News from the LAST TEN KILOMETERS

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The Last Ten Kilometers (L10K)
What it takes to improve health outcomes in rural Ethiopia

L10K aims to strengthen the bridge between households and Primary Health Care Unit, Ethiopia's basic health service delivery structure. It works to improve quality and increase demand, access and utilization of high impact reproductive, maternal, newborn and child health interventions.

L10K is funded by the Bill & Melinda Gates Foundation, UNICEF, and USAID, and implemented by JSI Research & Training Institute Inc.

L10K works with 12 local partners, in the four most populated regions of Ethiopia: Amhara, Tigray, Oromia, and Southern Nations, Nationalities and Peoples' (SNNP) regions.

JSI L10K The Last Ten Kilometers Project
JSI Research & Training Institute, Inc.

PROMOTING RESPECTFUL MATERNITY CARE

The concept of "safe motherhood" is usually limited to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. The notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women, including respect for women's autonomy, dignity, feelings, choices, and preferences.

A woman's relationship with maternity care providers and the maternity care system during pregnancy and childbirth is vital. Not only are these encounters the vehicle for essential and potentially life-saving health services, but women's experiences with caregivers at this time have the impact to empower and comfort or to cause long-term emotional trauma, adding to or detracting from women's confidence and self-esteem. Either way, women's memories of their childbearing experiences stay with them for a longtime and are often shared with other women and influences their decision to seek care from health facility.

A growing body of anecdotal and research evidence regarding maternity care systems ranging from the wealthiest to the poorest nation worldwide, shows that disrespect and abuse that women face during facility based childbirth is becoming an increasing problem. It is creating a community of concern that spans the domains of healthcare research, quality, and education. In 2010, a landscape report by Bowser and Hill, *Exploring Evidence for Disrespect and Abuse in Facility -based Childbirth*, summarized the available knowledge and evidence as shown below:

Seven categories of disrespect and abuse (Bowser & Hill 2010)

Category of Disrespect and Abuse	Description and example
Physical abuse	Any form of physical abuse, eg: kicking, pinching, slapping, episiotomy without anesthesia, rape
Non-consented care	Absence of informed consent or patient communication or forced procedures, eg: vaginal examination, episiotomy without consent
Non-confidential care	Share private findings to others, violation of audio privacy, visual privacy (non use of partitions, cover, curtain)
Non-dignified care	Any behaviour that makes the client feel uncomfortable or threatened, eg: shouting, scolding, insulted, laughed at, threatening to withhold services
Discrimination based on specific client attributes	Discrimination based on race, ethnicity, age, language, HIV status, economic status, educational level, etc.
Abandonment of care	Women left alone during labour and birth, failure of providers to monitor women and intervene when necessary
Detention	Any time a client is detained in a health care facility longer than medically necessary, e.g.: due to an inability to pay

In Ethiopia, facility based delivery rates are low; in 2014 it was estimated that only 15% of births occurred in a facility. The Ethiopian Federal Ministry of Health (FMoH) works to dramatically increase the number of health facilities in the country and better connect communities to these facilities to improve access and uptake of services. However, recent studies suggest that improving access is not sufficient to increase use. If quality of care and interpersonal care are perceived as being poor, these deter women from seeking delivery services from health facilities with skilled personnel.

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PROMOTING RESPECTFUL ...

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As a result, to improve maternal health in Ethiopia, L10K partnering with the Women and Health Initiative at the Harvard School of Public Health works to incorporate promotion of respectful care into its on-going approaches. This is a pilot project undertaken in four primary health care units of Amhara and Southern Nations, Nationalities, and Peoples' (SNNP) regions of Ethiopia. To determine the prevalence and manifestations of disrespect and abuse occurring in these facilities, a baseline study was conducted between July and September 2013. The study used post delivery client interview, observation of labor and delivery, and provider interview as data collection tool.

Overall, 21% of postpartum women reported any experience of disrespect or abuse. The most commonly reported categories of disrespect and abuse were non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care (13.7%). There were however, no reports of detention in facilities and discrimination.

Client reports of disrespect and abuse

Types of Disrespect and Abuse	Overall N=204, n(%)
Any form of disrespect or abuse	43 (21.1)
Non-consented care	36 (17.7)
Lack of privacy	31(15.2)
Non-confidential care	28 (13.7)
Abandonment of care	5 (2.5)
Non-dignified care	2 (1.0)
Physical abuse	1 (0.5)

It was observed that incidences of disrespect and abuse were as high as 70% during client-provider interactions. Most providers (82%) said that some form of disrespect and abuse towards clients occurred in their facility. Lack of information was also common.

The study showed that clients, providers, and structural factors influence the occurrence of disrespect and abuse in facilities.

