Rapid Assessment of Determinants, Factors and Opportunities to Early Pregnancy Identification, Focused Antenatal Care, Skilled Birth Attendance and Postnatal Care Service Utilization in Gurage and Sidama Zones of SNNPR

FINAL REPORT

CONDUCTED BY

MOMENTUM PROFESSIONAL RESEARCHERS AND TRAINERS PLC

FOR

SAVE THE CHILDREN

JANUARY 2015

LIST OF ACRONIMS

ANC	Antenatal Care
CBNC	Community Based Newborn Care (
COMBINE	Community Based Intervention for Newborn in Ethiopia (
DTL	Development Team Leaders
FCHPs	Female Community Health Promoters
FGD	Focus Group Discussion
GTP	Growth and Transformation Plan
HCT	HIV Counseling and Testing
HEWs	Health Extension Workers
HDA	Health Development Army
HSDP	Health Sector Development Plan
IMNCI	Integrated Management of Neonatal and Childhood Illnesses (
KII	Key Informant Interview
MMR	Maternal mortality ratio
MNCH	Maternal Newborn and Child Health
NICU	Neonatal Intensive Care Units
NMR	Neonatal Mortality Rate (NMR)
PHCU	Primary Health Care Unit
PNC	Post Natal Care
PSNP	Productive Safety net Program
SBCC	Social and Behavior Change Communication
TBA	Traditional Birth Attendants

ACKNOWLEDGEMENT

This study was undertaken by Momentum Professional Researchers and Trainers PLC for Save the Children, Saving Newborn Lives Project. The study was funded by Bill and Melinda Gates Foundation.

Momentum Professional Researchers and Trainers PLC would like to thank Bill and Melinda Gates Foundation for funding the study and Save the Children Country Office and field office staff in Gurage and Sidama zones of SNNPR for their field work facilitation, regular follow up and valuable feedback. Particularly, Mr. Getaneh Assefa, Dr Yenealem Tadesse and Mr. Bereket Mathewos from Save the Childrens CNBC team played a prominent role from the planning to editing and finalization of this assessment report. Momentum further extends its gratitude to the representatives of zonal & woreda health offices for facilitating field data collection and for provision of information for the success of the assessment. Most importantly, Momentum would like to thank the study participants in Hulla and Boricha woredas of Sidama Zone and Meskan, Mareko and Buee woredas of Gurage zone for devoting their time and providing information during the assessment.

EXECUTIVE SUMMARY

Save the Children is now implementing Community Based Newborn Care (CBNC) with the goal of reducing new-born and child mortality through further strengthening of the Primary Health Care Unit (PHCU) approach and the Health Extension Program. As part of this program, this rapid assessment was conducted to identify barriers, opportunities and determinants to early pregnancy identification focused antenatal care health facility delivery and postnatal care at community level in Gurage and Sidama zones of SNNPR region. A cross sectional study design which employed exploratory qualitative study methods including in-depth interviews and focus group discussion guides were used to gather information. The main sources of information were women who delivered within five months before the study and their mothers and husbands, Health Development Army Leaders (HDAs), pregnant women, woreda health office representatives, Maternal Newborn Child Health department experts, Primary Health Care Unit heads, antenatal care, delivery and postnatal care service providers, Health Extension Workers, traditional birth attendants and religious and community leaders. A total of 15 focus group discussions and 65 key informant interviewes were conducted in the five woredas in Gurage and Sidama Zones.

The study indicated that there is progress with early identification and notification of pregnancy both in Gurage and Sidama zones because of increased availability of health information, education and communication services provided by HEWs, other health professionals and HDAs. The main barriers to early pregnancy identification and notification were fear of being criticized for lack of birth spacing, shame associated with getting pregnant very soon specially among recently married couples, lack of trust for health professionals, lack of personal motivation and low awareness of the importance of early pregnancy disclosure. Especially in Sidama Zone, use of injectable family planning method (depo-Provera) was reported to be affecting normal menstrual cycle and mothers associated absence of menstruation with the method instead of the possibility of being pregnant. Utilization of focused ANC services is also improving in both woredas in the last couple of years mainly as a result of the work of HEWs, HDAs, health professionals and messages broadcasted through radio. However, lack of knowledge on the benefit of ANC service utilization, distance from health center, transportation problem, past experience of safe delivery at home, quality of service provided and religious influence are still the main barriers in utilizing available ANC services. Influence of husbands is also a factor in affecting a woman's decision to utilize ANC services especially in Sidama Zone.

There is a significant progress in health facility delivery in both zones and the availability of ambulance services, banning of traditional birth attendants, the pregnant women conferences and the "no woman should die while giving birth" campaign played a role in this regard. Still, a significant proportion of women deliver at home in both zones mainly because of fear of undergoing operation , unavailability of supplies like food and soft drinks that the mother needs at the health facility, limited ambulance service for kebeles far away from health center. Furthermore, absence of return ambulance transportation services, low awareness on benefits of heath facility delivery, lack of friendly service from health professionals and other traditional factors were reported as reasons discouraging health facility delivery.

Postnatal care service utilization was found to be far less than expected in both zones. The main reasons were the longstanding assumption in the community that there is nothing to worry about once a mother gave birth safely and fear of being asked to pay for the service. In addition to this, traditional beliefs and practices, lack of transportation, long distance from home to health facility and the limited number of HEWs and midwifes who are supposed to provide home based PNC service were reported as barriers for PNC service utilization. The most common health problems reported among newborns were breathing difficulty, diarrhea , refusal to breastfeed, stomach aches,fever, Jaundice, skin rush and diarhea. Perceived/ fear of financial costs of treatment and long rooted traditional ways of treating newborns were reported to be the main barriers for newborn health seeking behavior in both Gurage and Sidama zones. Especially in Sidama zone, "Amessa" is the most common traditional herbal treatment given to newborns when they are sick. However, the practice was reported to be decreasing from time to time.

In order to improve early pregnancy identification and notification targeted and focused SBCC interventions need to be implemented to raise awareness on major signs of pregnancy with specific focus on menstrual cycle and morning sickness. In addition, benefit of utilizing ANC, skilled birth attendance and PNC services should also be focused in social and behavior change communication interventions. Furthermore, there is a need for orienting health workers to pay more attention to early pregnancy identification as this is the entry point for the key services in the MNCH continuum of care. The existing opportunities and practices on the ground such as the registration of pregnant women, monthly pregnant women conferences, forums for religious and community leaders need to be strengthened further and capitalized on. High level advocacy activities are required to promote availability of ambulance return services for women who delivered in the health facility. Similarly, advocacy as well as training activities are also required to strengthen the human resource for community outreach services for home based PNC services.

1. INTRODUCTION

1.1. BRIEF OVERVIEW OF MATERNAL, NEWBORNE AND CHILD HEALTH SITUATION IN ETHIOPIA

Improving Maternal, Newborn and Child Health is currently one of the top priorities of the health sectors in Ethiopia. This priority has been reflected in the leading government plans and strategies of the country. For example, the current development plan of Ethiopia, the Growth and Transformation Plan (GTP) 2010-2015, aspires to decrease maternal mortality rate from 590/100,000 in 2010 to 267/100,000 in 2015. The GTP also plans to decrease under five mortality rate and infant mortality rate from 101 to 68 and 77 to 31. Similarly, the current Health Sector Development Program (HSDP) IV (2010/11-2014/15) also laid out its plans to achieve the goals of decreasing maternal and child mortality. Accordingly, HSDP IV targets to increase Focused ANC 1+ from 68% to 90% and ANC 4+ from 31% to 86%, increase deliveries attended by skilled birth attendants from 18.4% to 62% and increase postnatal care coverage from 34% to 78%.

