MATERNAL AND CHILD HEALTH NURSING PRACTICES IN RURAL HEALTH CENTRES, ETHIOPIA: PROSPECTS FOR HEALTH OUTCOMES

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DECLARATION

I declare that the thesis entitled: Maternal and Child Health Nursing Practices in Rural Health Centres, Ethiopia: Prospects for Health Outcomes is my own work, that it has not previously been submitted for any degree or examination purposes at any other university, that all the sources I have consulted or quoted have been disclosed and duly acknowledged by means of complete referencing.

12/02/2022

ELIAS AHMED SADIK **DATE**

DEDICATION

I dedicate this research study to my lovely wife, Aisha-Nile Haji Yusuf for her tireless efforts, contribution and commitment in the realisation and achievement of my academic vision.

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ABSTRACT

The Purpose of the study to provide evidence-based suggestions for maternal and child health nursing practice guideline improvements based on in-depth investigation of existing situations, challenges, missed-opportunities, innovative ideas and best practices that could improve the maternal and child health care practices.

The method of the study applied was qualitative study design which was conducted by using phenomenological and ethnographic approaches. Totally, 42 in-depth interviews and 12 focus group discussions were conducted. Among Key informant interviews, 24 (57.1%) were female participants and 18 (42.9%) participants were male. Each focus group discussion involved 6 individual participants in which 8 Fucus Group Discussions purely involved 48 (66.7%) female participants and 4 Fucus Group Discussions purely involved 24 (33.3%) male participants in the context of twelve rural health centres in six selected districts, namely: Babile, Chalanko, Dadar, Fadis, Kersa, Meta and Gursum which are found in East Hararghe Zone, Oromia, Ethiopia. The study involved healthcare managers, community leaders, religious leaders, health officers, midwives, nurses, health extension workers (HEWs), traditional birth attendants (TBAs), volunteer health promoters and mothers, as well as family members.

Data collection instruments used were In-depth interview questions, focus group guides and observation checklists with audio recorder and camera. In qualitative research, the triangulation of these methods was advantageous for enabling participation of a broad spectrum of participants and a range of views concerning the investigated phenomenon of MCH care practices.

Data analysis was performed based on the need for triangulation in this study and its vast sample size, both inductive and deductive analytical approaches were applied to analyse and interpret the collected data from these varied categories of research subjects by using the Atlas ti Version 8.2 statistical software.

The study found out the environmental, physical, institutional, material, financial, ethical, attitudinal, perceptual, behavioural, procedural conditions and human interaction that positively or negatively affect the quality of maternal and child health care services. The study further explored major barriers, enabling factors and innovative ideas for improving maternal child health care practices based on the lessons learnt from experiences in the context of local communities.

The study inferred useful insights on the nature of existing maternal and child health care related issues including: the rationale, purpose, components, methods of care and practice, nature of interaction, levels of satisfaction and level of dissatisfaction.

Based on the findings, the recommendations were given largely focus on multiple approaches and guidelines for improvement of maternal and child health practices by all stakeholders, from the personal, institutional/ organisational and governmental levels.

Key terms: Maternal health nursing, child Health nursing, Nursing Practice, Maternal Health, Child Health, Maternal Mortality, Opportunity, Challenge, Rural Health Centre, Prospects for Health Outcomes

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BCG	Bacille Calmette-Guerin (vaccine for tuberculosis disease)
CHW	Community Health Worker
CMR	Child Mortality Ratio
DPT	Diphtheria, Tetanus and Pertussis
FDRE	Federal Democratic Republic of Ethiopia
FMOH	Federal Ministry of Health
FP	Family Planning
HEW	Health Extension Worker
HIV	Human Immune Virus
HTP	Harmful Traditional Practice
IUD	Intra Uterine Device
MDG	Millennium Development Goal
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
NPT	Normalisation Process Theory
PNC	Postnatal Care
PMTCT	Prevention from Mother to Child Transmission
PPH	Postpartum Haemorrhage
SBAs	Skilled Birth Attendants
SDG	Sustainable Development Goal
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TB	Tubercle Bacilli
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UREC	UNISA Ethical Review Committee
WHO	World Health Organisation

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CHAPTER ONE
STUDY OVERVIEW

1.1 INTRODUCTION

This study focuses on maternal and child health (MCH) nursing practice issues in the rural health centres of Ethiopia. The study was chosen due to the seriousness of maternal and child mortality in the rural area in resource limited countries (UNICEF, 2017:26). Maternal and child mortality is greater in rural agrarian and pastoral communities, especially in a developing country such as Ethiopia (WHO and UNICEF, 2018).. Hence, in-depth understanding of MCH care nursing practices and influential factors in the rural area of Ethiopia is a critical issue for the health outcomes of the community.

The number of health workers in urban areas per 1000 people are three times greater than in rural areas, and the numbers of qualified health professionals are four times greater in urban areas than that of rural areas (African Union, 2014:50). Globally, the rural populations have fewer access to improved sanitation facilities than urban inhabitants/ residents (WHO Report, 2020:1). For instance, globally 51% of rural populations have access to sanitation facilities while 82% of urban residents have access to improved sanitation facilities (Drisse, Goldizen and Adair-Rohani, 2017:129). In African countries, there is greater child mortality in rural area than in the urban areas (Yaya, 2019:5). Furthermore, there was a 72.8% and 59.2% under-5 mortality rate of male and female children reported. Reasons for such disparities are located in the maternal education for both rural (80.4%) and urban settings (67.6%) (Yaya, 2019:5).

In Ethiopia, the rural communities are more disadvantaged than their urban counterparts. The reasons relate to poverty, lack of education, employment, access to health care and socio-economic disadvantage. Therefore, targeting MCH intervention is essential to reduce maternal mortality ratio (MMR) in the country (Gebre, Worku, & Bukola, 2018:5). Recently, the Sustainable Development Goal (SDG) 3 is trying to address disparities in MCH as a life-time priority. The focus of the SDG 3 programme is concerned with equal access to health promotion and disease prevention at community level (Schaffer & Rashid, 2016:400). Maternal health problems are among the chronic problems of the Sub-Saharan African countries. The problems are the cause for the death of millions of mothers and children in the African continent. However, African nations are trying to minimise the death of mothers and children by preventing all preventable cause of death in collaboration with concerned international humanitarian organisations and donor agencies.

To most of the African nations, minimising the death of mothers and children was an important component of Millennium Development Goal (MDG) 4 and 5 that improved 50% personal hygiene among English-speaking (Anglo) Africans and also improved 25% personal hygiene among French-speaking (Francophone) Africans in the continent (Federal Ministry of Health (FMOH), 2015:4). Table 1.1 below reflects the maternal, new-born and child mortality rates globally as point of comparison for the African continent.

Table 1.1: Global maternal, new-born and child mortality rate with respective years

Global Regions	MMR/100, 000 live births in the year 2015	NMR/1000 live births in the year 2017	Under-five MR/1000 live births in 2017
Africa	542	26.7	73.1
East Mediterranean	166	26.7	49.6
South-East Asia	164	21.3	36.0
America	52	7.9	14.4
West Pacific	41	6.2	12.6
Europe	16	4.6	8.9
Globe	216	18.0	39.1

Source: World Health Organisation, 2015; 2017.

On the other hand, Table 1.2 below is an illustration of the maternal maternity ratios in the context of the SDG3's age related progress report between 2015 and 2019.

Table 1.2: The performance indicator of SDG 3 progress report

Target indicator	2015	2016	2017	2018	2019
MMR per 100, 000 live births	420	412	_	_	199
Under-five death per 1000 live births	64	67	_	_	30
Under-5 Stunting rate (%)	40	38.4	_	_	26
Under-5 wasting rate (%)	9	9.9	_	_	4.9

Source: FDRE Voluntary National Review on SDGs Performance, 2017:46.

It is worth noting that the SDG 3.1.1 is targeted at reducing the global maternal mortality ratio by 2030. In the context of this study, is an apt MMR indicator of MMR. The goal of the SDG 3.1. is to reduce live births to less than 70 per 100 000 by 2030 (WHO, 2015; 2017). Similarly, the SDG 3.1.2 is an indicator of the under-5 mortality rate whose target is to reduce the under-five mortality rate to less than 25 per 1000 live births (Getachew *et al.,* 2020:2).

1.2 BACKGROUND TO THE STUDY

From the perspective of the researcher, the background is logically linked to the historical and current/ contemporary MCH contexts. Maternal and child health nursing practice is based on the engagement of relevant stakeholders (Necochea, 2015:17). In doing so, strengthening inter-personal relationships is very important for establishing networks,

communicating effectively, enabling participation, interacting harmoniously, collaborating kindly, assessing and incorporating cultural norms, personal beliefs and values in the practices.

Better health outcomes require access to quality of health care (Lassi, 2018:12). MCH interventions both in the facility and home-based services are significant and efficient for better health outcomes (Aston *et al.*, 2021:9-10). In this regard, the MCH interventions in both the facility and home-based services are more significantly efficient for better health outcomes.

1.2.1 Historical Context

Historically, efforts have been made to contextualise the impact and growth of the nursing profession and its influence on MCH care practices. To this effect, Florence Nightingale viewed nursing care as caring for, and nourishing relationships with others (Shetty, 2016:147). The history of traditional nursing care role in MCH has contributed to framing of current standards of care and ameliorating difficulties of the patient (Susan & Shelton, 2009:4). Maternal and child health intervention were given more attention in the Alma Ata Declaration in 1978 under the theme, *'Health for all by 2000'* that include human rights and community participation. All member nations of the WHO accepted primary health care as their national policy and considered maternal and child health care as critical components whose financial constraints were to be removed (Macarayan, 2020:9). Implementing this policy was a challenge aggravated by lack of community participation (Rosen, 2015:6).

