Executive summary

Save the Children UK has worked in Ethiopia since 1984, and in South Wollo, Amhara Region, have recently scaled up their Maternal Newborn and Child Health (MNCH) interventions across five woredas.

This report results from a qualitative study that aimed to: a) provide a better understanding of maternal health seeking behaviour in relation to the socio-cultural environment in South Wollo; b) identify and assess factors contributing to the low uptake of maternal health services; and c) make strategic recommendations concerning MNCH interventions in Ethiopia.

Using the methodologies of critical and applied medical anthropology, forty-six case studies were completed over a two-week period in January 2011. Through the detailed analysis of narratives of mothers, both pregnant and recently delivered, dominant themes were identified focusing on aspects of MNCH and maternal health seeking behaviour. Through discussions with first-time mothers and those who were multipara and grand-multipara, plus paternal and maternal grandmothers and other close family relations, it was possible to trace ante- and post-natal experiences longitudinally. Additional interviews were conducted with healthcare professionals to provide contextual background to the mothers' narratives.

Despite advances in delivery, access and uptake, MNCH services continue to be under utilised for complex and interrelated reasons. A number of key themes influencing maternal health seeking behaviour were identified.

- **Perception of a normal birth and perceptions of risk**

A 'normal delivery' is perceived to be short (around four hours), easy and at home. If a delivery is normal it is not considered to warrant medical intervention. Normal delivery does not require preparations or advanced planning. Mothers do not often consider giving birth at a health centre unless labour is protracted or there are complications leading to the perception of an increased risk to the mother and/or child. The survival of the mother rather than the child is the main concern and priority. Fear of death in childbirth, although not always strongly expressed, is a constant underlying worry. Although it is perceived as a 'normal' activity, mothers regard childbirth as dangerous and this sense of danger extends past labour into confinement. Labour and childbirth are never discussed amongst women, out of concern that such conversations may frighten an expectant mother. Whilst the perception of a normal delivery continues to dominate, maternal health is regarded as being safer and less risky now than in the past because of the existence of health centres and the availability of trained health professionals who can assist a mother during an abnormal delivery.

- **Motivation to attend a health centre**

Mothers are motivated to attend a health centre to confirm pregnancy and receive immunisations. These are seen to be preventative and readily acceptable. Physical examination and check-up are not key motivations, nor is health education. If a health centre is in close proximity, mothers are more likely to use its facilities where it is seen to be beneficial to deliver in the presence of trained health professionals. Some young mothers show preference to give birth at a health centre as a way to avoid the pressure of delivering in

front of relatives, particularly experienced older women. Most mothers do not plan to give birth at a health centre. For those that do, their main motivation is a long, difficult or complicated labour (excessive bleeding, breech birth and retained placenta). The latest labour is considered independently from previous deliveries. A mother who has given birth at a health centre once will not necessarily plan to deliver there in the future. Mothers make a clear distinction between attending a health centre and a health post. Delivery at home with a HEW or at a health post, is seen to alleviate many of the problems and concerns associated with giving birth at a health centre. Mothers routinely attend a health facility after delivery to vaccinate the baby around forty days.

- **Deterrents to health centre attendance**

The major factor deterring women from attending a health centre for delivery is the perception that a normal and traditional birth occurs at home. Normal labour does not require medical intervention because the mother is not perceived to be ill nor in need of treatment. Aspects of delivery at health centres that contrast markedly with home births deter mothers most. At home, a mother is surrounded by familiar people, male and female relatives, neighbours, and often a traditional birth attendant. Health centres do not permit people to accompany a mother into the delivery unit, and consequently many perceive that they are 'alone' during labour. A key issue is the position of delivery. At home, mothers are able to move freely and deliver in a kneeling position. At health centres, women are instructed to lie down, often with their legs in stirrups. Such physical exposure is deemed to be highly problematic. Women also dislike internal physical examinations, and the brightness of delivery units. The presence of male health professionals during labour, however, is not considered by mothers to be a deterrent. For women living in remote rural areas, the distance and lack of transport precludes them from delivering at a health facility. Having to be carried to the health centre on a stretcher is negatively perceived as a public display that labour is not normal and that a mother is in difficulty. There is a sense of shame connected to attending a health facility. The possibility of onwards referral and lack of immediate treatment also deters. Mothers are disinclined to return to a health centre during pregnancy if given insufficient information at their first visit. If a mother is sent away during early stage labour, she will often deliver at home rather than returning to a health centre. Mothers who deliver at home, even after a protracted labour, do not consider presenting for a check-up after the child had been born. That maternal health services are free is seen to be highly beneficial, yet the incorrect perception that services incur cost, does not deter mothers from attending.

- **Breastfeeding**

There is a lack of structured post-natal care. Besides mothers presenting their child for vaccinations after the forty-day confinement period, interaction with health facilities and health professionals is severely limited. The majority of mothers are not visited during the first forty days after delivery, and the baby does not receive designated postnatal checks. This lack of interaction curtails opportunities to check postnatal practices, particularly breastfeeding. Little information is given to mothers about how to breastfeed. Some mothers do not breastfeed immediately, but give butter, tea, sugared water or dough for the first three days. Of the mothers who do breastfeed immediately, many squeeze out the colostrum. Colostrum is thought to block the nipple, choke the baby or cause stomach problems. That said, there is a trajectory of common practice away from giving butter towards giving breast milk and breast milk with colostrum. Parents are seeing an improvement in the health of younger children who were breastfed immediately.

