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# Barriers and facilitators of maternal health service utilization in urban settings of Ethiopia: A Qualitative explanatory study

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## Abstract

# Background

Disparities in maternal healthcare utilization are unacceptably high in urban Ethiopia. However, little is known about underlying barriers and facilitators to maternal health services utilization, especially among low socioeconomic and marginalized urban subgroups. This study aims to identify barriers to and facilitators of maternal health service utilization in urban Ethiopia.

# Methods

A qualitative study using in-depth interviews (IDIs), key-informant interviews (KIIs), and focus group discussions (FGDs) was conducted in three purposively selected urban settings: Addis Ababa, Jimma, and Gambella. A total of seven IDIs and six FGDs were conducted among reproductive-age women who ever had a pregnancy or childbirth and reside in urban settings, and seven KIIs with health professionals at various healthcare levels from July 1 to 30, 2025. The information was collected based on the principle of idea saturation. All IDIs, KIIs, and FGDs were audio recorded, and complementary notes were taken. Each interview and FGD data were transcribed word-for-word in the local Afaan Oromo and Amharic languages and then translated into English. Finally, the data were analyzed thematically using ATLAS. ti 9 software and narrated in the linked pattern of maternal health service utilization.

# Results

This study identified eight major themes that explain barriers and six facilitators of maternal healthcare utilization. The main barriers include low knowledge and awareness, socioeconomic status, physical and geographic inaccessibility, health system capacity constraints, quality of care and provider behavior, cultural and social norms, women’s perceptions of safety, trust, and experience, as well as gender dynamics and household decision-making power. In contrast, good knowledge, awareness, and risk perception, family and social support, positive health system experience, health system readiness and accessibility, policy and institutional support, and community empowerment and engagement were found to facilitate maternal health service utilization.

# Conclusion

This study demonstrates that ongoing inequities in maternal healthcare utilization persist as a significant public health challenge in urban Ethiopia, stemming from interconnected socioeconomic, health system, geographic, and sociocultural barriers. Addressing these disparities requires pro-poor, equity-focused health policies and stronger urban health systems that provide respectful, affordable, and accessible care.

# Background

Inequitable utilization of the maternal health service continuum, including antenatal care (ANC), skilled delivery, and postnatal care (PNC), remains a critical public health challenge in low- and middle-income countries (LMICs). In practice, this manifests as women not receiving the recommended frequency of ANC contacts, delivering without skilled assistance, or missing essential PNC, despite the existence of proven, life-saving interventions. These services constitute an interdependent continuum where each element reinforces the next level of care. Timely ANC provides a pathway for risk screening, diagnosis, and health promotion; skilled birth attendance is vital for managing obstetric complications, and PNC ensures the health of both mother and newborn during the vulnerable postpartum period. A break at any point in this continuum significantly increases the risk of preventable maternal and neonatal morbidity and mortality(1,2).

Consequently, reducing preventable maternal death is a cornerstone of global health policy, explicitly mentioned in Sustainable Development Goals (SDG 3.1). This target aims to reduce the global maternal mortality ratio(MMR) to fewer than 70 deaths per 100,000 live births by 2030(3). Achieving this ambition requires a fundamental shift toward equitable access to continuous and high-quality care. In line with this goal, the World Health Organization (WHO) updated its antenatal care guideline in 2016, advancing from a model of four visits to eight contacts and a continuum of care. This recommendation requires the critical need for more frequent, integrated, and person-centered engagement throughout pregnancy to improve outcomes across the maternal health continuum(2).

Over the past two decades, Ethiopia has made significant investments in maternal health, prioritizing it within broader national health strategies aimed at achieving universal health coverage and related global goals(4). The recent national reproductive health strategy (2021-2025) emphasizes equitable access and utilization of maternal health services as central to achieving universal health coverage (UHC) and reducing preventable maternal deaths, particularly among vulnerable populations(4). In line with this, Ethiopia launched the Urban Health Extension Program (UHEP) in 2009 and has continued to revise urban health policies within successive health sector plans(HST-II) to address the unique challenges faced by the urban poor, such as fragmented social networks, inadequate sanitation, and financial barriers to care(5,6).

Despite these substantial policy efforts, persistent and complex challenges have emerged. A growing body of evidence reveals that conventional rural-urban dichotomies mask intra-urban disparities in maternal health service utilization(7–9). Alarmingly, maternal health outcomes in urban informal settlements can be worse than in rural areas, highlighting that a large proportion of urban residents, especially those living in informal settlements and slum areas, continue to underutilize these services(10). Existing studies, largely quantitative, identify poverty status as the primary stratifier of maternal health service utilization within cities(11–13). Which identifies a range of associated barriers operating at multiple levels, like low education, young maternal age, unemployment, and restrictive gender norms, lack of social supports, distance, parity, women's autonomy, abuse by the provider,

mistreatment, poor interaction with the provider, poor referral, transportation cost, financial hardship, and fee exemption(14–20). Studies from Nigeria, Kenya, and other sub-Saharan African cities further demonstrate that maternal mortality and adverse maternal outcomes can be higher in urban slums than in rural areas, underscoring the disparities of urban maternal health experiences and the limitations of simple rural-urban comparisons(21–23).

These quantitative evidences have documented disparities in maternal health service utilization. However, these studies largely focus on measuring coverage and service contact indicators and provide limited insight into how and why disparities persist within cities. On the other hand, existing qualitative findings from urban settings suggest that barriers and facilitators to maternal health service utilization extend beyond physical proximity to facilities. Geographic challenges within cities, including transportation costs, referral systems and waiting times, financial hardship, lack of awareness of maternal healthcare, interaction with provider, facility and ambulance drivers, cost of services, long waiting time, lack of road access, sociocultural beliefs, provider attitude, ignorance, decision making autonomy, limited medical supplies, provider shortage, and facilitators like improved healthcare understanding, family support, reliable transportation, compassionate care, community initiatives, free maternity services, health extension program continue to influence urban poor women despite living near health facilities(21,22,24–27). Financial barriers remain particularly relevant, as urban poor women frequently encounter out-of-pocket expenditures for medications, diagnostics, or informal payments even within officially free public facilities(8). In addition, experiences of disrespectful care, poor communication, discrimination, and limited responsiveness to women's needs have been shown to undermine trust in health services and discourage continued utilization across the maternal health continuum(28–31).

Despite these insights, there remains a paucity of qualitative research in urban Ethiopia that synthesizes both barriers and facilitators influencing maternal health service utilization, particularly from an equity perspective.  As a result, these gaps underscore the pressing need for a comprehensive understanding of the barriers and facilitators that shape maternal health service utilization in urban settings. Therefore, to address this gap, this study aims to explore the multilevel barriers to and facilitators of maternal health service utilization in urban Ethiopia, aiming to generate evidence to inform policies and interventions that promote equity in maternal health.

## Methods and Approaches

# The study setting and context

This study was conducted in purposively selected three urban settings in Ethiopia, including Addis Ababa (with high ANC4+ utilization), Jimma (moderate), and Gambella (low utilization) from July 1-30, 2025.  Public and private facilities, including health centers and hospitals, serve as the primary providers of maternal health services in these areas.

# Study design and Participant selection

A qualitative explanatory study design was employed to gain an in-depth understanding of barriers and facilitators of maternal health service utilization. Three categories of participants were included using purposive sampling, selected based on their relevance to the study objective. The study comprises 7 in-depth interviews (IDIs) with urban women who had given birth two years before the study or who were pregnant during the study period and residing in the selected urban areas.

Seven focus group discussions (FGDs) with urban women of reproductive age living in the selected urban areas, including informal settlements and slum areas. Participants in the focus group discussions (FGDs) were women who had given birth two years before the study or who were pregnant during the study period. The participating mothers were identified purposively with the help of the MCH focal person and urban health extension workers based on their experience with health service utilization and ability to discuss the matter. They were contacted a few days before the planned FGD to explain the objective of the study and request their participation to explore shared norms, perceptions, and community-level influences on maternal health service utilization. By taking into account a maximum variation in the use of maternal healthcare services, the study participants were drawn from different segments of the population by considering different dimensions that explain disparities in the utilization of maternal healthcare services.  Six key informant interviews (KIs) were conducted with health professionals, facility managers, maternal health coordinators, and policymakers at the regional and national levels.