Primary care intervention experiences show that implementation was contextual because people did not behave the way professionals thought. Evidence suggests Evidence suggests that MCH care practice needs to be understood as a process of complex interventions that consider not only outcomes and impact, but also the reasons for the (in)efficacy of programmes and interventions (Rosen, 2015:10). It is in this context that the vision of primary health care development in the African region was based on reflections on the Alma Ata recommendations and to revitalize their strategies based on lessons learnt from past experiences (WHO Report, 2008:3). In 2000, eight MDGs were developed and agreed upon by all member countries of the United Nations to actualise these lessons.

Among the eight goals, MDGs 4 and 5 focused on the reduction of child and maternal deaths by two-third and three-quarter respectively by the year 2015. Between 1990 and 2008, the maternal mortality reduction rate was 13% per year. Similarly, progress in

neonatal mortality (first 28 days) remained unchanged and still accounts for 41% of deaths among children younger than 5 (five) years (Bhutta, 2010:6). The success factors achieved in the MDG era were: a 35% prevalence rate of modern contraceptive usage among married women; 1% usage of injectables as a commonly used modern method among married women. Most of the of the intra-uterine devices (IUDs), implants and injectables were obtainable from the public sector, with 22% of married women displaying unfulfilled family planning needs (EMDHS, 2019:7). Of the total demand for family planning methods, 61% of the married women were content with the use of modern techniques. Childhood mortality was found to be higher among children who were less than two years, while the pregnancy-related mortality ratio was 412 deaths per 100,000 live births (EMDHS, 2019:8).

The USAID (2016:1-2) reported that 19,200 pregnant women received antenatal care, 14,000 pregnant women received postpartum family planning advice, 22,900 mothers delivered at health facilities, while 20,000 mothers received postnatal care in health facilities, 279 asphyxiated newly born infants were successfully resuscitated, 1,200 women were maternally advised, and their choice, received postpartum intra-uterine contraceptive. The major components that appear to be improved in rural MCH care practice were effective ante-natal (ANC), institutional delivery and post-natal care (PNC) (Jalloh, 2019:13). Ethiopia adopted MDG achievements that induced MMR reduction by 75%, which was subsequently reduced from 1250/100,000 live birth to 420/100,000 (Gebre et al., 2019:6).

Despite the improved mortality rate of mothers and children in Ethiopia, there were unfinished agendas for better health outcomes, such as access to MCH care, resource availability and allocation, as well as community participation and partnership formation. The global MCH policy also encourages community participation and engagement of family members, social workers, religious scholars and community leaders. The current context of MCH issues was described in SDG 3, which focuses on MCH intervention programme implementation of every five-year umbrella programme designed to achieve SDG 3 by collaborative and participatory efforts of stakeholders (UN Women, 2015:8-9).

Relevant lessons were learnt on the effects and influences of multiple factors on MCH nursing practices, which allowed the nurses' understanding of appropriate approaches to health assessment, planning, implementation, and evaluation of such practices in the context of religious beliefs and traditional customs as they relate to health within their living environments (FMOH, 2015:105-106).

1.2.2 Current Context

Lessons were learnt on how multi-factorial factors influencing MCH nursing practices that allowed the nurse to in-depth understand the right approach to health assessment, planning, implementing, evaluating and understanding religious beliefs and traditional customs as they relate to health within their living environment (FMOH, 2015:105-106).

The peer-to-peer support, proper follow up, use of documentation of care provision on partograph check-lists in the health centre were mentioned as they contribute to the quality of service improvement (FMOH, 2015:106). In 2015, about 5 (five) in every 9 (nine) children under the age of five years died due to preventable causes. Among these, 45% were neonatal deaths induced by the risk of suboptimal development (WHO, 2016:1). Preventable MCH problems were causes for the death of millions of mothers and children on the Africa continent (Nair, 2017:10). The current maternal and child health care delivery strategy addresses fifteen objectives under four major themes, namely: good governance/ leadership; health care delivery; quality improvement and assurance; and capacity building (FMOH, 2015:103).

The above-stated four themes were derived from the following objectives for improvements in the following areas: status of health; community ownership; health effectiveness and efficiency; equitable access of quality health services; managing health emergency risks; good governance enhancement; improving regulatory systems; management of logistics and supply chain; community engagement and participation; mobilisation of resources; research-based decision-making; enhancing innovation and technology use; human resources development and management; improved health infrastructure; and health policy enhancement (FMOH, 2015:113).

The FMOH integrated family planning with the national MCH programme and increased coverage as priority intervention areas for reducing maternal and child death through quality of care improvement (RMCH Manual, 2018:36). Proper antenatal follow-up has a great potential contribution to reduce maternal and child mortality. Therefore, it is recommended that every pregnant should attend ANC visits (Mulat, Kassaw, & Aychiluhim 2015:9). According to the Ethiopian health sector development and transformation plan, strengthening health care intervention practices and women's involvement are priority areas for the following reasons:

- transforming equity and quality of health care;
- information revolution; and

- developing a caring, respectful and compassionate health workforce that promotes gender equality and women empowerment, as well as increasing the use of health services (FMOH, 2015:105).

According to the WHO (2015b:1), research evidence was limited generally, and relatively left untouched. According to the WHO (2018:1), there were no studies that examined patients' experiences and association of quality measures and health outcomes at community level However, a study revealed that community health volunteers, religious and community leaders, were instrumental for improving the utilisation of health services (Gilmore & Mcauliffe, 2013:3). Hence, studying the nature of MCH nursing practices, including attitude, perception, social, cultural, institutional or environmental barriers as well as missed opportunities and experiences were critical issues in the study area.

1.3 RESEARCH PROBLEM

Maternal and Child Health was one of the priority issues in Ethiopia (Desta, Shifa, Dagoye, Carr, & Kim, 2017:4). According to the WHO (2015:12), Ethiopia experienced high maternal death rates. For instance, 830 women died daily as a consequence of complications of childbirth or pregnancy, and 9.2 million children aged below 5 years died yearly from causes that were preventable. It was further noted that most of these deaths were occurring in the Sub-Saharan African and South Asian regions (WHO, 2015:12). There are several factors that affect In these regions, the utilisation of health services is affected by factors such as: the authority of decision-making; socioeconomic impediments; constrained health care access; geographical location; and poorly trained and skilled health professionals (Kim, 2019:14).

Despite the expansion of MCH nursing care and significant decreases in death of mothers and children in Ethiopia, MCH nursing intervention was compounded by a range of factors, such as the poor quality of maternal and child health care, as well as lack of childbirth spacing caused by unintended pregnancies in Ethiopian rural communities (Kassa, Berhane, & Worku, 2012:5). These challenges existed due to lack of proper health promotion and disease prevention services.

Empowering women with all necessary supports are a major determinant for improving health outcomes. Other maternal and child health service problems were: poor governance, resource scarcity, lack of well-trained staff, poor access to healthcare facilities, and delays in seeking medical help (Mabaso, Ndaba & Mkhize-Kwitshana, 2014). On the other hand, missed opportunities, negligence and communication problems accounted for difficulties of properly attending to healthcare services and

awareness building on the danger signs pertaining to pregnancy and labour (Gebeyehu, 2014:174).

According to Mabaso et al. (2014:187-188), other MCH problems related to prevention practices of HIV/AIDS; eclampsia; infection; poor management of obstructed labour; unsafe abortion; referral delay in the health care facility; shortage of human and material resources; haemorrhage; poor health service coverage and lack of information.

1.4 RESEARCH AIM/ PURPOSE

The purpose of the study was to explore, describe and analyse the existing MCH care practices, challenges/barriers, and opportunities/enablers in selected Ethiopian health facilities and recommend suggestions to inform stakeholders in respect of better MCH outcomes.

1.5 RESEARCH OBJECTIVES

The research objectives generally specify the activities and processes the researcher undertakes to actualise the purpose of the study (Berg & Lune, 2012:46; Efron & Ravid, 2019:34). Accordingly, the research objectives in this study are articulated thus:

- To understand existing realities of MCH nursing practices in selected rural health centres in Ethiopia;
- To examine the barriers affecting MCH nursing practices;
- To identify enablers/ opportunities to improve MCH nursing practices;
- To explore innovative ideas for improving rural MCH nursing practices.

1.6 RESEARCH QUESTIONS

1.6.1 Main Research Question

Do maternal and child health nursing practices improve the health outcomes of mothers and children in rural health centres?

1.6.2 Secondary Research Questions

Whereas the main research question above addresses the research aim, the secondary research question mentioned below specifically present an interrogative version of the research objectives in this study.

- What is the existing nature of MCH nursing practices in Ethiopian rural health centres?
- What are the barriers affecting MCH nursing practices in the rural health centres?
- What enablers/opportunities are there to improve MCH nursing practices?
- Which innovative ideas could be explored and implemented to improve and sustain MCH nursing practices?

1.7 SIGNIFICANCE OF THE STUDY

The significance of the study is principally underlined by the extent of its positive contribution to the field of knowledge (epistemology) in a particular area of research, as well as the socio-economic benefits the study may yield (Ehrlich & Joubert, 2014:28; Harding, 2013:19). Accordingly, the study's epistemological significance is realisable in respect of its contributions regarding improvements in maternal and child health nursing practices by exploring what the informants know about MCH, how could they know and what they want to know including the rationale, purpose, components of services, care givers and customers interaction, satisfaction, dissatisfaction, enablers, barriers and innovative ideas to for improving MCH care practices in a sustainable manner for better health outcomes. Additionally, the study and its findings and recommendations also contributes to achieving Goal 3 of the Sustainable Development Goal (SDGs) 2030 strategy which focuses on the reduction of maternal mortality ratios by less than 70 per 10,000 live births, and neonatal mortality to lower than 12 per 1,000 live births; as well as under-5 mortalities at least lower than 25 per 1,000 live births (WHO & UNICEF, 2017:7).

