

DOWNLOAD PDF BEHAVIORAL DETERMINANTS OF CHILD HEALTH IN ETHIOPIA

Chapter 1 : Determinants of Full Child Immunization; Evidence from Ethiopia :: Science Publishing Group

According to the journal of Pediatrics and Child Health, "social determinants play a critical role in the early phases of conception, pregnancy and post-natal periods of children's development. Sensitive periods in brain and biological development start prenatally and continue throughout childhood and adolescence.

Recommendations to improve preconception health and health care—United States: Newborn screening for cystic fibrosis: Identifying infants with hearing loss—United States, — Toward a uniform screening panel and system [executive summary]. The black-white disparity in pregnancy-related mortality from 5 conditions: Differences in prevalence and case-fatality rates. *Am J Public Health*. US Socioeconomic and racial differences in health: *Am J Prev Med*. *Am J Obstet Gynecol*. The Social Embeddedness of Health. Do racial inequities in infant mortality correspond to variations in societal conditions? A study of state-level income inequality in the U. Despite an overall decline in U. Racial and ethnic variation in low birthweight in the United States: Socioeconomic Disparities in Adverse Birth Outcomes: *Am J Pub Health*. Family income gradients in the health and health care access of US children. *Matern Child Health J*. Office of the Surgeon General. HHS blueprint for action on breastfeeding. Breastfeeding and maternal and infant health outcomes in developed countries. From neurons to neighborhoods: The science of early childhood development. National Academy Press; The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. Neighborhood context and reproductive health. Infertility service use in the United States: *Natl Health Stat Report*. Infertility and impaired fecundity in the United States,

Other determinants of maternal health in Ethiopia are pregnancy related complications, access to maternal and reproductive health services, behavioral and nutritional status. A closer examination of the determinants of maternal health is important to inform policy makers and advocates invest on maternal health services in Ethiopia.

Review Article Childhood Mortality: This is an open access article distributed under the Creative Commons Attribution License , which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. Millennium Development Goal 4 calls for reducing under-five mortality rate by two-thirds between and The aim of this review was to assess trend of childhood mortality and its determinants from to in Ethiopia. A systematic literature search was conducted in the databases of PubMed and Ovid Medline, Cochrane Library, national medical journals, government websites, and Google Scholar. Original observational study designs and reports conducted entirely or in part in Ethiopia that included a primary outcome variable of childhood mortality and published between and were included. Ascertained relevant articles were appraised and the findings were integrated into a systematic review. Childhood mortality has declined in Ethiopia with more pronounced reduction over the last 10 years. Parental sociodemographic, socioeconomic, and behavioral variables and nutritional, environmental, and sanitary factors have been identified to affect child survival. Ethiopia has successfully achieved the Millennium Development Goal 4 to reduce under-five mortality. The objective of MDG 4 was to reduce mortality in children under-five years of age by two-thirds. Attaining the MDGs was expected to be tough for the developing nations [2]. As global drive for improving child survival rises, monitoring global and country level progress has become critical. The limited availability of data poses a significant challenge on generating accurate estimates of under-five mortality U5M , probability of dying between birth and the fifth birthday, for many developing nations [3]. Large and increasing differences are observed in childhood mortality among world regions. The rate of decline in childhood mortality CM , the probability of dying between exact ages of one and five, has accelerated over the past fifteen years [4], but high rates remain in sub-Saharan Africa where one child in every eight dies before age of five [5]. Few records available on CM in Ethiopia appear with different rates, underpinning the high CM burden. At the beginning of the MDGs neonatal mortality NM , probability of dying within the first month of life, and postneonatal mortality PNM , probability of dying between the 5th and 52nd week of life, were 63 and 70 while infant mortality IM , probability of dying between birth and the first birthday, and U5M were and per live births, respectively [7 , 8]. In contrast to the then set MDG 4 target of 68 deaths per thousand live births [9], there have been appreciable reductions in CM fifteen years down the road. Ethiopia appreciably performed well to cut child deaths. Despite the significant progress in reducing child deaths, children from poorer or rural households remain disproportionately vulnerable [3 , 9], as child survival interventions are not reaching the children who need them most. Childhood infections, breastfeeding, health service take-up, and maternal sociodemographic characteristics are known to have proximal effect on child survival while hygiene practices, standard of living index, and residence have distal effect [5 , 10 , 11]. The identification of country specific determinants of CM is a crucial step in planning and implementation of interventions [4]. So the aim of this review was to assess national progress in reducing childhood mortality and identify factors favoring and constraining the overall trend. Type of Records This review considers all observational study designs cross-sectional, cohort, and case control studies and government reports that assessed neonatal, postneonatal, infant, child, and under-five mortality and determinants of childhood mortality in Ethiopia. The records published between and were included. Meeting abstracts and editorial letters were excluded. Type of Outcomes This review considers records reported on primary outcome variable of neonatal, postneonatal, infant, child, and under-five mortality and cause and determinants of childhood mortality in Ethiopia. The literature search was more enhanced by browsing the websites of major publishers Oxford University Press, Wiley-Blackwell, Elsevier, and Nature Publishing Group and by searching the

