THE ETHIOPIA EXPERIENCE:

Evidence of positive effects of a demand creation strategy on household and community social norms related to maternal and newborn health

Save the Children

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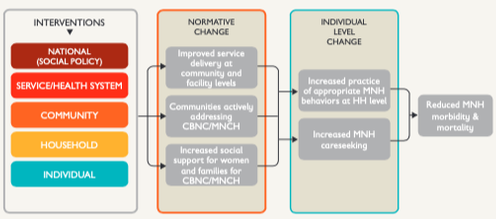
BACKGROUND

In Ethiopia, appropriate illness recognition & careseeking for newborn and childhood illness have been low, despite increasing service availability, contributing to continued high mortality rates. The Government of Ethiopia has scaled up the **Community-Based Newborn Care (CBNC)** program to bring critical prevention and care interventions closer to communities in need. Recognizing that creation of demand for services is a function of the health system, a strategy was developed. to enhance demand for maternal, newborn & child health/ community-based newborn care (MNCH – CBNC).

MNCH-CBNC Demand Creation Strategy

- **Aim:** to create an enabling environment to support appropriate MNCH practices.
- Set of interventions across levels of a social ecological framework (national, health system, community, household, individual).
- Strategies designed to empower communities to take collective action, facilitate increased demand for and access to services; and improve family practices.
- Builds on the existing Health Extension Program community cadres and engages other key players at community level, in order to strengthen the health system & for sustainability.
- Implementation timeframe & area: between 2015 – 2017 in 244 districts (woredas) across 21 zones in 4 regions.

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



Role of *Kebele* Command Posts (KCPs)

- *Kebele:* smallest administrative unit, similar to ward
- KCPs: existing local community groups with formal community development mandate
- Target for strategy's empowerment efforts
- Capacity strengthening guided by Save the Children, with support from FMOH and partners

Other demand creation strategy components:

- Supporting and revitalizing pregnant women's conferences
- Involving fathers and other family decision-makers during home visits
- Applying community bulletin boards for data use at health posts
- Improving planning/budgeting for MNCH services
- Using multiple community channels to engage around messages on careseeking and household practices
- Building and linking community social networks

EVALUATION METHODS

Evaluation Design

Embedded multiple-case study design uses multiple cases 'replication logic' to provide support for theoretical propositions by:

- Comparing similar results and
- Contrasting results for predictable reasons.

For design to be effective, theoretical framework must clearly identify conditions when a particular phenomenon is likely to be found (or not found);
Number of case replications depends upon desired certainty.

Sampling: purposeful selection

- One district in each of two zones where implementation was supported, then
- Two KCP from each district: 1 high implementation strength, 1 low implementation strength KCP selected per district

Defining implementation strength:

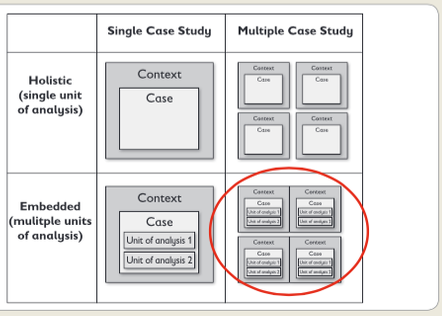
- Strategy aimed to strengthen KCP – with varying success
- Success in strengthening KCP = strength of implementation
- KCP characteristics to determine implementation strength (14) including
  - engagement of key stakeholders in demand creation
  - organizational strength of kebele command posts
  - community collective action
- Once strength assessed, KCPs categorized as high or low

Data collection

- Qualitative
  - In-depth interviews,
  - focus group discussions
  - Illness narratives,
- Key stakeholders (from each kebele): government health workers, community health workers, mothers, fathers, and mothers-in law

Analysis

- All interviews transcribed, then translated into English
- Coded using Nvivo 10.0.
- Individual case reports written for all four kebeles, then compared in a cross-case analytic report.