1.7.1 Expected Outcomes

As an expression of its significance, the current research was viewed as relevant insofar as fulfilling the following expected outcomes:

- identifying attributes of the existing practices, barriers and enablers of MCH nursing practices in the study area;
- providing insights on the potential of religious and cultural norms in communities in order to promote maternal and child health programmes;
- identifying implementation priorities for MCH interventions;
- pointed out the feasible coping strategies for overcoming impediments and also improvements to the quality of care, as well as providing insights concerning possible future MCH services; and
- serving as the basis for other interested researchers in the specific area of MCC quality and effectiveness

In addition to the above-stated expected outcomes, it is also to be noted that it is not always the case that every study would yield immediately realisable socioeconomic benefits (Harding, 2013:19; Marshall & Rossman, 2011:79).

1.8 THEORETICAL FOUNDATIONS OF THE STUDY

The study has opted for the Normalisation Process Theory is (NPT) to guide its theoretical grounding. The NPT is relevant for studying complex systems or processes and their contextual factors - which in the case of this study, are linked to care practices,

challenges and opportunities (Murray, Treweek, Pope, MacFarlane, Ballini, Dowrick & May, 2010:9-10). Also, the NPT augments to the MCH practice measures, but also to self-management and intervention management (Babler & Strickland, 2016:129; Lassi, 2014:3-4).

Nursing practice theories mainly provide understanding on practice issues and questions, while also directing routine and complex interventions in nursing practices (Fox, Gardner & Osborne, 2014:1; Nessun, 2020:3). The NPT comprises iterative and interrelated constructs relating to organisation of activities undertaken or work performed. These constructs are:

- coherent nature of work in relation to organisational readiness and adaptability to social systems, as well as the dynamic and collaborative interaction patterns;
- work performance in the context of the agents/ personnel involved and their cognitive abilities; and
- reflexive monitoring in terms of how the work is understood and performed by the agents, who are expected to appraise complex information about interventions concerning their strength, weakness, challenges and opportunities to frame concomitant actions (Dean, 2014:6).

1.9 DEFINITION OF KEY CONCEPTS

The definition of the below-cited key concepts enables clarification of their contextual, disciplinary, and practice-related meanings and application (Marshall & Rossman, 2011:119; Polgar & Thomas, 2011:48).

1.9.1 Challenge

According to Rafiki and Medan (2020:2), a challenge relates to a problematic situation with the potential to cause physical, mental, emotional, and other material and/ or non-material suffering. In this study, challenges relate to those factors that present barriers to implementation of successful MCH practices in the selected Ethiopian healthcare facilities.

1.9.2 Child Health

According to the WHO (2017:7), child hearth is a condition of wellness in the physical, social, emotional and intellectual spheres of children in their families, environments, and communities for optimal provision of opportunities for development.

1.9.3. Child Health Nursing

It is provision of physical, mental and emotional health care for a baby from conception up to maturity (Clark, Beatty & Fletcher, 2016:9).

1.9.4 Maternal Health

Maternal health relates to the health of women at the time of pregnancy, childbirth and the postpartum period 42 days following pregnancy termination (WHO, 2017:7).

1.9.5 Maternal Health Nursing

Maternal health nursing practice relates to the application of obstetric and gynaecological processes in addressing the needs of women during pregnancy, childbirth, and the postnatal period (Bethell, Simpson & Solloway, 2017:35).

1.9.6 Maternal Mortality

Maternal mortality is defined as the death of a pregnant woman or during 42 days of a pregnancy termination, notwithstanding the length and place of pregnancy, and any causes linked to pregnancy or its management (Bethell et al., 2017:35).

1.9.7 Nursing Practice

Nursing practice is defined as the holistic provision of care provided to all individuals irrespective of their age, cultural, socioeconomic and other backgrounds for restoration of their normal health status (Bethell et al., 2017:36).

1.9.8 Opportunity

Opportunity relates to a variety of circumstances designed to enable human progress through access to socioeconomic and other means of survival (Bethell et al., 2017:40).

1.9.9 Rural health Centre

A rural health centre is health facility that serves the rural community of 25,000 households under its catchment area.

1.9.10 Prospects for Health Outcomes

“It is the likely outcomes that show direction to strengthen key systems, such as human resources, financial management, marketing strategies, and organizational governance to increase providers’ capacity to respond to change and prospects for sustainability” (Mcarthur et al., 2019:1-12),

1.10 RESEARCH DESIGN AND METHODOLOGY

The research design and methodology encapsulates both the philosophical principles or paradigmatic perspectives on the one hand, as well as the systematically conducted plans, activities, decisions, approaches and strategies for managing the entire research process in conjunction with the methods of data collection and analysis procedures (Butterfield, 2012:13; Donley & Graueholz, 2012:21). For instance, Creswell 2014:116;

Edmonds & Kennedy, 2012:37, demonstrated the research design also encompasses the relevant sampling processes and procedures adopted for resolving both the research problem and its associated research aim, objectives and questions.

1.10.1 Research Approach

The study has adopted the phenomenological-ethnographic philosophical paradigm (worldview or perspective) to guide its qualitative (narrative and participant-centric) case study approach to gathering relevant information and data pertinent to maternal health care practices, opportunities and challenges with the sampled participants in their own familiar ecological or environmental surroundings (Denscombe, 2014:6; Edmond & Kennedy, 2012:37; Franklin, 2013:19). For its research methods, the study opted for the triangulation of in-depth interviews, focus group discussions, storytelling and observation checklists (see Annexure D). In qualitative research, the triangulation of these methods was advantageous for enabling participation of a broad spectrum of participants and a range of views concerning the investigated phenomenon of MCH care practices and its attendant opportunities and challenges in Ethiopia's rural contexts of the East Hararghe Zone.

1.10.2 Research Setting

The research was conducted at multiple research sites in six purposively selected districts in the Oromia, East Hararghe Zone, Ethiopia. Figure 1.1 below is indicative of the above-cited research areas.

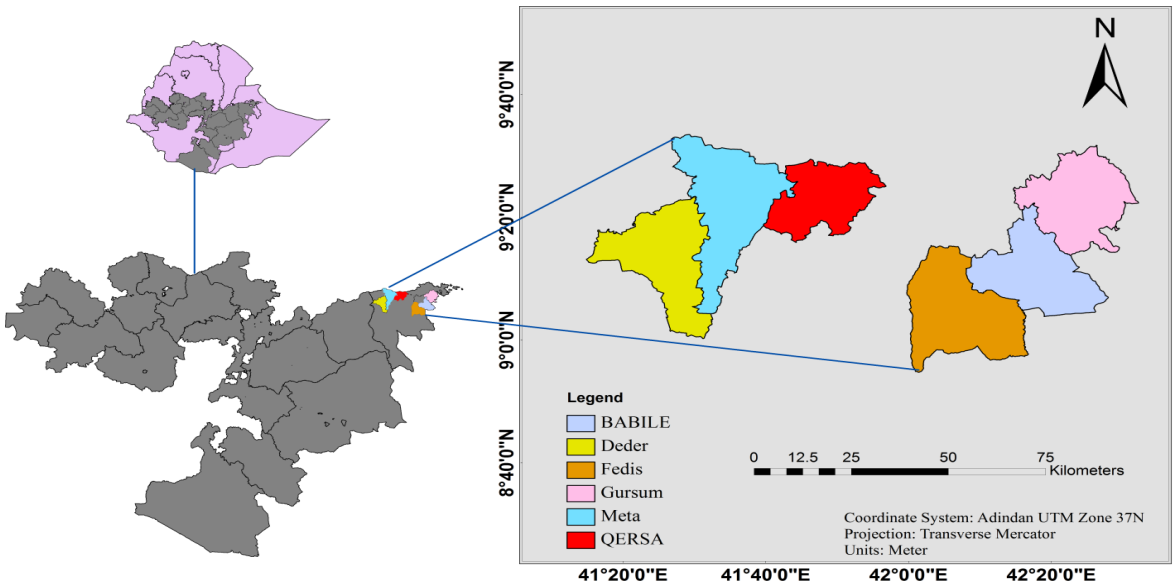

Figure 1.1: Map of the study area in Eastern Hararghe Zone of Oromia Region, Ethiopia

The afore-cited districts are: Dadar, Fadis, Babile, Gursum, Meta and Kersa. A total of twelve health centres were purposely selected in these districts to investigate challenges and opportunities in MCH nursing practices and processes related to health care in

various geographic, environmental, socio-cultural and infrastructural conditions of rural areas. Thus, the study area selection considered to include three high land districts and three low land districts for this study.

1.10.3 Study Population and Sampling Procedures

The study population consists of healthcare managers, community leaders, religious leaders, health officers, midwives, nurses, health extension workers (HEWs), traditional birth attendants (TBAs), volunteer health promoters and mothers, as well as family members. This population is situated across the six districts as shown in Figure 1.1 above, from which a total number (sample size) of 114 participants were selected for their involvement in the study. (Similar to all other related aspects, details of the research design are further provided in Chapter Four of this study). Figure 1.2 below depicts the twelve health centers in the selected six districts from which the sample size was eventually constituted.

