IMPROVING MATERNAL HEALTH: MDG 5 AND ETHIOIPIA'S URBAN HEALTH EXTENSION PROGRAM (UHEP)

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To my beloved mother, Meaza Yemaneberehan

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Acronyms

CHW – Community Health Worker

CIA – Central Intelligence Agency

CSA – Central Statistics Agency

FMOH – Federal Democratic Republic of Ethiopia Ministry of Health

HC – Health Center

HEP – Health Extension Program

HEW – Health Extension Worker

HP – Health Post

HSDP – Health Sector Development Program

ICF – Inner City Fund

IMR – Infant Mortality Rate

MDGs – Millennium Development Goals

MM – Model Mother

MMR – Maternal Mortality Rate

NGO – Non-Governmental Organization

PASDEP - Plan for Accelerated and Sustained Development to End Poverty

PMH – Primary Health Care

PMNCH – Partnership for Maternal, Neonatal, and Child Health

SMI – Safe Motherhood Initiative

UHEP – Urban Health Extension Program

USAID – United States Agency for international Development

WHO – World Health Organization

Abstract

Ethiopia's Urban Health Extension (UHEP) is an MDG-oriented national program that aims to create demand for basic health care services in urban settings. It aspires to do this through government salaried Health Extension Workers (HEWs) for the urban poor. Among its 16 health packages is the *Maternal and Child Health Services Package*. This study is an exploration of the maternal health aspect of this Package. Specifically, it attempts to look into the relevance of UHEP's maternal health interventions and explores the relationship between the global health agenda and local maternal health policies and interventions. Data were collected mainly through observational research and in-depth interviews with program beneficiaries and their Health Extension Workers (HEWs). Findings indicate that while the Program and its maternal health objectives are generally relevant to the concerns of the urban poor such as access to basic and maternal health services, the main driver, nevertheless, has been the relevance to global MDGs. This compromised the process of beneficiary identification, and highlights the need to integrate supply side interventions with local demand in order to strengthen the response of the urban poor.

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1. Introduction and background

1.1 Introduction

1.1.1 Statement of the problem

The main objective of this study is to explore maternal health interventions in Addis Ababa, the capital of Ethiopia, under the country's Urban Health Extension Program (UHEP). UHEP is Ethiopia's response to the global call on improving health particularly in the poor countries of the world. The Program encompasses 16 main packages of which maternal and child health is one. With endeavours to provide equitable access to health care services, UHEP seems to be generally relevant to address some of the health inequities in urban livelihood in Ethiopia. However, it lacks a baseline specific to targeted urban communities and their health related demands, and the basis of implementation seems to be overall health and health related indicators at various levels as opposed to actual situations of targeted communities in Addis Ababa.

For a a decade, the Millennium Development Goals (MDGs) have set a global health agenda that shapes national health systems and interventions in local communities. In line with the health related Millennium Development Goals (MDGs), global health initiatives have also shown a shift in attitude from one focusing on ill health and hospitals to a focus on public health in which communities and families should learn to control and take care of their own health (Lawn et al. 2008). The Millennium Development Goals related to child survival and maternal health (MDGs 4 & 5) are said to be "garnering a more cohesive commitment" and, a global technical agreement has been advanced to determine ways of improving survival in the poorest countries. However, achieving these improvements has remained a challenge (ibid).

The MDGs being the principal global agenda pursued by nations, the preoccupation of countries like Ethiopia with meeting the MDGs objective cannot be underestimated. The Health Sector Development Program (IV), the country's major strategic document, defines itself as "the expression of [the Government of Ethiopia's] renewed commitment to the achievement of the MDGs as one of the top global policies influencing the national policies and strategies" (FMOH 2010: 31). The priority attached with selected diseases and conditions for national health interventions that match diseases and conditions captured in the MDGs imply the vertical relations between global health agendas and national implementations.

Apparently, UHEP in general and its maternal health package in particular subscribe to these global health goals and areas of health intervention.

For most of its part, UHEP is a direct emulation of Ethiopia's Health Extension Program (HEP), the rural version of it, except some modifications when it was launched for the urban poor in 2009. The main agents of change in UHEP are the Health Extension Workers (HEWs). The global emphasis on the provision of primary health care and community ownership of health care delivery following the Alma-Ata declaration in 1978 has gained a renewed recognition in the era of the MDGs (Lawn 2008: 917), and that seems to guide the overall activities of UHEP. The recruitment of Ethiopia's HEWs under UHEP, however, lacks resemblance to most global practices in that, unlike Community Health Workers (CHWs,) who belong to the community, the HEWs are government salaried, mid-level health professionals often from elsewhere in the city. Their job is to interact with community members on matters of health such as child care, maternal health, HIV, malaria, sanitation, etc. The process involves recruiting community members for training on the 16 packages under UHEP, and each trainee is again expected to informally train five members of communities under her. Then the HEWs oversee this community interaction to eventually achieve change in the health seeking behaviour of the larger community. Each HEW is required to train 500 mostly female community members. The intention then is when each of the 500 trainees under every HEW in turn further trains five community members, there will have been achieved a fair coverage of the community in focus so as to raise the health and sanitation awareness as well as to reduce health inequities through improved access to health care services.

UHEP's ambitious endeavours of enabling communities to produce their own health through the health awareness interventions may be met with some practical difficulties of measuring achievement. One may appropriately ask a number of interrelated questions under the circumstances in which a program is designed with no studied baseline specific to it. First of all, what is the basis of the interventions? How does one know if the right targets are identified to benefit from these interventions? Is a national or regional health profile of a country enough of a foundation to launch a program in a specified urban community? Especially with UHEP, how can one be sure that its emulation of packages that seemed to have worked well for the rural population would generate similar results for the urban poor?

These are the questions that will be addressed and critically analyzed in this study to a certain level.

Also, the interconnection between globally set health goals, national programs and community health needs may not always be in harmony. This study is, therefore, a contribution to the understanding of such discrepancies of health polices and implementations at various levels. At the centre of this focal area lies the discussion of MDG 5, i.e. *reducing maternal mortality by two-thirds between 1990 and 2015*, at global level and its implementation in urban communities. The study will query as to whether the right targets are identified and the right interventions are designed. The investigation involves discussions particularly of the maternal health component of UHEP. This will be done by attempting to understand the interaction between model mothers that are trained by the HEWs and the HEWs and analyzing their individual perceptions and views on the package.

1.1.2 Research Questions

The following research questions are designed to help the exploration of maternal health care service provisions under UHEP and the perception of target communities as regards these interventions.

- How do model mothers under UHEP perceive maternal health care services provided by the Program?
- What approaches are pursued to provide services and support for UHEP beneficiaries?
- What are the practical challenges for these women to ensure maternal health?

1.1.3 Objectives of the study

The general objective of this study being to examine maternal health care interventions under UHEP in *Woreda* 5 of *AradaSub-city* in Addis Ababa, the following specific objectives are set in order to address the research questions.

- To describe the overall process of maternal health care provisions under UHEP;
- To explore relations between local maternal health policies and practices and the globally set MDG5.

- To identify bottlenecks limiting women's benefits from UHEP's maternal health interventions; and
- To suggest possible ways of furthering community benefits from maternal health care interventions of the Program.

1.1.4 Significance of the study

The urban version of Ethiopia's Health Extension Program is an understudied intervention. It is hoped that both the program implementers and researchers interested in digging more into the doings of UHEP benefit from this work. Particularly the Program implementers may consider the findings in this study useful to enhance their mode of intervention so as to be more responsive to the needs of communities in question.

1.1.6 Scope of the study

While the thesis may likely provide some general implications and inform the intervention processes in UHEP, given the fact that it is uniformly underway in Addis Ababa and other major cities, the findings are situated in one specific context and are not necessarily generalizable.

1.2 Background

Ethiopia launched the Health Extension Program (HEP) in 2005 to "meet the needs, demands and expectations of the pastoralist, agrarian and urban population" (Ethiopian Federal Ministry of Health Website). As stated in an official document for the Program, the Ethiopian government has designed the HEP as part of a series of Health Sector Development Programs "in line with the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) and to achieve the health-related Millennium Development Goals (MDGs)" (Federal Ministry of Health: Health Extension and Education Center 2007: 1). Later, the HEP was adopted for the urban setting as Urban Health Extension Program (UHEP).

The tenth largest country in Africa, Ethiopia covers an area of 1,104,103 square kilometres with 1 million sq. km. land area and 104,103 sq. km. water. It constitutes a major landmass of the Horn of Africa bordering Eritrea in the north, Djibouti and Somalia in the east, Kenya in

the south and the Sudan in the west (HSDP 2010). The country's latest census in 2007 estimates Ethiopia's population at 73.8 million (Central Statistics Agency of Ethiopia website). Other sources, however, provide a much larger figure ranging from 82.6 million to 93.8 million (WHO Country Profile; CIA: the World FactBook). Ethiopia is among the least urbanized countries with 83.6 % of its population living in rural areas and the remaining 16.4% living in urban areas. The youth under the age of 15 constitutes some 44% while those between 15 and 65 account for 52% of the population (HSDP 2010).

Ethiopia's contemporary endeavours to address health problems have necessitated the country to strive to alter a history characterized by "many decades without a national health policy, weak health care system infrastructure and low government spending" (Wamai 2009: 279). Over the last two decades, it has taken a wide range of critical steps that include the decentralization of the health system, the diversification of health financing from government, private, NGO, public, and household sources and not least from international donors (ibid). The country faces a great deal of health concerns that relate to poor service deliveries and ill-equipped facilities as well as shortage of human resources (Wamai 2009), and these problems are approached through the decentralization of the health and education services and the delivery of basic services (Gracia & Rajkumar 2008). Health system decentralization and provision of basic health care have led to significant improvements in the country's health sector. Not only has the health service system expanded, but per capita and overall health spending has also increased significantly. More into specific achievements, child immunization coverage, for instance, rose from 30% in 2002 to 53% in 2007 while antenatal coverage increased from 32% to 52% in the same period. Similarly, child mortality has dropped steadily (ibid).

The country developed the Health Sector Development Program (HSDP) in 1997/98 as its major policy implementation framework with the first phase covering the ensuing five years. Its principal focus was disease prevention and decentralizing health service delivery. The strategies for implementing HSDP-I were no fully met. Then HSDP-II was developed for the period between 2002/3-2004/5 with an additional emphasis on participating NGOs in the implementation of the basic health package. HSDP-III was developed for the period between 2004/5 and 2009/10. HSDP-III underlined the need for enhanced participation of NGOs in planning and implementing universal health care coverage at the Woreda/District level - the

grassroots level of administration in Ethiopia (Wamai 2009). Currently, HSDP-IV (2010/11-2014/15) is underway.

The HSDP-IV document outlines the major health problems in the country. Accordingly, preventable communicable diseases and nutritional disorders remain to be the major challenges contributing to the poor health status of the population. Despite some improvements, mortality and morbidity rates are high, and figures from 2005 show a life expectancy of 53.4 years for male and 55.4 years for female. The Ethiopian Demographic Health Survey (EDHS) for 2011 indicate that while infant mortality rate (IMR) decreased in the country, there still die 59/1000 children under the age of 1 (ICF International 2012). 90% of child deaths in Ethiopia are "due to pneumonia, diarrhoea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions" (FMOH: HSDP-IV 2010: 3). Similarly, maternal mortality rate (MMR), while declined, still remains among the highest with 350 women dying out of 100,000
(http://www.who.int/gho/countries/eth.pdf).
Major causes of maternal deaths include "obstructed/prolonged labor (13%), ruptured uterus (12%), severe pre-eclampsia/ eclampsia (11%) and malaria (9%)" (FMOH: HSDP-IV 2010: 3).

Ethiopia's health policy framework seems to also align itself with the growing attention of global health towards basic health care delivery system through community based approach instead of the curative approach to ill health. This is indeed the approach taken to address the country's child survival and maternal health problems (MDG4 & MDG5). The major program in this regard is the Health Extension Program.

