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Research Article

Reproductive and Maternal Health Challenges of Pregnant Women in Ethiopia: An Anthropological Appraisal

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Abstract

A very Poor attention is given to reproductive health issues of pregnant women in rural regions of African countries. Ethiopia is one of the countries in horn of Africa representing highest maternal mortality rate in the continent. The Government of Ethiopia has reformed health policy and program to promote community involvement in maternal health, promotion of emergency obstetric health care, health seeking behavior for optimal utilization of maternal health services by women during pregnancies. The women living in pastoralist and small land holders' communities are exposed to high risks of reproductive health hazards. Material delays comprising of delay in making the decision for referral, delay in arriving at hospital and delay in receiving appropriate maternal health services are major contributing factors for growing maternal deaths in Ethiopia. The illiteracy of woman, exposure to frequent pregnancies at adolescent age, poor decision making power of women in patriarchal society, poor employment status of women are main predicators of low utilization of maternal services and high ,maternal death in rural regions of the country. This article is based on synthesis of research projects completed by different authors on multiple dimensions of maternal mortality in Ethiopia. The promotion of referral support service and bridging up the referral gaps would address issues of maternal mortality and growing unsafe abortions among young mothers in rural regions of the country. This paper examines critically different socio – cultural barriers that prevent women living in rural area for accessing appropriate utilization of maternal and health services and infrastructure available.

Keywords: Reproductive health; maternal mortality; health policy; optimal utilization; antenatal care; socio-cultural.

Introduction

Ethiopia, located in horn of Africa, is not only second most populous country in sub- Saharan Africa but also ranked as 171 out of 182 poorest countries of the world (2009 Human Development Index) The maternal health and quality of life of women is most deplorable in this country where not less than 93% of deliveries are conducted at home. Out of 81 millions of people, 84% live in remote and rural regions. The utilization of health services has been characterized with service of one doctor per 1,00,000 population, annual maternal death of 20,000 mothers with non availability of skilled birth attendants to 94% of pregnant women and poor accessibility to emergency obstetric care. The inappropriate birth spacing and multiple pregnancies have undermined the reproduction heath of women in rural regions of the country (Kazembe, 2011).

On average, every Ethiopian woman is mother of five children. Ethiopia occupies highest rank at global level in terms of maternal and infant mortality and morbidity. As many as 89% of woman in Ethiopia fail to avail proper obstetric care for which annually not less than 350 pregnant mothers die per 100,000 live birth. This is highest record in the world. The poor utilization of maternal health services and modern health care services lead to high maternal death in this country. One fourth of total pregnant woman only receive antenatal care which is a serious concern for health administrators of the country (CSA and ICF international. 2012). It is recommended that provisions of antenatal care coupled with timely services of trained personnel attending deliveries and doses of tetanus toxoid injection prior to birth will scale down high level maternal mortality and morbidity in this region (Ethiopia Mini Demographic and Health survey, 2014).

Different studies have indicated that ANC is instrumental for early identification of pregnancy complications and facilitating preparedness for safe delivery. ANC also provides other benefits such as counseling on nutrition and healthy pregnancy delivery behavior, communication coverage, prevention against malaria and helping pregnant mothers availing timely services of trained birth attendants. The young and adolescent mothers living in rural regions of Ethiopia are exposed to multiple reproductive health hazards such as sexually transmitted diseases and HIV infections which take toll of millions of lives. ANC coverage not only provides screening of sexually transmitted diseases and HIV but also facilitates sex education and counseling for pregnant mothers. Different studies have supported that poor access to health care coupled with weak infrastructure, limited distribution system, inadequate number of government health outlets has led to 80% of mortality among mothers in rural regions of Ethiopia Mekonnen and Mekonnen, 2003).

The geographical location of remote villages in rural regions coupled with diversities of socioeconomic environment, climate and terrains have led to uneven access to maternal services and poor health outcomes. The cumulative effects of all these factors have significantly influenced on reproductive health and quality of life of rural women and resulted in multiple obstetric complications. A significant section of rural mothers accounting for 72% of total women in reproductive age group are deprived off prenatal care by trained doctors and midwives as compared to 94% delivering without assistance from trained health personnel. The women in reproductive age group are at high risks of death during pregnancy and delivery. The risk multiplies in case of rural and illiterate women living in patriarchal society..

