no. 43 Researching maternal, neonatal and child health service use in rural and pastoralist Ethiopia: A key informant research approach

Rosey King, Ruth Jackson and Elaine Dietsch
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Researching maternal, neonatal and child health service use in rural and pastoralist Ethiopia: A key informant research approach

ABSTRACT

Like many nations in sub-Saharan Africa, Ethiopia has both a high neonatal mortality rate and maternal mortality ratio and is unlikely to meet Millennium Development Goals 4 and 5 by 2015. This working paper examines how Key Informant Research (KIR) in rural and pastoralist Ethiopia will identify facilitators and barriers to the use of maternal, neonatal and child health services. The methodology is informed by Participative Ethnographic Evaluation Research (PEER) and Key Informant Monitoring (KIM). Key Informant Research (KIR) training will provide research skills to Health Extension Workers (HEWs) and Non-government organisation (NGO) staff to enable them to develop research questions, collect data and participate in preliminary data analysis. This will enable the identification of strategies that improve the identification of risk, enhance early referral, increase access, affordability and acceptability of skilled birthing services in rural and pastoralist Ethiopia.

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Abbreviations

ADRA  AusAID Development Research Award Scheme
ANC  Antenatal care
AusAID  Australian Agency for International Development
CSA  Central Statistical Authority
DHS  Demographic and Health Survey
EmONC  Emergency Obstetric and Newborn Care
HEP  Health Extension Program
HEW  Health Extension Worker
HSDP  Health Sector Development Program
KIM  Key Informant Monitoring
KIR  Key Informant Research
MMR  Maternal Mortality Ratio
MDG  Millennium Development Goal
MOH  Ministry of Health
PEER  Participative Ethnographic Evaluation Research
NGO  Non-government organisation
NMR  Neonatal Mortality Rate
TBA  Traditional Birth Attendant
TT  Tetanus Toxoid
WHO  World Health Organization

Introduction

The purpose of this working paper is to describe how researchers from Deakin University, University of Ballarat, University of Addis Ababa and Charles Sturt University are investigating ways to increase maternal, neonatal and child health (MNCH) service use in rural and pastoralist Ethiopia. The project is funded through the 2013 AusAID Development Research Awards Scheme (ADRAS). It uses a Key Informant Research (KIR) design. KIR is a methodology that has been adapted from the Participatory Ethnographic Evaluation and Research (PEER) approach (Price & Hawkins 2005, 2002) and informed by the Key Informant Monitoring (KIM) tool used by the Nepal Safer Motherhood Project (NSMP) (Price & Pokharel 2005). Our aim is to find innovative ways to improve the skills and capacity of Health Extension Workers (HEWs) and NGO staff in Ethiopia to increase the use of MNCH services. We will train HEWs and NGO staff to interview women and other local community members. HEWs and NGO staff will provide their own insights into barriers and facilitators of access to skilled care at birth. Data from the research will be used to provide insights and recommendations to improve the use of MNCH services.

This working paper provides background into the status of the Ethiopia’s MNCH and strategies currently being used to enhance MNCH. A brief introduction shows how the selected research methodology has been adapted from, and been informed by, PEER and KIM methodologies. PEER and KIM methodologies are described and three examples cited to highlight the advantages of using this methodological design in international development research. The rationale and process for using KIR is explained, as is the application of KIR methodology to this project and the limitations in its use.

Background

Reducing maternal and neonatal mortality in Ethiopia presents serious challenges for the government and NGOs as only 10 percent of nearly three million women per year receive skilled care at birth (Central Statistical Authority (CSA) and ICF International (ICFI) 2012). Ethiopia aims to achieve the Millennium Development Goals (MDG) 4 and 5 by improving
childbearing women’s access to skilled care at birth and strengthening facility-based MNCH services (CSA and ICFI 2012). The Ethiopian Ministry of Health (MOH) aims to increase institutional births attended by skilled health workers to 62% by 2015 (Ministry of Health (MOH) 2010). Ethiopia’s strong political leadership, conducive donor environments and well-coordinated health strategies prioritise MNCH. Nevertheless facilitating women’s access to skilled care at birth remains a challenge (AusAID 2010).

