College of Business and Economics

Department of Public Administration and Development Management

ASSESSMENT OF THE CHALLENGES AND OUTCOMES OF EMPOWERMENT STRATEGIES TO IMPROVE MATERNAL AND CHILD HEALTH (THE CASE OF HAIK HEALTH CENTER)

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This is to certify that the thesis prepared by Tekuamework Demessie entitled ***"Assessment of the Challenges and Outcomes of the Empowerment Strategies to Improve Maternal and Child Health; The Case of Haik Health Center"*** which is submitted in partial fulfillment of the requirements for Masters Degree of Public Management and Policy (Policy Study) in the Department of Public Administration and Development Management, complies with the regulation of the university and meets the accepted standards with respect to originality and quality.

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List of Acronyms

ANC- Antenatal Care

CHW-Community Health Workers

CPR- Contraceptive Prevalence Rate

DHS- Demographic and Health Survey

EJHD- Ethiopian Journal of Health Development

FMOH- Federal Ministry of Health

GTP-Growth and Transformation Plan

HDA-Health Development Army

HEP-Health Extension Program

HEW- Health Extension Worker

HIV/AIDS- Acquired Immunodeficiency Syndrome

HSDP- Health Sector Development Plan

IMCI-Integrated Management of Childhood Illnesses

IMR- Infant Mortality Rate

KSPA-Kenya Service Provision Assessment

MCE- Multi-Country Evaluation

MCH- Maternal and Child Health

MCHIP -Maternal Child Health Integrated Program

MDG- Millennium Development Goal

MMR- Maternal Mortality Rate

MNCH- Maternal Newborn and Child Health

NGO- Non-Governmental Organization

PNC- Post Natal Care

PPD- Partners in Population and Development

SNNPR-Southern Nations, Nationalities and Peoples Region

UHEP- Urban Health Extension Program

UMR-Under 5 Mortality Rate

UN- United Nations

UNDP-United Nations Development Program

UNICEF- United Nations Children's Fund

USAID- United States Agency for International Development

WB-World Bank

WID-Women in Development

WHO- World Health Organization

Abstract

The main objective of this study is to assess the major outcomes and the challenges that hinder the effectiveness of empowerment strategies to improve maternal and child health. The study also investigated the measures taken to empower the community and also find out the possible challenges that may hinder the effective implementation of the empowerment strategies. Moreover, it also assesses the attitude of the community towards the empowerment strategies. To this end, different policy documents, organizational reports and published and unpublished materials were reviewed. 42 health professionals working on maternal and child health issues in the health center filled questionnaires using census sampling method and 88 mothers who use service of the health center have filled questionnaires by convenience sampling technique. Maternal officer, child officer and head of the health center were interviewed using structured questions. Descriptive research design is also used in this research. The findings of the study revealed that, there are great measures taken by the government and health professionals to empower the community to use maternal and child care services. These measures are organizing women in to health development army (HDA) group, organizing women conference to provide information and making maternal and child care services free of charge. These measures brought about a major outcome in the health of mothers and newborns, increase health care coverage and significant reduction in maternal and child death. However, there are still challenges that hinder the full achievement of the empowerment strategies. These problems are the top down approach of the policy without the involvement of community groups, socio-cultural beliefs and perceptions, low educational level of women, less support of men partners and shortage of necessary logistics and qualified and experienced health professionals. To solve the above mentioned and other related problems, the researcher suggested some measures to be taken. These are; equip the health center with the necessary materials and qualified health professionals, increase the knowledge of women by supporting women education and giving trainings regularly, strengthen HDAs and different community associations, providing proper and long term training for health professionals, giving a great emphasis for community participation in designing and implementation of health policies and empower not only the community but also health professionals.

Glossary of Key Terms

Antenatal Care: Health care, including screening tests and counseling, provided to women during pregnancy. It is also referred to as prenatal care.

Antenatal Care Coverage: The percentage of women who have given birth who received antenatal care from a skilled attendant at least once during their pregnancy.

Continuum of Care: An approach to maternal, newborn, and child health that includes integrated service delivery for women and children from before pregnancy to delivery, the immediate postnatal period, and childhood.

Empowerment: is a process by which those who have been denied the ability to make choices acquire such ability. In the gender equation, empowerment is required for women since they are the ones who have generally been deprived of opportunities to make choices in their lives (Kabeer, 2005).

Empowerment Strategies: are strategies that aim to give citizens the power necessary to make confident decisions on matters that affect their life.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

Maternal Death: The death of a woman while pregnant or within 42 days of the termination of pregnancy, due to complications during pregnancy or childbirth.

Maternal Health: The health of women during pregnancy, childbirth, and the postpartum period.

Maternal Morbidity: Any injury, condition or symptom that results from, or is worsened by pregnancy.

Maternal Mortality Rate: The number of maternal deaths during a given time period per 100,000 women of reproductive age (15 to 49) during that same time period.

Millennium Development Goals (MDGs): A series of eight broad development goals established in 2000 and adopted by countries around the world, which encompass issues of poverty, education, and health. They are set to be achieved by 2015.

Millennium Development Goal (MDG) 4: The goal to improve child health; reduce the under-five mortality rate by two thirds between 1990 and 2015.

Millennium Development Goal (MDG) 5: The goal to improve maternal health; targets for achieving this goal include the reduction of maternal mortality by 75% between 1990 and 2015, and the assurance of universal access to reproductive health by 2015.

Newborn Health: The health during the first four weeks of a child's life.

Reproductive Health: The state of complete physical, mental and social well-being in all matters relating to the reproductive system, its functions and processes.

Safe Motherhood Initiative: A global initiative launched in 1987 aimed at reducing maternal and infant mortality, and improving women's health in general.

Skilled Attendants: Individuals with midwifery skills, such as doctors, nurses, and midwives, who have been trained to provide competent care during pregnancy and childbirth.

Under-five Mortality Rate (U5MR): (also called child mortality rate) is the probability of dying between birth and exactly 5 years as expressed per 1000 live births.

http://www.womendeliver.org/assets/Glossary_of_Key_Maternal_Health_Terms.pdf

Chapter One

1. Introduction

1.1. Background of the Study

Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations. It is the process by which individuals and communities are enabled to take power and act effectively in gaining greater control, efficacy, and social justice in changing their lives and their environment (Israel et al., 1994). The health promotion policy and practice place a high value on community development work because it aims to enable communities to identify problems, develop solutions and facilitate change. Community development has been suggested as offering “the most promising approach to reducing health inequalities”. It has been seen as a key strategy to mobilize citizens, organizations and communities for health action and to stimulate conditions for change. It is an approach aimed at facilitating community groups and individuals to "*empower* themselves", one that seeks "to recognize and value the health experience and knowledge that exists in the community and to use it for everyone's benefit". (Robinson and Elliott, 2000)

Women in developing countries are the backbone of a society and forerunners of the family welfare even though they get the smallest benefits from societal and family resources. This is particularly evident in developing countries where women are most marginalized and bear the consequences of poverty, underdevelopment, and traditional and cultural sanctions. Hence, this worsens the women’s health status and health indicators such as maternal mortality are considerably high. In order to overcome this devastating problem and to improve the general reproductive health of women, international initiatives recently have been focusing on broader approaches towards improving women’s general reproductive health (Yegomawork et al, 2003).

Women in Ethiopia comprise half of the total population. Ethiopian women are engaged in many economic sectors and are major contributors to the welfare of the society. It is unthinkable to create economic development without giving considerable attention to women’s right to fully participate in the planning, implementation, monitoring and evaluation of development activities.

FMOH further stated that women, as child bearers, are in the best position to shape the behavior of the future generation. This indicates that empowerment of women is very essential to enhance the health of mothers, children, households in particular and the society in general (FMOH, 2005).

Maternal health, as defined by the World Health Organization (WHO), refers to the health of women during pregnancy, childbirth, and in the postpartum period. Child health generally refers to the health of children from birth through adolescence, although the specific age range varies. Newborn health captures the health of babies from birth through the first 28 days of life. These are most often considered in concert since they are integrally related to one another. Maternal health has a large impact on whether a child survives and thrives. When a mother dies, her children are three to ten times as likely to die as well (WHO, 2005). The major direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor. Maternal and child health (MCH) care is the health service provided to mothers (women in their child bearing age) and children. The targets for MCH are all women in their reproductive age groups, i.e., 15 - 49 years of age, children, school age population and adolescents (WHO, 2015).

In the 1980's, the United States increased funding for MCH-related programs. At that time, it was estimated that 17 million children under the age of 5 died every year. The global under-five mortality rate has declined by nearly half (49 per cent) since 1990, dropping from 90 to 46 deaths per 1,000 live births in 2013. The total number of maternal deaths also decreased globally by 45% from 523,000 in 1990 to 289,000 in 2013. According to the World Health Organization, Congenital anomalies (also referred as birth defects) affect an estimated 1 in 33 infants and result in approximately 3.2 million birth defect-related disabilities every year. An estimated 270 000 newborns die during the first 28 days of life every year from congenital anomalies. The majority of these occur in low and middle income countries (USAID 2015).

There are many effective interventions/programs designed to reduce maternal and child mortality. However, the global progress report in 2009 on Millennium Development Goals (MDGs 4 and 5) depicted that many countries are not in a position to meet the 2015 goals (UN, 2009). A number of reasons have contributed for the delayed global progress. Funding shortages, lack of health care professionals, lack of access to education, economic status, availability of clean water, sanitation

and other complex factors (for instance Maternal Newborn and Child health (MNCH) is highly associated and affected by the status of women and children especially girls in a given community) affect the health of mothers and children (Moss, et al, 2010). 50% of the world's maternal and child death is reported from Sub-Saharan Africa countries (WHO, 2006).

Millennium Development Goal 5, improve maternal health, set the targets of reducing maternal mortality by 75% (MDG 5a) and achieving universal access to reproductive health by 2015 (MDG 5b). Despite significant declines, MDG 5a was not met. Progress in reducing mortality in developing countries and providing contraceptive services was insufficient to meet the targets. Looking beyond 2015, the Sustainable Development Goals offer a renewed opportunity to see improvements in maternal health for all women, in all countries, under all circumstances (WHO, 2015).

The global initiative has been approved and adopted by the Ethiopian government and is incorporated in the national Health Sector Development Plan (HSDP). Following the change of Government in 1991, a number of political and socio-economic reform measures were put in place in Ethiopia. Two of these were the development and introduction of a new National Health Policy in 1993 and, in 1997, the formulation of a comprehensive rolling 20-year Health Sector Development Plan (HSDP) which has been implemented in terms of four consecutive phases starting from 1997/8. The first and the second phase of the program were completed in 2002 and in 2005 respectively (FMOH, 2005). The two phases have further lead to the development of the third HSDP in July 2005, which was completed in 2010 (FMOH, 2010). The fourth phase is being implemented and expected to be completed in the year 2015. Both are the result of the critical assessment and analysis of the nature and causes of the country's health problems. The HSDP prioritized maternal, newborn, child and adolescent health services via adopting strategies such as Making Pregnancy Safe, national reproductive health strategy, national new born and child survival strategy and Safe Motherhood Initiative, which are conventional to have a greater impact on women's well-being (FMOH, 2005).

The Federal Democratic Republic of Ethiopia has about 2,000, the region of Amahara has 801 and in South wollo Zone 125 and also in Tehuledere woreda there are 4 Health Centers. There are 19 rural health posts, 6 private clinics and 7 pharmacies/ drug stores in the woreda. Among these Haik

Health Center is one of them. Haik Health Center was established in1947 E.C during the imperial era for the benefit of the people by the initiative of government to take care of the health of the society.

This Health Center was named a clinic ten years before. At beginning the Health Center was having 2 examination rooms and one room for office. There was no sleeping room from 1947 to the end of 1983. When the Health Center was established the number of nurses or health professionals were two. Two of them were nurses. Currently the Health Center has expanded substantially and has 89 health professionals & administrative workers treating patients. The Health Center gives service for 3 woreda residents and others patients. Now days, the Health Center has 3 bed rooms, 4 examination rooms, 2 pharmacy shops and 21 different administrative offices. Now the Health Center is running by health officers, nurses and pharmacy staff. The laboratory is equipped and is led by junior laboratory technicians. However, it has no X-Ray machine, ultra sound machine, but there is HIV and blood ultra-testing equipment. Currently, the Health Center serves 24 hours a day. Under the health center, there are 7(seven) health posts.

Women's empowerment is a core part of any development strategy. Empowering women is thus clearly a basic human rights issue. Believing this, the study is aimed to analyze the challenges and outcomes of different empowerment initiatives in improving maternal and child health in Ethiopia.

1.2. Statement of the Problem

Ethiopia has one of the highest maternal mortality ratios (MMRs) in the world (676 maternal deaths per 100,000 live births in the 2011 (EDHS, 2012). Despite the effort to expand coverage of health services, Ethiopia has struggled to improve its maternal health indicators (FMOH, 2007). Not surprisingly, the country's high MMR is associated with a lack of adequate access and continued under-utilization of modern health services (Regassa, 2011). The risk of maternal death is greatest during labor, increasing significantly during the second and third stages and continuing into the postpartum period (UN, 2012). It is estimated that 90% of maternal deaths could be prevented with timely medical intervention. The chances of death decrease considerably if women receive skilled maternal health care during delivery (Ronsmans and Graham, 2006). Despite the Ethiopian government's efforts to improve maternal health, as well as the increase in the number of health centers in the country, health service utilization is unacceptably low. Only about 34% of

women receive ANC, and perhaps most significantly, an estimated 90% of births still do not take place in a health facility with the assistance of a skilled provider (EDHS, 2011).

There are different reasons for mothers not to use maternal and child care services in the study area. Cultural norms carry significant weight in women's decision-making, particularly in the choice of a location for birth. Because of the weakness in service delivery, expectant mothers avoid deliveries in facilities and seek less effective birth solutions from home deliveries and traditional practices and this leads to a higher risk of poor maternal outcomes.

In addition, the level of maternal mortality and morbidity in the study area demonstrate the low level of maternal health services such as antenatal and postnatal care (ANC and PNC) and the shortage of trained personnel who can provide basic essential obstetric care during labor and delivery. The absence of appropriate and adequate services and quick access to services when obstetric emergencies arise is one of the most important factors for maternal death.

Socioeconomic, cultural and demographic factors are also affecting the use of ANC services. Women often lack access to relevant information, trained providers and supplies, emergency transport, decision making ability and other essential services. Most of the women in the study area are uneducated housewives and live in rural areas whom they may not have access to media and information.

