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Barriers to Uptake of Emergency Obstetric and Newborn Care Services in Sierra Leone: A Qualitative Study

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Abstract

Intractable high maternal and newborn mortality in Sierra Leone eight years after the end of the long civil war was of grave concern to public health officials and the general public. The objectives of the study were to identify demand-side barriers to the uptake of emergency and newborn care (EmONC) services and to suggest strategies to improve accessibility, utilization and client satisfaction.

Methods: In June 2008 background discussions were held with public health officials, nongovernmental organizations (NGOs) and professional associations about the delivery of maternal and newborn care services. Focus group discussions (FGDs) were conducted in four sites; at each site five groups of 8 participants each were recruited from communities adjoining selected health facilities. Additionally, semi-structured exit interviews were conducted with women awaiting hospital discharge after care for an obstetric complication. Training for the fieldwork was conducted as part of a 5-day participatory tools development and pilot study workshop. All exit interviews and FGDs were conducted in the local language; tape recorded, transcribed and translated. The data were stripped of any preset models and emerging themes were grouped into explanatory narratives.

Results: We showed that the main barriers to utilization of maternal health services and the uptake of EmONC services in Sierra Leone were the prohibitive, inconsistent and unpredictable cost of services, inadequacy of supply and skills of healthcare providers, poor quality of care, disrespectful care, perennial shortages of equipment and supplies, and the lack of public utilities.

Conclusion: Abolishment of user fees, improvements in both the quantity and quality of health care providers and rehabilitation of health facilities will be needed for Sierra Leone's progress toward its MDG 4 and 5 targets.

Keywords: Emergency obstetric and newborn care; Maternal mortality; Post-conflict; Barriers; Neglect and disrespectful care; Sierra Leone

Introduction

With a Maternal Mortality Ratio (MMR) of 857 per 100,000 live births [1] and neonatal mortality rate of 49 per 1000 live births [2] Sierra Leone has one of the highest maternal and newborn mortality rates in the world. Universal access to Quality Emergency Obstetric and Newborn Care (EmONC) services is one of the strategies for the reduction of maternal and newborn mortality [3].

Political commitments to addressing health issues in post conflict Sierra Leone is demonstrated by ten percent of the 2007 national budget allocated to health [4] one of the few countries with health share of national budgets approaching the 15% target set by African leaders in the Abuja Declaration [5]. Indeed, there is a strong commitment from the highest levels of government.

To specifically address maternal and newborn mortality, the Ministry of Health and Sanitation (MoHS), conducted an EmONC Needs Assessment in June 2008. Similar quantitative facility-based assessments have been conducted in many developing countries to look at accessibility, utilization and quality of EmONC services [6]. This demand-side qualitative study complements the 2008 Sierra Leone EmONC Needs Assessment [7, 8].

Some authors have focused on demand-side barriers to uptake of maternity services urban [9] or rural [10] settings, we report on perhaps the first qualitative study to focus on the barriers to uptake of services as part of an EmONC Needs Assessment in a post conflict setting.

Objectives of the study

- To identify barriers to uptake of EmONC services by mothers and for their newborns
- To recommend strategies to improve EmONC accessibility, utilization and client satisfaction

Methodology

In the preparatory phase of the study series of meetings were held with officials of the MoHS, health sections of relevant United Nations (UN) agencies, NGOs and professional associations to share consensus on the current state of health services and potential barriers to access and utilization of services. This was followed by a five-day participatory

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workshop of MoHS, UN agencies, civil society groups, and the data collection teams for tool development and training of field staff in June 2008; focus group discussion and interview guides were drafted, piloted in communities around Freetown, Sierra Leone and finalized.

