Policy Dialogue

Improving antenatal care utilization in Ethiopia

Dialogue Report

Kuriftu Resort and Spa, Adama, Ethiopia
Thursday, 12 May 2016

This report was prepared by Technology Transfer and Research Translation Directorate, at the Ethiopian Public Health Institute

This policy dialogue was informed by the following policy brief: Improving antenatal care service utilization in Ethiopia.

What is a policy dialogue?

A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?

People with relevant expertise and perspectives, including policymakers, civil society, the mass media and researchers

The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?

+ That discussion and careful consideration should contribute to well-informed health policy decisions

× The dialogue did not aim to reach a consensus or make decisions

What is included in this report?

+ Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

× These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

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Key Messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

The Problem

- The coverage for at least one antenatal care (ANC) visit is high compared to the WHO recommendation at least four visits and skilled birth attendance at health facilities. The reason(s) behind this fact should be explored.
- The problem is there is no tracing mechanism of mothers who make the first visit. The ministry of health tracks only the indicators not the mothers.
- Causes for the low level of ANC utilization listed in the policy brief are known internationally and should be enriched by local studies. Where local studies are not there or are not sufficient, studies should be conducted.

Policy Options

- Policy options should be listed in the order of their importance. For example, Behavioral Change Communication (BCC) campaign should come first.
- The options in the policy brief do not address the problem poor quality of care as a barrier to low utilization of ANC. Continuous Professional Development (CPD) could be one option to produce compassionate and caring health professionals to improve quality of care.
- There is no need for conditional cash transfer as one option, as mothers are exempted from user fees by policy. In addition to being difficult to implement, its possible benefits could be addressed by community based health insurance (CBHI), a program which is already being pilot tested by the government.

Implementation Considerations

- There are no training institutions in the country which produce experts in Behavioral Change Communications. This could be a possible barrier in implementing BCC.
- Conditional cash transfer may not work as it may create dependency and be costly and unsustainable to implement.

The Problem

It was aired that the figure indicating the magnitude of the problem in the policy brief is from Ethiopian Mini Demographic Heath Survey (EMDHS 2014) and such surveys may not show the current situation as they use data of the last three or five years of preceding the survey. However, it was also said that it is correct to use DHS data since Ethiopia is compared with the rest of the world with data generated from this survey.

So far there are different initiatives and achievements in maternal heath by the ministry of health and the current antenatal care coverage may have increased as a result and it is not included in this report. It was also said that rather than putting only the problem, the background section of policy brief could also include maternal health achievements in the country. Participants have also mentioned that the coverage for at least one ANC visit is high compared to WHO recommendation at least four ANC visits and skilled birth attendance at health facilities; the reasons why subsequent antenatal care visits and skilled birth attendance are low should be explored. One of the reasons could be the problem in tracking mothers after their first antenatal care visit as there is no system established. The ministry of health tracks only the indicators not the mothers.

Another point mentioned was that though the trend of ANC coverage at least one visit is increasing in the country there are problems in early initiation of ANC visit. Participants also pointed out that the causes for the low level of antenatal care listed in the policy brief are known internationally and should rather be enriched by local studies. Where local studies are scarce or are not there, participants called for local studies which would identify local causes for the low level of antenatal care in the country.

Access to health services:

Physical accessibility as a cause to low level of ANC stated in this policy brief does not clearly show the cause for not utilizing ANC services. For example, high level of ANC utilization in urban areas compared to rural areas is attributed to high physical accessibility in urban areas. But there are a lot of confounding factors related to rural and urban divide like education and information.

Though health posts are now many and are near to the communities, health centers and hospitals with equipped laboratories where focused ANC starts, may not be accessible for various reasons. On the other hand, though the government builds health facilities based on population ratio; topography, distribution of the community and poor infrastructure may render health facilities inaccessible. Therefore, when building health facilities the government should consider not only populaiton ratio but topography and infrastructure.

Socio-Cultural barriers:

Regarding the socio-cultural barriers more local studies must be sought and used. For example, the role of religion in utilizing ANCs should be considered. In some religions exposing a mother's body to a male person other than her husband could be considered as obscene. The role of husbands in seeking ANC care should have been spelled out. It is known that the socio-cultural factors vary across communities of various religions and cultures. For example, there is a community in western Ethiopia where mothers are expected to deliver in the forest. In depth studies of socio-cultural factors in relation to ANCs should be carried to understand the barriers.

Poor quality of care:

It is obvious there are problems in quality of care and the policy brief should include the client's perspective. The quality of care during the first ANC visit seems to be poor in quality and mothers may not come for the subsequent visits; therefore, efforts should be in place to improve quality of care. Besides the ANC services are not focused and are almost using traditional approaches of antenatal care services. The skill, knowledge and motivation of the health professionals currently is questionable (only 50% of the undergraduate students got the passmark in exit exam); interventions to improve the quality of pre-service trainings should be considered.

Policy Options

There is a need to prioritize the policy options; for example Behavioral Change Communication (BCC) campaign should come first as it is important to address the most important barrier, the

socio-cultural barrier. The two options BCC campaign and mHealth can also be integrated during implementation as they are very inter-related.

