



Barriers affecting demand for reproductive, maternal, newborn and child health (RMNCH) services in Ethiopia

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Question

What evidence is there on the barriers affecting demand for RMNCH services in Ethiopia? Are these different for agrarian and pastoralist regions?

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1. Summary

The main barriers affecting demand for reproductive, maternal, newborn and child health (RMNCH) services in Ethiopia are primarily associated with:

- **Women's autonomy and other gender norms**, such as women's participation in decision-making and their ability to use services on their own terms.
- **Traditional beliefs and practices**, and how these influence decisions such as the place of delivery, or women's access to antenatal and postnatal care.
- **Religious beliefs**, which are particularly dominant in decisions about the use of reproductive health care services.
- **Awareness and knowledge**, including awareness of the risks to mother and child, as well as awareness of the services available and how to access them.
- **Cost of services**, and the fear of cost, in that simply anticipating potential expenses can be a deterrent. This is despite the fact that most RMNCH services are free.
- **Physical access to services**, affecting rural areas in general, and remote pastoralist regions in particular.

These barriers intersect. For example, men are more likely to get involved in decisions about the use of health services if there are significant financial implications, or consequences for the family as a whole; men's decisions will also be shaped by their own personal beliefs. Women may have a high level of awareness about a particular service and its benefits, and know how to access it, but may still choose not to use it if that information is inconsistent with strong cultural beliefs, or their past experience of using the service.

Sub-national inequality in the utilisation of RMNCH services in Ethiopia is high, with particular challenges for the predominantly pastoralist regions of Somali and Afar. However, there are important distinctions between them. For example, there is a preference for home births in both regions, but not necessarily for the same reasons: in the Afar region the preference is associated with traditional and cultural beliefs concerning privacy, secrecy and ceremony, while in the Somali region it is driven by concerns about hygiene and the lack of water in health facilities.

The literature contains examples of other, more nuanced differences across the country. These are highlighted throughout the report, with some general conclusions made at the end. For example, migration is not just a factor in pastoralist regions; share-cropping in agricultural areas also leads to long absences and insufficient male support for women during pregnancy and labour. While women in the regional states of Somali, Afar, and Southern Nations, Nationalities and Peoples (SNNP) all demonstrate a preference to be treated by female health professionals, this is not an issue in Tigray, where there is even some preference for a male health worker because women are seen to give less respectful care.

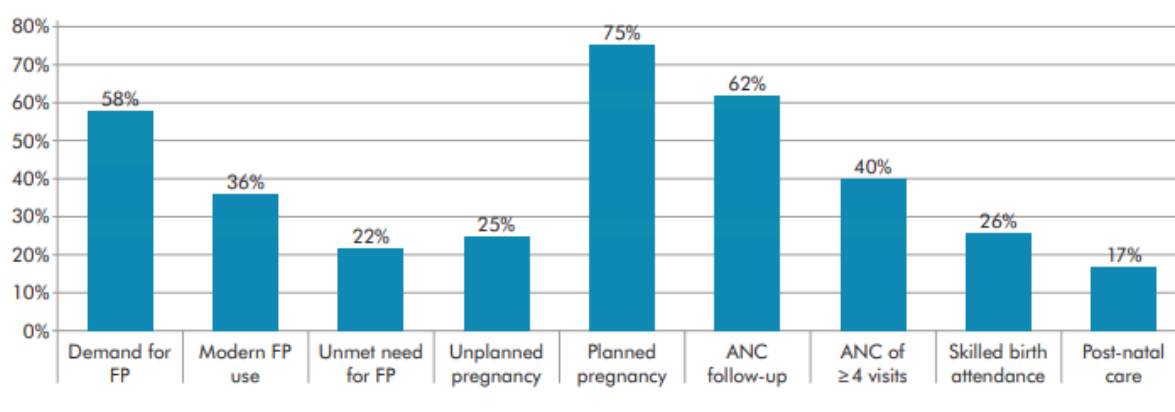
There is a significant body of literature on the topic, mostly academic studies with some grey literature, and generally standalone pieces of research, both quantitative and qualitative. The qualitative studies focus on specific locations, or particular aspects of RMNCH service provision. Less material was found that provides the comparative and systematic analysis required by the second half of the research question. The literature has a strong focus on gender, exploring both women's and men's perspectives and priorities, and some material that captures inter-generational views. No studies that address the relationship between RMNCH service provision and disability were found.