As a vehicle for bringing key maternal, neonatal and child health interventions to particularly rural communities, the HEP has envisaged to "reduce rates of maternal and child morbidity and mortality" (FMOH: HSDP- IV: 6). The Program seeks to achieve its goals by meeting objectives that relate to improving access and equity to primary health care interventions, increasing health awareness, knowledge, and skills among community members, promoting gender equality in accessing health care services, and improving the utilization of peripheral health care facilities (ibid).

HEP is initially implemented in what are called 'Model Families' identified by HEWs from within community members. The model families are required to have "acceptance and credibility" by the community, and then the HEWs assist them to be "early adopters of desirable health practices to become role models in line with heath extension packages" (FMOH: Health Extension and Education Center: 2007: 12). Once they have adopted these health practices, the model families are presumed to diffuse health messages "leading to the adoption of the desired practices and behaviors by the community" (ibid: 12).

In the end, HEP aspires to equip communities with necessary knowledge and skills to deal with preventable diseases, family health, and hygiene and sanitation. Drawn from within communities they would serve, Health Extension Workers (HEWs) are trained and recruited (ibid). The Health Extension Workers (HEWs) are mainly tasked to increase the knowledge and skills of the communities and households to prevent diseases and utilize health care services (Hailom 2011: 46).

The achievements made through the HEP in rural communities seem to have motivated the adoption of the Program for the urban poor. The Urban Health Extension Program (UHEP) generally aims to improve equitable access to health care services and prevent diseases for urban population particularly focusing on urban households, schools and youth centres (UHEP Implementation Manual). The specific objectives of the Program include:

- Raising individual awareness of health and bringing behavioural change in the communities so as to improve community health and disease prevention;
- Helping communities make decisions and develop a sense of ownership on matters of their own health through community organization along family members, neighbourhoods, schools and youth centers;
- Improving the coverage of basic health services; and
- Enhancing patient admission and referral procedures (ibid).

The Program embodies maternal and child health as one of its sixteen packages (UHEP Implementation Manual 2009, in-house unpublished document). UHEP, like its all other packages, has its maternal health package focused on communities and families with implementation strategies targeting awareness raising activities, community participation,

training provisions, etc (FMOH, UHEP Maternal and Child Health Services Package 2009, in-house publication).

2. Vertical and horizontal health interventions: A conceptual framework

Health services delivery may be understood and analysed in various ways. There are two dominant approaches to health interventions; the *vertical* and *horizontal* interventions. Despite an ever existing debate on vertical versus horizontal health interventions among researchers and service providers, there is a general lack of clear cut definition of what appears to be a dichotomy. Generally, *Vertical* health programmes, a.k.a categorical programmes, are "designed to a particular disease condition with clear objectives within a limited time frame, making use of a specific technology" (Olivera-Cruz et al. 2003: 68). A case in point is the small-pox eradication programme from 1957 to 1977. The understanding of the verticality of health interventions in this thesis is also extended to health service delivery systems in which a hierarchical approach is pursued as in the case of the MDGs directing national health systems and local health interventions. *Horizontal* health programmes, on the other hand, deal with "a delivery mode of health interventions through the regular infrastructure of health services" as in the case of primary health care which emphasizes service integration especially of preventive and curative care (ibid: 68-9). They are designed to "tackle several interrelated health issues by strengthening health systems and developing integrated delivery systems" (Béhague and Storeng. 2008: 644). In other words, they incorporate "health interventions as part of a primary care approach, usually delivered through government health facilities" (Victoria. et al. 2004: 1542-43). Vertical interventions may also be delivered in an integrated manner, "using the existing health system, but with a vertically organized managerial structure" (ibid: 70). An example used by Oliveral-Cruz, et al. (2003) is that in developing countries donors may support and NGOs run drug programmes within national health systems.

The competition for funding and the global attention to selected diseases and situations in the era of the MDGs has often shaped national implementations of health programmes and policies with their primarily vertical approach. Such programmes generally tend to deliver "selected interventions, often independently with specialized management, logistics, and delivery mechanisms" (Victoria. et al. 2004: 1543). Specific to maternal health, Béhague and Storeng (2008: 645) explore that the subfield has undergone two shifts, first toward and then away from vertical approaches. Established in 1987, the Safe Motherhood Initiative (SMI) took the lead to "separate maternal health from child health to highlight the much neglected

issue of maternal mortality." By so doing, SMI managed to garner support for such vertical interventions as antenatal risk screening, training traditional birth attendants, and providing emergency obstetric care (ibid).

Maternal health specialists have then increasingly recognized that vertical interventions cannot be effective without a functioning health system. The understanding initiated the integration of vertical maternal health programmes with other subfields. This has, for instance, been reflected in the merging of three subfields into the Partnership for Maternal, Neonatal, and Child Health (PMNCH) (ibid).

Nevertheless, the fierce competition between the various subfields has hampered a sustained vertical-horizontal synergy. Health interventions have often resorted to the vertical approaches in order to attract funding. Maternal health itself has often pursued the vertical approach lest it diverts funding and policy attention away from it otherwise. However, the competition for money and policy attention seems to have positioned maternal health subservient to other subfields such as child health (Béhague and Storeng 2008).

The vertical approaches can also be viewed from the global-local flow of health agendas in which national health systems and local health interventions function as a response to global health initiatives. Leikoff identifies two currently prominent global health regimes that strive to transcend limitations posed by national governance of public health. The first regime, he calls *global health security*. This regime, he further illustrates, focuses on infectious diseases that are "seen to threaten wealthy countries", and which often originate from Asia, sub-Saharan Africa and Latin America (2010: 59). Some examples include small pox, SARS, and influenza. The most important underpinning of the *global health security* regime is that it focuses on *outbreaks* "that *have not yet occurred*- and may never occur" (ibid: 59; italics original). It therefore seeks to implement a system of preparedness that provides an early warning to prevent possible catastrophe of a global scale.

The other regime is known as the *humanitarian biomedicine*, and it focuses on "diseases that currently afflict the poorer nations of the world, such as malaria, tuberculosis, and HIV/AIDS" (ibid: 60). It strives to alleviate the suffering of individuals regardless of geography and social groupings. Intervention, in this case, is viewed not as a 'collectivity' as

a national population, but rather as individual human lives (ibid). Ethiopia's Urban Health Extension Program, to a certain extent, seems to offer an example of the *humanitarian biomedicine* regime particularly with its focus on households and diseases afflicting local population rather than potential outbreaks. This will be further analysed in the discussion chapter.

What is even more apparent about UHEP is that it draws important elements from the global Millennium Development Goals (MDGs). Its objectives of ensuring access to primary health care services as well as the diseases and conditions it has identified for intervention seem to directly resonate with the MDGs. Not only the three health MDGs, namely child survival (MDG4), maternal health (MDG5), and HIV, tuberculosis, and malaria (MDG6) are among the packages, but also the global call for community participation and universal health coverage constitute the tenets of the Program. The Health Sector Development Program (HSDP) in Ethiopia, which is the principal national health system Program, and which also guides UHEP, ultimately aims at "…achieving the Millennium Development Goals (MDGS)"

(http://www.moh.gov.et/English/Information/Pages/Programs%20and%20Projects.aspx)

Specific to maternal health, nations currently receive a considerable pressure to "decrease maternal mortality rapidly as the deadline of the Millennium Development Goals (MDG) approaches" (Roalkvam in Bjørkdahl & Nielson B. 2012: 246). To this end, they place the medical and technocratic concept of childbirth at the centre of their design of interventions (ibid). This global process has exhibited a "prevailing tendency …to view all societies, organizations and institutions with the same lens" (ibid: 247). Health interventions are, therefore, often meant to enable citizens to make good and right health choices. Focus being placed more on cultivating good citizens governing their own access to health care, the reliance of citizens on the state's provision of essential health care services is less important. Furthermore, the shift in attention towards changing individuals and individual behaviour appears to have undermined the importance of reforming systems and power structures that create inequality in health and health choices in the first place (ibid). In the process, social questions are left to the private market as well as to "market-like structures within the confines of the state and of public policy," Roalkvam argues (ibid: 245).

As already mentioned, the subscription of national health systems to global health initiatives also involves a financial dimension. Availability of donor support can sometimes be the most important determinant of health interventions or programmes with little consideration for burden of disease, programme effectiveness or sustainability (Victoria, et al. 2004). Child health intervention are a good example in this regard because they are primarily driven by availability of donor support even when multiple programmes exhibit duplication of efforts and when even high quality programmes generate mediocre coverage (ibid). Victora, et al. further concur;

> Most countries have many governmental or nongovernmental organisation driven programmes aimed at providing several vaccines, micronutrients (vitamin A, iron, and iodine being the most common), insecticide treated materials in malarious areas, skilled delivery attendants, breastfeeding promotion, and growth monitoring, among others. Additionally, curative interventions for child survival often include oral rehydration therapy, antibiotics for pneumonia and sepsis, and antimalarials. Little attention is given to whether or not countries have the management capacity to implement these interventions at high coverage. (2004: 1541)

In summary, a vertical-horizontal synergy may be understood as a way to maximize the benefits of health interventions. While, in principle, such an integrated approach seems to be guiding global health initiatives, with increasing focus on primary health services and community participation as well as identification of critical diseases and conditions, vertical approaches seem to amass global funding. Moreover, the global health agendas such as the MDGs, though not theoretically enforcing strategies, may have been overemphasized in national health systems as though the goals were diffused even-handedly among nations of practically diverse political and socioeconomic contexts.

3. Research methodology

3.1 The qualitative research paradigm

This study is a qualitative study. Qualitative research has gained increasing acceptance in social sciences. Its philosophical underpinnings are grounded in viewing the subject matter of social sciences (people and their social environment) distinct from that of natural sciences (atoms, molecules, etc.). Qualitative researchers, therefore "express commitment to viewing events and the social world through the eyes of people that they study" (Bryman 2004: 279). The process involves the interpretation of the meaning that people being studied (subjects) make of their world.

Bryman (2004) identifies three main features of qualitative research. First, qualitative research views relationship between theory and research inductively in that theory in qualitative research is generated from the actual research experience. Second, the epistemological position of qualitative research is mainly interpretive as it attempts to examine the social world through the interpretation of it by its participants. Finally, its ontological position is described as constructivist since it understands social properties or meanings as "outcomes of the interaction between individuals rather than phenomena 'out there' and separate from those involves in its construction" (ibid: 266).

While some secondary quantitative data have informed the overall situation of health and equity in Ethiopia, my research, however, is predominantly a qualitative one. It attempts to understand the maternal health interventions in the urban setting through the interpretation of what the studied subjects make of these interventions in relation to their own lived experiences. I believe a qualitative account of people's actual experiences with interventions like those under UHEP can provide a better understanding particularly of the quality of these interventions than some quantitative measure of access or coverage would do.

3.2 Data collecting techniques

3.2.1 In-depth interviews

As one of the most dominant techniques of data collection within the field of qualitative research, in-depth interviews, if conducted well, can help the researcher to get people talk about their opinions, and feelings, and this in turn helps to tap into the understanding of their

social world. Natasha, et al. (2005: 29) establishes that in-depth interviews can be an effective technique to encourage research participants "to express themselves in a way ordinary life affords them." However, the technique can also pose some practical concerns because "people do not always say what they think, or mean what they say (Jensen 2002: 240). Interview accounts, therefore, are not "simple representations, true or false, of what people think"; they instead become sources of information "only through analysis and interpretation" (ibid: 240).

In this research, in-depth interviews were held with 15 'model mothers', 5 HEWs, and a district health official. Semi-structured interview guides were prepared for the interviews beforehand, and this allowed staying within the research's focus while at the same time it helped to expand or refine questions and discussions as the interviews went on. Except one interview which was conducted in the respondent's little shop, all the interviews were held in their homes. This obviously gave me a glimpse into their living conditions particularly in relation to housing and sanitation. All interviews but one had been tape-recorded upon the respondents' permission.

3.2.2 Observation

Apart from visiting homes of respondents, offices of the HEWs, and that of their coordinator, a very important observation was made into a 'Come Drink Coffee' gathering. This was an occasion that was meant to facilitate the provision of basic health information through interactions between HEWs and model mothers while enjoying traditional coffee drinking ceremony. My role was largely passive participation. Only few times did I step in to ask for clarification of some medical terminologies I was not familiar with.