references of the obtained records. For local grey literatures that were unavailable electronically, manual search was conducted in university libraries and health bureau. The following search terms were used: The search was peer-reviewed by ZB to increase its comprehensiveness. Selection of records was independently done by YM and SA. Differences between records were settled through discussion based on inclusion and exclusion criteria, reexamining the specific records jointly and consulting ZB for arbitration. ZB and SB verified the extracted data in order to reduce selection bias and minimize individual errors. Differences among researchers were settled by reevaluating the records until agreement was reached. Extracted information included i name of the first author, ii year of publication, iii objective, iv study area, v sample population, vi neonatal mortality, vii postneonatal mortality, viii infant mortality, ix child mortality, x under-five mortality, and xi causes and determinants of CM Table 1. In case of any missing information or uncertainty during records review, efforts were made to contact the authors for clarification. Characteristics of studies that met the inclusion criteria and were included in the systematic review. Synthesis of the Results Synthesis was done by constructing a clear descriptive summary of the included records. This was done by tabulating details about name of author, year of study or year of publication, number of participants, and major findings. Results were appraised in a descriptive way according to the facts extracted from each of the comprised records. Selection of records for this study is depicted in the flow chart Figure 1. Among records identified by manual search and online browsing, 48 were duplicates and discarded. Sixteen records were selected for a full-text analysis. Of these fully reviewed records, seven were later excluded as they did not fulfill the criteria. Flow diagram showing the procedure of selecting records for systematic review. Trend of Childhood Mortality Achieving the MDG 4 was always likely to be very difficult for low-income countries [2]. In “, neonatal mortality and PNM were 63 and 70, while infant mortality and CM were and 96 per live births, respectively. U5M during the same period was per live births [1 , 7 , 13 , 14]. Ethiopia was among the top five nations in NM. This means that one in every ten Ethiopian children dies before reaching age one, while one in every six does not survive to their fifth birthday [10]. Infant mortality and U5MR attained for the five years preceding the two surveys confirmed declining trend in mortality [5 , 9 , 10 , 13]. Neonatal mortality and PNM were 37 and 22 deaths per 1, live births, respectively. The survey showed a rapid decrease in infant mortality and U5M during the 5 years prior to the survey compared to the EDHS. U5M was also 59 per 1, live births, with one in every sixteen children dying before their fifth birthday [5 , 15]. The annual decrement for IM was 3. Neonatal mortality and PNM dropped from 63 to 23 and 70 to 22, respectively, with respective annual fall of 2. Overall trend on under-five mortality from to in Ethiopia [1 , 5 , 7 , 9 “ 13 , 15]. Determinants of Childhood Mortality Parental sociodemographic, socioeconomic, and behavioral variables and nutritional, environmental, and sanitary factors have been identified to affect child survival. Maternal Education The review revealed important role maternal education played in the reduction of child mortality. Records revealed that neonatal mortality [18] and U5M [19] were associated with parental illiteracy; particularly maternal education has a strong relation with CM [20]. Children born to mothers with secondary education had a significantly reduced IM [16 , 21]. Similarly in Jimma epidemiological assessment of determinants and causes of CM in , a reduction in death was observed in children of mothers with secondary or above level of education [22]. Further analysis of the EDHS reveals that risk of dying for a child born to uneducated mother was 2. In another study that analyzed birth history information of live births from the , , and EDHS to assess trends and determinants of NM in Ethiopia, neonates born to women with secondary or higher schooling had a lower risk of dying compared to neonates born to women with no education [25] Figure 4. Preceding Birth Interval Birth interval with previous child has a strong relationship with CM [20]. Analysis of the community and family survey data in Southern Ethiopia revealed that the risk of IM is significantly associated with short birth intervals of less than 18 months compared with an interval of 24“35 months [16]. In other records mortality among neonates [18 , 25 , 26] and infants [27] with a preceding birth interval of less than 24 months was found to be 2 times higher than those with a preceding birth interval of greater than 24 months. In epidemiological assessment of determinants of U5M in Jimma town, highest rate of death was observed in