Semi-structured interviews were conducted with women awaiting discharge from health facilities after treatment for an obstetric complication to solicit individual opinions and first-hand experiences of interactions with health facilities, and willingness or reluctance to use facilities for routine and emergency maternal and newborn care services in the future. Interviews took place in the presence of family members if respondents so desired. At the time of study design some of the researchers argued for a limited collection of demographic data because in a post conflict environment the collection of such data could be distressing to interviewees. In the interest of confidentiality, no questions were asked on the clinical condition of the patient. Interviews were held with 123 women in 69 health facilities – 30 hospitals, 19 Comprehensive Health Centers and 20 Maternal and Child Health Posts. Most of the interviewees were homemakers, petty traders and peasant farmers in the 25 – 49 age brackets. Refer to Table 1 for interview guide domains. Four sites, one in each geographical zone of the country, were selected for focus group discussions; Freetown, Western Area; Bo, Southern Region; Kailahun, Eastern Region and Koinadugu, Northern Region. The first two sites are urban and the other two rural. Each of the four sites was home to a reputable or better performing hospital that served as areferral center for other health facilities in its zone (Table 2). Focus group discussions (FGDs) were used to surface the opinions of the communities in which health services were situated. In the four study sites, fieldworkers approached potential participants on the premises of health facilities, and residents or shop owners in the neighborhood of health facilities. Willing volunteers who had previous personal experience of services in the health facility or experience during healthcare seeking by close family members were assembled into five focus groups of eight participants each. No incentives were given to participants. The five focus groups were male youth, female youth, adult female, adult male, and TBAs. Youth was defined as age 15 – 25 years and adult defined as age 25 – 49 years. A single female TBA group was formed in each site irrespective of age. In all sites, chiefs and community leaders facilitated access to communities and sometimes assisted with recruiting TBA focus groups. Refer to Table 2 for focus group guide domains and Table 3 for a description of focus group participants.

Male groups were included because of their decision making roles in care seeking, especially in the context of a cash-for-access service in a post conflict economy in which women had limited personal incomes. Youth groups were formed to address concerns that health services were not sufficiently "adolescent friendly". TBA groups were recruited to elicit frontline experiences of events leading to complications and maternal mortality.

A moderator and a scribe convened the FGDs. The moderators followed the FGD guide, while the scribe took notes, suggested probes, managed tape recording and time assigned to each topic. This structure was used in all sites. Each FGD lasted 90 to 120 minutes.

•Decision-making for care seeking
•Recognition of complications and danger signs
•Utilization of services by alternative care providers
•Likelihood of using the health facility again
•Perceptions of the health facility before and after receiving care
•Ease and cost of commuting to the health facility

Table 1: Domains in interview guide.

General Issues (All Discussants)	•Women and newborn health priorities of their communities •Decision-making about choice of delivery services •Access to EmONC healthcare •Perception of service & Client Satisfaction •Community-based support for women in emergencies •Danger signs •Suggestions on how to improve services for pregnant women, mothers and their babies
Women Only – both youth and adults	•Previous experience of maternity and newborn care services •Choice of home/TBA versus health facility birth •Likelihood of health facility birth at next pregnancy
Men Only– both youth and adults	•Perceptions of cost versus value of maternity services •Likelihood of reusing maternity services
TBAs Only	•Common maternal and newborn problems encountered during labour and delivery •Indications for referral to health facilities and perceptions of maternity services •Experiences of referral to health facilities •Nature of support received or expected from health facilities

Table 2: Domains in focus group discussion guide.

Characteristics		Gender		Total
		Male	Female	
		n=64	n=96	n=160 (100%)
Location	Rural	32	64	96 (60%)
	Urban	32	32	64 (40%)
Age (years)	Mean	29	33	31
	Range	16 - 49	15 - 60	15 – 60
Parity (women)	Nullipara	n/a	3	3 (3.1%)
	1 – 4	n/a	53	53 (55.2%)
	≥5	n/a	40	40 (41.7%)
Marital status	Married	46	73	119 (74.4%)
	Separated	0	1	1 (0.6%)
	Single	18	15	33 (20.6%)
	Widowed	0	7	7 (4.4%)
Highest level of formal Education	None	19	55	74 (46.3%)
	Arabic Studies	1	0	1 (0.6%)
	Primary	7	16	23 (14.4%)
	Junior Sec	15	17	32 (20.0%)
	Senior Sec	17	7	24 (15.0%)
	Tertiary	5	1	6 (3.8%)

Table 3: Description of Focus Group Discussants.