The participants were selected based on their roles in planning, implementing, or supervising maternal health services and were contacted by the principal investigator two weeks before the interviews. For this study, to ensure representativeness and to understand the multifaceted levels of the study, we used the maximum variation sampling technique and classified the participants into three groups: The first group, women, refers to mothers who gave birth before the study period or were pregnant during data collection. The second group was leaders, like heads of the health centers or hospitals, at the sub-city, regional, and national level, with expertise working on maternal health programs.  The third group, health-care providers, refers to health professionals, including doctors, health officers, nurses, and midwives, working at different health facilities in Addis Ababa city, Jimma, and Gambella towns, having direct relation with maternal healthcare services provision.

All the information was collected based on the principle of idea saturation.  Then, data collection was terminated when no new information was generated.

# Data collection Methods and Tools

Data were collected using an interview guide prepared for the key informant interviews (KII), in-depth interviews (IDI), and FGDs separately for this study(Supplementary file 1). First, the guides were prepared in  English and then translated into the local languages, Amharic and Afaan Oromo(32). Then, the guides

were pre-tested in the area not included in the main study, and issues related to the sequence of questions, the conceptual clarity of questions, and sensitive wording were corrected. The data collectors for the interviews and FGD were professionals with a background in health and health-related fields, holding master's degrees and having experience in qualitative studies. Moreover, they are fluent in the local language(s) and familiar with the culture of the local community where the studies have been conducted. In-depth interviews explored personal experiences, perceptions, and decision-making processes related to antenatal, delivery, and postnatal care, while FGDs captured shared norms, community-level barriers and facilitators, and collective experiences on maternal health service utilization. Key informant interviews (KIIs), on the other hand, provided insights into different levels of decision makers in the health systems and documented policy-level constraints. The place where KIIs were conducted was at the office or at the health facility where the interviewee worked; IDIs and FGDs were conducted in community halls or public rooms. All interviews and FGDs were conducted in local languages and were audio-recorded with consent. Additionally, complementary observations and notes regarding the remarks made by the participants and their interactions were captured during the discussions.

# Data Analysis Method

The principal investigator and the research assistants transcribed each interview verbatim in the local Afaan Oromo and Amharic languages, then translated the transcripts into English. The data were analyzed using a thematic analysis approach, following an iterative, inductive-deductive process. Transcripts were read repeatedly to ensure familiarization, after which open coding was conducted. Codes were organized into sub-themes and broader themes using a master codebook focused on barriers and facilitators of maternal health services. Data were coded to allow disaggregation of transcripts by participant type and setting. Code frequencies were generated to indicate the relative prominence of themes, coupled with interpretations that emphasized meaning, context, and patterns rather than quantification alone. For data organization and analysis, ATLAS.ti 9 software was used. Major themes from the focus group discussions, key informant interviews, and in-depth interviews are presented in the results section, with illustrative quotes included to support the main findings.

# Data quality assurance

Several strategies were employed to ensure rigor and trustworthiness. Triangulation was achieved through multiple data sources (IDI, FGDs, KIIs) and participant groups. Interview guides were pretested, and trained qualitative data collectors conducted the interview and discussion. Transcripts were cross-checked against audio recordings and field notes for accuracy.

**Trustworthiness**

The trustworthiness of the qualitative inquiry was established through credibility, dependability, confirmability, and transferability. The study began with in-depth interviews (IDIs) with individual women, then added focus group discussions (FGDs) with groups of women to explore the group dynamics. Subsequently, it also included health providers, facility focal persons, program managers, and policymakers. Data collection continued until idea saturation was reached.

Credibility was strengthened through prolonged engagement at study sites, continuous peer debriefing, and systematic exploration of divergent or negative cases. Facilitators summarized key points at the end of each interview or discussion and sought participant confirmation to ensure accurate interpretation (member checking). Triangulation of data sources across participant groups and levels of the health system further enhanced credibility.

Dependability was ensured by documenting all stages of data collection and analysis, including presentation of detailed methods, interview logs, and step-by-step analytic procedures. Confirmability was supported through reflexive documentation, including field notes on contextual events, researcher reflections, and emerging analytic insights. These records ensured that findings were grounded in participant narratives rather than in the researcher's bias.

Finally, transferability was facilitated by providing a rich and transparent description of the study context, participant characteristics, and data-generation procedures, enabling readers to assess the applicability of the findings to similar settings**.**

# Results

### Characteristics of the study participants

A total of seven focus group discussions (FGDs) were conducted (three in Addis Ababa, two in Jimma, and two in Gambella towns) with mothers. Additionally, seven in-depth interviews (IDIs) and six key informant interviews (KIIs) were held(Table 1 and Table 2). The number of FGD participants ranged from 8 to 10 in each group. Most women participating in FGDs were housewives and had at least one childbirth or pregnancy at the time of the discussion(*Table 3*). The key informant interviews involved leaders and policymakers at different levels of the healthcare system, including the federal Ministry of Health (MoH) Maternal and Child Health directors, regional health bureau experts, zonal/sub-city health office maternal health experts, and heads of hospitals and health centers. Overall, 60 women participated in the FGDs, and seven women took part in the in-depth interviews. All the IDI participants were married, and none of them were pregnant during the interview period. In addition, six key informant interviews were conducted, three with heads of health facilities, two with heads of zonal or sub-city health offices, and one with the MCH focal person from FMoH. Each FGD lasted an average of 79 minutes (range 70–86 minutes), the key informant interviews lasted about 39 minutes (range 37–41 minutes), and the in-depth interviews lasted about 41 minutes (range 29–48 minutes).

Table 1: Basic characteristics of the participants in the in-depth interview (Women)

| IDI Code | Age | Educational status | Religion | Number of children |
|---|---|---|---|---|
| IDI-01 | 25 | Grade 7 | Protestant | 2 |
| IDI-02 | 28 | Grade 2 | Protestant | 3 |
| IDI-03 | 35 | 10+1 | Orthodox | 3 |
| IDI-04 | 30 | Grade 8 | Muslim | 4 |
| IDI-05 | 35 | Not educated | Orthodox | 3 |
| IDI06 | 20 | $11^{th}$ | Muslim | 3 |
| IDI07 | 27 | 10+2 | Muslim | 5 |

Table 2:Basic characteristics of the participants in the Key informant interview (KII)

| KII Code | Age | Educational status | Responsibility related to maternal health | Service year |
|---|---|---|---|---|
| KII-01 | 33 | MPH | Regional Maternal Health Program Coordinator | 10 |
| KII-02 | 35 | BSc | Provider ( Midwifery) | 12 |
| KII03 | 40 | MPH | Head of the Health Center | 17 |
| KII04 | 30 | BSc-Midwifery | Provider | 15 |
| KII05 | 42 | MD | Head of Hospital | 17 |
| KII06 | 48 | MSc | National Maternal Health program lead | 25 |

*Table 3: Basic characteristics of the focus group discussion participants*

| FGD No | Number of participants | Place/site |
|---|---|---|
| FGD-1 | 10 | Gambella |
| FGD-2 | 9 | Gambella |
| FGD-3 | 8 | Jimma Bacho |
| FGD-4 | 8 | Jimma Kito |
| FGD-5 | 7 | AA-Bole |
| FGD-6 | 8 | AA-Kirkos |
| FGD-7 | 10 | AA-Addis Ketema |

**Barriers to and facilitators of maternal health service utilization in urban Ethiopia**

This study reveals that maternal health service utilization in urban Ethiopia is shaped by interacting barriers and facilitators operating across individual, household, community, health system, and policy levels.