Skilled attendance at birth is the most important intervention in reducing maternal mortality and one of the MDG indicators to track national effort towards safe motherhood. Skilled attendance at birth is the most important intervention in reducing maternal mortality and one of the MDG indicators to track national effort towards safe motherhood. According to the Mini DHS 2014,the percentage of deliveries assisted by skilled health personnel increased 10% in 2011 to 15% in 2014, which was below the HSDP target set[1]. Similarly, Similarly, HSDP IV 2005 Ethiopian Fiscal Year (EFY) report revealed that skilled delivery has improved to 23.1%. With regard to reducing child mortality, a report of UN Inter-agency Group for Child Mortality Estimated that Ethiopia reduced its under-5 mortality by two thirds between 1990 and 2012 (from 204 to 68 deaths per 1,000 live births) – the required reduction for meeting the target of Millennium Development Goal 4. This indicated 5% annual Under 5 mortality reduction rate between 1990-2012. Infant mortality rate reduced from 121 per 1,000 live births in 1990 to 47 deaths per 1,000 live births in 2012. Similarly, neonatal mortality rate (NMR) came down from 54 deaths per 1,000 live births in 1990 to 29 per 1000 live births in 2012. Number of neonatal deaths decreased from 120, 000 in 1990 to 88,000 in 2012.[2]

The government and partners are currently working to keep the momentum on the changes already gained and ensure the sustainability of outcomes. One of the key strategies to realize this is through strengthening and expanding community and facility based maternal, newborn and child health services. Currently, activities related to organizing and mobilizing the Health Development Army (DTLS) at all levels is being carried out intensively in order to promote behavioral change and ensure the implementation of all health extension packages in communities. To tackle the shortage of transportation facilities, the FMoH has procured and distributed more than 372 ambulances to regions and have started to provide the needed service at woreda level. Training of human resources, provision

[1] Central Statistics Agency (2014): Ethiopia Mini Demographic and Health Survey 2014 Addis Ababa, Ethiopia,

[2] United Nations Childrens Fund(2014); Levels and Trends in Child Mortality Report 2014, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation, 2014

of adequate drugs, medical supplies and equipment as well as equitable placement of adequate number of health professionals in health facilities are also the priority activities of the government to improve quality and accessibility of MNCH services[3]. In addition to this, strengthening routine immunization, expanding community and facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI), establishing newborn corners and Neonatal Intensive Care Units (NICU) are also among the key activities being implemented to reduce child mortality.

However, these efforts are not enough to address the existing challenges related to MNCH as still a significant proportion of mothers and children do not have access to basic MNCH services in many parts of Ethiopia For example, the Ethiopian Demographic and Health Survey 2011 showed that out of the 3 million babies that are born in Ethiopia annually, the majority (90%) are born at home without skilled birth attendants. The United Nations agencies report also indicated that the 2013 estimation of maternal mortality ratio (MMR) for Ethiopia was 420 maternal deaths per 100,000 live births. The neonatal mortality now accounts for 42% of the under-five mortality in Ethiopia. The risk of death is highest in the first day when half of the death in neonatal period occurs. In addition, an estimated 75% of neonatal deaths occur in the first week of life. In order to reverse these facts, there is a need to identify the key barriers that are limiting utilization of available MNCH services and design targeted interventions to address the barriers. For instance, the formative assessments conducted by Save the Children's Community Based Intervention for Newborn in Ethiopia (COMBINE) Project in East Shewa, West Arsi and Sidama identified multiple barriers related to pregnancy, postnatal and newborn health care. The most profound barrier for utilization of ANC services was insufficient awareness of the importance and benefits of ANC. Negligence and lack of money or transportation were also reported as among the reasons that pregnant women don't visit a health facility during a complication or danger sign. When it comes to new born health, specific danger signs such as difficult breathing, fever, hypothermia, and inability to feed were also found to be newborn conditions that are perceived to be treated using traditional medicine. Furthermore, Hamechisa beliefs in East Shewa communities prohibit female community health promoters (FCHPs) examination of newborns and also prohibit families from seeking care at a health centers. The assessment also showed that belief in malignant spirits such as budda play a similar role in Sidama communities. Generally, the assessment indicated that communities have very limited understanding of the availability of treatment for newborns at health centers and health posts

1.2. RATIONAL FOR CONDUCTING THE RAPID ASSESSMENT

Save the Children is now implementing Community Based Newborn Care (CBNC) with the goal of reducing new-born and child mortality through further strengthening of the Primary Health Care Unit (PHCU) approach and the Health Extension Program. This program is being implemented in three zones, namely East Shewa, Sidama and Gurage in phase one and additional zones will be covered in the next phases. This will give opportunities to test approaches to address barriers to care-seeking and

[3] Federal Ministry of Health (2012): Road Map for accelerating the reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (2012-2015), Addis Ababa.

improve the number of women and newborns receiving MNCH services. However, there are significant gaps in knowledge and understanding on barriers and opportunities related to births accompanied by skilled attendants. Little is also known about the main factors that affect early initiation of antenatal care and completion of the recommended number of visits. Also critical is understanding of the community's perceptions about service quality and their knowledge about available antenatal, delivery and postnatal/postpartum services. Additionally, exploring available communication channels in the community and how best to use these channels for social and behavioral change communication interventions will be essential to promote demand for skilled birth attendants.

Therefore, Save the Children has conducted this qualitative rapid assessment to identify the barriers, determinants and opportunities related to early identification of pregnancy, focused antenatal care, skilled birth attendance and post natal care visit in Gurage and Sidama zones of SNNPR Region. The findings of this rapid assessment are critical in informing the Community Based Newborn Care (CBNC) initiatives as well as the demand creation approaches for MNCH services in the target geographic areas.

1.3. OBJECTIVE OF THE RAPID ASSESSMENT

General Objective

The general objectives of this rapid assessment is to identify barriers, opportunities and determinants to early pregnancy identification, focused ANC, facility delivery and postpartum/postnatal care at community level in Sidama and Gurage Zones in order to prepare an effective social and Behavioral Change Communication Strategy.

Specific Objectives:

1. To identify determinants, Knowledge, beliefs, attitudes and practices of early pregnancy identification focused ANC, facility delivery/skilled birth attendance and postpartum/postnatal care in Sidama and Gurage Zones.
2. To explore beliefs, attitudes and practices for care seeking behavior for newborns in Gurage zone.
3. To identify decision makers, influential household and community members and decision making process in Sidama and Gurage Zones.
4. Explore available communication channels (sources of information) in the community and determine how best to use these channels for social and behavior change communication interventions in Sidama and Gurage Zones.
5. To explore knowledge, beliefs, attitudes and norms and practices related to the work of DTL and DTL-HEW working relationship in Sidama and Gurage Zones.

2. METHODOLOGY

2.1. STUDY DESIGN , STUDY AREA AND DATA SOURCES

A cross sectional study design, which employed exploratory qualitative study methods were used in this assessment. The assessment was conducted in two woredas of Sidama Zone and Three Woredas of Gurage Zone. A purposive sampling method was used and the study woredas and kebeles in each woreda were selected purposively to represent various ecological, cultural and geographical related actors in Gurage and Sidama zones of SNNPR. Accordingly, Meskan, Mareko and Sodoworedas were selected from Gurage zone while Hulla and Boricha woredas were selected from Sidama zone. After that, kebeles that are very far from the woreda town and those closer to the woreda town were selected to balance geographical and distance related factors that affect health service utilization. The selection was made in consultation with respective zonal and woreda health offices. In order to meet the main objectives of the assessment, qualitative data was collected from various individuals and groups. The following table summarizes the data sources as well as methods used to gather information from them.