Trustworthiness of the data was ensured by using multiple sources of information and multiple methods of data collection. In addition, participatory tools development and the multiple reviews of the draft documents by several stakeholders increased trustworthiness of the data.

Analysis

All interviews and FGDs were conducted in the local language. Recordings were transcribed and translated into English by two native speakers assisted by YH who is also a native speaker. Data were read several times by three of the co-authors – YH, MO and PA to identify main themes. KO performed coding and text analysis using Weft QDA [11], qualitative analysis software. Grounded theory [12] was applied by identifying emerging and recurring themes in the data and these were grouped into explanatory narratives relevant to the study objectives.

Ethical approval

The study was approved by the ethics committee of the MoHS.

All participants were informed in their local language of their rights as study participants and individual consent was obtained from all participants.

Results

Participants of our study experienced many barriers to the utilization of health services in general and to the uptake of EmONC services in particular. We present the data in themes and subthemes. Sources of data are presented in parentheses at the end of quotations.

Prohibitive cost of services

The high point-of-care out-of-pocket charges paid for health services were major barriers to the utilization of health services. Many participants in the study would not recommend the services to "their enemy".

"When it is time for delivery, they ask you to pay Le 40,000 or Le 50,000" [over US $15]- [adult female discussant].

"Last year I went to the hospital; I bled the whole day. I ended up having a miscarriage. My husband had to sell the seeds we were to plant to buy a pint of blood for Le 60,000"- [adult female discussant].

"Even if I see my enemy going there, I will advise her not to go because the hospital is not for poor people. Even if your child is dying, you have to have the money"- [adult female discussant].

Some of the participants were concerned about the perceived inconsistencies and arbitrariness of the fees charged, fear of being charged too much and the perceived unfairness of the charges; many reported borrowing or having to sacrifice crucial family necessities to cover the charges.

"Sometimes you spend money from one table to the other" and "We never know the exact amount" - [adult female discussant].

"As my sister just said, I have heard kombras [nursing mothers] say that their child was not as seriously sick as some other child; yet they were asked to pay the same amount"- [adult female discussant].

"They are not fair; the poor patient will die if he/she does not have money to meet these costs"-[adult male discussant].

Some participants suggested that the government should institute measures to enable them earn incomes to cover their basic needs.

"We want the government to provide micro credit to enable us to do business, get money and take care of our problems"- [adult female discussant].

Geographic inaccessibility and the burden of referral

First-level facilities often send patients to higher levels of care; the need for a rapid transfer of patients to higher levels of care when complications occur underscores the role of the referral system in accessing EmONC services. However long distances, poor road networks, lack of appropriate transportation and lack of funds to pay for the use of an ambulance where it is available hinder use of health facilities.

"Transport in this community is hard to come by. If the situation is not a serious emergency, the woman can walk but if it is urgent, an Okada [commercial motorbike taxi] is called in"-[adult male discussant].

"We had difficulties raising the fee for the ambulance that brought me here. The family had to contribute the money"-[interviewee].

Many of the participants in the FGDs identified the need for an efficient transportation system as key to reducing maternal deaths and propose efficient transportation, communication and ambulance systems for the country.

"The most urgent need for improvement of services is the provision of an ambulance". "We want the government to assist in the provision of an ambulance or any kind of vehicle"-[adult male discussant].

"The provision of communication links and transportation for outreach to villages where there are no health facilities is also important". "We also want them to help us with the roads"- [adult male discussant].

Culture, faith and fatalism

Culture and faith play very significant roles in perceptions of ill health, perceptions of care received and in predicting future use of health facilities. Reflections of the cultural and religious beliefs were expressed variously by study participants: divine intervention, destiny, cultural practice of delivering at home for some ethnic groups who see a woman who can go through the pains of labour as strong and the perception that delivering in health facilities was for those with problems in pregnancy.

"I delivered three children at the hospital, they all died. Since then I always deliver at home. I have no problems when I deliver at home. If God allows, I will deliver at home again because it is God that holds our lives"-[adult female discussant].

