



MALMÖ HÖGSKOLA

Master's thesis for Public Health

Empowerment as a strategy in improving maternal and child health in Ethiopia. The case of the Ethiopian government initiative.

A qualitative approach

Tilak Makonnen Kebede

Supervisor: Professor Per-Anders Tengland

2013-10-11

Master degree thesis
30 credits
Master Program in Public Health

Malmö university
Health and Society
205 06 Malmö

Empowerment as a strategy in improving maternal and child health in Ethiopia. The case of the Ethiopian government initiative.

A qualitative approach

Tilak Makonnen Kebede

Tilak Kebede, A 2012/2013, Empowerment as a strategy in improving maternal and child health in Ethiopia. The case of the Ethiopian government initiative , a qualitative approach, Master degree thesis in Public Health, 30 credits, Malmö University, Department of Health and Society, division of Public Health.

Abstract:

Aim: This study aimed at getting an understanding and critical analyses of the Ethiopian government empowerment strategy in improving maternal and child health in Ethiopia.

Method: This is an ethnographic study, in which mainly un-structured interviews, focus group discussions and participant observation were conducted to collect data for the study.

Results: The study concluded that the empowerment initiative has been promising to some extent in addressing the health concerns of women and children in Ethiopia. However, lack of bottom up health promotion strategies such as genuine community participation in the designing and implementation of the health program has greatly hindered the health promotion program from effectively improving the health status of women in the studied community.

Key words: Empowerment, women, Ethiopia, maternal health, child health, health promotion, health determinants, health service, public health

Dedication

I dedicate this thesis to all female health extension workers in Ethiopia, who are working so hard in difficult circumstances to improve the health and lives of many Ethiopian women and children.

Acknowledgement

First and foremost, I am thankful to God the Almighty, the Alpha and the Omega, the First and the Last, the beginning and the End for His unconditional love and blessings. Everything would have been impossible without Him.

I am also very thankful to all those wonderful Ethiopian women, men, health professionals and government officials who participated in this study, and made this study successful.

I would also like to give a special thanks to all my instructors at the department of public health in Malmo University, in particular my supervisor professor Per-Anders Tengland, for his constructive advice and mentorship throughout this thesis and study program.

My family (Abiyu, Ewawi, Mima, Chapa and Alexo) deserves the best gratitude for their prayers, love, support and encouragement.

I owe, Rode and Rune Swan, very special thanks for making my stay in Sweden wonderful throughout my study period and for showing me Jesus's love through everything you have done for me.

Last but not definitely least; my appreciation goes to the Munts family (Juliene, Phil and Hunter) for their unreserved support, love and prayers during my study period.

Table of Contents

Chapter 1 Introduction	1
1.1. Objective of the Study.....	2
1.2. Reserch Questions	2
1.3. Case Study Background	3
1.3.1. Ethiopia: Country Profile	3
1.3.2. Overview of the Health Sector Development Plan (HSDP).....	6
Chapter 2 Literature Review	9
2.1. Maternal and Child Health.....	9
2.1.1. Ethiopia: MHC Status	10
2.2. Empowerment for Health Promotion.....	13
Chapter 3 Research Design and Methodology	15
3.1. Qualitative Study.....	15
3.2. Ethnography	17
3.3. Sampling Technique	18
3.3.1. Selection of Area/Subjects	18
3.3.2. Presentation of Informants	19
3.4. Data Collection	20
3.5. Data Analysis.....	22
3.6. Secondary Data	23
3.7. Ethical Considerations	23
Chapter 4 Findings	23
4.1. Participant Observation	23
4.2. Health Program Activities at Grass Root Level	24
4.2.1. Specific Role on MCH Care	24
4.2.2. Health Services	26

4.2.3. 'One to Five' Group Leaders	30
4.3. Positive Outcomes	31
4.3.1. Reduction in Maternal and Child Mortality	31
4.3.2. Accessibility of Health Services	32
4.3.3. Acceptance of Health Services	33
4.3.4. Control over Reproductive Health	35
4.3.5. Increased Community Level of Awareness.....	38
4.4. Strategic Setbacks	41
4.4.1. Lack of Regulation	41
4.4.2. Lack of Coordination with District Administration	41
4.4.3. Lack of Community Participation.....	42
4.4.4. Lack of Employees Incentives	43
4.4.5. Lack of Training.....	43
4.5. Challenges	45
4.5.1. Shortage of Supply	45
4.5.2. Male Domination	45
4.5.3. Long Distance to Health Facilities.....	46
4.5.4. Low Health Seeking Behavior	46
Chapter 5 Discussions	49
5.1. Discussion of Methodology	49
5.2. Discussion of Findings	49
5.2.1. Positive Outcomes	50
5.2.1.1. Health Improvement/Control over Health	50
5.2.1.2. Local Leadership and Organizational Structure	51
5.2.2. Strategic Setbacks and Challenges.....	51
5.2.2.1. Bottom up Strategy	52
5.2.2.2 Health Promoters Training	56
5.2.2.3 Cross-Sectoral Collaboration.....	56

Chapter 6 Conclusion and Public Health Recommendations	57
References	57
Appendices	62
Appendix I.....	62
Interview Guide	62
Appendix II.....	62
Informed Consent.....	63

Acronyms

AIDS--Acquired Immunodeficiency Syndrome
ANC--Ante Natal Care
DHS--Demographic and Health Survey
DPT--Diphtheria, Pertussis and Tetanus Vaccine
FMOH--Federal Ministry of Health
GDP--Gross Domestic Product
HEP--Health Extension Package
HEW--Health Extension Workers
HIV--Human Immunodeficiency Virus
HMIS--Health Management Information System
HSDP--Health Sector Development Programme
HTP--Harmful Traditional Practice
ICCM--Integrated Community Curative Management
IMCI--Integrated Management of Childhood Illnesses
IMR--Infant Mortality Rate
MCH--Maternal and Child Health
MDGs--Millennium Development Goals
MMR--Maternal Mortality Ratio
MNCH--Maternal Newborn and Child Health
PHCU--Primary Health Care Unit
PMTCT--Prevention of Mother to Child Transmission
PNC--Post Natal Care
SNNPR--Southern Nations Nationalities and Peoples Region
TB--Tuberculosis

TVETI--Technical and Vocational Education Training Institute

UNDP--United Nations Development Programme

UNICEF--United Nations Children's Fund

VCT--Voluntary Counseling and Testing

WB--World Bank

WHO--World Health Organization

Master degree thesis
30 credits
Master Program in Public Health

Malmö university
Health and Society
205 06 Malmö

Chapter 1---Introduction

Women in developing countries are the backbone of a society and forerunners of the family welfare even though they get the smallest benefits from societal and family resources. This is particularly evident in developing countries where women are most marginalized and bear the consequences of poverty, underdevelopment, and traditional and cultural sanctions. Hence, this worsens the women's health status and health indicators such as maternal mortality are considerably high. In order to overcome this devastating problem and to improve the general reproductive health of women, international initiatives recently have been focusing on broader approaches towards improving women's general reproductive health (Yegomawork et al, 2003).

The global initiative has been approved and adopted by the Ethiopian government and is incorporated in the national Health Sector Development Plan (HSDP). The reproductive health initiative in particular gives a greater emphasis on the individual needs and rights of women. The principal strategies of the initiative are empowering women and enhancing their social status through the provision of equal opportunities for education, eradicating all kinds of inequity and augmenting their access to resources both at household and societal levels. The main focuses of the strategies are on the different situations in local communities and demands developing suitable interventions accordingly (Yegomawork et al, 2003).

In order to alleviate the health maladies Ethiopia is facing, the current Ethiopian government formulated a health policy, which has been implemented in terms of four consecutive HSDPs starting from 1997/8. The first and the second phase of the program were completed in 2002 and in 2005 respectively (FMOH, 2005). The two phases have further lead to the development of the third HSDP in July 2005, which was completed in 2010 (FMOH, 2010). The fourth phase is being implemented and expected to be completed in the year 2014/15.

Women in Ethiopia comprise half of the total population. Ethiopian women are engaged in many economic sectors and are major contributors to the welfare of the society. It is unthinkable to create economic development without giving considerable attention to women's right to fully participate in the planning, implementation, monitoring and evaluation of development activities. FMOH further stated that women, as child bearers, are in the best position to shape the behavior

of the future generation. This indicates that empowerment of women is very essential to enhance the health of mothers, children, households in particular and the society in general. For these reasons, the HSDP fully address this issue by prioritizing maternal newborn, child and adolescent health services via adopting strategies such as Making Pregnancy Safe and Safe Motherhood Initiative, which are conventional to have a greater impact on women's well-being (FMOH, 2005).

Most of the basics of the reproductive health program are usually known as maternal and child health programs. The 2003 *Ethiopian journal of health development* however stated that the new components (i.e. the promotion of women's rights and empowerment and the elimination of discrimination and violence) of the reproductive health are not fully grasped by health workers (Yegomawork et al, 2003).

1.1. Objective of the Study

General Objective

- To explore, understand and critically analyze the processes and practices of the empowerment strategy regarding maternal, newborn and child health services, in improving maternal and child health in Ethiopia. I also aimed at recommending possible schemes for future empowerment interventions to improve maternal and child health in Ethiopia.

1.2. Research Questions

1. How do the health professionals work to implement the empowerment strategy?

2. How do women in particular and community people in general respond to applied empowerment interventions, and why?
3. To what extent have the applied empowerment strategy, in what way, so far, contributed to possible positive outcomes for promoting maternal and child health?
4. What are the challenges and setbacks for the achievement of the empowerment strategy, and why?

1.3. Case Study Background

1.3.1. Ethiopia: Country Profile

Geography and Climate

Ethiopia is the oldest independent country in Africa. Ethiopia is also one of the biggest countries in Africa ranking in tenth place covering 1,104,300 square kilometers. Ethiopia is bordered by Eritrea on the north and northeast, by Djibouti and Somalia on the east, by Kenya on the south, and by Sudan on the west and southwest (FDRE, 2005).

Ethiopia is geographically diversified and the country's topography shows a wide range of differences from high peaks of 4,550m above sea level at Ras Dashen Mountain to 110m below sea level in the Afar Depression. The most part of the country lies above 1,500 meters above sea level. The general climate type is tropical monsoon, with temperate climate on the plateau and hot in the lowlands. The climate disparity is mainly classified into three i.e. the "Kola" or hot lowlands, below 1,500 meters, the "Wayna Degas" at 1,500-2,400 meters and the "Dega" or cool temperate highlands above 2,400 meters (FDRE, 2005).

Government and Administration

Ethiopia is a Federal Democratic Republic country according to the 1994 constitution. The governance and administration has three branches namely the executive, the legislative and the judicial. The Federal Democratic Republic of Ethiopia has nine regional states i.e. Tigray, Afar, Amhara, Oromia, Somali, Southern Nation Nationalities and Peoples Region (SNNPR), Benishangul-Gumuz, Gambella, and Harari and it also comprises a two city (Dire Dawa and Addis Ababa) administrations council. The regional states and the city administrations are further divided into 817 administrative Woredas (Districts). Each Woreda/District has an

administrative council consists of elected members and it is the fundamental decentralized administrative unit. The 817 Woredas are subdivided into 16,253 Kebeles, Kebele is the smallest administrative unit in the governance but it can include several villages (FDRE, 2005).

Demographic Situations

According to the 2007 population and housing census report the total population of the country is 73,750,932. This makes Ethiopia the second most populous country in Africa next to Nigeria. The census report also indicated the anticipated population for the year 2010 to be 79.8 million. The population is growing rapidly with annual rate of 2.7% since year 2000. The average household size is 4.7. The rapid population growth is worsening the gaps in basic health services mainly at times when the economic growth is low. The country is one of the least urbanized nations in the world where 83.6% of the total population residing in rural areas and urban residing population constitute only 16.4%. Addis Ababa is the capital of the nation where nearly 4% (2.7 million people) of the total population resides (CSA, 2010).

More than half of the total population i.e. 52% is in the age group of 15-65 years. The young population under the age of 15 accounts for 44% while population group over the age of 65 constitutes 3% of the total population. Male female ratio is almost equivalent. Women in the reproductive age group comprise 24% of the total population (CSA, 2010).

According to the 2005 demographic and health survey (DHS) report, the average fertility rate estimated to be 5.4 births per woman showing a substantial decline from the 1990s rate of 6.4 births per woman (an average decline of one birth per woman in 15 years). The fertility trend significantly differs among rural and urban areas with women in rural areas bearing an average of three more births per woman as compared to women living in urban areas (DHS, 2005).

Socio-economic Situations

The Ethiopian government pursues market-based and agricultural led industrialization economic policy for the nationwide development and administration of the economy. The Ethiopian economy is highly dependent on agriculture and 83.4% of the labor force, 43.2% of the Gross Domestic Product (GDP) and 80% of exports emanate from agriculture (MoFED, 2008).

Ethiopia is among the least developed countries in the world with *per capita* income of US\$100 or US\$720 in terms of purchasing power equivalence in 2002 (World Bank, 2004). Poverty is extensive with nearly 47% of the people living below the poverty line. According to the 2004 UNDP's Human Development Index (HDI) report of 177 countries, Ethiopia was ranked on 170 at 0.359 HDI value indicating very low human development while adjusted for gender the HDI value goes down to 0.297 showing gender inequality (CSA, 2000). The recent UNDP's report also showed Ethiopia's HDI rank to be on 174 out of 187 countries under the low human development category with HDI value of 0.363 (UNDP, 2011).