The emphasis so far has been on task-shifting Emergency Obstetric and Newborn Care (EmONC) services from specialists to midlevel providers, and improving access to EmONC by training health officers, midwives and nurses (for a census of EmONC services see MOH 2008). Additionally, a large cadre of HEWs at the community level provide an opportunity to reduce the first delay – the recognition of childbearing complications and the decision to seek EmONC (Thaddeus & Maine 1994; Barnes-Josiah et al. 1998; Jackson 2008, 2010). The Reproductive Health Strategy (MOH 2006a) and Health Sector Development Plan (HSDP) IV (MOH 2010) aim to reduce maternal and neonatal mortality based on an enhanced referral system. HEWs at the community level help with birth preparedness and complication readiness; and mobilisation of communities to facilitate timely referral to mid-level service providers (health centres) who in turn refer to hospitals that are equipped and staffed to provide comprehensive EmONC services if required. This “flagship” or referral system is the key to reducing the delays that currently contribute to maternal mortality and disability. More recently, the Road Map focused ‘on achieving targets of major components of maternal and newborn health, and strengthening health system and the capacity of Individuals, families and communities to improve Maternal and Newborn Health’ (MOH 2012, p. v). The main objective of the Road Map is to reduce the Maternal Mortality Ratio (MMR) to 267 per 100,000 live births and the Neonatal Mortality Rate (NMR) to 15 per 1,000 live births by 2015. Its specific objectives are to:

(i) strengthen the capacity of Individuals, Families and Communities to improve Maternal and Neonatal Health
(ii) increase skilled attendance during pregnancy, childbirth and postnatal period;
(iii) scale up the provision and utilization of quality Basic and Comprehensive Emergency Obstetric and Neonatal care;
(iv) increase use of key newborn care services and practices by households;
(v) increase access to Family Planning information and services at all levels;
(vi) strengthen the Health System Management and Partnership to Deliver Effective and Efficient MNH Services (MOH 2012, p. vii).

By 2014, all neighbourhoods or kebeles, the smallest administrative unit in Ethiopia, should have functional, women-centred health development teams. Each team is comprised of up to 30 women who work as a team to support the HEWs to enhance and consolidate the implementation of the health extension program (HEP). Development teams should be engaged in local-level behaviour change strategies based on shared discussion and building capacity to network with other groups or institutions (e.g. village leaders, religious leaders, health providers) (MOH 2012). The health development team and HEWs are both involved with improving the uptake of key MNCH services and should disseminate information to create demand and awareness of:

• pregnancy-related danger signs and the benefits of seeking skilled care,
• birth preparedness and complication readiness
• importance of antenatal care, skilled birth attendance, postnatal care (PNC) and family planning
• the negative health and social consequences of Harmful Traditional Practices (HTPs) associated with pregnancy and delivery,
• proper nutrition and micronutrients (MOH 2012).

Currently, of the 90% of women who birth in the community, only 0.8% percent are supported by HEWs at the community level, and the remainder birth alone or with the assistance of a family member or friend). Of the women who are referred to health facilities, only 15% are referred by HEWs (CSA and ICFI 2012; Hadley et al. 2011). Koblinksy et al. (2010) argues that there is an urgent need to increase HEW self-confidence and provide additional strategies to
increase demand for MNCH services. HEWs can provide community services including family planning, hygienic delivery through partnerships with Traditional Birth Attendants (TBAs), active management of the third stage of labour, an immediate post-partum visit to the mother and newborn to ensure breastfeeding support, continued promotion of birth preparedness and complication readiness, and knowledge of and communication means with a referral centre.

A recent report by Save the Children, Surviving the First Day: State of the World’s Mothers 2013, has identified that while there has been significant progress in reducing overall child mortality, the NMR remains highest in Sub Saharan Africa (34 deaths per 1000 births) (see also CSA and ICFI 2012). Overall Ethiopia has the sixth highest rate of newborn deaths and also the sixth highest number of first day newborn deaths (Save the Children 2013).

Reported causes of the higher NMRs and MMRs in Ethiopia are common to many developing countries. They include widespread poverty, low educational attainment, inadequate infrastructure and resources; and traditional practices and beliefs where childbirth is considered to be a natural process with no need of trained midwives in attendance; and there is delayed detection and referral of complications for mother or neonate. Because birth normally occurs at home; traditional healers may be utilised with limited referral pathways between these health care providers and mainstream medical, midwifery and nursing services (Dynes et al. 2013; Tesfay Gebrehiwot et al. 2012; Wild et al. 2010; Afsana & Rashid 2009; Price & Hawkins 2002; Karlsen et al. 2011).