**Barriers to maternal health service utilization in urban Ethiopia**

Analysis of 20 qualitative transcripts, including in-depth interviews, key informant interviews, and focus group discussions, revealed eight major themes explaining barriers and disparities in maternal health service utilization. These include barriers related to low knowledge and awareness, low socioeconomic status, physical and geographic inaccessibility, health system capacity constraints, quality of care and provider behavior, cultural and social norm factors, women's perceptions of safety, trust, and experience, as well as gender dynamics and household decision-making power. These themes reflect both structural and interpersonal factors shaping women's pathways to antenatal, delivery, and postnatal service utilization (Table 4).

Table 4:Barriers to maternal health service utilization in urban Ethiopia based on in-depth and key informant interviews, and focus group discussions

| Themes | Sub-themes/ Category | Codes |
|---|---|---|
| Knowledge, Awareness, and Information Gaps | Low maternal health knowledge | Lack of knowledge on ANC importance (26) |
| | | Limited awareness of danger signs (19) |
| | Postnatal awareness gaps | Lack of knowledge about PNC (23) |
| | | Misconceptions about facility care (15) |
| Economic barriers | Economic costs | Financial hardship (46) |
| | Household economic vulnerability | Cost of private facilities (31) |
| | Indirect costs and economic burden | Loss of income during pregnancy (14) |
| | | Food insecurity affects health (12) |
| Physical and Geographic accessibility barriers | Distance and location | Distance to facility (27) |
| | Transport barriers | Transportation unavailability (33) |
| | | Poor road/infrastructure (18) |
| | | Transportation cost/affordability (29) |
| Health system capacity constraints (Delivery of health services) | Workforce shortage and skills | Shortage of skilled providers (41) |
| | | Provider negligence/poor attention (56) |
| | System inefficiencies | Long waiting time(32) |
| | | Fragmented service /multiple visits (22) |
| | | Lack of facility preparedness(cleanliness, space) (19) |
| | | Unreliable referral system (38) |
| | Supplies and essential medicines | Medicine stock-outs (24) |
| | Diagnostic services | Lack of ultrasound availability (16) |
| | | Shortage of laboratory services (20) |
| | Postnatal and continuity gaps | Limited postnatal care services (27) |

| | | |
|---|---|---|
| Quality of care and provider behavior | Negative provider interactions | Disrespect and abuse (35) |
| | Discrimination and bias | Discrimination by wealth/status (28) |
| | | Preference for male vs female provider (21) |
| | Technical quality of care | Lack of empathy/support (30) |
| | | Inaccurate diagnosis/ultrasound error (17) |
| Cultural and social norm barriers | Traditional beliefs and practices | Home birth tradition(18) |
| | Social norms about pregnancy | Influence of elder/traditional beliefs (14) |
| | | Role of traditional birth attendant (22) |
| | Fear of taboos | Pregnancy hiding/secrecy (10) |
| Perception of safety, trust, and experience | Fear and safety concerns | Fear of poor outcomes (29) |
| | | Fear of C-section (20) |
| | Trust and satisfaction | Loss of trust in the health system (33) |
| | | Preference for private facilities (17) |
| Gender dynamics and household decision-making | Household power | Husband control/lack of support (34) |
| | Positive decision dynamics | Joint decision making (positive) (18) |
| | Gender responsibility | Unequal household responsibilities (16) |

**Facilitators of maternal health service utilization in urban Ethiopia**

In contrast to the documented barriers, the analysis also identified six interrelated thematic facilitators that enabled maternal health service utilization in urban Ethiopia. These facilitators operated across individual, household, community, health system, and policy level reinforcing women's ability and willingness to initiate and continue care along the maternal health continuum. These include good knowledge, awareness, and risk perception, family and social support, positive health system experience, health system readiness and accessibility, policy and institutional support, and community empowerment and engagement. Together, these facilitators illustrate how an enabling environment and

supportive system can mitigate inequities and promote sustained engagement with maternal health services utilization (Table 5).

Table 5: Facilitators of maternal health service utilization in urban Ethiopia based on in-depth and key informant interviews, and focus group discussions

| Themes | Sub-themes/ Category | Codes |
|---|---|---|
| Knowledge, Awareness, and Risk Perception | Understanding the importance of ANC | Awareness of ANC benefits (28) |
| | Recognition of danger signs | Awareness of pregnancy complications (21) |
| | Health education exposure | Information from HEW's/media (19) |
| Family and social support | Spousal support | Husband encouragement (32) |
| | Household decision dynamics | Joint decision making (18) |
| | Peer and community influence | Support from other mothers (24) |
| Positive health system experience | Respectful and caring providers | Respectful maternity care (27) |
| | Provider communication | Clear explanation and counseling (22) |
| | Trust in providers | Confidence in professional skill (20) |
| Health system readiness and accessibility | Facility availability | Nearby public facilities (26) |
| | Transport facilitation | Ambulance availability (23) |
| | Service continuity | Integrated ANC-delivery-PNC services(17) |
| Policy and institutional support | Free maternal health service | Free exemption for maternal care (35) |
| | Leadership commitment | Government prioritization of maternal death (29) |
| | Surveillance and response system | MDSR implementation (16) |
| Community empowerment and engagement | Community platforms | Pregnant mother's conferences(31) |
| | Women's empowerment | Increased autonomy and confidence (14) |
| | Outreach and follow-up | Health extension support (18) |

**Knowledge and Awareness of Maternal Health Services Utilization**

Limited awareness of ANC importance, danger signs, birth preparedness, and postnatal care appears as a key factor leading to late or missed service utilization, explaining the disparities seen in urban areas.

Despite living in urban environments, communities on the outskirts, and undereducated women often lack knowledge about the significance of maternal health services. Newly arrived migrants, slum residents, and those in peripheral areas have limited media exposure, minimal interaction with healthcare providers, and low school attendance, which hampers their understanding of maternal health information. Some participants feared tests like ultrasounds or misunderstood the purpose of facility-based delivery. Others did not realize the impact of missing ANC or PNC appointments. Additionally, misconceptions such as believing that ANC is only needed for complicated pregnancies contribute to poor early uptake and follow-up visits.

The KII participant expressed:

*"Some mothers think antenatal care is only needed when you are sick. They don't understand that ANC is also for prevention and early detection of problems." KII, age 33, Gambella town.*

Another IDI participant noted:

*"Some women don't come because they don't know the importance. They think everything will be fine like before." IDI, Age 27, Jimma town*.

Another woman emphasized the impact of misinformation:

*"Many mothers are unaware of danger signs. They wait at home until it becomes serious." Female FGD, Age 35 years, Addis Ababa.*

Postnatal care awareness(PNC) gap was a barrier that directly influenced discontinuity of care along the maternal health continuum. Many women reported that they were unaware of the need for postnatal care unless complications occurred. PNC was commonly perceived as optional rather than an essential component of maternal healthcare. Not a few participants believed that once childbirth was completed safely, there was no medical reason to return to a health facility.

*"Most mothers know about ANC and delivery, but postnatal care is not well understood. They don't see it as a necessary service." FGD, age 32 years, Gambella town.*

Another IDI participant stated:

*"… I thought postnatal care was only for vaccinating the baby. I didn't know they also check the mother." IDI, age 20 years, Jimma.*

Another KII participant from Addis Ababa mentioned:

*"Some women fear they will be blamed or questioned if they return after delivery, especially if they delivered at home or missed earlier visits." KII, Age 42 years, Addis Ababa.*

This limited understanding contributed to early disengagement from maternal health services, particularly among women facing financial and time constraints.

A KII participant pointed out that the PNC misconception was a barrier to service utilization by urban women.

*"Most mothers believe that once the baby is born safely, the danger is finished. They don't see the need to return for postnatal care. We tell them to stay at least 24 hours after delivery, but some insist on going home immediately, saying, 'I feel fine now.' They don't know that postpartum bleeding can happen later." KII, age 35 years, Gambella town*.