The last few years the share of the population living below the national poverty line has declined however, 35% of the population remains below the national poverty line. Similarly, in 2007 Gross Domestic Product (GDP) *per capita* was US\$780/average percentage of the population living on a little higher than US\$2 per day. This implies the larger portion of the population (78%) living under the World Bank's (WB) moderate poverty line (MoFED, 2008; WB).

Educational Status

In regard to education, the literacy rate of the general population in Ethiopia is low. The adult literacy rate (above age 15 who can read and write) accounts for only 36% and out of which female constitute 39% while male constitute 62%. According to the Ministry of Education progress report the national gross enrollment ratio has been 4.2% in 2008/9 and the gross enrollment ratio in primary school has grown to 91% (55.9% males and 44.1% females) in 2006/7. In addition, the gross enrollment ratio of higher education has been 4.6% in 2008/9 (MOE, 2010). The low literacy rate makes the general population more at risk of preventable disease (FMoH, 2010).

Health Status

The health status of the general population of Ethiopia is comparatively poor. The people of Ethiopia still suffer from a high rate of morbidity and mortality. The main health problems of the country are by and large due to communicable diseases and nutritional disorders. The 2005 Demographic and Health Survey (DHS) report indicated a life expectancy of 54 years i.e. 53.4 years for male and 55.2 years for female. The majority of the people (more than 85% of the

country's population or 75 million people) reside in rural areas where access to health care is limited (GHLI, 2009).

1.3.2. Overview of the Health Sector Development Plan (HSDP)

The program i.e. HSDP includes various components intending to tackle the country's main health problems. Reducing maternal and child mortality, decreasing the fertility rate and fighting HIV/AIDS, tuberculosis (TB) and malaria are within the components of the program (MOH, 2007). For this study purpose the focus will be on family health service, which incorporates maternal, newborn and child health. The family health service is a sub-component under the health service delivery and quality of care.

The vision of HSDP is "To have a healthy and prosperous society that can contribute to the development of Ethiopia" and the mission of HSDP is "To reduce morbidity, mortality and disability, and improve the health status of the Ethiopian people through providing a comprehensive package of preventive, promotive, rehabilitative and basic curative health services via a decentralized and democratized health system in collaboration with all stakeholders". The values of HSDP are

1. Focus on promotive, preventive and basic curative aspects of health care
2. Deliver integrated, efficient, quality, equitable and pro-poor health service
3. Efficient use of resources and application of appropriate technology
4. Involve the community on health care decision-making process
5. Promote transparent, result oriented and democratic working culture
6. Abide by professional ethics
7. Sense of urgency for the national development
8. Enhance teamwork, partnership and a multi-sectoral approach
9. Be gender sensitive
10. Be ready for continuous change

The health system of Ethiopia is described by a four level health system i.e. a primary health care unit (PHCU), the district hospital, zonal hospital and specialized hospital. A PHCU has been

planned to provide service to 25,000 people, whereas a district and a zonal hospital are each anticipated to serve 250,000 and 1,000,000 people, respectively. Specialized hospitals are intended to serve a catchment area with 5 million people (FMOH, 2005).

The smallest level in the Ethiopian health system is a PHCU, which consists of one health center and five satellite health posts. Health centers provide services with a health professional team including midlevel health professionals such as health officers, nurses, midwives, sanitarians and laboratory technicians. A health center gives comprehensive primary health care which comprises promotive, prevention, curative and rehabilitative services. One health center supervises and receives referrals from five satellite health posts. A health post is the operational center for two HEWs. Generally, a health post serves a kebele, which consists of approximately 1000 households or 5000 people (FMOH, 2005/2007/2010) (Datiko et al, 2009).

The development of the HSDP I further initiated the succeeding HSDP II and HSDP III. Since then, the FMOH has been developing and implementing different policies and strategies such as making pregnancy safer (2000), reproductive health strategy (2006), adolescent and youth reproductive health strategy (2006) and the revised abortion law (2005) for improving the health status of the people of Ethiopia. Free service for key maternal and child health services/health care financing strategy, training and employment of health extension workers at health post levels and employment of skilled health officers with integrated emergency obstetric and surgery are also included in the strategy (FMOH, 2010).

In regards to maternal and child health services the goals set for HSDP-I were to increase contraceptive prevalence rate from 9.8% to 25-20%, DPT3 coverage from 59.3% to 70-80%, and reduce population growth rate from 2.9% to 2.5-2.7%. Likewise, in HSDP-II the objectives set were to increase DPT3 coverage from 51.5%-70%, achieve polio elimination and certification by 2003, increase TT2 for pregnant women from 27% to 70% and for non-pregnant women from 14.8% to 32%, increase IMCI implementation to 80% of the health facilities, raise CPR from 18.7% to 24%, expand ANC coverage from 30% to 45% and improving the percentage of deliveries assisted by trained health personnel's from 10% to 25% (FMOH, 2005).

To be able to achieve the above goals prenatal and newborn health were considered as main concerns in the health policy. To address maternal and adolescent health services emphasis was given to the provision of Safe Motherhood services for normal pregnancies, deliveries and referral centers for high-risk pregnancies, post abortion care, addressing the sexual and reproductive needs of adolescents, promoting paternal involvement, abandoning HTPs, adequate nutrition education to mothers and children and provision of family planning services (FMOH, 2005).

Under HSDP-III the main goals to be achieved in family health service were to augment family planning service coverage (CPR) from 25% to 60%, institutional deliveries attended by trained health personnel from 12% to 32%, provision of BEmONC in (100%) of the health centers (HCs), CEmONC in 87% of the hospitals and in 20% of the HCs. Increasing DPT3/Penta3 coverage from 70% to 85%, improving the percentage of fully immunized children from 45% to 80%, and expanding the implementation of IMNCI from 36% to 90% in health facilities and CIMNCI implementation from 12% to 80% in the districts of the country were also targets to be achieved (FMOH, 2010).

To meet the above objectives huge investments have been made for procurement of equipments for clean delivery and B/CEmONC services. Training for health officers has been initiated and 5,000 officers were enrolled and 70% of them were able to graduate and were assigned to work. Besides, emergency surgery and obstetrics in master level program was introduced for health officers and the first graduates were assigned to work. A one-month in-service training in Maternal and Child Health (MCH) for Health Extension Workers (HEWs) was designed and implemented in all regions of the country. Key MCH Initiatives such as making pregnancy safer had been evaluated (FMOH, 2010).

Expanding health coverage through Health Extension Program/Package (HEP) has also been given a great emphasis in the HSDP. The HEP is one of the components and is a very essential strategy by which the government of Ethiopia aims to accomplish all the other goals. The HEP implemented in 2003 during the HSDP II, with the aim of enhancing equitable access to preventive essential health via community-based health services with a great emphasis on sustained preventive health actions and increased health awareness (MOH, 2007).

One of the strategies of the HEP is deploying two female Health Extension Workers' (HEW) in every kebele i.e. the smallest administrative unit in the governance. Women are selected since they can have access to the larger number of the population mainly concerning reproductive health issues (Argaw, 2007). This is expected to have a greater impact on empowerment of women in particular and on the effectiveness of the health program in general (FMOH, 2005).

HEWs are basically high school graduates who attended a one-year course in technical and vocational training and education centers. The main responsibilities of HEWs are preventive and educational. Referring patients to health centers for basic health care or to district hospitals for more complex health services are also part of their responsibilities (Argaw, 2007).

Chapter 2---Literature Review

2.1. Maternal and Child Health

Maternal health, as defined by the World Health Organization (WHO), refers to the health of women during pregnancy, childbirth, and in the postpartum period. Child health generally refers to the health of children from birth through adolescence, although the specific age range varies. Newborn health captures the health of babies from birth through the first 28 days of life. These are most often considered in concert since they are integrally related to one another. Maternal health has a large impact on whether a child survives and thrives. When a mother dies, her children are three to ten times as likely to die as well (WHO, 2005) (Lancet, 2007). Babies are most vulnerable to health threats during the first 28 days of life, and although in many developing countries children's health remains precarious throughout childhood, the riskiest time is during the first five years of life.

There are many effective interventions/programs designed to reduce maternal and child mortality however, the recent global progress report on Millennium Development Goals (MDGs 4 and 5) depicted that many countries are not in a position to meet the 2015 goals (UN, 2009). The MDGs

are end poverty and hunger, universal education, gender equality, child health, maternal health, combat HIV/AIDS, environmental sustainability and global partnership.

A number of reasons have contributed for the delayed global progress. Funding shortages, lack of health care professionals, lack of access to education, economic status, availability of clean water, sanitation and other complex factors (for instance Maternal Newborn and Child health (MNCH) is highly associated and affected by the status of women and children especially girls in a given community) affect the health of mothers and children (Moss, et al, 2010). 50% of the world's maternal and child death is reported from Sub-Saharan Africa countries (WHO, 2006). The following table gives the global picture of MNCH.

Key Maternal, Newborn, and Child Health Indicators (UNICEF, 2009)

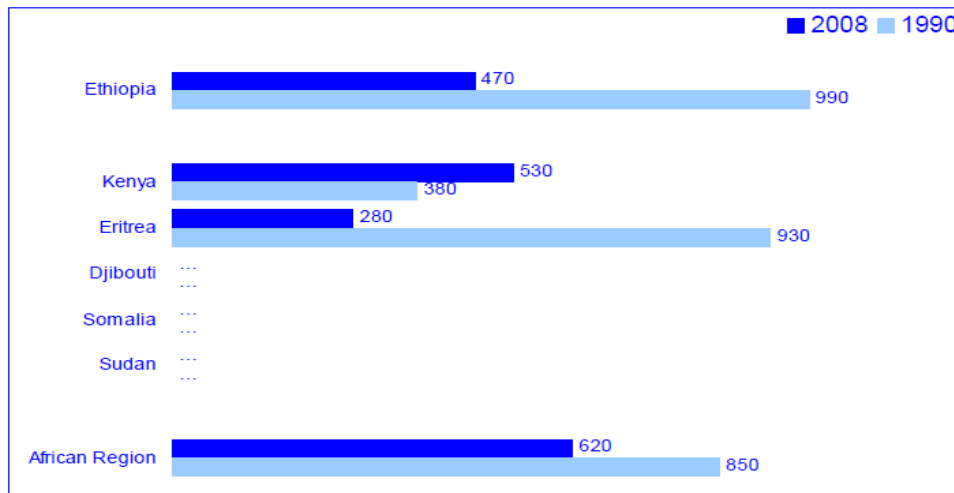
UNICEF Region	Maternal Mortality Ratio, 2005	Lifetime Risk of Maternal Death, 2005	Births with Skilled Birth Attendant, 2003–2008	Neonatal Mortality Rate, 2004	Infant Mortality Rate, 2008	Under-Five Mortality Rate, 2008	Infants Immunized against Measles, 2008
	(deaths/100,000 live births)	(1 in:)	(%)	(deaths/1,000 live births)	(deaths/1,000 live births)	(deaths/1,000 live births)	(%)
World	400	92	64	28	45	65	83
Sub-Saharan Africa	900	22	46	40	86	144	72
Middle East and North Africa	210	140	76	25	33	43	86
South Asia	500	59	42	41	57	76	74
East Asia and Pacific	150	350	91	18	22	28	91
Latin America and Caribbean	130	280	91	13	19	23	93
CEE/CIS	46	1300	97	16	20	23	96
Industrialized countries	8	8000	-	3	5	6	93
Developing countries	450	76	63	31	49	72	81

2.1.1. Ethiopia: MCH Status

Maternal Mortality Rate (MMR) in Ethiopia is significantly high with 590 deaths per 100,000 women (Lancet, 2010). Maternal deaths are mostly caused by obstructed/prolonged labor, which accounts for 13% of the maternal death. Ruptured uterus (12%), severe pre-eclampsia/eclampsia (11%) and malaria (9%) are among the major causes of maternal death and 6% of maternal deaths were due to complications from abortion. Lack of skilled midwives, poor referral system at health centre levels, insufficient availability of BEmONC and CEmONC equipment and shortage of finance of the health service are main challenges of supply side which hamper

maternal health improvement. Furthermore, cultural norms and societal emotional support to mothers', distance to functioning health centers and financial constraints are also categorized as the major causes of maternal deaths (FMOH, 2010).