Respondent	Method	Number of KIIs or FGDs conducted	
		Gurage Zone	Sidama Zone
Mothers who delivered with in the five months before the assessment	KIIs	6	4
Husbands of women who delivered in the five months before the assessment	FGD	3	2
Grandmothers of women who delivered with in the five months before the assessment	FGD	3	2
Pregnant women	KII	6	4
Traditional Birth Attendants(TBAs)	KII	3	2
Health Extension Workers(HEWs)	KII	3	2
Development Team Leaders(DTLs)	FGD	3	2
MNCH department experts at woreda health office	KII	3	2
Primary Health Care Unit(PHCU) heads at woreda health office	KII	3	2
ANC service providers	KII	3	2
Delivery + PNC service providers at the health center level	KII	3	2
Religious leaders	KII	3	2
Community Leaders	KII	3	2
Traditional Birth Attendants(TBAs)	KII	3	2

DATA COLLECTION METHODS

Qualitative data was collected using focus group discussions and key informant interviews.

- KEY INFORMANTS INTERVIEWS (KII):

Key informant interviews were conducted with mothers who delivered in the five months before the assessment, pregnant women, woreda health office representatives, MNCH department experts, PHCU

heads, ANC, delivery and PNC service providers, health extension workers, traditional birth attendants and religious and community leaders. A total of 65 KIIs were conducted in the five woredas targeted in this study both in Sidama and Gurage Zones.

- FOCUS GROUP DISCUSSIONS (FGDS):

A total of six FGDs, three FGDs in each woreda were carried out with husbands of women who delivered in the five months before the assessment, grandmothers and Development Team Leaders. An average of 8-10 individuals participated in each FGD. A total of 15 FGDs were conducted in the five study woredas in both Zones.

2.2. DATA COLLECTION, SUPERVISION AND ANALYSIS

Before conducting the assessment, training was given to both two field supervisors and eight FGD and KII facilitators. The training mainly focused on qualitative data collection methods, on how to use the study protocol and the instruments. Moreover, the trainees were acquainted with the ethical issues they need to consider and adhere to throughout the study period. Pretesting of tools was also done on the next day after the training. Based on the findings, the discussion guides were revised and used for the assessment. The FGDs and key informant interviews were conducted by experienced facilitators assisted by a note taker. All discussions were recorded based on consent from the participants. The data analysis involved thematic coding of transcripts and followed the basic sets like preparing and organizing the data, developing categories and a coding scheme, coding the data, displaying it and a detailed content analysis

3. MAIN FINDINGS OF THE ASSESSMENT

In this section, purely qualitative data gathered from three Gurage zones (i.e. Mareko, Meskan and Soddo woredas) and two woredas of Sidama zones (Hula and Boricha) were analyzed and presented separately under basic thematic areas. The source of the qualitative data were diversified mainly to represent wide arrays of ideas, beliefs, opinions and cultural practices in relation to mother, newborn and child health care within the studied community members. The qualitative data was organized under seven thematic area i.e. pregnancy identification and notification, antenatal care, delivery, postnatal care visit, newborn health care seeking sources of information and also belief, attitude and practice of HDAs and HEWs.

3.1. GURAGE ZONE

3.1.1. EARLY PREGNANCY IDENTIFICATION AND NOTIFICATION

This assessment generally indicated that there has been an improvement with regard to knowledge of the benefits of early pregnancy identification and notification. The most common reason the study participants mentioned for this improvement was the availability of community based health information, education and communication activities by HEWs, the HDA and health professionals. In addition to this, the participants reported that the 1-5 networking at the community level has played a significant role in early identification of pregnant women. As the 1-5 networking is formed of a group of neighboring women who knew each other, the group leaders have a chance to identify pregnant women from their group and advise her to start ANC. They also report her pregnancy to the HDA leader or the HEW. Participants reported that the 1-5 leaders' knowledge of each woman in their member goes to the extent of who is using contraceptives and who isn't as they meet in coffee ceremony sessions and other social gatherings and talk about their personal life and experiences. Thus, according to the participants, the presence of such community structure has contributed to early identification of pregnant women in the last few years.

Furthermore, the participants indicated that the efforts by the government and partners to address the barriers to access for health information and services has also contributed to the improvement in community awareness towards the benefit of early pregnancy identification and notification. This assessment also indicated that women identify their pregnancy or suspect about it when they experience absence of menstrual cycle, nausea, changes in appetite and pregnancy test. It was also reported that some women use the time of fasting and non-fasting days and months in order to trace the time of their pregnancy. The 'fortieth day of pregnancy' when, according to the participants, the fetus makes some noticeable movement in the womb was also mentioned as a clue to pregnancy identification. A woman who recently gave birth was asked how she identified her pregnancy status. She shared her experience as follows

"I was attending my period. When I missed my menstrual cycle, I informed my husband about it. There are also other symptoms like "nausea and other related physical and emotional changes."

A recently delivered mother who participated in the study

Absence of menstrual cycle was reported as the common reason for coming to health center for pregnancy check-up. The assessment indicated that a considerable proportion of women in the study woredas do not notify their pregnancy early. One of the barriers for early pregnancy notification is fear of being criticized for lack of birth spacing. It was learned that family planning education has brought significant changes in awareness in the gurage community in recent years. As a result, poor birth spacing and poor family planning practices are becoming unacceptable among most members of the community. Expression like "you got pregnant again?!" were reported to be common towards such women. It was reported that breast feeding mothers are especially afraid to notify others about their new pregnancy because of the shame attached to it.

The other barrier for early pregnancy notification is the shame associated with getting pregnant very soon among young girls, unmarried girls and women and those who are recently married. A religious leader interviewed stated the following on this

"They do not explicitly state that they are pregnant because of fear and lack of awareness. They should not be afraid because it is the gift of God and they do not have to be afraid of it. It could happen to any women".

A religious leader who participated in the study

The other mentioned barrier to early notification of pregnancy was lack of trust for the health professionals. A midwife commented the following on this

"Pregnant women are highly offended and feel frustrated if you tell them that they conceived twins or the position of the fetus is not appropriate"

A midwife who participated in the study

Furthermore, distance to the health center was also mentioned as is one of the major barriers to early pregnancy identification and notification in all the three woredas. This assessment indicated that husbands are in most cases the first persons who have the privileged to know the pregnancy status of their wife. This, according to the informants, was because husbands are expected to provide special care and attention to their pregnant women following the news of her pregnancy. They are expected to buy her new clothes, show more effort to make her happy, provide her special diet, and avoid any conflict with her at any expense.

A key informant commented the following on why the husbands are the first persons that women notify their pregnancy to

"It is because they are one flesh who are supposed to face both challenges and triumphs in life together. Early notifications of pregnancy to the husband is helpful to create trust, support in attending health care services and to prepare the woman and her family for the delivery"

A religious leader who participated in the study

The other people to whom pregnancy is notified are the HEWs. According to the participants, this is because HEWs use home visits as an opportunity to check or ask if there is a pregnant woman in the household or in the neighborhood. HEWs are also responsible for providing counseling on the importance of ANC, HCT and the support of husbands and refer them to the health centers. Women also notify their pregnancy to the Health Development Army members and the 1-5 leaders. The groups link the pregnant women with the HEWs for further counseling and follow up.

3.1.2. ANTENATAL CARE SERVICE UTILIZATION

Most of the participants of this study made it crystal clear that the number of pregnant women who attend ANC has been increasing from time to time. A health professional who is working in one of the study woreda suggested that the uptake of ANC services has increased dramatically. The major reason for improvement mentioned by most of the participants was the HEWs effort to raise awareness on the benefit of utilizing ANC services. HEWs were reported to be using home visits, community gatherings and other social events to promote ANC service utilization.
A recently delivered mother commented the following regarding the available ANC service:

"I have attended four ANC visits. Things have changed positively these days; Mothers attend ANC either at health center or HEWs provide them home based care and follow up. HEWs also identify and register pregnant mothers and follow them up to attend ANC up to the time of their delivery"

A recently delivered mother

Messages transmitted to the community through the Health Development Army, health professionals and mass media (mainly radio), were commonly mentioned as main reasons for the increasing number of pregnant women who attend ANC. Health professionals are also playing a role in promoting ANC service utilization by explaining that ANC services are provided free of charge for pregnant women.