There are many barriers that affect women’s ability to be able to access health care in developing countries such as Ethiopia including:

- Physical accessibility such as distance to a health facility;
- Travel time from home to the facility;
- Availability and cost of transportation;
- Decision-making (a woman’s husband is usually the key decision maker);
- Cost of services and medical supplies;
- Shortages of supplies (including clean birthing kits), equipment and trained health personnel; and,
- Unacceptability of institutional care by skilled birth attendants (Thaddeus & Maine 1994; Barnes-Josiah et al. 1998; Jackson 2010; Dietsch 2010a; Ministry of Health 2006a, 2006b).

The Research Project

This research project will explore current MNCH service utilisation, facilitators and barriers to women’s access to services at the kebele level. Decision making about ongoing utilisation of available local antenatal care (ANC), birthing and family planning services for the well woman and also decision making processes which occur within the community when a woman or newborn require EmONC will be explored. We have chosen to adapt PEER and KIM methodology to inform the Key Informant Research (KIR) selected for a number of reasons.

PEER has generally been used where the identification and selection of peer researchers are relatively homogenous which has made ‘selection of representative peer researchers unproblematic’ (Price & Pokharel 2005, p. 152). In this project, HEWs receive training to enable them to collect data ethically through interviewing women and key community members in their own local areas. They will then play a role in analysing the collected data in readiness for dissemination. In contrast to the established principles of PEER research, where PEER researchers do not have any pre-existing ‘special’ status in the community (e.g. being a teacher, peer education, community leader or health worker, this study will use HEWs as both data collection agents and preliminary data analysers. HEWs have ‘special’ status in that they are salaried government employees, commonly recruited from their own community. The criteria for recruitment is that they are at least 18 years of age, have grade 10 education and speak the local language.

HEW participation in a research role is important because they are female and because most health packages they deliver relate to issues affecting women and children; meaning that communication between women and HEWs is more likely to be culturally acceptable. The HEWs are assigned to kebeles (each kebele has a health post that serves around 5,000 people and functions as the operational centre for the HEW). HEWs work directly
with individual households, spending around 75% of their time visiting families in their homes; providing ANC, vaccinating children, and providing contraceptives to women (Araya Medhanyie, Spigt, Yohannes Kifle, et al. 2012; Araya Medhanyie, Spigt, Dinant, et al. 2012; Koblinsky et al. 2010).

We acknowledge that normally HEWs do not assist during many births at home and do not assist birthing women at the health post. HEW have many additional commitments to outreach activities, and they have only basic training in assistance during births at home. The project will utilise HEW and community knowledge to develop strategies which can support the HEW to enhance birth preparedness, early identification and referral for those women deemed at risk (Araya Medhanyie, Spigt, Yohannes Kifle, et al. 2012).

It is likely that HEWs are members of the same social groups as women in their kebeles so they would need less time to develop ‘rapport building typified by conventional anthropological ethnography’ (Price & Pokharel 2005, p. 153). Research also shows that women feel they have a positive interpersonal relationship with HEWs, knew HEWs in person, and preferred to receive health related information or advice from HEWs (Zewdie Berhanu et al. 2013). The starting point for both KIR and KIM is that the ‘social context is important in shaping maternal health outcomes and maternal health-seeking behaviour’ (Price & Pokharel 2005, p. 154). An adaption of this method will enable us to have access to trusted informants with local networks (HEW ) and will enable an in depth exploration of the complex issues which inform and determine decision making in rural and remote communities.

**PEER/KIM Methodology**

The PEER methodology adapted for this project has been commonly used in a number of ‘geographical and programme settings’ (Price & Pokharel 2005, p. 154) to monitor and inform international development interventions and programs focused upon human sexuality and reproductive health, including the take-up of family planning and women’s use of skilled care at birth. It has proved very effective in identifying sensitive data about intra-community and intra-household power and gender relationships; with consequent effects upon health seeking behaviour and decision-making. Many of the insights provided by these interviews and evaluations have potential resonance with the Ethiopian project. Three examples of these studies are discussed below. Other examples are available on the OPTIONS website http://www.options.co.uk.

The researchers in this project will adapt the PEER/KIM methodology for data collection. Following PEER/KIM methodological principles, we will enlist and train members of a particular social group or network to become researchers. In this study, we will be training HEWs as these women are embedded in the communities where the studies will take place. The KIR researchers will conduct interviews with a small sample of individuals from their own social network, or ‘people that they know’. During interviews, the aim is to find meaning that people ‘attribute to the social behaviour of their peers’ so interviewees are not asked to talk about themselves but ‘others like them’ (Price & Pokharel 2005, p. 153; see also Price 2002, p. 4).