It was pointed out that none of the options in the policy brief addressed the problem of poor quality of care. It was suggested that Continuous Professional Development (CPD) could be one option to have compassionate and caring health professionals and improve quality of care. In-service training, revising the pre-service education curriculum could also be some of the interventions to improve quality of care in the country.

Mobile Health (mHealth):

Regarding mHealth it was mentioned that it may not be a feasible policy option as there are problems in access to mobile phone and network services. In remote areas with no electricity mHealth is difficult to implement. However, it was also underlined that we should not fear to adopt new technologies such as mHealth; when given the opportunity communities are innovative and could tackle the problems using different source of power to charge their mobile phones. It was also said that we should use mhealth where it feasible because is the only way we could learn from practice. It was also noted that there are experiences in using mHealth in the country for different programs and there are achievements even though there were barriers during implementation.

BCC campaign:

Behavioral Change Communication (BCC) campaign is the priority option for the country in improving ANC attendance. However, there is a need for in-depth study in socio-cultural and religious factors for its effective implementation.

Conditional Cash Transfer (CCT):

There is no need for conditional cash transfer as one option, as mothers are exempted from user fees by policy. Besides its implementation is difficult where community based health insurance (CBHI) is in practice. Sustainability is also another problem to implement CCT. On the other hand participants have aired that although ANC services are exempted from user fees mothers

are paying for additional medicines and diagnostic services such as ultrasound and some laboratory investigations. There must be a mechanism to reimburse clients for expenses incurred upon them.

Implementation considerations

The following comments/suggestions were forwarded on the implementation consideration section of the policy brief:

The initiatives by federal ministry of health on information revolution and experiences gained from HIV/AIDS can be considered as enablers to use mHealth as an option in improving ANC service coverage. The launch of radio station at the ministry of health could be also another opportunity to implement BCC.

The terms “BCC vs IEC” in barriers section of the policy brief for BCC should be removed as there is no confusion between BCC and IEC. The term Behavioral Change Communication (BCC) is now familiar and now-a-days it is changed to Social Behavioral Change Communication (SBCC) and there is also a plan to change the name to Social Behavioral Change Intervention (SBCI).

There are no training institutions in the country which produce experts in Behavioral Change Communications. This a possible barrier in implementing BCC. Absence of structures for BCC in the health system could be a barrier for implementing BCC. Therefore, the Ministry of Health should work on mapping of human resource for health on behavioral change communications and a structure should be in place for BCC for its implementation.

There are problems in documenting best practices and lessons learned from failed activities. The same will be true for BCC, if documentation problems are unresolved.

If the current very high cost of airtime for broadcasting is unresolved, implementing BCC would be too difficult.

The third policy option, conditional cash transfer may not work as it may create dependency and is costly to implement. Sustainability is also another big issue with regard to this option. Besides there are strategies in practice to address the economic barrier for going to health facilities: the Community Based Health Insurance and the waiver system for maternal health.

Way Forward

- There should be a multi-sectoral collaboration: EPHI should involve different stakeholders like Charities and Societies Organization when preparing policy briefs and policy dialogues in order to explore local evidences by sharing documents.
- Participants of the policy dialogue should include social scientists like economists.
- The policy options included in this policy brief are demand side options and supply side options are not included.
- It is better if more local evidences are explored and included especially for the causes section of the policy brief.
- Refine and share the document for comments to all policy dialogue participants.

Appendix 1: Agenda

Policy Dialogue on Improving Antenatal Care Service Utilization in Ethiopia

Technology Transfer and Research Translation Directorate

Ethiopian Public Health Institute

(Kuriftu Resort & Spa, Adama, 12 May 2016)

Time	Activities	Responsible person
8:00- 9:00 AM	Registration	Wudenesh and Dr. Fasil
9:00-9:15AM	Opening remarks/ Introductions of participants and moderators	Dr. Yibeltal Assefa
9:15- 9:30AM	Objective of the policy dialogue and Overview of TTRTD	Dr. Mamuye Hadis
9:30-09:55AM	Going through the executive summary of the policy brief on "Improving antenatal care service utilization in Ethiopia"	Dr. Alemayehu Mekonnen and Participants
09:55-10:00 AM	Brief presentation on policy brief	Mr. Yosef Gebreyohannes
10:00-10:10AM	Procedure and rules of the dialogue	Dr. Alemayehu Mekonnen
10:10-10:30 AM	**Tea Break**	**Organizers**
10:30-11:30 AM	Discussion on problem section of the policy brief	Dr. Alemayehu Mekonnen
11:30-12:30 AM	Discussion on policy options section of the policy brief	Dr. Alemayehu Mekonnen
12:30-2:00 PM	**Lunch**	**Organizers**
2:00 – 3:00 PM	Implementation considerations part of the policy brief	Dr. Alemayehu Mekonnen
3:00-3:15 PM	Way forward	Dr. Alemayehu Mekonnen
3:15-3:30 PM	Closing Remarks	Dr. Yibeltal Assefa

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Competing interests

All authors declare that they have no competing interests

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