



How to improve maternal health service utilisation in Ethiopia

Maternal health in Ethiopia

In Ethiopia, as in many other low-income countries, maternal morbidity and mortality is unacceptably high. Due to this high burden and its grave consequences, maternal health is one of the top priorities in the national health agenda, thus receiving the most attention.

Guided by global health initiatives and with support from the international community, Ethiopia is implementing the primary health care model to improve access to basic maternal health services. However, utilisation of maternal health services along the full cascade of maternity care (family planning, safe abortion, antenatal care, institutional delivery, and postnatal care) is low due to socio-economic, cultural, and structural barriers.

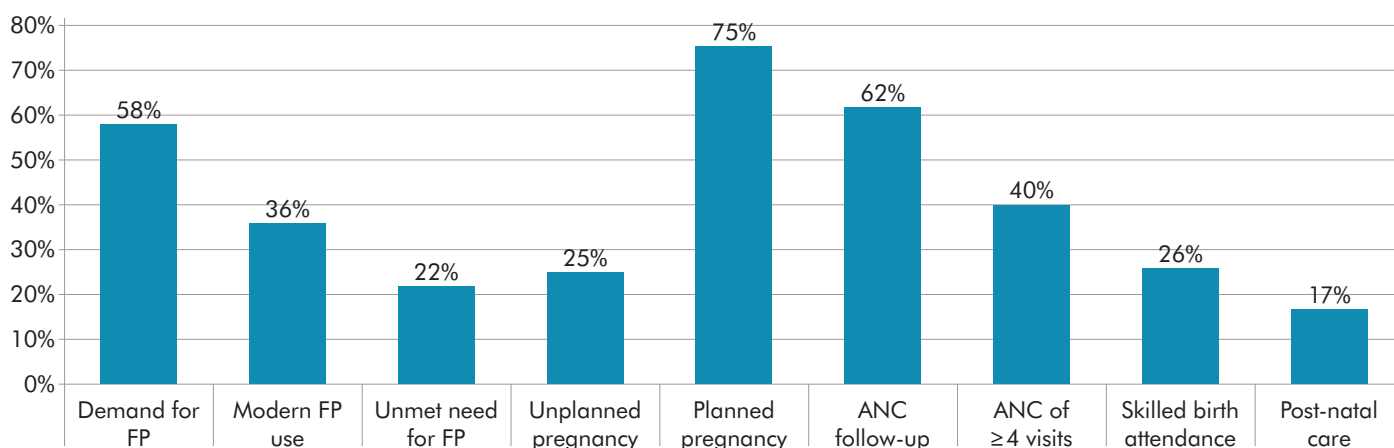
Underutilisation of maternal health services

According to the Ethiopian 2016 demographic and health survey report, total demand for modern family planning is 58 per cent, while family planning use is 36 per cent. This results in an unmet need of 22 per cent. Additionally, a quarter of women had unplanned pregnancies (8 per cent unwanted, 17 per cent mistimed). Among pregnant women, 62 per cent attended antenatal care (ANC), of which 32 per cent achieved the WHO recommendation of four ANC visits. Skilled birth attendance was also low with only 26 per cent of pregnant women giving birth in a healthcare facility. Above all, post-natal care was too low at 17 per cent (See Figure 1 below). A review of 76 quantitative and 16 qualitative studies was carried out to summarise the reasons for underutilisation of maternity care. The current issue brief presents the key facilitators and barriers to maternal health service utilisation in primary care in Ethiopia that were identified in the review.

Priority actions

- 1 Raise community awareness about the availability and benefits of maternal health service utilisation.
- 2 Improve the quality of healthcare delivery in all its dimensions.
- 3 Put in place a functional 24 hour ambulance service, that women can also use after delivery.
- 4 Ensure gender equality and women's empowerment to improve women's socio-economic status and their autonomy for decision-making.

Figure 1. Key findings along the cascade of maternal healthcare, EDHS 2016



Key findings

Facilitators of maternal health service utilisation

- 1 Individual-level: maternal education; having a regular income or occupation; women's autonomy for decision-making; and exposure to mass media.
- 2 Community-level: active support from community health workers or volunteers.
- 3 Facility-level: low-cost maternity care; access to quality healthcare delivery; availability of ambulance services or trained health workers.

Barriers to maternal health service utilisation

- 1 Individual-level: financial constraints associated with indirect costs; being unaware of service availability; self-reported distance from a healthcare facility; previous bad experience at the healthcare delivery; and self-discrimination associated with unplanned pregnancy.
- 2 Community-level: community's perception that pregnancy and delivery are natural events, which do not require medical attention, and local traditions or rituals, that promote home delivery.
- 3 Facility-level: poor quality of healthcare delivery; shortage of well-trained staff; lack of essential medicines and equipment; lack of, or poorly functioning ambulance services during the night time or after delivery; and disrespect or humiliation of women by healthcare providers.

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Implications

Despite improved access, low utilisation of maternal health services is evident in the entire cascade of maternity care. The government's decision to avail basic maternal health services at low cost (fee exemption) was indispensable to respond to women's concerns. However, indirect costs associated with medical supplies and laboratory investigations, and lack of ambulance services during night-time or after delivery require attention.

Improving access and quality of healthcare delivery in all its forms or dimensions may also need to live up to the community's expectations.

This might include:

- The expansion of caring, respectful and compassionate care.
- Improving client-provider relationship.
- Availing technically competent health workers.
- Ensuring continuity of care along the full cascade of maternity care.
- Ensuring essential medicines and services are available at all times.

Community conversations may be needed to communicate health information, to improve awareness about service availability and its benefits, and to correct misperceptions. Finally, it is necessary to ensure that gender equality and women's empowerment come up-front to strengthen women's socio-economic status and to improve their autonomy for decision-making.

Key references

Central Statistical Agency (CSA) [Ethiopia] and ICF (2016), Ethiopia Demographic and Health survey 2016, CSA and ICF: Ethiopia and USA

CREDITS

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