Maternal mortality ratio per 100,000 live births in Ethiopia and neighboring countries, 2008 and 1990 (WHO, 2010)

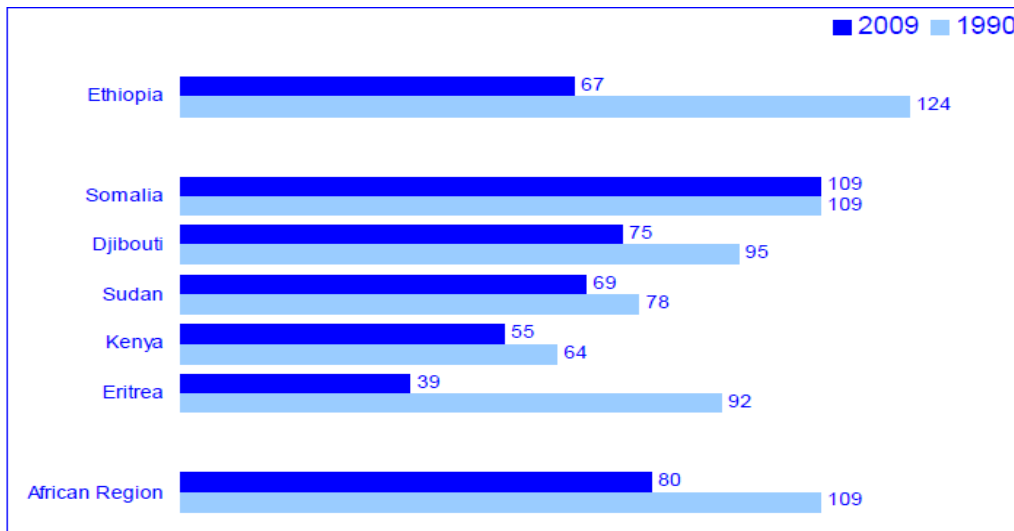


Source: IMGE 2009 Estimates

Definition: number of maternal deaths per 100 000 live births during a specified time period, usually one year.

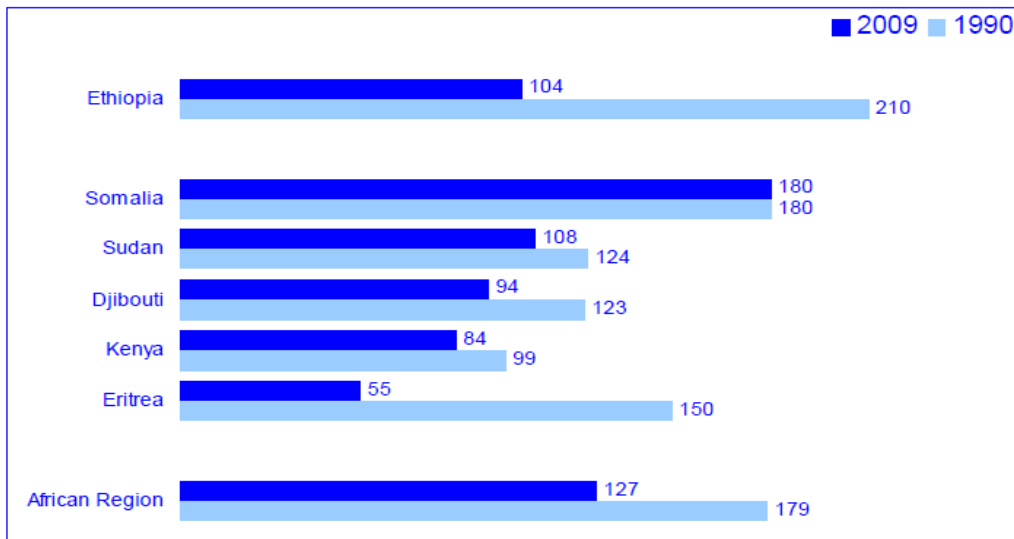
Infant Mortality Rate (IMR) has been 77/1000 (DHS, 2005). Child mortality rate of under-five years has been 101/1000 in the year 2010 (WHO, 2010) and more than 90% of causes of child deaths are attributed to pneumonia, diarrhea, malaria, neonatal causes (pre-maturity, asphyxia and neonatal sepsis), malnutrition and HIV/AIDS and are mostly due to a combination of these situations (WHO, 2010). Malnutrition and HIV are underlying causes in about 57% and 11% of these deaths respectively. The levels of mortality are worsened particularly by poverty, inadequate maternal education, lack of safe water supply and sanitation, and high fertility and inadequate birth spacing. About 472,000 Ethiopian children die each year before their fifth birthday, which places Ethiopia sixth among the countries of the world in terms of the absolute number of child deaths (FMoH, 2005).

Infant mortality rate per 1,000 live births in Ethiopia and neighboring countries 2009 and 1990 (WHO, 2010)



Source: IMGE 2009 Estimates: Definition: Infant mortality rate is the probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period.

Under-five mortality (per 1,000 live births) in Ethiopia and neighboring countries, both sexes, 2009 and 1990 (WHO, 2010)



Source: IMGE 2009 Estimates: Definition: under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period

2.2. Empowerment for Health Promotion

The Ottawa charter for health promotion is the first international conference on health promotion and was mainly a response to the emerging expectations for a new public health movement around the globe. The WHO definition and description of health promotion has been quoted as follows.

“Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being” (WHO, 1986).

The notion of empowerment has been frontrunner by the ‘new health promotion movement’ which evolved in the beginning of 1980s and which emphasized on attaining health equity and enhancing public participation in decision-making in health programs (Robertson et al, 1994). World Health Organization further legitimized the concept of empowerment in its declarations and strategic position papers (WHO 1978, 1992, 1998).

The empowering discourse of health promoters which was legitimized by WHO in the 1986 Ottawa Charter for health promotion (WHO, 1986) has emerged as a bureaucratic response to the growing social movements and to the contemporary health discourses of the 1960s, 1970s and 1980s (Stevenson and Burke, 1992; Labonte, 1994).

Practically two different health promotion discourses have emerged and co-exist. The conventional discourse focuses on disease prevention through life style management (top-down). On the other hand the radical discourse focuses on social justice via community empowerment and advocacy (bottom-up). Similarly, health promotion programming mainly uses two seemingly different health promotion approaches i.e. top-down and to a lesser degree bottom-up (Feather and Labonte, 1995).

As clearly stated in the WHO definition empowerment is the core theme in health promotion as enabling people to have control over their lives helps people to identify their own health problems and to get the necessary knowledge/awareness and courage to bring solutions to the problems. This entails that the expert role is substituted by the bottom-up strategy and as a result, the health practitioner/promoter undertake more of a facilitating role in health programs and in the end the health promoter handover the health programs/projects to the community people (Naidoo et al, 2000).

The rationale of health promotion is to enable people to increase control over, and to improve, their health. Thus, empowerment is a fundamental principle to achieve this. However, as a strategy empowerment varies depending on if it is the health promotion agency (top-down) or the community (bottom-up) who identifies the issue to be dealt with (Laverack, 2012).

This has brought a challenge in current health promotion as many health promoters pursue to use power over the community through 'top-down' programs simultaneously using the liberating discourse of the Ottawa Charter. The tension between the discourse and the practice persists due to lack of clarification on how to make the concept of empowerment functional in conventional/'top-down' program circumstances in which many health promoters still engaged in (Laverack, 2000).

The fundamental nature of empowerment is that it cannot be given by others instead it must be obtained by those who seek it. In order to create the feasible environment to make empowerment achievable those who have power or access to it (such as a health practitioner/health workers who have the chance to help empower individuals, groups, and communities) and those who want it (such as their clients) ought to work collectively (Laverack, 2006).

The ultimate objective of health empowerment program is to mobilize communities in action to alleviate social and physical disease risk factors and improve factors of quality of life. For instance, poor housing condition is a risk factor for deprived health status (Ronald et al, 1994).

There are two possible different aspects of empowerment. The first is as a goal and the second is as a process or approach. Empowerment as a goal is having the control over the determinants of one's quality of life while empowerment, as a process is to create a professional relation where the client/community is able to take control over the change process. This elucidates both the goals of the empowerment process and the means to use. Therefore, we can achieve empowerment in a combined sense (Tengland, 2008).

The above definition could also be applicable whilst working towards groups or community empowerment (for instance ethnic minorities, the homeless, delinquents, people with disability, etc). Professional teams that are engaged in supporting people or groups to be empowered can also apply it. Government and other concerned bodies can create the environment for empowerment both through creating a society that enhance its people's participation and control over their lives and through supporting organizations in which professionals engaged in assisting people to gain control over their lives (Tengland, 2008).

Chapter 3---Research Design and Methodology

3.1. Qualitative Study

Qualitative research design is used to carry out this study. The researcher tried to make an exploratory descriptive study to understand and critically analyze the effectiveness of the empowerment strategy in improving maternal and child health in Ethiopia.

Even though quite a few scholars have tried to define qualitative research, there is no one agreed-upon definition of qualitative research and mostly it is defined by what it is not i.e. by comparing it with quantitative research method (Dahlgren et al, 2007). In 1998 Creswell JW defined qualitative research as follows.

“Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting” (Creswell, 1998).

Qualitative research method is preferable to conduct in-depth studies and get quality information. This means that as the qualitative researcher tries to investigate a given social or human problem, he/she constructs the multifaceted and holistic pictures of the given research problem by considering the detailed views of respondents and the context of the observable facts. This helps to easily understand others social world and stories (Silverman, 2010).

Qualitative research is often conducted in a naturalistic situation in order to include the context in which the phenomenon occurs as a part of the phenomenon itself (Hinds et al, 1992). Therefore, the researcher does not try to control the “extraneous” variables. All dimensions of the research problem are explored and the intervening variables coming up from the context are regarded as part of the research problem (Morse, 1995).

It is mainly useful to apply qualitative methods when describing a phenomenon or research problem from the *emic* perspective i.e. from the native's point of view (Vidich et al, 1994). Qualitative methods are mostly exploratory aiming to describe a situation or understand a person or an event (Morse, 1995). In this project case the *emic* perspective can be the perspective of the women, health workers or other community people involved.

Qualitative research is considered as an act of interpretation and qualitative research takes its departure from the viewpoint of the informants. This is to say that it seeks for causes and facts from the *emic* perspective and in this case the findings are based on the subject's interpretations of events. Qualitative researchers mostly deal with small number of informants in contrast to quantitative research. Qualitative research has reality, based on data, as a starting point and furthermore, by relying on the data collected hypothesis, new concepts and even theories are generated. This is known as *inductive* reasoning (Creswell, 1998).

Nevertheless, qualitative researchers may examine emerging hypothesis or theories against data therefore, moving back and forth between data and theory. This type of research process is known as *abductive* method (Creswell, 1998).

3.2. Ethnography

Historically ethnography is emerged from cultural anthropology and focused more on the cultural patterns of village life. Ethnography was first included into health care research by nurse-anthropologists such as Aamodt (1982), Leininger (1969), and Ragucci (1972). These researches emphasized on the effects of culture on health care (e.g, Davis, 1992), institutions as a cultural setting (e.g., Germain, 1979; Golander, 1992), or a professional group organized as a cultural system (e.g., Cassell, 1992) (Morse, 1995).

Apart from its main discipline of anthropology, ethnography has become popular in health related research and ethnographic methods are used to examine specific research problems such as belief and health education (Editorial, 1993).

Ethnography is a systematic effort to learn the knowledge a group of people have and are using to organize their behavior. It includes actual study of a culture, which directs to higher level of concept comprehension than is likely by simply acquiring verbal definitions and examples (Spradley and McCurdy, 1972). One of the desirable qualities of ethnographic research is its potential to disclose the tensions and contradictions that come out from everyday life and the stress points and the fundamental fracture lines of the broader society in which it is rooted (Editorial, 1993).

Boyle in 1994 illustrated a classification system for ethnographies under the headlines of classical or holistic ethnography, particularistic and focused ethnography, cross-sectional ethnography, and ethno-historical ethnography. She further stated that however ethnography can be distinguished by type, most ethnographies share certain common characteristics i.e. they are holistic, contextual, and reflexive (Boyle, 1994).

Morse explained ethnography as a tool for getting access to the health beliefs and practices of a given culture. Ethnography allows the researchers to see phenomena within the context they occur, which facilitate our perception of health and illness behavior. Such kind of information is

essential to the provision of health care since understanding the culture of its clients is the key to a health program. The concept of culture can be used in its broad sense to analyze the beliefs and practices of ethnic groups such as in the work by Stein (1991) and Haggstrom, Axelsson, & Norberg (1994) on group behavioral norms such as clinical decision making and on groups of individuals experiencing a common illness such as stroke respectively (Morse, 1995).

3.3. Sampling Techniques

3.3.1 Selection of Area/Subjects

Empirical fieldwork for the primary data collection was conducted in rural Ethiopia in Amhara region in rural woreda (district) named Angolela. Amhara is one of the nine regions and the north western and north central regional state of Ethiopia. Based on the 2007 Ethiopian Census the region has a population of 17,221,976. Of the total 8,641,580 were men and 8,580,396 were women. Urban inhabitants account 12.27% of the population (CSA, 2010).

Angolela district is located 110 kilometers away from north east of Addis Ababa. The number of people living in the district is estimated to be 93,178 and there are 19,965 households. Nineteen kebeles and two rural towns are found in the district (CSA, 2010). There are 21 health posts and 4 health centers that are providing health services in the district.

Angolela district was selected purposefully in consultation with concerned bodies such as FMOH, Amhara regional health bureau and Angolela woreda administration and health bureaus. Full implementation of the health program, local language and accessibility in terms of security and transportation were considered to carry out the research in the woreda. From the selected project area, informants were selected with specific inclusion criteria i.e. community people particularly women (pregnant and non-pregnant) who are involved and beneficiaries/participants in the empowerment initiative project activities being implemented by the Ethiopian government.

Other informants such as health professionals, government officials and community men involved in the projects and who are in key positions and have a special knowledge of the phenomenon were selected based on their knowledge of the research problem. In addition, as a

qualitative study demands all the above mentioned informants were selected depending on their willingness to talk and based on the established relationships of trust with the researcher.