2. Utilisation of RMNCH services in Ethiopia

Ethiopia was one of 12 low-income countries which met the MDG target to reduce child mortality by two-thirds between 1990 and 2015. During the same period it also reduced maternal mortality from 1,250 to 353 deaths per 100,000 live births (UNICEF and PATH, 2016). Despite these achievements, challenges remain; maternal morbidity and mortality in particular remain unacceptably high (Lemma et al, 2018).

Figure 1 illustrates the utilisation of maternal health services in Ethiopia based on data from the 2016 Ethiopia Demographic and Health Survey (EDHS). This national data conceals significant regional inequalities, particularly for the two predominantly pastoralist regions of Somali and Afar. Modern family planning use is only two percent in Somali region, while in Afar, 90 percent of women deliver at home, and the same percentage have no post-natal check-up (Wester et al, 2018).

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



Source: Lemma et al (2018), Licensed under Attribution-NonCommercial-NoDerivs 3.0 Unported (CC BY-NC-ND 3.0), <https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/14203>

Faye et al (2020) examine sub-national inequalities in RMNCH coverage in sub-Saharan Africa. Figure 2 shows the composite coverage index (CCI) for countries in Eastern Africa and the very large disparity in Ethiopia.¹ The authors also find that while RMNCH coverage has increased in Ethiopia since 2000, so has sub-national inequality.

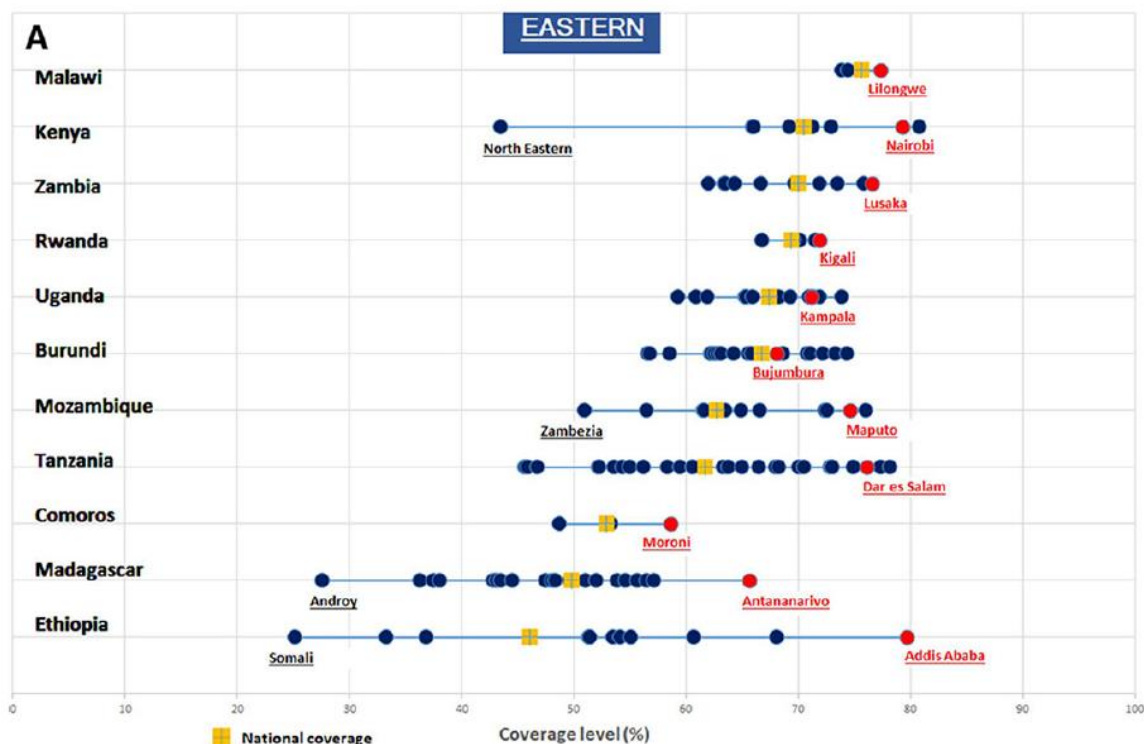
The utilisation of RMNCH services is affected by both demand-side and supply-side barriers. This review focuses on the former, and specifically the following issues raised in the literature:

- Women's autonomy and other gender norms
- Traditional beliefs and practices
- Religious beliefs
- Awareness and knowledge
- Cost of services

¹ The authors caution that sub-national inequalities are not directly comparable between countries given differences in the number of sub-national units and population size.