Interviewees are more likely to be comfortable and able to disclose information that is already hearsay and in the public forum. Interviewees will talk about other women or other issues that they know of, thereby providing information in the third person. Interviewees, will not talk about their own personal experiences, they will not disclose what is personal and private. The data is collected over a relatively short period. KIRs will record data on specially designed data collection sheets. The data will record key words, terms or narratives that are analysed collaboratively with the interviewee at the completion of the interview. In keeping with the principles outlined by Price and Hawkins (2005), members of the research team will regularly supervise and debrief the KIR throughout the interview period.

In the first cited example, (Nepal Safer Motherhood Project), the PEER methodology was adapted to monitor accessibility to midwifery and obstetric services and women’s social status and mobility (Price 2002; Price & Pokharel 2005). Key Informant Monitoring (KIM) ‘takes as its starting point that the wider social (including religious, cultural, economic and political) environment is important in shaping maternal health outcomes and maternal health seeking behaviour’ (Price 2002, p. 10). Key informant researchers selected a minimum of two women of childbearing age and carried out a series of three conversational interviews with each respondent. Women were asked about their perceptions of barriers to EmONC services; quality of midwifery and obstetric care; and social mobility (e.g. measured through perceived
improvements in communication with mother-in-law and husband, to reflect improved ability to make decisions regarding health-seeking behaviour).

In interviews enquiring about recognition of obstetric danger signs and the role of medical services, women described a general recognition of risk and life threatening obstetric problems and outlined a series of barriers to them being able to act on these danger signs. Some of these factors included women’s low social status whereby, they were unable to refuse the ‘husbands insistence on having sex during labour and shortly after birth; or the husbands expectation that women continue domestic and agricultural labour shortly before and after delivery” (Price & Hawkins 2002, p. 14). Even if women had personal assets, their husband often controlled these assets and the women may be unable access them. Husbands were discouraged from offering help or support to their wives before and after childbirth. Other issues included, dietary traditions and taboos that meant pregnant and postpartum women ate less nutritious foods. There was a lack of knowledge among men and older generation women (mother-in-laws) about the potential risk of bleeding and high parity during the antenatal; intrapartum and postnatal period. Other barriers included cost of access to services and a perception that medical services were expensive; did not give credit and were not good quality. There was also a general perception that traditional services were more affordable; treated the women well, did home visits and may treat the real (spiritual) causes of the ailments. (Price 2002).

Findings from the KIM interviews (Price 2002) have relevance to this project as possible factors that may act as possible facilitators and barriers for rural and pastoralist Ethiopian women accessing MNCH services, including:

• Perceived roles of different care providers (traditional and allopathic);
• How women who need to get to hospital access finance and transport (including broader constraints to accessing these resources);
• Perceptions of the availability, acceptability, affordability and effectiveness of care;
• Women’s relationships with husband and mother-in-law;
• Perceptions of wider social constrains/practices.

The second example is from a project about reproductive health in the Guraghe Zone, Ethiopia, auspiced by Marie Stopes International (Hemmings et al. 2008a). This PEER study investigated the social context of decision making around reproductive health in particular, attitudes to family planning and access to abortion and post abortion services. A group of 15 PEER researchers was selected as representative of the study group; that is, women of reproductive age; living in village and rural settings, with no position of authority in the community. The women participated in a four-day training workshop and worked with principal researchers to identify and clarify key issues to be explored. The PEER researchers practiced obtaining informed consent; learned about third person interviewing and practiced interviewing techniques with their colleagues. Over the next 10 days, each PEER researcher carried out interviews with a couple of friends, supervisors collected the data from the research team every few days. Data analysis was conducted with PEER researchers participating in a final workshop and again later by the research team utilising thematic analysis of the data (Hemmings et al. 2008a).

The main findings provided information about women’s perception and attitudes to family planning methods, access to abortion and post abortion care; attitude to child spacing and family size. Men’s role in controlling or vetoing the use and choice of contraceptives limited many women’s capacity for shared decision-making and many employed family planning methods without telling their husbands. Male gender norms meant that men were ridiculed if they participated in housework or child-care responsibilities. Some gender norms were perceived to be changing, for example, less tolerance of harmful traditional practices such as female circumcision and gender violence, and strong and well-educated women could exercise their human rights. Education for young girls was not a priority and young women; particularly those living in towns and away from the protection of their family, were extremely vulnerable to sexual exploitation and violence. Poverty and traditional attitudes about gender roles affected women’s health and health seeking behaviours. For example, traditional dietary practices meant that pregnant women and mothers were the last to eat, placing women at additional risk of malnutrition and hunger. Women were responsible for income generation and housework and this was hard work.
Women did not prioritise their own health, but relied on other mothers and knowledge from health professionals (including HEWs) as reliable sources of information on reproductive health matters.