The assessment found that the pregnant woman herself plays a crucial role in the decission to utilize ANC services or not. In addition, her husband also makes the decision whether his wife should access ANC services or not. Furthermore, community gatekeepers like religious leaders and community elders also have the power to influence the decisions of the pregnant woman or her husband on whether she should utilize AC services or not. A key informant indicated that the trainings given to religious and community leaders on maternal and child health issues in general and benefits of ANC and delivery service utilization in particular was one of the factors that contributed to increased ANC service utilization

According to the study participants low awareness about the benefit of ANC service utilization and long rooted misconceptions related to ANC are among the main barriers for utilization of focused ANC service. It was learned that a considerable proportion of mothers in the study woredas still believe that there is no need to take ANC now as they have previously delivered safely without any ANC follow up. A HEW said the following on this issue

"Health professionals and HEWs also commented repeatedly that even those people who know about availability of ANC services are negligent to use ANC services by saying "God knows everything" or "I already gave birth at home without attending ANC"

A HEW who participated in the study

The other frequently mentioned barrier for utilization of ANC service was distance to the health facility and transportation problem associated with it. A midwife commented the following on this

"Pregnant mothers are supposed to attend four ANC visits. But practically they do not often attend all the four visits and they mention the distance to the health center from their home as a challenge"

A mid wife who participated in the study

The other perceived barrier for utilization of ANC services was the fear of medical cost associated with ANC visits. According to key informants, there has been a perception in the community that women will pay for ANC services and this has for years limited their motivation and interest to access ANC services. Participants were also asked for the possibilities of traditional and cultural practices in relation to ANC. Most of them denied the presence of deeply rooted cultural believes against ANC. Of course, there were also participants who highlighted some cultural and traditional practices in relation to ANC. One respondent suggested that "in the past they used to think that bizarre things will happen in case a pregnant woman goes to health center for ANC". Visiting witchcrafts was also mentioned by one health professional that has been working in the area and has sound knowledge of the community customs.

One existing opportunity that can be utilized to promote utilization of focused ANC among Muslim women in Gurage are social gatherings called "Dado" and "Liq". Dadoo is a monthly gathering while Liq is held weekly to discuss about various social issues that require attention by the local community. During Liq gatherings, both male and female members of the community gather in one location but the males and females discuss their issues separately. However, dadoo is a gathering of female members of the community only. According to the participants, there are times when Christians also participate in dadoo meetings. Availability of the Health Development Army and the 1-5 networking at the grassroots level is also another opportunity that can be utilized to promote utilization of focused ANC services because members of the HDA can exert measurable level of influence on the community members if they are engaged in delivering strong message on the benefits of ANC service utilization. Furthermore, the availability of religious leaders and community elders who were already trained on the benefits of MNCH service utilization in general and health facility delivery in particular was reported as another opportunity available on the ground to promote focused ANC service utilization. A nurse interviewed in Meskan Wereda commented the following on this:

"Everything in which religious leaders are involved is easily and highly accepted"

The monthly pregnant women conference was also mentioned as an opportunity to be utilized to promote uptake of focused ANC service. In order to increase utilization of focused ANC services, the participants recommended the importance of engaging religious leaders to teach community during religious gatherings. In addition, participants recommended to actively engage schools as school children can share the information they got from school to their parents and neighbors.

3.1.3. SKILLED BIRTH ATTENDANCE SERVICE UTILIZATION

The practice of giving birth in health facilities was also reported to be increasing from time to time because of improved awareness among the community members about the benefits of health facility delivery. According to the informants, the number of mothers who believe that they will immediately get health care or professional support in case of birth related complications or prolonged labor has increased in the last few years. Participants have added that availability of ambulance also increased skilled birth attendance dramatically. Recently delivered mothers and pregnant women interviewed also agreed that, even though there are mothers who still give birth at home due to different reasons, the number of mothers who are giving birth in the hands of skilled attendant is increasing from time to time. The other reason mentioned for the increase in skilled birth attendance is the banning of traditional birth attendant from assisting home delivery. Regarding the current improvement in utilization of health facility delivery services, a HEW commented the following:

"The famous national motto which says "No mother Should Die While Giving Birth/life" has been cascaded down to the grassroots level and health professionals are working to achieve this goal in each kebele. "

A HEW who participated in this study

The study participants indicated that the main decision makers on whether a pregnant woman should deliver at home or at the health facility are the pregnant women herself, her husband and HEWs. Husbands were reported as key persons in influencing a pregnant woman's decision regarding her place of delivery. Understanding this, health facilities are trying to implement awareness raising activities targeting husbands on the benefits of skilled birth attendance. HEWs were reported to be playing a pivotal role in encouraging and counseling the pregnant woman to deliver at the health facility and also in encouraging her husband and family members to take her to the health facility during labor. HEWs also provide the phone number of ambulances to pregnant woman and her husband and use the monthly pregnant woman's conference to educate about the benefit of health facility delivery. The 1-5 networking also play a role in promoting health facility delivery by initiating the delivering mother to go to the health facility. They also gather the neighborhood and organize them to carry the delivering mother to the health facility when the ambulance is not available.

According to the study participants, one of the reasons affecting utilization of skilled birth attendance is the deep rooted misconception in the community that delivering mothers will undergo an operation ,which they literally described as "cutting one's body in to pieces" The participants indicated that such misconceptions have been circulated in the community as rumors. The other barrier reported was the high value that the community gives to traditional ceremonies like porridge preparation, coffee drinking

and the social company that women use to have while they delivery at home. As these ceremonies are not available at the health facility, women were reported to feel uncomfortable to delivery at the health center without these traditions. A HEW reported the following on this:

> ***"Mothers complain that they do not even get a cup of coffee let alone something to bite at health center". Eating genfo and taking bath with hot water which is believed to cure intestinal illness [stomach aches] are among the highly cherished practice at home during delivery. The arrival of newborn baby is welcomed warmly involving recognizable ceremonies and visits from community members. Skilled birth doesn't accommodate all these aspects of home delivery and it takes time for the community to adapt to the new demands of skilled birth attendance at health center".***
>
> ***A HEW who participated in the study***

The other barrier for utilization of skilled birth attendance service is the limited accessibility of ambulance transportation service, especially for kebeles that are very far from the health center or kebeles with no convenient roads. According to the participants, negligence and religious related beliefs are the other barriers affecting utilization of skilled birth attendance. Some Christian women highly believe that St. Mary is the one who makes the delivery safe and the midwife or the health professional doesn't have a role to play. Similarly, some Muslim women also believe that "it is only Allah who delivers pregnant women." These beliefs were reported as barriers for utilization of SBA services. History of previous home delivery was the other barrier for utilization of SBA service. According to the study participants, most mothers who has this experience do not have the courage and motivation to go to the health facility for SBA services. A health extension worker interviewed reported the following on this:

> ***Since most mothers previously gave birth at home in those past years, they argue that there is nothing new about this time. They say they gave birth to all of their children at their home and they even ask what is unique about this time. They think that delivery is just a normal thing which does not need the involvement of health professionals"***

3.1.4. POST NATAL CARE SERVICE UTILIZATION

Most of the study participants reported that the habit of visiting health facility for PNC services HEWs have tried to organize monthly conferences for mothers with children including monthly conference to provide PNC services such as vaccination of new born children and weight measurement services. However, a according to the key informants, the result so far has not been encouraging. In order to fill this gap, HEWs have been carrying out home visits to provide PNC services by checking the health status of the mother and the newborn and informing the parents what actions they need to take.

One of the barriers for utilization of PNC services is the belief that there is nothing to be worried about once a mother gave birth safely. The other barrier is the perceived fear of payment for PNC services.