3.3.2 Presentation of Informants

The participants were women, female health extension workers, health center focal person and maternal and child health care officers/government officials. All the informants have been given specific abbreviated names for the ease of the study, while keeping their personal identity hidden according to the ethical requirement of the study.

Gov—stands for Government official

W—stands for Woman

HE—stands for health extension worker

HC—stands for health center manager

H—stands for community man

Community Women

The six community women informants are beneficiaries and participants of the health program being undertaken in the woreda. The women belong to the age group of 20 to 40. Out of the six women participated in the focus group discussion two of them are newly married and conceived their first would-be born child. They are expected to give birth as well as experience labor within three or four months in their marriage life. Among the rest four, one has already six children and newly born infant while the other one has two children and a recently born infant. The rest two of the four, one is pregnant and has already two children. The remaining one has five children and one newly born infant.

All the women participated in the study are housewives. They are engaged in different kinds of household activities such as collecting cow pen, milking the cows, fetching water, food preparation etc in addition to child rearing. These activities are their main duties and considered as women's occupation in the community.

Health Extension Workers (HEWs)

The female health workers are assigned to work as HEWs in health posts at kebele (village) level. They are responsible to work on different health packages mainly on maternal and child health care activities. They all graduated from high school and have received additional training at Technical and Vocational Education and Training Institute (TVETI). These health extension workers participated in the discussion by representing their respective health posts i.e. Bura, Tsigereda, Chaha, Tengego and Kotu in Angolela woreda where the study conducted. Of the total six health extension workers, two represented Tsigereda health post. This is because the area coverage of the health post is comparatively larger than the rest three health posts.

Government officials

The two government officials are health professionals and also in charge of co-coordinating maternal and child health care in the woreda. It includes health extension program, mother's health care services and children's health and nutrition services. They have obtained undergraduate degree in Bachelors of Science (BSc) (one in Nursing and the other in Health Education Promotion). They are working as officers of the woreda/district maternal and child health care program respectively. Both of them are men.

Health center manager

The health center focal person/manager is also a health professional. He is a graduate of BSc in Nursing and works as a manager of one health center and four health posts. The health center manager undertakes administrative duties in supervising HEWs and health center workers as well as provides clinical services for adult outpatients, children and mothers.

3.4. Data Collection

The ethnographer applies different methods of data collection including participant observation, interviews and field notes. Other data gathering techniques such as records, chart data, life histories etc can be added (Morse, 1995). Ethnography as it has progressed over time indicates

not to a single data collection method rather to a various research techniques that can be applied in designing and conducting an ethnographic research (Parker et al, 2001).

Accordingly these data collection techniques were applied for this study. Data's were gathered through unstructured interviews or conversational interviewing style and focus group discussions with the community people such as women, health workers, government officials and other concerned community people in the project areas. These data collection methods are believed to give the opportunity for the respondents to freely discuss about their life story and the given subject matter (Silverman, 2010). Interview guide questions were used to maintain the focus of attention within the research questions. Documents, field notes, records, photographs, social network and diagrams were used whenever appropriate.

Participant observation is one of the common techniques of data collection and the researcher is ought to spend a significant period in the field (Sanday, 1979). The center of the research is to get the insider's perception of the given research problem and the consequent explanation of the culture (Field, 1983). Thus, participant observation and analysis was made since the study was carried out in a natural setting and the researcher spent a longer period in the field.

Un-structured Interviews and Focus Group Discussions

The interviews and focus group discussions were conducted in participant's native/local language i.e. Amharic by the researcher herself and it was audio taped. The recorded data were transcribed and translated into English version by the researcher herself. Amharic is the researcher's native language.

Two focus group discussions and two un-structured interviews were conducted. Each interviews and focus group discussions took an average of 60 minutes. The informants themselves selected the places where the focus group discussions and interviews conducted.

The first focus group discussion was conducted among six community women. The discussion was conducted in one of the participants/women's house. Among the six women participated in the study, two women were accompanied by their respective husbands and they also contributed for the study. Hence, this makes the total number of the first focus group discussion participants

eight. The second focus group discussion was carried out among six female health extension workers at woreda health bureau.

The first un-structured interview was carried out with two government officials at the same time. The interview was carried out at woreda health secretariat bureau where the two government officials work. The second un-structured interview was conducted with health center manager/focal person. This interview was also conducted at woreda health bureau.

3.5. Data Analysis

Ideally analysis in ethnographic studies goes beyond description to show aspects of social patterns or observed conduct. Geertz in 1973 explained thick description as an interpretive science that explores for meaning within the cultural norms, the culturally patterned behavior, and the cultural context. Similarly, the health care researcher is concerned with illustrating culturally embedded norms, which directs person's action in a particular culture in order that the provision of health care may be culturally appropriate or acceptable (Morse, 1995). Unlike survey and comparative research, ethnography does not depend on fixed and comparable units of analysis (Gille et al, 2002).

Ethnography is both the art and the science of description. Ethnography researchers have to be careful with regard to systematization. It is very crucial to take the emic perspective (the insider's or native reality) with the etic perspective (the external or social scientific reality) into account in order to have unbiased value in the development of community organization and health empowerment (Ronald et al, 1994).

The differences in understanding between the researcher and the participants can be elucidated as they arise and as the researcher increases an understanding of the research problem under investigation from the participant's perspective. Ethnography researchers start to understand the emic or the natives' standpoint and ethnographers learn from people instead of studying people (Spradley, 1979). Therefore, the collected data for the current study was structured and analysed in the form of themes and sub themes.

3.6. Secondary Data

The method used for searching secondary data's such as articles, journals, different publications, books and reports that would be relevant for this study was conducted using different sources. PubMed and BioMed databases, World Health Organization (WHO), Ethiopian Federal Ministry of Health (FMOH), World Bank (WB) and UNICEF's web sites and databases were among the major ones to look for the relevant secondary data.

3.7. Ethical considerations

The participant observation, interview and focus group discussions were carried out after getting an informed and signed consent from each participant. Prior to the focus group discussions and interviews, the informants were briefed about the procedure of the research. The researcher ensured that the informants understood the overall purpose and nature of the study project. The participants were informed that they can agree or refuse to contribute and also withdraw from the interview or focus group discussions at any time without explanation. The researcher ensured anonymity and confidentiality throughout the research process.

The participants were also informed that the study was approved by concerned bodies (Ethiopian Federal Ministry of Science and Technology National Research Ethics Review Committee and Malmo University Ethical board). The gathered information was kept confidential and anonymous, sensitive materials were locked up in a safe place during the research process and the audio tapes were discarded after completion of the research project.

Chapter 4---Findings

The findings of the interviews and focus group discussions were structured and presented in the form of the following themes and sub themes.

4.1. Participant Observation

During the four weeks empirical fieldwork, in Angolela woreda where the study conducted, I have made participant observation and observational analysis. During my stay in the community I visited health posts, health centers and the district health bureau. I also carried out some informal interviews or discussions, as opposed to formal interviews and focus group discussions,

with the community women, health professionals and government officials throughout the data collection period. I was invited to share meal, have coffee and chat at two of the women's house participated in the study.

This has helped me in different ways to cross examine the results obtained from respondents through focus group discussions and interviews. I spent time with health workers and examine their daily routines on job providing different health services. I was able to observe the actual health service provision for health program beneficiaries particularly community women and children. Among other health activities I had observed children getting immunized, women getting ANC and women having health education meetings with HEWs.

The empowerment initiative in terms of access and quality of health services has been transforming the lives of many women and children in the district in improving their health status. Many women and children have been able to make use of free health care which they would not be able to use otherwise. It is also observed that the health program activities are being carried out in a decentralized manner at different levels in the district i.e. from the highest district health bureau to health centers and health posts. This has helped to a greater extent in delivering health services in time for the community people. The findings presented in the results section are in agreement with the observation of the researcher. The major findings of the study and my observational analysis are presented in the discussion section of this study.

4.2. Health Program Activities at Grass Root level i.e. Angolela District Level

4.2.1. Specific Role on MCH (Maternal and Child Health) Care

Government Officials

The government official's facilitate the availability of inputs like packed child nutrition foods, growth follow up equipments and medications, Anti-8 vaccination kits (to prevent diseases such as polio, pneumonia, measles, tuberculosis, hepatitis and etc.) so that under-five children would get quality primary health services. Besides they ensure the availability of other inputs such as medications and equipments for ANC, PNC, PMCT, delivery services and family planning

contraceptives etc. at the health facilities, which are essential for maternal and newborn health care activities. It is also their duty to make sure these inputs are accessible to the health centers and health posts.

They are responsible in corresponding with woreda (district) non-governmental partners and facilitating capacity building trainings for grass root level HEWs. Providing moral support to HEWs, hiring of new HEWs upon their resignation and communicating zonal office for budget issues concerning MCH care activities are part of their responsibilities. They supervise the activities of both health centers and health posts with special emphasis for health centers since health center managers also supervise health posts. They provide technical support to health centers/posts and try to bring solutions to problems encountered at health centers/posts. Communicating with higher (zonal) health bureau for problems that are beyond the capacity of their office and conducting regular evaluations of the district's MCH care activities is also among their duties.

Health Center Manager and Health Extension Workers

The health center manager ensures community women and children are provided with basic MCH care facilities such as routine ANC checkups, delivery service as well as PNC for pregnant mothers and anti-8 vaccination, growth follow-up etc for under-five children found in the community. Health center professionals including the manager make rounds in the villages on weekly basis to make sure the community people, particularly women and children, are getting basic health care. Over all supervision of health professionals both at the health center and health posts, conducting meetings and facilitating supplies in collaboration with district health office are carried out by the health center manager. HEWs mainly provide child immunization, child growth follow up and health education for community women. They also provide ANC, delivery services and PNC at health posts.

Capacity Building Trainings for Health Professionals

The health extension workers have received various intensive trainings on maternal and childcare after they start working as health extension workers. The training they received after school has

helped them to a great extent to give a better service regarding maternal and childcare. This has helped them to effectively carry out their duties in the community.

“When we came from school we did not have any practical experience of delivery service. There is a big difference when you have training on probes and actual human beings. However, when we had child delivery training at zonal hospital we were able to acquire practical knowledge.” (HE3)

“Regarding children, we had training on ICCM which stands for Integrated Community Curative Management after we joined this program. It is about providing a coordinated infant/child health care. All the child care activities we carry out are based on ICCM.” (HE6)

The government officials are also provided with trainings concerning maternal and childcare.

“We had been provided with various trainings. We have been trained on children health and nutrition and maternal health care” (Gov1,2)

4.2.2. Health Services

The detailed activities of the health program that are being provided in the community are presented as follows.

Child Vaccination and Growth Follow-up Services

Health extension workers provide child vaccination for under-five children in the community. They give anti-8 vaccination (Measles, Polio, Pneumonia, Tuberculosis, Hepatitis etc) to under-five children by going in every household so that every child in the community gets immunized.

They follow up the development of children and provide minor curative services for cases such as diarrhea. If the case is severe, they fill in a referral form for the child to get further treatment at health center.

Under-five children also get growth follow-up to prevent child malnourishment. They find out the health issues that a child has at a certain time and they examine why a given child has not reached to the required weight, which is optimal for his age. They take the necessary medical treatment and give counseling service on child nutrition for mothers to provide foods available in

their houses by preparing it properly nutrition wise. In addition to this, they distribute packed child nutrition foods such as Vitamin A to the mothers for malnourished children.

ANC (Antenatal Care) Service

HEWs educate community women to get their first ANC at the health center and to further continue the ANC checkups either at the health center or health post. Any pregnant woman in the catchment area should get her first ANC checkup at the health center so that the women can be provided with better ANC services. This is because complete laboratory service and PMCT is only provided at health centers. HEWs also use the referral system for medical cases that are beyond their professional capacity. The health extension workers provide pregnant mothers in the community with Antenatal Care (ANC) checkups. If there are any pregnant women in any kebele (village), HEWs start to follow up their health condition beginning from the early period of their pregnancy.

Provision of vaccination and iron phallic acid/mineral for pregnant women is part of the ANC package. The HEWs give out the service at health posts. HEWs start giving the iron phallic acid/mineral right after they meet any pregnant woman for the first time and they continue to give it at least for six months. HEWs give the TT vaccination for any pregnant woman twice before she gives birth.

Every pregnant mother should get HIV test, which is part of the first ANC, which has to be provided at the health center. PMCT professionals give HIV testing at health center. Two health professionals trained in PMCT also provide PMCT service at health center. The HEWs teach the women about the advantages of the test and they make sure pregnant women get the test at health center. The HEWs make sure a pregnant woman gets HIV testing at health center. They teach the mothers about the benefits of the test both for the would-be child and the mother her-self in particular and the community/nation in general. They also provide ANC at household level when pregnant mothers couldn't come to the health post.

Birth Assistance and PNC (Postnatal Care) Services

Every pregnant mother in the community is expected to give birth at the health center with the help of qualified health professional like midwives and nurses. Midwife has been hired in the

health center so that women would be able to give birth with the help of qualified health professionals. However, in villages where the health center is far away the women are advised to give birth at the health post with the assistance of HEWs. PNC is provided both at health center and health posts. HEWs educate the community women to use health facilities for delivery as well as PNC. HEWs also provide delivery and PNC services by going to women's respective houses in cases where the women couldn't visit the health facilities.