groups with short birth interval [22]. In general, children born after long birth intervals lasting three years or more appear to have better survival chances in all these age periods [16]. This means that as the previous birth interval increased the risk of infant and child mortality decreased [29]. Age-specific mortality patterns indicate that the adverse effects of short interval are strongest in the infant period but appear to weaken in the 1â€”4 age categories [30]. Children from multiple births twins, triplets, etc. Under-five mortality by preceding birth interval in Ethiopia, [16]. Its effect except children born to mothers older than 20 years of age at first births has a significant impact on CM [29]. In particular, neonatal mortality and IM are very much influenced by the age of the mother [22]. Births to mothers in the age group of 15â€”19 face higher mortality risk than births to mothers in the age group of 25â€”29 or 30â€”34 [16]. Further analysis from the EDHS revealed that neonates born to mothers aged less than 18 years have higher mortality [25]. The risk of mortality is higher for children born from teenage mother and mothers aged 40â€”49 years 90 per [30] Figure 6. Marital Status of the Mother Single mothers had increased infant mortality compared to the married ones [22]. In both previous five-year periods of and , children born to married women play a significant role in the reduction of IM in comparison to children born to other categories [29]. In study of determinants of mortality among one- to four-year-old children in Ethiopia, a child born to currently unmarried mothers had a Breastfeeding The role breastfeeding plays in prolonging birth intervals and reducing fertility which in turn reduces CM is critical [16]. Further analysis in both and EDHS confirmed that breastfeeding is the most important factor for reducing IM and death rate was lower for neonates who were put to breast immediately upon birth [29]. Children never breastfed had higher risk of dying than those who were breastfed [31]. The likelihood of death among children who were not breastfed was 6 times higher compared to their counterparts [23]. A community based study done using verbal autopsy method in Gondar revealed that malnutrition is one of the causes of childhood mortality [33]. Childhood wasting, underweight, and stunting were also the main risk factors for under-5 mortality, but all improved dramatically during the MDG era [34] Figure 7. Trends in exclusive and complementary feeding in Ethiopia from to [5 , 10 , 11]. Infections Acute childhood diarrhea is the leading cause of death in children under five in Ethiopia, which is largely the result of lack of access to safe water, poor environmental condition, and crowded living conditions [35]. In Gilgel Gibe field research center , the most common causes of neonatal deaths were prematurity The main reasons of postneonatal and child mortalities were malaria, diarrheal diseases, meningitis, and pneumonia. Diarrheal diseases were the primary cause of death for children above one year. Figures from the three EDHSs also confirm that malaria, diarrhea, and pneumonia are the common causes of under-five mortality [5 , 10 , 11] Figure 8. Trends of the common causes of under-five mortality in Ethiopia from to [5 , 10 , 11]. Health Service Utilization One of the reasons behind the observed success in reducing under-five mortality has been the expansion of the coverage of health service. The health infrastructure and health extension programs have expanded significantly. As a result the ratio of health facilities to the population showed great improvements.

Chapter 3 : WHO | Social determinants approach to maternal deaths

Just as these social determinants shape unequal health outcomes and produce health inequities, it is being recognized that it is possible to improve health outcomes by analysing and acting upon salient social determinants 2.

Week 7 Activity 6- Social Determinants of Health Ethiopia- Michael Cooper When I think of social determinants of health I imagine all the factors that influence health rather positive or negative in our day-to-day lives. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature. Scientists generally recognize five determinants of health of a population, which are: This to me means the day-to-day factors that influence our lives for the better. Rather it be sex and age, drug use, or even as simple as our growing through education. These are all factors that keep a population thriving. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are what could be considered, beyond what a person can individually do to ones own health. That is, they are factors that are influenced from society not just individual behavior, which can have positive or adverse affects on health. Examples of social determinants of health include but are not limited to factors in educations, income, and even sex or gender. Though every country experiences social determinants of health, income seems to play the biggest role in societal growth. I chose to more so focus on adolescent health of Ethiopians in this blog, because the adolescents are the future of Ethiopia. How they develop and grow will one day affect the Ethiopian population and change lives in general. Sensitive periods in brain and biological development start prenatally and continue throughout childhood and adolescence. In the United States there are services readily available for people to use, if they are in distress and or ill. Many people would kill to have what Americans have. We should all take these factors into consideration and be thankful for what we do have. Adolescence and the social determinants of health. The Lancet, , Retrieved August 13, , from [http: Journal of Paediatrics and Child Health](http://Journal of Paediatrics and Child Health),46 11 ,

health seeking behavior, breast feeding, use of contra- ception, monogamy, low birth order, normal birth weight, child spacing, living in urban areas and good sanitation.