In contrast, improved knowledge and awareness of maternal health services utilization were found to be facilitators for service utilization. Women who understood the importance of ANC in monitoring pregnancy progress, identifying complications in the early stage of pregnancy, and receiving preventive interventions such as iron supplementation and counselling, motivated timely initiations of care and adherence to scheduled visits.

" *…. Once I learned that antenatal care is not only for sickness but for checking the baby and preventive problems, I did not want to miss any appointments." FGD, Age 26 years, Addis Ababa*.

Recognition of danger signs during pregnancy, including bleeding and severe headache, further strengthened women's perceived need for health care. Women who could identify such risk were more likely to seek care immediately and continuously from health professionals. Exposure to health education through HEW and media reinforced knowledge and corrected misconceptions about maternal health service utilization. Regular information increases women's confidence in health care and reduces fear in facility-based services.

*"…the health extension workers explained the risk and what to expect. That information made me feel prepared and less afraid." IDI, age 27 years, Jimma towns.*

**Economic barriers**

Financial hardship was among the most common barriers and a major cause of disparities in maternal health service utilization. Although maternal health services are officially free in public health facilities, women emphasized that out-of-pocket expenses remain unavoidable, particularly for medications, laboratory tests, and informal payments. For many urban poor, these costs are barriers and lead to delay or incomplete care.

*"It is said that the services are free, but when you go there, you are told to buy drugs from outside. If you don't have money, you just go back home." FGD, Age 30 years, Addis Ababa.*

Another FGD participant noted:

*“Maternal services are free, yes, but transport, food, and medicines are not free. For some poor women, even small costs become a big barrier.” FGD discussant, Age 29, Addis Ababa.*

Financial hardship especially affects continuity of care, making repeated ANC visits and postnatal follow-up difficult to sustain. Household economic vulnerability was exacerbated by the perceived inadequacy of public health facilities, which often force women toward private providers. However, the high cost of private care created some significant barriers, resulting in delayed care-seeking or selective utilization, where women attended only critical visits.

*“In public facilities, you wait too long, or services are missing. But private clinics are very expensive. Many women cannot afford them.” IDI, Age 27 years, Jimma.*

*“If you have money, you get care. If you don’t, you suffer. Even at government hospitals, they tell you to buy medicine from outside.” FGD discussant, Age 35 years, Gambella town.*

Another KII participant stated:

*“The poor mothers are the ones who give birth at home because they cannot afford transport or extra costs.” Male KII, Age 42 years, Addis Ababa*

The limited public health service readiness and unaffordable private care are deepening inequality between different wealth groups. Beyond direct medical expenses, indirect costs, particularly loss of income during pregnancy, significantly constrained service utilization. Many urban poor women relied on informal or daily wage labor, making facility visits financially hard due to time away from work. Women described having to choose between daily subsistence and seeking care, especially when multiple facility visits were needed.

FGD participant mentioned

*“If I miss one day of work to go to the health center, my children will not eat that day.” FGD, mother, age 33 years, Addis Ababa.*

Another IDI participant stated:

*“Pregnant women working as daily laborers face a serious dilemma: attend ANC or earn money to survive” IDI, age 28 years, Addis Ababa.*

Women also pointed out that these opportunity costs discouraged repeated visits, particularly for eight or more antenatal care and postnatal care.

On the other hand, food insecurity is explained as a compounding economic barrier that affects both health-seeking behavior and women’s physical capacity to engage with care. Participants reported that inadequate nutrition during pregnancy reduced their energy and motivation to attend health facilities.

IDI participant explained:

*"When there is no food at home, going to the health facility to seek care is the last thing on your mind." IDI, age 35 years, Gambella town.*

Another KII participant explained:

*"Some women avoid ANC because they feel ashamed to be told to eat well when they cannot even feed their family." KII, age 35 years, Gambella town.*

Conversely, study participants highlighted financial protection mechanisms, including fee exemptions, ambulance services, and household economic support, which facilitated service utilization by reducing out-of-pocket expenditure in urban Ethiopia.

**Family and social supports**

Family and social support, particularly spousal encouragement, was a critical facilitating factor for using maternal health services. Women consistently reported that emotional, logistic, and financial support from their husbands enabled them to attend ANC visits and delivery at health facilities.

*"My husband reminded me about my appointments and paid for transport. Without his support, it would have been difficult." IDI, age 28 years, Addis Ababa.*

Joint household decision-making further enhances service utilization by reducing delays and empowering women to seek care without conflict. In households where maternal health decisions were shared, women experienced fewer restrictions and greater autonomy. Support from peers and other mothers also played a reinforcing role. Informal discussions within neighborhoods help normalize facility delivery and encourage continuity of care.

*"…. other mothers told me about their good experiences at the health center in receiving antenatal care, so I decided to go early to check my status." FGD participant, age 33 years, Jimma town.*

**Physical and Geographic accessibility barriers**

Distance, transportation, and poor roads emerged as major structural barriers limiting the timely utilization of ANC, delivery, and postnatal care across all sites. Participants repeatedly emphasized that women living in peripheral neighborhoods or informal settlements are disproportionately affected. Long distances to facilities delay care-seeking, increase physical burden on pregnant women, and often result in missed appointments or home births. Transportation was described not only as unavailable but also unaffordable for many women, particularly during labor and emergencies. Road conditions, especially during the rainy season, further exacerbate delayed access.

*"We walk very far, sometimes more than 20 or 30 kilometers, to reach the health center. By the time you arrive, you are already tired and weak." FGD participant, age 28 years, Gambella town.*

FGD and KII participants noted that even in urban settings, services remain geographically inequitable, with women in outskirt areas having substantially poorer access. Without reliable transport and functioning referral pathways, women often arrive at facilities late, exhausted, or already in complications.

One FGD participant stated:

*"In our area, transportation is the biggest problem. Even when a mother is in severe pain, there is no vehicle to take her. Sometimes she starts giving birth on the road because the hospital is far and the roads are very poor." FGD participant, Age 32years, Gambella.*

A key informant participant similarly explained how distance and transport problems affect disparities:

*"Mothers who live far from the facility miss their ANC visits. Those in the center can come at any time, but for those from the outskirts, the cost and lack of transport force them to stay home." KII participant, Age 42 years, Addis Ababa.*

Transport unavailability, particularly during nighttime or in emergencies, was frequently raised as a life-threatening barrier.

*"…at night, ambulances do not come. Even if you call, they may arrive after many hours. By then, the mother might be in danger." FGD participant, Age 25 years, Gambella.*

On the other hand, transport cost also deterred women, especially those from poor households:

*"Sometimes they ask 1000birr for fuel for the ambulance. Poor women simply stay at home." FGD participant, Age 30 years, Gambella.*

Another FGD participant stated:

*"…sometimes the ambulance comes to take the laboring mother from home, but it does not take her back home after delivery because of fuel shortage." FGD participant, Age 24 years, Jimma town.*

As a KII participant stated:

*"We provide an ambulance, but in some areas the road is so bad that the ambulance cannot even last one year." KII, age 35 years, Gambella town.*

In contrast, the availability and accessibility of maternal health services in nearby areas are found to be important facilitators of service utilization. Women highlighted the importance of nearby public health facilities, which reduced travel time and the cost of transportation.

*"…the health center is close to my home, so I could go even when I felt tired." FGD, age 24 years, Addis Ababa.*

The availability of an ambulance dedicated to laboring mothers and emergencies was frequently mentioned as a good enabler, particularly if the ambulances are properly dedicated to night labor or complications.

*“The government has assigned an ambulance in all regions to support emergency transportation for laboring women and mothers with complications. This is an important initiative that should be continuously supported and fueled.” KII, Age 40 years, Jimma town.*

Continuity of care through integrated ANC, delivery, and PNC services also facilitates sustained engagement in maternal health service utilization. Study participants appreciated receiving multiple services within the same facility and from familiar providers.

**Health system capacity constraints**

Shortages of skilled providers, provider absenteeism, and unreliable referral systems were described as systematic failures that disproportionately affect poor women, those with limited social networks, and migrants. Across transcripts, participants emphasized that “lack of providers” is not only a numerical shortage but also reflects inconsistency and poor distribution of skilled personnel. Many women reported arriving for ANC or delivery only to find no midwife or doctor available, or being told to “return another day.