Indeed observational research gives an advantage of understanding the natural setting in which the researched phenomena take place. But it is also possible that the presence of a researcher can actually alter the natural setting because people may not necessarily be themselves in the presence of strangers. It is impossible to totally avoid the effect that the researcher's presence creates in people's actions and manners of communication. However, a rational choice of the level of involvement by the researcher can help reduce the impact of presence (Silverman 2006). In my case, my passive participation in the 'Come Drink Coffee'

session seemed to have helped a lot as participants gradually shifted their attention away from passive me either to the HEW lectures or elsewhere.

3.2.3 Official Documents

I reviewed some official documents that are relevant to my study. Apart from the Health Sector Development Program (HSDP) document that I referred to more extensively, the Addis Ababa City Health Extension Program: Implementation Manual, the Urban Health Extension Program: Implementation Manual, and the health related statistics document prepared by the Addis Ababa City Administration have been very helpful. I also did a quick review of documents designed for health packages for nutrition, HIV/AIDS Prevention and Control, Immunization, TB & Leprosy Prevention and Control, and Waste Management and Disposal.

3.3 Sampling

This research is a qualitative insight into maternal health in connection with poor community members in Addis Ababa. While it may be assumed that the findings can have some implication on the urban poor in a wider setting, it does not claim any generalizability of findings. As a result, purposive and conducive sampling techniques were employed. With the model mothers, I considered the extremely poor as perceived by the HEWs who helped me establish my contact with the mothers. My HEW respondents were those who I came into contact with during my first few visits of the Woreda Health Office. The reason I chose to conduct the research in the *AradaSub-city* mainly had to do with conduciveness. Of all the sub cities where I handed in the Addis Ababa Health Bureau's letter of permission to conduct my study, officers in Arada were the most cooperative.

3.4 Brief profiles of model mother respondents

The 15 model mothers interviewed for this study all live in slums in Woreda 5 of the *AradaSub-city*. The slams are basically situated in the Piazza area, the old centre of the city and not far from the Addis Ababa City Administration complex. The respondents' ages range from 22 to 48 and all but one have children. While none of them are formally employed,

some are engaged in petty trading such as selling locally brewed beer (tela), roast groundnuts vending, selling bread and coffee beans, and running a small commodity shop. One of them makes a living from washing clothes for people while another is a domestic worker. In the absence of any stable employment or business and given their taking care of the house chores, it cannot be wrong that they identify themselves as house wives. Other than the two widowers, all the women mainly depend on the earnings of their husbands despite their efforts to generate some income from the petty trades. However, working in the informal sector as guards, daily laborers, small taxi drivers, etc, the men earn small monthly income, too. The respondents are all poor whose monthly household income, by their own words, range somewhere between $8 and $83. Three of the interviewees are illiterate while seven quitted from elementary or junior high levels and five are high school dropouts.

Some discrepancy from people's reservation in Ethiopia to revealing real income notwithstanding, their low standard of living was obvious from their housing made of mud, tattered roofs, unemployment, low level of education or illiteracy, extended family size to mention but a few. One lady, for instance, was not comfortable to hold the interview in her little single thatched-roofed, mud-walled house that she had to use her neighbour's relatively larger living room. Her room houses seven people though - the spouses, three children and two extended family members. Another respondent lives in an approximately 2 square metre make-shift room extended to a common kitchen. It serves as living room with a single chair during the day. For the interview session, the mother had to take in the mattress and a blanket from outside for her to sit on as I occupied the only chair in the room. There she lives with her 10-year old son sleeping on a thin mattress. All the respondents use common toilets with a dozen or so neighbours, and sanitation is a big issue. A mother lamented that although her 6-year old child is old enough to use the common toilet, she would not allow him to do so due to poor sanitation in and around the toilet. She would help him at home instead.

3.5 Overall field experience

When I went to Ethiopia for my two-month field work on Friday, January 4, 2013, I had precise plans. I was determined to begin my work right away, and went to the Addis Ababa Health Bureau the following week. The contact I established about two months before I flew

to Ethiopia actually gave me a level of confidence to hope that the process of getting official permission to access my respondents would not be difficult. When I first met my contact at the Health Bureau just after the weekend on January 8, he told me that he informed the relevant official about me and my research topic. Then he said I could bring my letter from my university the next day and also tell the official who I am and also mention the name of my contact to him. Everything seemed perfect.

Not everything went as expected though. The official in question rarely appeared in his office because, according to his secretary, either he was on a meeting in the Federal Ministry of Health or somewhere in town, or he was travelling. When she was able to give my letter to him more than a week after, he referred it to the research team that was supposed to review my research proposal. Two problems emerged at this stage. Firstly, just the fact that I had an approved proposal would not suffice, and I was told to present an ethical clearance from my university. Because I was not running blood tests or any other medical procedures with my respondents, I argued that I needed no ethical clearance, and suggested they review my interview guides. Convincing them however was not easy and it took a few days before they finally said I could mention that in an application for permission. Second, I was told to rewrite my proposal in a format they wanted me to follow, and they showed me a sample. I did that in few days and submitted my new proposal together with an application that included a justification for not having an ethical clearance. In the proposal, I translated my interview guides into Amharic, a local working language, but they said they wanted part of my proposal including sections such as objectives, research questions, methodology, etc to also be translated. I did not understand this, because the research team members, among them a doctor, understand English. That would not matter. So I did what I was told to do and resubmitted. Now, I was told my application would await the meeting of the reviewers and this was not to take place until a week after the submission. When I was finally granted the permission, I was left with just one month to fly back to Norway. In a nutshell, it was a very daunting experience.

Then I started to anticipate more trouble ahead while going to the sub cities. At least to minimize a risk of further deadlock, I had permission letters written to all sub cities in Addis

Ababa although I already knew I would practically settle for a Woreda/District, which I eventually did.

3.6 Ethical Issues

I have kept all the information obtained from my respondents confidential and responsibly used it for my thesis. Their names remain anonymous through out the study. For the model mothers, I used MM as their common identification and used numbers from 1 to 15 to differentiate one from the other. Similarly, I used HEW as common for Health Extension Workers I interviewed and used numbers between 1 and 5 to distinguish them. The research objectives were explained to them all and no data was obtained without their consent to participate in my research.

4. Supplying maternal health in Addis Ababa

4.1 Overview

In Chapter 3, the vertical and horizontal divide in health has been highlighted. As they principally relate to how health services are delivered in a given programme, both approaches capture the supply side of a health system, and vary in their responsiveness to the demand of the health seeker. In general, the *horizontal* programmes are argued to be enabling a more holistic engagement with the demand of the health seeking individuals or communities while vertical programmes, although relatively more precise in their objective, do not often promote community self-reliance and lack in grassroots context (Oliver-Cruz, et al. 2003). This is apparently the case when they are directed from a global level.

This chapter will attempt to describe the approaches taken by the Ethiopian health system in particular relation to the maternal health care aspect of UHEP, the HEWs as its implementers and the model mothers as its beneficiaries.

4.2 Ethiopia's current health system in brief

Ethiopia has been implementing its Health Sector Development Program (HSDP) since 1997/8. HSDP is arguably influenced most significantly by the decentralization policy in which decision-making processes in "the development and implementation of the health system are shared between the Federal Ministry of Health (FMOH), the Regional Health Bureaus (RHBs) and the Woreda Health Offices."

(http://www.moh.gov.et/English/Information/Pages/Overview%20of%20the%20Ministry.aspx).

Health decentralization along nine regions and two special administrations (Addis Ababa and Dire Dawa) has, therefore, created "a four-tier system of national "specialized hospitals", regional "zonal hospitals", *woreda* (district) hospitals, and primary health care (PHC) units (El-Saharty, et al 2009: 12). Since 2002, decentralization of the health system has rendered the *woreda* health offices the responsibility for service delivery and management. This responsibility entails that the *woredas* manage personnel issues, facilities reconstruction, and

procurement. However, these processes are often led by federal and regional health departments.

4.3 Health Facilities in Addis Ababa

The decentralization of the health system appears to have helped the significant increase of health facilities over the last decade. In the year 1996/97, there were a total of 2600 functioning health facilities in the nation; and this grew to 4020 in 2001/02. The ratio of health facilities per 100000 populations grew from 4.5 in 1996/7 to 6 in 2001/02 (Wami 2009). With the building of tens of thousands of health posts particularly for the rural population under the HEP, each of which serving 5000 persons, the number of health facilities grew into 14000 in 2006/07. Latest indicators from 2010/11 capture further progresses made under HEP. Accordingly, Health Post (HP) to population ration mounted from 1: 8,668 in 2006/07 to 1:5426 in 2010/11. In the same period, health centre to population ratio accelerated from 1: 1,107, 128 to 1: 30,794. Similarly, hospital to population ratio grew from 1: 839, 983 to 1: 671, 402 (FMOH Health and Health Related Indicators 2011: 6).

The urban poor in Addis Ababa in general and *Woreda 5* of the *AradaSub-city* being the focus of this study, it was attempted to find data on health facilities in the capital. The Central Statistical Agency of Ethiopia has mapped out a facilities and services indicator atlas in 2011 for all the regions in the country. Accordingly, the Agency enumerated 40 hospitals, 39 health centres (HCs), 28 health posts (HPs) and 359 clinics of both private and public ownership distributed in the 10 sub cities of Addis Ababa. Of these, five hospitals, four health centres, one health post and 53 clinics are located in the *AradaSub-city* to which the *Woreda* selected for this study belongs. One hospital is shared by 42, 300 persons in *Arada*; one health centre is shared by 52, 875 persons and one clinic by 3, 991 persons. The population of the*Sub-city* is 211, 501 (CSA 2011: 17).

Table 1. Distribution of health facilities in Addis Ababa

Sub city	Population	Hospitals	Health Centers	Health Posts	Population sharing one Hospital	Population sharing one Health Center	Population sharing one Health Post
Akaki Kaliti	181,270	1	2	2	181,270	90,635	90,635
Nefas Silk Lafto	316,283	-	2	3	0	158,142	105,428
Kolfe Keranyo	428,895	5	3	1	85,779	142,965	428,895
Gulele	267,624	2	5	5	133,812	53,525	53,525
Lideta	201,713	5	4	3	40,343	50,428	67,238
Kikos	221,234	3	7	2	73,745	31,605	110,617
Arada	**211,501**	**5**	**4**	**1**	**42,300**	**52,875**	**211,501**
Addis Ketema	255,372	4	3	3	63,843	85,124	85,124
Yeka	346,664	7	3	8	49,523	115,555	43,333
Bole	308,995	8	6	-	38,624	51,499	0
Total	2,739,551	40	39	28			

Source. Adapted from CSA Ethiopia's Facilities and Services, 2011.

4.4 Maternal health care services in Addis Ababa

A significantly improved access to health services seems to stand out as one of the major successes of the HSDP and its HEP component, and maternal health has benefited greatly from this improvement. This will be highlighted in the next sub section.

When HSDP-IV was introduced in 2006/07, the national figure for antenatal care coverage was around 52 %. In 2010/11, this rose to 82%. For Addis Ababa, antenatal coverage in 2010/11 was 117% as expected number of pregnancy, that is 70, 819, was found to be much lower than the 82, 756 pregnant women who actually received antenatal care. (FMOH: Health and Health Related Indicators 2011: 20). In the same year, deliveries by skilled attendance in Addis Ababa was 67.4 %, the highest among all the regions, and post natal coverage for the city was 37.2%. Among the 70, 819[1] pregnant women in 2010/11, 10% of them received abortion care and 8% delivered in cesarean sections of the health facilities in Addis Ababa. Among the ten public hospitals in the city, five of them provide Comprehensive Emergency Obstetrics and Neonatal Care (C-EmONC) while 26 of the HCs in the city provide Basic Emergency Obstetrics and Neonatal Care (B-EmONC) (ibid). The latter indicator for hospitals and HCs however falls below the national plan under HSDP-III in which all the HCs and 87% of the hospitals were supposed to be capable of providing B-EmONC and C-EmONC respectively (FMOH: HSDP-IV).