Received Oct 8; Accepted Apr This article has been cited by other articles in PMC. Abstract Background Antenatal Care ANC , use of skilled delivery attendants and postnatal care PNC services are key maternal health services that can significantly reduce maternal mortality. Understanding the factors that affect service utilization helps to design appropriate strategies and policies towards improvement of service utilization and thereby reduce maternal mortality. The objective of this study was to identify factors that affect utilization of maternal health services in Ethiopia. The independent variables were categorized as socio-cultural, perceived needs and accessibility related factors. Data analysis was done using SPSS for windows version Bivariate and multivariate logistic regression models were used in the analysis. Results Thirty four percent of women had ANC visits, Utilization of ANC, delivery and PNC services is more among more autonomous women than those whose spending is controlled by other people. Conclusion Maternal health service utilization in Ethiopia is very low. Socio-demographic and accessibility related factors are major determinants of service utilization. There is a high inequality in service utilization among women with differences in education, household wealth, autonomy and residence. Strategies that aim improving maternal health service utilization should target improvement of education, economic status and empowerment of women. Antenatal care, Delivery, Postnatal care, Maternal health service, Determinants, Skilled delivery attendant, Ethiopia Background Worldwide, approximately women die every day from preventable causes related to pregnancy and childbirth. In , about , women died worldwide during and following pregnancy and childbirth [1 , 2]. The key indicators to measure this goal are the proportion of pregnant mothers who received ANC and the proportion of births attended by skilled delivery attendants [1 , 3]. Despite proven interventions that could prevent death or disability during pregnancy and childbirth, maternal mortality remains a major burden in many developing countries. Maternal mortality continues to be a major challenge in Africa and the maternal mortality disparity between developing and developed countries is very high. Most women die because they give birth without the attendance of a skilled health worker [1 , 2]. Ethiopia is one of the countries with high maternal mortality. The MMR was per , in the year ; it was per , live births in and per , in Evidence shows that high maternal, neonatal and child mortality rates are associated with inadequate and poor-quality maternal health care [9]. Moreover, evidences also show that killed care before, during and after childbirth saves the lives of women and newborn babies. As a result, the use of ANC, skilled delivery attendants and PNC are recognized as key maternal health services to improve health outcomes for women and children [1 , 9]. The antenatal period is critically important for reaching women with interventions and information that promote health, wellbeing and survival of mothers as well as their babies. The objectives of this research are: The research answers the following questions related with utilization of maternal health services in Ethiopia. Which factors such as age, education, parity, ethnicity, religion, geographic location are related to maternal health service utilization in Ethiopia? The data are thoroughly analyzed using bivariate and multivariate logistic regression. The survey data were downloaded from Measure DHS website after data use permission was guaranteed. The first DHS was performed in and the second was performed in [11]. Study design It is a community based analytical cross sectional study. The data was collected from a representative sample of women in the reproductive age group age from all regions in Ethiopia. Study population Source population: Sample size A national representative sample of 17, households was selected for the study. From these households, a total of 16, women in the reproductive age group were interviewed using a structured questionnaire 8. For this study, women who had at least one birth in the last five years preceding the survey were included in the analysis. Sampling procedures A stratified, two stage cluster sampling procedure was used to identify the representative samples. An EA is a geographic area consisting of a convenient number of dwelling units. On the first stage,

EAs were selected from the total EAs using probability to proportional size method. Then, on the second stage, a fixed number of 30 households were selected from each EA. A total of 17, households were included in the interview 8. The sampling frame excluded some special EAs with disputed boundaries. These EAs represent only 0. In Somali region, all the listed households were not included in the interview due to drought and security reasons which makes the data for the region not representative. Data collection procedures A structured and pre-tested questionnaire was used as a tool for data collection. The questionnaire was developed in English and then translated into three different local languages Amharic, Oromiffa and Tigrigna. The questionnaire was developed based on standard DHS survey questionnaires. Structured interview schedules were performed by trained interviewers. In order to maintain the quality of data to be collected, interviewers were trained, a pretest was performed before the actual data collection, frequent supervision was performed during data collection and interviews were performed using local languages 8. Operational definitions Skilled attendants: Professionals who have midwifery skills including doctors, midwives and nurses. ANC by skilled attendants: Use of skilled delivery attendants: A more autonomous woman is a woman who can decide on health care spending alone or with her husband. If the decision of health care spending is controlled by others husband only or other people , it is considered as non-autonomous. Bivariate and multivariate analysis techniques were used during analysis. Frequencies were first determined followed by cross tabulations to compare frequencies. At bivariate level, analysis was made by the chi square X2 test for categorical variables. All the variables were included in the multivariate model once they were significantly associated at the bivariate level. This is because these variables showed an influence on the outcome variable and there is a need to identify whether each has been confounded by another variable or not. Whenever there is a non-proportional allocation of samples, use of sample weights is an important step during analysis [12]. During EDHS , there was some non-proportional allocation of the samples to the different regions and their urban and rural areas in order to compensate for places with very low family planning coverage and low fertility areas. In order to ensure the actual representativeness of survey results at national level, sampling weights are used during the analysis. The sampling used during the EDHS is a two-stage stratified cluster sample methodology. As a result, sample weights were calculated based on sampling probabilities separately for each sampling stage and for each cluster. The first stage is sampling probability of each cluster in each stratum and the second stage comprises of sampling probability within each cluster households selected. Computation of the sampling probability for clusters and households is computed based on what the EDHS have computed. The complete sample weight computation is available with the data set that we get from measure evaluation 8.