*“Only one or two professionals are in the maternity ward. When they are not around, no one checks you.” IDI participant, Age 30 years, Addis Ababa*.

Another KII participant stated:

*“There is high staff turnover. You train someone today, tomorrow they leave the facility.” KII, Age 33 years, Gambella town.*

On the other hand, provider negligence and poor attention were mentioned as the single most frequently referenced barriers, with women describing experiences where examinations were delayed or performed incompletely:

*“…. they told me everything was fine on ultrasound, but on delivery day, they said there was no fluid. Nobody explained anything to me. This negligence put my baby at risk.” FGD participant, Age 43 years, Gambella.*

Long waiting times were widely cited as discouraging continued ANC follow-up:

*“You go for ANC, but you may not be seen on time. Sometimes you wait the whole day.” FGD participant, Age 29 years, Addis Ababa.*

Referral systems were described as “broken,” with delayed ambulance responses, lack of coordination between facilities, and inadequate emergency obstetric capacity. Participants perceived that wealthier women circumvent these issues by using private clinics.

One participant noted:

*"Sometimes the mother is struggling in labor, but the doctor responsible for the operation is not there… they call him, but he doesn't come. By the time he arrives, the baby or even the mother may already be in danger." FGD participant, Age 40 years, Gambella town.*

Another informant described how this leads to institutional mistrust:

*"There are skilled professionals, but they are few. Mothers might come three times and still not get proper care because the system is overwhelmed." KII participant, Age 40 years, Jimma town*.

Frequent stock-outs of medicines, lack of vaccination supplies, and limited ultrasound and laboratory services were consistently noted across sites. Participants described repeated scenarios of arriving for ANC, PNC, or child immunization only to be turned away due to the unavailability of essential medicines or equipment. These gaps led many families to seek private care where costs are prohibitive, or to delay or forgo services altogether.

FGD participant noted:

*"When we go for vaccinations, sometimes they say the medicine is finished. They tell us to come another day. This discourages mothers." FGD participants, Age 32 years, Jimma*.

Another FGD participant highlighted similar concerns:

*"If you don't have money for medicine outside, you just stay home. The hospital rarely has what we need." FGD participant, Age 26 years, Gambella*.

Another FGD participant stated:

*"A mother may come for ANC, then be sent to another room, another day, another facility without clear communication or transport." FGD, age 33 years, Addis Ababa*.

**Quality of care and provider behavior**

Disrespectful treatment, verbal abuse, discrimination based on economic status, and lack of empathy emerged as key deterrents to facility-based care. Women described feeling "unwelcome," "looked down upon," or "ignored" by providers. Several participants reported that some providers prioritize wealthier or well-connected clients while poor women wait longer or are spoken to harshly.

*"Some providers talk to you as if you are nothing. They shout, they don't explain, and they make you feel ashamed. When you ask questions, they say, 'Can't you see we are busy?' There is no empathy, especially when you are in pain." FGD, age 29 years, Addis Ababa*.

Participants stressed that negative experiences spread quickly through the community, reinforcing avoidance of services.

One participant shared:

*“Some doctors can be abusive … If they don’t like you or if you look poor, they don’t treat you well. Many women fear this and prefer to give birth at home.” IDI participant, Age 20 years, Jimma town.*

Several participants emphasized that disrespect was more pronounced during delivery care than during ANC, reinforcing the fear of facility-based childbirth.

*“During ANC, they are okay, but during labor, their behavior changes. That is why many women don’t want to deliver in a health facility.” FGD, age 38 years, Jimma town.*

Participants stressed that the absence of emotional support and respectful communication undermined women’s confidence and willingness to return for subsequent services, including postnatal care.

Discrimination based on economic status was widely reported. Poor women felt that providers treated them differently from wealthier or well-connected clients, often making them wait longer or addressing them in a humiliating manner. Such experiences reinforced perceptions of inequity within assumed free public services.

FGD participant emphasized how disrespect deters service use:

*“We wait for hours, and when our turn comes, they shout at us. It is discouraging, especially for first-time mothers.” FGD participant, Age 23 years, Addis Ababa.*

Another woman emphasized:

*“If you look poor, they don’t respect you. Those who dress well are treated first.” IDI participant, Age 27 years, Jimma town.*

Another FGD participant stated:

*“Some providers assume poor women don’t understand anything, so they don’t bother to explain about services and procedures.” FGD, age 31 years, Addis Ababa.*

Concerning the technical quality of care, particularly misdiagnosis, inaccurate ultrasound results, or inconsistent clinical assessment were reported to be the barriers to maternal health service utilization. Participants stressed instances where conflicting diagnoses or incorrect assessments led to confusion, fear, and mistrust of health facilities.

This is supported by the statement of an IDI participant:

*“One provider told me everything was fine, but later another said there was a serious problem. I didn’t know who to believe.” IDI, age 35 years, Gambella town.*

Another FGD participant noted:

*“They told me the baby was in a bad position, but later it was normal. That scared me a lot.” FGD, age 29 years, Jimma town.*

Key informants acknowledged that the shortage of skilled personnel and diagnostic equipment contributed to inconsistent clinical assessments.

*“Sometimes ultrasound is done by untrained staff, and the results are not reliable.” KII, age 35 years, Gambella town.*

**Cultural and social norm barriers**

Cultural expectations, traditional beliefs, and family influence continued to shape maternal health behaviors among urban women. Home birth traditions remained deeply rooted, with many participants describing childbirth as “a natural process” that should be managed at home, often under the supervision of experienced older women or traditional birth attendants (TBAs). These practices were reinforced by social norms around pregnancy, particularly the influence of elders such as mothers, grandmothers, and community leaders who were perceived as more knowledgeable and trustworthy than formal health providers. In addition, taboos and pregnancy-related secrecy were among barriers, with women concealing early pregnancies due to fear of bad luck, spiritual harm, or social judgment. Such practices were especially common among poorer women and those with rural origins now residing in urban settings, where traditional beliefs continued to coexist with urban health services. One FGD participant explained the persistence of home birth traditions:

*“Some women say our mothers delivered at home and were fine, so why should we go to the health center?” FGD participant, Age 18 years, Jimma town*.

Another participant explained the strong role of elders in shaping care-seeking behavior:

*“There are elders who tell mothers not to go early for checkups. They say it brings bad luck.” FGD participant, Age 26 years, Gambella town.*

Pregnancy secrecy was also emphasized, particularly during the early stages:

*“A woman may hide her pregnancy for months. She fears people will talk or that something bad will happen if others know too early.” FGD, age 38 years, Addis Ababa.*

**Perception of safety, trust, and experience**

Trust in the health system strongly affected service utilization. Women who had witnessed or heard of poor outcomes, such as delayed response, mismanagement, or newborn injuries, were more likely to avoid facility-based care or delay ANC. Fear of unnecessary C-sections was also frequently reported, driven by stories of surgical complications or perceived overuse of operations among wealthier women.

One participant explained:

*"There was a baby who fell from the provider's hands and died. Since then, mothers are afraid to utilize maternal health services from the health care provider." FGD participant, Age 33 years, Gambella.*

Another noted concern about C-section:

*"Some women fear the operation. They think doctors do it even when it's not needed." Female FGD participant, Age 45 years, Addis Ababa*

Concerning medical errors and unsafe C-sections, strong concerns were raised about provider mistakes during C-sections, causing trauma, disability, or death.

*"One health assistant left her in the wrong place, and she died…when the operation was done, she placed both the delivery tube and anesthesia tube together …. she suffered for 15 days and then passed away." FGD participant, Age 37 years, Gambella.*

Participants further described fear of cesarean section as an important psychological barrier to the utilization of maternal health services.

