Understanding Women Experiences of Seeking and Receiving Maternity Services in Montserrado and Bong Counties, Liberia

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Understanding women experiences of seeking and receiving maternity services in Montserrado and Bong counties, Liberia: An in-depth qualitative study

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Abstract

Since 2000, Liberia has struggled with a high maternal mortality rate (MMR) of approximately 1072 deaths per 100,000 live births[1]; most of which are attributed to preventable complications that could be addressed.[2] Despite efforts from governments and its partners, performance in indicators related to maternal healthcare services still rank amongst the lowest performing health indicators in Liberia. With little emphasis on the everyday experiences of women as it relates to the utilization of care at various health facilities, it is essential to assess and understand why different measures haven't yielded as much impact and how women live the everyday reality of accessing maternal healthcare services in the presence of these measures.

This study draws on women-centered approaches to improving maternal health services based on their lived experiences and personal perceptions on their experience of care with different cadres of healthcare providers.

It is essential to assess and understand the impact of women's everyday experiences in order to reduce maternal mortality in Liberia.

This paper is divided in two sections: Part 1 discusses the political economy as it relates to the context. Part two reports on the research project we completed on this topic "understanding women experiences of seeking and receiving maternity services in Montserrado and Bong Counties, Liberia."

We used an in-depth qualitative assessment of women's experience with maternal health care services. We conducted focus group discussions, in-depth interviews, and participant

observation. From four hospitals across two locations, we purposefully selected 72 women between the ages of 15-49, including pregnant women, mothers of infants, and skilled midwives who were directly involved in caring for women. Three main themes/categories emerged from our study: 1) challenges associated with accessing care at a public health facility; 2) women perceiving private caregivers/traditional birth attendants as a better alternative; and 3) lack of trust in the public healthcare system.

Our study uncovers the challenges pregnant women and mothers encountered while seeking and receiving services at public health facilities. It also suggests that when women have poor experiences seeking healthcare, they are less likely to utilize services. Such experiences may influence their decision of where, with whom and how to seek services and may expose them to increased risk of complications and maternal death. Therefore, healthcare providers should consider women's experience of care to develop more comprehensive strategies and interventions that will improve access to maternal health care services and improve the overall maternal health outcomes in Liberia.

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Part 1: Political Economy/Background

Understanding women's experiences of seeking and receiving maternity services in Montserrado and Bong counties, Liberia: An in-depth qualitative study

ABSTRACT

Since 2000, Liberia has struggled with a high maternal mortality rate (MMR) of approximately 1072 deaths per 100,000 live birth[1]; most of which are attributed to preventable complications that could have been addressed.[2] Despite efforts from governments and its partners, performance in indicators related to maternal healthcare services still rank amongst the lowest performing health indicators in Liberia. With little emphasis on the everyday experiences of women as it relates to the utilization of care at various health facilities, it is essential to assess and understand why different measures haven't yielded as much impact and how women live the everyday reality of accessing maternal healthcare services in the presence of these measures.

This study draws on women-centered approaches to improving maternal health services based on their lived experiences and personal perceptions on their experience of care with different cadres of healthcare providers. It is essential to assess and understand the impact of women's everyday experiences in order to reduce maternal mortality in Liberia.

We used an in-depth qualitative assessment of women's experience with maternal health care services. We conducted focus group discussions, in-depth interviews, and participant observation to gather our data. From four hospitals across two locations, we purposefully selected 72 women between the ages of 15-49, including pregnant women, mothers of infants, and skilled midwives who were directly involved in caring for women. Three main themes/categories emerged from our study: 1) challenges associated with accessing care at a

public health facility; 2) women perceiving private caregivers/traditional birth attendants as a better alternative; and 3) lack of trust in the public healthcare system.

Our findings highlight how women's experiences and perception of maternal health services at health care facilities, particular public facilities influence their decision of where, when, and how to access care. Therefore, the health sector, especially the public health sector, which is widely utilized by the majority of women, should consider women's experience of care. To develop more comprehensive strategies and interventions to improve access to maternal health care services and to improve maternal health outcomes in Liberia, "women experience of care" must align with the "provision care."

INTRODUCTION

"I'm about to lose another sister again! This is the same hospital again where I lost my first sister my people, someone please come for me, here's my case again! Can you people please save this one life for me?"-sister of an unconscious patient

I looked on as Yamah, the elder sister of an unconscious woman who had a still birth, knelt down in tears, pleading with the nurses and midwives at a referral hospital to help her sister. It was a sunny Saturday morning in Red light Gobachop market when Patience, a 7-month pregnant woman was rushed to our clinic, complaining of labor pain. According to her family, she had been receiving regular antenatal care (ANC) at public facilities but had not been able to get all her prescribed medications due to the lack of finance. While her family prepared for the coming of their newborn, with the belief that it was a normal labor, it turned out to be a still birth - the baby was dead three days before this woman came to the clinic. The midwives successfully delivered the dead baby, but the struggle to save the mother's life had just begun. As the nurses and midwives fought to save the mother while she groaned and fought for her life, the mother's

sister who escorted her stood outside sobbing with tears rolling down her cheeks. The only option was to refer her sister to a bigger hospital that could manage her case, especially given her high blood pressure (200/150 mmHg.) Her sister then walked up to me and asked, *"how do we take her to the hospital?" I said to her: "you need to find a taxi or motorcycle to transport her as soon as possible."*

After 25 minutes of searching, there was no means of getting a motorcycle or a taxi to transfer her sister given the location of the clinic. Located in the slum community of Gobachop, the clinic is about 25 minutes away from the nearest referral facility, in a very congested environment with petty traders covering the streets and making it very difficult for a vehicle or motorcycles to easily drive through. The family's anxiety and fear raised high because there was not even an ambulance or an accessible means of transportation to get this patient to the nearest referral facility. When a means of transportation was finally made available to transport the patient, the challenge of accessing a path to the health facility stood out. Bad road conditions and congested communities with no easy access for a vehicle extended a 20-minute drive to 45 minutes. As we drove through the congested and very populated market of Red-light honking and asking traders to allow our car to pass through, this woman continued to fight for her life. I could see her sisters from the view mirror crying and begging her to fight for her life. Looking at a woman with high blood pressure lying in the car while her family pleaded and cried for help, I could not hold back my tears and outrage. We immediately embarked on another journey to try to find the next available hospital. This time, we settled for a nearby private hospital. As we arrived, I went in and spoke with the nurses, who immediately came out and took the woman in. And they asked the family to fill out a registration form and deposit some money.

The story of this unconscious patient and her family is just one example of the experiences women encounter with the healthcare system in impoverished countries like Liberia. However, there is little emphasis on the everyday experiences of women as it relates to the utilization of health care services at various health facilities. It is essential to assess and understand the impact of women's everyday experiences on maternal healthcare indicators given the high maternal mortality rates as well as the current socio-economic and prevailing conditions in Liberia.

In 2017, "every day 800 women died from pregnancy and childbirth-related complications globally," and 94% of these occur in low resource countries like Liberia".[2] Despite efforts to improve skill birth attendance, further 7700 newborns still die each day from complications during pregnancy and childbirth and in the postpartum period.[3]

Baffled by the patient and other women's experience we formulated a question to guide us in the process of conducting our study. What are the experiences of pregnant women and mothers' seeking and receiving maternal health services in Liberia?

This study is important because it draws on women-centered approaches to improving maternal health services based on their lived experiences and personal perceptions on their experience of care with different cadres of healthcare providers.

The aim of this study was to understand the everyday experiences of pregnant women and mothers seeking and receiving maternal health services at four health facilities across Bong and Montserrado counties in Liberia.

The specific aims were:

- To identify (Free listing) and explore (in-depth one-on-one interviews, FGD) the factors that may affect women's experience seeking and receiving maternity services in Montserrado and Bong counties
- To assess women's experience of care at four health facilities in Bong and Montserrado counties (one-on-one, in-depth interviews, participant observation)
- To examine women's perception on how their experience of care may affect maternal health service utilization in Liberia (In-depth interviews, FGDs)

The experience of this patient and other women seeking maternal health services at health facilities across Liberia is deeply rooted in a history of prolonged impoverishment of a country that has experienced years of civil unrest and disease outbreaks

BACKGROUND/HISTORICAL PERSPECTIVE

Civil War and Healthcare in Liberia

Driven by the domestic politics of slavery and race in the US, Liberia was founded by free slaves from America, [3] and was the first African country to gain independence from colonial rule.[4] Liberia is located on the west coast of Africa and shares borders with Ivory Coast, Sierra Leone and Guinea and has 15 counties. Liberia's current population is estimated at 5,033,892 in 2020,[5] with over 1 million living in Monrovia.[6] Monrovia, the capital, is located in Montserrado, is the biggest and most populous of all counties with one-third of the country's population.[7]

Between 1989 and 2003, Liberia experienced a 14-year civil crisis, which was sparked by ethnic division, the abuse of power by the elite, a corrupt political system, and economic disparities.[8] A study conducted by the Peace Building Data Organization found that the historical division in Liberia between the natives and settlers as well as the use of force to impose the

settlers' rule on the natives contributed significantly to prolonging Liberia's civil war.[8] The current health crisis in Liberia is the remnant that brutal civil crisis, during which basic health and education infrastructure was destroyed, creating a health workforce shortage.[4] Prior strides made by Liberia to promote access to healthcare services were gravely affected by the Liberian civil crisis and the Ebola epidemic.[4]

Prior to the civil crisis in Liberia, 293 functioning public health facilities served a population of 3 million people;[9] of this total number, 242 were considered nonfunctional by the end of the civil unrest in 2003.[9] During the crisis, health workers fled the country leaving only 30 physicians to serve a population of 3 million in these 51 functioning public health facilities.[10]