"God decides because everything is destined; if when I am pregnant I happen to move from one place to another, the place where I have labour pain and eventually deliver is the place God has decided I would deliver"- [adult female discussant].

"Some deliver at home because it is their custom; like the Foulahs [a West African tribe], they prefer to deliver at home by their husbands; they can endure pain"-[adult female discussant].

Combining belief in traditional medicines, cultural practices and orthodox medical care appeared to be the norm for some participants, who also believed that for some health conditions, traditional medicines were more effective. These applied to care of the pregnant woman through to the development and growth of babies.

"When my child got convulsion, I had him treated at the hospital and I also tied this rope [charm to ward off evil spirits] round his neck"- [adult female discussant].

"Grannies [elderly relative] tie a rope [charm] round the waist of the child; with this rope the child could walk before one year; he may not even get sick. Sicknesses like convulsion may not affect the child. There are some sicknesses for which the native herbs work more effectively than hospital medicines".

Status of women and gender roles as barriers

Pregnant women should have the autonomy to decide on their healthcare needs and those of their children. Access to health services may be delayed or denied when third parties are involved in decision making for care seeking. For the vast majority of discussants and interviewees, decision makers were husbands or male partner responsible for a pregnancy, mothers-in-law and in some cases mothers or an older male such as a woman's brother. Mothers-in-law were responsible for decision making especially for a woman's first pregnancy.

"The man decides, in my own case, when I was pregnant, I was the

first to inform my husband that I intend going to the clinic; he consented. Women have no choice but to go to a TBA when the husband refuses permission to go to the facility"- [female youth discussant].

"If the man as the decision-maker and provider of the money refuses permission, this would result in serious palaver [problems], if my wife goes against my decision, I will not take any responsibility; I will not give her any support"- [male youth discussant].

"The delay caused during this quarrel may lead to suffering and maybe death of the woman. To avoid this, the woman would have to give heed to whatever is the final decision of the man"-[adult male discussant].

"Sometimes even though the pregnant woman may be married, some traditions say that everything pertaining to this woman's first pregnancy should be decided and carried out by her mother or mother-in-law"- [adult female discussant].

"When my wife had her first pregnancy, I did not even know she was pregnant, it was my own mother who first observed she was pregnant; thereafter, all decisions concerning that pregnancy were taken by my mother. After acquiring her own experience from that first pregnancy, decisions for all other pregnancies were made by me"- [adult male discussant].

When the husband's decision was to prevent a woman from using a health facility, some women expressed a potential for defiance of their cultural subjugation if faced with medical emergencies, some would use the health facility, while others would find an influential person or relative of the spouse to plead with him.

"You will just die if you don't go. You have to go to the hospital whether the decision maker agrees or not because it is your life"-[female youth discussant].

"I won't agree with him since it is my life that is involved. I will plead with him. I will find people to talk to him, and then I'll go" -[female youth discussant].

"You may report your husband to your relatives"-[female youth discussant].

Disempowerment of pregnant teenage and/or unwed women

Autonomy for care seeking and decision-making was even less among unwed women and pregnant teenagers who were often abandoned, ostracized or left without any parental financial and emotional support and thus unable to use health services.

"For under-aged pregnant pikin [children] *who may not have anyone claiming ownership and responsibility for the pregnancy, it is their parents and relatives that decide"- [adult female discussant].*

"There was a school girl who got pregnant, no one claimed ownership of the pregnancy; her father drove her out of the house; she was left to roam about until it was time for delivery, she was picked up and brought to the hospital, but she died"-[female youth discussant].

"Teenage pregnant mothers experience a lot of illnesses during their pregnancy and don't get any treatment, because no one claims responsibility for the pregnancy. They are left stranded without someone to care for them and the pregnancy financially. They don't even go to the clinic regularly"-[adult female discussant].

Young male partners of pregnant teenage girls or unwed mothers who may themselves be in school or unemployed often deny responsibility or runaway from fear of parental and family reaction. Parents of a pregnant girl may send her away to live in the home of the male partner.