- Physical access to services

Figure 2: RMNCH coverage (compositive coverage index) by country and sub-national unit.



Source: Faye et al (2020), licensed under Attribution-NonCommercial 2.0 Generic (CC BY-NC 2.0), <https://gh.bmj.com/content/bmjgh/5/1/e002232.full.pdf>

3. Women's autonomy

Wado (2018) examines the association between women's autonomy and reproductive health care-seeking behaviour in Ethiopia, using data from the 2011 DHS, and finds a statistically significant association between women's autonomy and their use of both modern contraception and antenatal care (ANC) services.² This finding is reinforced by the results of three recent qualitative studies into the use of RMNCH services in the regional states of Somali, Afar, and SNNP:

- Almost all female respondents in the Somali region reported that they had a limited role in decisions about using health services. While male respondents expressed positive support for their partners to access services at health facilities, this did not extend to family planning (although men's acceptance of family planning rises with their level of education). For women, other barriers to using family planning services were fear of social stigma, and fear that a delay in giving birth would lead their husband to take another wife or divorce them (Jalu et al, 2019).

² The three indicators of women's autonomy were: (i) participation in decision-making; (ii) attitudes towards wife-beating; and (iii) permission to seek medical care.

- In Afar, demand for family planning is constrained by the cultural preference for large families (Wester et al, 2018). As in Somali region, women's use of family planning services is also influenced by their fear of divorce and unwillingness to confront husbands. There is also limited discussion of fertility-related issues between couples (Medhanyie et al, 2018).
- In the Sidama zone of SNNP, a woman's use of maternal health services is influenced not just by her husband but by the views of her mother-in-law and other family members (Kea et al, 2018).

Assessments of the barriers to the utilisation of maternal health services in Oromia (East Shewa zone) and SNNP (Gurage and Sidama zones) also explored decision-making roles. Husbands in East Shewa were said to take the final decision about where a woman gives birth (Save the Children, 2015a), while husbands in Gurage were key in influencing that decision (Save the Children, 2015b). The influence of husbands was also a factor in women's decision to use ANC services in SNNP, particularly in Sidama (Save the Children, 2015b).

Male dominance in decision-making also extends to child health. Shaw et al (2017) examine care-seeking practices for children in two rural woredas³ of Oromia: Jimma and West Hararghe. Men are actively involved in decisions about care outside the home, particularly if these have implications for cost, transportation, or the mother's absence; in these circumstances most women also agreed that it was their duty to seek permission to leave the home for treatment. However, while men exercised ultimate authority, most women reported that the decision was collaborative, and one-third of women characterised the husband's involvement as 'passive', particularly in West Hararghe. Some women would also access care in their husband's absence. In nearly half of households interviewed, there was some disagreement on the type or timing of care required, and this was the most common reason for delay in accessing services. The disagreement might be between husband and wife or, as in Sidama, between the wife and her husband's elderly relatives.

Grandparents are also influential in Afar. King et al (2016) find that they may use their own experience of childbirth to dissuade a woman from delivering at a health facility, since they themselves had given birth at home without difficulty. Teklehaimanot et al (2019) note the same with regard to immunisation in pastoralist Borena zone, Oromia, where those who had reached adulthood without vaccination had less appreciation of the need for it.

4. Other gender norms

Gender preference for service provider

In their study into the use of maternal health services in three regions (Afar, SNNP, and Tigray), King et al (2016) find a reluctance among women in Afar and SNNP to be treated by male health professionals; Jalu et al (2019) find the same in Somali region. Muslim women in Sidama zone, SNNP, refrained from using skilled birth attendants in case they encountered a male health professional during delivery; some also believed that delivery would be prolonged if attended by a man (Save the Children, 2015b). However, the gender of the health provider was not an issue

³ Districts.

in Tigray, where there was even some preference for a male health worker because women were seen to give less respectful care (King et al, 2016).