From a GDP of over billions in 1988 before the civil unrest, Liberia is currently one of the world's poorest economies with a GDP of less than US 500 million.[9] This decline reflects the impact of the prolonged civil unrest experienced by the country.[9] Although significant progress was made by the government immediately after the war, the lack of capacity to deliver essential services including primary and secondary healthcare and the lack of reconstruction and rehabilitation. stood out as a significant challenge for the government in 2005.[9]

Even though Liberia is the oldest independent African country, it remains a low-income country with a gross domestic product (GDP) of US $495 per capita, and 54.1% of its population living below the poverty line (USD 1.25 per day.)[7] Despite the scars left on the health care system by the civil crisis, Liberia was able to make significant progress in achieving one key deliverable of the Millennium Development Goals (MDGs) in 2015; reducing child mortality.[4] Similarly, with the support from partners and donors, Liberia made significant progress towards reducing its maternal mortality rates (MMR).[7]

Recent (WHO) Country Cooperation Strategy 2018-2021 for Liberia reported that the total health expenditure (THE) currently stands at US $56, well below the WHO-recommended expenditure to provide essential health services to a population, US $86.[7] Moreover, out-of-pocket expenditure (OOPE) accounted for 85% of Liberia's THE, with significant disparities between and across different geographical locations. [7]

In 2014, Liberia's GDP growth was projected at 5.8%. However, it declined to 2.5% or less by the end of 2014 due to the Ebola epidemic.[7] In Liberia, women account for 51% of the population, and they have been severely affected by wars and disease outbreaks. [7]

Liberia is a signatory to several different initiatives and declarations, including the Sustainable Development Goals (SDG) 2030, Family Planning 2020, the African Health Strategy, the Paris Declaration, the Maputo Call to Action, and the UN Secretary General's Global Strategy for Reproductive, Maternal, Newborn, child and Adolescent health accountability and results.[7] All of these seek to improve access to health care services and financial security for the population and some focus specifically on improving access to maternal health services.[7] Upon signing the "Every Woman, Every Child Initiative", Liberia committed to spending at least 10% of the health sector allotment on reproductive, maternal, newborn, child and adolescent health.[7]

POSTWAR HEALTH SERVICES AND MATERNAL HEALTH

Amidst the devastating effect of the civil war on the health sector, the government of Liberia has strived to improve healthcare services for its citizens. According to WHO, the first democratically elected government in 2005 after the civil crisis faced a "dire health situation". Under-five mortality rate was 110 per 100,000 live births, and maternal mortality was 994 per 100,000 live births.[10] In response to the post-war health challenges, the government of Liberia

with assistance from donors and international NGOs launched the national health outlined plan in 2007 which included the basic package of health services.[11] The package included the administration of health services at hospitals and clinics across the country without charge.[12] Decreasing the high maternal and child morbidity and mortality was part of the preventive and curative portion of the package.[12]

The Ministry of Health and Social Welfare included maternal, newborn, and child health, as well as reproductive and adolescent health as key components to be covered by the basic package.[11] The idea of reliance on donors and partners funding for healthcare and infrastructure expenditure was reinforced after the civil crisis.[13] To roll out the basic package, the Ministry of Health partnered with both local and international NGO's to deliver these services.[13]

Currently, the Liberian health system is organized in a three-tier decentralized service delivery structure at the county, district, and community levels, with policy, planning, and resource mobilization and allocation decisions being made at the national level.[7] The provision of health services rests on both public and private providers, with 22% of the population accessing services from 10 private for-profit providers. However, of these ten private care providers, nine are in urban and peri-urban counties, Montserrado and Margibi.[7 14]

The recent WHO Country Cooperation Strategy documented that an increase in expectation and demand for accessible quality care pose significant challenges for the Liberian health system.[7] Some of the major challenges faced by the Liberian health system include: 1) shortage of and poor distribution of health workers, 2) inadequate number of health facilities, 3) ineffective procurement and supply chain management systems that result in frequent stockouts of drugs and supplies[7], and 4) a weak health management information system that constrains adequate planning and performance monitoring.[7]

The National Health Policy and Plan 2011-2021, states that all people should have access to "skilled, motivated, and supportive health workers within a resilient health system," and outlines a set of core objectives, including: 1) increasing the number of high performing facilities and institutes that promote continuous learning and assure quality; and 2) strengthening the workforce to be people-centered, gender-sensitive, service-oriented, and increase the number of well-equipped safe and enabling working and learning environments.[14]

Notwithstanding, Liberia's core health professional density is far below the WHO target of 23 core professionals per population: with only 12 core health professionals for 10,000 population.[7] The objectives of the national health policy plan remain futile as the current status of human resources for health in the Liberian health system appears to be in a daunting situation. [7]

Liberia's human resource for health situations is characterized by demotivated staff, low salaries, and lack of basic allowances, especially in rural settings.[7] There's an existing shortage of professional categories of staff and support staff, which has also complicated the provision of adequate health services.[7] Due to limited budgetary allotment, the public health sector is unable to support core health workers on the government payroll.[7]

In Liberia, there's a shortage of nurses, physicians, physician assistants, and midwives.[4] According to the Investment Case for Reproductive health, Liberia still has less than 1.5 skilled birth attendants per 1,000 population, which is below the minimum threshold of the 2.3 doctors, nurses, or midwives required to ensure women have access to a skilled provider at birth for 80% of the population.[4] There's only one registered skilled midwife for every 23,000 people, which is far below the WHO recommended workforce ratio of 1 midwife per 5 000 people.[4]

From a number of 51 health facilities in 2003, the number has grown dramatically: In 2016, there were 727 health facilities (hospitals, clinic, and health centers) serving the country; 62.3% public and 37.6% private (30.8% percent private-for -profit and 6.8% private-not-for-profit).[15]

Impact of the Ebola Outbreak on Maternal Health

The 2014 Ebola outbreak exposed the deficiencies of the Liberian health system and affected maternal health indicators.[16] Due to the overwhelming nature of the outbreak and the lack of personal protective equipment (PPE) for healthcare workers, health facilities were closed across the country.[16]

There was significant decline in the utilization of maternal health services during the outbreak;[4] this decline was attributed to the temporary closure of health facilities and lower attendance due to the lack of trust in the health system.[4] "Those who made it to the health facilities were shunned and not attended to, even pregnant women in labor, because of the fear of the Ebola, some even died". During the outbreak, ANC dropped from 16,000 visits in January 2012 to 4,000 by October 2014.[4] It was also reported that the heightened message of the "no touch" policy might have severely impacted women's ability to utilize maternal health services.[4]

The outbreak resulted in approximately 5,000 deaths including health workers, which further debilitated the already fragile healthcare system in Liberia.[4] Postwar challenges faced by the Liberian health system were further exacerbated by the 2014 Ebola outbreak.[7]

It is evident that the 14 years of civil unrest and the Ebola crisis had a disastrous impact on maternal health in Liberia. From the author's personal experience, there were instances when we had to distribute PPE to traditional midwives and conduct trainings for them. Increasingly,

TBAs were performing home deliveries as they were the only source of hope at the time. Consistent with the findings of Sillah, Ballah et al, my experience as a nurse further revealed that even in the aftermath of the Ebola outbreak, maternal health care services continue to remain underutilized in Liberia due to socio-economic challenges that women face when seeking and accessing these services.[17,18]

Women seeking care at health facilities across Liberia faced several barriers to accessing care, which also contribute to the continue high rate of maternal mortality.[18] A study conducted by Hayden and Menendez et al. suggested that the 2014 Ebola outbreak may have a lasting effect on underutilization of maternal health care services. According to them, during the epidemic, women lost trust in the healthcare system due to its failure to remain open and provide key maternal health services throughout the outbreak.[19 20] The situation left women who were in need of maternal health services with no choice but to seek maternity services from TBAs in their communities.[16]

During the Ebola outbreak, I had the privilege of working with these TBAs. Despite the absence of PPE, TBAs were willing to care for women seeking maternal care without any hesitation or refusal. The willingness of TBAs to touch patients when other health care practitioners implemented a “no touch policy” increased the level of trust in traditional midwives even after the Ebola crisis was over.

Contrary to the findings of Hayden in a study conducted in 2015, Menendez et al and Gizelis et al. reported in 2017 that during the Ebola crisis, deliveries shifted from public to private facilities due to the lack of PPE and a failed health system that got overwhelmed by the influx of patients and inability to keep health workers safe while they worked. This study further

explained that the overall health facility delivery rate did not increase or decrease, it remained constant—with no increase in home deliveries.

Even though Gizelis et al. disagree with some of the findings in Hayden and Menendez work, however, these researchers agreed on one thing, that the aftermath of the Ebola crisis along with the breakdown and closure of the already weak health system led to a lack of trust amongst patients and impacted women's willingness to use public services.[19–21]

The Burden of Maternal Mortality in Liberia

According to WHO reports, even though Sub-Saharan Africa achieved a substantial reduction of 40% in maternal mortality between 2000-2017, it also recorded the highest number of maternal deaths (196,000, 66% of global maternal deaths in 2017).[2] The world's least developed countries recorded a maternal mortality rate of 415 deaths per 100,000 live births for the year 2017.[2]

Liberia has struggled with a high MMR for years.[1] According to the Ministry of Health, in 2013, Liberia had a MMR of 1,072 death per 100,000 live births.[1] The major cause of maternal deaths in Liberia are hemorrhage (25%), hypertension (16%), unsafe abortion (10%), and sepsis (10%).[1] The low uptake of family planning and high-risk teenage pregnancies are also contributing factors to maternal deaths.[1] Neonatal deaths account for 35% of under-five mortality with prematurity, intrapartum related events and infections as the major causes of deaths.[1] The last Demographic and Health Survey was conducted in 2013 before the Ebola virus outbreak of 2014; therefore, these numbers may not reflect the reality as of 2019/2020.