There are community members who think that they will be asked to pay for the post natal care treatment service and they refrain from visiting health center due to financial limitation. In addition to this, the home vist by midwife nurses and HEWs after delivery was reported to be inconsistent and unsatisfactory because of the demanding nature of their work and their limited number. Furthermore, transportation problem to visit the health center for PNC services and the traditional belief that a mother who gave birth should not leave her house for two consecutive months were also reported as barriers for utilization of PNC services. A health worker summarized the main barriers as follows:

"The practice of utilizing PNC services in this community is far below the expectation and the coverage is very low. Women who delivered at the health facility don't want to stay longer right after delivery and complain that people are waiting for them at their home and that there is a big ceremony at home. Even after going home, they are not allowed to leave home with in the two months after delivery. They think they will die if they do so and efforts to mitigate this traditional belief are not adequate. In addition, the number of HEWs and midwifes who provide home vist afrer delivery is very low compared to the demand."

A health worker

In order to promote utilization of PNC services, the participants recommended that engaging religious leaders in the promotion of PNC services and training of health workers on the quality of PNC services should be given attention. According to the study participants, there are community members who believe that if a newly delivered mother leaves home early after delivery (within two months in most cases), she might be stricken by evil spirit or angel of death. In addition to this, there is a practice in the community to put butter on the mouth of the new born baby and encourage him/her to swallow it with the assumption to prevent intestinal pains and complications.

One of the traditional practices after delivery is "Wurwurta". In the Gurage community, family members of the newly delivered woman put fresh butter on her head and she gets her hair done in a new way. They also dress her new cloth. It was reported that it is a remarkable ceremony following the arrival of new born after few days.

3.1.5. NEWBORN HEALTH CARE SEEKING BEHAVIOUR

The common types of illness reported among newborn children in the study woredas were breathing difficultty, low appetite for breastfeeding, stomach aches,fever, Jaundice, skin rush, diarhea and exposing children to bad weather which they call "berd" or "nefas".

One of the barriers for health care seeking behavior for new borne children was the traditional explanation that community members give about the cause of the sickness. Skin rush, for instance, was misunderstood for "mich"- an illness inflicted by anger of evil spirit.' In addition to this, the traditional remedies that the community accepted for years to treat new borne children also affected health seeking behavior for newborns. A community leader reported that burning a newborns belly with fire was a common practice in the community to treat intestinal problems. Taking newborn children to

witchcraft when they are sick has also been a common practice in the community. However, all participants agreed that the frequency and prevalence of these practices has significantly decreased in the last few years as a result of awareness raising efforts by health workers.

The participants reported the availability of pediatric departments that provide treatment for children and infants at the health center level. However utilization of these services was reported to be lower than expected. One of the reasons mentioned for this is the limited knowledge of availability of such services by a significant proportion of the community. In addition to this, there are also mothers who are aware of the availability of such services but are not willing to utilize them because of traditional and cultural beliefs and practices that do not motivate utilization of such health facility services. A health worker commented the following about such community members:

"Most of the time, they do not care much on the treatment of the infants. They are very resistant to take the child outside of home before 45 days or two months. Even though quality treatment is provided at health center, every household member may not encourage taking infants to health center, this is not because of poor quality of treatment but due to lack of awareness"

A health worker

The assessment also found that, in most cases, it is the mother who is responsible to take the newborn to a health facility for treatment compared to husbands and other family members. A key informant commented the following on this

"Mothers are the ones who take their newborn children to health center. Fathers tend to control the properties and decide on financial issues. Thus, any intervention should give much emphasis on mothers"

In order to promote health seeking behavior for newborn children, the participants recommended that appropriate and up to date trainings should be given to the HEWs, DTL and other health professionals. In addition, they recommended that the mechanism for supervision and referral services carried out by HEWs need to be strengthened to improve the health seeking behavior of the community members.

3.1.6. SOURCE OF INFORMATION ABOUT HEALTH ISSUES

The man sources of information on health issues were reported to be the HEWs, health professionals, and HDA. HEWs were highly acknowledged by most of the informants as key source of health related information. HEWs organize several forums for mothers with children such as monthly conferences, campaigns for vaccination of new born children and they utilize these forums to pass health related information to the community... Radio was also a highly preferred source of information as far as mass media is concerned. Specifically, Debub Radio and Assela Radio were mentioned as sources of health related information. Ethiopia radio was also mentioned as a source of information about health issues. Access to radio programs has increased because of the use of mobile apparatus to listen to FM radio

programs, especially among young people in the area. A study participant said the following on the main sources of information on health in the community.

"The most common source of information in this community is radio. But, when it comes to health information in particular, HEWs are the main sources. For those who live in urban areas, TV also provides information. People have frequently heard the message which says "No woman should die while giving birth" from the media. The most preferred source of information among the community is, of course radio"

A midwife

3.1.7. PERCEPTIONS TOWARDS DEVELOPMENT TEAM LEADERS(DTLs)

It was reported that the DTLs meet once in a week with the HEW and the 1-5 network meets twice a week. The role of HEWs and HDAs was widely recognized in the community as far as health education and information is concerned. Compared to the DTLs and 1-5 leaders, HEWs have more respect in the community, are highly renowned and widely acknowledged by both health professionals and community members. On the other hand, DTLs are organized on voluntary basis without formal salary or any other type of incentives for their services. Their limited training and absence of incentives has affected their level of influence on the community and their commitment. Almost all of the participants of this study made it clear that the support given to the HDAs so far is very low.

Health professionals also provide supervision on the content and nature of the discussion they held among themselves. They look at the content of their report to the health extension workers and provide professional input. Even they are assigned or provided health professionals, in case there is a need. They also meet with elected community leader to evaluate actual performancesAccording to the study participants, there is no direct benefit or support given to the DTL except when the HEWs sometimes let them participate in some community events.

Health professionals also provide supervision on the content and nature of the discussion they held among themselves. There are also times when health professionals are assigned to support them during their meetings. Even though the support provided to the HDAs is not adequate, the participants suggested that the promising initiatives on the ground need to be capitalized on. A key informant from the disease prevention and health promotion department commented the following on this:

"We are expected to be involved in empowering and strengthening the HAD But we are busy and there are also some budget related issues. If the work of HDA has to be improved, there are materials, kits and other packages that need to be provided to them. Most of the time, the training is provided only for the HEWs and there are knowledge and skills gaps on the side of HDAs. HDAs don't have knowledge of the type and content of the training given to HEWs. Thus, the same training given to the HEWs should also be given to DTLs, members and the 1-5 networks"

A representative of woreda health office

Participants recommended that some form of incentives or benefit package need to be provided to the HDAs so as to strengthen their contribution. They added that trainings need to be given to them to improve their performance.

3.2. SIDAMA ZONE

3.2.1. EARLY PREGNANCY IDENTIFICATION AND NOTIFICATION

Generally the study participants in Sidama Zone agreed that the past few years have shown an improvement in the community in identifying pregnancy early. The main reason behind this recent improvement was linked to the functionality of the HDAs. This structure was reported to have played a crucial role in raising community awareness about the benefits of early pregnancy identification. Evidence to this, most of the mothers and grandmothers interviewed reported that early identification of pregnancy helps to take vaccination on time and also to make sure that the position of the fetus is appropriate. According to the study participants, most women in the Sidama community rely on changes in their menstrual cycle to detect their pregnancy. Similarly, interviews held with husbands and other community members also showed that absence of menstrual cycle serves as a clue to a women's pregnancy status. In addition to changes in manstrual cycle, some women also rely on observable signs of morning sickness such as loss of appetite and nausea to identify their pregnancy. Other members of the community including DTLs and 1-5 leaders reported that they use behavioral and physical changes as common clues to identify a pregnant woman. A grandmother commented the following on clues to identify pregnant woman:

"We know the pregnancy status of women in our neighborhood based on some basic observable behaviors. Pregnant women often flog their older children, vomit, or experience nausea, feel dizzy or tired and look more beautiful."