The evaluation from the Ethiopian study (Hemmings et al. 2008a) provided information that helped focus health messages and other strategies. There were a number of beliefs about the discussion and use of contraception that could be strengthened, and a number of other traditions such as dietary traditions; expectations about number of children and lack of importance of personal health concerns could be challenged and changed. The study identified a number of opportunities for communication including:

- Facilitating discussion groups: women responded very positively to the opportunity to discuss reproductive health, relationships etc. in groups;
- Through coffee ceremonies, marketplaces, Iddirs and other associations;
- Building the capacity of health extension workers with materials and skills;
- Through teachers and schools;
- At building sites and commercial farms (Hemmings et al. 2008a, pp. 6-7).

The study also found that:

- Service fees may make access unfeasible for poor women (especially for safe abortion, which costs about one month’s salary for women in this area) so alternative financing options (vouchers, exemption schemes etc.) to ensure access for the poor were required;
- Men and men’s groups should be targeted for health promotion in areas and on occasions where they gather;
- Mass media messages should be simple and memorable to facilitate repetition to friends without loss of accuracy (Hemmings et al. 2008a, p. 7).

In the final example, Hemmings et al. (2008b) utilised the PEER method whilst conducting a study investigating attitudes and behaviour related to reproductive health among vulnerable ethnic communities in three provinces in Southern Laos. In particular, community attitudes to family planning; utilising clinics and trained health care providers during birth; with an exploration of reasons why these communities are not utilising existing reproductive health services. However, rather than looking at ‘barriers to access’ (which implies that people want to access services but are prevented from doing so), the study asked ‘Why are ethnic groups not making full use of available reproductive and maternal health services, and what might prevent them from doing so in future?’ (Hemmings et al. 2008b, emphasis in original).

Findings from the Laos study highlighted that participants had negative perceptions of health services and service provision; and there was an absence of a perceived need for services. The cost of services was unpredictable and unaffordable, with associated costs of travel and a loss of time taken to access services. Participants had other priorities for money and were commonly very cash poor and reluctant to borrow cash required. If they did go to the clinic, they reported that staff sometimes treated them rudely. Many marginal ethnic groups felt threatened by development and the introduction of new ideas and behaviours. Promoting family planning and access to a skilled birth attendant were perceived as another assault upon their traditional lifestyle and practices. Consequently, there was some resistance to the new ideas and proposed behaviour changes (Hemmings et al. 2008b).

Other important factors included a lack of community engagement and participation with the services and the service plan. The community had no opportunity to discuss and identify what their own reproductive health priorities and needs might be. People were unfamiliar with services and the new technologies e.g. family planning. Men retained decision-making power but did not have an understanding of reproductive health or gender equality.

Three priority areas of behaviour change include an increased knowledge and awareness was required, of family planning for men and women, including potential and perceived risks. The community needed more engagement and capacity building to enable them to make healthy decisions when planning childbirth and in responding to obstetric emergencies. Finally it was determined that linkages be built between communities and health services in order to promote attendance for ANC and skilled birth attendants (Hemmings et al. 2008b).
Design and methodology for this project

The Key Informant Research methodology can be used to good effect to answer the following research questions in rural and pastoralist Ethiopia:

- What is the current MNCH service utilisation behaviour of pregnant women?
- What are the gender-related, socio-cultural, economic and practical facilitators and barriers to women accessing MNCH services for birth?
- What factors are associated with MNCH service utilisation?
- What is the association between HEW training, NGO maternal health programs and MNCH service utilisation?
- How can women in rural and pastoralist Ethiopia be encouraged to give birth with skilled birth attendants?

We suggest that using Key Informant Research (KIR) informed by PEER/KIM methodology will be effective for our purposes because it is adapted from traditional ethnographic approaches and has developed to facilitate genuine and rigorous engagement with communities. As illustrated in the examples provide, PEER and KIM methodology can identify social behaviours and the context in which reproductive health rights and decision-making enacted. The methodology enlists the support of trusted insiders or informants, who act as researchers; they undertake a brief training program and subsequently identify other members of the community who can be suitable as interviewees (Price & Hawkins 2005). This methodology is particularly useful when working with disempowered or vulnerable groups, where access by outsiders to sensitive information about sexuality, relationships and reproductive health is problematic, due to lack of trust or cultural dissonance. The method provides an alternative to traditional ethnographic research which generally takes place over a longer period of time (Price & Hawkins 2005).