Even though there is a decline in maternal and child mortality rate and increase in health coverage from the previous periods, there is still gap that should be filled. The above mentioned and other problems related to maternal and child death initiated the researcher to conduct a research. The researcher selected the study area because of knowing the area for long believing that the problem is deep there and it should be investigated to provide possible solutions. Therefore, the study focused on assessment of the outcomes and challenges associated with the empowerment strategies to improve maternal and child health.

1.3. Research Questions

1. What measures do the health professionals took to implement the empowerment strategies?

2. How do women in particular and community people in general respond to applied empowerment interventions?

3. What outcomes have the applied empowerment strategies bring on maternal and child health?

4. What possible challenges are there that may hinder the achievement of the empowerment strategies?

5. What are the possible solutions that help to address maternal and child death problems?

1.4. Research Objectives

1.4.1. General Objective

The general objective of the study is to assess the major challenges and outcomes of the empowerment strategies regarding maternal, newborn and child health services, in improving maternal and child health in Ethiopia.

1.4.2. Specific Objectives

1. To assess the measures taken by health professionals to implement the empowerment strategies.

2. To investigate the attitude of women and the community people towards the health empowerment strategies.

3. To find out the outcomes of the empowerment strategies on maternal and child health.

4. To examine the challenges that hinders the achievement of the empowerment strategies.

5. To suggest possible solutions that help to address problems related to maternal and child death.

1.5. Significance of the Study

As the Ethiopian government specifically Haik health center is implementing the empowerment strategies in order to solve the problem of maternal and child death, so the study findings will provide constructive recommendations that can assist the health center and in general the regional health bureau in decision making and help to mitigate the problems related to maternal and child health. In addition, Haik health center and others can use the finding of this study to evaluate how much the empowerment strategy is effective in improving maternal and child heath. It can also be used as a guideline or reference for those who want to make further study on related issues. Finally, findings of the study might help policy makers to know where and how to channel efforts

to formulate national, regional and local policies that empower women and help to decrease maternal and child death. The study would also contribute to the literature of the subject.

1.6. Scope of the Study

This study is limited only to the Ethiopian government empowerment strategies to improve maternal and child health. In addition, this study is limited with a particular reference of Haik Health Center.

1.7. Limitation of the Study

Even though different efforts have been made, the researcher faced some challenges while doing this study. To begin with, some of the respondents do not give values to the questionnaire and some others do not return it totally. Furthermore, since respondents have low level of awareness, some were not as such willing to fill the questionnaires. Shortage of organized information and data in the health center also hampered the research work. Lastly, because of meetings and some field works, it was difficult to get interviewees on time.

1.8. Organization of the Paper

This paper has been organized in five chapters. The first chapter is an introductory part, which contains background of the study, statement of the problem, research questions, objective of the study, methodology, significance and scope of the study. Second chapter deals with reviews of the literature, chapter three deals with data description and the fourth chapter is about data analyses and interpretation. The final chapter focus on summary of findings, conclusion drawn from findings and gives workable recommendations on the whole study.

Chapter Two

2. Review of Literature

2.1. Introduction

Maternal and child health (MCH) care is the health service provided to mothers (women in their child bearing age) and children. The targets for MCH are all women in their reproductive age groups, i.e., 15 - 49 years of age, children, school age population and adolescents. Throughout the world, especially in the developing countries, there is an increasing concern and interest in maternal and child health care. This commitment towards MCH care gains further strength after the World Summit for Children, 1991, which gave serious consideration and outlined major areas to be addressed in the provision of Maternal and Child Health Care services (Mesfin, 2003).

The policy environment of Ethiopia is rich with plans for improved maternal and child health dating back nearly two decades. Beginning with the Health Policy of Ethiopia (1993), the focus was and continues to be on community-based public health preventive and promotive interventions in the major areas of public health including maternal and child health. The national policies and strategic documents that relate specifically to maternal and neonatal health are Making Pregnancy Safer (MPS) initiative (2000), Child Survival Strategy (2005), Reproductive Health Strategy (2006), Adolescent and Youth Reproductive Health Strategy (2006), Nutrition Strategy (2008), and Revised abortion law (2005).

The government's health delivery system has adopted a strategy of integrated health services starting with primary health care and organized into a four-tiered system, consisting of primary health care units (health centre with 5 satellite health posts); district hospitals; zonal hospitals; and specialized referral hospital with catchments population of 25,000, 250,000, 1,000,000 and 5,000,000 respectively. Although health care is delivered mainly in the public sector, the role of the private and NGO sectors is growing (FMOH, 2009).

Improving maternal and child health is integral to the Millennium Development Goals (MDGs). In particular, Goals 4 and 5 call for, respectively, reduction in child and maternal mortality for the period between 1990 and 2015. Goal 4 targeted a reduction of under-five mortality by two-thirds, while Goal 5 set a 75 percent reduction in maternal mortality. The goals received national and

global attention over the last decade and a half. Countries and their international development partners mobilized support to expand childhood immunization and increase availability and utilization of maternal health services (Alemayehu, et.al, 2015).

2.2. Millennium Development Goals

In its 8th plenary meeting of 8 September 2000, the General Assembly of the United Nations (UN) resolved the Millennium Declaration (UN, 2005). The representatives of the 189 nations who attended the event "agreed on a vision for the future: a world with less poverty, hunger and disease, greater survival prospects for mothers and their infants, better educated children, equal opportunities for women, and a healthier environment; a world in which developed and developing countries worked in partnership for the betterment of all" (UN, 2009).

In 2001, the UN Secretary General proposed an action plan for implementing the Millennium Summit Goals which identified the eight Millennium Development Goals (MDGs) along with a set of 18 time-bound targets and 48 indicators (WB, 2003). Four new targets agreed to by member states at the 2005 World Summit with additional indicators, were included (UN, 2009). Specialized UN agencies are entrusted with the responsibility of monitoring the implementation of the MDGs in their respective areas of expertise, and submit progress reports to be compiled and published periodically by the UN headquarter in New York.

The UN holds the authority to compile and publish official progress reports on the MDGs submitted to it by its respective specialized agencies. Each year, the Secretary-General presents a report to the United Nations General Assembly on progress achieved towards implementing the Millennium Declaration, based on data regarding selected indicators, aggregated at global and regional levels. At times, the impartiality and credibility of the information is questioned since the UN's country offices do not possess the human and infrastructural capacity to gather data from primary sources. As a result, UN agencies heavily depend on secondary data made available to them by the national authorities. It is unfortunately a common practice for some governments to over or under report achievements for political or other reason.

The millennium Declaration was translated into a roadmap setting out eight time-bound and measurable goals to be reached by 2015. Among these, the study focus on goal four (reduce by

two thirds the mortality rate among children under five) and goal five (reduce by three quarters the maternal mortality ratio).

2.3. The Concept of Empowerment

There is no single, widely accepted definition of empowerment. On the one hand it is argued that "it is only by a focus on change to existing patterns of power and its use that any meaningful change can be brought about". On the other hand it can be said to involve "recognizing the capacities of such groups [the marginalized and oppressed] to take action and to play an active role in development initiatives" (Oakley, 2001).

Empowerment means individuals acquiring the power to think and act freely, exercise choice and fulfill their potential as full and equal members of society. As per the United Nations Development Fund for Women (UNIFEM), the term women's empowerment means: Acquiring knowledge and understanding of gender relations and ways in which these relations may be changed, developing a sense of self-worth, a belief in one's ability to secure desired changes and the right to control one's life, gaining the ability to generate choices and exercise bargaining power, developing the ability to organize and influence the direction of social change and to create more just social and economic order, nationally and internationally (Mohini G., 1998).

Thus, empowerment means a psychological sense of personal control or influence and a concern with actual social influence, political power and legal rights. It is a multi level construction referring to individuals, organizations and community. It is intentional, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources, gain greater access to and control over these resources (Himachalim D., 1990)

"Empowerment in its simplest form means the manifestation of redistribution of power that challenges patriarchal ideology and male domination. It is both a process and the result of the process. It is transformation of the structures or institutions that reinforces and perpetuates gender discrimination. It is a process that enables women to gain access to and control of material as well as information resources. The concept of women's empowerment throughout the world has roots in women's movement. It is since the mid- 1980s that this term became popular in the field of development especially with reference to women (Chandra, S.K., 1997).

Empowering women is a prerequisite for creating a good nation. When women are empowered, society with stability is assured. Empowerment of women is essential as their thoughts and their value systems lead to the development of a good family, good society and ultimately a good

nation. Women's empowerment is a process in which women gain greater share of control over resources-material, human and intellectual like knowledge, information, ideas and financial resources like money. It also implies an access to money and control over decision-making at home, community, society and nation and to gain power (Adams R., 1996).

Empowerment means moving from a position of enforced powerlessness to one of power. The work participation rate indicates to a great extent the economic empowerment of women in the society. The status of women is intimately connected with their economic position, which in turn depends on opportunities for participation in economic activities. Empowerment of women is a holistic concept. It is a multi-dimensional approach and involves a basic retaliation and awareness of women powers, potentialities capabilities and competences right and opportunities of all round development in all spheres of life women empowerment. Therefore it is a process which enables women to have access and control over various factors necessary for their economic independence, political participation and social development but such political participation and social up lift would be meaningless and almost impossible, if their economic independence is not achieved. The process of empowerment will be challenging, which has to be properly addressed at different levels both individual as well as collective through entrepreneurship (Oakley, 2001).

2.4. Gender Equality and Women Empowerment

Women's empowerment and equality is a fundamental human right and critical to achieve development objectives, including health. Women's increased political participation, control of resources including land, access to employment and education are crucial for promoting sustainable development. There are numerous pathways by which greater gender equality can lead to improvements in health and quality of life for women and their family members. Women with greater agency are more likely to have fewer children, more likely to access health services and have control over health resources, and less likely to suffer domestic violence. Their children are more likely to survive, receive better childcare at home and receive health care when they need it. At the same time, improved health outcomes for women can help to strengthen their own agency and empowerment. Healthy women are more able to actively participate in society and markets and take collective action to advance their own interests. They are likely to have greater bargaining power and control over resources within the household. Therefore collaborative action between

gender and health can help maximize the impact of gender policies on health and vice versa (PPD, 2013).

The ongoing struggle for equality can be traced to many decades of hard work by women's rights advocates, humanitarian organizations, and development agencies. "The manner in which development actors have perceived and addressed the role of women in the development process has undergone a series of significant conceptual and operational shifts over the last 50 years" (UNDP, 2003).

Women's involvement in development during the post 2nd World War era until the 1970s was characterized by what is known as a 'welfare approach'. This approach perceived women as passive beneficiaries of aid instead of agents for development, focused on their reproductive responsibilities and ignored their productive roles (UNDP, 2003). Brett (1991) also chronicled that in the 1950s and 1960s, some elements of women's issues in development were considered under the questions of human rights although women were not necessarily consulted in the process. Women's rights advocates stepped up their involvement by reacting to different initiatives and initiated a call for legal and administrative reforms to incorporate women's concerns into economic policies and practices (Brett, 1991; Leo-Rhynie, 1999). These movements led to what is called the 'Women in Development' (WID) approach.

The WID movement explicitly called for "social justice and political equality for women, improved education and employment opportunities, and increased health and welfare services" (Razavi & Miller, 1995). The WID movement introduced legislation to protect women's rights, most notably the CEDAW in 1979. CEDAW is the most important international agreement which triggered many organizations to undertake advocacy, lobbying, research, and outreach activities that have pushed governments and organizations to be more responsive to women's needs (Neuhold, 2005). WID also takes credit for the national women's machineries and WID units within development agencies that flourished in many countries during the 1990s (UNDP, 2003).

Notwithstanding its significant contributions, with the passage of time, the WID approach was criticized for being ineffective in terms of fostering improvement in women's lives. Although the world had experienced over two decades of modernization, the position of women actually declined in some sectors (Leo-Rhynie, 1999). As the UNDP (2003) reported, "in many cases, the

very act of separating women's programming from the central, mainstream programming which involved men, resulted in increased marginalization of women and their roles — precisely the opposite effect from that which was intended".

In an effort to address the gaps arising from the WID approach, a new approach, Gender and Development (GAD), began to feature in the early 1990s by advocating for gender mainstreaming. The different gender approaches that GAD embodies share a focus on the analysis of the different roles of men and women and their respective access to and control over resources and decision-making. Two of the main GAD approaches are: "the 'gender roles' framework developed by the Harvard Institute for International Development and USAID; and the 'social relations analysis', which is associated with the work of the Institute for Development Studies at Sussex" (UNDP, 2003).

2.5. Approaches to Women Empowerment

Women's empowerment, according to Bhasin (1985), involved the transformation of power relations at six different levels: Individual, family, group, organization, village community and society. In order to empower the rural poor especially the women, female development workers must first empower themselves.

Bhasin identifies three approaches to women's empowerment: the integrated development approach, which focuses on women's survival and livelihood needs; the economic development approach, which aims to strengthen women's economic position and the consciousness-raising approach, which organizes women into collectives that address the sources of oppression. To be effective, empowerment strategies must simultaneously address women's practical gender needs as well as strategic gender needs. Finally, an undemocratic environment and a fragmented understanding of the concept and process of empowerment will hinder experiments in empowerment.

2.6. Empowerment for Health Promotion

The Ottawa charter for health promotion is the first international conference on health promotion and was mainly a response to the emerging expectations for a new public health movement around the globe. The WHO definition and description of health promotion has been quoted as follows.

> *"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being" (WHO, 1986).*

The notion of empowerment has been frontrunner by the 'new health promotion movement' which evolved in the beginning of 1980s and which emphasized on attaining health equity and enhancing public participation in decision-making in health programs (Robertson et al, 1994). World Health Organization further legitimized the concept of empowerment in its declarations and strategic position papers (WHO 1978, 1992, 1998). The empowering discourse of health promoters which was legitimized by WHO in the 1986 Ottawa Charter for health promotion (WHO, 1986) has emerged as a bureaucratic response to the growing social movements and to the contemporary health discourses of the 1960s, 1970s and 1980s (Stevenson and Burke, 1992; Labonte, 1994).

Practically two different health promotion discourses have emerged and co-exist. The conventional discourse focuses on disease prevention through life style management (top-down). On the other hand the radical discourse focuses on social justice via community empowerment and advocacy (bottom-up). Similarly, health promotion programming mainly uses two seemingly different health promotion approaches i.e. top-down and to a lesser degree bottom-up (Labonte, 1994).

As clearly stated in the WHO definition empowerment is the core theme in health promotion as enabling people to have control over their lives helps people to identify their own health problems and to get the necessary knowledge/awareness and courage to bring solutions to the problems. This entails that the expert role is substituted by the bottom-up strategy and as a result, the health practitioner/promoter undertake more of a facilitating role in health programs and in the end the health promoter handover the health programs/projects to the community people (Naidoo et al, 2000).