*"Some mothers come to the health facility already convinced that they will undergo surgery. They are afraid, because they have heard stories in the community that others died after a cesarean section." FGD participant, Age 32 years, Gambella.*

This perception contributed to delayed care-seeking or complete avoidance of facility-based maternal health services, especially among women with limited access to accurate information and counseling.

Another participant stated:

*"Some women believe the ultrasound damages the baby. They refuse it because they think the machine has radiation." FGD participant, Age 28 years, Bole, Addis Ababa*.

In line with this, one participant stated:

*".... they fear the tests… they think if they check the baby too early, they may hear bad news. So they avoid the facility." FGD participant, Age 28 years, Addis Ababa*.

In contrast to barriers identified, positive interaction with the health system strongly influences women's continued utilization of maternal health services. Experience of respectful and caring providers fostered trust and reduced fear. Women who felt listened to and treated with dignity expressed greater satisfaction and willingness to return.

*"The midwife welcomed me and explained everything calmly. That made me trust the provider and continue to utilize antenatal care services." FGD participant, age 28 years, Gambella town.*

Clear and consistent provider communication, including on pregnancy progress and birth preparedness, further strengthened engagement in continued service utilization. Women valued providers who

explained procedures, tests, and test results, and follow-up plans in understandable terms. Confidence in the professional skills of healthcare providers was another enabling factor for the women to engage in the service utilization in urban Ethiopia. Trust in providers' competence reassured women that attending health facilities could manage complications related to pregnancy effectively.

**Gender dynamics and household decision-making**

Household power inequality strongly influenced maternal health service utilization. In several transcripts, participants indicated that husbands decide whether and when a woman accesses ANC or delivery services. Lack of financial, emotional, or logistical support often resulted in delays or avoidance of care. Some women described positive joint decision-making, but this was less common and more frequently reported among educated, urban households.

As one participant stated:

*"Some husbands don't know about vaccines or pregnancy care. They don't support the mother, so she misses appointments." FGD participant, Age 43 years, Jimma town.*

Another added:

*"If the husband refuses to pay for transport, the mother cannot go. It depends on him." FGD participant, Age 24 years, Gambella town.*

In contrast to this barrier, community-level platforms played an important role in promoting maternal health service utilization in urban Ethiopia. The participants highlighted that the pregnant mothers' conference provided an opportunity for shared learning and peer support on maternal health service utilization.

*"…At the pregnant mothers' conference, we learned from health workers and other mothers. The lesson I got from this conference encouraged me to complete all the visits." FGD participant, Age 28 years, Jimma town.*

*"When husbands attend pregnant mothers' conferences, they understand better and support care-seeking." FGD participant, 30 years, Jimma town*.

Additionally, women emphasized that increased women's autonomy and confidence enabled proactive health-seeking behavior. Regular outreach and follow-up by health extension workers further improved continuity of maternal health service utilization.

Another facilitator mentioned by the participants was a free maternal health service initiative. Fee waivers reduced financial barriers and encouraged maternal health service utilization among economically disadvantaged women.

*“Knowing that ANC and delivery services are free made me decide to go to the health center instead of staying at home.” FGD participant, age 33 years, Gambella town.*

Participants also acknowledged government prioritization of maternal health, highlighting visible improvement in health infrastructure, expansion of the maternal health workforce, and strengthened outreach programs targeting maternal and child health services. These efforts were perceived as a signal of political commitment and increased system readiness to respond to maternal health needs in urban settings.  In addition, the implementation of the Maternal and Perinatal Death Surveillance and Response(MPDSR) system was widely recognized as a key accountability mechanism. Participant noted that MPDSR enhanced responsiveness at facility and managerial levels by promoting regular case review, identifying avoidable factors, and encouraging corrective actions, thereby improving the quality of maternal health services.

One participant shared:

*“With the MPDSR system, every maternal death is reviewed seriously. It helps us identify gaps and take action so the same problem does not happen again. The death review meeting improved accountability. Providers are now more cautious and responsive because cases are discussed and lessons are shared. So, maternal and child health has become a government priority.”  KII, age 48 years, Addis Ababa.*

# Discussions

This study examined multiple barriers and facilitators that influence maternal health service utilization among women of reproductive age in urban Ethiopia. In line with global evidence showing that maternal health outcomes reflect deeply rooted social, structural, and health system inequalities (33–35). This study identified eight themes that explain the barriers to and six facilitators of disparities in maternal health service utilization. These themes include barriers related to low knowledge and awareness, low socioeconomic status, physical and geographic inaccessibility, health system capacity constraints, quality of care and provider behavior, cultural and social norms, women’s perceptions of safety, trust, and experiences, and gender dynamics and household decision-making power. Themes identified as facilitators were good knowledge, awareness, and risk perception, family and social support, positive health system experience, health system readiness and accessibility, policy and institutional support, and community empowerment and engagement. These factors reflect both structural and interpersonal influences shaping women’s pathways to antenatal, delivery, and postnatal service utilization. Such intersectional factors mirror global maternal health inequity patterns documented in both high- and low-income settings(33,35).

**Barriers and facilitators of maternal health service utilization**

**Barriers to maternal health service utilization**

**Knowledge and Awareness Barriers**

Low awareness about ANC/PNC timing, danger signs, and facility-based maternity care emerged as a major barrier to service uptake. Women living in informal urban settlements and peri-urban communities, newly migrated, low-income, and with limited education, described substantial knowledge gaps regarding the benefits of early and frequent ANC visits. This finding aligns with urban Ethiopian studies showing that awareness deficits significantly reduce ANC initiation and continuity(17,36–39).

Participants' poor knowledge attributed to limited media exposure, low literacy, and fragmented community health education patterns echoed in national surveys and urban slum studies across LMIC settings(38,39). What distinguishes the current findings is the way misinformation intersects with fear of procedures, particularly ultrasound and facility-based childbirth. Some women perceived diagnostic tests as harmful or unnecessary, reinforcing avoidance of care.

As one participant stated:

*“They told me the baby is not positioned correctly, but they did not explain what this means. I just waited for the next month.” (IDI, Age 25 years, Gambella town)*

The implications are profound: knowledge gaps do not operate in isolation; they shape how women interpret risk, trust providers, and evaluate whether a facility is “worth” the trouble of navigating distance or cost barriers.

Evidence from Ethiopia and other African countries indicates that strong community-based platforms can improve maternal awareness and increase service uptake (17,36,40,41). In our study, women reported benefits from health extension worker (HEW) home visits, confirming previous findings that HEWs are critical sources of trusted information for disadvantaged households (39,40).

**Socioeconomic Barriers**

Financial hardship, both direct and indirect, was one of the most prominent themes. Although Ethiopia's HSTP II promotes free maternal services, women still reported costs for medicines, diagnostics, transport, and private-sector referrals. This aligns with national and global literature showing that out-of-pocket payments remain substantial despite fee-exemption policies(14,18,20).

Indirect costs such as lost wages and the expense of accompanying family members were significant deterrents, consistent with evidence linking hidden costs to reduced service utilization among the poorest households(14,20). Low educational attainment amplified financial vulnerability by limiting women’s ability to navigate the health care system and service utilization. This finding is consistent with prior studies that showed financial hardship limits service utilization among low-income groups(20).

*As an FGD participant stated: “Only one medicine for anemia is provided… the rest we buy from outside. Transport alone is 200 birr.” (Female FGD participant, Age 28 years, Gambella town).*

Urban poverty is often underestimated, and proximity to facilities does not equate to financial accessibility.  Poor urban women face greater cost-related barriers than rural populations due to dependence on cash-based transport, expensive private alternatives, and fragmented public services. The findings also highlight catastrophic expenditure when complications arise: *"The professional fee was 16,000–17,000 birr… how can the poor manage this?" (Female FGD participant, Age 32 years, Addis Ababa).*

Although Ethiopia's fee waiver and community-based health insurance (CBHI) schemes are designed to protect the poor, participants reported uneven implementation and administrative barriers limited effectiveness among urban informal workers.