Chapter 5 : | Healthy People

Determinants of health are the biological, environmental, behavioral, organizational, political and social factors that contribute either positively or negatively to the health status of individuals, groups and communities.

Description of the Study Country 3. Objectives of the Project 4. Review of Literature 6. Conclusions and Recommendations 1. The majority of these deaths occur in Africa. Despite greater emphasis on the need to address the health of childbearing mothers, the progress of improving maternal health in Ethiopia is inadequate Tsegay et al. The annual maternal mortality rate in Ethiopia is estimated to be per , live births. More than 19 thousand maternal deaths occur annually due to pregnancy related complications in Ethiopia Tsegay et al. Lack of accessibility and availability of maternal health care services and shortage of skilled professionals are largely attributed to such high rates of maternal mortality in Ethiopia. Evidence suggests that, promoting social change and addressing social determinants of health can improve health outcomes. This paper will address major determinants of health in Ethiopia with particular emphasis 3 on maternal health. Maternal mortality, a key indicator of maternal health is attributed to inequalities in socio- economic, political and cultural conditions. The reduction of maternal mortality rate is dependent on effective family planning and reproductive health. Maternal health is also influenced by age, level of education, number of previous pregnancies, family structure, peer and community influence, the availability and accessibility of health care, legal, cultural and political environment. Addressing these factors is necessary to mitigate the problem of maternal mortality in Ethiopia. Ethiopia is currently implementing the Millennium Development goals MDG targeting social determinants of maternal mortality. Evidence has suggested that, economic empowerment and legal protection of women as well as policy changes to address harmful cultural practices and increasing access to education and economic independence of women are important approaches of reducing maternal mortality prevalence in Ethiopia. Description of the Study Country 4 Ethiopia is the second most populous country Africa next to Nigeria, with annual growth rate of 2. Of the total 83 million population, more than 84 percent live in rural area under subsistence agriculture. Despite long history of civilization, Ethiopia is the poorest country in the world with poor health care infrastructure. The country has poor performance in almost all measures of health indicators. The doctor to population ratio in Ethiopia is one for every , population. According to the United Nations Population Fund , the annual maternal mortality rate in Ethiopia is estimated to be per thousand live births, the highest among African countries. This is because more than 90 percent of all deliveries occur at home Tsegay et al. Delivery in the hospital is limited. Maternal health service utilization is limited due to inadequate access, poor quality and high cost. Although recent progress has been made, maternal health disparities 5 still exist in the rural areas. Objectives of the Project The overall objective of this project is to explore the socio-economic determinants and factors influencing maternal mortality rates in Ethiopia. This study will attempt to: Methodology A literature review on maternal mortality in Ethiopia was conducted using Walden library Academic Search Complete database and key words such as maternal mortality, Ethiopian life expectancy, maternal health, and social determinants of health, health inequality, inequality, disparity, cultural awareness, health literacy, and social 6 change. Only fifteen primary and secondary sources that met the inclusion criteria were used in the review. Review of the Literature The major causes of maternal mortality in Ethiopia are pregnancy related complications. The availability of health care services, socio-economic, cultural and religious factors are also responsible for high maternal mortality in Ethiopia. Large volume of literature review suggests that, socio- economic and demographic determinants of women, access and the tendency to seek care influence the utilization of maternal health services Addai, Although, women from higher socioeconomic group tend to utilize maternal health care services than their counter parts, education appears to be important determinant of maternal health Addai, Another factor determining the under utilization of maternal health care services in Ethiopia is cultural background or perception to ward illnesses Leslie and Gupta, ; Pelto, In the remote places of 7 Ethiopia, maternal health, the