The rationale of health promotion is to enable people to increase control over, and to improve, their health. Thus, empowerment is a fundamental principle to achieve this. However, as a strategy, empowerment varies depending on if it is the health promotion agency (top-down) or the community (bottom-up) who identifies the issue to be dealt with (Laverack, 2012).

This has brought a challenge in current health promotion as many health promoters pursue to use power over the community through 'top-down' programs simultaneously using the liberating discourse of the Ottawa Charter. The tension between the discourse and the practice persists due to lack of clarification on how to make the concept of empowerment functional in conventional/'top-down' program circumstances in which many health promoters still engaged in (Laverack, 2000).

The fundamental nature of empowerment is that it cannot be given by others instead it must be obtained by those who seek it. In order to create the feasible environment to make empowerment achievable, those who have power or access to it (such as a health practitioner/health workers who have the chance to help empower individuals, groups, and communities) and those who want it (such as their clients) ought to work collectively (Laverack, 2006).

The ultimate objective of health empowerment program is to mobilize communities in action to alleviate social and physical disease risk factors and improve factors of quality of life. For instance, poor housing condition is a risk factor for deprived health status (Ronald et al, 1994).

There are two possible different aspects of empowerment. The first is as a goal and the second is as a process or approach. Empowerment as a goal is having the control over the determinants of one's quality of life while empowerment, as a process is to create a professional relation where the client/community is able to take control over the change process. This elucidates both the goals of the empowerment process and the means to use. Therefore, we can achieve empowerment in a combined sense (Tengland, 2008).

The above definition could also be applicable whilst working towards groups or community empowerment (for instance ethnic minorities, the homeless, delinquents, people with disability, etc). Professional teams that are engaged in supporting people or groups to be empowered can also apply it. Government and other concerned bodies can create the environment for empowerment both through creating a society that enhance its people's participation and control over their lives

and through supporting organizations in which professionals engaged in assisting people to gain control over their lives (ibid).

2.7. Justifications for the Provision of MCH Care

Why should the care of mothers and children needs major consideration and be part of every program that is taking care of people's health? The important considerations and justifications include:

- Mothers and children make up over 2/3 of the whole population. Women in reproductive age (15 – 49) constitute 21%, pregnant women, 4.5%, children under15, 47%, children under 5, 18%, under 3: 12% and infants: 4%. (This working estimate is very important in developing countries for project planning and implementation)
- Maternal mortality is an adverse outcome of many pregnancies. Miscarriage, induced abortion, and other factors, are causes for over 40 percent of the pregnancies in developing countries to result in complications, illnesses, or permanent disability for the mother or child. About 80 percent of maternal deaths in are directed obstetric deaths. They result "from obstetric complications of the pregnant state (pregnancy and labour), from intervention, omissions, incorrect treatment, or from a chain of events resulting from any of the above.
- Poor maternal health hurts women's productivity, their families' welfare, and socio-economic development.
- Infectious diseases like malaria are more prevalent in pregnant women than in non-pregnant women (most common in the first pregnancy). In addition, an increasing number of pregnant women are testing positive for the human immunodeficiency virus. In Sub-Saharan Africa, 3 million women are estimated to be infected with the AIDS virus and a woman with HIV has a 25 to 40 percent chance of passing the infection on to her fetus in the womb or at birth.
- Nutritional problems are severe among pregnant mothers and 60 to 70 percent of pregnant women in developing countries are estimated to be anemic. Women with poor nutritional status are more likely to deliver a low-birth -weight infant.

- Low birth weight babies. Because many women are fed less, marry early, carry a heavy workload, and spend a considerable portion of their lifespan in pregnancy and lactation, they are exposed to persistent low nutritional status and high-energy expenditure. This predisposes mothers to bear low-birth-weight infants.
- Women often lack access to relevant information, trained providers and supplies, emergency transport, and other essential services.
- Cultural attitudes and practices impede women's use of services that are available.
- Given the magnitude of these problems and the interventions available, much has not been done. Most of these problems are silent. They remain, to a large extent, uncounted and unreported. Maternal and child health programs should focus on addressing these problems, clarifying policy and program alternatives and identifying cost-effective health-related program interventions that are likely to reduce maternal and child morbidity and mortality (Mesfin, 2003).

These outlined issues do not only show the importance of MCH care to the health of mothers and children or their immediate problems. Rather, they show the role and necessity of MCH care in the welfare of the family, the community and the country as a whole. Thus, MCH care an issue that has to be addressed in terms of national productivity and futurity of a country. The specific objectives of MCH Care focuses on the reduction of maternal, prenatal, infant and childhood mortality and morbidity and the promotion of reproductive health and the physical and psychosocial development of the child and adolescent within the family (Ibid).

2.8. Determinants of Maternal Health Care Services Utilization

2.8.1. Socio-Demographic Variables

There is a general consensus that the use of maternal health care services reduces maternal and child mortality, and improve the reproductive health of women. The considerable variation in maternal and child health in the developing world is believed to be partly due to differences in the availability of and access to health services. Although several studies have been carried out to identify and understand why maternal health care services are underutilized in developing countries, there is no universal explanation that applies to all places and time the determinants of

utilization of maternal health care services are not the same across socio-demographic and cultural contexts (Nancy P. et.al, 1999).

2.8.2 Cultural Practices and Women's Decision Making Power

Another important factor in the utilization of maternal healthcare services, especially in Africa, is the cultural background of the women. Women's powerlessness and their unequal access to material and other resources, and their inabilities to make informed choices are the fundamental causes of maternal death and disability. A range of barriers related to women's powerlessness could harm their health directly or by limiting their access to the services. This includes ignorance of good health practices, as well as lack of awareness of danger signs during pregnancy or misinterpretation (for instance that obstructed labor is associated with women's infidelity) (UNICEF, 1996).

2.8.3 Psychosocial and Personality Factors

The use of modern health services is often influenced by individual perception of the quality of modern health services and the religious beliefs of individual women. A women's attitude towards her pregnancy and the presence of social support have been found to influence ANC use in developing countries. A study revealed that women with low social support, who were younger, more often single, who had lower level of education and income, who smoked more as have higher biochemical risks than women with adequate social support. In developing countries, the presence of social support during pregnancy has been shown to provide psychological benefits and influence ANC use (Stock R., 1983).

2.8.4 Accessibility and Quality of Health Services

2.8.4.1 Accessibility of Health Services

Accessibility of health services have been shown to be an important determinant of utilization of health services in developing countries. In most areas in Africa, one in three women lives more than five kilometers from the nearest health facility. The scarcity of vehicles especially in remote areas cost of transport, poor road conditions and the difficulty of walking for hours to the nearest health facility may also pose problems for pregnant women. Walking is the primary mode of transportation, even for women in labor (Overbosch G.et.al, 2002). It is often those at highest risk

of adverse outcome are least likely to have access to health services, particularly preventive services. Risk factors such as very young, lack of education and poverty are associated with low use of the services (Dana A.et.al, 2003).

2.8.4.2. Quality of Health Services

Quality of care is an important consideration in the decision to seek care. The role that quality of care plays in the decision to seek care is related to people's own assessment of service delivery, which largely depends on their own experiences with the health system and those of people they know. The two mechanisms through which quality of care affects the decision to seek care are satisfaction or dissatisfaction with the outcome (e.g. effectiveness of the treatment and remedies prescribed), and satisfaction or dissatisfaction with the service received (e.g. staff attitude, long waiting time, hospital procedure, and availability of supplies, efficiency)(WHO, 1996). These factors will act as inhibitors of future utilization, thus affecting the decision to seek care.

2.8.5. Maternal Past Obstetrical History

Maternal past obstetrical history has a great contribution to the maternal delivery service utilization. The only individual variables that were significantly associated with delivery in a health facility were receipt of prenatal care during the last pregnancy and previous delivery in a health facility. Relative to women who had received 1 to 3 prenatal care visits during their last pregnancy, women who had received 4 or more visits showed an increased likelihood of choosing institutional delivery also reporting that their last child was born in a health facility (Stephenson R.et.al, 2006)

2.9. Empirical Study

2.9.1. Maternal and Child Health in Kenya

In order to reduce mortality among children under five, the government of Kenya, through the Ministry of Health has developed and implemented new approaches to child survival efforts. The Kenyan government is also committed to the achievement of Millennium Development Goal 4: reducing the infant and under-five mortality rates to 21 and 32 per 1,000 childbirths respectively by the year 2015. The Integrated Management of Childhood Illnesses (IMCI) strategy implemented by the Government of Kenya, in collaboration with the World Health Organization

(WHO), the United Nations Children's Fund (UNICEF), and other partners, encompasses a range of interventions that combines prevention and better management of childhood illness with nutrition, immunization, maternal health, and other health programs (Kenya National Health Sector Strategic Plan II 2005-2010). For example, Kenya's child survival program includes immunization through the Kenya Expanded Program on Immunization (KEPI), enhanced nutrition through growth monitoring, and intensified efforts to combat malaria through promotion of insecticide-treated bed nets.

The IMCI strategy, which promotes use of every opportunity by the provider to assess the child's current status and provide preventive interventions, has been recommended as a cost effective child survival intervention. IMCI aims to reduce morbidity and infant and child mortality by implementing three main components: improving health workers' skills in case management, improving the health systems, and improving family and community childcare practices. This is one of the best ways of delivering integrated child health care, as demonstrated by the WHO's Multi-Country Evaluation (MCE). Multi-Country Evaluation is a global evaluation to determine the impact of IMCI on health outcomes and its cost-effectiveness. Preliminary findings from an MCE study site in Tanzania show dramatic improvement in the quality of case management in health facilities implementing IMCI. Children seeking care at the health facilities in IMCI districts were more thoroughly assessed and received better quality care in comparison to districts where IMCI had not yet been implemented (Victora and Schellenberg, 2002). Further analysis of the MCE project data additionally demonstrated that IMCI was not associated with higher costs than routine child health care (Adam et al., 2005),

The 2004 Kenya Service Provision Assessment (KSPA) survey was conducted to assess, among other things, the care for sick children and availability of preventive services, immunization, and growth monitoring. Service provision was compared to standard guidelines for IMCI, although information was collected from health facilities that were not necessarily implementing IMCI. The survey shows that 4 out of 5 facilities offer all three basic child health services (curative care, immunization, and growth monitoring); however, there are gaps in providing these important basic and preventive care services. The results from the 2004 KSPA and the 2006 Kenya IMCI Health Facility Survey (HFS), which collected information from facilities implementing IMCI, both reveal that quality of care provided to sick children at the first level of health facilities needs

improvement. Opportunities to promote preventive health interventions each time a child is brought to a facility for consultation are being missed. Assessments of immunization, weight, and feeding practices for children less than 24 months occurred in only 66%, 53%, and 36% of cases, respectively (NCAPD, 2005). This also contributes to an explanation of the decrease in overall immunization coverage and existing levels of chronic malnutrition documented in the 2003 KDHS. Assessment for general danger signs in sick children is also poor. Only 6 percent were assessed for all three danger signs (inability to drink or breastfeed, vomiting everything, and convulsions) (CBS, 2004).

Treatment guidelines offer service providers the right methods for medication and infection control. Guidelines of any kind, including the new WHO-prescribed IMCI guidelines, were available in only 22% of facilities offering sick child services, while treatment protocols were found in only 1 in 5 facilities. Many child illnesses can easily and safely be treated at home as long as caregivers know what to do and what danger signals to watch for. 2004 KSPA results suggest that many health care providers are failing to help caregivers protect the children's health. Only 5% of caregivers of children with diarrhea received all three IMCI-recommended counsels (increased fluids, increased food in-take, and list of symptoms for which the child must be brought back immediately). Few counseling materials are available and these are rarely used. IMCI counseling cards for providers and mothers are each available in only 5% of health facilities. Visual aids for client education are available in less than 30% of facilities. IMCI aims to ensure good quality of health services by improving health workers' skills in case management of childhood illnesses; however, KSPA results show that only 9% of child health providers had received in-service training related to IMCI during the 12 months preceding the survey (NCAPD, 2005).

2.9.2. Maternal and Child Health in Ethiopia

2.9.2.1. Ethiopia: MCH Status

Ethiopia has a federal system of government. The country is divided into nine administrative regions: Afar, Amhara, Benishangul-Gumuz, Gambela, Harari, Oromiya, Somali, Tigray, and the Southern Nations, Nationalities and Peoples Region (SNNPR); as well as two city administrations, Addis Ababa and Dire Dawa. The regions are divided into zones, woredas, and kebeles which is

the lowest level of administration. The woreda is the most important local government structure, acting as the basis for most administration and management. Currently there are 956 woredas, representing around 100,000 people each and 16,541 kebele with average catchment populations of 5,000 people each (FMOH, 2010).

The health care delivery system in Ethiopia is organized in three-tier system. The primary level health care delivery system in rural setting includes five Health Posts associated with Health Centers and Primary Hospital. In rural setting the Health Center is primary entry point to the health system. The secondary level health care includes General Hospitals and tertiary level health care include Tertiary Hospitals. As more than 80 percent of the Ethiopian population resides in the rural part of the country, the HSDPs have given more focus to the primary health care units while strengthening the referral care at secondary and tertiary levels (FMOH, 2005).

Maternal Mortality Rate (MMR) in Ethiopia is significantly high with 590 deaths per 100,000 women (Lancet, 2010). Maternal deaths are mostly caused by obstructed/prolonged labor, which accounts for 13% of the maternal death. Ruptured uterus (12%), severe pre-eclampsia/eclampsia (11%) and malaria (9%) are among the major causes of maternal death and 6% of maternal deaths were due to complications from abortion. Lack of skilled midwives, poor referral system at health centre levels, and insufficient availability of equipments and shortage of finance of the health service are main challenges of supply side which hamper maternal health improvement. Furthermore, cultural norms and societal emotional support to mothers', distance to functioning health centers and financial constraints are also categorized as the major causes of maternal deaths (FMOH, 2010).

Infant Mortality Rate (IMR) has been 77/1000. Child mortality rate of under-five years has been 101/1000 in the year 2010 and more than 90% of causes of child deaths are attributed to pneumonia, diarrhea, malaria, neonatal causes (pre-maturity, asphyxia and neonatal sepsis), malnutrition and HIV/AIDS and are mostly due to a combination of these situations (WHO, 2010). Malnutrition and HIV are underlying causes in about 57% and 11% of these deaths respectively. The levels of mortality are worsened particularly by poverty, inadequate maternal education, lack of safe water supply and sanitation, and high fertility and inadequate birth spacing. About 472,000 Ethiopian children die each year before their fifth birthday, which places Ethiopia sixth among the countries of the world in terms of the absolute number of child deaths (FMOH, 2005).