A grandmother

A pregnant woman also shared her experience on how she identified her pregnancy

"I learned about my pregnancy because of absence of my menstrual cycle. After that, the fetus started to move in my womb. It was then that I became sure of my pregnancy"

HEWs, Kebele leaders, DTIs and 1-5 leaders were identified as key actors in identification of pregnant women in Sidama community. A DTL forwarded the following about the role they play in pregnancy identification:

"The DTLs usually identify a pregnant woman within the third or fourth month of her pregnancy. This is mainly because we register pregnant women through home visits. We advise them to visit the health center. We also tell her about the importance of balanced diet, and advise her to refrain from doing laborious activities like carrying heavy materials"

A DTL

Most study participants reported that women especially in rural kebeles of Sidama region are not as such attentive of their pregnancy status and sometimes fail to recognize that they are pregnant even until they are four or five months pregnant. One of the barriers reported for early identification of

pregnancy by the woman was uptake of family planning injection (Depo Provera) and its hormonal effect that delays menstrual cycle even after the method is withdrawn. According to the participants, most women who take this family planning method have experience of absence of menstruation for four months after the method is withdrawn. This experience deceives them because they think that the delay in menstruation is not because they are pregnant but because of the effect of the family planning method. A mid wife nurse commented the following on this:

"Most of the mothers in this locality use Injection for Family Planning. Injection has the tendency to affect the normal timing of menstrual cycle and they attribute the fact that they missed their period to the injection and do not think that they are pregnant."

A mid wife

Similarly, a pregnant woman who experienced this situation described her personal experience in the following manner:

"I used to take depo [Injection] for family planning purpose. I used to see my period after the fourth month of withdrawing the method. Finally, I was sick and I visited the nearby health center. They told me that I am pregnant. I thought I have missed my menstrual cycle because of the injection and not because of the pregnancy"

The other barrier for early identification of pregnancy was low awareness associated with the possibility of pregnancy while breastfeeding of older child. The health professionals reported that a considerable proportion of women in rural kebeles believe that they will not be pregnant with a new child while they are breastfeeding the older child. Thus, they don't pay attention to the pregnancy related changes they experience and they finally recognize that they are pregnant mostly after the pregnancy becomes noticeable on their body. The other reason reported for delayed identification of pregnancy was lack of knowledge and experience about signs of pregnancy especially among young girls on their first pregnancy. The study participants in Sidama indicated that husbands are the first persons to be informed about a woman's pregnancy followed by HEWs and health professionals. A grandmother claimed that women in the Sidama community are not afraid to tell their husband about their pregnancy but they feel shy to notify their pregnancy to their mother in laws or even mothers. The reason she gave was because pregnancy causes shyness among pregnant women. A recently delivered mother reflected a similar perspective on this as follows:

"I did not notify my pregnancy to anyone accepts my husband and my family members because being pregnant is shameful and it makes you shy."

A recently delivered mother

The study participants recommended that active community education and involvement need to be carried out by the HEWs, health professionals and DTLs to raise awareness on the benefits of early pregnancy identification and notification.,

3.2.2. ANTENATAL CARE SERVICE UTILIZATION

The key informants indicated that understanding of the benefits of focused ANC service utilization has increased in the last couple of years even though there are still some myths and misconceptions surrounding utilization of ANC services. The education given by HEWs and the previous projects implemented by partner organizations were reported to have played a role that contributed to the improvement. For instance participants mentioned that World Vision previously arranged vigil or forum for women in the community on which they discuss on the importance of ANC service utilization and this, according to them, has produced promising results. In addition to this, the monthly pregnant women conference was also reported as an opportunity that increased knowledge about the benefits of ANC service utilization and the practice of service utilization itself. The DTLs and 1-5 leaders register the name of each and every pregnant mother in their locality, encourage their attendance during monthly conferences and also follow their status. Health professionals interviewed added that the introduction of focused ANC has been instrumental in increasing the number of women who attend ANC service. A health worker commented the following on this

> ***"Before the introduction of Focused ANC, mothers were expected to visit the health center more than four times. But after the Focused ANC, we only expect them to come for four basic and special visits. We say special because we focus on special conditions that are observed during pregnancy like blood pressure. When pregnancy related complications occur, mothers may be required to visit for more than four times. In the past, they were expected to have seven ANC visits which is very difficult for pregnant women."***
>
> ***A health worker***

One of the reasons that pregnant mothers do not attend ANC visits was the fear that their body or their sexual organ would be exposed or seen naked by the health workers at the health facility. The other reason women do not utilize ANC service is because of the influence from their husbands who may not understand the benefit of the service. It was repeatedly mentioned by the study participants that husbands in Sidama community have a dominant role in the decision related to access to health services. The other barrier reported for utilization of ANC services was the traditional belief for the "Qallole" in Sidama community who forbid women not to attend ANC services at the health facility and also not to take sick children to the health facility for vaccination or treatment. Some pregnant women visit the "Qallole" during pregnancy to get the blessing and also take their children for possible treatment to these places when they are sick.

Massaging a pregnant woman's belly with butter was also a common traditional practice in Sidama even though the prevalence was reported to be declining because of the health education in the community and the banning of TBAs from such practices. A HEW also commented the following on what happens to a pregnant woman who was found getting Wogesha (masaging the belly) services from a TBA:

"If a pregnant woman is found getting "Wogesha' (massaging of the belly during pregnancy) services from a TBA, she will be condemned to detach from community life and communal affairs and rights. This has played a role in motivating pregnant women to utilize ANC services at the health facility instead of visiting TBAs".

A HEW

The other barrier for utilization of focused ANC service in Sidama zone is the problem of transportation because of the difficult topography of the land which made several kebeles inaccessible for public transport.

3.2.3. SKILLED BIRTH ATTENDANCE SERVICE UTILIZATION

With regard to skilled birth attendance in Sidama zone, the study participants generally agreed that the number of women who deliver at the health facility has been increasing from time to time. A health worker quantitatively described the trend saying that in the past only two or three mothers visit delivery wards per week but nowadays the number has grown to 9- 15 deliveries per week. A midwife also stated that most mothers used to prefer to give birth by the help of traditional birth attendant but these days they prefer to come to the health center for delivery services. One of the reasons behind this improvement in utilization of skilled birth attendance was reported to be the monthly pregnant women conference at the kebele level which brought significant change in knowledge, attitude and behavior related to skilled birth attendance among pregnant women and other community members. Most of the women who participated in this study also mentioned that they are motivated to give birth at the health center because of the education they already received and also because they witnessed other women who delivered at the health center safely and had a healthy baby.

A Pregnant woman interviewed in Hula kebele said the following on this.

"I have decided to give birth at the health center. Most women give birth at the health facility and they are healthy. But they do not get any other support. These days, all pregnant women give birth at the health facility and I do not know a single woman who gave birth at home"

A pregnant woman

A former traditional birth attendant also shared the following on what happens during delivery at the health facility.

"They cut the umbilical cord with a safe material and the child will be wrapped with clean blanket and given breast immediately after delivery. Women who deliver at home do not get this kind of care and treatment"

A former TBA

One of the barriers reported for utilization of skilled birth attendance service was low awareness of the benefit of the service along with the deep rooted acceptance to home delivery. The study participants reported that some women in their community still feel that skilled birth attendance is a disgusting and shameful practice. A recently delivered woman who gave birth at home described her feeling about health facility delivery as follows:

"Giving birth at the health facility is very embarrassing. Our mothers and grandmothers gave birth at their home. I was busy with household chores and accidentally I experienced labor. There was no one around and I gave birth alone without support from anyone"

A recently delivered mother

Health workers also reported that women complain that they don't even get a bottle of soft drink (Mirinda) nor any other drinks while they delivery at the health facility and compare that with the varieties of drinks and care they would get when they deliver at home surrounded by their family members. Furthermore, the participants reported that Muslim women do not want to be even touched by male health professionals even though health professionals want to provide the required health care. Thus, several Muslim women in Sidama were reported to refrain from utilizing skilled birth attendance service for fear that they might encounter a male health professional during delivery. In relation to this, the participants indicated that there is a belief among Muslim women in Sidama that the delivery will be prolonged if a woman is attended by a male health professional. A midwife reiterated her experience on this as follows:

"There was an occasion when I went to assist a delivering mother at her home and a male health professional was also with me. The delivering mother was not comfortable about that and she said that the baby will not get out (delivered) when he/she sees the male health professional. They think the delivery will take prolonged time in the presence of a male health professional."