The result of the study was used to inform selection of interventions for these facilities (where there will be an end line assessment to measure progress in the promotion of respectful maternity care). Interventions currently being tested include;

- Infrastructure improvements of facilities to encourage birth companions, ensure infection prevention, increase availability of beds in post-natal ward, and improve privacy.
- Orientation of providers on promoting choice of mothers, ethical conduct and women-friendly care including calling women by their name; consent for all procedures, information about care, treatment and status; preferred birth positions, and birth companions.

EDITORIAL

Most women and their families expect to receive care from a health facility which is well equipped, comfortable and clean and has health providers who are caring, empathetic, supportive, as well as respectful and who can effectively communicate to facilitate informed decision. However, a significant number of women experience treatment and care that does not correspond with their expectation and it is this memory of their childbearing experience which is tainted with disrespect and abuse, that stays with them for a longtime.

While it is likely that disrespect and abuse are often multi-factorial and may be perceived differently and sometimes normalized depending on the specific setting, many stakeholders and maternal health experts agree that disrespect and abuse in facility based childbirth represent an important barrier to skilled care utilization (a key MGD indicator i.e. MDG5—Improve Maternal Health—) and quality of care. It is an important concern especially in countries like Ethiopia where the maternal mortality rate is as high as 497 deaths per 100,000 live births (Kassebaum 2014) and yet the skilled birth attendance is very low.

A recent assessment carried out on disrespect and abuse during facility based childbirth at primary health care units, questioned 103 women of how much their delivery experience influenced their decision on where to deliver in the future. Eighty five percent responded that it influences their decision a lot and eight percent said it influences it somewhat. Only four percent said that the influence is very little and three percent said it doesn't influence them at all.

Despite the numerous factors that influence low facility deliveries, understanding that childbirth can be a very frightening experience for many women is imperative. To help reverse the situation to a joyous occasion all women need to have a sense of being valued, respected, and understood by maternity care providers. Ensuring that health facilities are well equipped and have skilled health providers on its own cannot guarantee improved facility delivery. Maintaining a woman's dignity while bringing new life into the world is one of the important factors for a woman to seek health care.

Hence, the Ethiopian Ministry of Health continues to improve facility birth by enhancing skilled attendants, and now has considered respectful care as an important element in the health care package. Likewise, L10K in supporting the government's effort is now focusing on promoting respectful care in all facilities it works with. Evidence collected during a baseline assessment carried out by L10K has been used to inform selection of interventions to be implemented in four facilities . To increase acceptability and sustainability, the selected interventions will be included in on-going quality improvement efforts of these facilities. The impact of the intervention will be measured and is hoped to provide input to the growing global evidence of interventions that promote respectful maternity care.

UPDATES

High level delegation visit Tigray

US Agriculture Deputy Minister, five female senators and their Assistants made a visit to Hakfen kebele, La'ilay Adiyabo woreda in Northwestern Zone of Tigray region on August 27, 2014 . The aim of their visit was to get a glimpse of how the health system in Ethiopia operates especially at community level. Thus, they visited Hakfen health post which is one of the many facilities L10K supports in the zone. They were briefed by Woiynalem and Fitsum the, HEWs, and learnt of how data is gathered and used, how health service is provided by the health post, how community mobilization is undertaken and supplies are made available.

The group observed that the HEWs grow a small vegetable garden in the compound of the health post and they use it as a demonstration site for some of their community teachings.

The visiting group met and talked to community elders and health development army (HDA) members. They heard of how in recent years encouraging changes have been observed in the health practices of households. The Deputy Minister and the Senators' stated how impressed they were with the roles women played as HEWs and HDAs in bringing about these changes. The fact that women headed households such as the HDA's, serve as a model household in health and agricultural practices was also remarkable they said.

The visiting group and the community that warmly welcomed them

Findings on disrespect and abuse in health facilities

One of L10Ks innovative community based strategies that helps improve the quality of health care services from the provider's, client's and community's perspectives is called Participatory Community Quality Improvement (PCQI). During the PCQI process of identifying barriers to quality maternal and neonatal health care services, lack of respectful maternity care was identified as a major hurdle.

Hence, L10K in partnership with Women and Health Initiative of the Harvard School of Public Health undertook a qualitative assessment of the nature and levels of disrespect and abuse existing in health facilities. Four primary health care units in two regions were assessed: in Southern Nations, Nationalities, and Peoples' region Kebet and Lante and in Amhara region Deneba and Denbecha health centers. A workshop to disseminate the results of the assessment was organized by L10K on July 23, 2014 in Addis Ababa. Partners and staff of the assessed health facilities attended.

The exercise of the dissemination workshop was to share outcomes and make suggestions to design an action plan and inform future implementation.

Representatives of the studied health centers appreciated that the findings were shared and said that during their regular meetings they shall further discuss issues of concerns raised at the workshop. Others also said that the findings can be used as a tool to look into how the provision of health care as a whole needs to be improved.

The workshop was concluded with the study team providing recommendations at policy, facility, and community levels.

The full report of the study shall be made available on L10Ks website shortly.