The MOH developed the first comprehensive National Child Survival Strategy (2005-2015) in 2005 which was being implemented as part of the 3rd and 4th HSDP cycles. The implementation of this strategy had boosted the child survival efforts of the country through improved coordination, partnership, resource mobilization and scale up of high impact interventions. As a result of these efforts, Ethiopia has recorded significant reduction in childhood mortality and had achieved the MDG4 target in 2012. Several factors are believed to contribute to the reduction in under five mortality including the improvement in overall socio- economic status and the significant increase in access to primary health care services, from 68% in 2005 to 92% in 2010. In terms of interventions; reductions in malnutrition, increases in vaccination, Vitamin A, ITNs, family planning and water & sanitation were the main contributors for the improvements in child survival in the last two decades (USAID, 2012).

Maternal and neonatal morbidity and mortality rates are attributable to a range of socioeconomic, political, and demographic factors. The dangers associated with giving birth at home are ever-present in communities throughout the country. However, awareness of these dangers has done little to increase facility-based delivery rates. Given the diverse challenges that pregnant women face throughout the continuum of care, a broad range of measures are needed to improve women's health. Both globally and in Ethiopia, there has been an acceleration of efforts to improve the availability, accessibility, and quality of maternal health services and develop policies in support of facility based birth with a skilled provider. As a part of these efforts, and to critically examine the complex issues inhibiting institutional births, USAID asked the Maternal Child Health Integrated Program (MCHIP) to identify cultural practices, perceptions, and beliefs that influence women's decision to seek facility-based maternal health care in Ethiopia (USAID, 2012).

Despite an effort to expand coverage of health services, Ethiopia has struggled to improve its maternal health indicators (FMOH 2007). Not surprisingly, the country's high MMR is associated with a lack of adequate access and continued under-utilization of modern health services (Mekonnen and Mekonnen, 2003).The risk of maternal death is greatest during labor, increasing significantly during the second and third stages and continuing into the postpartum period. It is estimated that 90% of maternal deaths could be prevented with timely medical intervention. The chances of death decrease considerably if women receive skilled maternal health care during delivery. Ensuring the availability of appropriate and adequate services and quick access to

services when obstetric emergencies arise is one of the most important aspects of safe motherhood programs in developing counties. In addition, the high levels of maternal mortality and morbidity in developing countries such as Ethiopia demonstrate the need for maternal health services such as antenatal and postnatal care (ANC and PNC) and for trained personnel who can provide basic essential obstetric care during labor and delivery (Mekonnen and Mekonnen, 2003). Despite the Ethiopian government's effort to improve maternal health, as well as the increase in the number of health centers in the country, health service utilization is unacceptably low. Only about 34% of women receive ANC, and perhaps most significantly, an estimated 90% of births still do not take place in a health facility with the assistance of a skilled provider (MEASURE Evaluation & Central Statistical Agency, 2012).

Studies have produced evidence suggesting that multiple socioeconomic/cultural factors act as barriers to accessing care throughout a woman's pregnancy and these factors are particularly evident in the decision to seek care and assistance during and directly after pregnancy. Women generally claim that they faced obstacle(s) to seeking and receiving appropriate health care during their pregnancy (USAID, 2012). In ethnically and demographically diverse countries such as Ethiopia, there are many challenges that contribute to low facility use, particularly for delivery. Many times the only assistance available to a mother is the care provided by a relative or friend or a traditional birth attendant (MEASURE Evaluation & Central Statistical Agency 2012; Central Statistical Agency of Ethiopia 2011). Where a woman delivers, who attends her in labor, and how quickly she can be transported to referral-level care are crucial in determining birth outcomes. Cultural norms carry significant weight in women's decision-making, particularly in the choice of a location for birth (Warren, 2010). Cultural barriers are significant determinants of care-seeking behavior, particularly as it relates to facility-based delivery (Mekonnen and Mekonnen, 2003).

2.9.2.2. The Health Extension Program and Health Extension Workers (HEWs)

The Health Extension Program is a community-centered strategy to deliver preventive, primitive services and selected high impact clinical interventions at community level. HEP has provided excellent platform to engage the community regularly, foster community ownership and bridging the gap between the community and health facilities through health extension workers. Through HEP, rural communities have been able to access essential health services provided at village and

household levels, and has served as a vehicle for bringing key maternal, neonatal and child health interventions to the community with free of service charge (FMOH, 2014).

Given the huge deficit of skilled health professionals not least because of the demand of health workers in high income countries and their deteriorating working conditions at home, the need for community health workers in poor countries has become inevitable. Community health workers in low income countries have been tasked to render certain basic health services to their communities (WHO, 2007).

Who are these community health workers (CHWs)? WHO defines them as follows:-

> *Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (cited in Lehmann & Sanders 2007: 3)*

Accordingly, formally trained health professionals, medical as well as physician assistants, mid-level and paramedical workers are not normally considered to be community health workers.

With the introduction the Health Extension Program in 2003/4 within Ethiopia's HSDP framework, Health Extension Workers have been the principal personnel in the implementation of the Program. For the rural population, HEP aims at providing equitable access to preventive and selected curative health interventions. This aim is addressed through 30,000 HEWs of government-salaried young local women with grade 10 education. The women are given a one-year training prior to employment. UHEP, on the other hand, has constituted its HEWs of women with a diploma in nursing. It is important to note at this juncture that while the rural HEWs in Ethiopia fulfill the definition of CHW to a greater extent, the urban HEWs, mid-level professionals who are not necessarily among members of the communities they serve, remain outside the realm of what usually constitutes CHWs (Koblinsky et.al, 2010).

The Government introduced new social mobilization scheme, the Health Development Army (HDA), which is a network of women volunteers organized to promote health, prevent disease through community participation and empowerment. It is a network created between five

households and one model family to influence one another in practicing healthy life style, work to empower the community to generate its own health. To date, the Ministry of Health has been able to mobilize over three-million women to be part of an organized HDA (FMOH, 2014).

2.9.2.3. Maternal Health Care under Urban Health Extension Program (UHEP)

Ethiopia is a major contributor of death toll of mothers in the world. The low level of maternal health services is among the main causes of maternal mortality. Figures from 2005 indicate that use of skilled birth attendance nationally was 6%; cesarean section 1%; postnatal care 6%; and contraceptive prevalence rate 14%" (Koblinsky et al. 2010). As part of its commitment to the Millennium Development Goals (MDGs), the Ethiopian government has made maternal health improvement its primary goal of the Health Sector Development Program (HSDP III).

The broad framework of HSDP embodies the Health Extension Program (HEP) as a nationwide health intervention which was initially launched in rural Ethiopia and later adopted for the urban poor (UHEP) as the main vehicle to achieve the health related MDGs. Like its rural version (HEP), UHEP is directed towards improving access to health services for the urban poor. It commits itself to doing this by providing health care facilities at the Woreda (district) level (the basic decentralized unit of administration) and also by enabling households to "take responsibility for producing and maintaining their own health" (FMOH: HSDP IV 2010: 18).

Maternal and Child Health Services Package is just one of the sixteen packages under UHEP. The general objective of the package is to rescue mothers and children from illnesses, death and states of disability, thereby ensuring their proper physiological and mental growth. Some of the objectives that relate to the supply side interventions for maternal health include:

• Providing appropriate prenatal, antenatal and postnatal health services;

• Facilitating proper referral services for child delivery;

• Providing mothers with information on harmful traditional practices;

• Enabling mothers (and children) to get vaccination services;

• Promoting breastfeeding practices and the use of supplementary food for babies;

• Raising households' and communities' awareness on pregnancy and family planning so that they can give appropriate care to mothers; and

• Informing and educating mothers on health hazards resulting from unsafe abortion, etc. (UHEP: Maternal and Child Health Services Package 2009: 2).

2.9.2.4. Objectives of the MCH Program in Ethiopia

General Objective: To improve maternal and child health services in order to decrease maternal and childhood morbidity and mortality.

Specific Objectives

• To provide primary health care services

• To extend integrated MCH services into the rural areas.

• To prevent malnutrition and infection among mothers and children through education in health and nutrition

• To promote the use of safe water, sanitation and immunization

• To promote supply and promote effective FP programs.

• To provide services at a cost commensurate with the financial, material and manpower resources of the country.

• To initiate, develop and co-ordinate operational and other relevant research in MCH (Mesfin, 2003).

2.9.2.5. Strategies of the MCH Program

• The health services at all levels shall carry out integrated services. Health education programs are to be included.

• The health services shall be continually expanded

• The skills and knowledge of the health personnel shall be constantly improved.

a. Adequate emphasis on MCH shall be ensured in the curricula of health workers.

b. An adequate number of health workers for the various levels shall be trained.

c. Textbooks, manuals and other reference materials will be distributed to all health institutions.

d. Knowledge shall be continuously upheld through appropriate training and supervisory activities.

• Revision and improvement of the referral system

• Co-ordinate with other organizations and institutions involved in activities related to MCH.

• To engage the participation of the agricultural extension workers and the Ethiopian Nutrition Institute in the promotion of the production and utilization of supplementary feeding mixes.

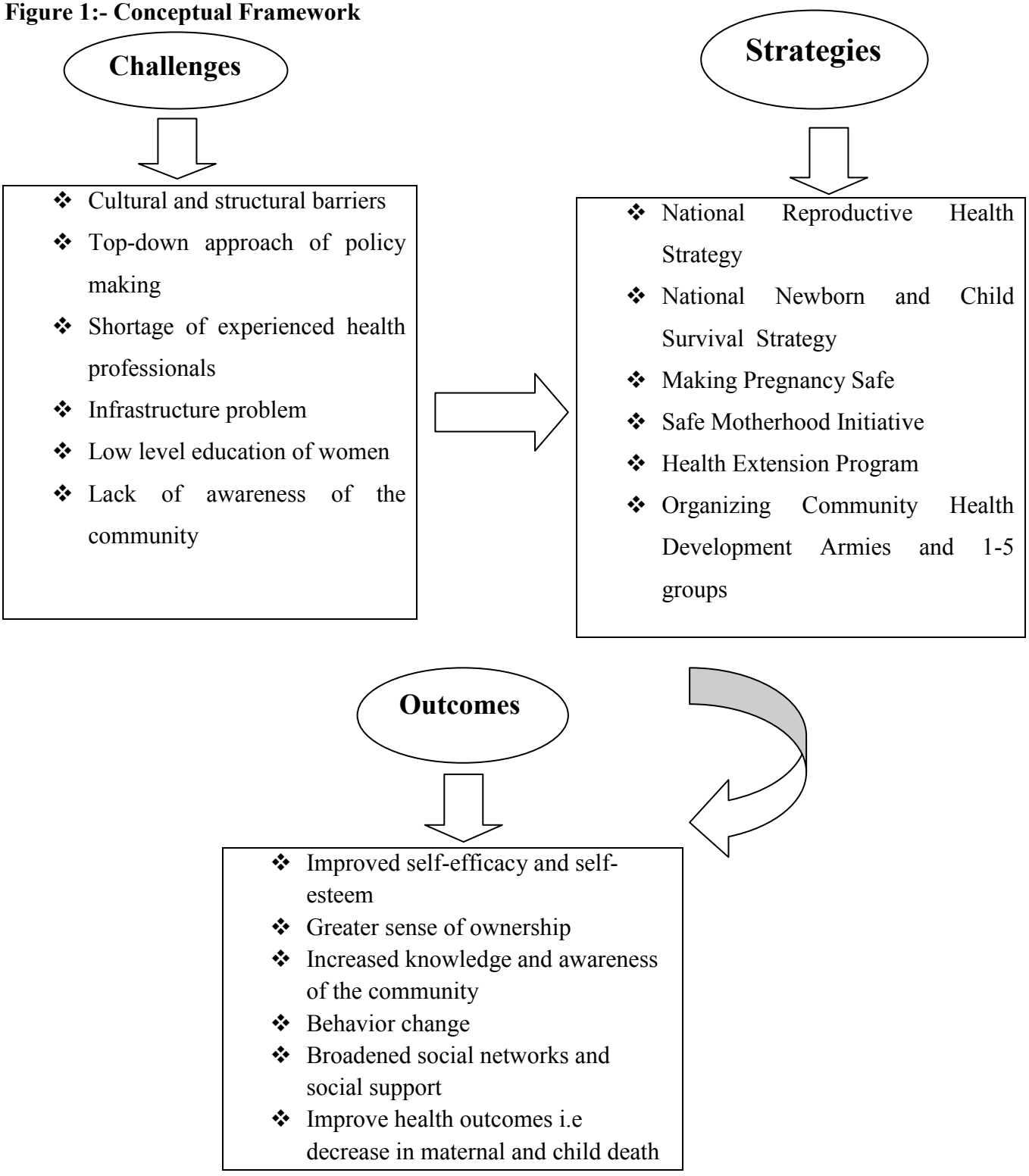
• Promote community participation and involvement as an essential component of the MCH Program.

• Seek resources for the expansion of services from the government and Non-Governmental Organizations.

• Manpower training and research should be carried out whenever necessary and feasible. Regions should develop their respective in service training capability and implement a training program to develop and upgrade the skill and knowledge of the health workers (Mesfin, 2003).

2.10. Conceptual Framework

Figure 1:- Conceptual Framework



Source: - Own construction, 2016

The above conceptual framework shows the effect of independent variables to dependent variables in the study. Empowerment can have a positive impact on communities' self-efficacy, self-esteem, sense of control and, in some cases; empowerment can increase individuals' knowledge and awareness and lead to behavior change which has a direct effect on improving health outcomes. By involving people and communities in various aspects of decision-making, including the planning, implementation and evaluation of interventions, it is assumed that levels of empowerment are greatly increased and positive health outcomes are more likely.

Chapter Three

3. Research Methodology

3.1. Research Design

Research design is a plan or a blueprint of how one intends conducting the research. (Babbie & Mouton, 2001). The research design used in this research is descriptive study design. Descriptive research studies are those studies which are concerned with describing the characteristics of a particular individual, or of a group.

The researcher employed both qualitative and quantitative survey design for the study that has been realized through questionnaires and key informant interviews. This helped to identify the challenges and outcomes of the empowerment strategies to improve maternal and child health.