Husbands' involvement in health care

Men's influence on women's use of maternal health care services was illustrated above, and their wider involvement in maternal health care is now starting to be explored in more depth. A qualitative study by Teklesilasie and Deressa (2020) looks at the barriers to husbands' involvement in maternal health care in five woredas of Sidama zone, SNNP region. The authors note that there is no universal definition of 'husbands' involvement', but for the purposes of their study they use the following: 'when a husband accompanies his pregnant wife to the health facility for at least one ANC visit, or delivery care or PNC visit but not for his medical problem' (p. 3). The main barriers to men's involvement in maternal health care were identified as follows:

- **A belief that childbirth is a natural process** and can be managed at home without medical help.
- **A belief that pregnancy and childbirth are women's business**, and that women and men have different roles in caring for pregnant women and women in labour: i.e. that women provide body care and help with household responsibilities, while men provide physical, emotional, financial, and practical support.
- **A preference for care by traditional birth attendants (TBA)**, associated with (i) husbands' worries about unkind treatment from health staff; (ii) women's experience of reassurance and familiarity during birth, encapsulated in the phrase: 'they [i.e. TBAs] just give care as a woman' (p. 5); and (iii) negative attitudes from health workers to men's involvement.
- **A perception that men's involvement is a new, unfamiliar, and foreign idea.** Reluctance was high among women, not just men, who regard ANC and maternity services as 'female' spaces, designed and reserved for women, who may find it difficult to express their opinion openly in front of their husbands.

5. Traditional beliefs and practices

In their three-region study, King et al (2016) find that traditional beliefs and their influence on the utilisation of maternal health services are particularly strong in Afar. Afar-specific studies by Medhanyie et al (2018) and Wester et al (2018) draw similar conclusions. Some examples of these beliefs are:

- Concerns about protecting the 'secrets' that surround birth and female genital cutting, which reinforce a preference for delivering at home with TBAs.
- Social obligations to visit others at times of illness or delivery, which are less easy to accommodate in a health facility.
- Cultural importance attached to washing after birth, and to other ceremonies and types of food.
- Women being confined to the house for 40-45 days after delivery, which is a major barrier to their use of post-natal care (PNC).

Similar beliefs and practices were found in studies in Oromia and SNNPR:

- In East Shewa zone, Oromia, women are discouraged from leaving home for two months after the birth. While some PNC home visits are provided, the service is not consistent (Save the Children, 2015a).
- In Gurage zone, SNNP, communities place high value on traditional ceremonies involving coffee or porridge, as well as the social company that women enjoy when delivering at home. As in East Shewa, women are encouraged to stay at home for two months after delivering in the belief that evil spirits will cause harm if they do not (Save the Children, 2015b).

Kea et al (2018) describe a range of cultural beliefs and practices in Sidama zone, SNNP region, which also affect the use of maternal health services. For example:

- Women traditionally conceal their pregnancies in the early months, preventing timely use of ANC services.
- Communities consider women who give birth at health facilities as weak.
- There is a culture of burying the placenta inside the home to bring good fortune to the baby; inability to do this was identified as an important deterrent against institutional delivery.

King et al (2016) find that resistance to using skilled birth attendants is reduced when more culturally sensitive services are provided. For example, in Adwa woreda, Tigray, some health centres are displaying pictures of Mariam (the Ethiopian Orthodox saint for birthing women) and allowing women to wear perfume or burn incense during labour.

6. Religious beliefs

Qualitative studies in Somali and Afar regions find that both women and men believe that decisions about family size rest with Allah and that children are God's blessing. Even so, Somali women understand the advantage of birth spacing (Jalu et al, 2019). Some studies point to differing interpretations of what Islam allows with regard to child spacing, contraceptive use and female contact with male health providers, with communities sometimes holding more conservative views than religious leaders (Wester et al, 2018; Medhanyie et al, 2018).

In SNNP, Kea et al (2018) found some evidence that Christian beliefs, and an assumption that God would help mothers during labour, influenced a preference for home births in Sidama zone. The same was found in Gurage zone, where religious beliefs among both Christians and Muslims, and a belief that God, rather than health professionals, would protect, were reported as barriers to skilled birth attendance (Save the Children, 2015b).

Demissie et al (2019) evaluate a programme to improve the uptake of child immunisation in two woredas (Assosa and Bambasi) of Benishangul-Gumuz regional state. Both woredas are lowland areas inhabited by predominantly Muslim agrarian communities and some Christians who had relocated from Amhara. The original stakeholder discussions for the programme did not identify religion as a barrier to vaccination, although the evaluation sampling was designed to explore this. Qualitative interviews revealed that opinions about vaccination had changed in the past decade among both Muslims and Christians and that there were now high levels of acceptance. However, 'a small minority' of Muslims were reported still to believe that vaccination was unacceptable (p. 32); the reasons were not explored, although the authors speculate an association with family planning, since both services are provided at the same facility.