Given the devastating impact of the Ebola crisis on the overall health care sector, it is commonly accepted that the plight of women, especially in terms of maternal healthcare has

worsened. Some experts (Hayden 2015, Menendez et al.,) have argued that if a post-Ebola survey was performed; taking into account the additional stress the outbreak placed upon the already weakened health care system, the actual MMR in Liberia would be even higher.[19] [20]

However, the most recent findings from WHO, point to a significant decrease in Liberia's maternal mortality rate as of 2017.[2] According to this report, Liberia's maternal mortality rate dropped from 1,072 to 661 deaths per 100,000 live births.[2] According to Liberia's investment plan for reproductive and maternal health, the national target for ANC and facility-based delivery by 2021 are 85% and 80 respectively, and Liberia is well on track with an increase from 71.2-79.8% in ANC and 40.9-74.6% in facility-based delivery.[4]

However, from the author's experience and perspective as a frontline nurse and community worker in hospitals and communities across Liberia, coupled with the current reality of inadequate healthcare services and socio-economic challenges, the Liberian healthcare system has struggled to provide maternal healthcare services and related programs.

A study conducted by Yaya et al in 2019 suggest that while key maternal health indicators have improved with emphasis on facility-based delivery, an important proportion of women in Liberia are still deprived of these services.[22]

This failure has been attributed to the existing gap in the availability of essential drugs, equipment and medical supplies at the facilities.[4] Actually understanding the failures from the first-hand experiences of women who are the beneficiaries and most often affected by maternal health programs and services will help policy makers and implementers identified solutions to holistically solve such problem.

The current socio-economic crisis in the country has further exacerbated the situation; In August of 2019, health workers carried out work strikes for up to a week in demand of four

months of previously unpaid salary payment and extended supply shortages.[23] During this time, pregnant women and mothers were denied access to all public health care services for more than a week [23] Similarly, the current economic hardship has further constrained women's ability to pay for health care. While the existing literature on this topic in the Liberian context is sparse, some of the issues concerning the experiences of women have been identified.[18]

Social Theory and Maternal Health in Liberia

WHO defines social determinants of health as "the conditions in which people are born, grow, live, work and age"[24] and has asserted that "these circumstances are shaped by the distribution of money, power, and resources at global national, and local levels".[24] In the author's opinion, it is impossible to think about improving maternal healthcare without addressing the social determinants of health.[24] The new 2030 Sustainable Development Goals (SDGs) launched by the United Nations General Assembly in 2015 (WHO,2015) establishes health as a basic human right and is listed as a priority under SDG 3, which is key to reach other SDGs.[25] Many of the non-health related SDGs were linked to the SDG 3s, recognizing that health is affected by many economic, social and environmental determinants.[25] The UN acknowledges that achieving success in health relies heavily on addressing the determinants.[25]

Cognizant of the fact that social determinants are major contributors to health, it is worth highlighting that thousands of women in Liberia still lack access to healthcare due to different factors, including poverty, bad road conditions, inadequate health facilities, distance to health facilities, lack of skilled health workers, poor infrastructures, etc.[18]

According to the most recent Demographic and Health Survey conducted in 2013, 65% of Liberians reported walking to health facilities as their main means of primary transportation,

followed by 30% who relied on public transportation, and another 4% who used motorcycle.[1] The report further estimated that 75% of people in rural areas were more likely to walk, whereas people from urban households were more likely to use public transportation.[1]

Women have reported that distance to the nearest health facility and transportation costs were major barriers to accessing care.[1] Four out of ten women in Liberia have indicated needing to travel a long distance to a health facility as a significant barrier to accessing health care.[1] Kenney et al. in 2015 reported that distance had a negative effect on the uptake of health care services, particularly in rural Liberia.[26]

From my experience working in Grand Bassa, a rural setting in Liberia, for over two years, women would often describe the extreme efforts required to get to the nearest public referral facility due to bad road conditions and lack of availability of transportation. This entailed having to walk hours or sometimes using motorcycles when they could afford to pay to be able to get to their destination. No other means of transportation available to them.

Recent research conducted by Kambor-Ballah et al., stated several reasons for the underutilization of maternal health services. Bad road conditions and the lack of adequate transportation were major barriers reported by women.[18] In their findings, women complained that these barriers existed at two levels: getting from their homes to the local health facilities and from the local health facilities to referral facilities.[18]

Cost of accessing maternal healthcare services for women determines the utilization of maternal healthcare services for 47% of women seeking these services in Liberia.[1] Yet, 96% of women do not have health insurance in Liberia.[1] Despite the abolition of “fee for services” by Liberia’s Ministry of Health (MOH) across all public facilities in 2005 after the civil crisis, there are still hidden expenditures associated with receiving care that women must pay for, including

the use of an ambulance when there's a need to be transported.[18] I have witnessed instances where prior to getting to a health facility, a woman and her family members were asked to purchase a specified amount of fuel for a government-operated ambulance that should have been covered by the MOH's free healthcare package. In cases where women or their families cannot afford this payment, they are denied access to transportation by ambulance even if medically indicated. This is an example of hidden fees, which pose serious constraints on women's ability to access maternal care. Having had the privilege of practicing as a registered nurse across Liberia has allowed me to witness different instances where affordability and accessibility have acted as major barriers to women seeking maternal healthcare services. Many women complained about not having the financial means to attend a health facility. This results in seeking care from TBAs, whose services are either less costly or entirely free of direct cost.

Even in instances where transportation is available, care remains out of reach for some women. Kambor-Ballah et al. found that once at the health facility, "point-of-service fees" (also known as user fees) represent another barrier to care.[18] A major finding of their research highlights that even after the official elimination of health care user fees by the government of Liberia, these services have resurfaced as "informal, out-of-pocket expenditures" made by patients and their families.[18] Examples of point-of-service fees include drug costs, medical supplies, materials costs, and consultation fees.[18] Consistent with the findings presented by Kambor-Ballah et al., in all the facilities I have worked, women bring the "birth preparedness kit" with them. This kit contains bleach, surgical disinfectant, alcohol, soap, tissue, *lappas*, sanitary pads, as well as essential supplies for the baby.[18]

Due to the inability of health facilities to provide essential supplies, health workers are left with no other option than to request these items from pregnant women even though services

should be free.[18] These supplies usually help health workers to disinfect equipment and avoid infections in patients and health care workers. Health facilities usually experience stockouts of essential drugs and materials needed for patient care, and as a result, women are asked to purchase those materials or pay for them before they can be cared for.[18] Women who cannot afford to pay for these materials will often be denied admission into the health facility or made to wait without being cared for. In an extreme example, during the Ebola outbreak, I witnessed a situation where a pregnant woman had to give birth to twins in front of a hospital with the aid of a traditional midwife because her family could not afford a deposit fee of US $400 for a caesarean section.

What is frustrating to me is that these surrounding situations that have prevented women from accessing care at a health facility remain ignored and policies that demands for women to access care at health facilities continue to be promoted without taking these factors into consideration.

Cultivating a better understanding around women's lived experience within the colonial history of Liberia, the prolonged civil unrest, disease outbreaks and their legacy are critical to developing and introducing impactful programs and policies. Getting women's perspectives on the everyday challenges they encounter while seeking maternal health service needs to be considered prior to stakeholders developing and implementing programs and policies. Not adequately understanding the problems women face and imposing inadequate solutions will cause more harm than good.

Learning from women about their maternal health care experiences will help inform the development of sustainable solutions in partnership with women and their communities to address their needs and improve maternal health care services and outcomes in Liberia. This

could significantly contribute to reducing Liberia's MMR and meeting WHO's SDG of reducing maternal death to less 70 deaths per 100,000,00 live birth by 2030.[25]

CONCLUSION

The 14 years of civil unrest and the Ebola outbreak left a devastating effect on the Liberian healthcare system. Systemic barriers and practices in public health facilities across Liberia have led to a lack of trust in public health service providers, resulting in the underutilization of some services. These experiences, coupled with punitive policies, which are supported by the Ministry of Health, have left women with a dilemma in which they have to choose where and when to seek maternal health services. Although efforts have been made to improve the system, there's still a lot to be done. Improving maternal health outcomes should include promoting the utilization of maternal health services that creates better maternal healthcare experiences reflecting women's voice and choices. The "experience of care" and "provision of care" to achieve individual and facility-based outcomes should be considered at every level of the care ladder.

In addition, further studies that focus on strategies aimed at bridging the existing gap of trust for private caregivers over public health facilities is also required. The majority of women and children widely use public health facilities in Liberia; therefore, improving and strengthening the public health systems in Liberia would contribute to increasing the utilization of maternal health services as well as reducing the number of maternal and child deaths.

Part 2: Publishable Paper

Abstract

Since 2000, Liberia has struggled with a high maternal mortality rate (MMR) of approximately 1072 deaths per 100,000 live births[1]; most of which are attributed to preventable complications that could be addressed.[2] Despite efforts from governments and its partners, performance in indicators related to maternal healthcare services still rank amongst the lowest performing health indicators in Liberia. With little emphasis on the everyday experiences of women as it relates to the utilization of care at various health facilities, it is essential to assess and understand why different measures haven't yielded as much impact and how women live the everyday reality of accessing maternal healthcare services in the presence of these measures.

This study draws on women-centered approaches to improving maternal health services based on their lived experiences and personal perceptions on their experience of care with different cadres of healthcare providers.

It is essential to assess and understand the impact of women's everyday experiences in order to reduce maternal mortality in Liberia.

We used an in-depth qualitative assessment of women's experience with maternal health care services. We conducted focus group discussions, in-depth interviews, and participant observation to gather our data. We selected a purposeful sample of 72 women from four hospitals across two research locations, including pregnant women, mothers of infants, between the ages of 15-49, and skilled midwives who were directly involved in caring for women. Three main themes/categories emerged from our study: 1) challenges associated with accessing care at a public health facility; 2) women perceiving private caregivers/traditional birth attendants as a better alternative; and 3) Lack of trust in the public healthcare system.