A midwife

The other barrier identified was shortage of transportation when they return back home after delivering at the health facility. This is because ambulances only take delivering woman to the health facility and do not provide return services after delivery.

In order to increase utilization of skilled birth attendance services in Sidama zone, the health office has been taking several steps. It was reported that the women conference in most parts of Sidama zone used to be held once a week and recently it has been made twice. In addition to this, midwifes have been assigned to work in each health center even though their number is still low compared to the demand of services. The participants recommended that increasing the number of midwife nurses and strengthening public awareness on the importance of utilizing skilled birth attendance service need to be given attention to increase serve utilization.

3.2.4. POST NATAL CARE SERVICE UTILIZATION

The utilization of PNC services was reported to be lower than expected especially compared to utilization of ANC and skilled birth attendance services. The participants generally agreed that only few women in Sidama zone utilize post natal care services.

One of the barriers to utilize PNC services was limited knowledge about the benefit of the services. Most women believe that once they delivered safely, there is no need to return to the health center for PNC service. The other barrier is unavailability of transportation service, especially in remote rural kebeles of Sidama Zone. The other barrier reported was shortage of health extension workers to provide home to home visit and PNC service. The limited number of midwife and the high turnover of HEWs was also repeatedly mentioned as a barrier to strengthen and sustain the home based PNC service provision in Sidama zone. A health worker commented the following on this:

"Mothers who delivered at the health center get the first PNC service on the sixth hour while they are there. Thus, there is no problem with this. However, they are expected to return on the sixth day but most of them don't come because of different reasons. We have very limited number of midwife and they are not able to conduct home visits to all women who delivered. Thus, they delegate the task to HEWs to follow the status of those mothers who gave birth".

A health worker

However, the interview with recently delivered women in two kebeles shows that HEWs are not providing home to home postnatal care service in a consistent way. HEWs were reported as key actors in educating women about the benefit of using PNC services and in motivating women to utilize PNC services. The study participants reported that HEWs and DTLs visit women who delivered at their home and there is no challenge they face in assessing the mother or the newborn during their visit.

3.2.5. NEWBORN HEALTH CARE SEEKING BEHAVIOUR

The common illnesses among newborn children identified by participants include pneumonia, cough as a result of exposure to cold weather, diarrhea, stomach ache and jaundice.

One of the barriers for utilization of newborn health care service was reported to be low awareness of the benefit of the service and the traditional and cultural practices related to newborn treatment. According to the participants, most of the newborn illnesses are given cultural explanations and remedies that inhibit the chance of the newborns to have access to health care services at the health facility. For instance when the newborn cries, the community members believe that it is because of stomach ache and they usually give the newborn a traditional herb called "Amessa." Amessa is a root of Acacia tree believed to have medicational value and is boiled and given to newborn children to drink when they have stomach ache. Mothers also give Amessa to those children who are underweight and who refuse to breastfeed. When asked on the potency of Amessa, a recently delivered mother said the following:

"There are of course lots of times when there is no improvement after taking Amessa."

The participants generally agreed that the tradition of using Amessa has been declining. Mothers indicated that the education given to them not to give anything other than breast milk to children under six month has changed their mind. The newborn treatment seeking behavior has also been reported to have improved gradually over the years. Participants added that there are also conditions where

mothers give their newborn water and other types of drinks which causes diarrhea. The other barrier for newborn health care service utilization is the resistance among women to take their newborn outside of home due to fear of people with evil eyes or 'budda'. A health worker also commented the following:

"Some community members in Sidama have a religious practice called 'Hara" and they frequently visit the place as a church. When a newborn is sick there is a tradition to take the child to the 'Hara" for possible remedies instead of coming to the health facility. Thus, we need to collaborate with religious leaders to address such practices"

A health worker

Furthermore, the perceived fear of payment for treatment was also reported as a barrier for newborn health care service utilization. Health workers reported that the community members have been repeatedly educated that medical service for children under five is free. However, discussions with the community members also indicated that they pay some amount of money for consultation (card) in health centers and they feel that even that amount is not affordable to many people. The other reason that mothers do not take their newborns to the health facility for treatment was reported to be lack of support or permission from their husbands. It was reported that a considerable proportion of men in Sidama either have low awareness of the benefit of newborn health service utilization or have fear that they may incur costs as a result of the treatment. Thus, they prefer to try cultural and traditional options of treatment for children.

Almost all of the participants reported that mothers take newborn children immediately to health center when they get sick. It was also reported that the primary responsibility to care for a newborn child is left to the mother and fathers, in most cases, were reported to lack the initiative in taking newborns to the health facility for treatment. With regard to the mourning of the death of newborn in Sidama zone, the participants reported that the death of newborns is mourned too much but not in an explicit manner. A grandmother stated the following on this:

"Everybody feels desperate but for the sake of other children we do not cry. There is difference between how to bury and cry when newborns and adults die. When newborns die, we do not cry because other children may be terrified. We take them to health center and if they die, it is the will of God, we can't do anything"

A grandmother

HEWs also claimed that they are giving emphasis to the treatment of newborns especially after the training they were given on integrated childcare. HDAs also reported that they are playing a crucial role in encouraging community members to take their newborns to the health center for treatment. A DTL who was interviewed in one of the kebeles in Sidama zone stated the following on this:

"After delivery, we visit the mother and the newborn for seven times. We advise the mother to take the child for vaccination and also to give only breast milk until the child is six months old.

Because of exposure to cold weather, newborn children usually get sick and mothers take them to the health center. In the past, treatment seeking behavior for newborns was very low but now we have educated them about its benefit"

A DTL

3.2.6. SOURCE OF INFORMATION ABOUT HEALTH ISSUES

The participants reported that the main sources of information on health related issues in Sidama were health workers, the DTLs and 1-5 leaders, print materials like pamphlets and brochures that are available at the health center. Especially for the rural community in Sidama, the DTLs are the key sources of information on health issues. Radio was also mentioned as a preferred media to communicate information and messages on various health issues. The most preferred time to listen radio is during early in the morning and late at night. The ideal days to listen to radio program are on the weekend. The Debub FM radio program broadcasted in sidama language was reported to be the most favorite radio program.

3.2.7. PERCEPTION TOWARDS AND PRACTICE TOWARDS HDAs

The participants reported that the community has a good knowledge about and perception towards the HDA. According to key informants, the selection of HAD leadersis based on performance and knowledge of the packages of the health extension program including whether a woman used family planning methods, utilized ANC and skilled birth attendance services and the like. On how a certain woman is chosen as role model, the following statements were quoted from interview held with HEWs

"She has to be a role model for the rest of the community members and she needs to have the energy to cry or shout loudly in case a certain woman gives birth at home so that the community members will gather and take her to health center"

A HEW

The HDA get technical support from HEWs and the health workers at the health center also supervise them at least ones per a weak. The DTLs have regular frequent meeting on which they discuss problems they encountered and the number of pregnant women they registered. They also provide community education on issues related children and mothers.