utilization of maternal health care services is limited due to religious beliefs and poor perception about the effectiveness of modern health care services. Another important determinants of maternal health in Ethiopia are poor decision-making power of women on reproductive health and sexuality Mekonnen Y. Another important determinant of maternal health care service utilization in Ethiopia is accessibility. The lack of transportation and lack of good road condition are important determinants of accessibility to the nearest health care services. As a result, most deliveries occur at home. Studies on the determinants of maternal health care utilization in Ethiopia are limited. Most of these studies are focused on urban areas of Ethiopia. A study on maternal mortality conducted in Addis Ababa, showed that women who did not receive maternal health care services are the 8 poor and uneducated groups of the population Kwast and Liff, Discussions The subsequent sections of this discussion, health inequalities, social determinants of maternal health, health literacy, cultural awareness, social change and efforts and policy interventions will be discussed. Mothers from low socioeconomic status have higher maternal mortality rates than their counter parts. Availability of transportation, location and distance to health facilities influence maternal mortality rates in Ethiopia. Other determinants of maternal health in Ethiopia are pregnancy related complications, access to maternal and reproductive health services, behavioral and nutritional status. A closer examination of the determinants of maternal health is important to inform policy makers and advocates invest on maternal health services in Ethiopia. Improving health literacy and cultural awareness is one method of achieving successful public health services in Ethiopia. Public health professionals should have the necessary competencies and skills to work with low health literacy population in Ethiopia. Health literacy is affected by level of education, ethnic and linguistic background, cognitive and physical development, income and culture. In Ethiopia, women with low health literacy skills have increased risk for multiple adverse health outcomes. A typical example could be misuse of medications or prescription that may lead to permanent disability or death. Efforts or Interventions to reduce health inequalities: Challenges and Opportunities Recently, the Ethiopian government has recognized the importance of maternal health and the need to develop health care system to improve access. The Ethiopian Ministry of Health MOH in collaboration with other donor organizations and stakeholders are working to improve maternal health through funding, training and technical support to health workers Machel, The nation-wide community based Health Extension Program HEP , introduced in , and is now making an impact in terms of providing preventive services directly to women of reproductive age. Maternal health care services are an important focal point for health information delivery and services that encourage maternal health Birmeta et al. Some of the barriers for the successful implementation of maternal health program in Ethiopia are access, infrastructure, cost and inaccurate data presented to health officials about maternal mortality situations. So, there are opportunities for addressing barriers related to cost, access, resources and accurate data 6. Application of Positive Social Change The current social order in Ethiopia is the result of prolonged and bitter revolution to bring about radicalized changes in the life and culture of traditional Ethiopian society. Evidence suggests that, promoting positive social change and addressing social determinants of health can improve health outcomes mothers. Educational and economic empowerments of mothers are critical aspects of reducing maternal mortality rates in Ethiopia. Because, some 13 remote places in Ethiopia are disadvantaged on the incidence of maternal mortality than others. An intervention that targets the empowerment, education of women in those areas is required. Positive social change is needed to change the socio-economic and political conditions of women in Ethiopia. For example, reducing teenage pregnancy and avoiding early marriage practices are important measures to reduce maternal mortality in Ethiopia. Policy Development The health of mothers is not an individual issue. It is a societal, community and national issue because the health of women and mothers determine the prosperity of future of a nation Machel, So, identifying the factors responsible for poor maternal health outcome in Ethiopia will assist policy makers to propose public health policy or strategy that reduces 14 maternal mortality. Since women in Ethiopia are economically, politically and socially marginalized, sustainable, innovative and strong leadership on health equity and equality is needed to promote maternal health in Ethiopia. The Ethiopian constitution guaranteed

the right to health care service to all citizens of Ethiopia regardless of socio-economic status. Recognizing the increasing demand of health care services in the country, the Ethiopian government began to allocate large amount of resources to provide public health services to all citizens of Ethiopia. Conclusions and Recommendations The review demonstrates that despite greater emphasis on reducing maternal mortality in Ethiopia, the progress is still inadequate. The situation of maternal mortality is even worst among rural, uneducated and poor women. The most important determinants of maternal mortality in Ethiopia are socio-economic, cultural and demographic factors. These finding have policy implications. For example, study suggested that education improves maternal health care utilization. Because rural women have limited accessibility, availability and utilization of maternal health services, an intervention that targets the empowerment, improvement of income and education of women is required. Traditional religious and cultural practices have negative impact on the utilization of maternal health services in Ethiopia. Education targeting on these practices have important policy implications. Finally, tackling 16 poverty is an urgent national concern for improving maternal health in Ethiopia. Determinants of use of maternal-child health services in rural Ghana. *Journal of Biosocial Science* 32 1: Review of Maternal Mortality in Ethiopia: A Story of the Past 30 Years. *Ethiopian Journal of Health Sciences*, 24 Suppl , 3â€™ Determinants of maternal health care utilization in Holeta town, central Ethiopia. *African Health Sciences*, 11 1 , â€™ Health Literacy Community Youth Mapping. Factors associated with maternal mortality in Addis Ababa, Ethiopia. *International Journal of Epidemiology* 17 1: Utilization of formal services for maternal nutrition and health care. International Center for Research on Women. Investing in the Life of Healthy Societies and Economies. Africa Progress Panel Policy Brief. Cultural issues in maternal and child health and nutrition. Determinants of maternal health service utilization in Ethiopia:

Chapter 6 : Childhood Mortality: Trends and Determinants in Ethiopia from to –A Systematic Review

A community-based cross-sectional study was conducted in Nekemte town, western Ethiopia from 15 October - 26 November, mothers of index under-five children living in the households selected randomly from Kebeles in the town constituted the study population.