KIRs will be tapping into their social networks; it is expected that different and contradictory narratives will emerge. Meanings and understandings that community members attribute to the behaviour of others is developed from the data collected. These issues are congruent with general ethnographic method and expectations (Angrosini & Mays de Pérez 2003). Tensions or conflicting issues and statements provide important data about the nature of power, hierarchy, social relationships and agency in the context of reproductive health behaviours (Price & Hawkins 2001, 2005; Angrosini & Mays de Pérez 2003).

Careful selection and emphasising the voluntary participation of suitable researchers is important because it is recognised that researchers must be representative of social groups in the communities studied. Researchers must be cognizant with their own particular situation, their gender, age, religion; socio economic circumstance; and power base within the community and understand that all these factors will impact upon the data collection (Angrosini & Mays de Pérez 2003). There will be multiple truths, perspectives and stories intersecting and overlapping each other, based upon the social categories to which individuals belong (Angrosini & Mays de Pérez 2003).

In this Ethiopian study, HEWs and NGO staff will be recruited from three locations in rural and pastoralist Ethiopia. As KIRs, they will attend a three-day training workshop facilitated by the researchers before they return to their community. HEWs will be trained in the process of conducting research ethically; interview techniques; develop their own research questions and design an interview schedule; learn how to recruit participants; how to conduct their own data analysis; identify key issues and incorporate lessons learnt into their practices. They will:

- Record questions to guide their interviews, shaped by what they feel to be the most important issues;
- Practice asking open-ended questions, probing, and asking for stories;
- Practice and observe others asking for consent to participation
- Learn about “third-person interviewing” rather than personal questions as interviewees are not asked to talk about themselves or to identify people, rather ‘other people like them’
- Learn how to record findings, key phrases and/or events given most importance by the interviewees.
At the completion of the workshop, HEWs will identify and obtain informed consent from three community members: we suggest two women and perhaps one man who may be a kebele leader. If individuals give consent to participate they will be interviewed twice by the HEW in the following week. Suitable questions and conversational prompts will also be developed and elaborated at these workshops. The way in which phenomena is understood and spoken about by interviewees will differ depending upon, age, gender, ethnicity, religion and so forth (Price & Hawkins 2005). The research team will supervise the piloting and elaboration of these questions and conversational in the field.

Suggested issues to be explored will relate to decision making around reproductive health, access to skilled caregivers at birth, family planning and place of birth. The aim will be to encourage interviewees to identify meanings attributed to the behaviour of others. Interviewees will be asked to talk about, or tell a story about someone they know who are like them (Price & Hawkins 2002). In keeping with PEER principles, KIR researchers will not record detailed script or narratives; instead, they will record key phrases or events given most significance by the interviewees. During the data collection period in the kebeles, the research team will travel to and spend time with each KIR. The intention is to discuss the interview process and refine prompts if necessary. HEWs will use data collection sheets to identify the multiple issues that arise in different conversational contexts.

At the completion of the interviews the KIRs will be brought together for a final debriefing workshop which is in keeping with the recommendations of Price & Hawkins (2005). This will provide an opportunity for the KIR researchers to work together to identify what they believe to be key issues emerging from the interviews and lessons learned. At this point the KIR researchers can bring their own understandings and viewpoints to bear on the interpretation of the narratives, the final workshop will act as a highly charged focus group, where discussion between the KIR researchers, the research team and program staff, will contribute to insights, raise awareness and encourage open discussion about the issues under investigation (Price & Hawkins 2005).

Ethics

This project has received ethical approval from Deakin University (2013-055). Ethical approval is also being sought in Ethiopia. An important component of the training workshops will be to teach KIRs about the ethical conduct of research, how to recruit participants and conduct interviews. KIRs will be required to follow an informed consent procedure and ensure that all participants collaborate freely and without coercion. KIRs will need to take all reasonable steps to ensure that the data collected is non-identifiable. Following OPTIONS (2007) lead, we want to ensure that the KIRs have a realistic understanding about what they can reasonably expect in terms of outcomes from the research. KIRs and the people they interview are adequately compensated for their time and any costs incurred as a result of involvement in this project.