Our findings uncover the challenges pregnant women and mothers encountered while seeking and receiving services at public health facilities. It also suggests that when women have poor experiences seeking healthcare, they are less likely to utilize services. Such experiences may influence their decision of where, with whom and how to seek services and may expose them to increased risk of complications and maternal death. Therefore, healthcare providers should consider women's experience of care to develop more comprehensive strategies and interventions that will improve access to maternal health care services and improve the overall maternal health outcomes in Liberia.

INTRODUCTION

"If a traditional midwife is caught delivering a woman at home, they are asked to pay a fine, and it's not small money. If you even stay in that community as a traditional midwife and a woman gives birth in the community, you are assigned before you finally decide to bring her [to a health facility], you will pay a fine of 5,000 Liberian dollars ($ 26.00 USD), and if the patient stays at home until labor, you will also have to pay the fine because that's why we have the maternal waiting home at the facility. As a traditional midwife, your duty is to make sure to bring women, but they don't do it because they are not used to doing it"- (Skilled midwife, 42yrs, Bong County)

"There's a fine for the trained traditional midwives and the pregnant woman. TTMs who assist a delivery have to pay 2,000 Liberian dollars [$US 15.00] and women who give birth [in their communities] have to pay the same amount. That money is given back to the community leadership or town chief"- (Skilled Midwife, 48yrs, Montserrado county)

In 2017, "every day 800 women died from pregnancy and childbirth-related complications," [and] 94% of these occur in low resource countries like Liberia".[2] Since 2000, Liberia has struggled with a high maternal mortality of 1072 deaths per 100,000 live birth.[1]; Most of these are attributed to preventable complications that could be addressed.[2] As a means of preventing and reducing the high mortality rates, the Liberian government and its partners (local and international) formulated several mechanisms; one such mechanism is encouraging women to utilize health facilities for maternal health services. Specifically, the government encourages women to give birth at health facilities with the assistance of a skilled birth attendan.[27] This is enforced at the community level by imposing fines on women who, and any traditional birth

attendants who assist them to, deliver at home.[27] Maternal mortality rates have decreased from 1072 in 2013 to 661 deaths per 100,000 live births in 2017.[2] However, women in Liberia still die from preventable complications during childbirth in Liberia.[28] With little emphasis on the everyday experiences of women as it relates to their utilization of care at various health facilities, it is now essential to assess and understand why these measures have fallen short and the real everyday experiences of women accessing maternal healthcare services under these measures. Liberia is a signatory to several different initiatives and declarations: (1) The Sustainable Development Goals 2030, (2) Family Planning 2020, (3) The African Health Strategy, (4) The Paris Declaration, The Maputo Call to Action, and the UN Secretary General's global Strategy for Reproductive, Maternal, New-born, child and adolescent health accountability and results.[7] population and with some emphasis on improving access to maternal health care. In particular, Every Woman, Every Child Initiative, Liberia committed to spending at least 10% of the health sector's allotment on reproductive, maternal, newborn, child and adolescent health.[7] The signing of this and other initiatives reaffirmed the government's commitment to prioritizing maternal, newborn and child health and mobilizing resources to achieve this goal according to the Gbarnga declaration (Vision 2030).

This commitment is consistent with the WHO Maternal, Neonatal and Child Health (MNCH) framework, which proposes a set of standards and strategies for health systems to simultaneously improve both the provision and experience of care for patients.[29] Moreover, this framework recognizes that creating the demand for and access to high maternal & newborn services is predicated upon the perspectives of women, their families and communities on the quality of maternal care services.[29] It also draws on women centered approaches of improving maternal health services based on their lived experiences with different cadre of healthcare

providers and personal opinions.[29] The framework also suggests the aligning the "provision of care" with "experience of care" to provide a better "individual and facility level outcomes."[29]

Existing literature provides limited insight into how women's experience might inform improved health systems. Some studies report that women have lost trust in the health system and, therefore, are unwilling to use maternal healthcare services.[19,20] One study attributed women's loss of confidence in the healthcare system to the failure of hospitals and clinics to remain open and provide assistance during the Ebola outbreak of 2014, leading to an underutilization of maternal health services even after the outbreak.[21]

Kambor-Ballah et al. also reported social determinants such as transportation, bad road conditions, which could be considered as factors contributing to the underutilization of services.[18] However, ascertaining from women's accounts an in-depth understanding of the factors leading to the underutilization of these services will help inform the development of comprehensive and women-centered strategies to improve both the provision and experience of maternal healthcare in Liberia.

We formulated a set of questions to guide us in the process of conducting our study. What are the experiences of pregnant women and mothers' seeking and receiving maternal health services in Liberia?

This study seeks to make visible the lived experiences of women seeking and accessing maternal health services in health facilities across rural and urban Liberia (Montserrado and Bong counties). Our focus is to understand what is at stake for these women amidst all of these challenges. Conducting an in-depth qualitative study that focuses on understanding women's personal experiences will uncover the challenges women are faced with why maternal health services have

been underutilized according to existing pieces of literature. The study will provide better and improved experiences for women accessing these services.

Methods

Study design

We conducted an in-depth qualitative study to understand the experiences of women seeking and receiving maternal health services in a population of pregnant women, mothers, and skilled midwives in Liberia from August to December 2019. We selected four hospitals that are located in two counties, Montserrado & Bong; there are two hospitals in each. In each county where the study was conducted, one (previously)private facility and one public facility were selected.

MONTSERRADO COUNTY is located in northwest Liberia, and includes the capital, Monrovia.[30] It is divided into five districts and 22 zones. Among the 15 counties, it covers the smallest area but has the largest in population, with 1.1 million residents.[30] This represents more than 32% of the country's population.[30] Our research was conducted in two of the five districts of Montserrado: Commonwealth District (11,876 residents) and Greater Monrovia (970,824 residents). The Montserrado County hospitals are Eternal Love Winning Africa (ELWA HOSPITAL), a non-governmental hospital in Monrovia that was founded in 1965 by a religious group call "serving in Mission" (SIM)[31] and Redemption Hospital, a government hospital also located in Monrovia.

BONG COUNTY is rural and located in central Liberia. Bong is the 3rd most populous county in Liberia, with 407,041 residents; it has a lower population density than Montserrado.[32] It is divided into 12 districts, 42 clans, and 1 township.[32] The county has 37 health facilities

including 3 hospitals, Phebe hospital in Suacoco, Bong mines hospital in Fuahmah district and CB Dunbar in Jorquelleh.[32]

Our research was conducted in two of these districts: Jorquelleh (79,000 residents) and Suacoco (28,277 residents) districts; across two hospitals. Phebe in Suacoco (previously private, but currently run by government) and CB Dunbar Hospital (government-run) in the township of Jorquelleh.

Phebe hospital is located in Suacoco, which is one of the most significant towns in Bong county; Serving as the first and biggest referral hospital in the county, attached to the hospital is the Link Maternal Waiting Home /Big Belly House. Women who live far distances away from hospitals and clinics or stand an increased risk of complications during delivery are encouraged stay at this house until they give birth.

The women interviewed for this study were between the ages of 15-49 years old and fell into two groups: (1) pregnant women between 5-9 months pregnant who were attending ANC visits at one of our study facilities, and (2) women who had given birth within the past year to a baby between one day and 12-months of age. These women willingly shared their experiences with the research team.

Also, skilled midwives working in one of the study facilities with a vast amount of experience working with pregnant women and mothers were interviewed. A purposive sampling method was used to select study participants. Participants were selected to gather information about different experiences and perceptions regarding the impact of women's health care experiences on maternal outcomes.

Participants were recruited by us directly working with midwives involved in care for pregnant women and mothers of infants at the facilities. Midwives were asked to use the recruitment script

to inform women about the study and refer interested, eligible women to the student researcher or recruiter who was present at the facility.

Procedures

The research team has seven members, the PI Carole Mitnick and Arlene Katz are on the faculty of the Department of Global Health and Social Medicine at HMS, Jafet Arrieta, the student researcher, a local research assistant, a local midwife recruiter, and a local data entry clerk. The student researcher designed and conducted the research with support from the research committee headed by PI. The student researcher interacted with research participants through interviews, organizing and coordinating meetings with members of the research team. Local study team members collected contact information from participants and scheduled interviews after obtaining informed consent. There were several data collection strategies: individual semi-structured interviews, ethnographic observations, and focus group discussions (FGDs) that were used to collect data to answer the research question.

Two FGDs were conducted with mothers of infants in Montserrado and Bong counties. Discussions were held in private meeting rooms away from the recruitment hospital. Each group consisted of 10 participants. Group norms were established, and women were reminded to respect the views of others, speak with respect to each other, and not discuss another woman's issues outside of the meeting room. Focus group discussions were conducted in Liberian English, lasted 60-90 minutes, audio recorded and transcribed after each meeting. Also, field notes were taken during these meetings. Women were asked to share their experiences and challenges seeking maternity services, such as routine antenatal care visits, immunization for babies, birth deliveries, and emergency care services at various health facilities within the research location. The student PI led the FGDs with support from the research team.

In-depth one-on-one interviews with the pregnant women and midwives were conducted by the student PI. The interview topics included experiences and challenges relating to seeking and receiving antenatal care, accessing care with family support, interacting with midwives and other healthcare workers etc. Each interview lasted 60-90 minutes. Conversations with respondents were conducted in Liberian English, audio recorded, and transcribed by the student PI and transcriber. Field notes were taken to provide context as well as capture special moments and emotions during interviews. Pregnant women were asked to share their experiences and challenges in seeking antenatal care services at various facilities in Montserrado and Bong counties. Midwives were asked to share their experiences and challenges giving care to pregnant women and mothers. Each interview was conducted at a location of the participant's choice, either in their homes or another location away from the hospital.