Family Planning Services

Health extension workers educate the community women about family planning. They also provide different types of contraceptives at health posts. They provide short-range contraceptive, which is effective for three months once given at the health posts. They also provide the community women with pills and condom according to their choice. They refer those women who want a long term contraceptive to health centers. Nurses at the health center provide long-range contraceptives, which are effective for more than a year.

Health Education and Communication Services

There are various traditional medical practices the community people perform. Most of these traditional practices have been causing severe health complications for both women and children that contributes for very high number of maternal and child mortality. Thus, creating awareness among the community people about these harmful traditional practices is one of the major activities HEWs undertake by going to every household for 'house to house teaching'.

For instance, in the community there is a belief that labor will be easier if a pregnant woman works very hard during pregnancy and massaging pregnant women's belly with butter. HEWs educate the women in particular and the community people in general about the risks of such practices on pregnant mothers as well as the fetus/pregnancy. Hence, they create awareness among the community people to evade such kinds of harmful traditional practices in the district.

HEWs create the awareness among the community women that every pregnancy has different characteristics and they educate the women to strictly follow their ANC checkups in the nearby health post and health center. They discuss about the problems associated with child delivery with traditional birth attendant and make the community women aware about the importance of

delivering a child with professional birth assistance and getting the necessary PNC at health facilities.

HEWs encourage mothers to tell them freely what they do to their newly born infants. They discuss with the mothers about everything from traditional practices to feeding culture such as making newly born babies swallow butter and feeding them cow milk and other solid foods and its negative consequences to create the awareness among the women. HEWs also educate the community about the benefits of vaccination in preventing disease such as measles and to bring their children when they get sick to health institutions so that they get the right medical treatment.

Most community women do not discuss with other people about their reproductive health concerns. It is considered as a private matter in the society and hence the women find it difficult to openly talk about such issues with health professionals. The health extension workers educate the community women to alleviate the problem. For instance, the mothers may have infection after they gave birth and they try to keep it a secret. HEWs educate and advise the mothers to tell health professionals freely if there is anything that they encountered regarding their health. They instruct the mothers to come to the health institutions when they encounter such problems. They also make them aware that such thing will cause grave danger on their health.

Extensive education has been given on having a proper diet for pregnant mothers. Despite the availability of food, the women lack the knowledge of how to diversify and increase their nutritional intake. During house-to-house rounds HEWs educate the women about the problems associated with such kind of feeding style both to the health of the mother and the fetus. HEWs advise the women to have proper feeding style and diversify their nutrition intake and increase the amount of food intake during and after pregnancy for a healthy mental and physical growth of the fetus/child. The health extension workers also provide education/trainings on proper breastfeeding so that the women can have the knowledge of how to breastfeed well their infants.

The clinical health professionals at health center including the health center manager are also involved in educating the community women to make use of the health services available in the community and to increase their awareness concerning MCH care facilities.

4.2.3. 'One to Five' Group Leaders

Leaders of the 'one to five' groups are women and each leader has five women followers. The 'five' refers to the women followers whereas the 'one' refers to the leaders. For instance, in one village there are 30 households and thus there are five "one to five" groups. Among other community women the leaders have been selected by health professionals since they have better understood the health education given to them and are using the health services provided in the community. These women leaders have been able to improve their health as well as their children's'.

Thus, the leaders in their respective groups educate and make the other women aware of their reproductive health issues as well as their children's health. The other women in the 'one to five' group are expected to follow the leaders' way of life in respect to maternal and child health. These leaders also communicate and work very closely with HEWs in educating the community women about maternal and child health care. The leaders inform and update HEWs regularly about the women's health condition in their group. They report to HEWs about pregnant women and even about women who have given birth in their houses with traditional birth assistance. Hence, this helps HEWs to be informed and provide the necessary ANC, delivery and PNC to the community women.

"I present myself as an example and tell them my story. I tell them that I had a safe pregnancy since I followed my ANC checkups properly. I gave birth at health center with the help of health professionals and I had a safe delivery and PNC. I am living a healthy life/motherhood since I am using family planning contraceptive. I tell them that my children haven't had even flu in the past since my children have completed the anti-8 vaccinations." (W2)

"I tell them that vaccination is beneficial and it is important for the healthy development of children. I would tell them that we could prevent diseases such as pneumonia by having our children vaccinated. Children would not catch measles or other diseases. Thus, the women talk about it among themselves. This is what we ('one to five' leaders) all are doing" (W2)

“/.../we gather up women and teach them about ANC, PNC, child delivery, child health etc. we also educate them by making rounds in every house” (W2)

4.3. Positive Outcomes

The positive outcomes of the health program are presented as follows in form of sub themes.

4.3.1 Reduction in Maternal and Child Mortality

As a result of the health program there have been positive outcomes in improving maternal and child health in the community. The community has witnessed transformation in maternal and child health ever since health institutions started functioning.

Child/infant mortality has almost been eradicated. *“The infant mortality rate in our woreda has decreased drastically. There is not even a single infant death case in our woreda nowadays. We have not received a report from health centers or health posts in this regard.” (Gov2)*

“We don't see children dying from pneumonia, measles, meningitis etc after the health extension workers came to our community. Many toddlers used to die before the introduction of child vaccination. (W4)

The placement of health professionals at health centers and health posts has contributed for achieving tremendous results in activities such as child vaccination.

“Child vaccination has been very successful since the health extension workers go door to door to provide the service. This program has allowed us to reach out every child in every household. I believe a huge infrastructure is being laid out.” (HC)

All the women participated in the discussion reported that their children, who are below the age of nine years, have received anti-8 vaccination and growth follow-up. HE workers gave the vaccination and growth follow-up by going in each and every household.

I have six children. The little ones were vaccinated by HEWs. The older children have not been vaccinated before. There was no vaccination available in our village. (W1)

I have two children and they have finished their vaccination. The first one is 6 years old and the second one is 3 years old. My children have been vaccinated during the rounds the health professionals carry out in each village. HEWs also come and follow-up the development of my children regularly. (W3)

As a result of the health education that has been given, the women started to visit health institutions for ANC, delivery and PNC services.

“I gave birth to my youngest child at the health center. I followed all my ANC and PNC checkups regularly as I have been thought by health workers.” (W2)

“I am also following up my checkups every month ever since my menstruation was late. I am on my 7th month of pregnancy. I go to health center for my checkups. I am doing this because I have learned how to read and write a little. The health professionals also taught us about maternal and child health issues. This helped us improve our health. The availability of health service here in our village benefited us greatly.” (W6)

Thus, maternal mortality has been decreasing especially compared to previous times.

“The reports about complications/death in relation to mothers giving birth or pregnancy have greatly decreased from that of before. It is not to say that it has completely vanished but it has indeed decreased at large.” (Gov1)

4.3.2. Accessibility of Health Services

The availability of health facilities has enabled the women to get health services in their locality. This has a huge impact in improving maternal health in terms of accessibility by reducing very long distance travel they used to make just to get medical services.

“Previously people used to go to Debrebirhan (zonal city) to get medical treatment. It is very far away. Now everything can be provided where they live unless it is a very severe case. We have also started ambulance service in cooperation with Red Cross.” (HC)

“Before the establishment of health center/posts in our community many women used to die before reaching to zonal hospital and without getting any medical help.” (W6)

“One of the kebeles where I work is found at a seven hour walk distance from Chacha (district town). It was extremely hard for a mother to come all the way to Chaha to get health services. But, now there is health center and health post in nearby kebele called Tsigereda which can be found in an hour walking distance.” (HE4)

The free health care service has enabled community women to utilize health services and it has contributed for a substantial improvement in maternal and child health.

“The health services are given for free and hence we are able to use the health care. If we go to private clinics in towns, we would be required to pay two thousand Ethiopian Birr or more which we wouldn't afford.” (W2)

“Previously it was not free to deliver a child at health institutions and women used to give birth with the help of traditional midwife. However, now any pregnant woman who goes to the health institution to give birth or get any service in relation to pregnancy is not required to pay. Thus, most community women are able to use health service.” (Gov2)

“We are very lucky to have this support and we are able to better ourselves. We have been provided with health services for free.” (W6)

4.3.3. Acceptance of Health Services

The community people have started to understand the benefits of health care. They accepted the health services provided and the number of health service users is increasing from time to time.

“The percentage of pregnant women showing up at the health centers has grown from the previous 5% to 20% and 30% nowadays. Mothers are the ones that come by themselves for checkups and to give birth at the health centers. Model women are being created.” (HC)

Sense of ownership is growing among the community people. *“The community itself started to follow up the vaccination of the newborn babies in their respective communities. Whenever there is a child born, the community reports the birth to the health workers.”* (Gov1)

“Previously selected community members were paid to motivate the community to come and use children's health activities that were done in campaign form. At this time, there is no payment. However, the level of the work force has not decreased at all. Better yet, we are getting improved results. The people have accepted especially the health services provided to children.” (Gov2)

In previous times women had to be convinced and pressed to use health facilities. However, now things have been improving and many women started to accept the health education they are given and they are becoming willing to go to the health center without any one's pressure. The women have also understood the health education they have been taught and they are practicing it in their life.

“A pregnant woman has to feed herself, nutritious foods, three times per day after 3 or 4 months of her pregnancy. If she only eats once a day, it will cause a problem on her health. She should not do heavy works or travel long distance. She should not lift heavy objects. I do the same as I have been educated” (W5)

“As I have been taught I breastfeed my baby for the first six months. It is hard for infants with the age of less than six months to digest foods other than breast milk. A child should be vaccinated after 45 days of his/her birth.” (W2)

A pregnant woman should make series of checkups beginning from the month that her period is late for safe pregnancy and a healthy development of the fetus. Hence, I have followed all my ANC checkups properly” (W2)

Many community women started to accept the teachings of their fellow community women leaders. Thus, the women are following the lifestyle of their leaders.

“Many women are willing to put what they have been thought into practice. Most women are also going to the health center to follow up their antenatal checkups. I would say the pregnant women in the area are doing their checkups and they are going to health facilities for delivery and PNC.” (W2)

The women want the continuation of the health program. It is also important to continue educating the women about their health issues. This will help to make all the community women beneficiaries of the health services.

“I think it would be best if the program continues like this. I did not encounter any problem to get any health service when I go to the health center/health post. The women should be educated persistently and we need to change the perception of the community. Thus, they could go to health facilities to get proper health services. Prevention is better than curing.” (W2)

The community men participated in this study also want the continuation of the health program and stress on giving more health education meetings for women. *“The women should be taught about their health issues constantly so that all the community women will be beneficiaries of the health services.” (H1)*

4.3.4. Control over Reproductive Health

The community women are becoming aware of their health issues and started deciding on matters that affect their health.

“I have not had any complications during my sixth pregnancies and delivery with the help of traditional midwife. It was good. However, now I know the difference so I prefer medical facility over traditional one. It is where I can get quality service so that I can stay healthy. (W4)

“HIV is transmitted through sex and blood. The traditional birth attendants do not use glove or any other protection mechanisms. The traditional midwives might have HIV/AIDS and as a result

the virus could be transmitted to the woman. Thus, I prefer to give birth at the health facility”
(W6)

“I gave birth to my seventh child at home with the help of health professional. I convinced myself that I have to practice what I have been taught by HEWs and I followed all my ANC checkups. I wanted to give birth at the health center but my baby was born earlier than the appointment date given to me by the midwifery. However, the health extension worker managed to come to my house within a short time and I had a safe delivery.” (W4)

Health extension workers provide the women with intensive health education meetings. The focus of these meetings is to educate the women about ANC, PNC, delivery, child vaccination etc. Thus, many women are becoming aware of the health issues that affect their lives. This has helped the women to make informed decisions on their health.

“I have learned that giving birth with the help of traditional birth attendant at home can cause many problems. The baby may have wrong position and this may cause death. There might be narrowness of vaginal opening. The traditional midwives are not capable of dealing with such situations as that of health professionals” (W4)

Many women started using family planning services after orientation has been given to them by HEWs. The contraceptives are available at health centers/ posts and the women have been given the right to choose the type of contraceptive they want to use.

“I used contraceptive for the past five years and then I stopped using it at the end of the five year. The health extension workers, during their rounds, came and asked me if I wanted to use contraceptives. They taught us about the benefits. After sometime I got pregnant with my seventh child and I gave birth recently as I said earlier. The program has helped me a lot. I am also planning to start using contraceptive soon” (W4)

“I am also planning to use birth control medicine after I give birth. The health workers told me to come to health center and that I can choose any of the contraceptives available at the health center” (W5)

The family planning service has enabled the women to decide on the number of children they want to have. Hence, it helped in promoting the health status of women and decreasing fertility rate. *“There are no surprise pregnancies because of the availability of contraceptives.”* (HE3)

“I am using contraceptive thanks to the health workers. I do not want to burden myself with having so many kids. Two of the women in my ‘one to five’ group also use contraceptive because they want to have less number of children” (W2)

“Many mothers did not use family planning because of not knowing what to do. There were women who give birth almost every year. The health program is reducing these problems at large.” (W5)

The already existing traditional associations are also used as a strategy to provide health education meetings and trainings. As a result, the women are able to share experiences about health and related matters that affect their life most. This has brought a far-reaching result in helping the women to be aware of their rights in relation to their men counterpart, which has a significant role in their health.

