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ETHIOPIA: DEMAND CREATION FOR MATERNAL, NEWBORN & CHILD HEALTH

Background

To deliver on its commitment to end preventable newborn deaths, the Government of Ethiopia has scaled up Community-Based Newborn Care (CBNC).[1] Appropriate illness recognition and careseeking for newborn and childhood illnesses in Ethiopia have been low despite increasing service availability, contributing to high neonatal and child mortality rates. Sustaining CBNC requires a strategic demand-creation approach based on understanding the barriers to care-seeking as well as social norms and beliefs. An evidence-based, demand-creation strategy, when applied through a systems strengthening approach, can improve health-seeking behaviour and MNCH service uptake.[2]

In 2014, Saving Newborn Lives (SNL), in partnership with the Federal Ministry of Health (FMOH) and local and international partners, developed a demand-creation strategy for maternal, newborn and child health/community-based newborn care (MNCH-CBNC) services. The design process included a desk review of global and local experiences related to demand creation for MNCH-CBNC, consultative workshops, cross-learning visits, and a MNCH-CBNC demand-creation design workshop for key FMOH and MNCH-focused organisations. From 2015 to 2017, Save the Children, USAID, and UNICEF worked in 21 zones across four regions to integrate the demand-creation strategy into existing government CBNC delivery platforms.

The strategy had three objectives:

1) Create enabling social norms that support appropriate MNCH-CBNC behaviors.
2) Improve MNCH-CBNC-related household practices and norms.
3) Increase timely careseeking for maternal and newborn illnesses.

Recently delivered mother and baby who benefited from the project in Gimbichu Woreda

Creating demand for service uptake for MNCH-CBNC in Ethiopia

Demand-generation strategies are used to sustain service uptake and complement the scale-up of supply-side approaches to existing health systems. In Ethiopia, demand generation is not yet recognized as an integral part of health systems and service-delivery thinking. However, it is increasingly understood as an important component for FMOH and its MNCH partners to consider. "Demand generation" is a marketing term used here to mean targeted promotion of careseeking to drive awareness and uptake of services and products. There is good evidence that well-planned and well-resourced demand-generation strategies are effective in various health areas. Demand-generation strategies that go beyond individual promotion of careseeking and include community support for household behavior change have a better chance for lasting change in service uptake.

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The Demand-Creation Strategy for MNCH-CBNC

The Demand Creation Strategy for MNCH-CBNC works to address barriers to families for appropriate careseeking and for improved newborn care practices.[3] It promotes cost-effective, sustainable interventions that empower communities to take collective action; facilitate increased demand for and access to MNCH-CBNC services; and improve family MNCH-CBNC-related practices.

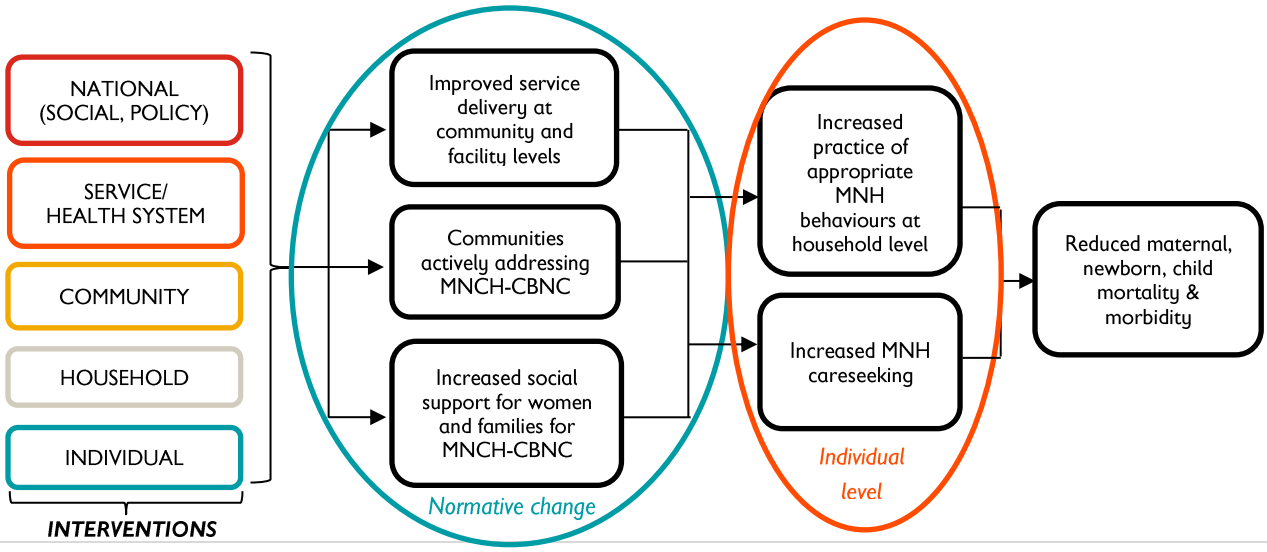
The aim of the strategy is to increase demand for services and careseeking behaviour – as opposed to the more commonly used community mobilisation campaign approach of raising awareness about an issue or persuading people to participate in activities that others prioritised and planned. Save the Children developed the strategy in order to 1) help communities understand MNCH-CBNC practices, beliefs, and attitudes; 2) invite and organise participation of those most affected and interested in MNCH-CBNC to explore, prioritise, plan, and act together; and 3) monitor and evaluate their progress The strategy outlines how to support individuals closest to the newborn to reinforce behaviour change and to improve family demand for services. Individuals include (initially) women/mothers, fathers, grandparents, families, friends, and neighbours; and those who influence and enable decision-making such as trusted community networks, mothers-in-law, grandparents, trusted elders, religious and spiritual leaders, and influential community leaders.