PARTICIPANT OBSERVATION- We spent 8 hours per day for 5 working days at each of the participating hospitals, observing the delivery of maternal health services at these facilities. Access to and the utilization of maternity services and delivery facilities were the objects of observation. The interactions between health workers and women seeking maternity services were also observed to characterize the relationship between them. As a registered nurse, the student PI asked for permission to work with the health workers for the duration of the observation. This enabled her to be present and observe interactions during private screenings. Observations were also carried out in public places within our study facilities. Handwritten notes were taken in the field and written up into a formal set of field notes at the end of each day of observation. During the observation, no identifiable patient information was recorded.

Analysis

We used an inductive narrative and content analytic approach with category construction and comparative analysis to interpret our data. We reviewed and edited the data, and open-coded a subset of our data. We then piloted our open codes on a second subset of data to verify our initial codes. We created a codebook, identifying text relevant to the research questions labeling, defining, and giving illustration for every theme with specific examples from the transcripts. Using an iterative and narrative analysis process, we arrived at three broad categories and similar codes were grouped into these categories to characterize participants' responses.

Each category was labeled, elaborated and illustrated with excerpts from the data. Categories were then examined and grouped together linking ideas to a broader concept. Narratives from the data were used to compare and contrast multiple viewpoints that elaborated and refined the broader concepts. Participant observations and field notes were also used to inform our findings from the interviews. Dedoose (version 8.3.20) was used to assist with the data analysis.

Ethical considerations: The study received local IRB approval from the Liberian National Research Ethical Committee (NREB) and from Harvard Medical School. Informed consent was provided by all participants.

Results

We recruited 48 participants from four hospitals in two areas, Bong and Montserrado Counties. Skilled midwives (N=8) participated in in-depth one-on-one interviews; there were four skilled midwives interviewed in Montserrado and four others in Bong. Pregnant women (N=20) participated in the in-depth one-on-one interviews; there were ten pregnant women interviewed in Montserrado and ten others in Bong. Mothers of infants (N=20) participated in two separate focus group discussions: ten mothers of infants participated in these discussions from Montserrado and ten more from Bong.

TYPE OF PARTICIPANTS BONG COUNTY **PHEBE HOSPITAL FGD N = (5)** INTERVIEWS N= (5) **CB DUNBAR HOSPITAL FGD N = (5)** INTERVIEWS N= (5)	**AGE**	OCCUPATION				MARITAL STATUS			EDUCATION	
		STUDENT	HOUSEWIFE/FARMER	TEACHER	BUSINESSWOMAN	MARRIED	WIDOW	NOT MARRIED	EDUCATED	NOT EDUCATED
PREGNANT WOMEN N= (5)	16-48 YRS	3	0	0	2	2	N/A	3	3	2
WOMEN WHO GAVE BIRTH IN THE LAST YEAR N = (5)	20-38 YRS	2	0	1	2	3	N/A	2	4	1
SKILLED MIDWIVES N= (4)	38-49 YRS	N/A	N/A	N/A	N/A	1	1	2	4	0
HEALTH FACILITIES N= (2)	N/A	N/A				2 (8HRS/DAY X5DAYS) PARTICIPANT OBSERVATION			N/A	

TYPE OF PARTICIPANTS MONTSERRADO COUNTY ELWA HOSPITAL FGD N = (5) INTERVIEWS N= (5) REDEMPTION HOSPITAL FGD N = (5) INTERVIEWS N= (5)	AGE (15-49 YEARS)	OCCUPATION				MARITAL STATUS		EDUCATION	
		STUDENT	HOUSEWIFE/FARMER	TEACHER	BUSINESSWOMAN	MARRIED	NOT MARRIED	EDUCATED	NOT EDUCATED
PREGNANT WOMEN N= (5)	20-48 YRS	3	0	0	2	2	3	3	2
WOMEN WHO GAVE BIRTH IN THE LAST YEAR N = (5)	18-38 YRS	2	0	1	2	3	2	4	1
SKILLED MIDWIVES N= (4)	40-57 YRS					3	1	4	0
HEALTH FACILITIES N= (2)	0	0				2 (8HRS/DAY X5DAYS)			

Our results section presents key findings derived from the interviews, participant- observation, and narrative analysis based on our field participant observation.

INTERVIEWS

1. CHALLENGES ASSOCIATED WITH ACCESSING CARE AT A PUBLIC HEALTH FACILITY

A. The hidden cost of services and care at public health facilities

Public health facilities in Liberia are, by law, free of charge for users. Unfortunately, women go to these facilities with the expectation of receiving free services, but they are later hit

with the reality of having to pay for everything, including the materials used on them. Citing several instances in which women were asked to pay for care services, interviewees recalled different scenarios where these hidden costs became visible. These costs include system-sanctioned fees—in this nominally free system—and other fees from outside the formal structure. Experiences ranged from health care workers asking women to purchase medications and supplies in public facilities to them needing to buy fuel for ambulances and generators before getting transported to a hospital or being admitted. Further, drugs intended to be dispensed for free were being sold by health workers in public hospitals and private drug stores.

"They said govt hospital is free in Liberia, but it is not free, because when you go to the hospital, they will just put on the board, free service, you who can read, will read it, but then enter in the hospital. When you enter, before they screen you, that's money, they get their box, when they screen you, they will ask all necessary questions, when you explain, they will send you to lab, that lab, you will pay money, but it is already written free service but you will pay money. Then will you come back from the lab and go to the screener, when they finish with you, they will say let our basket over there"- (Focus group discussion, R#2)

"They will tell you to go buy the meds, they say they don't have the medicine in the hospital, but they can be having it in their bags, when you are coming out, then somebody will say let me see the meds they put on papers, I think I have it here, come and buy it from me"- (Pregnant woman/business woman, adult, Montserrado County)

"When you go, they will say no meds, if you want meds, you will pay money to them in that same facility, then they give you meds from their begs, sometimes they will give you papers and say go buy it, sometimes, if you want to act like you know more, then they will say go buy it, no meds here, they people are not supplying us"-(Focus group discussion, Mother, R#2)

"The name is just there that they are offering free services, but everything even medications, they will buy it. At certain time, even the lineless sheets we use to screen, take history, and admit patients on, they were asked to buy it. So, the name "free" is just there, but it's not free"- (Skilled midwife, 39 years, Montserrado County)

"They can't check you without the gloves, you have to present the gloves before they can check you. If you don't give those things, they can't check you oooo, except someone help you and give it to you" (Focus group discussion, Mother, participant 11)

B. Detaining women and their babies after delivery

The posters and signpost on the wall read "free service." Yet, to enforce the payment of the fees described above, according to an interviewee, women coming to the hospital/clinic without money or the required delivery essentials are not allowed to leave the hospital or clinic after delivery. They must pay the delivery fees/hospital bills or replace the delivery materials used on them at the hospital before the woman and her baby are released to go home**.**

"When pregnant women come, and you give birth, you must pay before we discharge you. In the government hospital, if you are on the postpartum ward or in the maternity waiting home, you spend maximum 2days, and if you don't pay, we will take you to the pp ward, and if you can't still pay, some patients family will come and appeal to allow them pay on Friday which is the market day because they will be able to bring crops and sell it to get money, but they must pay before they leave"-(Skilled midwife, 45 years, Montserrado County)

"After I deliver, they held me in that hospital for three days until my husband filled up that bag with the materials they requested before letting me go. They couldn't even allow me to get

outside, I had to be indoors until my husband filled up the bag before they allowed me to go"- (Pregnant woman, adult, Bong County)

"If you give birth at the hospital, you will leave there, they will seize you and the baby until your family settles the bill. Yes! They will seize your baby, or you will be there until you get that money and pay"- (Pregnant woman/beautician, 21 years, Montserrado County)

C. Long wait times at hospital

Interviewees emphasized the number of hours a woman had to spend at the public hospital/clinic before receiving care during regular antenatal visits. According to one woman, women arrive at a public health facility as early as 6:00 am, and some women will spend up to 10 hours waiting before leaving to go home. Outlining some of the challenges, one interviewee recalled the stress she'd experienced from the delays from health workers, especially those who worked in the laboratory. Another interviewee recounted instances where health workers gave preferential treatment to women who were willing to provide them with money and ignored those without money, even if they came earlier. A woman who got to the hospital/clinic earlier could be left unattended for hours because of her inability to meet the nurse or midwife's financial demands. On the contrary, a woman coming into the facility late would go earlier than other women who'd come earlier if she could afford to give the nurse or midwife some money. Such actions resulted in long wait times for women at these facilities.

"Even the lab, when they send us for the lab, they will tell you that the person who is responsible for the lab is not here, whereby the person is there, but they a picking and choosing those who have the money, if you don't have money how will you do your lab? At the end of the day you will just keep sitting and by even time you will say let me just go"- (Pregnant businesswoman, adult)

"Imagine you come 6:00, you will stay in the clinic until 5pm in the evening and you will not even get any medicine only the paper (prescription)" -(Pregnant woman/Farmer, 41 years, Bong County)

"But sometimes, people who have money, when they come, the nurses will serve them while you who came earlier will be sitting and waiting forever. You will just them being served, and we can't say anything, because if even we talk, what will come out of it? Nothing!" -(Pregnant college student, 27 years, Bong County)

"Even the lab, when they send us for the lab, they will tell you that the person who is responsible for the lab is not here, whereby the person is there, but they a picking and choosing those who have the money, if you don't have money how will you do your lab? At the end of the day you will just keep sitting and by even time you will say let me just go"- (Pregnant businesswoman, adult)

2. TRADITIONAL BIRTH ATTENDANTS (TBA's) AS A BETTER ALTERNATIVE

A. The comfort of giving birth in different positions

A woman being able to choose the delivery position she feels comfortable with for giving birth is not common in hospitals and clinics across Liberia. Women have been made to understand its health workers' duty to decide how to position a woman giving birth to a baby. In contrast, interviewees described traditional midwives creating an atmosphere that allows women to decide which position they prefer to give birth in. Outlining the complaints some women give about the height of a regular delivery bed in the hospitals/clinic, interviewees asserted that some

women preferred to lay down on the floor or a lower bed to have their baby. Unfortunately, this is something skilled midwives do not allow for in a regular hospital/clinic setting for different reasons. However, the traditional midwives allow women to have their will if it brings them comfort and ease during the process.

