

Improving skilled birth attendance in Ethiopia

Report

Dire International Hotel, Adama, Ethiopia
Thursday, 05 June 2014

This report was prepared by Technology Transfer and Research Translation Directorate, at the Ethiopian Public Health Institute

*This policy dialogue was informed by the following policy brief:
Improving skilled birth attendance in Ethiopia.*



What is a policy dialogue?

A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?

People with relevant expertise and perspectives, including policymakers, civil society, the mass media and researchers

The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?

+ That discussion and careful consideration should contribute to well-informed health policy decisions

× The dialogue did not aim to reach a consensus or make decisions

What is included in this report?

+ Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

× These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

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Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

The problem

- One of the major problems in the health system is that there is a poor quality of health care. So what is the point of increasing skilled birth attendance if mothers do not get quality care? As a result a mother might not see the difference between giving birth at home and a health facility.
- It was aired that the magnitude of the problem mentioned in the policy brief goes against what people hear in mass media
- Antenatal care visits are not used to mobilize mothers to increase skilled birth attendance
- The three delays (delay in decision to seek care, delay in reaching care, and delay in receiving adequate health care) were mentioned as important factors contributing to the low level of skilled birth attendance in the country.

Policy Options

- There is no need for conditional transfer, as mothers are exempted from user fees. Besides its implementation is difficult.
- Community mobilization and cultural adaptation of birthing services (altering the environment of health facility delivery units to better suit the personal and cultural needs of mothers) are very pertinent option for the country. However, regarding cultural adaptation there is a need for in depth study.
- Various views have been aired at the use of maternity waiting homes:
 - Use of waiting homes is a failed experiment.
 - There are maternity waiting homes in many places but are not utilized.
 - Researches must be conducted why they are not utilized.

Implementation considerations

- Wrong expectations of policy makers that there will always be aid by donors for the health sector is one of the barriers contributing for financial constraints in the health sector and should be mentioned in the policy brief.
- One of the barriers for all the policy options except community mobilization is lack of evidence. Lack of evidence therefore should be mentioned as a barrier and generating evidence on the options should also be considered as implementation strategy.

The views, opinions and insights in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue. These opinions may or may not be consistent with or supported by the policy brief that informed this dialogue or other evidence. It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated. Nor should it be assumed that they represent the views of the authors of this report.

The Problem

A participant has aired that the magnitude of the problem mentioned in the policy brief goes against what we hear in mass media. The mass media is telling us there is progress while the policy brief says the problem is serious. However, another participant said that there is no discordance with the facts in the policy brief and what the mass media or the Ministry of Health says; the low level of skilled birth attendance in the country is also accepted by the Ministry of Health. The source of the confusion could be the different contexts in which facts are mentioned.

One of the major problems in the health system is that there is a poor quality of health care: for example mothers are not satisfied with the care delivery in the country or mothers are maltreated by care providers, health facilities in the country are not mother friendly, health facilities are poorly equipped. So what is the point of increasing skilled birth attendance if mothers do not get quality care? As a result a mother might not see the difference between giving birth at home and a health facility.

Definition of a skilled birth attendant must be clear before we discuss the issue of skilled birth attendance. It was raised that the WHO definition was the one used in the policy brief: that is nurses, midwives, and doctors are considered skilled providers. On the other hand it was suggested that personnel trained in delivery should rather be considered as skilled birth attendants instead of saying only nurses, midwives and doctors.

One of the reasons for low level of skilled birth attendance in Ethiopia is we do not provide skilled attendance at home. Skilled attendants should go to the mothers instead of mothers coming to health facilities. However this idea was negated by the idea that the country does not have enough health work forces to provide skilled attendance at home.

The three delays (delay in decision to seek care, delay in reaching care, delay in receiving adequate health care) were mentioned as important factors contributing to the low level of skilled birth attendance in the country.

The fact stated in the policy brief that 61% of mothers believe that skilled attendance is not necessary should not be considered as a cultural barrier. Rather this shows that the health education being conducted in the country is not effective.

The other problem mentioned was that ambulances take mothers to hospitals but they do not return mothers to their homes. Hence mothers do not want to go to health facilities for delivery.