RESULTS

Strengthened kebele command post developing MNCH community action plan

Cross-case analysis revealed improvements in maternal and newborn health, both through temporal trends as well as differences between high- and low-implementation strength *kebeles* (see table). KCP strengthening was noted as one of the most important components of the strategy by key informants. Community action cycles were an important component of the demand creation strategy, but strategy effectiveness depended on strengthened KCP commitment and ownership. Where there was KCP commitment to the community action cycles, planning and implementation at the community level was effective in improving health outcomes, such as care-seeking and institutional deliveries.

Kebele Command Posts Characteristics – Before and After Intervention

Kebele Command Post

Membership:

- Average 8 – 10 members
- Mostly male
- Representatives of key sectors from existing formal leadership structures
- Health extension worker

Objective: Broad-based development

Recognized by political structures

Strengthened *Kebele* Command Post

Membership:

- Average 15 – 20 members
- Gender-balanced
- Religious leaders
- TBAs (non-delivery roles)
- Families with pregnant women and small children (affected populations)
- Health extension worker
- Representative from Women's Development Army

Objective: specific around a MNCH-CBNC goal

Recognized by multiple stakeholders

> *"In our village, we have seen changes. For example, in earlier times men didn't care for pregnant women, but today he is aware of what he should do for pregnant women. This has been seen after we started discussion in one-to-five groups."*

59 year old Women's Development Army member with two children and some education, High implementation strength *kebele*.

> *"It was in previous times that they said he is too small, he cannot handle the medication. But nowadays everybody knows and they will take them to where there is treatment."*

23 year old mother, High implementation strength *kebele*.

Key Evaluation Results by Level of Intervention

HEALTH FACILITY

Expected Conditions

- Humanized care at health facility
- Demand creation is a health systems responsibility
- Health system is responsive to community needs

Evaluation Results

High implementation strength kebeles

- Regular meetings held between health center and community
- Health centers responded to community needs

Across all kebeles

- Three forms of communication between communities & health centers:
  1. Health center staff visit community meetings & receive feedback;
  2. Health extension workers submit monthly reports to health center staff, including complaints; and,
  3. Community communicates issues via strengthened KCP, which in turn communicates to health center
- Pregnant women's conferences: one of most successful strategies to provide health education & track pregnant women
  - Almost all pregnant women attended

COMMUNITY

Expected Conditions

- MNCH and Family Planning are male issues
- Early antenatal care & institutional deliveries valued
- Communities are engaged in MNCH
- Pregnancy is discussed early
- All newborns are valued

Evaluation Results

Low implementation strength kebeles respondents more likely to state disadvantages to early discussion of pregnancy

High implementation strength kebeles

- Husbands, mothers-in-law, and Women's Development Army members said antenatal care should start early (months 1-5), and attributed to work of Health extension workers, Women's Development Army leaders, and one-to-five groups

Across all kebeles

- More active one-to-five groups
- Other community meetings, such as those held by idirs, provided opportunities for KCP members to address MNCH issues
- Meetings were perceived as effective at strengthening demand for MNCH services

HOUSEHOLD

Expected Conditions

- Families dialog and support for MNCH and Family Planning
- Supportive male engagement
- Belief that newborns can survive if small and/or sick

Evaluation Results

High implementation strength kebeles

- Husbands more knowledgeable about MNCH issues
- Mothers-in-law were less fatalistic about newborn survival
- Couples discussion of pregnancy typically started around the second or third month

Across all kebeles

- Traditional treatments or customs no longer used in the same way
- Mothers-in-law discussed MNCH issues but not pregnancy-related issues (for cultural reasons)
- Family planning discussions occurred most frequently between husbands and wives
- Husbands and mothers-in-law agreed that sick newborns should be taken to health facility
- Some husbands said they would give food/provide better food to the mother to benefit the baby through her breastmilk

CONCLUSIONS

- Community capacity strengthening using a multiple component approach is important to increase demand for and appropriate use of MNCH services in a relatively short timeframe.
- Integrating community empowerment with demand-creation activities and involvement of community structures such as primary health care units and *woredas* could help institutionalize these approaches.