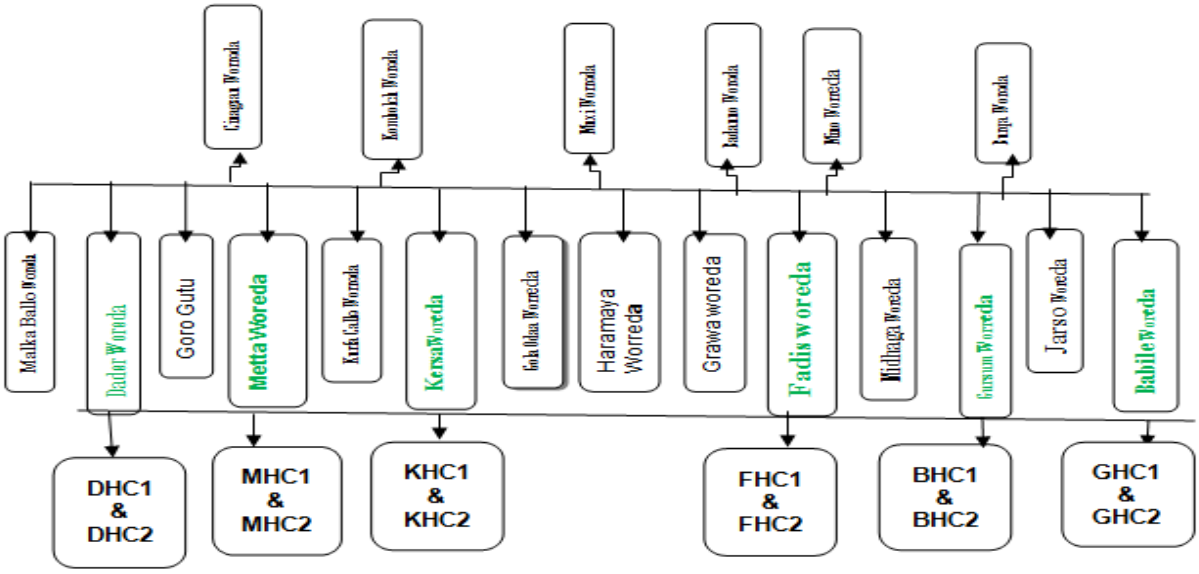

Figure 1.2: Coded twelve health centers selected from the selected six districts

In the present research, two sample frame types were utilised for recruiting the various categories of research participants from the identified sample frames, which are construed as the information base from which the sample was chosen. The study targeted a combination of information sources, namely: modern health practitioners (i.e., care providers and their facilities), health office managers, health extension workers, traditional birth attendants, mothers and their relevant family members, religious leaders and community leaders. The available lists of these participants were used as information sources.

1.11 DATA COLLECTION METHODS AND PROCEDURES

The main data collection instruments in this study were the in-depth interviews, document analysis and observation of participants (see Annexure D). The collection of data was conducted in phases, the purpose of which is to optimise its rigour and generation of multiple insights and their implications for the study (Guest, Namey & Mitchell, 2013:34). These phases could be translated as: the broadly-based exploratory phase; the in-depth conceptualisation and refinement of previously gathered data; and the emergence-induced phases.

In this case, the broadly- based exploratory phase entails data collection and pre-arranged initiatives to acquire data on broader and pertinent issues, cases, and patterns affecting MCH nursing practices, as well as their effectiveness and impediments (Guest et al., 2013:34). Meanwhile, the in-depth conceptualisation and refinement of previously gathered data implies the re-examination stage of previously treated concerns and issues more profoundly. On the other hand, the emergence-induced phase entails the stages and processes for 'catching up' with developing issues and focused questions concerning the nature, impact and intensity of MCH care practices in the selected study areas.

As the dominant data collection tool, the semi-structured interviews were effective for collecting qualitative data concerning human life and experiences of the participants, while also allowing open-ended and broadly-based engagement between the participants and the researcher (Khaldi, 2017:27). Additionally, the semi-structured interview mode enabled the research to further probe for elicitation of more and spontaneous responses and reactions by the participants. In this regard, the interviews were effective in generating voluminous data on the environmental, social, perceptual, cultural, institutional, attitudinal, and infrastructural factors affecting maternal and child health nursing practices.

1.11.1 Data Management and Analysis

Data management is premised on the treatment of raw data and preventing it from contamination (De Vos, Strydom, Fouché & Delport, 2012:103). Since it is implied that the management of data follows its collection, but precedes its analysis, both the interviews and focus group discussions were audio-recorded with the verbal permission and consent of the participants. The intention was to ensure that the original or raw oral statements and responses of the participants were retained in their original and unaltered state (De Vos et al., 2012:103). On the other hand, participant observation was managed through real-time on-site notes written by the reporter to ensure that he does not miss

any significant developments that could not be captured on audio (Smith, Flowers, Larkin, 2009:20; Williams, 2007:70).

Qualitative data analysis mostly involves with the organisation and processing of a particular category of data in conjunction with other related data categories and meaningful interpretation in both the abstract/ theoretical and empirical contexts (Fink, 2010:12; Mills & Ratcliffe, 2012:147). The reciprocal interactions between the abstract/ theoretical and empirical analyses and concurrent interpretations were intended to broaden perspectives from which to view the participants contribution regarding MCH practices, strengths and weaknesses. The focus of the analytical processes was to generate data categories and provide theoretical explanations through thematic analysis (Mills & Ratcliffe, 2012:147; Squires & Dorsen, 2018:16). In this regard, the entire process of thematic data analyses also involved making sense of data sense by uncovering participants' common understanding of concepts, patterns, insights and examination of factors affecting the effectiveness and quality of MCH nursing practices; as well as their social, administrative and institutional processes. Both the data collection and analysis contexts are presented and discussed in greater detail in Chapter Four.

1.12 ETHICAL CONSIDERATIONS

According to Epstein and Carlin (2012:899) and Gray (2019:36), ethical considerations constitute the most reliable means to monitor and guide the researcher's treatment of research participants or subjects in accordance with acceptable moral, professional and legal standards and conduct. Such monitoring is necessary because research subjects do not suddenly lose their humanity, human rights and dignity only because they have agreed to be part of the researcher's empirical data collection processes. Accordingly, the applicable ethical considerations in this study pertain to: permission to conduct the study; informed consent; privacy, confidentiality and anonymity; justice to participants; and protection from harm and risk.

1.12.1 Permission to Conduct Study

Seeking permission to conduct the study from relevant authorities is a fundamental pre-requisite for the researcher before the study is conducted. In this regard, the University of South Africa and the Oromia Regional Health Office were critical for respectively granting permission for the study to commence and with approval for the involvement of the selected participants. The Ethical Review Committee (REC) in the UNISA Department of Health Studies initially reviewed and confirmed approval of the research proposal and subsequently granted ethical clearance as a formal indication for the study to formally begin (UNISA, 2016:1).

Subsequent to the granting of ethical clearance by UREC (see Annexure A), the researcher applied to the Oromia Regional Health Office for similar permission to conduct the study with participants at the respective twelve sites (see Annexure B). Attached to the letters of permission to the Zonal and District Health Offices were the participant informed consent form (see Annexure C) - the details of which are provided in the next sub-section.

1.12.2 Informed Consent

The principle of informed consent entails that participant voluntarily agree to be involved in a study following a full disclosure of the study by the participants (De Vos et al., 2012:108; Leedy & Ormrod, 2015:65). Also entailed in the notion of informed consent is the understanding that participants are autonomous beings who can decide of their own volition (uncoerced) whether or not they desire to take part in the study. As such, they are entitled to be respected, treated with dignity, accorded their full human rights during, and even after their involvement in the study, and also treated fairly and equally without any discrimination based on race, gender, or social class standing (Leedy & Ormrod, 2015:65).

The full disclosure of the study (as part of the informed consent) clearly indicated that the study was only for the researcher's doctoral studies, and that none of the sampled participants were compelled to take part against their will. They were also at liberty to withdraw from the study at any time that they desired without any penalties or reprisals against them for refusing to take part. The main purpose of the study was outlined to the participants, as well as the expected form of participation; that is, answering interview and focus group questions orally (see Annexure D). They were also informed that there were no personal or health risks involved in the study (McEvoy, Tierney & MacFarlane, 2019:33). Instead, they would benefit by sharing their own experiences, and from knowledge obtained during these empirical engagements with regard to MCH nursing practices in rural health centres.

1.12.3 Privacy, Confidentiality and Anonymity

This principle implies that neither intrusive nor invasive threats or measures should be posed to participants directly or otherwise as a result of their involvement in the study (Mason, 2014). Therefore, personal identities and actual contributions to the study should be protected from undue external scrutiny or publicity. As such, the researcher has ensured that the names and places of residence of the participants were publicly known by any individual or organisation not directly connected to the research.

The principal investigator used monikers and pseudonyms to identify participants during the semi-structured interviews and focus group discussions. No persons or third parties were allowed to access the data except the researcher and his supervisor. The information provided by the participants was not disclosed in a manner that divulged their identities. Furthermore, all hard copy records and digital copies of the collected data were kept in a steel combination safe lock cabinet and the researcher's password-controlled laptop. These documents will be destroyed after five years from the date of the researcher's submission of the final research report to his supervisor (Mouton, 2014:290).

1.12.4 Justice to Participants

In terms of the above principle, the researcher is enjoined to ensure a fair (non-discriminatory) selection of participants with undue considerations of their race, class, gender or creed (Patten & Galvan, 2019:16; Whitley & Kite, 2012:38). All participants in this study were selected in a non-discriminate manner. Furthermore, they were also informed of their right to any legal recourse to counteract any perceived form of non-compliance by the researcher to acceptable standards of ethical behaviour and conduct (Whitley & Kite, 2012:38).

1.12.5 Protection from Harm and Risk

The researcher is obliged to protect the participants from any form of physical harm, psychological trauma, social discrimination, and economic loss (Patten & Galvan, 2019:16; Thanh & Thanh, 2015:26). The researcher ensured that the study was conducted in safe and healthy environs in compliance with the Covid-19 risk adjusted strategies as also prescribed by UNISA (2020a:1; 2020b:1). Participants were not harmed intentionally as a result of their lack of knowledge or negligence. In addition, the researcher did not exercise any unequal power relations between himself and the participants, and among the participants themselves. Neither was there any discriminatory considerations in relation to the participants' educational background.