Table 2. Maternal health care indicators for Addis Ababa

Total Number of expected Pregnancy	**Antenatal coverage** (%)	**Deliveries by skilled attendant**	**Deliveries by HEWs**	**Postnatal care coverage**	**Abortion Care**	**Caesarian section rate**
70, 819	116.9[2]	67.4	0	37.2	10.0	8.0

Adapted from FMOH: Health and Health Related Indicators, 2011

[1] Source of data calculates percentage out of number of expected pregnancies vs number of women who were actually pregnant and got antenatal care in the city's health facilities.

[2] That was because expected number of pregnancy, that is 70, 819 was found to be much lower than the 82, 756 pregnant women who actually received antenatal care.

4.5 Maternal health care under Urban Health Extension Program (UHEP)

As indicated elsewhere, 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: 105). 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).

However, in specific relation to the site for this study, *Arada Sub-city*, and Addis Ababa at large, it was not possible to determine what changes have been brought in the health and health related indicators as a result of UHEP as well as its maternal health package. That was because there was no baseline study conducted for the Program in particular. In fact all the mothers but one responded that they have always sought proper medical care prier to their exposure to UHEP. This begs the question of how then the maternal health interventions were relevant to the needs of target communities. Given the few mothers approached for this study, however, no conclusion is in order.

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).

Improving access to maternal health care, however, does not seem to be the biggest problem for the respondents as they maintained in the interviews that they already get the services even before the introduction of UHEP. This all may say little about the quality of the health service delivery. However, neither do the data suggest improvement in the quality of health care as an effect of the Program.

4.6 The Health Extension Workers (HEWs) under UHEP

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 workers (CHWs) any way? 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 (Koblinsky, et al. 2010: 105). 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 fulfil 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.

4.6.1 HEWs in the Study Setting

Official information obtained from the Woreda Health Office indicates that *woreda* 5 of *AradaSub-city* has a population of 21,023 of which 11,142 are female. Number of pregnant women for the year 2012/13 is estimated at 388 while number of children aged above 5 years is 1194.

The *Woreda 5 Health Office* has 16 HEWs engaged in mainly raising community awareness on the health packages and report on a daily basis their activities and problems encountered at the work sites. Working under two supervisors and the Head of the Woreda Health Office, these HEWs start each workday with a brief evaluative meeting with their supervisors at 8 am, 30 minutes earlier than the official beginning time for the other staff. Although meetings were off-limit to the researcher, tension was often observed after the end of these meetings with some HEWs feeling too much burden from supervisors' expectations and requirements from these junior nurses.

Under UHEP, each HEW is expected to train and recruit 500 model families (largely female model mothers) within the community and each model mother in turn will recruit five model mothers under her, and so on. In the end, the Program aims to cover the community at large so as to enhance community health, prevent diseases and improve health seeking behaviour. However, training sessions and awareness raising programs do not always happen as scheduled as the community members often engage in their *"more pressing matters for their subsistence"* (HEW1). The five HEWs approached for this study all have recurrently rescheduled their sessions with communities to weekends or to times outside working hours for which they do not receive any allowance or other forms of benefit except their salary and housing allowance ranging in total from 1283 Ethiopian birr ($71.3) to 1354 Ethiopian Birr ($75.2). These extra engagements without extra payment, I noticed, were not necessarily practiced from personal conviction of the HEWs but often to *"reach the quota assigned for us (number of model mothers) that we are required to cover in a given period*" (Interview HEW1). It is not uncommon, a HEW said, to *"go out in the site with your work plan but end up meeting community members in some lengthy dispute. Then, you leave your work aside and try to mediate between them"* (HEW1 interview). Often, a work plan can be a general guide but its implementation is greatly influenced by factors such as community interest, trust in the Program and convenience of timing for communication in the face of poor communities' hustle and bustle to make ends meet.

The HEWs are generally positive to the Program. They claim to have witnessed people showing more interest to go to health facilities even for health concerns they might have previously considered unimportant. They also believe that a lot of the improvements in health indicators for maternal health care, child survival, HIV prevalence, etc correlate with UHEP and its community participating packages. However, their frustration about its being overambitious is immediately evident. They find it daunting to try to improve community health mainly through changing health seeking behaviour without necessarily addressing the material conditions in these communities. It is *"not realistic to teach them about keeping healthy while the content of their [common] toilet is overflowing. We try to take such matters to relevant offices and that is a challenge of its own kind."(Interview HEW3).* Hence the interventions sometimes become inappropriate to the conditions of the targeted communities.

The interaction between the HEWs and their community recruits has not always been smooth. Even this researcher witnessed two model mothers who were not on speaking terms with their HEWs. The mothers, according to my HEW informants, were cross with the HEWs because they were not selected by the nurses for a training organized by an NGO. That was not because they were necessarily interested in the training *per se*, but because they missed "the small allowance" behind it. Such competitions for the rare material benefit from the Program is not limited to that incident, but rather what seems to often drive active participation among some mothers (Interview HEW1, HEW2). It appears that UHEP's maternal health interventions are largely informative that they do not live up to material expectations of beneficiaries.

Trust is also an issue for the interaction between communities and their HEWs. Although the community generally shows a great deal of respect to what the HEWs are doing, they "doubt our competence", complained an informant, and added:

The community have a problem [with us]. They say 'ok' when we tell them on the spot. They lie about going to a health facility. They don't take us seriously [professionally]. They think only a nurse sitting in a health centre in her white gown is qualified (HEW1).

While it was not clear what the source of disinterest was, the 'Come Drink Coffee' session attended by this researcher indeed well tallies with the HEW's lamentation about not being taken seriously. The maternal health session which was passively attended by about a dozen of mothers was almost reduced to a conversation between the teaching HEW and one active participant who, in her own words, "stopped giving birth". Not only the session was seriously unattended by the rest of the participants side-talking while sipping their coffee, even the woman who seemed very interested in the teaching cast her doubts on some of the tips from the HEW. On one occasion she told the HEW that *"as far as my experience goes, you better not advice people to use 'yemikeberewin' [implanon and depo-provera]. The pills are much better"*, and perhaps out of discontent, the HEWs briefly and quickly responded, "it depends on the individual. It's up to the mother to choose" (Observation from the Come drink Coffee Session).

HEW holding a maternal health session with model mothers

UHEP is a narrative of both success and frustration for the Head of the Woreda Health Office, too. Although he understands that research is scant on the contribution of UHEP to enhanced community health, he seemed to have little doubt that the Program has a great share in changing communities' health seeking behaviour. He stated, through UHEP, "*we have created a society that appreciates hygiene; created awareness on stigma and discrimination and the maternal and child morbidity and mortality rates have decreased*" (Interview with Head of Woreda 5 Health Office and the Woreda's Chief Coordinator of UHEP). He also remarked that the HEP in general is a very appropriate vehicle to meeting the health MDGs. However, his confident remark was deeply overshadowed later as our conversation developed especially when he discussed his community's level of participation in the Program.

UHEP was introduced following the success of the rural HEP. [But] the rural HEP is much more effective than our urban version. UHEP has nurses as HEWs because the urban population is assumed to have generally better education and a higher level of awareness…Because of better exposure to media and other sources, urban dwellers think they know and they think they are more aware of health issues [but they are not]. They show

negligence [to the discussions under the Program]. They have not internalized the packages (Interview with Head of Woreda 5 Health Office and the Woreda's chief coordinator of UHEP).

The Head also appeared to have envied the obligatory skilled birth attendance that he witnessed under HEP in which "*a husband receives penalities if his wife delivers their baby at home, so he has to take her to a health center* (ibid).

However, he also realizes the difficulty of mobilizing the mothers without responding to some of their practical challenges that relate to their poor livelihood. He attaches high hopes of change with stronger collaboration with NGOs specially in providing nutritious food for *"malnourished children. We're identifying them and will refer them to NGOs [for support]. We're also introducing nutrition for children to be provided at the health centres"* (Interview with Head of Woreda 5 Health Office and the Woreda's chief coordinator of UHEP).

4.6.2 Linking the Supply Side with the Demand Side of Health

In principle, UHEP can generally be regarded as an appropriate, pro-poor vehicle for addressing health problems at the grassroots level with a remarkable potential to elicit community participation. It indeed provides a horizontal platform for the urban poor to involve in maintaining health environment through concerted efforts of HEWs to effect behavioural change in the communities. In practice, however, the Program in general and its maternal health interventions in particular seem to require a more profound presence of target communities for better participation in the processes and enjoyment of improved health seeking behaviour.

A very important consideration, in this regard, relates to the need to examine the responsiveness of the supply side interventions to the demand of the health seekers. Mothers approached for this study have all shown humbleness in their opinions about the relevance of UHEP for their maternal health needs. Initially, they greatly acknowledged the efforts by the HEWs to enhance the understanding of health and sanitation among the community. In

relation to maternal health interventions under the Program, a model mother started: "*They (HEWs) let us know a mother must not die [from birth]….from HIV. She can save herself with life prolonging medicines…What they tell us is informative enough (MM1)"*. As the conversation developed, however, she implied the irrelevance of the health awareness teachings because she "*…stopped giving birth long time ago, my children are grown enough…My daughter actually is studying nursing in a private college" (MM1).* Another model mother said she was "*…very friendly with them (HEWs). I've learnt a lot from them (HEWs) about keeping healthy during my pregnancy…They taught us about sanitation and personal hygiene (MM6).*" Later she described herself as a high school dropout who already knew what to do regarding medical follow up during pregnancy and afterwards as well as personal hygiene. Therefore, in some cases, there appears to be some loose links between the interventions under UHEP and the demands of target communities, that is, the urban poor.

For most of my model mother respondents, the *Maternal and Child Health Services Package* may not be hugely relevant in connection with their own maternal health conditions. I encountered only two mothers with a history of child birth or pregnancy after they got involved with the health interventions under UHEP. The others have children either older than the Program or born before the women were trained as model mothers. As a result, the influence of the Program on all the prenatal, antenatal and postnatal follow up of the mothers considered for this study may not be very significant. This however by no means suggests that the Program is totally irrelevant to maternal health situations and child upbringing endeavours. What is perhaps unavoidable is to question whether measuring success by way of indicators such as antenatal coverage, etc would be an effective means of determining the impact of maternal health interventions as in the ones under UHEP. It could be a mistake to undermine the possibility of many mothers and their maternal health conditions ill-incorporated in the narrative of health interventions that overemphasize access to maternal health care services. UHEP can hardly claim to influence many of the mothers interviewed for this research to change their behaviour in seeking particularly prenatal, antenatal and postnatal services. However, the mothers generally said to have gained useful consultations from the HEWs on contraceptive use.

To sum up, UHEP, of which child survival and maternal health care is a part, technically attempts to address issues, among others, of maternal health through information and knowledge diffusion on health matters relating to access to health services. To this end, so much hope is attached to HEW interactions with the urban communities. In the process, the Program aims to contribute to the country's performance towards meeting MDG 5. The responsiveness of these interventions to the needs of the urban poor, however, may need to be scrutinized to match the high aspirations for change. As one HEW lamented, she was "*sick and tired of telling them to eat nutritious food during pregnancy when I actually know they have almost nothing to eat*" (HEW1). A model mother's grievance was even more telling; when they cannot afford to pay for waste disposal of the full toilet she shares with a dozen neighbours, "*sister [the HEW] always teaches us about sanitation*" (MM5). UHEP may be better reinforced through a more refined alignment of maternal health interventions with the demand side of health to which the next chapter will be devoted.

5. The Demand side of maternal health

5.1 An overview

Access to health care, in its simplest sense, may refer to the geographical availability of health care services. More broadly defined, however, it involves four dimensions of access: *availability, accessibility, affordability, and acceptability* (O'Donnell 2007: 2821). A geographical availability of a health center, for instance, does not necessarily entail the availability of sufficient medical and human resources to run it. Neither would it necessarily mean it is equally accessible to the poor as much as it is to the well off. People also widely differ in their ability to afford and willingness to accept health care services or/and health interventions. As a result, there is a large gap "between the potential and actual benefits of health care" particularly in developing countries (ibid: 2821).