"One mother of a pregnant teenager said, I have no money, if you want, go to the man that impregnated you or jump na street [jump in front of a car] *and she did not want to know about the girl"-[female youth discussant].*

"When I impregnated one lady, I ran away because I was afraid because my mother threatened to stop me from going to school, she said that I was not matured enough to impregnate a woman, that was why I ran away and went to Freetown. The girl's mother decided that the girl should move to our house, until two or three months when her mother took her back"- [male youth discussant].

In a minority of cases, when the family had the means, they looked after the pregnant girl.

"*When I impregnated a girl, her relatives had money and did not want her to die, so they took her to the hospital to deliver"* [male youth discussants].

Unfriendliness of health services to adolescents

Many of the participants reported that adolescents were hesitant when accessing health services. Adolescent pregnancies are problematic because most pregnant young girls do not want people to find out they are pregnant. Participants also reported that health workers were abusive to teenagers and unwed mothers while many of these girls did not have the resources to pay for antenatal care due to poverty.

"Some women are shy especially the young girls [teenage and unwed] *who do not want the community to know that they are pregnant. They conceal their pregnancy by tying their stomach tightly until it is almost time for delivery before coming to the hospital"- [adult female discussant].*

"School children [teenagers] *conceal their pregnancy for up to six months without antenatal care. It is only when problems occur that they are rushed to the hospital. It might be too late to save the mother or the child or both"- [adult female discussant].*

"The volunteer nurses do abuse the patients; they tell them "na we say le u go ledon under man"? [Did we ask you to sleep with a man?] -[female youth discussant].

Awareness of complication and danger signs

The perception of danger triggers a care seeking response. Awareness of dangers signs was high, and participants mentioned some signs of complications or emergencies during pregnancy, delivery and in the newborn. The danger signs identified included bleeding during pregnancy, convulsion, excessive pain, vomiting, blurred vision, fainting vaginal discharge and a fever

"If the woman bleeds during her pregnancy; if she has a convulsion; and if she throws-up; and if the placenta does not come out or if she bleeds, or has blurred vision" - [adult female discussant].

"I was bleeding and fluid was coming out [premature rupture of membranes] with no labour pains. I knew it was a bad sign"- [interviewee].

"Some women during pregnancy get fits which makes them fall down [unconscious]"- *[adult male discussant].*

"Pus and offensive vaginal discharge followed by premature labour pains requires immediate medical attention"- [adult female discussant].

"When we come to the clinic the nurse always advises us to report at once whenever we experience persistent fever in the evening hours because fever can affect the unborn child which may result in stillbirth"- [adult female discussant].

In the discussions with the TBAs, they reported that they identified cases they perceived as requiring emergency care and referred these.

"We refer when it is the woman's first pregnancy or if an under aged girl".

"I refer short women or when their feet are swollen".

"If the afterbirth does not come out I would refer her to the hospital".

Delay in transition from unskilled to skilled care

Related to the awareness of danger signs is promptness of decision-making to seek healthcare.

"My wife *was with a TBA for two days and was then transferred to the MCH Aide for a day before she was transferred to the hospital"- [adult male discussant].*

"I was at the home of a government hospital volunteer [unemployed but trained midwife]; she gave me an unknown injection. I was with her for two days after which she decided to refer me"- [interviewee].

"The TBA referred me to a health center. I was also referred to the hospital because the labour was not progressing: no labour pains and no movement of the baby"- [interviewee].

Long waiting time and other delays in facilities

Participants in the groups reported that health facilities were not being used due to the fear of having to wait in long queues to be served especially because of the number of clients attending the health facilities and the relatively small number of service providers available.

"Waiting time is long. One can stay in the hospital from 8am to 4pm, because the facility is small in size, the number of clients is high, and the number of staff is too small"- [adult female discussant].

"The doctor was busy; my wife and I waited for five hours before we sent for the granny on the farm"- [adult male discussant].