The difference between facility based delivery and skilled birth attendance should be clearly mentioned in the policy brief. Though facility based delivery could be associated with skilled attendance, it is possible skilled attendance could also be provided at home. Mothers could prefer giving birth at home even in developed countries. Therefore giving birth at home should not be seen as a problem rather it could also be a mere choice by mothers.

We are thinking of increasing skilled birth attendance; but are our facilities ready to cope up with increased demand in case we succeed in increasing the demand? On the other hand it was mentioned that since our facilities are under utilized it is good to take the risk and increase demand.

Policy options

The first two options: Community mobilization and cultural adaptation of birthing services (altering the environment of health facility delivery units to better suit the personal and cultural needs of mothers) are very pertinent options for the country. However, regarding cultural adaptation there is a need for in depth study.

Antenatal care visits are not used to mobilize mothers to increase skilled birth attendance. The government is using community mobilization to increase skilled birth attendance using for example 'monthly pregnant women conferences'.

Various views have been aired at the use of maternity waiting homes. Use of waiting homes is a failed experiment. There are maternity waiting homes in many places but are not utilized. Researches must be conducted why they are not utilized.

Waiting homes are being constructed by the community and food is provided for mothers staying at them. The government is promoting maternity waiting homes.

There is no need for conditional transfer, as mothers are exempted from user fees. Besides its implementation is difficult.

The use of risk approach, targeting high risk mothers to deliver in health facility, was mentioned as an option to reduce maternal mortality. However, it was also mentioned that during delivery all mothers are at risk therefore interventions should target all mothers. Besides it was also mentioned that the policy brief is not about high risk mothers but about increasing skilled birth attendance in the country.

Implementation considerations

The following comments/suggestions were forwarded on the implementation consideration section of the policy brief:

The policy brief should consider health insurance schemes as one of the implementing strategies for financial barriers.

Wrong expectations of policy makers that there will always be aid by donors is one of the barriers contributing for financial constraints in the health sector and should be mentioned in the policy brief.

There is a manual for community mobilization, health development army manual, for community mobilization. Absence of strategy or manual for community mobilization as barrier should therefore be removed from the policy brief.

One of the barriers for all the policy options except community mobilization is lack of evidence. Lack of evidence therefore should be mentioned as a barrier and generating evidence on the options should also be considered as implementation strategy.

The implementation consideration for the barrier, 'burnout of health extension workers' on community mobilization option should additionally include reducing workload of health extension workers by redesigning the curriculum for health extension program, motivating health extension workers, and increasing the number of health extension workers, as implementation strategies to this barrier.

Culturally competent curriculum for health care providers training should be considered as one of implementation strategy for the barrier 'possible resistance of care providers' for option 2 (cultural adaptation of birthing services).

The fourth option 'conditional cash transfer' should rather be changed to 'conditional reward' as conditional reward is broad and can include rewards in kind. There is some experience on conditional reward in the country in relation to increasing immunization coverage (providing sugar and soap for mothers who comply) and school attendance. There is also some good experience of conditional cash transfer on increasing treatment adherence in HIV positive people. However it was also mentioned that implementation of conditional cash transfer could be difficult.

It was also mentioned that conditional cash transfer might not address the root cause for low level of skilled birth attendance.

Appendix 1: Agenda

Policy Dialogue on Improving Skilled Birth Attendance in Ethiopia

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems project

(Dire International Hotel, Adama 5th June 2014)

Time	Activity	Responsible Person
8:00-9:00AM	Registration	Wude and Ahmed
9:00 -9:15 AM	Opening Remarks/ Introduction of participants & moderators	Dr. Yibeltal Assefa
9:15-9:30AM	Objective of the policy dialogue & Overview of TTRTD	Dr. Mamuye Hadis
9:30-10:00AM	Going through the executive summary of the policy brief	Prof. Mekonen A. (Moderator)
10:00-10:10AM	Procedure and rules of the dialogue	Moderator
10:10-10:30AM	Tea/Coffee break	
10:30-11:30AM	Problem section of the policy brief	Moderator
11:30-12:30PM	Policy options section of the policy brief	Moderator
12:30-2:00PM	Lunch Break	
2:00-3:00PM	Implementation considerations part of the policy brief	Moderator
3:00-3:15PM	Way forward	Moderator
3:15-3:30	Closing remarks	Dr. Yibeltal A.

Appendix 2: Participants

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Competing interests

None

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