Developing interview questions

Participants in the workshop will refine the key analytical areas and work together to develop the questions and conversational prompts. The prompts will act as aid to continuing or returning to key areas during the interview. Key points and issues are recorded on the data collection tool and the interviewer will verify with the interviewee that the key issues recorded are indeed those of most importance from the interviewee's perspective. The key interview questions will be finalised during the training workshops. Preliminary questions to be considered for potential use have been informed by the findings from previous research conducted by Jackson (2010) and the three PEER / KIM exemplars discussed above. Some preliminary areas of investigation are described in Box 1.
Box 1: Suggested analytical areas of investigation to discuss with KIRs in this research project

<table>
<thead>
<tr>
<th>Interview</th>
<th>Information required to monitor change:</th>
<th>Issues around which to ask the questions:</th>
</tr>
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| **1. Identify barriers to use of health services and EmONC: perceptions, including quality of care** | • What do women recognise as the risks of pregnancy?  
• What are the perceived risks and benefits of maternity care services?  
• What are the benefits and risks of birthing without a skilled birth attendant?  
• What social, economic or transport barriers restrict women’s access to these services?  
• What makes it easier for women to access services? | • Perceived role of different care givers; e.g. TBAs, HEWs, medical practitioners, nurses and midwives  
• Perceived risks of pregnancy  
• Are women accessing ANC? If so, how many visits?  
• How many tetanus vaccinations (TT) are women having?  
• In what circumstances would you use a traditional birth attendant?  
• How do women who need to get to hospital access finance and transport (including broader constraints to accessing these resources)?  
• What is their knowledge of health and illness; including illness causation?  
• Traditional beliefs and practices in relation to childbirth/postpartum including circumcision |
| **2. Improvements in social status and mobility** | • In what ways are women enabled or hindered to express their needs, influence decision makers, and make decisions?  
• How can women-centred health development meetings provide support and consolidate the implementation of the health extension program? | • What are the perceptions of relationships with husband and mother in law (significant others).  
• Who do women talk to about health and fertility issues?  
• How does the family structure, impact upon relationships?  
• Perceptions of wider social constraints/practices e.g. who controls money and decisions made about the money and other matters?  
• Social expectations of women’s role in the community: Family planning/fertility decision making; fertility and status  
• Other factors motivating women’s reproductive health choices?  
• How can we involve men more and help them make informed decisions, as they are key decision makers? |
Data Analysis

The data recording process is not intended to produce vast quantities of conversational narrative qualitative data, but to produce data that can be processed into a readily usable format. Data analysis will involve:

- The research team interviewing (debriefing) the HEWs and NGO staff during follow-up visits.
- The second stage will involve an in-depth social or ethnographic analysis of the interview data. At the end of the data collection period, KIRs will be interviewed by a member of the research team in order to synthesise the key issues emerging from the conversational interviews. The women’s narratives then serve as primary (ethnographic) social data, with the KIRs serving as the social analyst’s key informants. In-depth interviewing of the HEWs and NGO staff (as key informants) is complemented with participant observation—the HEWs providing the researchers with access to their respondents in the “community setting”. The data collection sheets will be used as the basis for the researcher’s discussion with the HEWs (with the sheets kept by the HEWs as a diary of their observations and conversations). The researchers explore in depth these observations and conversations with each HEW individually during the debriefing and at the HEW data analysis workshop.
- Stage three will be a HEW data analysis workshop. After the social analysis, the HEWs conduct their own data analysis process. During the workshop HEWs will be asked to work as a group to identify key issues emerging from the interviews and lessons learned for the project. The data analysis workshop is facilitated by the researchers who have carried out the in-depth analysis of HEWs interviews, and is attended by project staff and other key stakeholders and partners.

Analysis of issues and communities must acknowledge that there are multiple power bases and perspectives represented. A principle of ethnographic analysis is related to the distinction between what is ‘ideal; and what is ‘reality’ where behaviour is evaluated in terms of social and cultural norms, what are the cultural notions of propriety and how they are successfully flouted or transgressed’ (Angrosini & Mays de Pérez 2003, p. 115). Analysis will highlight prevailing knowledge, attitudes to traditional and biomedical health services, beliefs and values, and provide some insight into the complex dynamics and decision-making processes that accompany access and utilisation of contemporary reproductive health services. Analysis of these discussions will highlight how power is projected within communities; how this is deflected and embodied in keeping with principles outlined by (Angrosini & Mays de Pérez 2003).