Quantitative research is based on the measurement of quantity or amount. It is applicable to phenomena that can be expressed in terms of quantity. Quantitative research involves studies that make use of statistical analyses to obtain their findings. Key features include formal and systematic measurement and the use of statistics.
Qualitative research is concerned with qualitative phenomenon, i.e., phenomena relating to or involving quality or kind. The subject of this study were those health professionals who are working in Haik Health Center, three health officers and service users of the health center.

3.2. Study Population

In Haik Health Center, there are 89 health professionals, 2 officers (focal persons) working on maternal and child issues and 7(seven) health posts. Among these, 25 and 18 health professionals in the health center and health posts respectively work on maternal and child health. It is estimated that 2378 mothers and children will use the service of health center in the current year 2008 that means 198 people will come to the health center monthly.

3.3. Sampling Techniques and Sample Size

In order to gather the required information, all health professionals who are working on maternal and child health are selected by using census survey method i.e. 25 from the health center, 18 from

the 7 health posts. Census survey method is a complete enumeration of all the items in the population. The reason behind using census survey method was, it can be presumed that in such an inquiry when all the items are covered no element of chance is left and highest accuracy is obtained.

2378 mothers and children are estimated to get the service of the health center in the year 2008. By taking into consideration the time of data collection, the researcher has selected 198 people that will come to the health center monthly. Among 198 mothers and children, the researcher took 50% i.e. 99 mothers; because the children are not able to fill the questionnaire. Generally, questionnaires were distributed to these 99 mothers by using convenience sampling method. Convenience sampling is a statistical method of drawing representative data by selecting people because of the ease of their volunteering or selecting units because of their availability or easy access. Structured interview was conducted with 2 officers (focal persons) who are working in maternal and child health issues and with head of the health center.

3.4. Data Sources and Collection Techniques

In order to achieve the objectives of the study, both qualitative and quantitative data were gathered from primary and secondary sources. The primary data was gathered from health professionals and officers who are working in the health center and customers by using questionnaire and key informant interviews.

The questionnaire contains both open ended and close ended questions. This helped to get first hand information from the health professionals and customers of the health center.

In addition, secondary data was collected from books, organizational reports, broachers, internet, published and unpublished materials.

3.5. Method of Data Analysis and Presentation

After the collection of relevant data, descriptive method of data analysis was used to analyze the data. The reason behind using descriptive method was to clarify and describe both qualitative and quantitative data. Descriptive research includes surveys and fact-finding enquiries of different kinds. The major purpose of descriptive research is description of the state of affairs as it exists at present.

The processed and analyzed data are presented in the form of table, chart and percentage. From the analyzed, processed and interpreted data, the researcher has drawn conclusion by summarizing the main points about the study and forwarded some workable recommendations.

3.6. Ethical considerations

The researcher considers the research values of voluntary participation, anonymity and protection of respondents from any possible harm that could arise from participating in the study. Thus, the researcher introduce the research and its objective and as it is conducted for fulfillment of a Masters Degree study program and not for any other hidden agenda by the researcher and request the respondents to participate in the study on a voluntary basis and refusal from participating is permitted. The researcher also assured respondents the confidentiality of the information given.

Chapter Four

4. Data Analysis and Presentation

The purpose of this study is to assess the challenges and outcomes of empowerment strategies to improve maternal and child health in specific study area of Haik Health Center. The data are gathered through questionnaires, interviews, and document reviews.

The survey questionnaires were administered to mothers and health professionals of Haik Health Center. To collect the data, 99 structured questionnaires were prepared and distributed to mothers who use the service of the health center and 43 questionnaires to health professionals. Among these questionnaires, 88 and 42 questionnaires were properly filled and returned respectively. The result in a response rate is 88.8% and 97% respectively. Furthermore, the researcher conducted structured interview with three key informants who have a great role in the implementation of the empowerment strategies to improve maternal and child health. These are head of Haik Health Center, Tehuledere Woreda maternal and youth affairs officer and child health officer.

Secondary data was also reviewed from several related documents. The data collected were examined, compiled and evaluated to address the research problems. Data was presented in the form of percentage, tables and charts.

In this chapter, data is appropriately described in order to make further analysis. Background of the study area and respondents i.e. mothers, health professionals and interviewees have been presented. Again, the responses of mothers, health professionals and interviewees on the issues raised have been discussed separately based on response categories established by the researcher.

4.1. Profile of Respondents

In the personal information of respondents, sex, age, educational qualification, work experience, occupation and marital status are the basic features considered in this study. This information helps to have a broad image of the reality. Especially, the education status and occupation of mothers has a huge impact on the implementation of the empowerment strategies to improve maternal and child health. The educational qualification and work experience of health professionals is also a major determinant to know whether there are qualified health professionals or not that can implement the empowerment strategies effectively.

Table 1:- Age and Education Level of Mother Respondents

No	Item	Frequency	%
1	**Age**		
	18-25	36	40.9
	26-35	41	46.60
	36-45	11	12.5
	Above 45	0	0
	Total	**88**	**100**
2	**Education Level**		
	Illiterate	23	26.13
	Read $write	15	17.04
	10^{th} grade completed	28	31.81
	Certificate	12	13.63
	Diploma	8	9
	Bachelor degree	2	2.27
	Above	0	0
	Total	**88**	**100**

Source- Survey questionnaire, 2016

As we can see in table 1 item 1, 40.9% of mother respondents are in the age group of 18-25. The other 46.6% are between 26-35 age group, 12.5% are in the age range of 36-45 and there is no one above 45 year.

Concerning their education level, 26% of respondents are illiterate, 17% can read and write, 31.8% completed grade10, those who have certificate are 13.6%, 9% have diploma and 2% have bachelor degree. This shows that most of the women do not have good educational background which has also an effect on their level of awareness on the usage of maternal and child care services.

Table 2:- Occupation and Marital Status of Mothers

No	Item	Frequency	%
3	**Occupation**		
	Housewife	62	70.45
	Government worker	17	19.31
	Self employed	9	10.22
	Other	0	0
	Total	**88**	**100**
4	**Marital Status**		
	Single	6	6.81
	Married	75	85.22
	Divorced	7	7.95
	Widowed	0	0
	Total	**88**	**100**

Source- Survey questionnaire, 2016

Table 2 above refers to mother respondents' occupation, 70% of mother respondents are housewives, 19% are government workers and 10% are self employed. So, most of mother respondents are housewives who are dependent on their husband. This affects their decision making power on how to get health assistance at their pregnancy and delivery time.

Table 3, item 4 describes about the respondents marital status. 6.8% of them are single, 85% of them are married and 7.9% are divorced.

Table 3:- Sex and Age of Health Professionals

No	Item	Frequency	%
5	**Sex**		
	Male	9	21.42
	Female	33	78.57
	Total	**42**	**100**
6	**Age**		
	18-25	11	26
	26-35	22	52.38
	36-45	6	14.28
	Above 45	3	7
	Total	**42**	**100**

Source- Survey questionnaire, 2016

When we see the gender composition of health professionals, 21% of them are male and 79% are female. So, we can say that there is a great participation of female health professionals in the health center.

Concerning the age variable in Haik Health Center, 26% of health professionals are in the age group of 18-25, 52% are between 26-35, 14% are at the age group of 36-45 and 7% are above 45 years.

As portrayed in table 4 item 7 below, the educational qualification of health professionals is not high. i.e. 38% of them have certificate and 61.9% have diploma with no one having bachelor degree or above.

Table 4 item 8 shows the work experience of respondents. i.e. 47% of health professionals have 1-5 years of experience, 33% have 6-10 years experience, 14% have 11-15 years of experience and 4.7% have above 16 years of work experience.

Based on this data, the educational qualification and work experience of the staffs of Haik Health Center is low with no one having bachelor degree and above.

Table 4:- Educational Qualification and Work Experience of Health Professionals

No	Item	Frequency	%
7	**Educational Qualification**		
	Certificate	16	38.1
	Diploma	26	61.9
	Bachelor degree	0	0
	Master	0	0
	Above	0	0
	Total	**42**	**100**
8	**Work Experience**		
	1-5 years	20	47.61
	6-10 years	14	33
	11-15 years	6	14.28
	Above 16years	2	4.76
	Total	**42**	**100**

Source- Survey questionnaire, 2016

4.2. Availability of Necessary Equipments and Qualified Health Professionals in Haik Health Center

Table 5:- Availability of the Necessary Equipments and Qualified Health Professionals

Do you think that Haik Health Center has all the necessary equipments and health professionals to help mothers and children?					
No	**Item**	**Health professionals**		**Mother respondents**	
		Frequency	**%**	**Frequency**	**%**
9	**Yes**	**14**	**33**	**17**	**19**
	No	**28**	**67**	**71**	**81**
	Total	**42**	**100**	**88**	**100**

Source- Survey questionnaire, 2016

According to table 5, 33% of health professionals and 19 % of mother respondents replied that the necessary equipment and qualified professionals are available in Haik Health center. And 67% and 81% of health professionals and mother respondents respectively stated that, there is shortage of qualified health professionals and the necessary medical equipments in the health center. The availability and optimal utilization of medical equipments is important for improving the quality of health services. But, based on the dominant responses, it is possible to say that there is shortage of qualified health professionals and the necessary medical equipments in Haik Health Center. Lack of medical equipments and qualified health professionals limit the capacity of health institutions to deliver adequate health care.

Some of the core inputs that are deemed necessary for health care delivery are competent health care staff, financial resources, essential medicines and supplies, adequate physical facilities and equipments, and operational policies. Increased inputs lead to desired health outcomes and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system (Shenghelia, et al., 2003).

In Haik health center, there is shortage of many medical equipments that are necessary for maternal and child health. According to the responses gained from respondents, shortage of BP apparatus, thermometer, generator, incubator, ultra sound machine, x-ray and ECG with trained professional to administer, shortage and inconvenience of delivery and examination rooms, experienced midwives, are some of the problems existed in the health center that makes the treatment given to mothers and children difficult. According to mother respondents, there is also shortage of qualified, experienced and disciplined health professionals.

Access to skilled assistance and well-equipped health facilities during delivery can reduce maternal mortality and morbidity, and improve pregnancy outcomes. Availability of skilled attendants at delivery has a great effect on maternal and prenatal mortalities. There is a strong correlation between skilled care attendance at delivery and lower levels of maternal mortality. Care during pregnancy, delivery, and postnatal period, adequate supplies, equipment, and infrastructure as well as an efficient system of communication for transport, and referrals support for the skilled attendant can positively improve the health of the mother and infant.

4.3. Skill Enhancing Trainings on Maternal and Child Health

Table 6:- Skill Enhancing Training

Have you taken any skill enhancing training on maternal and child health issues?			
No	**Item**	**Frequency**	**%**
10	**Yes**	**40**	**95**
	No	**2**	**5**
	Total	**42**	**100**

Source- Survey questionnaire, 2016

Based on the response from table 6, 95% of respondents have taken skill enhancing training on maternal and child issues and 5% of health professionals do not take training related to maternal and child health care.

Training presents a prime opportunity to expand the knowledge base of all employees. Education and training can play a significant role in determining health care professionals' proficiency with the most recent interventions and technologies. In order to improve the quality of clinical care provided by health care professionals, different in-service training models should be adopted. Such trainings may include basic or advanced courses related to maternal and child health care.
The responses gained from the health professionals reveals that, most of them have taken training on abortion, vaccine management, preventing maternal and child health, preventing communicable diseases and methods to reduce maternal and child death. But the trainings are short term and are not that much important to improve the skill of health professionals.

The supervisors who train health extension workers are not well trained and this hinder them from effectively undertaking their duties/affecting the supervision. Lack of essential trainings related to delivery has been a challenge and causing frustration among health extension workers. Lack of incentives such as skill enhancing trainings for health professionals has in some way resulted in negligence on job and this may create lack of empowerment among health workers.

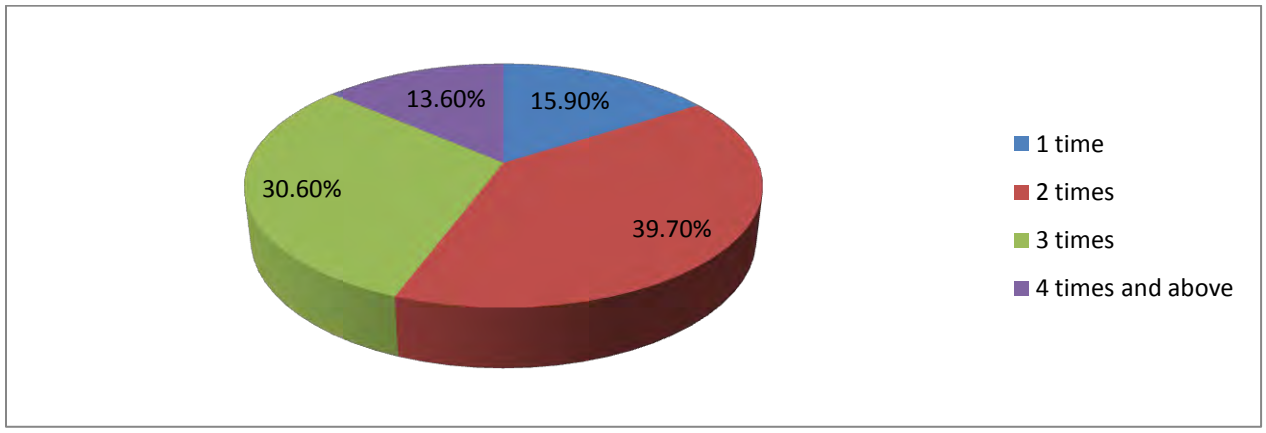
4.4. Antenatal and Postnatal Care

Concerning on the use of antenatal and postnatal care, 16% of respondents have taken antenatal and postnatal care only one time,40% of them have taken 2 times, 30% use the service 3 times and 14% of respondents have taken antenatal and postnatal care 4 times and above.

Even if ANC is more effective in preventing adverse pregnancy outcomes when it is sought early in pregnancy and is continued throughout pregnancy, a considerable number of respondents do not make the minimal number of visits (four) as recommended by the WHO. But, most of them have taken antenatal and postnatal care 1-3 times. From this we can conclude that there is still gap in awareness of the society on the importance of antenatal and postnatal care.

But use of at least one requested antenatal care visit positively predicts use of institutional delivery services because it can increase women's familiarity with health centers.

Figure 2:- The Use of Antenatal and Postnatal Care



Source- Survey questionnaire, 2016

WHO recommends a minimum of four ANC visiting is needed to accomplish the essential level of ANC for every pregnant woman based on the time references of fetus development. Even if recent empirical evidence has shown that four visits suffice for uncomplicated pregnancies, more visits are only recommended in case of pregnancy complications (Dana, Noreen and German, 2003). Antenatal care is a critical element for safe motherhood, and it reflects the degree of utilization of maternal health services. In Ethiopia the proportion of women aged 15-49 attended at least once by a skilled health provider during pregnancy improved from 26.7 percent in 2000 to 27.6 percent in 2005 and to 39.6 percent in 2014(USAID, 2015).