“Women are also organized in cooperatives like ‘Edir’ and ‘Equb’ so that they would discuss their problems collectively on the very concerning issue of maternal and child health care. We have a scheme that has a team of 100 percent women. Women are also made aware of their rights via the woreda women’s affair in collaboration with the health program.” (Gov1)

“/.../When we go out for children’s vaccination campaign, we bring with us women leaders of ‘one to five’ so that they would understand that they can do things just like the men. Nowadays, women are given significant recognition. The husbands also send their wives to meetings.” (Gov2)

“Husbands used to force their wives to give birth to several children and this was very common previously. However, now most women just come and say that they want to start using family planning without any fear.” (Gov1)

Women started to freely discuss about health issues that affect their lives, which was considered as a wrong act before the implementation of the health program. *“In the past mothers could not talk about their health issues. It was a taboo for a mother to be seen using a toilet or discuss about her reproductive health. However, these backward notions have been alleviated with the strategy, which is now in place. These days, mothers could freely talk about their health issues. At least we have reached to a time that they have realized their duties and rights as far as our woreda is concerned.”* (HC)

“We, women, discuss about our reproductive health issues in different occasions, such as ‘Edirs’ and meetings or when health professionals come to our village, on a regular basis.” (W2)

As a result of the health education they received the women are also minimizing the harmful traditional practices they used to perform. *“These days when we do our rounds we do not see a mother who is staying in a dark room after she gives birth. If children get sick, they do not waste time sitting at home and looking for traditional medicines. Because of this a mother brings her baby to the health center as soon as he/she gets sick.”* (HE1)

“There are some women who still give birth at their houses. However, these women use new or sterilized cutting tools to cut the umbilical cord. This is a result of the health education they have been given.” (HE4)

“Harmful cultural practices were pervasive. However, these cases have been reduced almost by half because of the health program.” (W4)

4.3.5. Increased Community Level of Awareness

The ‘one to five’ leaders have been very influential in creating awareness among community women. The health program in general is benefiting the whole of the community. *“Most of the women are becoming aware of the important health issues of maternal and child care, after these women leaders started giving trainings. This is a very good start.”* (H2)

Men have also become part of the program and started to be aware of their wives right. *“We started witnessing husbands bringing their wives for antenatal checkups and HIV/AIDS testing*

without anyone's pressure. They even rent a house around the health center when her expected date of delivery is approaching. Some men bring their wives when they get sick, using animal transportation or traditional stretcher, to health centers". (HC)

"Women these days come to health centers with their husbands to make regular checkups even if they are not sick. When we write their referral to health center for ANC, we write on the card with spouse or alone so that they could go together. Unless the husbands are away for work or other reasons, they started going to the health center with their wives." (HE2)

!.../They even allow their wives to participate in health education meetings. Women started participating in meetings equally. Women are giving suggestions. I can say that we have eliminated the problem by more than 50 percent. (HC)

"My husband would not allow me to do heavy tasks such as lifting up heavy water containers while I was pregnant. Hence, he helps me a great deal. He is willing to do anything for me." (W2)

The community men leaders are also helping the women to go to health institutions. They said they would continue to help the women in every possible way. Awareness creation on maternal and child health is also being given for community men too. The village leaders are working towards abolishing the traditional method of giving birth.

"I am one of the village's leaders, nowadays we are teaching the men too. We are also working to ensure that the traditional midwives do not involve in any medical service giving activity and this would not be a problem in the near future." (H2)

"Pregnant women do not engage in community development labor intensive work. Hence, we keep records of those women and we make sure they follow ANC." (H1)

Traditional birth attendants have come to realize the importance that women should visit health facilities for any pregnancy related checkups.

"As a result of the health program even the traditional midwives found at two kebeles named Addisamba and Gelila started sending the pregnant women to health centers. As a solution, first traditional midwives were made to have HIV/AIDS testing and data was collected. Secondly, in

collaboration with NGOs training was given to them in different skills so that they can engage in other profession. ” (HC)

“/.../We have found some traditional midwives/birth attendants infected with HIV/AIDS when we made them test. They do not use glove while giving delivery service and they are not careful enough to protect both the women and themselves. ” (HC)

Discussion was conducted with traditional midwives and it was made clear to them that they are exposing the mothers to HIV/AIDS. Moreover, the traditional midwives were oriented about the government's goal, which is for every mother to give birth with the help of a professional midwife/nurse or even higher professional in the future.

“We tried to create the awareness among the traditional midwives and that they should not give any delivery services instead they have to send pregnant women to health centers. We have reached to an agreement with the community people and traditional midwives to bring every pregnant woman to health institutions as soon as their labor starts. ” (HC)

“/.../As a result, there was a case when one traditional midwife brought about 16 pregnant mothers to us. Of the sixteen mothers four have given birth recently at the health center. Even though traditional birth attendants are not provided with other jobs, there are some incentives given to them such as trainings and priorities are given to them in such matters. ” (HC)

Some women also suggested the traditional practice of giving birth with traditional birth assistant to be abolished from the community. Instead the community women should have a safe delivery at health institutions health with health professionals' assistant.

“I think it is good if the traditional method of giving birth should be eliminated. The traditional midwives are not capable of solving most of the health complications that may arise in relation to the pregnancy or delivery. Thus, before such incidents occur and run erratically to health institutions to save life, it is much better to have a safe delivery at health center. ” (W2)

4.4. Strategic Setbacks

The strategic setbacks of the health program are presented as follows in form of sub themes.

4.4.1. Lack of Regulations

There are no regulations or rules set by the government for the community people concerning usage of health services. This has been one of the reasons for the women not to fully utilize the health services provided in the community.

“The community people have been provided with health services and are getting awareness and other aspects of the service. However, things are not conditional here. The community should be guided in a way that if it does something it will be rewarded, and if it doesn't do according to a regulation some benefits should be withheld.” (HC)

“/.../If these kinds of enforcing conditions were implemented, we would have every pregnant woman and mothers come to health centers for ANC, delivery, PNC, health education meetings etc. Thus, this program shouldn't have taken this long. They have been given too much of a choice.” (HC)

4.4.2. Lack of Coordination with District Administration

There is lack of cross-sectoral collaboration mainly with district administration office in mobilizing community people for health program activities. Much emphasis is given to the agricultural activities.

“Coordinated works are very low and yet health program involves improving the level of awareness of the community concerning health. In this regard the coordination with the district administration, to mobilize and educate, the community about health care activities, is very poor. The focus of attention is largely on agriculture.” (Gov2)

“If the mobilization of the people was enabled, we could have got very insightful ideas even from ten households. This will help to improve the health package, which in turn benefit mothers and children in particular, and the nation at large. At this stage we only discuss with one person at a time. HEWs have to visit every household.” (Gov1)

The health program is perceived as a separate program, by the district administration, from other government activities such as agriculture. In addition, in order to engage in any health activity the management expects payment. This is mostly because of the involvement of many NGOs in the health program.

“In most cases health programs are supported by NGOs. As a result, there is a tendency among the district management to label health activities as an isolated program. This highly affected the health program which in turn affected the community.” (Gov2)

“There is also a trend of seeking some kind of benefits (allowance) from our office (district health office) to undertake any activity related to health. This is because health issues are mostly addressed in collaboration with NGOs.” (Gov1)

4.4.3. Lack of Community Participation

The health strategy is designed at federal level based on the number of women and children in each cluster/village using the national population statistics. Neither the community people nor the health workers at grass root level have taken part in the designing of the health program. This has been a problem for the effective implementation of the strategy.

“For instance, some villages suggested the traditional ceremony (the community do when a woman gives birth) to be done at health institutions. This has been one of the reasons why many women refuse to utilize the health services provided. After having discussion with the community people in social gatherings, now we agreed that they could do their ceremony at the health institutions. With this, we were able to increase their number by more than 50 percent from that of last year.” (HC)

“/.../Last year, we provided delivery service only for 13 mothers in our health center. This year we have provided delivery service for 28 mothers within six months. If the health program had been designed with community participation including lower level health professionals, we would have known how to provide the health services before the implementation of the program” (HC)

4.4.4. Lack of Employees Incentives

The government health strategy does not incorporate any staff motivating mechanisms such as incentives in form of education, trainings and other motivating tools. This would help encourage the health professionals to be more committed to their duties in the health program.

“We make rounds in villages and we are providing health service for the community right where they live. For instance, we might not get extra pay after we travelled such a long distance. Our shoes wear-out; we get very tired and so on.” (HC)

“/.../The health strategy does not include motivating and work improvement tools. It only focuses on implementing the plans/strategies. If improvements are made in the area of short and long term trainings/education as well as other skill enhancing activities, I am sure that there would be an effective work because the professional will have the interest to work and fully engage in the program.” (HC)

Loss of interest in their work among HEWs and their frequent resignation are also hindering the ongoing MCH care activities. *“The community people are reluctant to hear what the HEWs educate. Many women do not put into practice what they have been taught unlike people from cities. Most of the community people tend to be occupied with their daily routines. As a result, there is high turnover of HEWs due to loss of interest in their job.”* (Gov1)

4.4.5. Lack of Training

Health extension workers are trained in midwifery only for normal deliveries. As a result of this, they are not able to provide complete service to the community people. This could cost a mother's life in villages where health centers are located in far distance. Thus, further training for health extension workers is very essential.

“All women have different types of physical appearances/physiology. Some of the women may have narrow vaginal opening as result they may need stitches. We are not qualified to do such minor operations. Though we refer the woman to health center, in villages where health posts are far away from health center the woman might die before getting the necessary medical help.” (HE2)

“HEWs have only a high school education until tenth grade and a one year additional training. Therefore, there is a high need to further enhance their capacity so that they can provide full medical support.” (Gov1,2)

Not all HEWs are providing delivery services at health posts. This has been one of the reasons affecting the successful implementation of the health program and impeding from fully addressing the needs of the community women.

“If all HEWs had started giving midwifery services at health posts, we would have achieved our goal by 100 percent. The women wouldn't have needed to come to the health center unless there is some kind of complication or it is beyond the capacity of health extension workers.” (Gov1)

Health professionals at health centers lack updated trainings such as VCT (Voluntary Counseling and Testing) and HMIS (Health Management Information System), which are essential to perform duties on job.

“HMIS is a new system which helps to gather data regarding health especially maternal and child care. There is no trained professional in HMIS. We try to do the work among ourselves via sharing experiences with one another and other health centers. (HC)

“We do not have a professional trained in VCT services. We do the task through the PMCT professionals helping one another.” (HC)

The government officials and health center manager do not have the necessary knowledge of ICCM that is very crucial to undertake their responsibilities effectively. *“We do not have the knowledge of ICCM. However, it is under our supervision.” (Gov1,2, HC)*

4.5. Challenges

The challenges encountered in the ongoing health program are presented as follows in form of sub themes.

4.5.1. Shortage of Supply

Some health centers do not have electricity and hence it is impossible to give laboratory services at those health centers. Laboratory service is very necessary to diagnose children with diarrhea, a pregnant mother with TB, and children under the age of five with TB etc., which are very critical health issues in the community.

“There is no electricity at two health centers found in our district. As a result, the laboratory equipment has not been functioning for a year even though the professional was in place. The health professionals normally come to the district town health center to work on these issues.”
(Gov2)

4.5.2. Male Domination

Lack of men's support is also a reason for why some women do not use health services, which is affecting the women's health as well as their children's.

“Those men/husbands with little education background motivate their wives to follow their pregnancy checkups regularly. On the other hand the uneducated husbands give their wives a bad eye every time they mention the issue. They just want their wives to stay at home for no reason” (W2)

Some women do not even get the permission from their husbands to attend any health education meetings. *“The men's pressurize their wives when they are called for health education meetings or trainings. The men say that there are lots of domestic chores to be done by the women. Thus, the men do not motivate/allow her to go.”* (Gov1)

“Some women even have pressure from their husbands not to use family planning/.../One in every ten husband cares for his wife's health.” (W2)

4.5.3. Long Distance to Health Facilities

The health centers/posts are not located in close proximity to all households in the community. Long distance to health center is still a problem to access health facilities for some community people residing in distant districts from the health center.

“For instance, ‘Gelila’ kebele is a four hour drive from where we are (where the health center located). It is very far away. Of the four hour road the 2 or 3 hours road is very steep. It will be hard to come from there to the health center. However, there is health post and two health extension workers assigned in the kebele.” (HC)

Accordingly, it has been difficult for some women to go to health center especially when they have labor. Hence, the women suggested the importance of preparing a place/house, where they can stay, around the health center as their date of giving birth approaches so that all women can have safe delivery.

“Everything concerning the health program is practical and very good. The little problem we have is a housing facility for pregnant women as our day of delivery approaches.” (W4)

“Most women follow up all the checkups throughout the pregnancy period. Nevertheless, at the end the labor may come unexpectedly. Many of the women worry about where they could stay around the health center even if they know their expected date of delivery. Thus, they decide to give birth at their house.” (W5)

4.5.4. Low Health Seeking Behavior

Despite the encouraging results that are being seen as a result of the health program, it is difficult to say the community is fully engaged in the ongoing health care activities. There is still reluctance from the community women to make use of the health services provided. The desired behavioral change, among the community people mainly women, has not been achieved yet particularly considering the longer period of the health program since its implementation.