**Geographic and transportation Barriers**

Contrary to traditional assumptions that distance is a predominantly rural issue, women in this study, especially from emerging towns, experienced significant geographic barriers. Informal settlements, peripheral neighborhoods, and new urban expansions often lack functioning roads or reliable transport. *"We walk more than 30 km on foot… carrying the child on our backs." (Female FGD participant, Age 33 years, Gambella).*

This study revealed that distance from health facility, lack of transportation, and uncomfortable road topography, especially in summer, were mentioned as important barriers to equity in healthcare service utilization. Previous studies in Ethiopia confirmed that far-to-reach regions, districts, and areas often face special issues and problems compared to non-far-to-reach areas(37,39). Several studies have also shown that traveling to a health center was challenging for women residing in far-located areas, with the cost of transportation, unreliability, and unavailability of services being the main obstacles to equity in accessing healthcare services (42–44).

Another important finding from this study was the issue of marginalized populations. Some key informants and FGD discussants reported that the health facility does not have a specific plan to provide health services to marginalized poor people, such as beggars around churches and mosques, and along roads, especially maternal health services. Hence, this may create critical inequity in maternal healthcare service utilization among the poor. This finding is consistent with studies from other Ethiopian regions documenting inequities affecting mobile or socially marginalized populations (45,46).

Poor urban populations may live geographically close to hospitals but face long, unsafe, or expensive travel routes. Ambulance delays of 6–12 hours further reduce timely access, a pattern consistent with the second delay.

**Health System Capacity Constraints**

Women consistently described shortages of skilled providers, long waiting times, limited emergency care capacity, and weak referral systems. These findings align with SARA assessments showing

persistent staffing gaps and inconsistent service readiness across Ethiopian health facilities(6,47). Respondents highlighted the need to ensure reliable availability of health professionals, especially midwives and doctors, at the health centers and hospitals during opening hours and emergency times, so that services would be available during working hours and on weekends.

*“There are good doctors… but many are negligent. Mothers wait long and still are not seen.” FGD participant, Age 28 years, Jimma).*

Referral delays, especially during obstetric emergencies, were frequently cited. This reflects the “second delay” described in global maternal health literature, where inadequate referral coordination contributes substantially to maternal morbidity and mortality(15,48,49).*“Referral is very difficult and not fast… many women lose their lives this way.” (FGD participant, Age 28 years, Gambella).*

On the other hand, women generally reported inadequate postnatal care, poor continuity across the continuum of care, and partial antenatal care, sometimes restricted to certain treatments like deworming. According to the national assessment (6,47), urban primary health care units (PCHU) are increasingly overburdened and find it difficult to provide comprehensive and consistent maternal health services, which is consistent with our findings. Maternal health service utilization disparities are exacerbated, especially among socioeconomically disadvantaged groups, by structural health system limitations such as a lack of midwives, restricted service availability on weekends and at night, and high staff turnover.

Additional challenges noted by participants include long waiting times and the repeated loss of patient cards at health facilities. Women shared that they spent considerable time searching for misplaced cards. This not only delayed their care but also affected their trust in the health system. Several participants mentioned that these experiences made them hesitant to return for future ANC, delivery, or postnatal visits. These operational issues show the need for digital patient record systems in health facilities, which would allow for quick and accurate retrieval of health information. Implementing electronic medical records and a registration system could significantly reduce waiting times, prevent card-related disruptions, and improve overall service continuity.

**Quality of Care, Disrespect, and Provider Behavior**

Barriers to equity in access and utilization of services go beyond issues of accessibility and availability. Disrespectful care and negative attitudes also hinder access to healthcare services. Negative attitudes of health workers, particularly in the form of verbal expressions, repeatedly emerge as barriers to equitable service utilization. Female FGD discussants highlighted the issue of non-compassionate and disrespectful care provided by health professionals at the health facility, noting they often receive poor-quality care and that compassionate care is lacking for the poor. Improving quality and outcomes at health centers serves as an incentive for increased service utilization. In many African countries, low quality of health services has been identified as a significant obstacle to equitable access (50). In this study, some participants mentioned that cultural factors, such as home delivery and traditional birth

attendants, are barriers to equitable maternal health service utilization. Other studies from Sub-Saharan Africa show similar findings (51). This indicates that traditional beliefs and community norms hinder the pursuit of modern healthcare and the use of services at health facilities. *"There is discrimination… some are served first, others are ignored." (FGD participant, Age 25 years, Jimma).*

*"The provider dropped the baby… afterwards, the mother became mentally affected." (FGD participant, Age 32 years, Gambella).*

These findings align with multi-country WHO studies revealing mistreatment rates exceeding 35% in many African facilities(19). Importantly, this study highlights how mistreatment undermines trust, leading to avoidance of facility delivery and reduced engagement in ANC/PNC, consistent with literature from Kenya and Tanzania demonstrating that negative past experiences strongly predict future non-utilization(52,53).

On the other hand, discrimination and differential treatment within health facilities further exacerbate inequities. Evidence from Ethiopia and other LMICs indicates that poorer women often experience delayed, disrespectful, or low-quality care compared to wealthier women, undermining trust in the health system and discouraging subsequent service utilization(16,54,55). These experiences contribute to a cycle of avoidance and disengagement, reinforcing disparities in maternal health outcomes among urban populations.

**Cultural and Social Norms**

It is not unusual to witness women still depending on TBAs, traditional healing, and cultural birth customs despite living in an urban area. Cultural perceptions of childbirth as a natural process, desire for familiar attendants, and secrecy around pregnancy all contributed to delays. Similar findings have been reported in Addis Ababa's informal settlements, where newly urbanized migrants retain rural cultural norms despite physical proximity to health services(56). These norms often interact with health system weaknesses: when women expect disrespect or inadequate care at facilities, traditional alternatives become more appealing. These findings mirror previous Ethiopian studies documenting persistent traditional practices, especially among migrants from rural areas(57).

Some participants described spiritual beliefs or traditional rites (e.g., postnatal restrictions) that postponed facility visits. This aligns with other studies showing that cultural norms can delay recognition of complications and reduce early care seeking(13,46,56).

**Gender Dynamics and Decision-Making**

Women described restricted financial autonomy and dependence on husbands for transport, money, or permission. This finding shows that women with limited decision-making power are significantly less likely to use skilled delivery or complete ANC schedules. In this study, women noted that husbands controlled financial decisions, transport access, and the timing of facility visits. Conversely, joint

decision-making was associated with better service uptake, consistent with findings that women's empowerment improves maternal health outcomes(58).

**Perception of Safety, Trust, and C-Section Fears**

According to this study, there are ambivalent perceptions regarding caesarean delivery, with some women interpreting payment for surgical delivery as a marker of modern care and actively requesting surgery (*"Now mothers come having paid for pre-operation… they refuse natural birth and insist on surgery." Female FGD participant, Age 28 years, Addis Ababa)* while others reported fear and fatalistic beliefs about surgery based on community narratives (*"Some mothers enter thinking they will undergo surgery… many are afraid because others died." Female FGD participant, Age 38 years, Addis Ababa)*. Such mixed perceptions reflect broader evidence that women's attitude toward caesarean section are shaped by complex socio-cultural and psychosocial factors, including fear of labor pain, perceived safety, and experiential influences from family and peers. These findings highlight that in contexts where the quality and consistency of maternity care are variable, fear of surgical complications and distrust of health services may coexist with elective demand for surgery, leading to complex decision-making patterns around place and mode of delivery. This mirrors studies from Addis Ababa and other African settings, where misconceptions about C-sections fuel avoidance of facility delivery (59,60).

Overall, the themes in this study demonstrate that maternal health inequities arise not merely from the absence of services but from a fundamental misalignment between women's needs and the health system's capacity to meet them. Women rarely encounter a single, isolated barrier. Instead, challenges intersect and reinforce one another: limited health literacy heightens fear of medical procedures; financial constraints delay care-seeking; and negative provider behavior drives women toward cultural or informal alternatives. These cumulative disadvantages fall disproportionately on the urban poor, recent migrants, and socially marginalized groups.