One of the challenges that HDA face is the limited support they get from health workers. According to their view, there are conditions when the health workers feel apathetic and negligent in providing consistent technical support to them. The other challenge reported was lack of incentives for the HDA while they are carrying out community outreach services. A key informant reported that World Vision once started paying HDAs some amount of money as incentive but that did not continue when World Vision withdraws the project from the area. As a result, it is only the health workers who carryout community outreaches because the HDA became less functional after the incentive was ceased. The level of influence of the HDA in bringing behavioral change among the community members was a

contested issue of discussion among study participants. There were people who believe that the HDA level of influence has been increasing. They presented their argument as follows:

"In the past they were not as such strong and influential. But now they are influential because they are currently covering activities and areas that the HEWs are not able to cover in the wider community. All DTL are assigned to a specific catchment area and discuss monthly about the health status in their respective catchment area and this has been proved successful"

On the other hand, there were respondents who argued that HDAs are not influential because of their limited knowledge and the poor supervision they get from the health workers. The content of their education was also reported to be redundant and unclear. One pregnant woman commented the following:

"I have been attending those meeting held by HDAs and it's always about sanitation and proper toilet use. Nothing more, nothing less"

4. CONCLUSION AND RECOMMENDATIONS

4.1. CONCLUSION

Gurage Zone

It was found that there is progress with early identification and notification of pregnancy in Gurage zone mainly because of the increasing awareness on the importance of early pregnancy identification and the availability of health information, education and communication services provided by HEW, HDA and health workers. In addition, barriers like lack of infrastructure and low accessibility have been relatively resolved in the past few years.

Several factors were indicated as barriers to early pregnancy identification and notification in Gurage zone. These factors include fear of being criticized for lack of spacing, shame associated with getting pregnant very soon specially among recently married couples, lack of trust for health professionals, lack of personal motivation and low awareness of the importance of early pregnancy identification and notification. Health workers, HDAs, husbands, parents, mother in laws and neighbors were reported to be active players in the identification and notification of pregnancy.

Regarding utilization of focused ANC services, there is an increasing uptake of the service in the last few years because of awareness raising activities conducted by the HEWs, the DTLs and 1-5 leaders, health professionals and messages transmitted through media channels mainly radio. Husbands, HEWs, , community leaders , the DTLs and 1-5 leaders were reported to play an influential role in the mother's decision to utilize focused ANC services.

The main barriers for utilization of focused ANC services were lack of knowledge on the importance of the service, distance to the health center, transportation problem and past experience of safe delivery at home.The number of pregnant mothers who deliver at the health facility has also been increasing in Gurage zone. Availability of ambulance services, banning of traditional birth attendants from assisting home delivery and the awareness raising activities done by the HEWs and HDAs were the main reasons for the improvement.

The main reasons for home delivery were fear of undergoing operation, unavailability of food and soft drinks at the health facility, limited ambulance service for kebeles far away from health center, low awareness about benefits of heath facility delivery and lack of friendly service from health professionals.

The habit of visiting health facility following delivery is very minimal. The assumption that there will be nothing to worry about once a mother gave birth safely, fear of being asked to pay for service and traditional beliefs and practices which hinder health seeking behavior following delivery were the man barriers for utilization of PNC services.

It was found that breathing difficulty, low appetite, stomach aches or intestinal complication in relation to digestion, fever, Jaundice, skin rush , bacterial infection and exposing children to bad weather are among the common illnesses that newborns face in Gurage zone.

SIDAMA ZONE

In Sidama zone, there is currently a better trend in early identification of pregnancy mainly because of the activities of HEWs and the 1-5 networking. The main barriers for early pregnancy identification were related to history of using injectable family planning methods, low awareness on signs of pregnancy and continued breastfeeding of older child. Husbands were the first persons to be informed about pregnancy followed by HEWs and health professionals.

Similarly, utilization of ANC service has also been increasing in Sidama zone. However, a significant proportion of mothers still do not visit health facilities for ANC services. The main barriers for utilization of ANC services are low awareness about availability of the service, traditional practices discouraging access to services, long distance from home to health facility, transportation problems due to inconvenient topography and influence from husbands.

Regarding delivery, there is a significant progress in Sidama zone. It was however reported that there are still women who deliver at home. The main barriers for health facility delivery service utilization were history of safe home delivery, perceived lack of friendly service at the health facility, absence of ambulance return service after delivery and other cultural and traditional factors that promote home delivery.

The proportion of women who utilized PNC service was reported to be lower than expected. This was mainly because of limited transportation services, shortage of trained health professionals to provide home outreach PNC services and low awareness on the importance of postnatal care services.

The common types of illness among newborn children in Sidama zone include, cough as a result of exposure to cold weather, diarrhea, stomach ache and jaundice. Amessa is the most common traditional herbal treatment given to newborn children when they are sick. However, the practice is decreasing from time to time as a result of aggressive efforts to educate the community about benefits of health facility services for newborn children. One of the common barriers to health seeking behavior for newborns was the perceived payment for treatment. HEWs, HDAs and radio are the main sources of information on health issues in Sidama.

RECOMMENDATIONS

- In order to promote early identification of pregnancy, SBCC activities with key messages focusing on major signs of pregnancy with specific focus on menstrual cycle and signs of morning sickness need to be carried out to raise community awareness and knowledge in rural areas.

- Husbands are reported to be the first persons to be notified or know about their wife's pregnancy. Thus, community level forums need to be organized to promote their engagement and raise awareness on benefit of early pregnancy identification. In addition, targeted and tailored messages targeting men should also be delivered through radio.

- Specific focus on follow up for early identification of pregnancy need to be given to women who have been using family planning methods (Depo Provera), recently married women, breastfeeding women and single/unmarried young women and girls as these are the population groups having unacceptable delays in pregnancy identification and notification.

- Early identification and notification of pregnancy is a determining factor for the other follow up services in the continuum of care on MNCH. Thus, the DTLs, HEWs and other health workers need to be given a sensitization workshop on the importance of focusing on early pregnancy identification to achieve the desired results on ANC, health facility delivery and PNC service utilization

- The registration of pregnant women and the pregnant women forums/conferences need to be supported and strengthened as this is an entry points for promotion of focused ANC service utilization.

- There are some traditional practices like porridge preparation that are carried out at the health facility to motivate mothers to deliver at the health facility. These practices need to be replicated at a wider level and other activities like coffee ceremony and the like that also involve families of the delivering mother need to be adopted to make the service friendly and promote skilled birth attendance.

- High level advocacy or sensitization need to be carried out with concerned government offices to arrange possibilities for provision of return ambulance transportation services for mothers who delivered at health facility as the absence of this service is discouraging women to use health facility delivery services in the first place.

- To promote utilization of PNC services, home visit services by HEWs and HDA need to be strengthened through addressing human resource gaps in engaging HEWs to conduct home to home PNC services.
- Perceived fear of payment was one of the key barriers for utilization of MNCH services in both woredas. Thus CBNC implementation needs to be initiated in all target health posts and other possible solutions need to be considered to address this barrier. In addition to this, activities to

generate demand for MNCH services need to intergrate messages about MNCH services that are free of charge.

- Religious and community leaders were reported to be currently engaged in the promotion of ANC and health facility delivery service utilization. Additional strategies should be implemented to engage these people in influencing the community to get rid of cultural and traditional practices that discourage utilization of ANC, health facility delivery, PNC and newborn health care services.

- Developing / adapting and availing clear, simple visual messages (as most of the mothers are illiterate) and locally appropriate counselling /teaching tools for HDAs, HEWs and community mobilizers would help in promoting knowledge and awareness about availability and utilization of MNCH services.
- Broadcasting simple messages via local FM radio stations, school mini-medias and other existing channels could be an effective way to reach men, students and the younger generation.
- Integrating community mobilization activities with the local cultural and social events or traditional ceremonies associated with pregnancy and delivery could be an effective and appropriate way to reach the community with targeted messages.
- There sould be coordination among the health post, HDAs and religious and community leaders to educate the community as changing people's awareness and attitude is a challenging task and should not be left to the HEWs alone

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