Subha Sri, CommonHealth India. It is adapted from a chapter in a forthcoming volume: Nambiar D, Muralidharan A. *The Art of the Possible: Forthcoming with Orient Blackswan*. Political choices and social organization that distribute power and resources unequally across populations reproduce unequal health outcomes. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries¹. Just as these social determinants shape unequal health outcomes and produce health inequities, it is being recognized that it is possible to improve health outcomes by analysing and acting upon salient social determinants². This then is the essence of the social determinants approach that we use to analyse Maternal Health. Additionally, we recognize that health inequities because of structural factors like unequal opportunities, unequal access to resources and power inequalities are an issue of social justice and therefore of human rights. Thus a rights perspective is congruent with the social determinants approach. A discussion paper by UNDP² describes a framework to analyse the structural and social determinants of maternal health. Figure 1 shows the elements of the framework. The categories of factors as described in the framework are: In the framework proposed by WHO, although cultural and social norms are presented under structural factors, we believe that they also stem from the community context and can also be considered as intermediary factors. Policy into Practise on Social Determinants of Health. This case study describes a collaborative effort in India the Dead Women Talking Initiative to illustrate the implications of a social determinants approach to maternal deaths. Detailed description of the DWT initiative is given elsewhere in this document. Here we describe the results from the documentation of maternal deaths across 10 states and 31 districts in India using the SDH framework described above. The deaths were documented between January and December Results The framework described above is used to discuss social determinants of maternal health at the individual, family, community and health system level. Certain structural factors – policies and programmes - that resulted in system induced vulnerabilities are also described. Individual attributes Age and parity Majority 78 out of of the women who died were very young, less than 25 years old. Further, 26 of them were between 16 and 20 years of age and all except one of them were married. Almost 40 percent of the women died during their first pregnancy and another 38 percent during their second or third pregnancy. At the other end of the spectrum were older women with a history of several pregnancies. Work In addition to being responsible for their daily household chores, most of the deceased women were wage labourers or agriculture workers. Some of them were also migrant workers and some worked until the last month of their pregnancy. Four of the women were community level workers in public institutions - the lowest and most peripheral workers in the hierarchy of these institutions. Altogether, it was very likely that these women came from extremely poor conditions. Community factors Caste and Religion Almost 45 percent of the women who died were from scheduled tribes and a further 17 percent were from scheduled castes¹. Migrants At least six out of the women who died in this sample were migrants either from within the state or from other states. Geographical location Another group of women who were especially vulnerable and were excluded from care were those in remote hamlets, a typical feature of most tribal villages as well as most of rural India. Families revealed that these hamlets did not receive any services at all. Her family had been resettled because her village was in an area declared a tiger reserve. The resettlement village was 10 km away from the road and was inaccessible during the rains. There was no Anganwadi Centre² in the village, the ANM did not visit there and no immunization took place. Sheela, who was pregnant with her first child, did therefore not have any antenatal care. She delivered at home, developed post-partum haemorrhage and died before the family could get a vehicle to transport her to a