During both the semi-structured interviews and focus group discussions, the researcher adhered strictly to the questions in the schedule, and all participant categories were asked similar questions to ensure that equal treatment was applied and prevailed. The researcher also refrained from asking questions of a personal nature that probed or invaded the personal spheres of the participants' lives. Most importantly, the researcher ensured that any possible risks to the participants were eliminated, which in itself, is also a reflection of the inherent beneficence of the study insofar as its intention to do no harm to participants.

1.13 TRUSTWORTHINESS MEASURES

According to Thompson and Hickey (2016:27) and Walliman (2017:108), trustworthiness measures refer to strategies and processes which the researcher applies for ensuring the study's methodological appropriateness and scientific rigour as viewed from the perspectives of the academic community and the general public. To that effect, trustworthiness in this study was ensured through the measures of criteria of credibility, transferability, dependability and confirmability.

1.13.1 Credibility

Credibility (which is internal validity in quantitative research studies) relates to the degree of confidence the qualitative researcher has in the truth-value of the research findings (Scotland, 2012:16; Van der Riet & Durrheim, 2014:37). In other words, credibility is reflective of the degree of congruence and authenticity between the study findings and the actual reality depicted by these findings. The researcher applied prolonged engagement and peer debriefing to ensure the findings' trustworthiness. Prolonged engagement implies the researcher spending extended periods of time with the participants to understand the contexts that influence their decision-making and understanding of the phenomenon of maternal health care practices (Van der Riet & Durrheim, 2014:37). On the other hand, peer debriefing entails the preparation of participants before, and during the empirical process in order that they were aware of the implications of their involvement. The researcher allowed the participants to pronounce their inner challenges and concerns and translate these as therapeutic sessions.

1.13.2 Transferability

Transferability (referred to as external validity or generalisability in quantitative research) relates to the extent of the study findings' applicability in other contexts with different participants for the purpose of resolving a similar problem that prevailed at the original research site (Kumar, 2015:19; Santos, 2017:44). However, it is generally believed that transferability is not always possible in qualitative research because of the degree of inherent participant subjectivity. The researcher demonstrated the research study's findings by means of an audit trail. The researcher then documented all the study processes and decisions that informed such processes from conceptualisation of the study to its ultimate conclusion with the final research report. Therefore, the audit trail served the purpose of preserving a research record for other researchers who may be interested in similar MCH studies for applicability or relevance in other situations being studied (Kumar, 2015:19).

1.13.3 Dependability

Dependability (referred to as reliability in quantitative studies) is premised on the extent of replicability, stability and consistency of the findings over time, and irrespective of other factors and influences in the external environment (Maxfield & Babbie, 2014:27). The researcher applied a triangulation of data sources in the form of semi-structured interviews, participant observation, and focus group discussions (see Annexure D). The fundamental purpose of the triangulated data collection approach was to ensure that the dependability of the findings was reinforced and strengthened by a range of perspectives from various participant categories or samples, which was advantageous for obviating possible bias by the researcher. In this regard, the findings could justifiably be considered as reflecting the participants' authentic contributions, and not the researcher's own preferred version of reality or truth (Maxfield & Babbie, 2014:27).

1.13.4 Confirmability

Confirmability (referring to objectivity in quantitative research) relates to the degree of independent corroboration of the research findings by others not directly linked to any aspect of the study and its related aspects (Grove, Burns & Gray, 2013:39; Padgett, 2012:24). In this regard, the researcher subjected both the preliminary and final research findings to independent verification by an MCH practitioner who was not one of the study participants. Also, the researcher regularly consulted with his supervisor to ensure that any possible methodological gaps were identified during the course of the study.

Collectively, the confirmability of the study and its processes by the researcher's supervisor and an independent reviewer (MCH practitioner) ensured that the findings of the study were not found to be incompatible with both the researcher's conclusions and recommendations, which could render these findings as an unfounded red herring (Neuman, 2011;43; Punch, 2014:26).

1.14 CHAPTER LAYOUT

The seven chapters of the study are laid out as indicated below:

Chapter One: Study Overview

This chapter provides an introduction of the research topic and synoptic discussions concerning the background; statement of the problem; the research purpose, objectives and questions; the significance and theoretical framework of the study; definition of concepts and the research design and methodology; data collection and analysis; as well as the ethical considerations and trustworthiness measures applicable in the study.

Chapter Two: Literature Review

The chapter provides an outline of the major topical issues attendant to MCH practices from a variety of secondary sources, such as relevant books, research reports from accredited journals, and search engines and databases. The main topics emerging from the reviewed literature include, but not limited to: MCH nursing philosophies; the global and Sub-Saharan African contexts of MCH practices; MCH stakeholders; as well as MCH challenges and best practices.

Chapter Three: Theoretical Framework

This chapter situates the Normalisation Process Theory and other conceptual models of nursing as pivotal to understanding both the abstract and practical domains of MCH practices, strengths, weaknesses, and challenges. The more salient focus is on both the fundamental principles of the chosen theory and conceptual models and their applicability in the context of the research topic.

Chapter Four: Research Design and Methodology

The chapter focuses primarily on the study's pre-data collection aspects, in terms of which the processes and strategies of data collection and analysis are explained, including details of the sampling context.

Chapter Five: Data Presentation and Analysis/ Interpretation

In this chapter, the actual data is presented and integrated in the context of the semi-structured interviews, participant observations and focus group discussions. The themes that emerged from the triangulated data are also clearly highlighted in this chapter.

Chapter Six: Discussion of the Findings

This chapter focuses entirely on discussing the findings of the previous chapter (chapter five) in the context of prevalent literature perspectives to either validate or disprove the assertions emerging from the empirical domain of the study.

Chapter Seven: Summary of Main Findings, Conclusions and Recommendations

The focus of the chapter is on concluding the study with specific emphasis on a synoptic overview of the study and its objectives. It is on the basis of these main findings that the chapter also highlights the researcher's own recommendations that propose improvement measures in the sphere of maternal and child health nursing practices.

1.15 CONCLUSION

This introductory chapter of the study basically outlined the most salient aspects in relation to the research topic. The various research variables highlighted in this chapter are further provided in more details throughout the study's chapters.

As previously stated, the next chapter focuses entirely on reviewing literature perspectives relevant to maternal child health care practices, challenges, opportunities, and best applicable innovative ideas in the context of the research topic.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is based on an in-depth exploration and investigation of the existing body of scholarly or scientific knowledge, which is essential for providing the theoretical background and information about a research topic (Notar & Cole, 2010:6; Polit & Beck, 2010:106). In the context of this study, the reviewed literature also describes the collaborative processes and perspectives regarding services to improve the quality of care for maternal and child health (Raven, 2011:7; Trudel, 2015:185-186). According to Pautasso (2013:3), the review of literature is most achievable by:

"Defining a topic and audience, searching and researching the literature, taking notes, choosing types of review, keeping focused, but showing broad interest, finding logical structures, making use of feedback, including relevant research referring to objectives and being up-to-date without forgetting older studies"

Meanwhile, Onwuegbuzie and Frels (2016:62-63) corroborates that the literature review process involves the exploration and search, storage, organisation, selection and analysis of pertinent information about what is already known and what still needs to be investigated; or provide direction for future studies on similar topics. Furthermore, Borketey and Borketey (2017:31) and Hughes and Kahl (2018:629) intimate that the review of literature provides contextual insights of problems for establishing the trustworthiness factors and aspects of research; that is, credibility, transferability, dependability and confirmability of the study. In that regard, a research study largely depicts the importance of reviewing literatures through rereading, refining and modifying for the purpose of identifying more relevant ideas from the current body of knowledge during study period in relation to the research topic (Borketey & Borketey, 2017:31).

According to Paré and Kitsiou (2015:192), a cogent review of literature is generally conducted in three steps, namely: gathering relevant documents as input; analysis or critical review and focus on available knowledge and indicating gaps as evidence and justification for the proposed research's contribution to new information; and writing the research report to establish a solid output and stand point for discussions on answers to the research questions. The various literature review steps proposed above are a part of the two dominant types of literature review, namely: systematic and non-systematic (narrative) reviews) (Snyder, 2019:338). Both the systematic and non-systematic reviews of literature are applied in this qualitative study. In a narrative (non-systematic) review, there is flexibility in searching, identifying and selecting secondary sources that are

suitable for the study (Mills & Ratcliffe, 2012:147). Such review also demonstrate how studies fit together, which enables the effective formulation of plausible conclusions (Paré & Kitsiou, 2015:8-9). Therefore, the narrative (non-systematic) literature review is objectively focused

2.1.1 Situatedness of MCH in a Literature Review Context

Reviewing literature is helpful for integrating and contextualising theoretical and conceptual frameworks that guide research, determine variables and influence data analysis in the process of the study (Snyder, 2019: 334). Therefore, the flexible and continuous process of literature review in this study enabled the acquisition of secondary information relating to the existing realities of MCH nursing practices, challenges, coping mechanisms, missed opportunities and innovative experiences in the context of socio-economic, socio-cultural, environmental, religious, institutional and healthcare factors (Hughes & Kahl, 2018:629).

In consideration of the above, the reviewed literature is viewed as an appropriate methodological instrument for deriving and encapsulating major philosophies and assumptions about maternal and child health nursing practices, which are women-centred in relation to the term, 'midwife' - which literally means ''with woman'' (Marsh, 2015:68). Therefore, the midwifery philosophy aligns midwives with the recognition of women, respecting and safeguarding the mother and the child's right to health. Similarly, the philosophy of nursing practices in any setting, incorporates the assumption that health affects all members of the family and influences the process and outcomes of health care attitudes, beliefs, behaviours and decisions that are made jointly with other family and community members (Marsh, 2015:68).