In their analysis of young people's sexual and reproductive health needs, Muntean et al (2015) note that over 80 percent of urban and rural youth report being exposed to religious institutions, a higher figure than are exposed to health interventions. While religious leaders are known to shape community opinion on matters of sexual and reproductive health, the authors found no study that evaluated the impact of religious institutions on sexual behaviour (Muntean et al, 2015).

7. Awareness and knowledge

There are three aspects to this: (i) awareness of risk; (ii) awareness that a service exists, what it involves, and how to access it; and (iii) an individual's experience of using a service, or what they hear from others, and how that then informs their healthcare choices.

Information alone may not be the critical factor that determines the utilisation of services. For example, Shaw et al (2017, pp. 9-10) conclude that the low utilisation of health posts⁴ for child illness is not explained by low awareness of, or perceived need for, this option, but rather is linked to socio-cultural factors concerning how child illness is understood and negotiated within families and communities. The authors also emphasise the importance of information and advice gathered from women's social networks. A similar point is made by Jalu et al (2019) who note the influence of word-of-mouth in the Somali region's oral culture, which may have either a positive or negative influence on the utilisation of RMNCH services; this includes information gathered from non-Somali neighbours with experience of using a particular service.

Awareness of risk

Several studies note that women's awareness of risk affects their use of maternal health services, particularly antenatal and postnatal care. Women may feel well, or have had no complications with previous pregnancies, and would therefore not seek services unless this changed (Kea et al, 2018; Medhanyie et al, 2018; Save the Children, 2015a and 2015b). Jalu et al (2019) identify women's low perception of risk as the main reason for the low utilisation of postnatal care services in Somali region.

Awareness that a service exists, what it involves, and how to access it

Lack of reliable information is a particular constraint in two areas: the use of safe abortion services, and the use of sexual and reproductive health services by young people.

Seid et al (2015) explore the barriers to safe abortion services in a qualitative study in the East Shoa and Arsi zones of Oromia. Despite legislation in 2004 that sets out the conditions under which abortion is allowed, many still believe that it is illegal. This in turn deepens the sense of stigma associated with accessing the service and the fear of being seen by family or neighbours, particularly in a context where religious disapproval is high and shapes the opinions of women, communities and service providers. The authors found that in this case there was no urban advantage: neither urban nor rural women knew about the services available or where to go. The

⁴ Health posts are the lowest level of the health system, serving a population of 3,000 – 5,000 people.

study concludes that expanding access to legal abortion does not in itself guarantee a decrease in unsafe procedures.

Muntean et al (2015) find very limited knowledge among young women and men about sexual health, with the exception of HIV, and limited access to information. They note that open discussion of sexual matters, within families, schools or communities, is not culturally acceptable in a society where religious influence is strong. Jain et al (2019) explore the association between stigma and the use of family planning services by young married couples. They find that anticipated stigma – such as being embarrassed to discuss contraceptive use with providers, worry about parental or community attitudes, or fear of being seen when using services – is significantly associated with an unmet need for voluntary family planning in a society where early marriage is still common and the pressure to demonstrate fertility is high.

Experience of using health care services

Disrespectful care was a barrier mentioned in several studies:

- King et al (2016) identified it as a barrier for some women in all three regions studied (Afar, SNNP, and Tigray), particularly at higher levels of the health system. In SNNP, women expressed a preference for attending a health post rather than health centre, where staff were sometimes rude or abusive to rural women. In Tigray there had been problems with mistreatment of rural women at Adwa hospital. The authors find evidence that if women are treated well, they will access skilled birth attendance at facilities.
- Some pregnant women in Sidama reported that they did not plan to use health facilities during their current pregnancy and would not advise others to do so, given poor experiences of care on previous visits (Kea et al, 2018).
- Shaw et al (2017) comment on the asymmetrical relationship between health providers and women, in terms of social class and literacy.