**Facilitators of maternal health service utilization**

Despite the multiple barriers identified, this study also revealed several facilitating factors that enhance maternal health service utilization in urban Ethiopia. These facilitators function across individual, interpersonal, community, health system, and policy levels. These facilitators are important in addressing maternal health service disparities. Other studies also documented similar patterns, where facilitators often mitigate structural constraints and enable women to navigate complex pathways to care(24,28,50).

**Knowledge, Awareness, and Risk Perception**

Women who have good knowledge and increased awareness better understand pregnancy-related risk and seek maternal health service utilization. Women who understood the importance of early ANC initiation, regular follow-up, and facility-based delivery demonstrated greater motivation to seek care, even in the presence of socioeconomic and logistical challenges. This finding aligns with other studies(11,28,30). Participants with better risk perception viewed maternal health services as preventive

and lifesaving rather than optional. This finding corroborates with other studies indicating that improved risk perception strengthens women's confidence in informal health services and increases care-seeking behavior(17,53). Community-based education platforms, particularly health extension worker (HEW) outreach and women's group discussions, were frequently mentioned as trusted information sources, consistent with other findings(17,39). This implies that strengthening targeted, context-specific maternal health education, especially in informal urban settlements, can improve risk perception and sustain demand for maternal health services.

**Family and social support**

Family and social support appear as a critical facilitator of maternal health service utilization. Women who received encouragement, accompaniment, and financial assistance from their husbands and other family members were more likely to attend ANC and deliver services at health facilities. This finding is consistent with other studies showing that household support and shared decision-making positively influence service uptake (30,36,58). Social support from neighbors, women's networks, and community groups also played an enabling role, particularly among recent migrants and economically marginalized women. Similar observations have been reported by other studies, where peer support helped normalize facility-based care and minimize misinformation(31). Therefore, maternal health programs should incorporate family-based and community-inclusive approaches, including male engagement strategies, to enhance supportive environments for women.

**Positive health system experience**

Positive health system experience characterized by respectful care, clear communication, and provider responsiveness was identified as an important facilitator of continued service utilization. Women who felt respected and well-informed during facility visits expressed greater trust in the health system and willingness to return for subsequent care. This aligns with other studies that respectful maternity care increase facility based maternal health service utilization and client satisfaction(19,34,53). Additionally, participants emphasized that a positive experience could offset fear or negative perception and facilitate continued service utilization. Similar findings have been reported by other studies(53).

On the other hand, health system readiness, including availability of skilled staff, essential supplies, functional referral mechanisms, and reliable ambulance services were explained as a facilitator of service utilization. This is consistent with other studies that highlight the role of service readiness and functional accessibility in improving maternal health service utilization(47,61). Although urban areas are often assumed to have better access, this study reinforces that functional accessibility, rather than physical proximity alone, determines utilization. Similar findings have been reported among urban poor populations in Ethiopia, where service reliability and affordability shape care-seeking decisions(11,18).

**Policy and Institutional Support**

Policy and institutional support mechanisms, including free maternal health services, the urban health extension program, and primary health care reforms, were perceived as enabling factors. Participants acknowledged that free-exemption policies reduce financial barriers. This finding is consistent with other studies that demonstrate policy support increased maternal health service utilization (18,51). However, women also noted that institutional support varied across settings, suggesting that policy benefits depend heavily on local execution and system capacity. Similar findings were reported by other studies (18).

**Community Empowerment and Engagement**

Community empowerment and engagement through women's development groups, community leaders, and participatory forums are perceived as important facilitators of maternal health service utilization. Collective discussion and shared responsibility helped challenge harmful norms and encouraged timely care-seeking. This finding aligns with other studies emphasizing community engagement as a driver of equitable maternal health service utilization (58,62,63). In urban areas, where traditional community cohesion may be weaker, structured community platforms played a great role in linking women to health services and reinforcing accountability.

In general, the facilitators found in this study show that enhancing the use of maternal health services needs an integrated, multilevel intervention. Strengthening women's knowledge-enhancing social support systems, improving service quality, ensuring system readiness, reinforcing policy implementation, and promoting community engagement are reinforcing strategies. Integrating these elements into urban maternal health programs is essential for achieving equitable, sustainable, and high-quality maternal health care in urban Ethiopia.

**Strengths and Limitations of this study**

Strengths of this study include the use of multiple qualitative data collection approaches, including in-depth interviews, focus group discussions, and key informant interviews, which enabled triangulation of information from different sources and perspectives. Trustworthiness was further strengthened through systematic procedures, including cross-checking transcripts with audio recordings, maintaining detailed field notes, and independent review by two experts. In addition, interviewing in the participants' own language facilitated rich data generation. The inclusion of participants from all levels of the healthcare system and women with diverse experiences and opinions on disparities in maternal health services utilization. Despite these strengths, the study has some limitations. As a qualitative inquiry, the findings are context-specific and may have limited transferability to other settings. Since the study was conducted only in three urban towns, the perspectives of women and healthcare providers in other urban areas may not be adequately represented.

# Conclusions

Our findings illustrate a complex web of structural, sociocultural, and health system barriers and facilitators that collectively influence maternal healthcare utilization in urban Ethiopia. The key drivers of disparities include health system capacity gaps, socioeconomic constraints, poor quality of care, low trust and fear of negative outcomes, gender power imbalances, and service availability gaps. While improved knowledge, awareness, and risk perception, strong family and social support, positive health system experience, adequate system readiness and accessibility, supportive policy and institutional frameworks, and community empowerment and engagement enhance women's ability to seek and sustain maternal health care. These barriers and facilitators do not operate in isolation but interact to disproportionately affect low-income women, recent migrants, and those with limited social support, thereby reinforcing intra-urban disparities in maternal health outcomes. Addressing these inequities requires comprehensive and coordinated interventions that simultaneously reduce structural barriers and strengthen enabling factors.

To remove these disparities, the Ethiopian Ministry of Health needs to implement accountability mechanisms to address provider negligence and disrespect, enhance referral coordination, and improve emergency response readiness. In addition, the development and effective implementation of pro-poor and urban-responsive maternal health policies are essential to reduce financial and social barriers. Integrating community-based empowerment strategies with health system strengthening and policy reforms will be critical in achieving sustainable and equitable improvements in maternal health service utilization in urban Ethiopia.

## Abbreviations

ANC Antenatal Care

EDHS Ethiopian Demographic Health Survey

FMoH Federal Ministry of Health

FGD Focus Group Discussion

HSDP Health Sector Development Program

IDI In-depth Interview

KII Key informant Interview

SDG Sustainable Development Goal

SPH School of Public Health

SSA Sub-Saharan Africa

UHC Universal Health Coverage

## Declarations

# Ethics approval and consent to participate

Written ethical approval for the study was obtained from the Institutional Research Ethics Review Committee (IRERC) of the College of Health Sciences, Addis Ababa University (Protocol No.040/24/SPH) and the study adhered to all guidelines of the Declaration of Helsinki. Following ethical clearance, official letters of cooperation were subsequently obtained from the relevant offices. Before the interview, participants were fully informed about the study's objectives, procedures, potential risks and benefits, and their rights as research participants. They were clearly informed that participation in the study is voluntary and that they could withdraw at any time without any consequences. Confidentiality was ensured by using unique identification codes instead of personal identifiers, and participants were assured that the information collected would be used only for research purposes. The interviews and discussions were conducted in convenient and comfortable locations for participants. Written informed consent was obtained from all participants before conducting interviews and audio recordings. Throughout the research process, participants' privacy and confidentiality were strictly maintained.

# Consent for publication

Not applicable

# Availability of data and materials

All relevant data are within the manuscript and its Supporting Information files.

# Competing interest

The authors declare that they have no competing interests.

# Funding

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# Authors' Contributions

WD contributed to the design and conception of the study, analyzed and interpreted the data, and prepared the manuscript. WM participated in data analysis, the interpretation and review of the manuscript. All authors read and revised the draft manuscript and approved the final version.

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