The review of literature provided valuable illumination on factors affecting favourable health outcomes in maternal and child health nursing practices, including health promotion, family planning, immunisation, health education, healthcare provision, leadership participation and collaboration processes (Singh, Negin, Orach & Cumming, 2016: 10-11). All these contextual factors can interact to inform on critical literature review and perspectives relevant to the research topic in a local setting. Thus, the literature review provided a context for establishing the contributions made by others in the sphere of the research topic, which enabled the researcher to compare both the Ethiopian and international contexts and to determine whether any lessons could be learnt in the context of maternal and child health nursing practice and policy.

2.2 GLOBAL CONTEXT OF MCH POLICY

Women constitute 70% of the global health workforce, making a vital economic contribution to achieving the SDGs with efforts of nurses and midwives per population (Modi, Dholakia, Gopalan, Venkatraman, Dave & Shah, 2019:32). The aim is to provide quality of care by using women-centred, family centred and community-centred approaches supported by technology and communication platform in response to the needs of community through excellence practices, collaborative partnership, and improved participation (Modi et al., 2019:32).

The World Health Organisation (2018b) defined postpartum haemorrhage (PPH) as a 500ml and more loss of blood within 24 hours after delivery of a baby. In low-income countries, prevention of PPH is necessary by improving quality of care by networking throughout MCH continuum of care. This can contribute to SDG 3 achievement by reducing MMR by 70/100,000 live birth by 2030, reducing neonatal mortality in all countries to 12 or less per 1000 live births, reducing stillbirths to 12 or less per 1000 total births and reducing under-five death to less than 25 per 1000 live births focusing on quality of care and mothers' experience of care (World Health Orgnization, 2018b:6-7). Table 2.1 below is a depiction of the global context of MCH policy development.

Table 2.1: Global context of maternal and child health policy development

1948 to 2020	Globally, the maternal and child health policy journey began in 1948 during the foundation of the World Health Organisation (WHO) and going on up to 2020 and will continue.
1948	The WHO recognised maternal and child health (MCH) as one of the priority areas.
1978	The Primary Health Care Policy promoted MCH and included antenatal care and delivery care and the training of MCH workers focusing on the survival of the child.
1985	The Primary Health Care Policy raised awareness and asked the neglected maternal component in MCH, stating: "Where is the 'Mother' in the MCH?". Then, Safe Motherhood Initiative was introduced.
1987	A greater emphasis was given to community-based care and risk reduction, focusing on the training of traditional birth attendants, obstetric care at first referral level as well as emergency obstetric care as an integral part of MCH.
1994	In MCH care, family planning was made an informed choice with antenatal care; referral and skilled delivery care; obstetric care that avoids excessive use of Caesarean sections; abortion care and enhancement of the effective ongoing programme.
1997	There was a pattern shift in antenatal care on improving the accessibility, quality, and utilisation of emergency obstetric care for women who developed complications, rather than on having contact with all pregnant women.
1999	An advanced safe motherhood through human rights improved women empowerment to ensure choices; social investment in delaying of early marriage with first birth; access to skilled attendance at delivery; access to

	quality reproductive health services; prevention of unwanted pregnancy and addressed unsafe abortion.
2000	The MCH again was given due attention globally through embodiment in the MDGs 4 and 5 achievement in 2015 (Gross and Wydra, 2013:181).
2016-2030	Improving the quality of care and patient safety was critical for ending maternal and child deaths and for achieving SDGs by 2030.

Source: Compiled from Gross and Wydra, 2013 and Oxford Research, 2018.

Delivering services across the continuum of care, both at the facility and the community level was an integral component of the global strategy for primary health care in the continuum of care. On the road to 2030, it is believed that attaining the SDGs is unlikely without a concerted effort of collaboration with CHWs to improve maternal and child health outcomes through the continuum of care as a formal community-based cadre in PHC facility to impact health outcomes positively (Oxford Research, 2018:8).

2.2.1 Maternal and Child Health in the Context of Africa

There is evidence to suggest that nearly 75% of African communities still trust their religious leaders in matters of maternal health and child birth (Widmer, 2011:221). The Millennium Development Goals 4 and 5 (MDGs 4 & 5) aimed at reducing the MMR by 75% and CMR by two-thirds as MDG 4 by 2015. However, the success was not as forecast due to critical shortages of skilled birth attendants in many African regions.

The World Health Organisation reported that there are only 2.6 physicians and 12.0 nursing/midwifery personnel per every 10,000 people in Africa (Ameh & Van Den Broek, 2015: 3). This is confirmed by Agyepong (2017:42-43), who state that African health challenges lie beyond the health sector due to factors such as shortage of resources, wastage of time, poor water sanitation, lack of social protection, poverty, lack of safer road infrastructure, lack of cleaner air and emergence of infectious diseases.

Furthermore, a study conducted in Kenya revealed that women need their husbands' consent to attend a maternal and child health care facility, indicating the importance of family and community support and vitality of service acceptance by the community beyond accessibility, availability, affordability, accommodation and responsiveness of services facilitating and comforting traditional birthing (Lori, 2013:1099). According to a study conducted in South Sudan, the priority needs to address the post 2015 maternal and child health agenda focused on socio-cultural and religious beliefs of the community (Mugo, 2015:9).

2.2.2 Maternal and Child Health in the Context of Ethiopia

A study conducted in parts of Ethiopia emphasised that one of the ways of improving maternal and child health was to expand the health extension programme and mid-level health professionals for primary caregivers at community level (Abebe, 2020:67-68). Ethiopian health policy strategies and programmes are basically preventive and supportive to take intervention to the community regarding maternal education through MCH care intervention and participation in health care delivery (Bang, 2018:228). In addition, MCH success factors were linked to economic progress, health sector partnership development and collaboration, community involvement, policy improvement, health extension programmatic interventions, health worker training, and scaling up of services (Kuruvilla, 2014:542).

Ethiopia has made a great effort and improved the health status of mothers and under-five children in respect of MDGs 4 and 5. This was due to increased skilled birth attendance in general. However, mortality rates were significantly higher in rural areas than in urban areas (114 vs 83/ 1000 live births). For example, children born and raised in rural areas had at least a 38% higher risk of dying prior to age five compared with their urban counterparts (Assefa, 2017:5). The equity gap that could not be addressed by MDG 4 and 5 should be filled by increasing the number and needs of the most marginalised and disadvantaged rural populations. The success factor investments should also be applied across multiple sectors in order to accelerate progress towards the achievement of sustainable development goals that are emphasised in the design of the post-2015 SDG 3 (Kuruvilla, 2014: 15).

Ethiopia adopted a basic emergency obstetric programme in 2010, when the health workforce coverage was at 2.8 skilled health-care professionals per 10 000 population, far fewer than the WHO recommended minimum of 22.8 skilled health-care professionals per 10 000 population. However, attempts were made to address this issue with a so-called flooding policy of health-care professionals in all of Ethiopia as part of the latest Health Sector Development Plans from 2010–2011 to 2014–2015 (Ruducha, 2017:6). In that regard, the immunisation, malaria, family planning, nutrition strengthening health system, reproductive health, water sanitation/hygiene, prevention of mother-to-child transmission (PMTCT) of HIV/AIDS and paediatric HIV care and treatment were supported by maternal and child survival programmes in 24 countries around the world (Kahrmann, 2019:7-8).

The Ethiopian National Health Policy strategic plan of immunisation's primary objective was to vaccinate an estimated 90% of national coverage and 80% in every district by 2020 that would ensure access to basic health services through expanding the health infrastructure, improving the human capital, improving cold storage, and monitoring and evaluation in the health sector (FMOH, 2015:9). The government of Ethiopia has made significant gains in improving the health status of its citizens by improving the life expectancy of its citizens from 45 years in 1990 to 64 years in 2014. Maternal mortality ratio has declined from 1400 deaths per 100,000 351/100,000 and under-five mortality rate has declined to 64 deaths per 1000 births due to strong due to people of Ethiopia and government commitment and support from development partners (FMOH, 2015:5). However, the government recognises the need to maintain progress to create demand and to expand access at health care facilities providing quality health services in an equitable manner (Abebe, 2020:67-68).

There is also the realisation that the major goal of broadening health access is possible through developing clinical and administrative standards as key elements of health reform interventions by engagement of community toward quality improvement and client satisfaction (Mesele *et al.*, 2019:6). Empirical evidence from literature reviews revealed the implications of the pathway for maternal health education that affects the behaviour of mothers (Colvin, 2013:193-198). Accordingly, strengthening continuous supervision and partnership also helped to identify opportunities for local resource mobilisation to support community initiatives (Mozambique Report, 2015:12).

The WHO and UNICEF (2015:12) reported that only about 95% of the facilities had the necessary equipment, while diagnostic items were available in slightly more than half of the overall health facilities. Iron and folic acid tablets were available in about 68% of facilities, and tetanus toxoid injection was available in 36% of Ethiopian health facilities.

2.2.3 Importance of Maternal and Child Health Nursing Practices

The WHO guidelines have pointed out that MCH nursing practice was important for educating, counselling, training, preventing and treating maternal illnesses and complications (FMOH, 2015:39). However, factors such as lack of respect, lack of privacy, lack of continuity of care, negligence and bad behaviour contribute to the reasons for pregnant mothers' aversion to facility-based delivery services (Assefa *et al.*, 2019:4).

The importance of human services in maternal and child health care is the first element that determines the outcomes of such services (Turkmani, 2013:1171) A study conducted in Australia underlined the importance of MCH services close to the community to

increase health care utilisation in order to reduce potential occurrences of death and diseases. Other factors linked to the success of MCH services in the self-same study were associated with expansion of roads and increased cell phone usage (Turkmani, 2013:1171). It was further noted that maternal and child health practices of a community based health facility had a satisfactory outcome due to the availability of supplies; efficient decision making processes; as well as improved organisational, inter-personal, intra-personal, attitudinal, managerial, economic, and environmental factors (Ayivi-Guedehoussou, 2017:42).