There are mainly two sides involved with the access problem. One is the supply side in which good quality and effective health care may not be provided. The other is the demand side whereby "individuals may not utilize services from which they could benefit" (O'Donnell 2007: 2820). The two sides are related as poor quality hardly arouses interest from the public. Moreover, the demand side should profoundly shape a health care intervention or the supply side at large so that the latter can properly respond to the actual needs of its beneficiaries.

This chapter, therefore, will attempt to reflect on the maternal care interventions under UHEP from the perspective of the model mothers approached for the study. By so doing, it is hoped to demonstrate the linkage between the interventions under the project (supply side) and actual needs of the beneficiaries of these interventions (demand side).

5.2 Understanding the demand side of health

The demand side of health refers to "the behaviour and inputs of the recipients" of health service delivery such as individuals, households and communities. (Standing 2004: 6). Through a further review of the way the term 'demand side' is used in the literature, Standing identifies five distinct meanings. The first relates to ensuring community leverage on public health through provisions of land for facilities, labour contribution or time donation for mechanisms of local management, etc. Secondly, behaviour change interventions aimed at

modifying individual, household or community behaviours are linked to the 'demand side' of health. Thirdly, the term further captures endeavours of changing provider/supplier behaviour in a manner that it caters for the recipient's demand. This is often done through actions ranging from consultation to community involvement with planning, designing, management, etc of health service delivery. The fourth meaning associated with the 'demand side' is channelling resources directly to users by way of vouchers, coupons or cards, and it is referred to as *demand side financing.* Finally, the demand side approach has a constituency in health production through mobilizing multiple stakeholders in the form of partnerships across users and the public, etc in which users may play different roles (ibid).

UHEP in general and its *Maternal and Child Health Services Package* in particular to a degree consider the demand side of health. To the main, the Program involves a decentralized form of public health intervention so as to effect behaviour change at household and community levels. Moreover, together with local administration, it sometimes facilitates free medical treatment cards for the extremely poor households. However, these cards are used within limited public health facilities and it is in no way meant to enable users expand their choices for quality services. Mobilizing multiple stakeholders and co-planning of activities are also among UHEP's implementation strategies. Specifically, the *Maternal and Child Health Services Package* enlists implementation strategies such as introducing the package to the community, doing a baseline survey, participating the community in the planning process, coordinating activities with relevant government and non-government organizations, etc (UHEP *Maternal and Child Health Services Package* 2009). As the major donor, the USAID, for instance, has been involved with the project and it is represented in the regional team overseeing UHEP. According to information obtained from the Woreda Health Office, the local administration also partakes in the Program monitoring and evaluation process. Nevertheless, not all these strategies may be comprehensively utilized. As mentioned earlier, no baseline survey, for instance, has been conducted.

It is evidenced that the poor make the least use of effective health interventions. This is a paradox to the fact that "the poor also tend to be the least healthy and most probably have the most to benefit from health care" (O'Donnell 2007: 2822). Many millions of them suffer and die from illnesses or conditions for which there are actually effective interventions.

O'Donnell (2007) concurs that the gap between the potential and actual benefits of health care interventions is so large in the area of reproductive health that, for instance, raising coverage rates of maternal health interventions from its current level to 99% would reduce maternal deaths three-fourths. On the demand side, factors contributing to these missed opportunities include low level of education or/and cultural elements obscuring the recognition of benefits from health care, economic constraints suppressing utilization even if there is recognition, etc.

Income and prices of health care services are among the main constraints of utilization of health care for the poor. There is actually "a strong relationship between living standards and the utilization of health care… [and] the probabilities that a woman receives prenatal care and receives medically supervised delivery rise with income (O'Donnell 2007: 2825). Also prices of health care determine demand particularly among the poor who are more price sensitive than the better off. User fees often "effectively exclude the poor from essential services" (ibid: 2825). Studies, however, indicate that fee waivers for health care in Africa have not elicited similar results. In Uganda, for instance, abolition of user fees increased utilization of health care by the poor. This was not true in South Africa, where fees for maternal child health services were removed (ibid).

5.3 UHEP beneficiaries and their health care utilization

Communities targeted under UHEP apparently have income and price deterrents to effectively utilize health care services. The maternal health interventions under the Program mainly involve provision of information and training to raise community awareness on maternal health care. Some free medical cards for the extremely poor may have allowed for access to basic care in some circumstances. Nevertheless, they are by no means medical insurance schemes for quality health care services. The income and price deterrents, therefore, seem to prevail in the livelihood of the urban poor more than, for instance, cultural factors.

In their relation to demand for health care services, cultural factors may also determine the utilization of health care services. These can mean norms leading to deep-rooted attitudes

toward health care interventions. On example in this regard may be preferences for traditional over modern therapies (O'Donnell 2007). Seeing at least from the delivery of their children in health facilities, it is difficult to associate a tendency of such preferences for traditional child birth with the respondents in this study. If at all there is any contribution that the maternal health care interventions have made to motivate beneficiaries' utilization of health care services particularly for child delivery, it would arguably be marginal. None of the respondents said they have a traditional birth experience for the children they gave birth to in Addis Ababa even before the introduction of UHEP. Those who were assisted by traditional birth attendants during delivery and who also did not get basic maternal health care during their pregnancy had the experience only for the children they had from rural life. It appears that the generally better access to health care services and relatively better health awareness in pursuance of urban livelihood have played an important role for the urban poor to favor utilization of basic health care services over traditional birth attendance. Under the circumstances, UHEP and its maternal health care interventions look somehow misplaced particularly with its informative and awareness raising activities of marginal relevance.

5.4 UHEP and Family Planning

Perhaps the most significant contribution of UHEP's maternal health care initiatives for the urban poor women and their families may have been change of patterns of contraceptive use. Respondents have tended to emphasize the important role of the interventions in changing their previously held views of the use of contraceptives even when they were asked to discuss other benefits. A mother said she makes all her decisions on what contraceptive and when to use it "*surely after I get Sister's [HEW's] advice. She is really great!*" (MM2). Another mother explained:

"I felt it was important to make sure that I don't conceive at least three years after the birth of my first child. The nurse [calling her name] told me the options and I finally decided [to take] the injection that keeps me safe for 3 years" (MM6).

While one mother said that she "*naturally stopped giving birth now*" (MM2) and another laments for "*may be having infertility problem*", all the others maintained that they use contraceptives and the information provided by the HEWs as to the range of options they have, and so on has been very useful for the choices they make.

The respondents also believe that their perception of HIV/AIDS and knowledge of positive living, and preventing and controlling it has been enhanced with the introduction of UHEP in their neighborhoods. A mother of 4 grown children said she was encouraged to take HIV testing because she often felt sick. Then, *"I was found positive and currently I and my husband are taking the medicine [ART]. ...The nurses are always around when we need them for information and advice. Thank God we are still fine and sending our children to school"* (MM14). In a way, UHEP seems to be more successful with the contraceptive use aspect of its maternal health care interventions.

5.5 UHEP and determinants of maternal health

UHEP has attempted to align its goals and practices with MDGs and global health initiatives that put a considerable emphasis on access to basic health care and community ownership of health initiatives. It has promoted access and decentralization of health care delivery systems. In the mean time, the health needs of communities extend wider than just access problems. In fact, although quality is always a question, access to basic health care services and communities' willingness to use these services do not seem to be much of a problem that need interventions as big as UHEP, which is the major national urban health program.

The situation entails the need to identify other priority areas for more robust intervention in maternal health in Addis Ababa, or at least in the *Woreda* under study. This brings us to the issue of social determinants of health. The basic knowledge is that "the lower an individual's socio-economic position, the worse their health" (Marmot 2007: 1153), and the preoccupation of the maternal health interventions under UHEP with behavior change individuals and communities appears to greatly miss out this major determinant of health. The realization of health equity "will take not just access to health care but also action on the social determinants of health (ibid: 1155). At the center of the problems related to social determinants of health lies the issue of freedom and empowerment. Health equity necessitates not just technical and medical solutions but also empowerment of individuals, communities and nations (ibid). Given a huge disparity between the rich and poor in enjoying freedom to

control their own lives, neither physical access to health care nor the mere promotion of a desired health seeking behavior would do justice to the plights of the poor.

UHEP has integrated maternal health care with a number of other conditions and diseases to intervene in a promotional manner while the concerns in the community are of material, psycho-social and political nature. In other words, little relevance can be sought between, for instance, mainly promoting better health seeking behavior and actually enabling the poor to better their material conditions. Given the low level of education, unemployment, absence of decision making power, etc., it is also difficult for the Program to address psych-social and political needs of poor women only through improving their access to health care and improving their health seeking behaviors. There is a big difference between promoting healthy feeding and actually creating the conditions in which it is possible to eat healthy. *"It is good they teach us about the usefulness of eating nutritious food"*, a mother said smiling, *"but you do that when you have [can afford] it"* (MM14). To state her difficulties to afford a balanced diet, another mother preferred to use a local proverb which can roughly translate in to *"One lives on what the home can provide, never can he live like the neighbor*" (MM1).

It should, at this juncture, be noted that this is not to say UHEP has an inherent problem in and of itself as regards its ways of mitigating health inequity. In fact, health inequity has always suffered from a globally systemic problem of social inequalities. The difference between the wealthiest 10% of Americans and the poorest 10% of Ethiopians, for instance, is 1 to 10,000 (Birn et al. 2009). Further, local context seems to be positioned subservient to global expectations while designing policies and implementing programs for marginalized segments of society at national and community levels. As much as nation states realize that a stronger emphasis on local realities can lead them to more realistic achievements, they also know that they work under the influence of global finance, which gives due regard to global expectations. As a result, they may have to be in a constant struggle to strike balance between fairly responding to demands at the local and the global levels, a difficult dilemma to entertain.

6. Discussion

6.1 UHEP and its maternal health interventions: approach and priorites

Ethiopia's Urban Health Extension Program (UHEP) offers an example of the difficulty to separate between the vertical and horizontal modes of health interventions. It can be seen as an integrative approach for its focus on basic health care service delivery which is channelled mainly through government facilities. It has also integrated a number of diseases and conditions within its health packages. Still, maternal health is juxtaposed with child health to form the *Maternal and Child Health Services Package.* Perhaps due partly to its strong relation with the MDGs, which are mainly designed to address development challenges in poor nations of the world, UHEP and maternal health within it also resonates with Leikoff's (2010) *humanitarian biomedicine regime* in that the diseases and conditions selected for intervention are of huge relevance more to local situations. Although eventual coverage of communities and populations is the target, its interactive approach to households also implies the understanding of health as a matter of individual wellbeing.

The more vigorous approach taken by UHEP as a whole, however, is the integration of a number of diseases and conditions on which it aspires to raise community awareness in line with the MDGs. Its sixteen packages include diseases and conditions such as malaria, tuberculosis, HIV/AIDS, maternal and child health, vaccinations, family planning, adolescent reproduction health, nutrition, hygiene and sanitation, mental health etc. UHEP clearly draws on the health MDGs through its packages designed for diseases and conditions prioritized in the MDGs.

The integration under UHEP of maternal health with child health seems to fit with the assertions of Béhague and Storeng (2008) that there is recognition for an integrated approach for the subfield to be effectively addressed. Even more, the whole Program has incorporated various disease and environmental conditions to be tackled through the regular health infrastructure. In a way, the design of interventions within UHEP clearly relates to the definition of horizontal modes of intervention in which several interrelated health issues are tackled "by strengthening health systems and developing integrated delivery systems" (Béhague and Storeng. 2008: 644).

However, practical experiences within the Program seems to suggest that vertical approaches pursued by health initiatives in and outside UHEP structure seem to create a disparity of focus between child and maternal health relatively favouring the former against the latter. This obviously implies the greater leverage of vertical approaches to mobilize resources (Victoria, et al. 2004) even on seemingly horizontally integrated packages of health.

During the interviews both with the model mothers and HEWs, there was no indication of whether the respondents understand the two components of the Package as related but distinct. In fact, the interviewees often resorted to child health issues even when they were asked questions that related to maternal health. It was very common for the HEWs, for instance, to describe their activities on maternal health with dominant accounts of how they help parents with information on child health issues such as vaccines, nutrition and hygiene for children. Similarly, model mother respondents often reduced the maternal health matters to family planning because they seemed to have largely perceived UHEP's maternal health program as a mechanism helping them to properly use contraceptives. Therefore, the maternal health component of the package may have been undermined by the Program as child health takes relative prominence, and this is partly because support for child health can better be mobilized through interventions like vaccinations and nutrition.