The strategy encourages the implementation of a combination of community empowerment approaches. These include:

- Strengthening kebele command posts
- Supporting pregnant women's conferences
- Encouraging teamwork for demand creation and service delivery
- Actively engaging men and other decision-makers in families
- Using multiple communication channels
- Using community-based data for decision-making
- Creating an enabling environment at community and facility levels
- Promoting a non-delivery role for traditional birth attendants
- Offering family-friendly health services and matching demand with quality services
- Building and linking community social networks

Central to the success of the strategy is strengthening the kebele command post (KCP) role and capacity to explore, plan, and act together for improved MNCH-CBNC. This requires support from woreda cabinets, woreda health offices, health centre performance review teams (PRTs), health posts, and civil society partners, including faith-based groups. A conceptual framework (Figure 1) illustrates how social norms and individual practices will be improved to reduce mortality and morbidity. Applying interventions at multiple levels creates an enabling environment by improving service delivery; supporting active community engagement; and increasing social support for women and their families. As a result, individuals make positive changes in MNCH household behaviours and increase MNCH careseeking.

Figure 1: Conceptual framework of the demand-creation strategy for MNCH-CBNC



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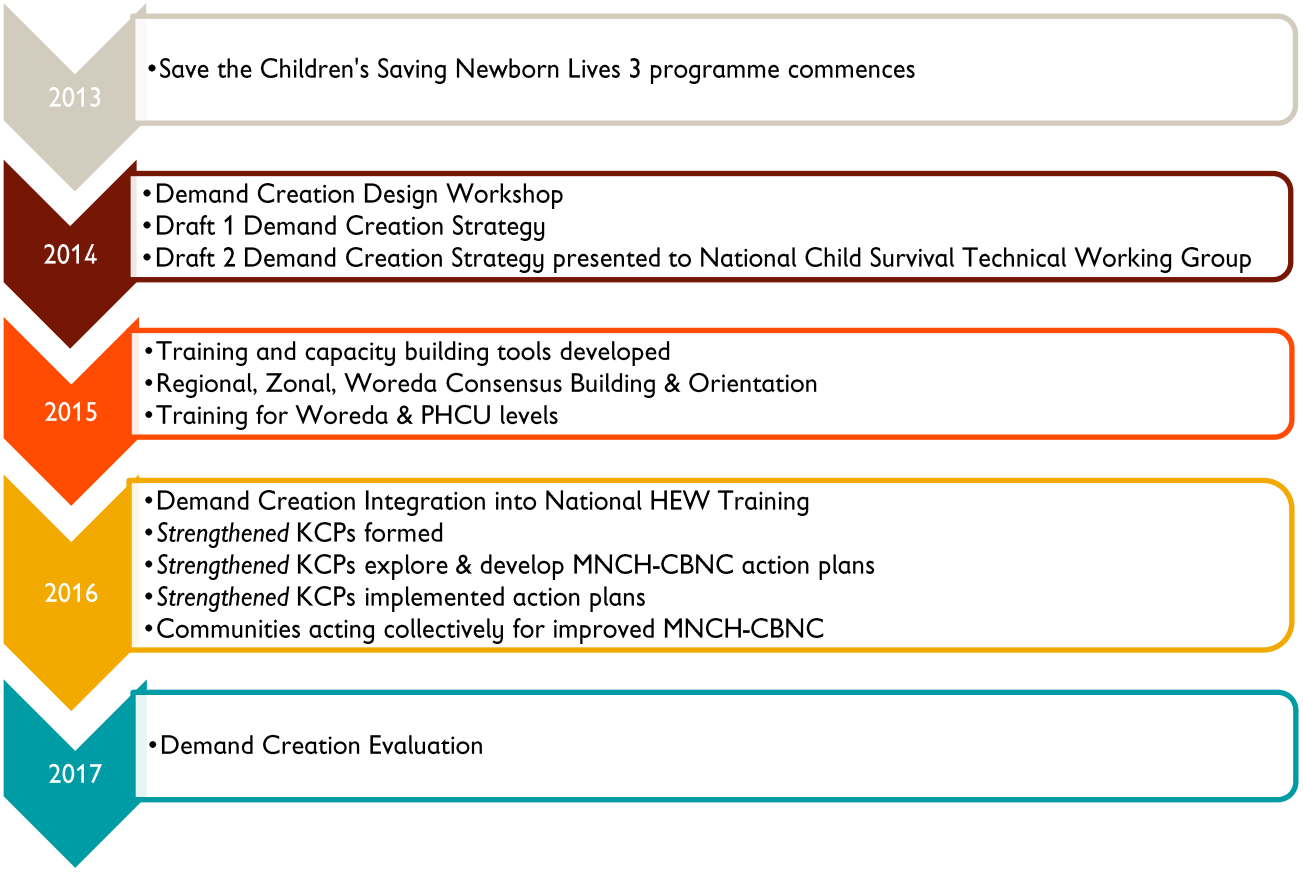
Implementation Process