Other improvement and satisfaction factors were linked to the importance of public health education; client and community participation; as well as vaccination of mothers during pregnancy for the benefit of their health and their children's health outcomes (Buynder et al., 2019:2819). Patient participation was also viewed as a positive factor in the complexity of nursing care practice for improving patient integrity, mutual respect, as well as the care provider's cooperation; all of which increased quality and safety in care provision, while also contributing to the accomplishment of expected goals and intentions with each patient in accordance with the patient's ability to participate (Abrandt-dahlgren, 2017:74-75).

The study by Goossens and Beeckman (2018:7) revealed the importance of promoting preconception care to address pre-pregnancy weight and nutritional status, as well as screening tests to determine the outcomes of pregnancy, childbirth and reduce maternal deaths and pregnancy-related complications. According to World Health Organisation (2017:1), collaborating centres for developing nurses and midwives should focus on improving nursing and midwifery education and capacity, and also promote evidence-based nursing and midwifery practices.

In rural areas, MCH priorities should focus on access to health care and early intervention services, rural health stakeholders working at local level, mental health, infrastructure, skills, and health coverage (Bolin, 2020:331). According to a study conducted in Uganda, MCH challenges were located in maternal and child morbidity, nursing practice, education and policy as major areas for prioritisation in the quest to improve the health of the population (Spies, 2015:184). Despite the country's policy of free maternal and child health services, there were about 20% health facilities that required women to buy supplies for maternal and child health services (MCH Care Services in Ethiopia, 2013:74). Modern contraceptive use, rather than traditional contraceptive use, was significantly higher in urban areas compared to rural areas, which highlights the prioritisation of rural health services (Assaf *et al.*, 2017:140). A study by Rosen (2015:10)

reported that maternal and child health nursing practices lack the required element of respectful care, sufficient communication and information sharing by providers, adopting a patient-centred approach and availability of health system resources as structural factors. Cheng, Fowles & Walker (2006:40) assert that other determinants of positive MCH nursing practice were cultural, lifestyle behaviour, resource, environment and social factors.

In some MCH contexts, evidence-based practices had a positive effect that was socially recognised and appreciated for midwifery practices which enabled the sharing of certain obstetrics and gynaecology knowledge, skills and practices (Turkmani, 2013:1168). A study by Dunlop (2010:42) demonstrated that the remaining agenda for future research should focus on innovative practices and evidence-based preconception care practices and approaches to prevent further loss of life, such as: maternal screening from nutritional status, STIs and HIV/AIDS, as well as counselling about risk of pregnancy, infertility, chronic conditions, and medications.

2.3 RECOMMENDED STANDARDS IN CONTINUUM OF MATERNAL AND CHILD HEALTH CARE

The practice of nursing is guided by standards established by nursing leaders, professional associations and, to some extent, governmental bodies such as the Public Health Service's Bureau of Health Professions (PHSBHP) and department of maternal and child health for better learning and teaching practices of health care services (Victoria, 2011:21). However, a study conducted in Ethiopia indicated that MCH nursing practice could be influenced through the use of standard guidelines, enhancing performance auditing, awareness, motivation, supervision, experience of nursing, and midwifery (Takele, 2018:16).

According to the Australian national standards for maternal, child and family health nursing practices, the nurse maintains capacity for maternal, child and family health nursing practice, critically analyses maternal, child and family nursing practice, conducts nursing assessment, engages in therapeutic and professional relationships, and engages in lifelong learning to inform and promote healthcare practices (Grant, 2017:7-8).

According to the WHO (2018a:24), the quality and standards of care entail broad themes such as structure (i.e., infrastructure, human resource and supplies) and process (i.e., information sharing, clinical process, emotional support, patient safety, privacy and respectful care (World Health Organisation, 2018a: 24). In this regard, gaps in the quality of MCH nursing processes across public health facilities is located in aspects such as:

inadequate patient privacy in the labour room and postnatal ward; patient abuse; poor hand washing practice; poor sterility techniques; substandard clinical care; and demand for illegal payments (Saxena, 2018:14-15). The WHO (2018:3) made recommendations for standards in the continuum of MCH that involved: screening of HIV and sexually transmitted infections (STIs), cervical pre-cancer and cancer with informed consent and choice, as well as rescreening three years after the first screening.

Implementation research studies ought to include qualitative design to improve maternal and child health nursing procedures and practices in tandem with the prescribed standards that advance conditions for maintaining privacy and confidentiality for women (Martínez-Serrano, 2018:131-132). Similarly, the clinical processes of care should emphasise adherence to the standard operating procedures for providing health care to patients. Patient safety which refers to safe provision of care with minimal risks and harm to the service users. Furthermore, information sharing should emphasise the provider-client information exchange for the purpose of diagnosis and the determination of preference for treatment; as well as social, emotional and psychosocial support provided by the provider. In the same vein, the privacy standard should emphasise on respectful and prompt treatment by the provider throughout the process of care in hygienic and sanitary environments (Saxena, 2018:14-15).

According to the Victoria Association of MCH Nurses (2015:12), maternal and child health standards focus on legal requirements for privacy and confidentiality; timely and proper documentation of (objective and subjective) data that portrays a clear, accurate and detailed picture of the client, nursing intervention plans, and client outcomes as proof of practice. Similarly, the WHO (2018a:20-21), the following eight standard guidelines in MCH care services provide information about what should be done at all levels of healthcare:

Standard 1: Every woman and new-born receive routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period;

Standard 2: The health information system enables data use for ensuring early, appropriate action to improve the care of every woman and new-born;

Standard 3: Every woman and new-born with condition(s) that cannot be dealt with effectively with the available resources is appropriately referred;

Standard 4: Communication with women and their families is effective and responds to their needs and preference;

Standard 5: Women and new-borns receive care with respect and preservation of their dignity;

Standard 6: Every woman and her family are provided with emotional support to improve and strengthen the woman's capabilities;

Standard 7: For every woman and new-born, competent, motivated staff are consistently available; and

Standard 8: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines and equipment for regular maternal and new-born care and complications management.

2.3.1 Preconception Maternal Health Care

Preconception care in maternal and child health programmes was found to be one of the major factors that determined maternal and child health outcomes, including pregnancy and child birth (Dean, 2014:3; Hughes & Kahl, 2018:630). Preconception care relates to the collection of health interventions designed to best prepare and improve the woman's physical and emotional health in order to increase the possibility of a successful pregnancy and healthy infant (Wilson, 2018:532). Preconception has many components that can be implemented under reproductive health program like youth friendly service (YFS) depending on the needs of young men and women (Kereta *et al.*, 2021:74). Preconception care in community groups is associated with factors such as significant increase in antenatal care, lower neonatal mortality rate, increase of breastfeeding rates, as well as improved use of clean delivery kits in MCH practices at community level (Lassi, 2018:5).

Preconception care for a population could encompass aspects such as: alcohol related advice, smoking, diabetic condition, nutritional status, immunisations, and cancer screening (Lassi, 2018:5). The promotion of preconception health care was encouraged for the best health outcomes of mothers and children, especially that such promotion has the potential for substantial public health benefit, considering the large number of unplanned pregnancies due to the gap between preconception and pregnancy confirmation that results in health risks before, and after pregnancy (LifeInt-Opray, 2015:7). Preconception care for women, men and couples with chronic diseases and sexually transmitted disease is another important area of intervention.

According to a study conducted in Southern Ethiopia, there was a relatively low level of health service utilisation due to factors such as: a woman's age, marital and educational status, knowledge about preconception care services, and availability of preconception care unit (Demisse, 2019:9). Other important aspects that influence the MCH outcomes include, adaptation to a healthier preconception lifestyle, offering preconception health information, and improving women's preferred uptake of preconception care (Goossens

& Beeckman, 2018:7). According to Lassi (2016: 2). prevention and optimisation after diagnosis, pregnancy-associated hypertension and diabetes mellitus diagnosis would be best before conception for problems linked to pregnancy termination and sustaining the proper care of mothers and children throughout gestational ages and stages. Accordingly, preconception interventions should be aimed at improving the provision of services to communities, mostly through community health workers in order to increase demand for services and promoting healthy behaviours in maternal and child health care (Johnson, Atrash & Johnson, 2008:7; Lassi, 2016: 2).

Additional research and preconception intervention services are recommended for all women and men, which is an approach to understand how service systems can support the provision of preconception care in maternal and child health nursing (Hemsing, Greaves & Poole, 2017: 8). It is imperative to reduce the risk of maternal and infant mortality and pregnancy-related complications in order to increase access to quality preconception as well as inter-conception care. These preconception issues are dominant in rural areas of due to, *inter alia*, a lack of qualified maternal care providers, including certified midwives and obstetricians (Office of Disease Prevention and Health Promotion/ ODPHP, 2019:42).

2.3.2 Prenatal Maternal Health Care

Antenatal care is a key component of the Health Sector Development Program (HSDP), whose primary objective is to enhance social behaviour change and communication, while also improving the health of the population through the promotion of preventive, curative and rehabilitative health services (Fetene, Binyam, Hibret, Halima, Omer, Canavan, Smith & Berman, 2016:7). This also requires the improvement of access to, and quality of affordable health services (HSDP FMOH, 2016:74). Similarly, prenatal MCH could be exacerbated by factors such as: lack of awareness and access to nutrition counselling services such as iron folic acid supplementation, use of iodized salt and utilisation of insecticide treated bed nets, during antenatal care follow up (Bezabih, Wereta & Kahsay, 2018:13).