Health professionals in Haik Health Center stated that antenatal care is needed four times in the pregnancy period to detect early complication and any danger sign during pregnancy, to know the condition of the mother and the fetus. To educate pregnant women about their own health and of their children is also an opportunity that can be incorporated from ANC.

And also respondents of health professionals mentioned the role of ANC for providing information on danger signs and how to handle them. ANC also makes it possible to screen for sexually transmitted diseases such as HIV. Furthermore, other potential benefits of ANC stated by the respondents are counseling on nutrition and healthy pregnancy/delivery behavior, provide tetanus immunization, iron and folic acid tablets, malaria prophylaxis and help women to decide their place of delivery by creating familiarity with the health facilities. ANC is effective in improving maternal and child health outcomes if there is a feasible health system where women can receive emergency obstetric care when needed. Immediate postnatal visit is needed (within 24 hours) and a second postnatal visit after 3 days of the delivery to maintain the health of the mother and newborn, control other complications after delivery and maintain sepsis.

Mother respondents also stated their reason to take antenatal and postnatal care as to know the situation of the fetus, to get professional advice on what they have to do for their health and to get immunization that can prevent them and their child from different diseases.

4.5. Place of Delivery

Table 7:- Place to get Delivery Assistance

No	**Where do you get delivery assistance?**		
11	**Item**	Frequency	**%**
	From a trained professional	83	94.3
	From traditional birth attendant	5	5.68
	Total	**88**	**100**

Source- Survey questionnaire, 2016

As illustrated in table 7, 94.3% of respondents get delivery assistance from skilled health professionals and 5.6% of them get from traditional birth attendant. This shows us that most of the respondents are aware of the importance of getting delivery assistance in health centers from skilled professionals. But the remaining 5.6% must be reduced to bring a full achievement.

Giving birth in a health facility has been suggested as the single most effective intervention that may reduce maternal mortality below 200 per 100,000 live births (Campbell and Graham, 2006). Ethiopia has expanded the physical accessibility of maternal healthcare services. The number of health centers, which are part of primary healthcare units, has increased substantially in the country from 412 in 1997 to 2689 in 2010. The number of health posts increased from 14,192 in 2009/10 to 16,048 in 2012/13. As a result, the ratio of health posts to population reached 1:5,352 in 2012/13, indicating that the standard of 1:5000 was almost achieved. The number of health centers increased from 2,142 in 2009/10 to 3,100 in 2012/13, indicating the ratio of health centers to population declined from 1:37,299 in 2009/10 to 1:27,706 in 2012/13, which is very close to the standard of 1:25,000 set by the Ministry of Health (FMOH, 2014).

Ethiopia has set a national target of reaching an institutional delivery rate of 32% by 2010, however, according to recent studies; only about 12% of births were reported to take place in health facilities in north-western and south-eastern Ethiopia (Yesuf EA et al, 2014). Maternal mortality rate decreased from 523 in 2010 to 353 in 2015 (WHO, 2015).

94% of mother respondents replied that they choose a trained health professional for their delivery than traditional birth assistants. Most of the respondents stated their reason to deliver at health institutions is to get professional assistance in case some complications may occur at the time of labor and delivery, to gain advice on what to do after delivery and some of them chose to deliver at health institutions because of its closeness to their neighborhood.

The reason for 6% of the respondents to choose home delivery by traditional birth attendants was, they waited for long time before receiving the service, the health professionals were not respectful and some health professionals are not sensitive to their privacy and care little to give them psychological support and there is no suitable waiting room in the health center.

Decision making power in the household is also mentioned as a reason to be able to get and use services before, during, and after pregnancy and childbirth. Women's involvement in household decision making is positively associated with the use of maternal health services. The more women

household self decision making autonomy, the more to deliver at health institution or utilize health services.

4.6. The Importance of Taking Vaccination

Table 8:- Taking Vaccination

No	**Have you and your child taken vaccination?**		
12	**Item**	**Frequency**	**%**
	Yes	73	83
	No	15	17
	Total	**88**	**100**

Source- Survey questionnaire, 2016

According to table 8, 83% of respondents and their children have taken vaccination and 17% of them do not take vaccination. The data shows that most of the respondents and their children have taken vaccination. This can help us to say there is a great achievement in creating awareness to the community on the use of vaccination.

The main rationale for childhood vaccination is that it reduces child mortality significantly and is a cost effective way to improve child health, particularly for poor households located in high disease environments. Indeed, there is evidence that vaccination guards not only against a particular disease but also can provide a wide range of health benefits making it a particularly valuable public health measure. Vaccination of children can be thought of as an investment in human capital, with children's health improvements resulting in their higher work productivity and earnings as adults (David E, et al, 2011).

Infection or illness during pregnancy can be harmful to mother and baby. For this reason, immunization before, during and after pregnancy are important parts of prenatal care. To avoid the risk of hospitalization and serious complications for the mother and baby, it is recommended that pregnant women receive the vaccines to protect against flu, tetanus, diphtheria and pertussis. All four mandatory vaccinations for infants are poliomyelitis, tetanus, diphtheria and hepatitis B. Respondents who replied that they and their child take vaccination stated its importance as, to

protect their children from polio, to improve their immune system and to avoid transmitive diseases. But most of the respondents replied that, they take vaccination without knowing its importance for their health. This is due to problems related to awareness creation of the concerned bodies on the importance of vaccination to the health of the child and mother. So, maternal and child health bureau, women affairs office, health professionals and other concerned bodies should cooperate to educate the community to achieve the preventive aspect of the health policy.

4.7. Training on Breast feeding and Preparation of Supplementary Food

Table 9:- Training on Breastfeeding and Supplementary Food Preparation and Feeding

No	**Have you ever get training or explanation from health professionals on breast feeding practices and supplementary food preparation and feeding practice to your child?**		
13	**Item**	**Frequency**	**%**
	Yes	13	14.8
	No	75	85.2
	Total	**88**	**100**

Source- Survey questionnaire, 2016

Concerning on getting training on breast feeding and supplementary food preparation, 14.8% of respondents say 'yes' and 85.2% of respondents replied that they didn't get any training on breastfeeding and supplementary food preparation for their child. From this we can say that there is less work done in creating awareness about the importance of breast feeding and supplementary food preparation for children more than six months to avoid problems related to nutrition.

Under nutrition accounts for nearly half of all deaths among children under 5 years of age. As a result of under nutrition, about 162 million children remain stunted, and 51 million children under-5 years of age suffer from wasting, which is a strong predictor of mortality. Childhood under nutrition not only inhibits a child's physical development, but also is linked to cognitive impairments (USAID, 2014).

Breast milk is best for body and the benefits of breastfeeding extend well beyond basic nutrition. In addition to containing all the vitamins and nutrients the body needs in the first six months of life, breast milk is packed with disease-fighting substances that protect the body from illness. A study by the National Institute of environmental Health Sciences showed that children who are breastfed have a 20 percent lower risk of dying between the ages of 28 days and 1 year than children who weren't breastfed, with longer breastfeeding associated with lower risk. Furthermore, most infants are developmentally ready for other foods at about 6 months. Supplementary food can reduce the problems related to nutrition and under weight.

Some of mother respondents who got training on breastfeeding and supplementary food preparation stated the knowledge they gain as the importance of breastfeeding for brain development of the child and to avoid infections and other childhood illnesses. Maternal and child health officers replied that they have planned to organize meetings for mothers to train them on how to prepare supplementary foods. As the responses of the respondents show, there is a great gap in giving training on the importance of breast feeding and supplementary food preparation for the children even if it has a significant role in the reduction of child mortality.

In this case, maternal and child health officers, health extension workers and other health professionals have the responsibility of creating awareness to the community about the importance of breastfeeding and children's supplementary food preparation by organizing different seminars and participating the elderly.

4.8. Causes of Maternal and Child Death

Many women living in developing countries including Ethiopia are at risk of pregnancy-related complications including hemorrhage, obstructed labor, pre-eclampsia/eclampsia, and infection. Problems that may complicate pregnancy and delivery, such as anemia, hypertensive disorders, and multiple pregnancies, also need to be detected and managed. In many developing countries, the presence of malaria, HIV, or syphilis can also harm a pregnancy, as can experience of intimate partner violence. If detected and managed early and correctly through accessing high-quality ANC services, pregnancies can be made safe and result in healthy babies.

Based on the responses gained from questionnaires, the main causes of maternal and child death occurred at the study area are lack of quality of care during delivery, post partum and ante partum

hemorrhage, unsafe abortion, infection, malnutrition, dehydration, sepsis after delivery, mother to child communicable diseases, pneumonia, anemia, prolonged labor, hypertensive disorders in pregnancy. The problems that occurred often at the study area that cause maternal and child death are infrastructure problems, choosing traditional birth attendants rather than professionally assisted delivery especially in rural areas and lack of quality care. At night shift, there will only be one midwife who takes care of all mothers who came to give birth. Therefore, if many mothers come at a time for delivery, it is difficult for one midwife to handle and this will decrease the quality of health care service given at the health center.

4.9. Participating in Designing and Implementation of Health Policies

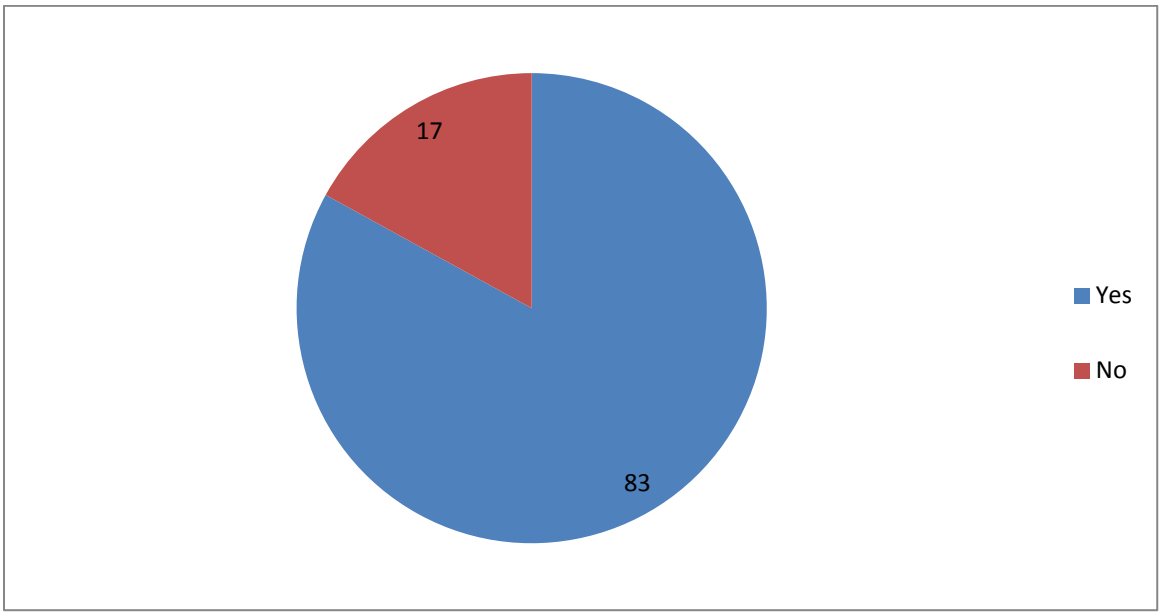
Table 10:- Participating in Designing and Implementation of Health Policies

Have you ever get the opportunity to participate in any health policy issue/ in designing and implementation of health programs?			
No	**Item**	**Frequency**	**%**
14	**Yes**	**0**	**0**
	No	**88**	**100**
	Total	**88**	**100**

Source- Survey questionnaire, 2016

For the question related to participating on health issues, all (100%) of mother respondents replied that, they never had the opportunity to participate on any health policy making and implementation process.

Figure 3:- Health Professionals Participation on Health Policy Issues



Source- Survey questionnaire, 2016

83% of health professional respondents have participated on health policy issues and 17% of respondents do not have the opportunity to participate on any health policy making and implementation process.

Public participation is defined as the sum total of all citizens and communities deliberately taking part in a goal-oriented activity. Public participation involves the participation of members of the public who are interested in solving issues in question. The secret of public participation is to ensure that the relevant "publics" are approached on any particular issue (Craythorne, 1997).

All mother respondents did not take part in the process of designing and implementation of any health strategy/program. The health strategy is designed by the government and other concerned partners using a top down approach. The community people are playing mostly the recipient role in the implementation of the health program.

Health professionals also do not get the opportunity to participate in any policy making process. But, most of health professionals participated in health policy implementation like giving health education to the community, in the prevention and controlling of communicable diseases, on how

to prevent maternal and child death, organizing health development army, organizing the community in to group to identify and solve problems.

To create awareness on the community about the preventive aspect of the health policy, the HEWs and other health professionals are working. Health extension workers train selected cell leaders on weekly basis on maternal health care for the implementation of the maternal and child health care package. They train leaders of the health development army on monthly basis. They use the 1-5 cell based structures of women and 1-30 health development armies to educate and pass health information to members of cells. Health extension workers supported by health facility providers like maternal and child health officers, also give educational input to all kebele dwellers on biweekly basis. The general kebele meeting enables participants to reflect on what they learned and challenges they faced in the process. They use the meeting to look for away forward that cells should do till the subsequent meeting. The process repeats where communities set the agenda on translating into practice all maternal and child care services: identifying pregnant women, counseling them to be registered in health posts, and taking laboratory tests in health centers, following up all required checkups of ANCs, preparing for facility birth, and accessing post partum care services for the mother and new born.

Maternal health officer has the role of monitoring and evaluating HDA achievements based on their roles, aggregating the outcome, fulfilling logistics, giving training for health extension workers and HDAs, evaluating whether the health packages are implemented by HDAs or not, organizing discussions for the community by their one to five group for example to take IUCD, long term family planning methods, to make deliveries on health centers and strengthening the relationship between HEWs and HDAs.

Child health officer has the role of giving training for HEWs and HDA leaders on nutritional issues, breastfeeding, and supplementary food preparation.

The role of head of the health center is implementing health extension packages, organizing youth ambulance service (youths in the community carry the mother to health centers in the time of delivery) for remote areas by collaborating with HEWs and HDAs, receiving feedback, evaluating the work done, evaluating the problem existed in every kebele to give solutions.