Ethiopia Mini Demographic Survey (2014) reveals that one in every 14 women in the country is pushed to door of death during pregnancy and child birth. The child mortality is manifested in terms of death of 13 Ethiopian children before first birth day and 8 before attaining five years of age. This is a serious health challenge which needs to be addressed on top priority basis. A wide range of socio – cultural and environmental factors contribute to growing reproductive health hazards and undermining the quality of life among rural women. The foremost factor is early marriage and exposure to consecutive pregnancies at adolescent age that result not only in higher rate of maternal and infant mortality but also in infection of sexually transmitted diseases and obstetric fistula. Women suffering from obstetric fistula in Ethiopia are included among two to three millions of affected women worldwide. Obstetric fistula is reported as serious health challenge for rural women in Ethiopia.

The death of women due to pregnancy related complications and death of pregnant women within 42 days of termination of pregnancy are challenging maternal health Issues in Ethiopia. The factors such as marital status, place of residence, maternal education, provision of skilled attendance during delivery, reduction of gender discrimination and creation of easy access facilities around rural regions of the country would go a long way to eliminate bottlenecks of poor utilization of maternal health services in the country.

Mehari and Wencheko (2013) in their study validated that mother's education, mothers employment status, birth order, husband's partners education and household economic status influence significantly the utilization of maternal health services in rural regions of Ethiopia. The household wealth favours better utilization of maternal health care services as women in rich families are facilitated to use institutional health facilities than women in poor and middle income families The employed mothers are in advantageous position to use health facilities than unemployed ones . The resource crunch and inappropriate focus given on education and job opportunities for mothers are reported as bottlenecks for maternal health care utilization**.**

Materials and Methods

This piece of research is outcome of synthesis of research articles published in different peer reviewed journals. A well designed synthesis matrix has been adapted to respond critically to frame of research questions and key hypotheses relating to variation in utilization of maternal health services, creation and use of easy access facilities in rural regions, institutional stimulants and barriers affecting the use of maternal services as analyzed in past research studies.

The study critically examines the cumulative effects of gender discrimination, empowerment of women, access to education, provision of services of skilled attendance at delivery on variation is utilization of maternal health services. The researcher has rigorously made desk review of 14 published articles that facilitated comparison, contrast, scientific interpretation and critical evaluation of findings of past research for drawing conclusion and recommendations of this article. This study has also critically examined how Millennium Development Goal and Health Sector Development Programme have transformed strategic plan and outcomes as related to reduction of maternal mortality in Ethiopia. This paper based on qualitative content analysis presents collective picture on structural determinants preventing reduction in maternal mortality and enhanced access to reproductive health among women in poor homes and rural regions of the country.

Results

Ethiopia as one of the East African Countries has not only adopted the agenda of UN Millennium Development Goals to promote quality of life but also incorporated sustainable development Goals agenda to reduce maternal mortality ratio to less than 70 per 100,000 births by 2030. The Federal Government of Ethiopia has reformed the health policy and improved health infrastructure and personnel in terms of making health system accessible, affordable and acceptable both in rural and urban areas of the country. An innovative health intervention under package of Health Development Programme was introduced in phased manner from 2012 not only to accelerate primary health care for mothers and children but also per prevention and control of communicable diseases. Such innovative intervention addressed promoting quality and equitable health services available to large chuck of Ethiopians apart from implementing health financing mechanism directed towards reducing the barriers hindering optimal utilization of health infrastructure and maternal health services available. The Government of Ethiopia has adopted the agenda of WHO to scale down not only maternal morbidity and mortality but also perinatal and neonatal morbidity and mortality experienced by women in child bearing age group of 15–49 years. The Maternal and child health care (MCH) programme adopted has geared up interventions to reduce unwanted pregnancies, sexually transmitted diseases, HIV infections and incidences of cervical cancer among pregnant women. The prevalence of numerous inimical cultural practices as genital mutilation, adolescent pregnancies, domestic and sexual violence damaging reproductive health of women are targeted under theses health interventions.