"As *soon as I came the nursing assistant examined me and called the doctor, but he was ill. So I had to wait till the next day; about 8-9 hours. I was really worried"- [interviewee].*

Sometimes women had to wait several hours for such life-saving procedures as caesarian sections and blood transfusions.

"She was attended to by the nurses immediately we arrived but the C-section was done 12 hours later. I was discouraged because of the delay in performing the C-section"- [adult male discussant].

"I received emergency attention but the treatment was delayed because there was no blood donor. However, blood was donated later and I appreciate God"- [interviewee].

Perceptions of care

The perceptions of availability and quality of care were important to decision making about utilization of health services. Many of the participants expressed positive images that could encourage them to use maternity and newborn care services including effective management of emergencies, availability of round the clock care and experienced staff.

"They [mission health center] are good in handling emergency situations and referral cases. A friend of mine was too short to deliver; they transferred her to a hospital where they did a caesarian on her"- [adult female discussant].

"It is better to be in the hospital. Now I know that the hospital is very important. I am happy for the care and love they have shown me. It is a blessing for me to be here. They saved my life. Otherwise I would have been dead by now. I am very happy; I never knew how I was brought to the hospital but now I am fully conscious"- [interviewee].

Human resource concerns

There were lots of concerns expressed about the inadequacy of human resources with the kinds of skills to address the pressing needs of pregnant women and their newborns and the unavailability of staff when emergency care was required, hence the continued utilization of TBAs, home deliveries and health care seeking outside the official health system.

"My wife had pains at night, I went to the hospital to call the nurse but she was not there so she delivered at home"- [adult male discussant].

"The center is the only place women in the community have but it is not serving the community well because of the constant absence of the nurse"- [adult female discussant].

"She [TBA] *brought me straight to the center and I delivered there in the absence of the nurse who was away on a workshop"- [adult female discussant].*

Some the participants wanted, *"Training to improve on the work of the TBAs" [adult female discussant]*; or *"Allowance for TBAs to make them work better"[adult female discussant]* and the *"Provision of uniforms to make us feel more like health workers" [TBA].*

The attitude of health workers

The attitude of health workers to patients may influence prompt healthcare seeking by patients. Many of the participants including in the TBA groups made very positive comments about the attitudes of health workers in their health facilities.

"The nurses treated me nicely. Sometimes, I come here without money to pay for treatment; but the nurses treat me freely or on credit"- [adult female discussant].

"After delivery the nurse dressed the baby's cord, she gave the child marklate [vaccines] *and she gave me some tablets. If I should deliver another child I would do it in the hospital because I wasn't treated badly by the nurse"- [adult female discussant].*

"If you come with a patient in the middle of the night, they attend to you and allow us to stay with the patient"- [TBA].

There was however an equally sizeable number of participants, who described very bad attitudes such as rudeness to clients, poor interpersonal skills and perceived impatience with clients on the part of their health workers, especially nurses and midwives.

"The nurses don't talk nicely to patients. They are often rude when visiting hours are closed and they even slam the door in your face"- [adult female discussant].

"I am afraid of going to the hospital because if you have labour pains at night, the nurses on duty abandon you or cut you with a blade to deliver quickly"- [female youth discussant].

"When I had my first child at the hospital, they cut me with a blade to allow passage for the baby. When I delivered my second child at the grannies [elderly relative], they were patient until I delivered on my own"- [adult female discussant].

"The doctor does very well to help pregnant women deliver but the nurses are not caring, they often refuse to attend to patients when called upon for help"- [adult male discussant].

Trust in health service providers

A prerequisite for effective patient-provider interaction is the patient's trust that the provider is knowledgeable and motivated to provide the best care available. Testimonies of many participants suggest that the lack of trust in the knowledge, skills and practices of the provider was common.

"The nurses are unable to diagnose properly and to tell us the stage of our pregnancy or whether the child is in the right position"- [adult female discussant].

"She [the nurse] is not good at her job. Instead of telling a pregnant woman how old the pregnancy is she asked the woman [pregnant client] to tell her"- [female youth discussant].

"When she injects one person with one needle, she keeps it to inject other people"- [adult female discussant].