4.10 Engaging the Elderly to Create Awareness

Table 11:- Engaging the Elderly

Have you tried to engage elderly and leaders of one to five group to create awareness to the community on maternal and child health issues?			
No	**Item**	**Frequency**	**%**
15	**Yes**	**38**	**90.5**
	No	**4**	**9.5**
	Total	**42**	**100**

Source- Survey questionnaire, 2016

According to table 11, 90.5% of respondents replied that they engaged the elderly and one to five group leaders to create awareness to the community on maternal and child health issues and the remaining 9.5% of them said that they didn't give the opportunity for the elderly and leaders of one to five group to create awareness to the community on maternal and child health issues.

4.11. Measures Taken to Empower the Community

Women's empowerment and equality is a fundamental human right and critical to achieve development objectives, including health. Women's increased political participation, control of resources including land, access to employment and education are crucial for promoting sustainable development. There are numerous pathways by which greater gender equality can lead to improvements in health and quality of life for women and their family members. Women with greater agency are more likely to have fewer children, more likely to access health services and have control over health resources, and less likely to suffer domestic violence. Their children are more likely to survive, receive better childcare at home and receive health care when they need it. At the same time, improved health outcomes for women can help to strengthen their own agency and empowerment. Healthy women are more able to actively participate in society and markets and take collective action to advance their own interests. They are likely to have greater bargaining power and control over resources within the household (PPD, 2013).

Based on the responses from questionnaires and interviews, the measures taken to empower the community are training health extension workers and health development armies, giving health education on maternal and child health for patients who came for examination, giving advice on nutrition and personal hygiene, providing professional assistance and advice to women by organizing conference to create awareness, government has made care received at health facilities and ambulance services free of charge though limited in coverage. It has made some improvement in the management of complications by assigning two skilled midwives in each health center and making emergency services for mothers with complications open 24 hours. Strategies like emergency obstetric care and safe motherhood initiative are being implemented to protect the life of mothers and newborn.

The interviewees replied that, an ecologically driven health development army (HDA) of thirty members sub structured into community cell based networking of 1-5 has been introduced to guide social mobilization and community participation in health as of 2012. The networking requires all women to be teamed in 1-5 cells, actively participate in learning and practicing good health. The leader of a cell is selected for demonstrating better performance in translating the health packages to practice. The best performing woman is the leader of the health development army of 30 members. All stakeholders at community and leadership position give credit to the social network of HDA for enhancing maternal and child care seeking behavior in beneficiaries and responsiveness of health providers in health facilities to meet health care needs of mothers and children. The impact of the networking is that communities are empowered and are assuming ownership with regards to dealing with their health care needs. They are demanding for availability of quality of maternal health care services at closer locations. So, through the use of innovative methodologies and approaches, communities can assume leadership in producing good health.

The pregnant mothers' conference which is conducted on monthly basis help women to ask questions and express their fear to providers including reporting about experiences of women who gave birth in health facility. Cell leaders and members mostly reflect their experiences in putting the package into practice. They agree on the steps to be followed to speed up the implementation of the family health package and other packages as well. If there are families that show resistance

to antenatal care and institutional birth, they are identified and counseled by HDAs and health extension workers.

According to the interview response, community based associations such as youth, women, and farmers; kebele and district leadership, NGOs and government sectors such as agriculture office, women, children and youth affairs, education and communication office reinforce community health workers activities in their endeavors to inculcate in communities the values and benefits of institutional maternal health care services. Any obstacle in implementing a package is dealt at cell level. If problems related to underage marriage, rape and coerced sex are reported they are dealt at command post level.

4.12. Attitude of the Community on Empowerment Strategies

The interviewees replied that, attitude of the community on the empowerment strategies is being improved, they are accepting the importance of women education, and there is continuous effort to avoid harmful traditional practices. The communities evaluate the results by monthly meeting. But, as the response gained from health professionals and interviewees indicated that, there is still resistance from the community in accepting the empowerment strategies because of some socio cultural perceptions, less involvement of men partners and women's dependency on their husband.

4.13. Outcomes of the Empowerment Strategies

Based on the responses gained from questionnaires and interviews, the 'one to five' group and HDA leaders have been very prominent in creating awareness among community women about health care activities. The women have been able to freely discuss about their reproductive health issues among themselves. This has helped to increase the health service utilization by the women and the community people in general are becoming part of the empowerment initiatives and sense of ownership is growing gradually. Some traditional birth assistances have become part of the program and are working in educating community women to use health services for maternal and newborn/child care. The health program has enabled the women to have control over their reproductive health and decide on matters that affect their health and life. It is observed that the women's ability to make informed decisions concerning their health issues is increasing from time to time and this to a great extent is helping to improve their reproductive/maternal health.

The responses show that, women are reducing harmful traditional practices that are endangering their health as well as their children. They are making a healthy choice of getting maternal and child care at health institutions than traditional treatment. There is a significant reduction in maternal and child mortality, many women start to take vaccination, antenatal and post natal care, and decrease in home delivery. Particularly, the placement of HEWs in health posts has accelerated this enormous achievement as they provide vaccination and child growth follow up by making rounds in the villages and even in each and every household in the community. There is increase in awareness of the community, increase health care coverage from 25% in 1983 to 83.3% in the study area and increase women education. There are 672 development groups, 2982 one to five groups, 16, 347 organized women and 47 HEWs in the woreda. Post partum care has been enhanced to 86% since the HDA networks have been made operational. Family planning service was 30% in 1983 and now it has reached 100%, prenatal service reached to 90% and professionally assisted delivery increased to 60%. But these achievements are not enough to achieve MDG goals in reducing maternal and child death.

4.14. Challenges that Hinder the Implementation of Maternal and Child Health Empowerment Strategies

Even though there are positive outcomes that should be encouraged, further effort is needed to make the entire community women beneficiary from the health program and to bring the desired improvements in maternal and child health.

Lack of awareness of the community, negligence and reluctance of health professionals to take action, low level education of women, shortage of medication, shortage of experienced health professionals, infrastructure problem, continuous turnover of health professionals, lack of the necessary equipments, socio cultural perceptions and practices of birth are major inhibiting factors for women in their decision making with regards to place of birth.

Advising mothers on breast feeding, managing the new born, sanitary and hygienic practices including routine vaccination are only provided to rural residents considering the urban residents to have knowledge about maternal and child health issues. This may create a huge gap in the awareness level of the people and hinder the full achievement of the empowerment strategies in all areas.

The health strategy is designed at federal level. Neither the community people nor the health workers at grass root level have taken part in the designing of the health program. This has been a problem for the effective implementation of the strategy.

There is no continuous staff motivating mechanisms such as incentives in form of education, trainings and other motivating tools to make health professionals more committed to their duties in the health program. Health extension workers are trained in midwifery only for normal deliveries. As a result of this, they are not able to provide complete service to the community people. This could cost a mother's life in villages where health centers are located in far distance. The health centers are not located in close proximity to all households in the community. Long distance to health center is still a problem to access health facilities for some community people residing in distant districts from the health center.

Despite the encouraging results that are being seen as a result of the health program, it is difficult to say the community is fully engaged in the ongoing health care activities. There is still reluctance from the community women to make use of the health services provided. The desired behavioral change among the community people mainly women, has not been achieved yet.

4.15. Solutions to Improve Maternal and Child Health

Respondents replied that, participating men partners, promoting family planning service regularly, health professionals should give health information for the community, strengthening HDAs, fulfilling infrastructures like road, water, education, making health centers equipped with the necessary materials, making regular follow up and evaluation, collaboration with other sectors and the community, increasing women education, making correct reports only on the work done, participating the community on health policies and training should be given regularly to health professionals.

Failure to meet what communities are demanding in health care service delivery would result in dissatisfaction and lack of trust in the health system. Therefore, respondents said that, government should mobilize resources to improve the supply side of maternal and child health care services. It has to upgrade the capability of health extension workers to assist in birth since most villages are located far from accessible road by car. Maternity waiting homes should be expanded, well resourced and conducive to accommodate women expecting birth coming from distant and inaccessible villages.

Chapter Five

5. Summary of Major Findings, Conclusion and Recommendations

5.1 Summary of Major Findings

- Most of mother respondents are housewives who are dependent on their husband and are less educated. This has an effect on their level of awareness and decision making power on the usage of maternal and child care services.
- All the health professionals working in the health center have only certificate and diploma educational level.
- Even if the standard level of taking antenatal care is four times, most of the respondents took antenatal and postnatal care less than 4 times.
- Most of the respondents and their children have taken vaccination. But, most of them do not have knowledge on its importance to their health and about 85% the respondents didn't get any training on breastfeeding and supplementary food preparation for their children from health professionals or other officials.
- All of mother respondents never have the opportunity to participate in any health policy making and implementation process. And 83% of health professional respondents have participated not on the making but on the implementation of health policies and programs.
- About 95% of health professionals have taken training on maternal and child health issues. But most of them complained it as insufficient because it takes place in a short period of time.
- Socio cultural perceptions, low educational level of the community, shortage of experienced and qualified health professionals, infrastructure problem, lack of the necessary equipments and top down approach of policy making are some of the major challenges for the effective implementation of the empowerment strategies.
- There is a huge shortage of many necessary medical equipments, medicines and qualified health professionals in the health center that makes the treatment given to mothers and children insufficient.
- The health professionals have worked hard to participate the elderly and one to five group in awareness creation activities and they have also organized the health development army

(HDA), which has thirty members sub structured into community cell based networking of 1-5 for community mobilization and participation on issues concerning their health.

- Different measures have been taken to empower the community to use maternal and child health care services. Among the measures taken organizing HDAs, organizing women's conference to create awareness, providing ambulance and 24 hour service free of charge are some.
- Different community based associations, governmental and nongovernmental organizations played a great role in creating awareness to the community on the importance of institutional delivery and the negative effects of harmful traditional practices.
- The empowerment strategies have brought many positive outcomes in improving the health of mothers and children. It helped mothers to make decision on the place of their delivery, to take vaccination, antenatal and postnatal care and health care coverage has increased to 83.3%.

5.2 Conclusion

The empowerment initiative in terms of access and quality of health services has been transforming the lives of many women and children in improving their health status. Encouraging results are being observed. Many women and children have been able to make use of free health care which they wound not be able to use otherwise.

The HDA approach to health promotion was able to create context based synergy of players and resources for change in health. The network of 1-5 and 1-30 has an ecological capacity to engage members in the making of health discourses by relating the health information and messages they get from health extension workers and health providers in health facilities to their way of life.

Health professionals and officers are working to empower the community by organizing women conferences and organizing the community into HDA and 1-5 groups to create awareness on maternal and child care issues.

The HDA approach allows more input to be generated by beneficiaries and engage community health workers and health facility based providers in the process of learning and confidence building while mitigating heath problems. In effect this has transformed the health extension program from a sort of orientation to an educational program. The approach is inclusive. Each team has to work through all possible means such as counseling, family discussion to bring

members to the same level of understanding of health care. The approach addresses accountability to health care at individual, team and institutional levels. It empowers communities to deal with health risks, not through fear but through confidence building, for they learn how to prevent risks such as choosing a health facility for birth instead of home.

Even if one of the core values of the Ethiopian HSDP is involving the community on health care decision-making process, the empowerment initiative of the health program is by and large a top down approach. The community people did not take part in the process of designing the health strategy program. The health strategy is designed by the government and other concerned partners using a top down approach.

The empowerment initiative has been promising to some extent in addressing the health concerns of women and children. However, lack of bottom up health promotion strategies such as genuine community participation in the designing and implementation of the health program, socio-cultural beliefs, shortage of necessary logistics and qualified and experienced professionals have greatly hindered the health promotion program from effectively improving the health status of women.

5.3. Recommendations

In order to strengthen the positive outcomes and avoid the challenges that hinder the effective implementation of the empowerment strategies to improve maternal and child health, the following recommendations are provided based on the findings of the study:-

- Women should be given the chance to get education by creating collaboration between health promoters and education bureau to make them be able to decide on matters that affect their life.
- The education level of health professionals should be improved by giving free education opportunity in government and private institutes. Strengthen collaboration of HEWs with other health providers, community health workers and traditional birth attendants to ensure the continuity of care and social support. Proper competency based training of HEWs should be ensured.
- Women should be given training on the importance of taking antenatal and postnatal care to their health by HDAs. Encourage at least 4 antenatal (ANC) visits, labor/delivery and an immediate postnatal visit (within 24 hours) and a second postnatal visit at 3 days with a trained health worker; all obstetric and neonate emergencies should go to a trained health worker.

- Health development armies, health extension workers and other concerned bodies should create awareness to the community on the importance of taking vaccination, breastfeeding and supplementary food preparation by organizing conferences.
- Community participation should be given strong emphasis and needs to be incorporated as a fundamental part of the health strategy. In the making of health policies and programs, there needs to be an involvement of health promotion practitioners and community people or other stakeholders. Health promoters should engage very closely with community people in identifying and prioritizing health problems. People's participation in the process that affects their lives is very fundamental to bring a real improvement and development.
- Long term training should be provided to health professionals to provide skills-based and high-impact service.
- Lack of awareness, and conformity to traditional practices, appear to be major constraints that prevent women from seeking skilled delivery services. Therefore, behavior change, awareness creation, communication and related activities should be strengthened to tackle cultural barriers and traditional practices. Strengthen linkages between the community and the health delivery system and develop local means of transport for use during emergencies
- The health centers should be equipped with the necessary supplies and qualified health professionals for better service quality and health posts should be strengthened to deal with emergency situations. Develop capacity of the health system to effectively deliver health education. Improve the set up of facilities and providers' skill on counseling couples. Maternity waiting homes should be designed to be client-friendly to meet the private needs of women. This can be achieved by increasing budget of the health sector and gear international aid in health towards strengthening facility based services such as training of health providers, strengthening key components of health systems like logistics, equipment, and facility space.
- The structures in place should be strengthened through training of cell and HDA leaders and community health workers. As facilitators of health communication and educational activities they need more training in agenda setting. Include critical MNH issues in the existing community conversation and community dialogue activities.
- It should not be only just the risk of death that encourages women to deliver in the facility, but the accessibility and availability of a caring and competent staff. In addition, providing

culturally competent services has the potential to improve health outcomes, increase the efficiency of clinical and support staff, improve client satisfaction with services and improve response to emergency situations. The ambulance services have to be strengthened by putting more ambulances into operation; midwives at heath centers must be able to deliver care services.