facility. Son preference as an overarching determinant of maternal death came up in the stories of two women. One of them was diagnosed with a heart ailment in her earlier pregnancy. She already had three children including one son, but the desire for two sons, propelled her to the fourth pregnancy despite her family being aware of the risk. In another maternal death case, social stigma and lack of care was highlighted in relation to the pregnancy of an unmarried woman, dying after an unsafe abortion. Health system factors Lack of availability of emergency obstetric care Lack of availability of emergency obstetric care and its poor quality emerged as a significant issue from our analysis of maternal deaths. In at least 38 of the maternal deaths there was a clear lack of adequate health care services the so called 3rd delay 3. Blood “ a critical gap Blood seemed to be unavailable in emergencies. In situations of emergency, blood transfusion was either delayed or inadequate. This was noted for at least 46 percent of the maternal deaths we documented, with probable causes of death such as post-partum haemorrhage, anaemia and ante-partum haemorrhage. Absent or inadequate antenatal care At least 12 of the women who died had not received any form of antenatal care at all and anaemia was the cause of 22 deaths contributing to at least 4 more deaths. Prevention, detection and treatment of anaemia did not seem to be a priority during antenatal care. Absence of post-partum care Of our sample of deaths, 82 deaths took place in the post-partum period, with 52 of these happening in the first 24 hours after delivery. However, post-partum care was found to be highly inadequate both within the facility and in the community. Post-partum care largely seemed to be absent in facilities and women were discharged soon after delivery and families left to fend for them in the case of any complication. Once the woman was discharged from a facility, there seemed to be no system of following her up at home and providing any care to her. Referrals and emergency transport Referrals and emergency transport. Of the maternal deaths documented, women attempted to seek care in a health facility and died either in a facility or on way to it. Further, due to refusal by the admitting hospital due to lack of funds and other reasons³⁶ of the women who dies visited three or more facilities seeking care when they were faced with an obstetric emergency. One of the women visited as many as 7 facilities in search of care. While there was difficulty in getting vehicles to transport women from one facility to another, families often also narrated that they faced difficulties in getting designated ambulances or vehicles to come to their homes to pick up women during an emergency. Structural Factors Several system-induced vulnerabilities could be seen in the narratives. Policies and programmes of the government meant to improve health outcomes, actually affect the most vulnerable most adversely. The ANM however insisted that her husband should undergo sterilization as they already had two children. In this scenario, no antenatal care was provided to Shanta this time, nor did she seek care. She later delivered a boy who however died of prematurity. Shanta went into depression and died four months later of a worsening infected ulcer on her leg. Another case in point is the Janani Suraksha Yojana “ a cash incentive program to promote institutional deliveries. In the sections above, we described how individual, family, community and health system as well as structural factors interact to produce adverse “ in fact “ fatal consequences for women. Many of the women whose stories we documented were socially, economically vulnerable, from social groups that have been historically deprived of the fruits of modern development. In several of their lives, these multiple vulnerabilities coalesced to produce cumulative effects. Previous studies have also shown that these groups have a disproportionately higher maternal mortality as compared to women from more privileged socioeconomic groups. A rights-based approach to providing universal access would focus on equity and social justice and make special provisions for women with vulnerabilities to ensure they definitely have access to care. However, based on the narratives of the deaths, it seems that women with vulnerabilities are actually getting left out of services like antenatal and post-partum care because of the way health services are structured and delivered presently. While health sector response in terms of provision of quality antenatal, intrapartum, postnatal and emergency obstetric care, along the maternal health continuum is critical, it is not enough to stall maternal mortality. Maternal Health services cannot be improved in isolation. Maternal health care services have to be contextualized within the broader comprehensive primary health care approach “ only then will social determinants of maternal health be addressed. This will also ensure addressing other

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health issues like anaemia and infectious diseases convergent with maternal health care. Maternal health services also need to be located within broader reproductive health services offered at primary health care level, across the life cycle – adolescent health and nutrition, contraception, safe abortion services, reproductive tract infections and so on. Longer term policy action is required to address the social inequities that disadvantage the scheduled castes and scheduled tribes, to invest in programmes that will improve their education and health status – provide more facilities and delivery points, additional skilled providers in remote areas. Strong and effective governance is required to ensure that equity policies and programmes introduced by the government. Governance is also required to regulate the private sector and ensure that it provides quality essential maternal health services, without corruption. Inter-sectoral coordination is required to address several intermediary factors like roads and transport systems, nutrition and food security, safe and healthy workplaces as well as violence against women. The inter-sectoral coordination has to permeate from the policy and programme design level to the community level with coordinated services being provided through the ICDS and women and child development, health and education department at the very least. In addition to the individual attributes of women that may contribute to maternal deaths, we highlighted the community factors – mainly their historical disadvantages like belonging to the scheduled caste and scheduled tribes social groups – as well as health system factors and structural determinants, that contributed to their deaths. Recognition of the social and structural determinants is the first step to begin addressing the reasons underlying maternal deaths. Action is required at all levels – level of the individual woman and her family and community, the health systems level, and at the structural level in terms of developing the requisite policies and programmes. Notes 1 Scheduled castes and scheduled tribes are historically disadvantaged groups in India that are recognized and given a special status under the Indian constitution for affirmative action. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health education, immunization, health check-up and referral services of which the latter three services are provided in convergence with public health systems. References 1 CSDH Closing the gap in a generation: Roles for Development Actors, Discussion Paper. Bureau for Development Policy. Too far to walk: Maternal health policy in India: CommonHealth, Jan Swasthya Abhiyan; Maternal and Perinatal death inquiry and response. An investigation of maternal deaths following public protests in a tribal district of Madhya Pradesh, Central India. Economic and Political Weekly. Why it exists and how we can change it. Women and Gender Equity Knowledge Network.

Chapter 7 : Social Determinants of Health | CDC

on the determinants and trends of infant and young child feeding practices in Amhara Region, where Alive & Thrive is implementing its program in partnership with the Ministries of Health and Agriculture.

Chapter 8 : Maternal, Infant, and Child Health | Healthy People

socioeconomic determinants of child health emphasize the effects on health of several constraints such as parental knowledge, physical resources, and government programs, along.