The HEWs coordinate efforts to enrol children for basic nutrition handouts and to ensure full vaccinations for them, and they have been encouraged by the cooperation from some NGOs. Some casual trainings for model mothers aside, HEWs would not say the same about the level of NGO support for maternal health issues.

6.2 Community-HEW Interactions: Mutual respect and skepticism

More than anything else, UHEP is once more an urban *campaign* meant to change the health seeking behaviour of the urban poor. To this end, the Program has deployed HEWs who reach out households and communities. Meeting the behaviour change objectives is envisaged to be realized through frequent and effective interactions between program beneficiaries and HEWs. The HEWs not only make house-to-house assessment of target communities, but they also facilitate meetings both with a group of model mothers already trained to reach out their neighbouring dwellers and with larger community members.

Gatherings sometimes take a more informal scene with traditional coffee ceremony creating a friendly atmosphere.

Overall, these interactions seem to have been based on mutual respect between mothers and HEWs at least for the occasions this researcher was able to observe. The interview accounts also confirmed this; but the situation does not necessarily imply mutual trust. The model mothers' commitment to cooperating with the HEWs for better achievement of the Program can sometimes be easily compromised by whether they get some material benefit such as allowance for partaking in trainings. The selection of participants in such trainings also creates tension between the HEW and model mothers that the latter's interest in UHEP interventions at times fail to prevail above their immediate needs. This often leads to a sense of frustration and scepticism among HEWs. Besides, although the mothers seem to have respected the interactive and informative approach of the HEWs, it may not necessarily mean that they have fully understood the professional side of these nurses. The HEW interviewee, as highlighted elsewhere, lamented that the community associated more professional status with nurses working in health centre as opposed to HEWs working in neighbourhoods. This somehow captures the frustration of HEWs with communities' poor understanding that may lead to restricted success in the behaviour change trail.

Perhaps the preference of health professionals versus community members with mid-level education did not seem to help the situation. Unlike the rural HEP, UHEP has preferred the recruitment of government salaried mid-level health professionals to community health workers who are members of the community they serve. The government may be justified for hiring salaried HEWs because the urban poor will find it difficult to pay these service renderers to make them much more answerable to the community. However, one would wonder if recruiting community members with some high school education after basic health training would have elicited better interaction, mutual trust and acceptance. Perhaps, as much as it has emulated the rural HEP packages, UHEP may need to look into the experiences of community recruited HEWs in the rural setting, and how much the rural HEWs and their belonging to the community, although paid by the government, has added to the overall success.

6.3 Program relevance to beneficiaries

6.3.1 Model mothers' perceptions of UHEP and its maternal health package

Generally, the model mother interviewees for this research understand UHEP and the maternal health package within it as a well-meaning mode of intervention. The information provision and the household level interactions between HEWs and families appear to have highly impressed the model mother respondents for this study. However, the Program predominantly involves raising awareness followed by little or no mode of intervention in response to the material and social conditions of households. This has sometimes strained interactions and drained interest among community members. The lack of interest exhibited during the coffee session teachings was perhaps indicative of how the model mothers were not desperate for awareness in the absence of practical assistance for their impoverished situation. Interview accounts also imply that the respondents perceived health not just as a change in health seeking behaviour, but also mainly as change in troubled livelihood.

Specific to maternal health, they mainly associate the *Maternal and Child Health Services Package* with contraceptive use, HIV/AIDS prevention or/and positive living, and family planning. What was also apparent in their comprehension of the package is that they have related it more to issues such as nutrition, breastfeeding, vaccinations, and hygiene for their children than the various phases of maternal care during pregnancy and childbirth.

The respondents' marginal association of maternal health with prenatal, antenatal, and postnatal care renders a bit of a paradox because the *Maternal and Child Health Services Package* document actually gives due emphasis to these phases of childbirth. In other words, the programme dwells on the "medical and technocratic concept of childbirth" that Roalkvam (in Bjørkdahl & Nielson B. 2012) discusses in relation to the health interventions designed by nation states in order to achieve MDG5. The respondents do not seem to attach a profound importance to these elements of maternal health. Their awareness on clinical birth attendance has been already substantial before UHEP was introduced. The Program has arguably not brought a different health seeking behaviour for their experience of birth attendance. Although poverty hinders overall quality of life for the urban poor, their relatively better access and proximity to health facilities and more awareness on maternal health may have contributed to their pursuance of modern medical means for their maternal health concerns..

6.3.2 Beneficiary identification and Program relevance

Generally, the women have regarded their changing patterns of contraceptive use and family planning as the outcome of maternal health information and knowledge they acquired from the HEWs. In that relation, UHEP's maternal health interventions have been responsive to the needs of women in the communities. However, UHEP is more of an all-inclusive campaign that identifying the most relevant community members for maternal health interventions does not seem to be at the centre of the selection of model mothers. Sometimes better education and also better acceptability of women among the community may have been more important at least in the first few batches of recruits. As a result, there are situations whereby strong relevance has not necessarily been sought for all the model mothers under the Program. The assumption may be that the mothers can still help community members in their immediate environs with their information dissemination and communication endeavours. Thus, the focus on community coverage of health information and training in UHEP and its maternal health interventions cannot be over exaggerated. After all, the ultimate goal of UHEP relates to enhancing health seeking behaviour of the urban poor through predominantly awareness raising activities.

The approach begs the question of whether it can effectively mobilize community members who do not find profound meaning in the interventions to further their already existing behaviour of, for instance, adhering to skilled birth attendance. Respondents have utilized health facilities during their pregnancy and childbirth experiences prior to their exposure to UHEP and their interactions with HEWs. Perhaps, showing the desired commitment to actively partaking in the Program mainly for the sake of assisting others may not be enough of a motivation for the poor. Particularly in the absence of effective incentive mechanisms, it may not actually be realistic for UHEP to have high expectations from these women who are in a constant struggle to make ends meet.

UHEP, nonetheless, must have still been a proper response to a lot of women in Addis Ababa who are outside basic maternal health care coverage. In fact, health indicators calculated skilled birth attendance and postnatal coverage in Addis Ababa to be 67% and 37% respectively (FMOH 2011). This indicates that there are still more urban women out there yet to be addressed through UHEP's maternal health interventions.

6.3.3 Applicability of health information

The issue of relevance in the maternal health interventions is not solely related to problem of whether or not the typical beneficiary has been identified. It extends to whether the information and training provided for women is useable even when it is actually relevant to their maternal health situation. UHEP's *Maternal and Child Health Services Package* (2009), for example, underlines the need for a pregnant woman to eat nutritious food, to rest and relax and avoid heavy household tasks. It is unlikely such things are new knowledge to women, but their practical relevance can be questioned given the women's impoverished conditions, their vital role of doing house chores and running errands even during pregnancy, etc. The situation calls for the need to integrate the awareness raising activities with the activities of health initiatives in and outside the regular health infrastructure so as to better the material and social conditions of the beneficiaries. While necessary, such integration efforts are, however, by no means easy to work out. Mention has already been made that support for maternal health concerns is not as strong as it relatively is for child health.

The poor socio-economic condition of the urban poor women makes it difficult for them to maintain good maternal health. The respondents in this research are formally unemployed, have limited or no educational background, earn low income; and all these conditions apparently restrict their power of decision-making. We can notice that UHEP is approached from biomedical and behavioural change perspectives of health, and the social determinants of health have not been captured in the Program.

Both at global and local levels, health inequities mainly stem from "unequal distribution of power, income, goods and services" (Marmot, et al. 2008: 1661). Although disparity of access to health care itself is a social determinant, ill health is often reflective of "immediate and structural conditions in which people are born, grow, live, work, and age" (ibid: 1661). Basing a country's urban poor health program largely on individuals' health seeking behaviour hardly becomes effective if it is not integrated with initiatives tied to the social determinants of health.

Life chances, as Birn et al. (2009) posits, are structurally constrained. Behavioural change initiatives need to consider coordinating their activities with interventions at various levels that respond to challenges posed by poor nutrition, inadequate housing and inability to

maintain optimal hygiene, low income, etc. (ibid). Placing the utmost responsibility for ill health on individuals' behaviour undermine the need for government commitment to address the plights of the urban poor. A focus on behavioural changes shifts attention away from the necessary reform of health systems in order to provide the poor with basic health care services (Roalkvam in Bjørkdahl & Nielson B. 2012). The more horizontal interventions of maternal health need to integrate rigorously with vertical programs run by civil societies, international NGOs, private service providers etc. This would very likely help maternal health care enjoy what Béhague and Storeng (2008) call vertical-horizontal synergy.

6.4 The global-local synergy in UHEP's maternal health package: A dilemma

Medical and technocratic concepts of childbirth surely dominate the *Maternal and Child Health Services Package* of UHEP. Focus is placed on maternal and child mortalities and ways of mitigating them. The principal mechanism, in this regard, is enhancing the coverage of prenatal, antenatal, and postnatal care as well as family planning and HIV/AIDS prevention and control. The maternal health objectives strongly link up to MDG5. Therefore, the influence of the global MDGs on national health systems and programs that is highlighted in my theoretical framework section is obvious in UHEP and its maternal health component.

As indicated earlier, UHEP mainly involves an integrated approach in which ill health is largely addressed through improving access to health delivery services and changing health seeking behaviour. It appears to have captured important elements of the horizontal mode of health interventions not just with its primary focus on the delivery of primary health care services but also through its strive to enhance community participation in and production of health. On the other hand, the Program also offers a vertical dimension due to its disease-specific and service-specific interventions. The *Maternal and Child Health Services Package* is mainly addressed through improving access to such maternal health services as prenatal, neonatal and postnatal care and comprehensive child vaccinations. This is basically an approach pursued by many global health initiatives. Travis, et al. (2004:901) write; "Many of the current global initiatives to achieve the health MDGs have strong service-specific or disease-specific foci."

It is fair to argue that UHEP holds onto MDGs and overall global health initiatives rather fondly and, in that regard, it takes on a vertical approach whereby the Program is designed in a manner that it is responsive to globally set agendas and goals. This may not always be exercised as desired by nation states but as imposed by global actors. The MDGs are said to be primarily an end for which nations are encouraged to design "a country- owned and credible long term strategy" (Mutasa 2005: 22) to achieve the goals. However, national programs often fall short of this potential partly because donor-imposed aid conditions greatly affect policy-making and implementation.

Mutasa identifies two forms of donor influence in relation to achieving the MDGs. First, global financial institutions "use aid conditions to channel aid based on their assessments of compliance to their policy prescriptions." Second, bilateral donors also channel their MDG aid resources "into highly conditioned budget support" for national poverty reduction and sector-wide programs (2005: 22). Often, the financial and policy leverage of global health agenda makes it difficult for genuine ownership of national development policy and local interventions as African countries have limited capacities to control aid allocation and monitor outcomes (ibid).

6.5 Changing roles of the MDGs: From an end to a means

The MDGs, while expressing desired ends in the eight global goals, did not originally imply particular means to meet these ends. There has been no official development strategy or policy framework forced into countries to pursue in a uniform manner. However, the MDGs are often said to be either misunderstood or deliberately misappropriated by some actors to support their own agendas of mostly absorbing more foreign aid or masquerading a particular policy framework. Perhaps against their origination as globally set goals with no policy prescription, the MDGs in practice seem to have been understood as one-size-fits-all targets. This is particularly apparent in the way that African countries try to strongly tie their development performance to whether they have been within or outside the MDG targets. The understanding seems to have been that the numerical MDG targets will have been achieved by each and every country in the world. This thinking mainly misses the point that the MDGs are not even-handed, and they are highly demanding for poor countries in Africa and elsewhere in the world. The argument therefore goes that the world may not achieve the MDGs not because Africa is lagging behind, nor because growth is too slow, aid is too low,

etc. It will be mainly because disparities within society in many countries have been so immense that they have slowed down national progress (Vandemoortele 2009).