With the support of FMOH, Save the Children implemented the Demand Creation Strategy for MNCH-CBNC[3] through existing health systems, including the government's Health Extension Programme (HEP) delivery platforms comprising health extension workers (HEWs), the Women's Development Army (WDA), zonal and woreda health offices, primary health care units (PHCUs), and communities. To foster ownership and a common vision for demand creation, orientation and basic training were provided at the start of the process to key regional and zonal woreda and PHCU health stakeholders and other administration officials, including cabinet members. An MNCH-CBNC Demand Creation Training Package[4] supported implementation of the strategy by providing guidance on how to strengthen the capacity of FMOH zonal, woreda, PHCU, and community partners to implement community-empowering demand-creation approaches. Figure 2 shows the timeline of the implementation process.

A mother-in-law and baby who benefited from the project in Gimbichu Woreda

Figure 2: Timeline of strategy development, implementation and evaluation

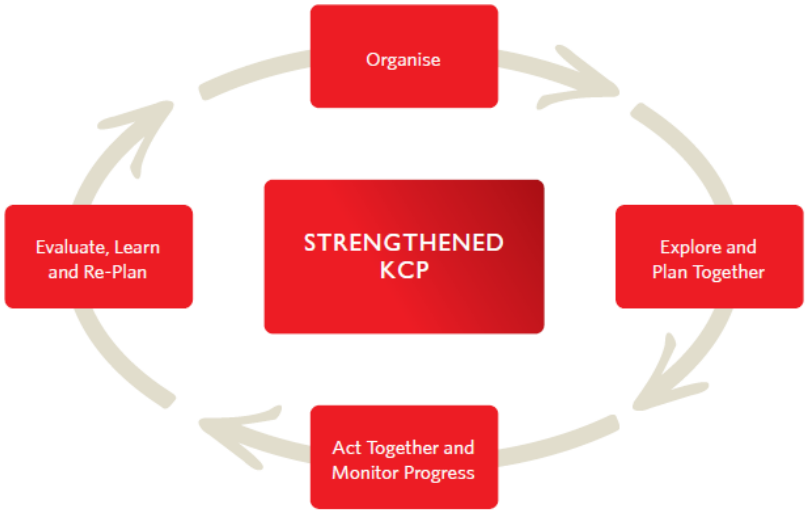


By level, Save the Children undertook the following activities:

- **Federal level**: At the national level, sensitization activities ensured ownership of the activities by FMOH and key stakeholders. A *Demand Creation Orientation Guide for HEWs* was developed and integrated into the CBNC training package in areas where Save the Children supported implementation of CBNC. This was done to build understanding and consensus about MNCH-CBNC demand-creation activities to all HEWs.
- **Zonal and woreda levels**: At the zonal and woreda levels, emphasis was placed on creating understanding and ownership over the MNCH-CBNC demand-creation process and promoting a balance of service delivery and demand-creation interventions in the planning and budgeting process. Save the Children conducted a three-day demand-creation workshop with zonal and woreda health offices and other administration officials, including cabinet members and PHCUs. The workshop oriented participants to key MNCH-CBNC demand-creation approaches and strategies, including how to plan, budget, and monitor implementation.
- **PHCU level**: In PHCUs, the PRTs were expanded to include representative staff working on MNCH-CBNC. The more fully representative expanded PRT was able to more effectively plan, implement, and monitor MNCH-CBNC demand creation efforts in their geographical area. A series of six Supportive Supervision Guides and Helpful Tools were eveloped to assist PHCUs in the step-by-step implementation of MNCH-CBNC demand creation strategies with their community partners. These were woven into ongoing systems and functions of PRTs. Woreda health offices used these guides to train PHCU PRTs.
- **Community level**: At the community level, Save the Children focused on building capacity and linking the existing community groups and networks for improved MNCH-CBNC. This involved KCPs, faith-based organizations (FBOs) and other key community groups. Understanding community leadership structures (formal and traditional), decision-makers, and gender and power relations underpinned implementation. As the PRT rolled out the demand-creation strategies to the community level, a strengthened KCP was formed of those individuals most interested in MNCH-CBNC. The strengthened KCP averaged 15–20 members. Key to the effective functioning of this group was ensuring a gender balance so that voices of women were equitably represented. The demand-creation strategy applied a stepwise, community-strengthening process to help communities organize, explore, plan, act together, monitor progress, evaluate, and learn (Figure 3). A Community Partners Guide for Demand Creation was developed to provide user-friendly tools to apply each stage of a community action process.

  All tools developed and used in the implementation process are available online at www.healthynewbornnetwork.org/resource/demand-creation-mnch-cbnc-ethiopia

Figure 3: Stages of the community strengthening and mobilisation process for MNCH-CBNC



Community action cycle adapted from Save the Children & Health Communication Partnership. 2003. How to Mobilize Communities for Health and Social Change Guide.

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Strengthening Implementation through Adaptive Management

Midway through implementation of the demand creation approach, a most-significant-change (MCS) process was applied as an adaptive management tool to allow local partners to reflect on the process, adjust strategies where necessary, share learning, and build local ownership. MCS is a qualitative, participatory methodology used to monitor and evaluate programs.[5] The process involves the collection of stories of change from a wide range of people at various levels where a project was implemented, followed by the systematic selection and prioritization of the most significant stories by designated stakeholders and staff based on criteria they determine. Through the criteria setting and story selection, MSC allows stakeholders to input their values and subjective attitudes towards what constitutes significant change in a program, reflect on what is working, and address challenges as the program evolves. This methodology "delivers a rich picture of what is happening, rather than an overly simplified picture where organizational, social and economic developments are reduced to a single number".[5]

The process was facilitated by an external consultant, an anthropologist who visited selected sites in all three SNL zones and conducted discussions with stakeholders, including mothers, mothers-in-law, husbands, KCP members, PHCUs, woreda and zonal health authorities, and program staff. The results of discussions were validated in workshops that brought together members of the MNH community and those involved in demand-creation activities. There were a number of lessons learned and gaps identified that informed implementation practice, including the need for continual mentoring, refresher training, and tools to evaluate performance. Specifically, the MSC process suggested that the range of demand-creation approaches outlined in the MNCH-CBNC Demand Creation Strategy fostered improved linkages between PHCUs and communities, advanced the institutionalization of demand creation into the health system, and created a sense of ownership and commitment by communities and government partners to improve MNCH-CBNC outcomes.

Key lessons identified through the Most Significant Change process

- Working hand-in-hand with government stakeholders at the zonal, woreda, and PHCU levels allowed partners to advance their capacity to use the qualitative MSC monitoring tool to reflect on learning and improve implementation. The MSC process supported cross-learning at multiple levels of the health system, through Woreda/PHCU Partner Reflection Workshops where Woreda and PHCUs applying effective demand creation approaches shared implementation to practice.
- Improved collaboration and learning was demonstrated by allowing government partners to jointly assess and address gaps in their MNCH-CBNC demand-creation approaches.
- Overall the program had limited time to implement demand creation approaches, hindering the original plan to apply the MSC adaptive management process twice per year and the ability to regularize the process and tools for ongoing cross-learning.
- Additional time is required during the MSC process to allow for partner to adequately define and rank significant change. Political instability and disease outbreaks was a barrier to applying the MSC tool effectively in certain geographical areas.