The MCH package has been designed to provide multiple services to women under reproductive age. These services are:

A. Primary health care,
B. Prevention of infection and malnutrition among women and children,
C. Promotion of family planning programme,
D. Sanitation, safe water supply and immunization,
E. Extension of MCH services across rural areas of the country.

The intervention strategies adopted under MCH package have covered training of health workers, improvement of skills and knowledge of health personnel, improvement of referral system, promotion of community participation and inter departmental coordination and cooperation towards scaling up the MCH intervention across rural regions of the country. The cumulative components of deferent interventions under MCH package and innovative Health Sector Development Programme (HSDP, IV) have geared up improved access to reproductive health care and reduction of maternal mortality. (Mekonnen and Mekonnen, 2003). The studies conducted by different scholars on episodes of maternal mortality across different regions of Ethiopia conclude that three delays are major contributing factors for growing maternal deaths in most of the rural homes. These delays take heavy toll of women's life during deliveries. These delays are:

a. Delay in decision to health care,
b. Delay in identifying and reaching medical facility, and
c. Delay in receiving adequate and appropriate treatment.

The factors stimulating such delays are socio-cultural dynamics of the community based maternal health care where pregnant women live. The accessibility of facility and quality of care system always haunt superstitious rural women which force them to delay in decision making when labour is obstructed (Fig. 1).

The young pregnant mothers are exposed to multiple reproductive health hazards culuminating to death due to multiple factors. These maternal deaths are classified in Table 1.

The unexpected fear and apprehension for attending biomedical health care

The rural women are frequently haunted by fear of physical abuse and ridicule by hospital staff, fear of being forced for undesired painful surgical operation and fear of receiving very poor quality of services at hospitals. In most of pastoralist communities of Ethiopia, the woman's status is determined by her reproductive ability. Inability to deliver vaginally is often stigmatized as a form of reproductive disability. On this ground, fear of cesarean delivery at hospital prevents a section of pregnant women seeking biomedical maternity care at hospitals. In some cases, the women who experience difficulties in pregnancies and admitted in hospitals are often underestimated. Cesarean deliveries, obstetric fistulas, obstructed labour are considered negative aspects of womanhood. Fears among women are often compounded by linguistic confusion. Surgery of womb during complicated delivery coupled with blood transfusion is treated damaging for survival of mother and child by a sector of rural illiterate and superstitious women and their families. (Negussie and Obare, 2004).

The rural women have a strong negative feeling and fear about abusive behavior of under skilled hospital staff, overworked doctors and nurses. Women seeking abortions and fistula complications experience abusive behavior from hospital staff and often stigmatized. (Mannava *et al*., 2015) The studies have validated that delay in treatment and high risk fatality episodes are attributed to cultural stigmatization of women by hospital staff.