"Some of these women especially in the rural areas, they will tell you that they are unable to give birth lying down on the delivery table. They will prefer to lie down on the ground and give birth. I had an experience in Jorwah, a woman got in labor, but because the law was so strong that any TTMs caught doing home deliveries will be fine by the town chief, the TTMs refused to deliver her in the town. When they brought her to the hospital, she said I born all my children on the ground, I'm unable to lie down on this bed and push; that's why I don't come to the hospital to give birth" (Skilled, midwife 55yrs, Montserrado County)

B. Emotional support for pregnant/delivering mother

Emotional support plays a significant role in the entire peripartum process. It is also a determinant of why and how women trust a particular cadre of health workers. Interviewees cited several ways traditional midwives provide emotional support for women during the laboring and birthing processes. Communicating with women in their local dialect, creating rapport, counseling, and touching them during the labor and delivery process were all factors that contributed to a smooth process and brought some form of relief.

"The old ma them can really take care of women and talk to them good, when you are going through the pain and you go to them, they will be talking to you nicely and petting you, aww! Ma, hold your heart [be patient], you will soon move from there, they will be talking to you and petting you to the extent that any kind of way the ask you to lie down you will lie down that way,

when the pain is hot, they will be rubbing you just for that child to come out safely, because they are old people"- (Pregnant woman,41years, Montserrado County)

"Because they can speak the same dialect I can speak. Another reason is that they can talk to us good; they can visit us every day. Every morning, when I'm, lying down until certain hours, they will come and knock my door to ask what's happening to me. They will check on me every morning to make sure I'm, ok" (Pregnant woman, 20years, Bong County)

"Myself, I can't stay home to say I will give birth there, but sometimes when you really in there and can't see any of your family member around, it's really troubling. You need your family to be around as a sign of support for you, but they will stop them and tell them to stay away until you can give birth. Like that some people will just prefer to stay home and give birth where they can easily see their family members around. With the home delivery, the oldma (traditional midwife) them will allow my people to come in and find out what's happening" – (Pregnant woman, 41years, Bong County)

C. Preference for home delivery due to the lack of delivery essentials

Every woman must have a mandatory package of essential delivery items: tissues, sanitary pads, chloride, baby clothes, diapers, etc. during her labor and delivery process at the hospital. Due to the inability of health facilities to provide these essential materials, health workers are left with no options other than to make it a mandatory prerequisite for women to give birth at the hospital/clinic. According to the interviewees, due to several different constraints, women often cannot afford/gather these necessary delivery essentials that have been requested for by the hospitals/clinics. Thus, women would opt for a home delivery with a

traditional birth attendant to avoid getting turned away for care or held after delivery at the hospital. Citing several reasons why a woman would prefer giving birth at home with a traditional midwife, one primary reason that cut across was that whether a woman had the required delivery essentials or not, they'd still be able to receive care from a traditional birth attendant. Traditional birth attendants primary concern was to assist and provide care for women during the labor and delivery process. In contrast, women who are unable to gather these delivery essentials and take them with them to the hospital/clinic, due to the lack of money or other challenges, are either refused care or detained in the hospital after delivery until those items are provided by her family. As a result of these challenges, women who aren't able to pack their bags wouldn't go to the hospital for delivery for fear of being refused care or detained after delivery

"And when we asked these women why are you giving birth behind the house [at home], they tell us, when we used to give birth in the hospital, they will provide the mama and baby kit with all the materials we need for delivery, but now a days it's not like that and if I go and I don't have money to buy these things, the people will not want to accept me or they will talk to me bad way. So, it's better I stay right in my community where the oldma them will help me"- (skilled midwife, 42years, Montserrado County)

"Ahhhhhhh! That's one of the major challenges right there. The pack your bag thing! You see, there's a lady in that community who doesn't have a husband, she probably went to do her lil thing [have fun] and got pregnant in the process. All the men refused the pregnancy and she doesn't have form of support to take care of that pregnancy, she's a single mother who doesn't have anything. And she's been asked to pack her bag, she really wants to come to the hospital, but doesn't have money to pack the bag. At the end of the day, she resolves to going to the TTM

to conduct that delivery, because she will never get refused by the TTM because she didn't pack her bag"- (Skilled midwife, 49years, Bong County)

D. Traditional birth attendants serving as birth companions

Outlining the many benefits, an interviewee stressed the importance of traditional birth attendants accompanying women through the birthing process. According to one interviewee, traditional birth attendants are willing to accompany pregnant women to their ANC visits and deliveries and be with them throughout the entire process. Traditional birth attendants played the role of an advocate, companion, and counselor, as well as being physically present with women during their ANC visits and labor and delivery processes. For traditional midwives, this was a very effective way of gaining women's trust, support, and cooperation.

"Women feel very safe and comfortable to give birth in the hospital once they are escorted by the traditional midwives, and the traditional midwives are allowed in the room with them.; because the traditional midwives will be there to advocate for her, pamper her, so they feel more safe and trust them" - (Pregnant woman, 27years, Bong County)

"Yes! It's necessary to have them as companion to women, because skill midwives we are only in the facilities, we are not in the communities but the TTMs are everywhere in the communities. Sometimes they visit pregnant women, and you see them running to the health center with pregnant women. When pregnant women are sick, trembling at home, its traditional midwives who usually visit them and discover the problems. Because women can be home and going through these things, but they don't want to go the hospital; it's usually the TTMs who can go and talk to them to even come to the waiting home. So, it's necessary for Government to make

sure TTMs be all facilities and work with skilled midwives"- (Skilled midwife, 42years, Bong County)

"The Kpelle midwives [TTM] they can help us ooo, they can help us. When we are going to the clinic for treatment, once you tell them, they will carry you to the clinic and be there until you finish, then you and them come home together" – (Pregnant woman, 20years, Bong County)

E. Respect for traditional practices surrounding labor and delivery

According to some interviewees, women feel secure and more willing to cooperate when their caregiver respects and recognizes traditional rites, rituals, and beliefs during the birthing process. Respondents cited several concerns around stigmatization, which often resulted in these women giving birth at home. Traditional birth attendants and women respected these women's traditions and beliefs and considered them very important factors for building trust and rapport with women.

"A woman will come in labor with a thorn up panties, the skilled midwife will be like " is this the type of panties you should be wearing here"? on the other hand, the traditional midwife will see that thorn up panties and she will never make a comment to that woman or look down on her. Instead she will not pay attention to it; the traditional midwives are people who joined the sande society and were trained to keep their mouths [keep secrets]. But most of our skilled midwives have never joined any sande society, they've never been initiated into any society to learn these things"- (Skilled midwife 48years, Bong County)

"One time we went to one village, there was a delivery there, and when you want to go to that place they were doing the delivery, you have to take off all your clothes and tie the lappas here [pointing over your breast], so all my friends started saying, for me I don't able to go there, so, I said, what happened, they explain, so I said, am coming, I am going there; that's how I undress

and tied the lappas right up here[pointing over her breast]. So, if you go in the interior and you want to assist any traditional midwife with delivery, you have to dress like them. So, when I got there, everybody started thinking that I came from that Sandi bush too, and I was able to help them, because the patient was bleeding"- (Skilled midwife, 55years, Montserrado County)

"You know they just have this myth, some of them went to the Sande bush [female circumcision] and will never want to open up until you the nurse or midwife make them feel safe or show them that you understand their condition" – (Skilled midwife, 55years, Montserrado County)

F. High level of trust for traditional midwives

An *i*nterviewee stressed how important friendly long-term relationships and interactions between women and traditional birthing attendants (TBAs) is in the community. These friendly bonds make women see TBAs as their go-to person for maternal health care and delivery services. From the way traditional birth attendants talked to women, showed them respect during regular home visits, and accompanied them during pregnancy, childbirth, and postpartum periods, traditional midwives gave women every reason to trust and work with them.

"For traditional midwives when a woman goes to them; they will welcome her, sometimes even bring food and ask the woman to eat with them before the checkup. The traditional midwives don't discriminate! They can never discriminate; you have TB, HIV, you educated or not, you crazy, you sound, you got money, no money, they can treat everybody equal. The traditional midwives see themselves in the women; they speak the local vernacular spoken by the women in their community" -(Skilled midwife 48years, Bong County)

"Women trust the TTMs because of the care they can give them. The oldma them (TTMs) can care for people, in the rain, in the sun, when you see these oldma them bringing people at midnight, you will be surprise. Even when a woman is in pain around 1, 2 midnight, those oldma

them can be coming with their flashlight to escort these women. Sometimes their clothes very wet under the rain, even when the patients are in the ambulance, the oldma them will be in that ambulance on the rough road just to escort their patients. They can come from far off, walking distances, sometimes they will put the patients on motorbike and the TTM will walk several hours to come meet the patient at the hospital. She will make sure and follow the patient in that delivery room with the midwives until that patient gives birth; she will wash the patient's clothes and be there until that patient is discharged before she can go home"- (Skilled Midwife, 39 years, Montserrado County)

"Women trust them because they live in the same community with the women. Whatever happens to them, the TTMs are their first point of contact before they can even think about the clinic or hospital. They trust them to the extent that when they are coming to the clinic, the TTMs will come along with them. Even when they are in labor and they come with the TTM, it's advisable to allow the TTM stay in the labor room if you really want the woman to cooperate with you. The TTMs are really helpful, if you allow them in the labor room, they will help with the delivery as well serve as a very good companion to the woman. But if you put them out of the delivery room, while the patient doesn't have any relative in the room with you, if anything goes wrong, the TTM will say you are the cause. They will shift all the blames on you, so usually for us here, we allow the family to go out, and the TTM will serve as a liaison between the family, the woman and we the skilled midwives until that woman can give birth" (Skilled midwife, 42 years Bong County)

"Not because I'm a skilled midwife, but the truth is, women, trust the traditional midwives. The reason here is that, most of us skilled midwives are very rude and lack humanistic approach"- (Skilled midwife, 48years, Bong County)

G. Challenges with transportation

According to one interviewee, some women have to undergo difficult journeys to reach a health facility, sometimes having to walk by foot for several hours. The financial challenges related to transport include lacking access to ambulance services or public transport when needed, being unable to pay for public transport even when it's available and being required to purchase gasoline/fuel for an ambulance before getting transported. As the interviewee outlined these different challenges, it was clear why many women preferred to stay home and seek care from a TBA that lived in their community.

