EDITORIAL

Reinvigorating maternal health service delivery in Ethiopia

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Introduction

Maternal mortality is one of the major public health concerns in Ethiopia despite the government's consistent proactive measures. Scores of women are still dying in the country in connection with obstetric complications of hemorrhage, sepsis, obstructed labor, hypertensive disorders of pregnancy. Recent estimates reveal that maternal mortality has declined by 72%, from 1250 to 353 per 100,000 live births during the period 1990 to 2015. Yet, the rate is still one of the highest in the world (1).

The Federal Ministry of Health (FMOH) has introduced multi-pronged approach to reduce maternal and newborn mortality by improving awareness, access to services and building the capacity of health facilities. Such measures however are not commensurate with the multitudes of factors at individual, community, and facility levels that are operating in tandem in keeping maternal mortality and morbidity daunting (2,3). Hence, the deployment of HEWs in all kebeles in Ethiopia since 2005 has targeted 18 packages of the Health Extension Program including selected curative services (4)

Undoubtedly, the introduction of HEP has resulted in improved ANC attendance. Thirty-two percent of women were reported to have made at least four antenatal visits during her pregnancy, an increase from 10 percent in 2000 (5). This is quite an accomplishment. However, such improved ANC attendance did not translate in to corresponding proportion of women delivering in health facilities assisted by skilled providers, which is staggering below 15% (6). This figure may have doubled from yet unofficial EDHS 2016. Still, large majority of women deliver at home without skilled assistance. Anonymous reports documented distance to the nearest health facility, sudden onset of labor, failure of prior preparation for labor and delivery, health professional's maltreatment of women looking for healthcare services and on the other hand, the friendly home setting and close assistance by neighbors and relatives as factors encouraging women to deliver at home.

In connection to this, there are limited but useful studies that cast doubt on whether community members in general and women in particular are convinced about the use of available maternal health services (3,7). In the design of interventions at community level, local discourses such as: pregnancy as normal state of marital life, values bestowed to privacy and concerns to open oneself up to young providers, competing responsibilities at home and requirement of regular visit to health facility, waiting away from home and concern over children and livestock back home are critical elements that may shape programming.

The 'heavy-handed interventions' at community level by HEWs, women development army, one to five networks, as well as local leaders may have contributed to reported gains. However, it is not clear if programmers and implementers are sensitive to local discourses as implications to interventions and sustainability. Here, the important question is: "Are women convinced to make use of available maternal health service or are they compelled to do so by frontline health workers and local structures irrespective of their interest?" It is also wise to ask on what would happen to the gains over the last few years when the unprecedented 'control' over pregnant women to ensure use of maternal health service is not there. Perhaps ethnographic studies may help to ascertain on how maternal health service delivery is promoted; organized, utilized and how local community would like to organize and sustain maternal health service utilization.

Among the several investments to reduce maternal mortality, bridging potential delay to reach health facility in time is just one. Establishment of maternal waiting homes is considered the best solution to ensure timely intervention by keeping women at risk around health facility before their due date. In Africa, this initiative dates back to 1950's when Nigeria

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developed maternity waiting places adjacent to district hospitals. Due to its positive impact in addressing access related concerns, this initiative has been adapted and is operational in a number of Sub-Saharan African countries (8). In Ethiopia, maternal waiting home has been implemented for over three decades and now the government is taking more proactive measure to avail such homes close to health facilities (9). Currently, complementing community level endeavors, maternity waiting homes are widely spreading in the country to increase institutional delivery assisted by skilled providers. One of the articles in this journal paid attention to the situation of maternity waiting homes initiative in Ethiopia where challenges were highlighted with useful recommendations. It is yet critical to document if women as well as the family would take such initiative positively, given especially children and livestock who remains back at home is a source of concern for the family particularly women. Perhaps this is another area of future research to provide an insight on how maternity waiting homes are received by the community and considered by potential users in cross-cultural settings. Such initiative could bring about desired results if local contexts are taken into consideration and local people have a stake in the initiative and assume ownership.

The other one of the papers in this issue highlights the fact that every community has health care resources within their grip as an alternative option. Local community members make choices on the use of available health care resources at community level based on the type of problems encountered. The paper argues that if integrated, modern and local health care resources may facilitate improved health care at community level. The paper shades light on the fact that there are still useful resources at community level that need to be explored, developed, and utilized to reduce maternal mortality in Ethiopia.

It is not clear if available resources are tapped enough to complement the already tireless endeavors, nor if it is known on how much resources are available in cross cultural settings. Among several local traditional health care services, traditional birth attendance continues to play major role in maternal health care although this resource remains outside the 'modern' health system (10, 11).

Thus, meaningful contribution to maternal health programs and decreasing the already precarious maternal mortality requires bridging boundaries between local wisdom and modern resources. Maternal health care initiatives could benefit from conscious attention paid to local socio-cultural contexts and resources in the design of programs. Besides, sustaining successful maternal health program requires proper awareness by the public and clients with a due focus on its components and what these mean to them as an individual mother and the community at large. Ownership of initiatives by the community is largely affected by such conviction. The fact that Ethiopia is a country of multiple cultures, it is critical to contextualize every initiative to every culture instead of assuming every program fits well to one particular culture. Furthermore, defining barriers and how community would be able to address such barriers may as well facilitate successful outcomes.

From the preceding argument, exploring available local resources for health care in general and improved maternal health care in particular, developing and accommodating such resources, avoiding one-size fits approach would optimize opportunities and improve maternal health. Although there are a number of research outputs on maternal health, the use of these for improved programming remains grey area. Tracking new initiatives, generating evidences on how interventions roll, identifying gaps and revising programs as deemed necessary would help reinvigorate maternal health response in Ethiopia.

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