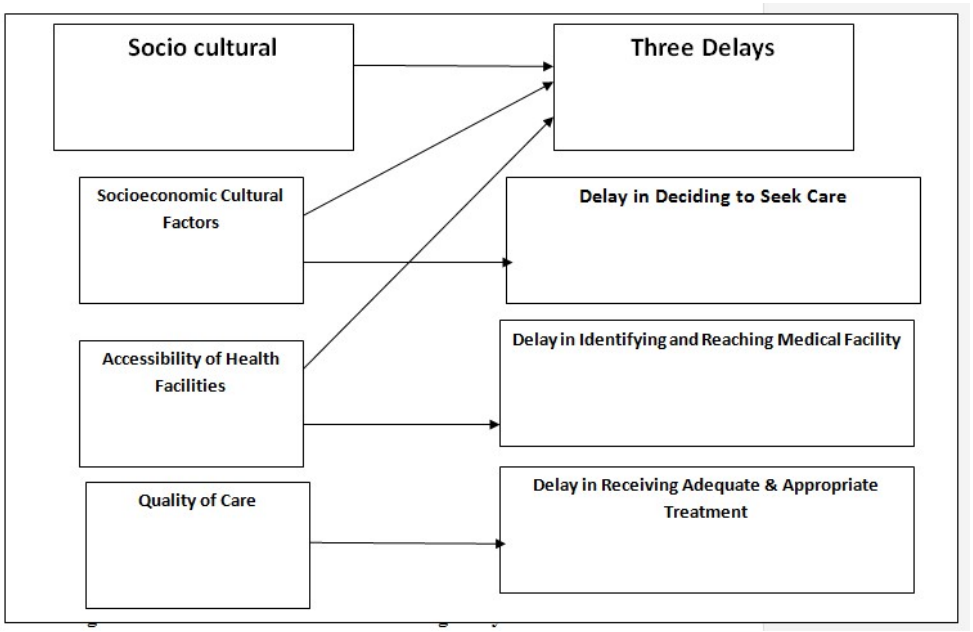

Fig. 1: Socio-cultural barriers stimulating delays

Table 1: Table showing categories of maternal deaths based on timings and causations.

Maternal Death
Deaths of pregnant women within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or coincidental causes.
Direct maternal death
Deaths resulting from obstetric complications, labour and puerperium, omissions, incorrect treatment, of from a chain of events resulting from any of the above while pregnant or within 42 days of the end of pregnancy .
Indirect maternal death
Deaths resulting from previous existing disease, or disease that developed during pregnancy and which is not due to direct obstetric causes, but which is aggravated by the physiologic effects of pregnancy while pregnant or within 42 days of the end of pregnancy.
Coincidental maternal death
Deaths from unrelated causes which happen to arise during pregnancy or with 42 days of the end of pregnancy.
Late maternal death
Deaths occurring between 24 days and one year after abortion, miscarriage or delivery that are direct or indirect maternal causes.
Pregnancy – related deaths
Deaths occurring in women while pregnant or within one year of the end of a pregnancy, irrespective of the cause of the death.

In patriarchal societies, social relationship determines the reproductive capacity of women. In rural areas, the pastoralists' households encourage polygamous culture where co wives live together with husband. In such households, a very little care and attention is provided to pregnant women, where they are restricted to avail benefits of antenatal care. In such communities, male dominance not only owns women's reproductive capacity but also determines maternal health seeking behavior during obstetric emergencies. This is a serious reproductive health challenge for women.

The sate motherhood is determined by multiple factors such as provision of antenatal care including regular prgenancy examination, immunization, proper nutrition and self care of pregnant women. Antenatal care of pregnant women is very important as it ensures that pregnant woman and her fetus are in the best possible health.

Table 2: Socio-cultural factors of ANC coverage of rural pregnant women of Ethiopia.

Variable	ANC coverage (%)
1. Mothers age at birth	
15-19	32%
20-24	28.4%
35-49	25.1%
2. Education of Mothers	
Illiterate	23.3%
Primary and above	42.6%
3. Employment status of mothers	
Employed	34.1%
Not employed	25.8%
4. Birth order	
1	36.8%
2-4	28.9%
5+	24.3%
5. Wealth Index	
Poor	21.4%
Middle	30.5%
Rich	42.6%

(Source: Mehari and Wencheko, 2013)

The young mothers in age group of 15-19 years are facilitated to be covered under ANC care than mothers in older age groups. The educated, employed and women from rich households are reported to be in advantageous position for availing the ANC services. Illiterate women living with co wives in pastoral communities are prevented from antenatal care. They have been deprived off birth preparedness, prevention of obstetric complications and knowledge about obstetric emergencies care. They are more prone to reproductive health hazards and maternal motility A significant section of rural women are reported for not being registered in antenatal care system for which they are deprived off availing timely treatment for obstetric emergency care services (Table 2).

A large chunk of women are handicapped to avail antennal care during pregnancy. This is a challenging reproductive health issue. Antenatal care during pregnancy covers following services:

i) Care before birth,
ii) Preparing women to develop delivery plan based on their expectations, needs, circumstances and resources,
iii) Provision of counseling, education, screening and treatment to pregnant mothers.