Nevertheless, the confusion with the MDGs does not seem to stem merely from failure to understand that the globally set goals do not force a global strategy into national contexts. It may have also emanated from global expectations of countries to meet the goals even when the MDGs are not even-handed. It would hardly satisfy global actors to see the world reduce poverty by half within the set time, for instance, mainly because of the tremendous achievement made by countries like China and India (Clemens et al. 2007). In fact these countries have succeeded with marginal global aid (ibid). The global financial commitment aspired through the MDGs (MDG 8) seems to presume that poor countries can meet the MDGs if the commitments were to be translated fully into technical and financial assistance of the expected level.

However, attaching potential success for Africa in the MDGs to global aid has become problematic. Clemens (2004:4) argues that while aid may play a positive role in promoting development outcomes, it is highly unlikely that even "additional aid on the scale suggested by [MDG] costing studies…lead to the achievement of the MDGs." This is partly because the MDGs and particularly the health MDGs cannot be comprehensively captured through supply side responses to which development aid can mainly be applied. The demand component of health outcomes are marginally related to additional expenditures on certain interventions and more "affected by broader social and economic changes" (ibid: 12). Dominantly vertical global health initiatives and aid models are hardly the response to the demand side of health. Regarding this limitation of interventions, Clemens makes the following assertion.

> Many of the available interventions in terms of policy reforms or increases in resources are supply-side responses, and can do little to increase demand, which is linked to longer-term social and economic changes. Lack of demand is partly responsible for the low levels of education, health care, and other development indicators…. This offers one reason why outcomes seem to change only slowly, and also suggests that there may be a limited potential role for aid in meeting extremely ambitious, universal, time-bound goals (2004: 30).

At this juncture, it is not so difficult to understand that the policy and resource leverage of global health actors hugely affect national health performance, but not necessarily to elicit best outcomes. MDG focused interventions seem to be often preoccupied with the supply side of health expressed in the form of such indicators as access to basic health care services. Meanwhile, they have missed out the demand side indicators to a great extent. The MDGs may or may not be met by a range of poor countries of the world within the deadline. But what looks more important is that development need not be desperately tied to countries' achievement of these goals. This is because, on the one hand, encouraging progress can be and has been made by many poor countries even when the MDGs may be unlikely to be met (Clemens et al. 2004). But, on the other hand, the issue of development takes more than meeting some global health objectives. As observed in this study, many respondents had basic maternal health services during pregnancy and birth, and they subscribe to modern family planning schemes. However, their poor socio-economic conditions seem to have been unaffected by the supply side responses to their health concerns.

This is not to undermine the MDGs and global health targets and their relevance to national contexts. After all, they mainly meant to address the plights of the global poor. And the relevance of global health goals and interventions must have actually enabled the decline of maternal and child mortality, HIV/AIDS prevalence, etc. However, the tendency of national health programs to make their interventions ultimately no more than a response to the MDG race undermines the need to address broader demand that may be more important for the poor segments of society.

7. Conclusions

The study has attempted to explore maternal health interventions in Ethiopia's urban setting in particular connection to the Urban Health Extension Program in Addis Ababa. Following on eight years of encouraging health extension performance in rural Ethiopia, UHEP has worked towards achieving health equity by creating demand for basic health services among urban households through information provision and health training. Maternal and child health is one of the 16 packages under the Program.

I have looked into maternal health interventions within UHEP in just one Woreda in the *Arada* Sub-city of Addis Ababa. The main techniques employed to gather data are in-depth interviews with model mothers and HEWs. Observation was also very useful particularly in relation to understanding the daily routines of HEWs and their interaction with program beneficiaries. As UHEP embodies both horizontal and vertical approaches to health, the concepts around horizontal and vertical modes of health intervention have been utilized as my theoretical framework within which I attempted to work out my discussion of findings.

The maternal health interventions under UHEP are a vital instrument of tackling health inequities in urban settings. The promotion of access to maternal health care services and skilled birth attendance surely resonates with the needs of the urban poor. UHEP's incorporation of a host of diseases and conditions also implies the recognition of the importance of the horizontal approach to health. Maternal health endeavors can only be meaningful if other health concerns of the urban poor are simultaneously dealt with, and the position of UHEP in that regard is commendable.

However, the Program seems to have failed in identifying the most appropriate targets. It has not established a baseline, and in some cases, it looks as though it adopted a behavior change campaign on households who already hold onto the desired behavior. None of my respondents, for instance, sought to pursue skilled birth attendance as a result of awareness raising services created through UHEP.

While UHEP can generally be said to have pursued a horizontal approach, it may not, however, have maintained the right balance in its level of emphasis on the various diseases

and conditions. The *Maternal and Child Health Services Package* document, for instance, treats both maternal and child health fairly equally; but in actual practices, child health seems to have taken more prominence. The dominance of child health matters in my interviews with model mothers even when discussing maternal health is indicative of just that imbalance.

More vigorously though, maternal health interventions within UHEP seem to have been designed as a response to MDG5 in particular focusing on the promotion of access to basic maternal health services and skilled birth attendance. The determination to follow on the MDGs sometimes comes at the expense of undermining the demand side of health which has more far reaching implications on the political and socio-economic conditions of target communities. The preoccupation with coverage of and access to basic health care or the supply of health services snatches attention away from genuine attempts to integrate supply related efforts with interventions that respond to overall impoverished state of urban dwellers.

In general, national health systems and local health interventions have increasingly dwelled upon global health agenda, and the case of UHEP and maternal health in Ethiopia is, in a way, an illustration of this vertical relationship between global actors and local implementers. The relationship often involves power manifested mainly in the form of policy and financial reliance of poor nations on global health initiatives and international financial institutions. As if by destiny, nation states may always have to live with this dilemma of changing the lives of the poor based on either what the local milieu suggests is a reasonable thing to do or on what national policies and local development activities are accorded with global expectations. Given their highly limited capacity to monitor and finance their own development, poor nations usually resort to the latter choice.

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Appendix I : Semi-structured interview guide for selected model mothers

A. Demographic details

Age _____	No. of children born in health centers- _____
Education_____	No. of children born without any assistance from health professionals (Who helped in this case?)
Income level (Monthly)_____	**Religion_____**

B. Warm-up

- How're you doing?
- Thank you for being so kind to talk to me
- Introducing myself, etc.

C. Health practices before UHEP in site

- Where did you get maternal health care services? (How far is it from home? How do you travel there?)
- Where did you give birth?
- How often did you visit health centers during pregnancy and after birth?
- Any experience of miss/near miss? Suspected or reported (disclosed) cause?
- Any enduring complications or ill-health for any of your children?
- Any enduring complication or ill-health for yourself before or after birth?
- Who was the main source of family income?
- What was the share of house chores for you like during the period of pregnancy, and soon after birth?
- Did you use contraceptives?
- Who often decided on whether to use contraceptives?
- What was your main source of information on contraceptives?

- Can you tell me some of the major challenges (before HEP) you faced in relation to maternal health (in keeping yourself as well as your babies healthy and strong)?

D. Health practice following HEP in site

- For how long have you been part of the 'Model Family' under HEP?
- How do you generally view the Program? What is it for you personally?
- Has anything changed for the better in your life since the Program? What and how?
- Where do you get maternal health care services now?
- Have you given birth after your recruitment in the 'Model Family' group?
- Was the experience of pregnancy period and birth different from previous ones? (How?)
- How do you generally describe your relationship with Health Extension Workers (HEWs)?
- What are their major contributions to your behavior of seeking maternal care services and overall maternal care practices?
- Have you improved on your behavior of visiting health centers during pregnancy and after birth? (If yes, how?)
- How important is the services you get through HEP for this change? Can you explain?
- Any experience of miss/near miss? Suspected or reported (disclosed) cause?
- Any enduring complications or ill-health for any of your children?
- Any change in the share of house chores during the period of pregnancy, and soon after birth? If yes, how and why?
- Who is the main source of family income?
- Do you use contraceptives?
- Who often decides on whether to use contraceptives?
- What is your main source of information on contraceptives? (Media, family member, HEWs, etc)
- Can you tell me some of the major challenges (before HEP) you have faced in relation to maternal health (in keeping yourself as well as your babies healthy and strong)?

- Do you think there are more factors determining your maternal health situation than just access to health care services and health information?
- If yes, can you tell me some of these?
- As part of the ‘Model Family’ under HEP, what are you doing to influence or change the maternal health care practices within your community?
- Do you think you are registering success? If yes, how do you measure it?

Appendix II: Semi-structured Interview guide for HEWs

-Educational background

- Monthly salary

- Other benefits

- Number of model mothers you trained so far

- How do you describe your daily work routine?

- How often do you meet your trainees?

- What areas you prioritize in relation to maternal health?

- How do you view the level of cooperation from the model mothers?

- How much are you encouraged with the level of behavior change you observe in your trainees as a result of UHEP?

- What major challenges do you see in implementing the Program?

- How do you understand UHEP and its child and maternal health package in relation to the MDGs?

- Do you feel a lot of pressure in your work? If so, can you explain?

- How do you like your work and your work environment?

- What do you think should be done to make the Program more effective and successful?

Appendix III: Interview Questions to Head of Yeka Sub-city, *Woreda* 5 Health Office and the Woreda's Chief Coordinator of UHEP

- Professional background?

- Monthly salary?

- Do you receive other benefits for your position as a UHEP Coordinator?

- How long have you been the coordinator of UHEP?

- Can you briefly describe what you normally do as UHEP's coordinator?

- What makes you happy about the Program?

- How do you evaluate the effectiveness of the Program?

- Do you have some critical viewpoint about the way the Program is designed for the urban poor?

- What are your priority areas for the maternal health interventions under UHEP?

- How do you evaluate the rate of success?

- Can you tell me what you think are limiting the effectiveness of the Program, if any?

- What do you think can enhance the level of success in the Program?

- How do you relate UHEP with the country's endeavors to achieve the health MDGs?

Appendix IV: UMB Letter of Recommendation for the researcher's field work

Norwegian University of Life Sciences
Department of International Environment and Development Studies, Noragric

Official in Charge
Telephone +47 69 96 53 31
E-mail
Universitetstunet 1, Tivoli, 1432 Ås, Norway

Our Ref
Your Ref Ingunn Bohmann
Date 06.12.2012

To whom it might concern

Letter of recommendation

I hereby confirm that Zewge Abate Assefa, born 10.04.76, is currently enrolled as a full-time student at the Master programme; International Development Studies(M-IDS), at The Norwegian University of Life Sciences (UMB).

The student was admitted 02.08.10 at UMB, and is expected to finish his studies by the end of June 2013.

All students who attend this programme must go to fieldwork and collect data and do their own research for their final Master thesis. Mr. Assefa's will do his research on determinants of maternal health for the urban poor in Addis Ababa through the analysis of Ethiopia's Health Extension Program (HEP), a program launched in 2005 as part of meeting the MDGs. His study involves interviews with model family members under HEP, Health Extension Workers (HEWs) as well as observation of healthcare centres, interactions between HEWs and mothers under the Program, etc. Among other he will need assistance from relevant officials leading the program (HEP).

According to the plan, the field work will be conducted in Ethiopia from the beginning of January 2013 until the beginning of March 2013.

The research proposal has been treated and approved at the Department of International Environmental- and Development Studies (Noragric), and by his supervisor, Professor Sidsel Roaldkvam, at the University of Oslo.