"When we go with our children, the injections they give to them make their hands and feet become heavy. They complain that the nurse doesn't know how to inject them"- [adult female discussant].

Infrastructure, equipment and supplies

Many of the respondents expressed their concerns with the high cost of or lack of medications or drugs and the cessation of distribution of insecticide-treated nets and packages of supplementary foods to pregnant and lactating women.

"Lack of medication and high cost of drugs is problematic. The doctors are doing their best but there are no drugs"- [adult female discussant].

"Mosquito nets to help prevent malaria are not supplied in the area"."They [the government] *used to supply nets, clothes and other items which encouraged women to come to the hospital. This should be restarted"- [adult male discussant].*

Others were concerned about overcrowding in public health facilities include use of the same wards by both men and women, lack of furniture for clients and a lack of appropriate and necessary equipment.

"*We don't have a place to admit patients and there isn't enough equipment. The hospital is small. The hospital should be expanded"- [adult male discussant].*

"The buildings are very small and if it comes to admission both sexes share the same room".

"We usually sit down for long on top of stones. There is no place to sit"- [adult female discussant].

"They [public health facilities] *don't have the equipment to treat patients. They lack equipment to check status of pregnancy and other signs of complications"- [adult female discussant].*

Discussion

The overwhelming concerns of participants were about the prohibitive cost of health services. Some were concerned with the unpredictability of the fees and the practice of collection of fees as-you-go-along from department to department in health facilities. Cost as a barrier to utilization has been well described in West Africa [13-15]. In a post conflict setting where low levels of income are pervasive this is not surprising; many sold household goods and property to afford their healthcare costs. Despite widespread poverty, out of pocket payments for health care in Sierra Leone is one of the highest in Africa; studies in Bo, Kailahun and Tonkolili districts found that a fee of even 500 Leones (US 17 cents) excluded up to 50% of patients from seeking care. The excluded resorted to alternative cheaper care, TBAs and from unqualified practitioners or forfeited care all together [16-18].

Many participants also expressed the inequalities associated with the high cost of services; "the poor patient will just die if they do not have the money". Note that participants did not ask for free services but "affordable" services and income-generation services such as microcredit.

Cost and inconvenience of transportation to distant hospitals were frequently mentioned as barriers to the uptake of services and leading to utilization of TBAs. Similarly, transportation related barriers leading to the use of faith healers for delivery were described in rural Nigeria [13]. When referral services are lacking, the indirect economic cost to friends and family is unimaginable. It has been suggested that the reluctance to place this kind of burden on the family and relatives causes delay in decision-making and a barrier to uptake of services [15]. Many of the participants recommended the provision of better roads, communications and ambulance services. A Gambian study reported that lack of transport and delays in decision-making were only next to substandard care in contributing to maternal deaths [19].

A sense of helplessness among participants was apparent. Even though childbirth was associated with risks, previous personal uneventful non-facility deliveries made women to "hope for the best": expecting God will see them through. This fatalism is reinforced by financial and geographical inaccessibility of health facilities. To the extent that one's chances of pregnancy related survival is barely improved due to poor quality of care in health facilities, this sense of helplessness will persist.

Lack of women's autonomy on childbirth matters as widely expressed by participants is a barrier to uptake of institutional delivery [20, 21] poor women generally defaulted to the choice of their men. Women with more means may challenge this tradition. Male dominance is therefore strengthened by healthcare costs and the gender disparities in income.

Unwed pregnant women, particularly pregnant teenagers, experienced significant stigma. We revealed the multiple layers of authority involved in decision making about a teenager's pregnancy care; first is the male partner or his mother, then the teenager's mother in consultation with relatives and at the very bottom of the decision making pyramid is the pregnant teenager. The cost of health services and the unwed or adolescents' lack of income perpetuate their disempowerment. After bearing severe disempowerment and ostracism, they then face abusive and disrespectful care in health facilities.