"From Gbondoi here is either two hours, but when you are on motorbike, it will take like 1:45 minutes to get there. Walking is like 4 hours, but if you are really walking fast, it will take 2 hours and 45minutes" (Pregnant woman, 42years, Bong County)

"For the transportation, it's not easy, when you call the number, that number will ring, no answer and they can't return your call. No ambulance in the country, so when the woman is in emergency situation, they can send the family to go look for car. And to go look for car in this red-light community is not easy, and they will charge you, everything is USD in this country, the last time we were carry one girl, the driver charged 25usd." *(Focus group discussion, participant #6)*

H. Domestic difficulties

Women are faced with several domestic issues during pregnancy, delivery, and postpartum periods that are often overlooked and not taken into consideration. According to one respondent, most women cannot afford food, do not have enough money to meet their essential needs or visit a hospital, and—worse of all—lack support from partners and family members.

The interviewee further explained that for some women men who are/were their partner would often deny their involvement with the pregnancy from the beginning or simply refuse to help his partner during her pregnancy.

"The main reason is that, most of them will get pregnant, and no father for the pregnancy. That's one of the main reasons you will get from women, from the ANC, they will tell you. The man will deny the pregnancy and neglect the woman, sometimes the man will not deny the pregnancy, but he will not support the woman, he will leave the house and hardly come home to that woman"- (Skilled midwife, 42-years, Bong County)

"Women are not getting support from family; we are just doing things on our own. Like in my case, everyone in my family feels that am married so, nobody cares about me anymore, everything I go through, I go through its own my own, it's just my husband and myself. I worked, at the end of the month, when I take pay, I go to the hospital"- (Pregnant Woman, 33years, Montserrado County)

"My uncle can do everything because we live in his house. But the only thing that my one can do all the work in the house. They use have someone to cook, but they put her out, so now only me can do all the work in the house. In the morning I go to the market, buy the food and cook at the same time I'm taking care of the six children. After cooking, I have to wash all the clothes before I can bath the children is already midnight"- (Focus group, respondent #7)

3. LACK OF TRUST IN PUBLIC HEALTHCARE SYSTEM

A. Attitude of skilled health workers towards women

Interviewees shared that a negative interaction with or poor treatment from a midwife nurse as a significant factor for women's preference for private caregivers or delivering at home. According to an interviewee, most health workers at the public health facilities are aggressive and rude to

women; the workers lack empathy, as well as go about denigrating poor women who are unable to meet their needs.

"They are very bad and rude! After I gave birth to the triplet, one of them was jerking (convulsing), I call the midwife I say oh the girl just jerking in my hand ooo. She yelled at me and said, "move from here mehnnn, you better go and sit down with that girl". I say oh, the girl is dying in my hands, I call to help and you saying that? And the next thing she had to tell me was "old woman like you, is this your first time to have child? When you see the girl jerking you don't want to do?" then I ask her, but how do I know what to do, I'm looking up to you to tell me what to do or give me medicine to give to her. She just grabs the girl from me, took her away and that's how I was sitting and crying. She later brought the girl back to me and said, "take all the clothes from the girl and lay her down so cold breeze can blow her." That was how I did it and my baby came through. I almost insulted that midwife that day, but my mind told me to just bear it because my baby was sick, and I needed help from them. Some of them can really talk to us bad"- (Pregnant woman, adult)

"And sometimes they don't want to come to the clinic because of the way the midwives can talk to them, some of the midwives are very aggressive. Let me just give you an example, there was one midwife in this facility, I will not call name at the time it was just on clinic level. She used to blast and talk to her patients very bad and even beat on them, they had to take her from there and send her to another place because she couldn't be there"- (Skilled midwife, 45 yrs)

"One of the things I've noticed about Liberian midwives, most of them want to have a cordial relationship with only women who have money. Once you have money Yassah, anytime you want them to give you care; they will not complain because you have money to give them" (Skilled midwife, 48 yrs)

B. Reluctant to attend public facilities because they won't get treatment

Interviewees considered attending public health facilities for treatment as a waste of time. According to them, women are usually given prescriptions to purchase supplies and medications from a local pharmacy outside of the hospital or clinic. The women recalled instances when they couldn't afford to purchase medications and supplies due to not having enough money. They had to go home with the same illness for which they visited the hospital/clinic. Interviewees admitted that due to this situation, most women got disappointed after receiving a prescription rather than medication for their conditions; As a result, most women would return home and not bother going back, especially if they could not financially afford to pay for the prescribed drugs. They also cited instances why most pregnant women attend public health facilities only for regular antenatal visits when they would get checked and or need to do laboratory testing. Women adjusted to getting a prescription and returning home once they'd been told about their pregnancy's progression and that there baby is ok.

"Attending a government facility, a woman is aware that she will only be given paper with prescriptions to go and purchase her medications. So, they usually feel weak about coming to the government hospital or clinic. You see some of them dragging and coming around 11am, 12pm, all because of the believe that they will only be given paper (prescription) to go and buy medications. They will always tell we the midwives "just check me and let me go, no medication here" sometimes out of frustration, they will leave like that and go home" – (Skilled midwife, 42 yrs)

"Going to the government hospital is no problem, but when you go there, you will sit free and go home free. So, I just forget about it" (Pregnant woman, interview 6)

"Hmmmm for the government hospital, we only go there because we them to check and tell us how the baby is lying that's all; but we don't get anything else from them. At the end of the day, they will give you paper to go and but medicine and any other things you need"

"These are some of the problems we are faced with, if you are not in the position to buy the medicine, you will just go home with the same problem while it gets worse"- (Pregnant woman, interview 13)

"You will end up spending your whole day there and coming back home with the same sickness without meds" (Pregnant woman, interview 17)

PARTICIPANT OBSERVATION

During our observation, there were discrepancies between the private and public facilities in terms of care, cost, and location. Private facilities were more expensive in terms of cost for care but were better equipped than public facilities. Essential equipment and supplies such as gloves, medications, etc. were available at the private facilities; the price paid for service was all-inclusive. Health workers appear more confident to render care at private facilities because they were paid on time and had the necessary supplies that enable them to work.

There was a prepaid system set up at one of the private facilities where our study was conducted; women made a previous payment between 7 and 10 Liberia dollars (USD 35-50.00) in preparation for delivery at that facility. Once a woman completes her payment, she receives a "pink card' which indicates a green light to been accepted in case of labor at any time. At private facilities, there is less uncertainty; costs are clear and upfront.

At the public facilities, upon arrival, there's a sign at every entrance that says, "all services here are free of charge." However, women pay for literally everything including gloves

used to carry out physical exams during antenatal visits. Mothers are also charged for immunization record books before a child receives an immunization. Before an ambulance can depart the facility to pick up a pregnant woman or mother, her family must provide 5-7 gallons of gas (current price per gallon: 562.00 Liberian dollars=USD 2.84). After she arrives at the facility, her family must also provide a similar amount for running the generator that produces electricity. In the case of emergency, an initial amount of money must be deposited before admission; this amount varies from facility to facility.

A pregnant woman must also present a "packed bag" with birthing essentials. Each pregnant woman bag must include (2), lappas (4), underwear (6), bath soap (2), powder soap (2pck), laundry/ bar soap (2), Dettol (1bottle), chloride (1bottle), sanitary pad (2 packs), small towels (2), and a home-based / antenatal card with her records. In the absence of these requirements, women are usually turned away or detained after delivery until her family can fulfill such requirements or replace the used items.

"When I walked around the community and asked the men why you don't send your women to the maternal waiting home, they will always tell me that they are unable to feed two homes. They are unable to spend 100.00 Liberian dollars every day for the woman at the same time spend 300 0r 400.00 for the kids at home. So, they prefer to keep the woman at home, when she gets in labor early, they will try and make a way to the hospital, if not, we will take her to the oldma them [Traditional midwife]"- (Skilled midwife 46yrs, Bong County)

Consistent with our findings from the interviews and observations at our study facilities, this account details another reality for pregnant women seeking care at maternal waiting homes across Liberia. Our observation at this waiting home added more context to our research findings. The link Maternal Waiting Home or Big Belly House as it is locally called, is a transit

house built closer to the hospital and was established to host pregnant women living far from a hospital or who were at high risk for complications during delivery. The goal is to ensure pregnant women give birth in health facilities with the assistance of skilled birth attendants.
We spent a night and half of the day at home; during our participant observation and interaction with residents, we discovered that pregnant women must provide food and everything they need to stay at the house until they give birth.

The challenges surrounding stay at the maternal waiting home at the same time worrying about sustaining the family at home prevented most women from coming to the house and would prefer to stay in their community and give birth with the help of a traditional midwife.
It was the 7th of January 2020 at 3:00 pm when I was taken to the Link Maternal Home in Phebe, Gbarnga Bong county. Gbarnga Bong county is a rural setting that happened to also be one of our research locations, as well as home to Phebe hospital, which was one of our research facilities.