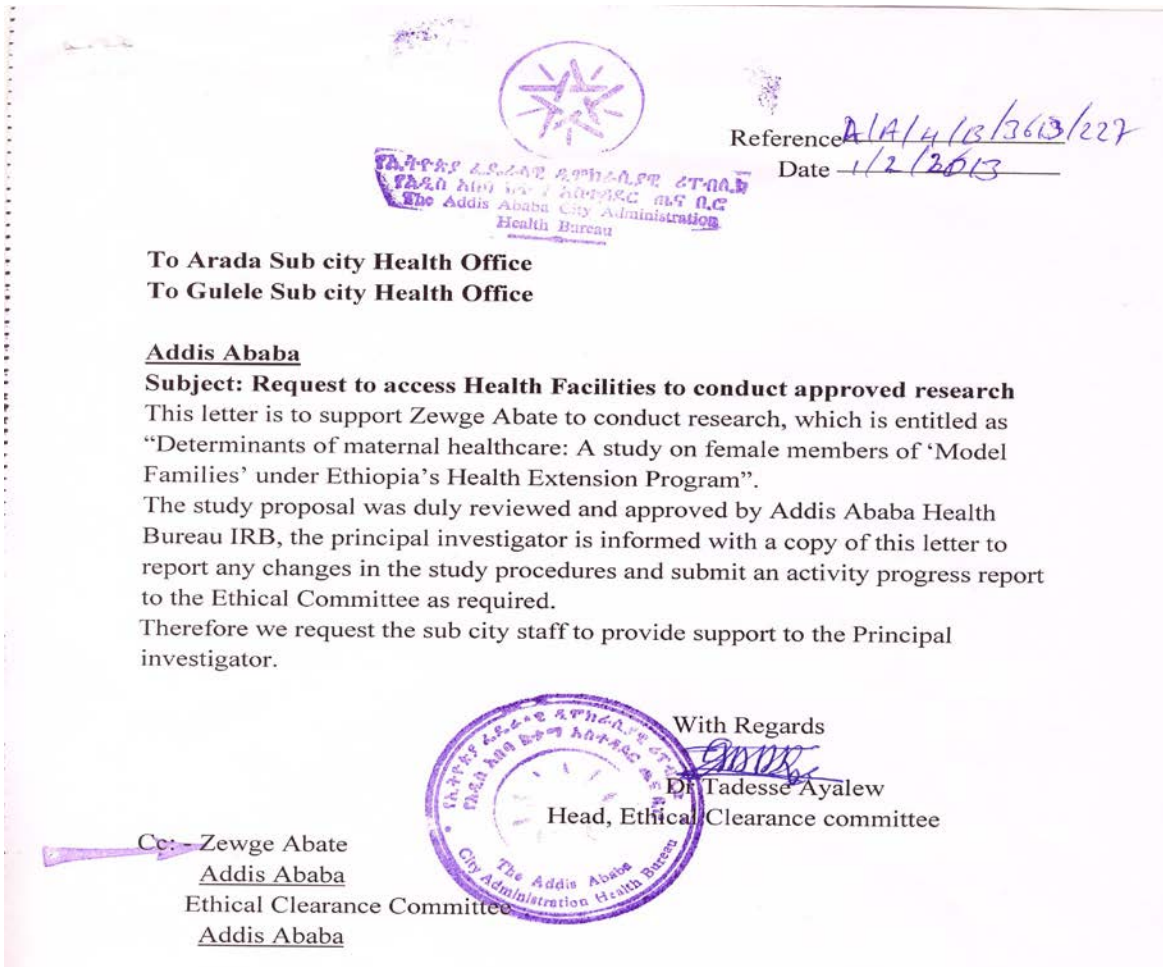
We ask you kindly, if possible, to assist our student and help him to accomplish his work if necessary.

Please contact me if you have any further questions.

Sincerely yours

Ingunn Bohmann
Study coordinator, Noragric
Norwegian University of Life Sciences
Tel: +47 64 96 53 31
Email: ingunn.bohmann@umb.no

Appendix V: Addis Ababa Health Bureau letter of permission for the field work



The Addis Ababa City Administration
Health Bureau

Reference A/A/4/13/3613/227
Date 1/2/2013

To Arada Sub city Health Office
To Gulele Sub city Health Office

Addis Ababa

Subject: Request to access Health Facilities to conduct approved research

This letter is to support Zewge Abate to conduct research, which is entitled as "Determinants of maternal healthcare: A study on female members of 'Model Families' under Ethiopia's Health Extension Program".

The study proposal was duly reviewed and approved by Addis Ababa Health Bureau IRB, the principal investigator is informed with a copy of this letter to report any changes in the study procedures and submit an activity progress report to the Ethical Committee as required.

Therefore we request the sub city staff to provide support to the Principal investigator.

With Regards

Dr Tadesse Ayalew
Head, Ethical Clearance committee

The Addis Ababa City Administration Health Bureau

Cc: - Zewge Abate
Addis Ababa
Ethical Clearance Committee
Addis Ababa

1/2/2013

ETHICAL REVIEW COMMITTEE

Tel: + 251 115 513911 P.O. Box 30738 Fax No. +251 115 515689

Research title;.

Principal Investigator; Zewge Abate

CRITERIA/ITEM	RATING
1. consent form Does the consent contain all the necessary information that the subject should be aware of?	☑Yes ☐Requires revision ☐No ☐ Not applicable ☐Not attached
2. Are the objectives of the study clearly stated?	☑Yes ☐ No
3. Are provisions to overcome risks well described and accepted? a. Justice b. Beneficence c. Respect for a person	☑Yes ☐No ☐Not well described ☐Not applicable
4. Are the safety procedures in the use of vaccines, drugs and other biological Products acceptable?	☐Yes ☐No ☑Not applicable
5. Are the procedures to keep confidentiality well described?	☑Yes ☐No ☐Not applicable
6. Are the proposed researchers competent to carry out the study in a scientifically sound way?	☑Yes ☐No ☐Not applicable ☐Unable to assess
7. Does it have material transfer agreement?	☐Yes ☐ No ☑Not applicable
8. Recommendation	☐Approved with condition ☑ Fully Approved
9. Remarks	

Ethical Clearance Committee Members;

Name Signature

1. Dr Tadesse Ayalew
2. W/ro Frie Hailu
3. W/ro Hana Kumssa

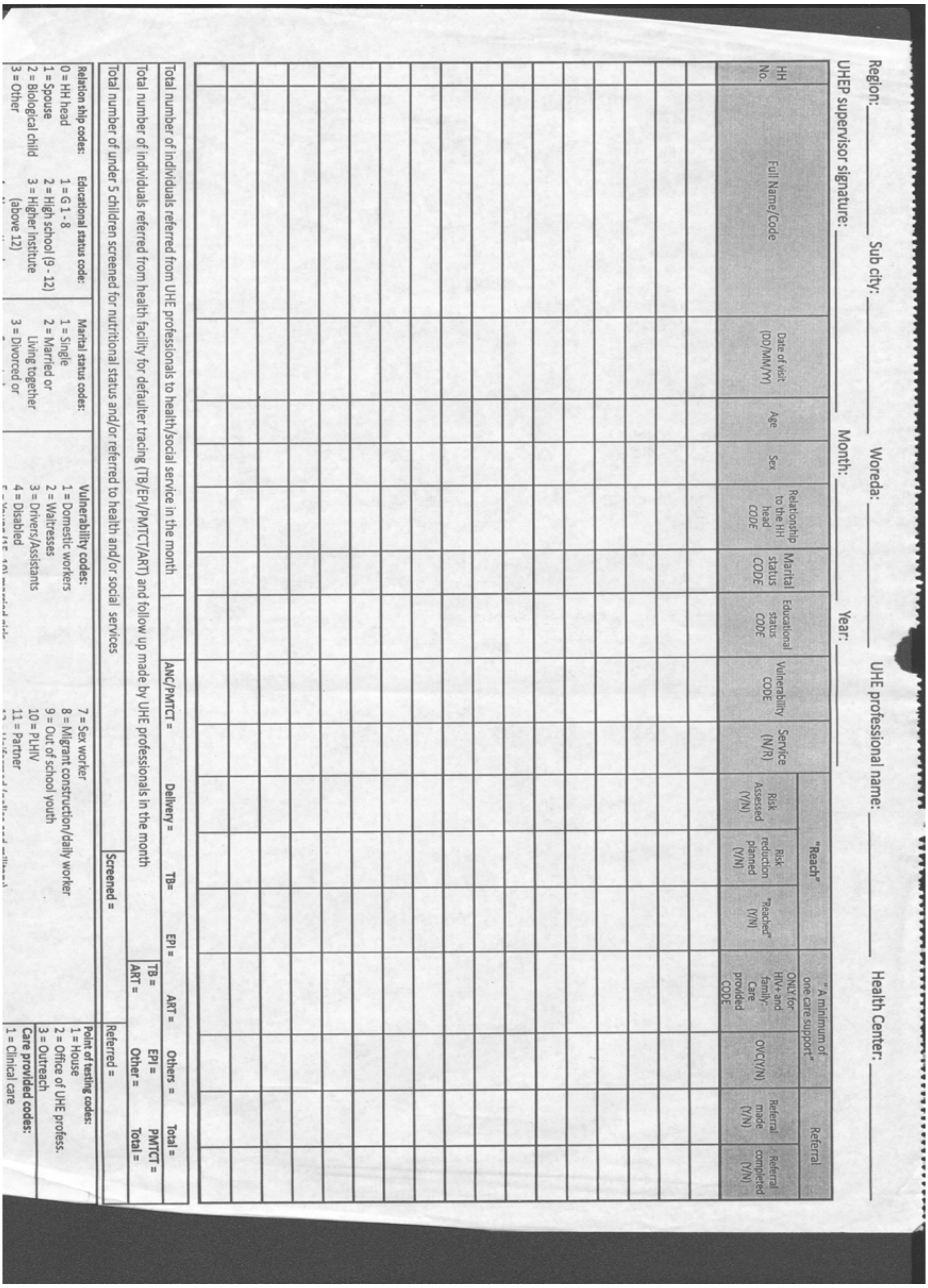
Appendix VI: HEWs daily report sheet

Region:________ **Sub City:** ________ **Woreda:** ________ **UHE professional name:**________ **UHEP supervisor signature:** ________

HH No	Full Name/Code	Date of visit (DD/MM/YY)	Age	Sex	Vulnerable (Yes/No)	Type of service provided	Service		Referral made (Yes/No)	Referred for (ANC, PMTCT, Delivery, FP, PNC, etc)	Referred to (HC, social service, etc)	Referral Completed (Yes/No)	Follow up conducted (Yes/No)	Appointment date (DD/MM/YY)	Remark
							N	R							

N.B. Service N = New and R = Repeat

Appendix VII: HEWs monthly report sheet



Region:______ Sub city: ______ Woreda: ______ UHE professional name: ______ Health Center: ______

UHEP supervisor signature: ______ Month: ______ Year: ______

										"Reach"			" A minimum of one care support"		Referral	
HH No.	Full Name/Code	Date of visit (DD/MM/YY)	Age	Sex	Relationship to the HH head CODE	Marital status CODE	Educational status CODE	Vulnerability CODE	Service (N/R)	Risk Assessed (Y/N)	Risk reduction planned (Y/N)	"Reached" (Y/N)	ONLY for HIV+ and family: Care provided CODE	OVC(Y/N)	Referral made (Y/N)	Referral completed (Y/N)

Total number of individuals referred from UHE professionals to health/social service in the month		ANC/PMTCT = Delivery = TB= EPI = ART = Others = Total =
Total number of individuals referred from health facility for defaulter tracing (TB/EPI/PMTCT/ART) and follow up made by UHE professionals in the month		TB = EPI = PMTCT = ART = Other = Total =
Total number of under 5 children screened for nutritional status and/or referred to health and/or social services	Screened =	Referred =

Relation ship codes:
0 = HH head
1 = Spouse
2 = Biological child
3 = Other

Educational status code:
1 = G 1 - 8
2 = High school (9 - 12)
3 = Higher institute (above 12)

Marital status codes:
1 = Single
2 = Married or Living together
3 = Divorced or

Vulnerability codes:
1 = Domestic workers
2 = Waitresses
3 = Drivers/Assistants
4 = Disabled
7 = Sex worker
8 = Migrant construction/daily worker
9 = Out of school youth
10 = PLHIV
11 = Partner

Point of testing codes:
1 = House
2 = Office of UHE profess.
3 = Outreach

Care provided codes:
1 = Clinical care

Appendix VIII: HEWs group meeting (with program beneficiaries) report sheet

Region:______ Sub City: ______ Woreda: ______ UHE professional name: ______ UHEP supervisor signature: ______

S. No.	Group Name	Date of event (DD/MM/YY)	Number of participants			Type of service provided	Service #		Remark
			Male	Female	Total		N #	R #	

N.B. Service N # = Total New attendants and R # = Total Repeat attendants