Many women begin by entrusting delivery care to relatives, then TBAs and in the event of complications initiation of referral to health facilities may take considerable time as care is stepped up from relatives to TBAs and to the health system. Some patients then access the primary care service where there is no skilled attendant before

they try another facility where they may yet be referred to a hospital. Some participants experienced up to three days between onset of complication and arrival in the facility of definitive care. Ignorance of the services available in different health facilities, long waiting time when they eventually arrived at facilities with requisite services and delays with receiving definitive care all contributing to maternal mortality: all three Thaddeus and Maine delays blending to prevent effective uptake of EmONC services [22].

Majority of participants in the exit interviews [which were only conducted in hospitals] had favorable perceptions of the services that they experienced unlike the negative perceptions from focus group participants. This may be explained partly by normalization [23] whereby recipients of bad services learn to accept such services as normal; in the absence of quality services bad but lifesaving services appear normal. Fear of criticizing the institution while on its premises could be another reason for the favorable reviews.

Second to cost of services, poor supply and poor quality of human resources were barriers to accessing EmONC services. Absenteeism was common among health workers, often perceived to be due to official duties in district health offices. Complaints of disrespectful care and malicious or needless mutilation (episiotomy) were common. Recent data from Ghana suggests that disrespectful care could be a barrier to utilization of health services [24]. These experiences create fear and discourage subsequent uptake of both routine and emergency care in facilities.

Some participants advocated for greater support for TBAs to "help them work better" with health care providers since they were the preference of most women. This goes against current understanding that the training of TBAs has not yielded significant reduction in maternal morbidity or mortality [25, 26] however, training of TBAs has been found to increase utilization of antenatal care services [27].

A recurring theme in the discussions was the lack of equipment and supplies. The perennial lack of drugs, lack of provision of food and the lack of distribution of incentives such as insecticide treated nets (ITN) did not encourage women to use health facilities which were perceived as overcrowded and lacking diagnostic equipment and basic utilities.

Conclusions

In this paper we have shown that the main barriers to utilization of maternal health services and EmONC services were prohibitive, inconsistent and unpredictable cost of services; inadequacy in supply and skills of healthcare providers; disrespectful care especially of adolescents and unwed mothers; and the perennial shortages of equipment and supplies.

In order to address MDGs 4 and 5 in Sierra Leone we recommend a short-term strategy to provide free maternal and new born services. The long-term goal should be services free of out-of-pocket costs at the point-of-need through a national health insurance scheme. Free services will improve the autonomy of women; all pregnant women including teenage and unwed mothers will have better access to healthcare services.

The supply of skilled birth attendants (SBAs) needs to be accelerated. MCH Aides do not have sufficient midwifery skills and no woman should be left in the care of an unsupervised MCH Aide. Thus rapid expansion of midwifery training enrollment is imperative. Deliberate consideration should be given to task-shifting and task-sharing as strategies for expanding coverage of maternal and newborn services.

A deliberate process of coaching and mentoring to ensure that SBA shave supportive and caring attitudes to mothers is important to encourage utilization of maternity services. Pre-service and in-service training of SBAs should include a focus on respectful care and patients' bill of rights. Some aspects of customer care or "needs of service user" [28] trainings and adolescent friendly service delivery should be considered. Senior health care providers must model respectful care and expect same from subordinates.

Health MDGs will not be met without overall improvement in development. Contributions from non-health sectors must be sought. Many study participants rightly demanded improvements in the conditions of roads and telecommunications to facilitate access to EmONC services. Geographic inaccessibility could be minimized by close coordination with non-health sectors in selection and prioritization of roads for rehabilitation, location of new communications masts etc.

This study contributes to the growing body of literature on barriers to the delivery of emergency obstetric and neonatal care services in poor and post-conflict settings as well as the literature on disrespectful care as barriers to uptake of health services.

Limitations to the study

The study was conducted using experienced fieldworkers with a five-day experiential refresher training exercise with limited quality assurance support in the field due to the need for security clearances to visit several areas outside the capital. Inadequate demographic data were collected on exit interview participants. In retrospect, household interviews with women who used maternity services and who survived obstetric complications would yield better data, though more expensive than the exit interviews.

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