- **Decision-making processes and the ability to act**

Decision-making processes in Ethiopia are dominated by men, and the male head of a household is usually responsible for making the final decision. Most women claim their husbands know they use contraception and the decision to do so is collaborative. However, some husbands prevent their use, and some women hide contraception from their husbands. Most women plan to deliver at home and only consider attending a health centre if the progression of labour warrants it. The actual decision to take a labouring woman to a health centre is usually a collective one, made by the woman and her husband in collaboration with relatives and neighbours present. But women are not always in a position to force others to take action on their behalf nor to take the action they desire. A woman's agency to act is socially limited in Ethiopia. It is important that the wider community is educated in maternal health to enable positive decisions to be taken collectively, and to give women the right and ability to determine their own actions.

- **Level of knowledge and health education**

Health education given to mothers is not being packaged or delivered in a way that is easily accessible. There is a widespread desire for more health education and information on all aspects of MNCH. Many women are unable to identify early-stage pregnancy. A loss of appetite is seen as the key sign, and many afford little or no significance to a lack of menstruation. Others do not realise they are pregnant until they feel movement in their stomach. There is a great need to give more sustained health education to women and the wider community. Key messages should be consistent and delivered in a sustained and accessible manner. Parental advocacy and experience sharing are constructive ways to encourage both attendance at health centres and positive health seeking behaviour.

Recommendations are based upon issues the community in South Wollo identified as priorities and are derived from the socio-cultural ethnography presented in this report. Incorporating the ideas and perspectives of the intended beneficiaries into MNCH interventions, will increase their relevance, appropriateness and acceptability. The following seek to maximise the drivers leading to appropriate and timely maternal health seeking behaviour, and minimise the barriers preventing it.

- **Maximise every visit**

The majority of mothers visit a health centre at least once during their pregnancy, but many do not maintain regular contact and the low rate of delivery at a health facility, suggests that the potential of the first visit is not being maximised. Mothers must regard their visits as positive to encourage return visits. Every opportunity to interact with a mother must be used effectively. Health professionals should attempt to foster a positive relationship, provide useful information and key messages, and encourage the mother to attend regularly and for delivery. Mothers should never be sent away from the health centre without receiving useful health advice and being given clear guidance about when to return. Dismissing women during the early stages of pregnancy or, worse, during the early stages of labour is a critical error that will dissuade many from attending again. Mothers who have given birth at a health facility should be actively encouraged to return for future deliveries.

- **Improve and expand health education**

Devising and delivering health education should capitalise on the fact that most interviewees wanted more information. Messages must be clear, concise, consistent and accurate. The benefit of services needs to be stated explicitly. Appropriate and relevant explanations should reinforce instructions given and frequently repeated. Health education must be more inclusive and facilitate the provision of information to the general community. It is insufficient only to educate women on issues of MNCH, especially if they are not in a position to act. Information needs to be disseminated in a more systematic way on all aspects of MNCH and targeted towards specific groups. Male and female educators should be employed, and speak to both mixed and single-sex gatherings. New platforms should be developed that facilitate education outside a health facility setting. Using parental advocates as powerful social tools will encourage and reinforce positive behaviour change. The coverage and distribution of supplementary education material must be increased as the SC UK's Birth Preparedness Plan and the government's Family Health Card are both very well received. Health Extension Workers and Community Health Promoters should use these materials to convey key messages to the community and act as a point of entry.

- **Facilitate more post natal care**

Despite standard policy, most mothers are not visited during their postnatal confinement. This is a missed opportunity for effective management of the mother and newborn's health, and to reinforce key messages about postnatal care, including breastfeeding and vaccinations.

- **Maximise maternity units**

To better encourage women to utilise maternal health services, the perception of a health centre as a place of illness needs to be altered, and a change in the culture of attendance, effected. The new maternity units in four of SC UK's intervention woredas, provide a valuable opportunity to create a delivery environment that is more acceptable to women. SC UK should advocate, and put into practice, policies that actively address mothers' concerns about attending a health centre. Mothers should be encouraged to stay at the health centre after delivery to facilitate the baby's twenty-four hour check-up. Careful consideration must be given to the most appropriate and effective way of opening the new units and introducing them to the community. In due course, the impact and utilisation of the maternity units must be evaluated. If it can be demonstrated that improving the delivery environment has a positive impact on uptake, then the maternity units and their more socially sensitive practices, should be showcased as an exemplar for improving the conditions of service delivery and encouraging positive maternal health seeking behaviour.

There exists great potential to improve MNCH in Ethiopia, not only to expand the provision of quality services, but, crucially, to focus on the context of delivery to develop effective utilisation and increase the rate of uptake. This should be at the forefront of any MNCH campaign and a priority for policy makers globally.