- Cross-sectoral collaboration should be strengthened to ensure community participation in health empowerment. Empowering those who work towards empowering others like community people needs to be taken into account and it has to be ensured throughout the implementation processes of health programs. Proper and long term training and different incentives should be provided to health professionals to minimize staff turnover and avoid negligence.
- Strong commitment of local and federal government officials laid the groundwork for effective formulation, implementation, and evaluation of key programs, strategies and interventions. Continued support is needed to maintain and increase this momentum. Regional, urban-rural, and wealth status disparities in access and utilization of health care services must be addressed, through demand-generation activities that confront barriers to access and quality of care.

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Appendix I: Questionnaire for Health Professionals

Addis Ababa University

College of Business and Economics

Department of Public Administration and Development Management

Masters of Public Management and Policy (policy studies)

Dear respondents, my name is Tekuamework Demessie. I am masters student at Addis Ababa University in the department of Public Administration and Development Management. Currently, I am conducting research thesis in the special field of "Public policy". My research topic is entitled "Assessment of the challenges and outcomes of empowerment strategies to improve maternal and child health".

The objective of this study is to assess the impact of health empowerment strategies in maternal and child health and the challenges that hinder their effectiveness. The answer given by the respondents for this research will be kept confidentially and only used for the purpose of this study. The researcher also believes that real answers that the respondents give possess high importance that might be used by policy makers and planners that work on maternal and child health issues. Hence, I ask you to be honest and forthcoming in your response. Furthermore, any information that you provide is valuable to this study. I would like to extend my appreciation and thanks in advance for your cooperation and committing your precious time.

General guideline

- Don't write your name
- The questionnaire should be filled by employees of Haik Health Center
- Put "X" mark to close ended questions

Part 1:- Personal Information of Respondents

1. Sex A. female ☐ B. male ☐
2. Age

   A. 18-25years ☐ C. 36-45 years ☐

B. 26-35 years ☐ D. above 45 years ☐

3. Educational qualification

A. Certificate ☐ C. Bachelor Degree ☐

B. Diploma ☐ D. Master ☐

E. Above ☐

4. Work Experience

A. 1-5 years ☐ C. 11-15 years ☐

B. 6-10 years ☐ D. above 16 years ☐

Part 2:- Questions Related to the Study

5. Do you think that Haik Health Center has all the necessary equipments and health professionals to help mothers and children?

A. yes ☐ B. No ☐ C. I don't know ☐

6. If your answer for question no 4 is 'no', what equipments are not available in the health center and what should be done to increase the number and qualification of health professionals in the health center?

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7. Have you taken any skill enhancing training on maternal and child health issues?

A. Yes ☐ B. No ☐

8. If your answer for question no 7 is ‘yes’, what knowledge have you gained from the training?

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9. How many times is antenatal and postnatal care necessary? And why?

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10. Have you ever get the opportunity to participate in any health policy issue/ in designing and implementation of health programs?

A. Yes ☐ B. No ☐

11. If your answer for question no 10 is ‘yes’, what was your role and what issues were raised?

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12. What measures have you taken to empower the community/ to create awareness about the empowerment strategies to improve maternal and child health?

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13. Have you tried to engage elderly and leaders of one to five group to create awareness to the community on maternal and child health issues?

A. Yes ☐ B. No ☐

14. How do members of the community evaluate the empowerment strategies?

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15. What are the main causes of maternal and child death?

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16. What are the major outcomes observed after the application of the empowerment strategies?

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17. What are the challenges that hinder the implementation of maternal and child health empowerment strategies?

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18. What options/solutions do you suggest that can improve maternal and child health?

Appendix II: English Questionnaire for Mothers

Addis Ababa University

College of Business and Economics

Department of Public Administration and Development Management-

Masters of Public Management and Policy (policy stream)

Dear respondents, my name is Tekuamework Demessie. I am masters student at Addis Ababa University in the department of Public Administration and Development Management. Currently, I am conducting research for my thesis in the special field of "Public policy". My research topic is entitled "Assessment of the challenges and outcomes of empowerment strategies to improve maternal and child health".

The objective of this study is to assess the impact of health empowerment strategies in maternal and child health and the challenges that hinder their effectiveness. The answer given by the respondents for this research will be kept confidentially and only used for the purpose of this study. The researcher also believes that real answers that the respondents give possess high importance that might be used by policy makers and planners that work on maternal and child health issues. Hence, I ask you to be honest and forthcoming in your response. Furthermore, any information that you provide is valuable to this study. I would like to extend my appreciation and thanks in advance for your cooperation and committing your precious time.

General guideline

- Don't write your name
- The questionnaire should be filled by women who use maternal and child health care of Haik Health Center
- Put "X" mark to close ended questions

Part 1:- Personal Information

1. Age

A. 18-25years ☐ C. 36-45 years ☐

B. 26-35 years ☐ D. above 45 years ☐

2. Education qualification

C. Illiterate ☐ D. Certificate ☐

D. Read and write ☐ E. Diploma ☐

E. 10th grade complete ☐ F. Bachelor Degree ☐

G. Above ☐

3. Profession

A. House wife ☐ C. Self employed ☐

B. Government worker ☐ D. Other ☐

4. Marital status

A. Single ☐ C. Divorced ☐

B. Married ☐ D. Widowed ☐

Part 2:- Questions Related to the Study

5. How many times have you taken antenatal care?

A. 1 ☐ B. 2 ☐ C. 3 ☐ D. 4 and above ☐

6. What benefits do you perceive in antenatal and postnatal care for the mother and the child?

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7. Have you and your child taken vaccination?

A. Yes ☐ B. No ☐

8. What do you think is the benefit of vaccination for the health of the mother and the child?

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9. Where do you get delivery assistance? And why?

A. From a trained professional ☐ B. From traditional birth attendant ☐

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10. Have you ever get training or explanation from health professionals on breast feeding practices and supplementary food preparation and feeding practice to your child?

A. yes ☐ B. No ☐

11. If your answer for question no 10 is 'yes', what knowledge have you gained from the training?

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12. Have you ever get the opportunity to participate in any health policy issue/ in designing and implementation of health programs

A. Yes ☐ B. No ☐

13. If your answer for question no 12 is 'yes', what was your role and what issues were raised?

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14. Do you think that Haik Health Center has enough equipments and health professionals to help mothers and children?

A. yes ☐ B. No ☐ C. I don't know ☐

15. If your answer for question no 14 is 'no', what equipments are necessary and what should be done to increase the number and qualification of health professionals in the health center?

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16. Do you think that delivering in a health center has an advantage for the health of the mother and child? Why?

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17. What do you think is the main cause of maternal and child death?

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18. What are the major tangible outcomes observed after the application of the empowerment strategies?

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19. What do you think should be done to improve maternal and child health?

Appendix III:-Amharic Questionnaire for Mothers

አዲስ አበባ ዩኒቨርሲቲ

ቢዝነስና ኢኮኖሚክስ ኮሌጅ

የህዝብ አስተዳደርና ልማት አመራር ትምህርት ክፍል

ዉድ መላሾች ስሜ ተቋምወርቅ ደምሴ ነዉ። የአዲስ አበባ ዩኒቨርሲቲ የህዝብ አስተዳደርና ልማት አመራር ትምህርት ክፍል የሁለተኛ ዲግሪ ተማሪ ነኝ። በአሁኑ ሰዓት በፖሊስ ትምህርት የመመረቂያ ፅሁፌን እየሰራሁ ነዉ። የመመረቂያ ፅሁፌ ርዕስ የእናቶችና የህጻናት የጤና ማሻሻያ ስትራቴጅዎችን ዉጤትና ዉጤታማነታቸዉን የሚያደናቅፉ ችግሮችን መገምገም ነዉ።

የዚህ ጥናት አላማ የእናቶችና የህጻናት የጤና ማሻሻያ ስትራቴጅዎችን ዉጤትና ዉጤታማነታቸዉን የሚያደናቅፉ ችግሮችን መገምገም ነዉ። በመላሾች የሚሰጡ መልሶች ሚስጥራዊነት የተጠበቀ ሆኖ ለዚህ ጥናት አላማ ብቻ ይዉላል። ተመራማሪዉ እንደሚያምነዉ በመላሾች የሚሰጡ ትክክለኛ መልሶች በእናቶችና በህጻናት ጤና ዙሪያ ላሉ ህግ አዉጪዎችና እቅድ አዘጋጆች የጎላ ሚና አላቸዉ። ስለዚህ የምትሰጧቸዉ መልሶች ላይ ሀቀኛ እንድትሆኑ እጠይቃለሁ።በተጨማሪም ማንኛዉም የምትሰጡት መረጃ ለዚህ ጥናት ዋጋ አለዉ። ዉድ ጊዜያችሁን ሰዉታችሁ ስለተባበራችሁኝ ከልብ አመሰግናለሁ።

ጠቅላላ መመሪያ

- ስም መጻፍ አያስፈልግም
- ይህ መጠይቅ በሀይቅ ጤና ጣቢያ የእናቶችና ህጻናት ጤና ክትትል የሚያገኙ እናቶች መሞላት አለበት
- ለዝግ ጥያቄዎች "x" አስቀምጡ።

ክፍል 1፡- የመላሾች የግል መረጃ

1. እድሜ

   ሀ. 18-25 ☐ ሐ. 36-45 ☐

   ለ. 26-35 ☐ መ. ከ45 በላይ ☐
2. የትምህርት ደረጃ

   ሀ. ያልተማረ ☐ መ. ሰርተፊኬት ☐ ረ. ዲግሪ ☐

   ለ. ማንበብና መጻፍ ☐ ሠ. ዲፕሎማ ☐

   ሐ. 10ኛ ክፍል ያጠናቀቀ ☐ ሰ. ከዚያ በላይ ☐
3. ስራ

   ሀ. የቤት እመቤት ☐ ሐ. የግል ተቀጣሪ ☐

   ለ. የመንግስት ሰራተኛ ☐ መ. ሌላ ☐
4. የጋብቻ ሁኔታ

   ሀ. ያላገባ ☐ ሐ. የፈታ ☐

   ለ. ያገባ ☐ መ. ባል የሞተ ☐

ክፍል 2፡- ከጥናቱ ጋር የተያያዙ ጥያቄዎች

5. ስንት ጊዜ የቅድመ ወሊድና ድህረ ወሊድ ክትትል ወስደዋል?

   ሀ. 1 ☐ ለ. 2 ☐ ሐ. 3 ☐ መ. 4 እና ከዚያ በላይ ☐

6. ከቅድመ ወሊድና ድህረ ወሊድ ክትትል ምን አይነት ጥቅሞች ያገኛሉ ብለዉ ያስባሉ?

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7. እርስዎና ልጅዎ ክትባት ወስደዉ ያዉቃሉ?
   ሀ. አዎ ☐ ለ. አይደለም ☐
8. ክትባት መዉሰድ ለእናቶችና ህጻናት ጤና ምን አይነት ጥቅም አለዉ ብለዉ ያስባሉ?

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9. የወሊድ ድጋፍ የት ነዉ የሚያገኙት? ለምን?
   ሀ. ከሰለጠነ የጤና ባለሙያ ☐ ለ. ከልምድ አዋላጆች ☐

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10. ስለጡት ማጥባትና ለልጅዎት ተጨማሪ ምግብ አዘገጃጀትና አመጋገብ ተግባራት ስልጠና ወይም ገለጻ ተሰጥቶዎት ያዉቃል?
    ሀ. አዎ ☐ ለ. አይደለም ☐
11. ለጥያቄ ቁጥር 10 መልስዎ አዎ ከሆነ፣ ከስልጠናዉ ምን አይነት እዉቀት አገኙ?

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12. በጤና ፖሊሲ ጉዳዮች በህግ ማዉጣትና ትግበራ ወቅት የመሳተፍ እድሉን አግኝተዉ ያዉቃሉ?
    ሀ. አዎ ☐ ለ. አይደለም ☐
13. ለጥያቄ ቁጥር 12 መልስዎ አዎ ከሆነ፣ የእርስዎ ሚና ምንድን ነበር? ምን አይነት ሃሳቦችስ ተነስተዉ ነበር?

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14. ሀይቅ ጤና ጣቢያ እናቶችና ህጻናትን ለመርዳት የሚያግዙ አስፈላጊ መሳሪያዎችና የጤና ባለሙያዎች አለዉ ብለዉ ያስባሉ?
    ሀ. አዎ ☐ ለ. አይደለም ☐
15. ለጥያቄ ቁጥር 14 መልስዎ አይደለም ከሆነ፣ ምን አይነት መሳሪያዎች አስፈላጊ ናቸዉ? በጤና ጣቢያዉ ያሉ የጤና ባለሙያዎቹን ቁጥርና ብቃት ለመጨመር ምን መሰራት አለበት?

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16. በጤና ተቋማት መዉለድ ለእናቶችና ለህጻናት ጥቅም አለዉ ብለዉ ያስባሉ? ለምን?

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17. ለእናቶችና ህጻናት ሞት ዋና መንስኤ የሆኑት ምንድን ናቸዉ?

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18. በማነቃቂያ እስትራቴጂዎቹ የታዩ ዋነኛ ተጨባጭ ውጤቶች ምንድን ናቸዉ?

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19. የእናቶችና ህጻናትን ጤና ለማሻሻል ምን መደረግ አለበት ብለዉ ያስባሉ?

Appendix IV

Interview Questions for Maternal and Child Health Officers and Head of the Health Center

1. What kind of empowerment strategies have you used to improve maternal and child health?
2. What is your role as an officer in the implementation of the empowerment strategies?
3. What is the attitude of women and the community as a whole towards the empowerment strategy?
4. Do you work in collaboration with other sectors like education bureau, women's affairs, city administration and community leaders to create awareness to the community on maternal and child health issues?
5. Have you ever given the opportunity for the community to participate in a health policy issue to create ownership of the community on the policy?
6. Have you tried to give the chance for men partners to participate on maternal and child health issues?
7. What are the major outcomes observed after the application of the empowerment strategies of the health sector development program?
8. What are the challenges that hinder the implementation of empowerment strategies?
9. What do you suggest for the future to improve maternal and child health?

Declaration

I, Tekuamework Demessie declare that this work entitled **"Assessment of the Challenges and Outcomes of Empowerment Strategies to Improve Maternal and Child Health; The Case of Haik Health Center"** is outcome of my own study and that all sources of materials used for the study have been duly acknowledged. I have produced it independently except for the guidance and suggestion of the research advisor.

This study has not been submitted for any degree in this University or any other University. It is offered for the partial fulfillment of Masters Degree of Public Management and Policy (Policy Study) in the Department of Public Administration and Development Management.

By: Tekuamework Demessie

Signature_____

Date_____

Advisor: Mulugeta Abebe (PHD)

Signature_____

Date_____