation of maternal health care services, often supported by the active involvement of husbands and health care providers in ensuring access to institutional maternal health services. These trends indicate the potential benefits of expanding the focus of maternal health promotion policies to further include these actors so as to improve the support networks and provision for pregnant women, and assist in ensuring access to institutional maternal health care. In particular, state- and NGO-backed public education and awareness-raising interventions aimed at improving the social standing of women, and increasing their influence on household decision making processes

particularly in relation to household budgets and health-seeking decisions, could further improve the utilisation of maternal health care services.

In both Ghona and Kiterini, greater awareness of (maternal) health concerns including hygiene and disease (notably HIV) meant both expectant mothers and traditional birth attendants were concerned about their vulnerability to infection and negative health outcomes. Recognising the continued infrastructural and other barriers to women in Ghona and Kiterini accessing institutional birthing services, the further integration of these care providers into the maternal health care system and provision of training and equipment to conduct safe and hygienic deliveries could further enhance maternal health outcomes (Ray and Salihu, 2004; Tomedi et al., 2013). Beyond such efforts, further measures to reduce both perceived and actual barriers to accessibility would seem to be most effectively targeted not at upgrading additional clinics to provide maternal health services (see issues raised by Straneo et al., 2014) but in improving the availability, and reducing the cost, of transportation for pregnant women to reach appropriate medical care as part of a more holistic development plan (see WHO, 2005).

Changes not only in individual but also in community attitudes towards birthing practices are evident in Ghona and Kiternini. Whereas more traditional beliefs and practices continue to inform birthing practices in Kiterini, increased community exposure to and support for institutional birthing are promoting behavioural change both in expectant mothers' accessing antenatal support as well as institutional birthing in both Ghona and Kiterini. These changes are not only expressed in the changing stigma, in a shift away from the valorising of homebirths, but also in emergent

individual and collective practices to overcome financial and logistical barriers to institutional services.

These emergent practices underscore not only the vital role of collective beliefs and attitudes informing individual birthing practice, but also potential ways in which broader development strategies – including microfinance initiatives – could support efforts to improve maternal health outcomes. Thus, more contextually-sensitive and holistic approaches to maternal health care improvements encompassing efforts to promote individual and collective attitudinal and behavioural changes could have positive outcomes for maternal health care. Our findings highlight the importance of developing culturally sensitive health provision practices while recognising culture as dynamic and mutable, such that incremental changes in attitudes and behaviours can lead to self-reinforcing cycles of actions and attitudes. Further engagement by NGOs and health care workers to foster changes in communal attitudes around of traditional and modern childbirth would likely promote collective and individual attitudinal and behaviour change to assist expectant mothers in accessing modern maternal health care facilities.

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