Other factors which were found to discourage institutional deliveries were:

- **Concerns about cleanliness at health facilities.** The lack of water at health posts in Somali region was found to be the main reason in this study why women prefer home births (Jalu et al, 2019).
- **Concerns about privacy and unfamiliarity** (such as different delivery positions) at health facilities (Kea et al, 2018; Save the Children 2015a and 2015b).
- **Fear of being left alone** at health facilities where women are not accompanied to the labour ward, and where there are no home comforts (Sisay et al, 2014).
- **Misplaced fears that surgical procedures may be required** (Save the Children, 2015a and 2015b; Jalu et al, 2019).

8. Cost of services

While most RMNCH services are free, other costs associated with their use can act as a disincentive, such as travel, food, accommodation, care (if consumables are not available at the health facility) and lost income (King et al, 2016). Fear of payment, even when it was not required, is also a barrier – for example to the use of PNC services in Gurage and Sidama (Save the Children, 2015b).

Several studies find instances of inappropriate payments being demanded. For example:

- Ambulance drivers asking for payment in Kafa zone (King et al, 2016), or for fuel in Sidama zone, both in SNNP (Kea et al, 2018).
- Hospitals demanding payment for delivery services (Kea et al, 2018).

Cost is a particular issue for women seeking legal abortion services which, unlike other maternal health services, are not free. Women's anticipation of high cost is also a deterrent. This barrier is especially acute given the sensitivity of the issue within the family and women's economic dependence on their husbands (Seid et al, 2015).

9. Physical access to services

Physical access to RMNCH services is an obvious constraint in pastoralist regions, where transportation is poor, health facilities may not be fully functioning, and mobile phone networks have insufficient coverage to allow for help to be called in emergencies (Medhanyie et al, 2018). There may also be gender implications – for example, discouragement of unaccompanied travel by women in Afar (Wester et al, 2018). Teklehaimanot et al (2019) capture the various constraints on accessing immunisation services in the pastoral Borena zone of Oromia, including mobility, low population density, the challenges of walking long distances carrying children, and the competing demands on women's time in pastoral societies.

Jalu et al (2019) distinguish between three aspects of distance and their impacts on the utilisation of health systems: (i) distance between households, which affects extension; (ii) distance between households and health facilities, which affects access to care; and (iii) distance between health facilities, which affects referral. Distance was a major barrier to using health services in Somali region.

However, access is a challenge for many rural communities (Kea et al, 2018). Women in SNNP and Oromia regions raised a specific concern that, while ambulance services were sometimes provided to reach a health facility when in labour, no support was available for the return journey when women and their babies may also be at risk (Save the Children, 2015a and 2015b). King et al (2016) found conflicting messages from health centre staff to health education workers about when to refer women and when to call ambulances, and that ambulances were also being misused for other purposes.

10. Sub-national differences

Urban advantage

Jalu et al (2019) explore the utilisation of RMNCH services in urban, agro-pastoralist and pastoralist areas of the Somali region. Those in urban settings have easier access to health facilities and higher exposure to information through the media and other networks. Further, health professionals tend to migrate to urban areas once trained. However, as the study by Seid et al (2015) showed, there are still gaps in the health information available to urban populations.

Mobility

Mobility is the obvious barrier for pastoralist communities in utilising health services. The two woredas in Oromia region studied by Save the Children, with their differing livelihood profiles, illustrate this point. The main barrier for women in accessing ANC services in the agricultural Bora woreda is a lack of knowledge about their benefits, while the main barrier in pastoralist Fantale woreda is the practice of extended seasonal migration for five or six months of the year by men, sometimes accompanied by women. Women may start ANC services but have to discontinue them. For the same reason, delivery with a skilled birth attendant is higher in Bora than Fantale, where labour may be sudden, and the woman far from a health facility or out of range of mobile phone networks (Save the Children, 2015a).

However, mobility is not only a barrier for pastoralists. In Adwa, men move to Western Tigray for six months each year to sharecrop. This means that if a woman needs to visit a health facility there may be no-one to look after the family, cattle, or house, and there may not be enough men to help with transportation (King et al, 2016).

Common barriers, different causes

The literature finds similar barriers across different pastoralist areas, but not necessarily for the same reasons. For example, the predominance of home births in Afar is associated with traditional and cultural beliefs concerning privacy, secrecy and ceremony, and with the practical constraints of infrastructure and communication. In the Somali region, however, a key barrier to using institutional facilities is hygiene, and specifically the lack of water in health posts.

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