The Big Belly House, as it is locally called, is 20 minutes away from the Phebe hospital, one of our study locations. The House is situated in an isolated area surrounded by trees. We recruited participants who were residents at this home and visited them to conduct our interviews. Residents were pregnant women at term staying at the maternal waiting home and awaiting delivery. Arriving at the maternal waiting home, after 20 minutes of walking, the resident midwife took me inside. As a first-time researcher, it was a bittersweet experience for me; instead of having an interview, we had to do a round of counseling.
"There's no support for this maternal waiting home; I need help so that our women will start coming back in their numbers like it was before. Every month, we had an attendance of 18, 24, but nowadays, it has dropped to 8, 10, 4. The women don't have money to take care of themselves while they are here. When we had Africare [NGO] here, things were ok because they were

supplying us. But now, it is no more, and the women are finding it difficult". - (Skilled midwife, 46 yrs, Bong County)

Sobbing and nodding her head, the resident midwife expressed her frustration at not receiving adequate support at the maternal waiting home. We decided to take a walk through the facility. Walking through the corridor of the house, I could see pregnant women lying in rooms awaiting their due dates. After a failed attempt to interview some of the women, due to insecurities, I decided to spend a night there. It was a long night characterized by fear. In these settings, women were not very open to discussing personal issues, especially with a stranger. It was difficult to get consent from women at the center because, according to them, they never understood what the process was about, and according to them, I was a stranger.

As the darkness took over, there was no sign of getting electricity. The maternal waiting home was dark, and everyone relied on their cell phones for light. I spent a night at the Big Belly House trying to build rapport with the women. During our observation the next morning, we observed women making contributions towards the purchase of food. After the money was collected, a caretaker went to the market to prepare food for these women. I joined them; we cooked and ate together the next morning. After this interaction, I didn't have to introduce myself to the woman anymore; they felt very comfortable talking to me.

At this center, every woman must come along with all of the things (toothpaste, toothbrush, soap, and a packed bag for delivery) she'll need while at the waiting home, as well as money to feed themselves until they give birth and leave the house.

"Hmmmm, the living condition is not bad, just that everyone can contribute towards the feeding; that's all. Each person brings a certain amount, and we put it together to be able to cook and eat. For me, when I was coming, I brought my own money, and I think that's how it is for

everyone here. Everyone can feed themselves while you are here, and when you are coming, you have to bring everything you will need until you leave here." (Pregnant woman, 21yrs, Bong County)

During our observation, the Big Belly House had only four women awaiting delivery with three caretakers. You would have thought that women would utilize such a facility, especially women from faraway distances. Unfortunately, this was not the situation; Challenges ranged from an inability to feed themselves while at this waiting home to the feeling isolated from family and loved ones, coupled with personal problems; these challenges prevented women from coming to the waiting home.

"Some of them are also worried that they will be isolated from family, friends, and loved ones when they come to the waiting home"- (Skilled midwife, 46yrs, Bong County)

DISCUSSION

Women's healthcare experiences leave them with a dilemma of choosing between "safe" deliveries at overburdened, unwelcoming, and costly public health facilities and "unsafe" deliveries with private caregivers/TBAs who are present, dependable, and more attentive to women's needs and experiences. According to WHO, "respectful maternity care is referred to as care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality; ensures freedom from harm and mistreatment and enables informed and continuous support during labor and childbirth."[22] While there have been efforts to encourage health facility deliveries amongst pregnant women and promote access to skilled healthcare professionals and timely referrals,[22] facility-based labor and delivery may not be able to guarantee good quality care for many women.[6]

The experiences and perspective of women accessing maternal healthcare services serve as a significant indicator for evaluating the success of these services in Liberia. Utilizing maternal healthcare services is influenced by the experiences and quality of care a woman receives with her every encounter with a hospital/clinic.

Women value the trust, dignity, respect, and empathy they experience in their interactions with traditional midwives. They are reluctant to sacrifice these benefits by excluding traditional midwives from their birthing experience. Women are faced with the dilemma of choosing which caregiver they prefer for certain kinds of services; therefore, they rely heavily on the prior experiences and relationships to decide where issues of trust were appropriately placed based on how they'd been handled by a particular care provider. The words of the women captured what matters to them in care: being accompanied, 'walked with', 'emotionally supported', as stated by Kleinman, " The laying on of hands, empathic witnessing, listening and moral solidarity through sustained engagement and responsibility are all core moral tasks of care giving.[33]According to him, the theory of caregiving also identified "presence"-being there, existentially even when nothing practical can be done and hope itself is eclipsed-as central to caregiving."[33]

According to Bohren et al., disrespectful and undignified care is prevalent in many health facilities across the globe, with low-resource countries being emphasized.[34] The study further highlighted that allowing healthcare workers to have a monopoly over the birthing processes and ignoring women's opinion may expose pregnant women who might have appear healthy to unnecessary medical procedures.[23]Our research found that while women were conscious of the benefits associated with giving birth at a hospital or clinic, some systemic barriers and practices existed within these settings that influenced their decisions to receive care in their communities. The study also uncovered that women fully understood the risk associated with giving birth at

home assisted by a traditional birth attendant. Women understood that a traditional birth attendant may lack the sophistication, skills, and knowledge necessary to manage complications during the birthing process. However, women preferred traditional midwives for their delivery because of the level of respect, trust, emotional connectedness that existed between them, as well as the sense of empathy traditional midwives portrayed. To this end, our qualitative analysis draws upon three categories/ themes supported by sub-categories that better explain our findings.

1. CHALLENGES ASSOCIATED WITH ACCESSING CARE AT A PUBLIC HEALTH FACILITY

While pregnant women and mothers are conscious of the benefits and importance of seeking care and giving birth in a hospital/clinic, there are bottlenecks/challenges they must face to access such care, especially in public hospitals/clinics. These challenges remain an overwhelming problem that each woman must deal with based on what she thinks is best. Aware of these risks, women also believed that they could have a dignified delivery with a traditional midwife who lived nearby. Seeking care at a hospital/clinic comes with a lot of challenges. Women find themselves in this dilemma where they must seek attention or give birth in a hospital or be fined, regardless of how they feel about the process. On the other hand, they want to seek care or have their baby at a place where they feel respected, cared for, loved, and part of the care and decision-making process for them and their unborn child; Somewhere they shouldn't have to choose between safety and financial ruin or safety and having their preferences respected.

2. TRADITIONAL BIRTH ATTENDANTS PERCEIVED AS A BETTER ALTERNATIVE

Our research started with a goal of trying to understand and close the gap between WHO quality improvement framework for maternal and child health in facilities, and the actual experience of care. To achieve better individual and facility-based outcomes, the "provision of care" must respond with the "experience of care".[29] Interviewees stressed how important it was for public health facilities to deliver on the promises indicated on their signs and in their policy documents: free maternal health services to pregnant women and mothers. The consequence of promising free care and conditioning care delivery on payment has resulted in a breach of trust between women and the healthcare system.

However, when trust issues surrounding the delivery of these services emerge, women are left with no choice other than to find alternative care with private caregivers who offer better care experiences regardless of what it might cost them. Interviewees outlined several reasons why a woman would favor traditional birth attendants over public facilities. From having the luxury to decide a birthing position to receiving physical and emotional support, having a dignified and respected delivery in the absence of delivery essentials, a companion during the peripartum processes, and a caregiver close by to avoid transportation challenges are key. All of these experiences, coupled with respect for traditions, pointed out why a woman would prefer a private caregiver/traditional midwife. While the absence of essential drugs and supplies appears to be a significant problem for health facilities, women are concerned about dignity, respect, and the way they are made to feel during these times rather than just getting medications.

3. LACK OF TRUST IN THE PUBLIC HEALTHCARE SYSTEM

There are existing pieces of literature that give different perspectives on this topic. Hogan et al., in 2019, attributed poor maternal health outcomes to the use of traditional birthing practices.[35] Hayden attributed the lack of trust in facilities due to the Ebola outbreak, which

forced hospitals and clinics to shut down.[19] Their inability to provide services during the crisis remains a contributing factor to the underutilization of maternal health services. Based on our findings, women's experiences were consistent with Arthur Kleinman's theory of social suffering and caregiving.[36] Women's experiences provided perspectives that highlight the genuine caregiving demonstrated by trained traditional midwives, something lacking in the public health facilities.

Since pregnant women and mothers manifest a high level of trust and preference for traditional midwives, it seems logical that they could serve as the link to facility-based deliveries. Involving traditional birth attendants in maternal health service delivery could improve the utilization of maternal health services and give women better experiences during pregnancy and birth.

Limitations

Due to limited time and resources, we were unable to interview traditional midwives to get their opinion on the feasibility of including them in the delivery of maternal health services for women. This study participants were purposefully selected; the results might not, therefore, be generalizable.

CONCLUSION & RECOMMENDATIONS

The 14 years of civil unrest and the Ebola outbreak left a devastating effect on the Liberian healthcare system. Systemic barriers and practices in public health facilities across Liberia have led to a lack of trust in public health service providers, resulting in the underutilization of some services. These experiences, coupled with Ministry of Health policies that mandate delivery in health facilities, have left women with a dilemma around seeking

maternal health services. Although efforts have been made to improve the system, there's still a lot to be done. Improving maternal health outcomes should include promoting the utilization of maternal health services that create better maternal healthcare experiences that reflect women's voice and choices. There's a need to improve pregnancy and birthing experiences for women by considering strategies that focus on the supply of birthing kits, building and equipping maternal waiting homes to meet the needs of pregnant women during their time of transit, integrating, redefining job description, and compensating traditional birth attendants to work with hospitals. However, further studies focusing on strategies to bridge the existing gap of trust for private caregivers over public health facilities are also required.

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