“It has been seven/eight years since the health extension workers are hired. However, we are not able to complete the maternal/child health package and to bring the desired attitudinal or

behavioral change. There is still lack of awareness and the package is not yet fully understood by the community people.” (Gov2)

Some of the women are not able to talk about it now because they are not well aware of the situation since they do not attend health education meetings. They are very reluctant to let go of the traditional methods.” (H1)

“/.../By now, all the community women should have understood and make use of the maternal and child health services. We should even have family planning in every household.” (H2)

It has been difficult to change the perception of the community about medical follow-ups, traditional way of giving birth and its associated traditional practices. This has been causing a serious consequence on the health of mothers and children. *“The most challenging issue for us is communities understanding of medical checkups. The women think that they have to do ANC checkups only when there is an illness. Otherwise, they do not want to come to health institutions. It is also the same scenario for delivery as well. This has been and is still a huge challenge.” (HC)*

Some women are not yet ready to make use of the health services provided to them since they haven't had any complication with the traditional method of giving birth. *“I am not sure if I am going to the health center for ANC checkup or delivery if I get pregnant next time. I have not had any problem with the help of the traditional birth attendant.” (W1)*

“Now I am pregnant but I haven't been at health center for my ANC because it has been good with the traditional birth attendant.” (W3)

Furthermore, the women consider themselves 'healthy' and hence they did not need to see a health professional. *“There are some women that often get sick though I have never been sick. They say their body hurts and so on. But, I am healthy. That's why I gave birth at home to my sixth child too” (W1)*

“I have not had any prenatal checkup. I did not go to make checkups because I was not sick. There was no reason for me to go to the health institution for ANC or PNC.” (W3)

Some women do not consider the health program as important and beneficial at all. *“The problem is that some women themselves do not trust what is being given to them. Some women want to be like they were before and continue using traditional health care. There are also some women that complain and say ‘what we do doesn’t benefit them’ and insisting to go back to their daily routines.”* (Gov2)

There are significant number of women that do not go to the health center for checkups and delivery. One of the leaders participated in this study has also pointed out the following reasons for why those women are reluctant to be part of the health program and change their life styles. *“In my ‘one to five’ group there is one woman that has given birth recently at her home with the help of traditional birth attendant. This is because she hasn’t had any problem with either her pregnancy or delivery previously. There are others who think just like her”* (W2)

“There is a perception among the community people that once any woman has given birth to a baby safely in her house; they assume that the next pregnancies would also be delivered safely. This has created an enormous challenge concerning maternal and child health” (HC)

“When we tell them the benefits they would get from the health services, they would say it is not the health professionals that decide about their health or their babies but God. They are still trapped in the old ways.” (W2)

The other reason why the women choose traditional methods is due to un-satisfaction with the delivery services provided to them. *“Some of the women who went to health institutions to give birth told the other women that their legs were tied while in labor. Thus, the other women thought that they would not move as they want and some still prefer the traditional method which they think is comfortable and allows them to freely move.”* (W2)

It is still very problematic to minimize the role of traditional birth assistances. The community gives a special status to the traditional birth attendants and thus the women still use the services provided by traditional midwives. This has significantly contributed for horrific incidences of maternal mortality. *“The traditional birth attendants have a particular prestige in the community. Thus, it is very challenging for them to trade that prestige for another profession. Recently two*

mothers have lost their lives in relation to child delivery with the help of traditional midwife”
(HC)

“The first woman also died after she gave birth at her home with the help of traditional birth attendant. Soon after her legs started getting swollen and she became unconscious. The woman’s family took her to religious healing place called “Tsebel” however she lost her life. (HC)

“/.../The other woman gave birth at home with the help traditional midwife. However, the placenta wouldn’t have come out. Hence, they used the traditional method they call “mezekezek” to get rid of the placenta and this eventually led her to death.” (HC)

Chapter 5---Discussions

5.1. Discussion of Methodology

The health program of the Ethiopian government initiative is a countrywide strategy, which is being implemented throughout the country. However, the current study was conducted in only one district among the many projects that are functioning in the country. This is due to time and limited resources to collect additional data from other districts. Therefore, the results of this study cannot be generalized for the whole of health programs that are being undertaken in other parts of the country though this study could provide and serve as a basis for future similar studies.

5.2. Discussion of Findings

For this section of the study, the major findings of the current study can generally be summarized into two categories. The first is the positive outcomes of the empowerment initiative, which are witnessed in different ways in improving the health of mothers and children in the community. The second is the challenges and setbacks, which are encumbering the successfulness of the empowerment initiative. From each category the very most important sub themes shall be discussed as follows.

5.2.1. Positive Outcomes

The empowerment initiative in terms of access and quality of health services has been transforming the lives of many women and children in the district in improving their health status. Encouraging results are being observed. Many women and children have been able to make use of free health care which they would not be able to use otherwise.

5.2.1.1. Health Improvement/Control over Health

A tremendous result has been achieved in reduction of child mortality since the implementation of the health program. In particular the placement of HEWs in health posts has accelerated this enormous achievement as they provide vaccination and child growth follow up by making rounds in the villages and even in each and every household in the community. The community has also started witnessing a reduction in maternal mortality even though the achievements are not as satisfactory as that of improvements attained in child health.

The community has also started owning the health program activities such as child vaccination. It is very promising that community people are engaged in and have reached to the level where they follow up children's immunization in their villages. It is also very encouraging that even some traditional birth assistances have become part of the program and are working in educating community women to use health services for maternal and newborn/child care instead of traditional remedial care.

The underlying principle of empowerment for health promotion is to enable people to increase control, and to improve, their health. Even though empowerment as an approach varies based on whether it is the community or the health promotion agency that identifies the health problem to be addressed (WHO, 1986 Laverack, 2012). Empowerment as a goal is having the control over the determinants of one's quality of life (Tengland, 2008).

The health program has enabled the women to have control over their reproductive health and decide on matters that affect their health and life. It is observed that the women's ability to make informed decisions concerning their health issues is increasing from time to time and this to a great extent is helping to improve their reproductive/maternal health. Nowadays women are

deciding on the number of children they want to have and reducing harmful traditional practices that are endangering their health as well as their children. They are making a healthy choice of getting maternal and childcare at health institutions than traditional treatment.

5.2.1.2. Local Leadership and Organizational Structure

One of the very important domains of empowering community people to improve their health is enhancing local leadership via creating the opportunity where community selects their representative's (Laverack, 2009). One of the very interesting findings in this study is that the 'one to five' group leaders have been very prominent in creating awareness among community women about health care activities. The women have been able to freely discuss about their reproductive health issues among themselves. This has helped to increase the health service utilization by the women.

Organizational structure is a key feature of empowerment through strengthening organizational structures of community-based associations to be active in tackling the health problems of their community (Laverack, 2009). The involvement of community people such as men and leaders of the villages, through local associations, in the health program has been playing a great role in supporting community women to fully engage themselves in the program and utilize maternal and child health care services. This has indicated that the community people in general are becoming part of the empowerment initiatives and sense of ownership is growing gradually.

5.2.2. Strategic Setbacks and Challenges

Even though the above-mentioned positive outcomes have been promising, further effort is needed to make all the community women beneficiaries of the health program and to bring the desired improvements in women reproductive health and or maternal health. The health program lacks a key approach, which needs to be incorporated in the strategy and require considerable emphasis. It has been eight years since the health program started functioning in the community however the health program has not been able to fully address the health concerns of the community and to bring a sustainable result in regard to women health service utilization. The

following important points need considerable attention by the concerned government bodies and non- governmental partners that are working towards improving maternal and child health.

5.2.2.1. Bottom up Strategy

Involving the community on health care decision-making process (bottom up) is one of the core values of the Ethiopian HSDP nevertheless as the findings of this study indicated the empowerment initiative of the health program is by and large a top down approach (FMOH, 2005). The community people did not take part in the process of designing the health strategy program. The health strategy is designed by the government and other concerned partners using a top down approach. It was observed that the community people are playing mostly the recipient role in the implementation of the health program. Therefore, community participation should be given strong emphasis and needs to be incorporated as a fundamental part of the health strategy.

In conducting or facilitating empowerment health programs, throughout the process, there needs to be an equitable relationship between health promotion practitioners and community people and or other stakeholders by creating the atmosphere where all involved can be active participants (Laverack, 2009). An increase in fare participation starting from the community level to that of societal level is highly associated with health improvement (Beaglehole et al, 2004).

Health promoters should engage very closely with community people in identifying and prioritizing health problems and keep record of the learning outcomes of activities and accomplishments for future interventions. This is very crucial instead of using communities or groups as a means to achieve pre-set objectives. In order to achieve this, civil society associations such as church groups, cooperatives, interest groups, neighborhood associations etc can serve as a vital organizations where community people come together and discuss on matters of common concern that affect their health (Buchanan, 2000).

People's participation in the process that affects their lives is very fundamental to bring a real improvement and development (Macedowall, 2006). Community concerns have to be included in public health policies and programs in order to achieve a sustainable end result. Thus, public health researchers and practionioners must create the environment for close interaction with

community groups to have the opportunity to incorporate the voices of the community people (Beaglehole et al, 2004).

Active community people involvement in health program strategies is central principle in the Alma Ata declaration. It emphasizes on the right of people's participation both individually and collectively in the planning and implementation of activities that affect their health. It helps to improve the health and well being of a given community to a great extent (Segal, 1998; Beaglehole et al, 2004). Top down health promotion strategies tend to overlook active community participation and thus it is mostly dubious to be successful and to bring the desired improvement (Beaglehole et al, 2004).

Top down health promotion programs have a fixed and specific timeframe where health problems are basically identified by outside agent such as government. Its appraisal emphasizes on targets and outcomes. Health promotion programs are generally described by top down strategy. Top down strategies emphasis on the expert role and give less attention to the central role of community participation. Hence, it is highly recommended that top down programs should acknowledge and incorporate community people's active engagement in health promotion programs. This helps government agencies or government-funded NGOs to better deal with the major health concerns of a given community can promote health (Laverack, 2007).

In bottom up health promotion program however, the community plays a major role in identifying the health problem as well as running of programs through skill training. Its appraisal is mainly focuses on capacity building. The community is an active participant during the process of the health promotion program. In addition, the community is also entrusted for activities such as planning, report writing and evaluation (Laverack, 2007).

In one of the health centers where this study conducted 764 women are expected to visit health centers/posts annually to get the necessary maternal care. In other words 764 pregnant mothers should come to the health center to have ANC every year. In addition, these women are also expected to give birth and get PNC with the help of professional birth assistance.

However, the numbers of women who make use of these services are less than by 50% from the estimated figure. Significant population of the community women are not yet using the health

services provided rather they prefer the traditional/local medical care for pregnancy as well as ANC/PNC. The community people particularly women seem not to fully engage themselves in the ongoing empowerment programs that are in place to improve the community's maternal and child health.

The community women for so long have been having their ANC and as well as delivery and PNC with the help of traditional birth attendant. They have also been raising their children in same manner using their own traditional skills and what is culturally appropriate in the given community. This has been part of the women's life in particular and the community people in general. It is widely believed, among women, that it is appropriate to go to health institutions for birth assistance and pre/post natal checkups only if they encounter visible complications during birth (Wahed, 2009). Thus, it hasn't been easy for the community people to let that go and start using the health services provided in the community and to make a dynamic shift in their life. Community women's preference of having birth at home with traditional birth assistance is a deeply embedded cultural belief.

It is not a matter of providing free health care with qualified health professionals rather it is a question of providing the health facilities in the way the community people in particular women want it by taking culture and tradition into account. Having a good understanding of a given community and their perception of ill health should be given a greater emphasis than prioritizing provision of acceptable, accessible, and affordable health services to the community. Community participation and involvement in decisions that affect their health is a key to health promotion (Walleye et al, 2001). Empowerment for health promotion goes beyond provision of adequate and effective health improving services. It is a genuine participation and involvement of community people where their voices can be heard in matters that concern their health (Laverack, 2009).

Study conducted in rural Nepal has showed that the use of community participation and or participatory learning exercises in women's groups in a poor rural population in Nepal has brought a reduction in neonatal and maternal mortality (Manandhar et al, 2004). The women in the intervention clusters had antenatal care, institutional delivery, trained birth attendance, and more hygienic care, which contributed to an enhancement in birth outcomes. As a result of

group/community participation, the women were better able to define, analyze, and then, via the support of others, communicate and act on their health concerns regarding childbirth. The group participation strengthened social networks and improved social support among women and between women and health-services delivery providers (Laverack, 2006).

People's role in a given community is an important factor in determining their behavior and influencing their choices in matters that affect their health (Buchanan, 2000). Factors such as culture, upbringing, society, socio-economic status, etc., which are beyond the individual's control, should be taken into account in health promotion programs. This is since these factors by and large continuously shape and influence people's lifestyle (Holland, 2007). History, politics and the like play a significant role in influencing people's health directly or indirectly. Health promoting strategies should take such causative factors into account to effectively address the needs of a given community and to improve their health status. The empowerment approach enables health promoters to deal with the complex determinants of health concerns through engaging the resources and skills of community people and organizations (Israel et al, 1994).