"Strengthening the KCP was recognized by all discussants *as the most important part of the DC strategy and its contribution, especially the contribution of its newly added members, in bringing about significant change in terms of uptake of available MNCH services."*

- Discussants at ZHD, East Shewa

"*Mainly as a result of the DC strategy, massive awareness is created among communities."*

- PHCU discussant, Gurage

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Evaluation Results

An evaluation using qualitative and quantitative data was conducted to answer two primary questions:

1. To what extent did the package of demand-creation activities contribute to a change in the enabling environment at household, community, and health facility/system levels (i.e., normative change)?
2. To what extent did the demand creation activities contribute to a change in MNCH-related careseeking and household behaviors (i.e., individual change)?

The study employed an embedded multiple-case study design.[6] Qualitative data were collected using 1) key informant interviews with zonal and regional Save the Children staff and HEWs; 2) in-depth interviews with women who had given birth in the last three months; 3) group interviews with woreda officials, project staff, PRT members, and HEWs; 4) focus-group discussions with fathers, mothers-in-law, KCP members, and HDAs; and 5) illness narratives with mothers and families. A cross-case analysis of the case studies revealed similarities and differences between low- and high-implementation strength kebeles. To measure implementation strength, a set of 14 criteria were set, with each KCP receiving one point for each criterion if they did not accomplish the implementation task. Criteria considered issues such as engagement of key stakeholders in demand creation, organizational strength of KCPs, and community collective action related to the community action cycle.

A score of 6 or less was considered high implementation strength, and a score greater than 6 was considered low implementation strength. For the secondary data analysis, selected data extracted from registers at health centers and health posts in the four sampled kebeles were analyzed to determine whether service utilization changed over time between low- and high-implementation strength kebeles.

The evaluation showed that the strategy has potential to contribute to maternal, newborn, and child health including:

- changed attitudes toward harmful traditional practices
- increased male involvement in decision-making and support for MNCH care practice and careseeking
- women disclosing pregnancies earlier to families
- greater understanding among women of the importance of utilizing health services including antenatal care, institutional delivery, and careseeking for sick newborns
- changed attitudes related to immediate and exclusive breastfeeding and appropriate care of the umbilical cord

Success of the Demand Creation Strategy is attributed to:

- Strengthening the KCP membership to include HEWs and those interested in maternal and newborn health and building their capacity to prioritize, plan and act together
- Community participation and ownership, especially of faith-based entities
- Strengthening the Women's Development Army in demand-creation activities
- Improving the quality of care in facilities to be more family friendly

With support from all levels of the health system and communities, the Demand-Creation Strategy has the potential to help improve the health of women and children in Ethiopia.

Strengthened kebele command post developing MNCH community action plan in Gibichu Woreda

Community bulletin board in Shoeho Kebele

Conclusions & Recommendations

The implementation of the Demand-Creation Strategy for MNCH-CBNC, supported by Save the Children, reveals that increased community capacity and mobilization will catalyse ownership of maternal and newborn health. Community capacity strengthening, including the KCP, HEW, and WAD will provide a foundation for a broad spectrum of MNCH and health programs and will be important for future growth in demand for MNCH services in Ethiopia.

Our effort for creating demand for MNCH-CBNC services both depended on and supported improved MNCH-CBNC household practices and norms; timely careseeking for maternal and newborn complications and illnesses; and enabling social norms that support appropriate MNCH-CBNC behaviour. Sustaining the success of CBNC will require integrating community empowerment with future demand-creation activities and involvement of community structures such as PHCUs and woredas.

Key recommendations to FMOH and partners include:

- Prioritize efforts to intentionally **strengthen the KCP** across all kebeles by inviting active participation of key community groups and individuals, including those most marginalized or interest in MNCH.
- Ensure supportive supervision from the PRT within the PHCU and woreda health officials.
- **Engage mothers and key family decision-makers, especially men,** in RMNCH initiatives to influence social norms.
- Strengthen the capacity of the **HEW and Women Development Army platforms** and work with them when planning for health service provision and implementing demand-creation strategies.
- **Integrate indicators for demand-creation activities** into supervision checklists and routine reporting systems.
- **Advocate for commitment from zonal and woreda levels** (including a budget line) for demand-creation activities as well as for integration with the health management information system to keep the government accountable for sustaining demand-creation activities.
- Plan for a **longer timeline frames** (at least three years) to ensure successful implementation of demand-creation activities.
- **Continue investing in quality of care and human resources** for health at the facility level, including cultural adaptations. Consider extending the number of HEWs to more than two per health post.

A newborn who has benefited from the project in Gimbichu Woreda

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Access information about the Demand Creation Strategy for MNCH-CBNC efforts including the full strategy, the training package and case studies at:
www.healthynewbornnetwork.org/resource/demand-creation-mnch-cbnc-ethiopia

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