Dissemination workshop on findings of a baseline study on Respectful Maternity Care

Introducing PCQI at Harvard University

The Harvard University, School of Public Health through the Women and Health Initiative organized a seminar to discuss global public health issues on September 12, 2014. L10K Project was invited to present its work about community engagement in improving maternal and newborn health. Representing the Project, Melaku Muleta, Quality Improvement Technical Advisor and Ali Karim, Senior M&E Advisor made a presentation on one of L10Ks community strategies – participatory community quality improvement (PCQI). They presented the preliminary findings of a pilot study made on PCQI and illustrated the process and the outcome of PCQI and how with other interventions, such as Basic Emergency Obstetric and Newborn Care and with the involvement of the public sector, PCQI has added value in improving maternal and newborn health care outcomes.

Around 30 students studying for their masters and doctoral degrees attended the seminar and through the discussion that followed, they tried to further learn of the context the intervention is applied in. Questions on how members of the community are kept motivated to follow through the PCQI process and help sustain it were raised. The students also questioned why home delivery posed health risks for mothers in Ethiopia when in some parts of the developed world this is what is being promoted as a choice of mothers.

After an hour of presentation and discussion, the students felt it was an enlightening introduction to community interventions. They expressed that it shed light on the divergent nature of maternal and new born health care which is defined in the context it is practiced.

VOICES OF CHILDBEARING WOMEN, COMMUNITY, AND HEALTH WORKERS ON DISRESPECT AND ABUSE

To asses level of disrespect and abuse of women during facility based child birth, a baseline study was conducted between July and September 2013 and employed women who were self-selected for delivery. The study was conducted in the health facility and the women were interviewed immediately after delivery. Hence, the researchers believe, that the women might not have been as open in expressing their real feelings of what happened during labor and delivery. Furthermore, the study did not incorporate the views of women who delivered at home. Cognizant of such limitations L10K conducted a follow up qualitative assessment of disrespect and abuse between March and April 2014 in the catchments of four primary health care units in Amhara and SNNP regions. The assessment employed in-depth interview and focus group discussions and its subjects included women who delivered at health facilities and at home, family members who accompanied child bearing women to health facilities, and midwifes. Below is the voice of the study subjects:

Regarding dishonored care/disrespect some of the women stated, "

".. I was in severe pain and I got out of bed, she [the midwife] yelled at me and told me to get back into bed. But I couldn't ... she asked me if there was someone who had come with me. I told her my family is waiting outside. ... she called one of them and they helped me back into bed ..."

Friends and family members accompanying a woman to deliver are also mistreated:

"... I accompanied my neighbor [*when her labor came*] *to the health facility where she had her regular antenatal care follow-up. The midwife on duty told us to go inside and look for a bed and she was very impolite. When I asked which bed, she yelled at me ..."*

Non-health workers like janitors were also reported as mistreating women who had delivered:
".. it was the third time that I had a stillbirth in the same facility ... I've been at the facility every year for the past three years. The janitor was cleaning after I had delivered and she said 'you come here to give birth to a dead child and you just make us busy cleaning'."

Regarding non-consented care almost all women were aware of what was going on but they were not asked whether they were willing to have the procedure or an examination.

A mother said, *".. he used a metal instrument to take the baby out and told me to react when I have contractions ... he did not ask my permission to do so."*

A health worker stated that most of the time the urgent nature of the woman's labor does not give them time to follow certain ethical procedures like obtaining consent *".. sometimes the mothers come very late and some may even deliver on the way. So when the head is visible I directly do my job and have no time to ask for their consent..."*

On the issue of confidentiality of information it was reported that people who are not close family members enter into the labor ward without the consent of the woman.

"... I want my privacy, I do not want anybody to be in the labor ward with me while I am in labor ... I heard that a stranger was in the ward when one woman was delivering and that person spread gossip in the village about what happened during the delivery process and the woman was made fun out of..."

Midwives also allow apprentices to attend the delivery without the consent of the woman to deliver. A woman who delivered at home after regularly going for her ANC follow-up at the health center said, *"... there were many students surrounding me* [*during my ANC follow-up*], *and everyone would palpate my abdomen. When I got home I was in pain for the next few days . So I decided not to go for my delivery. I had thought of going to another health facility but that was too far away and I did not have money for transportation. So I delivered my baby at home."*

There are also times when discussion between health care takers and clients can be heard by people waiting outside the labor ward. *"... I was accompanying a family member and the doctors told us to wait outside, but we were able to hear every communication and see the progress of labor, though an opening [in the doorway]..."*

Despite their keen interest to deliver at health facility some women are forced to deliver at home:
"... though I wanted to go to a health facility, I could not as my husband left me to go and work on his farm while I was in labor. I had to manage my delivery on my own [at home] ..."

Assessment of disrespect & abuse during childbirth in two regions of Ethiopia: A qualitative study in four PHCUs (Kebet, Lante, Deneba and Denbecha), July 2014

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