Community participation has recently been incorporated in the ongoing health strategy by using the already existing social associations and role model women that are important communication channels in addressing other community women. This has helped the health professionals to identify the needs of community women and to include their needs as part of the ongoing health care provision. As a result of this, community maternal health service utilization has increased significantly. Thus, community participation should be further strengthened and need to be implemented in a well-organized way by providing the necessary training for the 'one to five' women leaders and local/social association leaders.

Health education and communication should also be given for community women on a continuous basis to reduce prevalent cultural perceptions, which are highly degrading the health status of women and children in particular and the community people in general.

5.2.2.2. Health Promoters Training

In the ongoing health program government officials and health center manager supervise an activity such as ICCM, which is mostly undertaken by health extension workers. However, the supervisors are not trained in such areas and thus hindering them from effectively undertaking their duties/affecting the supervision. Lack of essential trainings related to delivery has been a challenge and causing frustration among health extension workers. Lack of incentives such as skill enhancing trainings for health professionals has in some way resulted in negligence on job. This is creating a sense of disempowerment among health workers. Empowering those who work towards empowering others like community people, in different levels, needs to be taken into account and it has to be ensured throughout the implementation processes of the program.

5.2.2.3. Cross-Sectoral Collaboration

Women's preference of health facility delivery and birth assistance by trained birth attendant can be influenced by other determinants such as women's age, education, income, number of children and health seeking behavior (Ergano et al, 2012). In the current study education has also been the fundamental aspect for any women to be able to convince her-self to go to the health post or health center. Those women who attended elementary school are well aware of the negative consequences of harmful traditional practices such as giving birth at home with the help of traditional birth attendant. Integrated intervention is very crucial and highly recommended for sustainable implementation of the health program. Thus, it is very important to continue working in a better collaboration with other sectors like education and women's affair.

As stated in the 1978 Alma Ata Declaration on primary health care and successive reviews of primary health care reforms emphasis on inter-sectoral collaboration to deal with socio-economic determinants of community health. Ensuring universal access to health services is one of the components (WHO, 1978; WHO, 2008; WHO, 2008). In addition, health promotion is not only the responsibility of the health sector however goes beyond healthy life-styles to well being (WHO, 1986).

Lack of coordination with the district administration has also been one of the challenges to mobilize community people and discuss concerning the health program activities. Cross-sectoral

collaboration is very essential in ensuring community participation consequently coordination with other government bureaus such as the district administration is vital for successful achievements of the health program. This needs a coordinated effort from all the community members including leaders of the community. Collaboration with other sectors such as education (e.g. teachers) and agriculture (e.g. agricultural extension workers) is very crucial for health promotion (Walleye et al, 2001).

Chapter 6---Conclusion and Public Health Recommendations

The empowerment initiative has been promising to some extent in addressing the health concerns of women and children in Ethiopia. However, lack of bottom up health promotion strategies such as genuine community participation in the designing and implementation of the health program has greatly hindered the health promotion program from effectively improving the health status of women in the studied community. This is the major and very crucial finding of this study and the need of incorporating bottom up strategies in top down health promotion programs is a key for effective public health interventions. This is also a very important recommendation for future public health empowerment initiatives in promoting maternal and child health in countries like Ethiopia.

References

Argaw, H. (2007) The Health Extension Programme (HEP) of Ethiopia Summary of Concepts, Progress, Achievements and Challenges. WHO Ethiopia Country Office.

- Boyle, J. (1994). Style of ethnography. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp.159-185). Thousand Oaks, CA: Sage.
- Buchanan, D. R. (2000). *An Ethic for Health Promotion: Rethinking the Sources of Human Well-Being*. Oxford University Press, USA.
- Central Statistical Authority (CSA) (2000). *Ethiopia Demographic and Health Survey*. Addis Ababa.
- Central Statistical Authority (CSA), 2010. *Ethiopia Population Census and Housing Survey*. Addis Ababa.
- Creswell JW. (1998). *Qualitative inquiry and research design. Choosing among five traditions*. Sage publications, London.
- Datiko DG, Lindtorn B: Health Extension Workers improve Tuberculosis case detection and treatment success in southern Ethiopia. A community randomized trial. *PLoS One* 2009, 4(5):e5443. doi:10.1371/journal.pone.0005443.
- Demographic and Health Survey, 2005.
- Editorial, 1993. *Social Science Med.* Vol. 37, No. 12, pp. vii-viii, Great Britain.
- Ergano K, Getachew M, Seyum D, Negash K: Determinants of community based maternal health care service utilization in South Omo pastoral areas of Ethiopia. *J Med Medical Sci* 2012, 3(2):112–121.
- FDRE, 2005. Country Profile.
- FMOH, 2004/05, HSDP III, (HSDP I & II Overview)
- FMoE, 2010. Progress Report.
- FMOH. 2010. Health Sector Development Program IV (2010/11-2014/15) final draft.
- Federal Ministry of Health of Ethiopia: Health Extension Program in Ethiopia Profile. Addis Ababa: Health Extension and Education center. Ministry of Health; 2007.
- Federal Ministry of Health of Ethiopia: Essential Health Services Package for Ethiopia. Addis Ababa: Ministry of Health; 2005.
- Federal Ministry of Health of Ethiopia: Health Sector Development Programme III. Addis Ababa: Annual performance report, Ministry of health; 2010.
- Federal Ministry of Health of Ethiopia: Health Sector Development Program III (2005/6-2009/10). Addis Ababa: Planning and program department, Ministry of Health; 2005.
- Geertz, C (1973). *The interpretation of cultures*. New York: Basic Books.

- Glaser, B.G., AND Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine.
- Glenn Laverack. (2012). Global Health Promotion. Where are the champions of global health promotion? Vol 19(2): 63–65. SAGE Publications.
- Glenn Laverack. (2009). *Public Health: Power, Empowerment and Professional Practice*, Palgrave Macmillan.
- Glenn Laverack (2007). *Health Promotion Practice : Building Empowered Communities*. Buckingham GBR, Open University Press.
- Glenn Laverack. (2006). Improving health outcomes through community empowerment: A review of the literature. 24(1): 113-120.
- Glenn Laverack. (2000). A planning framework for community empowerment goals within health promotion. 15(3): 255-262. Oxford university press.
- Hinds, P.S, Chaves, D.E, and Cypess, S.M. (1992). Content as a source of meaning and understanding. In J.M. Morse (Ed.), *Qualitative health research* (pp.31-49). Newbury Park, CA: Sage.
- Israel, Barbara, Checkoway, Barry, Schulz, Amy, Zimmerman, Mark(1994), Article "Health education and community empowerment and measuring perceptions of individual, organizational and community control" *Health Education and Behavior*.
- Janice M. Morse and Peggy Anne Field. (1995). *Qualitative research method for health professionals*. Sage publication, USA.
- Jennie Naidoo and Jane Wills. (2000). *Health promotion: foundations for Practice*, second edition Harcourt Publishers Limited.
- John walleye, John Wright, John Hubley Edited by John walleye, John Wright, John Hubley(2001), *Public health: an Action Guide to Improving Health in Developing Countries* Oxford University Press.
- Kellie Moss, Allison Valentine, and Jen Kates, with assistance from Kim Boortz and Adam Wexler. (2010). U.S global health policy. The U.S. government's efforts to address global maternal, newborn, and child health: *The Global Health Initiative and Beyond*.
- Labonte R. 1994. Death of program, birth of metaphor. In: Pederson A, O'Neill M, Rootman J (eds). *Health promotion in Canada*. Toronto: W.B. Saunders, pp.72-90.

- Lars Dahlgren, Maria Emmelin and Anna Winkvist. (2007). *Qualitative methodology for international public health*. Print och media, Umea University.
- Leonie Segal. (1998). *The importance of patient empowerment in health system reform*.
- Macdowall, Wendy, Bonnell, Chris; Davies, Maggie(2006), *Understanding Public Health: Health Promotion Practice*. Buckingham, GBR: Open University Press.
- MoFED, 2008 Macro economic development report.
- MoH (2007) *Guidelines for Health Extension Programme*. Ministry of Health, Ethiopia.
- Robert Beaglehole and Ruth Bonita(2004), *Public Health at the CROSSROADS, Achievement and prospects*, Second Edition, Cambridge University Press.
- Sanday P. R. (1979) *The ethnographic paradigm(s)*. *Administrative Science Quarterly* 24, 527-533
- Silverman, D. (2010) *Doing Qualitative Research. A practical Hand book*. Third Edition. London: Sage Publications.
- Spradley J. P. & McCurdy D. W. (1972) *The Cultural Experience: Ethnography in Complex Society* Science Research Associates Inc., Chicago.
- Spradley, J.P. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Stephen Holland. (2007). *Public Health Ethics*. Polity Press, Cambridge, UK.
- Stevenson HM, Burke M. 1992. Bureaucratic logic in new social movement clothing: the limits of health promotion research. *Canadian Journal of Public Health* 83(Suppl.1) S47-53.
- Tengland Per-Anders. 2008. *Empowerment: A conceptual discussion*. 16:77-96.
- The Lancet, "Women: More than Mothers," editorial, Vol. 370, Issue 9595, October 13, 2007, p. 1283.
- The World Bank (2004). *Public Expenditure Review (PER)*, Addis Ababa.
- UN, *The Millennium Development Goals Report 2009*, 2009,
www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf.
- UNDP. (2011). *Human Development Report*.
- UNICEF, *State of the World's Children 2010: Statistical Tables*, November 2009,
http://www.unicef.org/rightsite/sowc/pdfs/statistics/SOWC_Spec_Ed_CRC_Statistical_Tables_EN_111809.pdf.
- UNICEF Ethiopia. (2011). *Factsheet Health*.

Vidich, A.J, and Lyman, S.M. (1994). Qualitative methods: Their history in sociology and anthropology. In N.K. Denzin and Y.S. Lincoln (Eds), *Handbook of qualitative research* (pp.23-59). Thousand Oaks, CA: Sage

Wahed T: Beyond the inception phase of the birthing centers: acceptance within the community. Manoshi Research Brief. Dhaka, Bangladesh: ICDDR and BRAC; 2009:2.

World Bank Development Data & Statistics online database. Available at:
<http://go.worldbank.org/1SF48T40L0>

WHO, *World Health Report 2006: Working Together for Health*, 2006,
http://www.who.int/whr/2006/whr06_en.pdf.

WHO. 1978. *Declaration of Alma Ata*. Geneva: World Health Organization.

WHO. 1986. *Ottawa Charter for Health Promotion*. Geneva: World Health Organization.

WHO. 1992. Sundsvall Statement on Supportive Environments for Health.
http://www.who.ch/hpr/Textfiles/Sundsvall_English.html.

WHO. 1998. The Jakarta Declaration on Leading Health Promotion into the 21st Century.
http://www.who.ch/hpr/WHO_HPR_Web_Site/declare.htm.

WHO, 2010, World Health Statistics

WHO, “Maternal Health,” webpage, http://www.who.int/topics/maternal_health/en/.

WHO, *World Health Report 2005: Mothers and Children Matter – so does their health*,
http://www.who.int/whr/2005/whr2005_en.pdf.

World Health Organization, United Nations Children’s Fund: Report of the International Conference on Primary Health Care. USSR: Alma Ata; 1978:6–12.

World Health Organization: Report on the review of Primary Health Care in the African region. Brazzaville, Republic of Congo: WHO Regional Office for Africa; 2008.

World Health Organization: The world health report 2008: Primary health care now more than ever. Geneva: World Health Organization; 2008.

Yegomawork Gossaye, Negussie Deyessa, Yemane Berhane, Mary Ellsberg, Maria Emmelin, Meaza Ashenafi, Atalay Alem, Alemayehu Negash, Derege Kebede, Gunnar Kullgren, Ulf Hogberg. 2003. Butajira Rural Health Program: *Women’s Health and Life Events Study in Rural Ethiopia*. The Ethiopian journal of health development *Official Journal of the Ethiopian Public Health Association*. 17(2)1021-6790. <http://www.cih.uib.no/journals/EJHD>.

Appendices

Appendix I

Interview Guide

For community women, men and community based organization leaders

What is your educational background?

What is your occupation?

Who is the breadwinner of the family?

How do you describe your and your family and or community health situation/status?

How did you come into contact with the project?

How do you understand the purpose of the project?

How would you describe your living condition before and after your involvement in the project?

What could have been done to improve the project?

For staffs (health care professionals, government officials etc)

What is your role in the project?

What is your educational background?

How do you understand this project that you are part of?

Do you consider the project as successful/unsuccessful? Why/Why not?

What could have been done to improve the project? How?

Appendix II

Informed Consent

Dear Informant!

It is known that you have participated in Ethiopian government empowerment initiatives i.e. Making Pregnancy Safe and Safe Motherhood.

My study will investigate and analyze the effectiveness of the strategies used in the project i.e. Making Pregnancy Safe and Safe Motherhood initiatives in improving/promoting maternal and child health in Ethiopia/Africa.

I would like to ask you to participate in either focus group discussions and or in an interview or both. It may last for an hour or more. The meetings will be recorded with a voice recorder and the researcher will take notes. Your information will be confidential and you will be made anonymous in the resulting study. You can withdraw from the study at anytime without explanation.

Signatures Informant

Signatures Researcher