Transcriptions and field notes will be thematically analysed. Studies on the Options website http://options.co.uk/peer discuss variations that are appropriate to use in a study such as this one. One single approach to thematic analysis will be inadequate to reveal the depth of meaning in the stories shared by the various participants (women, HEWs and NGO staff). Therefore a tiered approach to thematic analysis will be adapted from that described by Bernoth, Dietsch and Davies (2013). Narrative thematic analysis will be used to appreciate how the stories are told, taking into consideration cultural nuances and the content of their stories to reveal the implicit themes evident in the experiences the participants shared. Narrative analysis provides insights into how stories and can highlight contested meanings, where the discrepancies between what is ‘ideal’ and what is ‘reality’ highlight the assertion of power and the embodied, deflected or reflexive responses. Other principles of interest here concern how behaviours are negotiated and reinvented in relation to norms within and outside the group (Angrosini & Mays de Pérez 2003; Price & Hawkins 2002). Content analysis will be used to describe and interpret the experiences shared and finally, critical discourse analysis will be used to enable a critical lens to be applied (if appropriate) to the themes derived through narrative and content analysis. This integrated approach to thematic analysis (Bernoth et al. 2013) means that themes will be revealed, described and interpreted in a way that honours participants telling of their accounts and experiences while having the potential to expose some of the contestation of power that may become evident.
Limitations to the research

Reports about PEER and KIM methodologies discuss limitations that will have implications for the KIR methodology. These include limitations to the amount of qualitative data that researchers are able to record as the data recording sheets are only a guide to the main issues that emerge during interviews (Price & Pokharel 2005). There may be concerns about the capacity of HEWs to perform effectively but these concerns should be able to be addressed by providing quality training, coaching and mentoring throughout the data collection process (Hayden 2007).

There may also be concerns that the sample size used in the research is small with potential ‘that the sample of respondents may be biased and unrepresentative’ (Price & Hawkins 2002, p. 1334). However, this concern can be countered as a strength of the research approach as ‘it draws deeply upon the experiences of ‘groups’ of individuals through the use of multiple third person interviews, rather than more shallowly from a larger number of respondents’ (Price & Hawkins 2002, p. 1334).

A more significant criticism can be made about how the data is validated as it is impossible to know if researchers and interviewees are indeed telling the ‘truth’ about their social lives and behaviour. However, it is also argued that this is the greatest strength of PEER (and by implication KIR) ethnography as the main focus of the method is to analyse contradiction and difference ‘in the discourses of different people within a social network, rather than on gathering “social facts”’(Price & Hawkins 2002, p. 1334). In particular, the method draws on gossip as a way to provide insights into social context.

Gossip is the local currency of social networks, providing invaluable insight into relationships of power and vested interests that operate under the surface. Instead of discarding gossip as invalid because it derives from biased accounts, the peer ethnographic method embraces and analyses gossip as an essential component of ethnographic data. In our use of the peer ethnographic approach we are not seeking social ‘truths’, as positivist methods may understand them, but a rich and dynamic social commentary, in which subjective identity is created and in which sexual and reproductive behaviour is given meaning (Price & Hawkins 2002, pp. 1334-1335).

Finally, we acknowledge that the process of working with interpreters means that during the process of translation, depth and richness of data and subtler meanings are often lost or can be misinterpreted (Hayden 2007; Rubel & Rosman 2003). Pausewang (1973) describes some of the difficulties of research in Ethiopia in relation to language and states that ‘a translation into clear, simple, and illustrative language which can be understood by all, and does not give room for ambiguities and misinterpretations, is an aim which will probably never be reached’ (1973, p. 36). The process of translating is one that is fraught with difficulty, because the ‘values of the culture of the source language may be different from those of the target language and this difference must be dealt with in any kind of translation’ (Rubel & Rosman 2003, p. 6). Katan (1999) describes how the ‘cultural mediator’ is more than a translator or interpreter. The ‘cultural mediator’ needs an understanding of how culture operates and must be able to frame a particular communication with its context of culture before disassociating from that frame when creating a new text in another culture. We suggest that translation offers the most obvious way to communicate Ethiopian culture to outsiders; this is similar to the way anthropologists analyse field material to gain understanding of the meanings and behaviours of peoples other than their own.

Conclusion

Using KIR methodology, local attitudes and perceptions around the use of maternal, neonatal, and child health services in rural and pastoralist Ethiopia will be determined. The research described in this paper provides the starting point for a methodological approach that involves individuals from their own social networks becoming key informants based on their own local knowledge and that of others in their communities. We hope that our research will provide data that will lead to improved HEW and NGO staff effectiveness that, in turn, leads to increased demand for skilled birth attendance and thereby reduce maternal and neonatal mortality.
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