Different studies have validated that antenatal care and institutional deliveries lead to improved pregnancy outcome for mothers. Appropriate ANC visits by pregnant women facilitate their preparedness for delivery identification and mitigation of the risks associated with pregnancy. Failure of rural women to receive appropriate ANC during pregnancy not only leads to undesirable pregnancy outcomes but also maternal morbidity and mortality in Ethiopia. A large number of maternal deaths in Ethiopia occur during delivery at home, labor and within 24 hours of post-partum.

There are numerous socio – cultural factors that affect health care seeking behavior among pregnant women and lead to maternal deaths. These factors are:

- Unsafe home delivery,
- Genital cutting,
- Early marriage and exposure to adolescent reproductive health hazards ,
- Higher preference of women for more children,
- Birthing without skilled attendant,
- Poor preparedness for delivery,
- No attempt to identify pregnancy complications,
- Delay in seeking services of health professionals at health facilities,
- Non availability of adequate and appropriate treatment at health facility.

The globally accepted safe motherhood programme needs to be articulated at rural regions of Ethiopia for scaling down high maternal mortality. The pregnant women need to be prepared to handle obstetric complications by adopting following measures:

a) Timely registration of pregnancy
b) Awareness on danger signs
c) Preparedness for delivery
d) Plan for availing skilled attendant
e) Plan for transportation
f) Arranging a birth companion

The comprehensive packages of above interventions have geared up significantly educating families of pregnant women the importance of skilled birth attendant at delivery, encouraging and empowering religious and community leaders to work with community midwives and organizing informational campaign to enhance community awareness about benefits of institutional deliveries .

The cumulative effects of all above interventions have not only improved maternal health conditions but also increased proportion of rural mothers opted for deliveries assisted by skilled birth attendants during last couple of years. Greater focus has been given towards reduction of

infection, hemorrhage obstructed labour, abortion, obstetric fistula and hypertensive diseases experienced by rural mothers in pregnancies.

Conclusion

There is an urgent need to envisage a realistic solution based package incorporating low cost, low technology and reproducible interventions. The rural women experiencing prolonged or obstructed labour value pluralistic medical care. The community has little understanding that the consequence of obstetric emergencies or obstructed labour can be deadly if timely biomedical intervention is not sought. Biomedical maternal care need to be affordable, accessible and acceptable by community. It is reported that pregnant women experiencing emergency obstetric complications admitted that hospitals more quickly and offered services more effectively if they are registered in an antenatal care system.

The IEC (Information, Education and Communication) strategies need to be well designed to educate rural women and their families regarding risks of three delays and benefits of timely registration in antenatal care system. Because, the pregnant women registered in antenatal care system are more likely to get timely emergency care quickly than unregistered women. The evidence based studies have demonstrated the dramatic effects of antenatal care and awareness on reduction of maternal mortality and morbidity in resource poor settings. Multifaceted approach covering intensive community awareness on obstructed labour coupled with an efficient healthy system of prenatal care and competent accessible emergency obstetric services need to be designed for reducing the burden of obstetric fistulas experiencing by a significant section of pregnant women in rural areas. In rural areas, the men need to be sensitized about the reproductive health issues of their mothers, wives and encouraged to play an important role to strengthen the system of maternity care functioning effectively. There is an urgent need to gear up enhanced community support to structured programme of midwifery care through awareness creation combined with a vigorous community education and ongoing social marketing campaign. A community based system of training, supporting and utilizing local childbirth monitors be envisaged to adapt the circumstances in which skilled midwives are handicapped by lack of financial resources, logistics barriers and shortage of trained personnel.

The substantial and sustained reduction of maternal mortality can be achieved through continuum of care from the community to the first referral level, backed up by a public awareness program. Adequate referral and treatment to address the emergency obstetric complications is missing in rural settings. There is an urgent need to gear up community level interventions to enhance access to obstetric care environment around functioning health care facilities.

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