Abortion is a serious reproductive health issue in relation to maternal health rights, which is also viewed as interference of government in cultural norms and women's private lives (Aderemi, 2016:71). The WHO (2018:5) recommendations on intrapartum care provide guidelines that detail the procedures according to the context of intrapartum care throughout labour and birth; care during the first, second, and third stages of labour; immediate care of the new-born and the woman after birth; as well as suggestions over time in the future updating of guidelines.

The importance of educating the family, counselling and information dissemination efforts about the breastfeeding benefits and management is realised in MCH nursing practices due to its risk reduction of childhood malnutrition and mortality; diarrheal diseases; obesity and upper respiratory tract infections; as well as improving childhood innate immunity and increasing intelligence (Walugembe, 2015:3). Breastfeeding also enables mothers to lose weight after childbirth, achieve low risk of breast and ovarian cancers, increased self-confidence, better bonding with their babies, and reduction of risk of type-2 diabetes mellitus. Moreover, breastfeeding mothers with gestational diabetes are more likely to have good glucose levels (Busch, 2019:A6).

The nursing process has been described as the core and essence of nursing, central to all nursing actions (Taft, 2015: 6). The nursing process includes continuous input from patients, their families and communities; assessment or diagnosis; planning, outcomes, and interventions through all phases of the nursing process, with the active and equal role of the woman as far as possible (Ethiopian Standards Agency (ESA), 2012:42). A study conducted on domestic violence screening indicated the need to involve mothers in the care practices for improved sustained screening behaviour of practitioners (Taft, 2015: 6).

The use of the World Health Organisation recommendation of four visits in antenatal care utilisation would be the best practices for improved maternal and child health outcomes (Akowuah, Agyei-baffour & Asibey, 2018:4). The contemporary health policy/programme of focused antenatal care to politely attend the maternal health condition throughout pregnancy in MCH care is one of the best opportunities for both care givers and clients in rural health nursing practices; which is achievable through antenatal care home visits, group work and consultations, enhancing communication and effective practices in the rural community (Balfour-Awuah et al., 2015: 61; Fraser, Grant & Mannix, 2016:2557).

In Ethiopia, the health policy strategy was aimed at delivering MCH interventions to the rural population by focusing on quality of care with regard to immunisation, antenatal care, access to contraception and family planning, and assisted deliveries (Memirie, 2016:6). The health policy of the country's view of a PHC unit entails a primary hospital that has five satellite health centres, each of which consists of five satellite health posts (Memirie, 2016:6). Furthermore, MCH intervention would then include: counselling, antenatal care; health promotion; maternal screening; health education; family planning; maternal nutrition; facilitating childbirth; and postnatal care (ESA, 2012:35). Postnatal care includes immediate maternal and new-born care; immunisation, management of severe acute malnutrition; care of under-five children including excusive breastfeeding;

infant and young child feeding; as well as PMTCT, VCT and STD screening and management (Mann, 2016:11-13).

The eight essential RMNCH interventions in Ethiopia pertained to: postnatal and new-born care; family planning; immunisation; antenatal care (minimum four visits), skilled birth attendant, child health care and safe water including sanitation. Accordingly, the Ethiopian government shifted its focus by rapidly increasing the number of health posts from 4211 in 2005, to 16 048 in 2013 and front-line health workers in all parts of the country from 2737 in 2005 to 34 850 in 2013; and also rendered implementation of health care policy possible (Dunlop, 2010: 42; Ruducha, 2017:1146).

2.3.3 Perinatal Maternal Health Care Practices

In 2012, the World Health Organisation recommended the use of uterotonic for prevention of PPH, and emphasised on eight priority areas: contacts in antenatal care visits, midwife-led continuity of care, community mobilisation and participation, packages for home visits to improve antenatal care utilisation and perinatal outcomes, particularly in rural settings (WHO, 2018:8). At the same time, maternal nursing practices were also recommended for all women in the second and third trimester to reduce infectious disease transmission, including the provision of folic acid, iron, calcium, zinc, and TT; screening tests for HIV, STIs and TB; as well as counselling on nutrition and danger signs of pregnancy and antibiotic administration (WHO, 2018:3).

Also recommended was birth preparedness and complication readiness to increase the use of skilled care at birth and to increase the timely use of facilities, as well as identifying and managing obstetric and new-born complications. The expansion of wellness services in rural Ethiopia over the past decades demonstrates a commitment to improving MCH outcomes. Favourable conditions for the collaboration of midwives and HEWs is mandatory for improvement.

According to Berhe (2017:11), routine counselling to all mothers about essential new born care during ANC, delivery and PNC, as well as empowering women to promote essential new born care practice are recommended for prenatal MCH care practices. Meanwhile, the WHO (2015:21) has also recommended MCH nursing interventions in preventing and treating genital tract infections during labour and childbirth in order to improve outcomes for both mothers' and children's health (WHO, 2015:2). In this regard, health care providers and policy-makers were likely to place a high value on the potential public health impact and benefits (WHO, 2015: 21).

In Sub-Saharan African countries, the use of standard guidelines in labour and delivery to influence quality improvement and better achievement of perinatal care service delivery health outcomes could be attained by addressing the poor management of healthcare workers (Mulenga et al., 2018:10). The Ethiopian national health policy has focused on a comprehensive health service delivery system to address mainly communicable diseases, malnutrition and improving maternal and child health. Based on this policy, the rural health centre facility standard is to be applied to all centres (Maureen *et. al.,* 2020:16).

It is the duty of the MCH nurses to take interest in the overall welfare of people by applying ethical standards or principles related to nursing care and action for promoting, preventing, maintaining and restoring health. Therefore, durable perinatal MCH care practice is also dependent on the adherence of nurses to professional ethical standards in their practices (Aderemi, 2016:73-74).

2.3.4 Postnatal Maternal Health Care Practice

Working in partnership helps to influence policy, improve nursing practices, and also demonstrates the influence of institutional MCH health nursing practices. Prevention of maternal mortality due to postpartum haemorrhage could be resolved by addressing maternal and perinatal health coverage inequality (Chetty, Yapa, Herbst, Geldsetzer, Kevindra, Jan-Walter, De Neve & Bärnighausen, 2018:6). To do so, health professionals, health managers and other stakeholders need relevant practice information and guidelines, which encompasses postnatal mothers' three visits at the MCH care facilities. The first visit within 24 hours, the second visit at 3-6 days and the third visit at 6 weeks after delivery are recommended (Chetty et al., 2018:6). However, postnatal care visits are recommended for the 24 hours' visit, 2-3 days postnatal visit, during the 7-14 days' visit and at the 6-week post-natal visit for the purpose of enhancing early exclusive breastfeeding, umbilical cord care, reinforce new-born care, counselling, assessment of mothers, mineral supplementation, prophylaxis and psychosocial support (WHO, 2015a: 3).

A mother who gives birth in a health facility should receive postnatal care for herself and her new-born for at least 24 hours in the health facility. When child birth happens at home, the first postnatal visit should be conducted within 24 hours (WHO, 2013:30). The essential services at primary level are family planning, prevention of STIs and HIV/AIDS, iron, folic acid and zinc supplementation, calcium supplementation to prevent hypertension, vaccination, malaria prevention, counselling on drug use, safe abortion and

provision of prophylaxis like uterotonic, skilled birth attendance, and postnatal care for both mothers and children.

2.3.5 Neonatal Nursing Care Practices

Some of the activities recommended for best practices in maternal and child health focus on: the use of informal leaders, developing and maintaining competency, coordinating and strengthening networks in neonatal care practices (e.g., resuscitation and kangaroo mother) for frequent horizontal communication, relying on up-to-date information, and doing extra home visiting (PCMCH, 2018:31-32).

According to the MCH quality improvement standards, the availability of a health facility at community level is viewed as an opportunity to discuss their concerns, advocate health, care and provide health education at childbirth and immediately after delivery (WHO, 2018:46). Similarly, inadequate care in supplies, health worker shortages, poorly equipped facilities, under-prioritised neonatal care, under-funded health facilities, inadequacies in medicines and equipment remained challenges in MCH nursing practices in under-resourced environments.

2.3.6 Nursing Care of Infants

In the Australian context, mothers, grandmothers, volunteer consultants, frequent rural home visitors, community members, partners and family members were found to be contributory factors to better health outcomes for children even before their first birth day (Grant et al., 2017:8). Infants are the primary vulnerable group that face the risk of malnutrition, which can be prevented by addressing its causal factors such as lack of dietary diversity, prevailing infant feeding and care practices and addressing gender inequalities (Grant et al., 2017:8).

The Nigerian maternal, new-born and child health strategy focused on tetanus toxoid during pregnancy, voluntary counselling and testing for HIV, skilled attendants at childbirth, breastfeeding within one hour of birth, and exclusive breastfeeding among infants less than 6 months old (Edet & Edet 2013:1147). Other considerations included one and three doses of DPT and all vaccinations (BCG, measles, and three doses each of DPT and polio vaccines) and intermittent preventive treatment for malaria as determinants for the health outcomes of infants and children that should not be missed (Edet & Edet, 2013;1147). Such an orientation to health promotion and disease prevention on mothers and infants would positively impact the health outcomes of a generation (Ogbo, 2016:2-13).

2.3.7 Nursing Care of Under-Five Children

The study by Smith et al. (2017:4) emphasised health promotion intervention as a major tool to address many maternal and child health problems in the community in relation to maternal and child health nursing practices. Such interventions were intended to improve participatory approaches, care-seeking behaviour, collaborative efforts, health rights advocacy and appropriate resources at individual, household, community and facility level.

Ethiopia has achieved substantial progress in several areas of primary health care, and has reduced its under-five mortality by two thirds between 1990 and 2012 meeting the required reduction for the MDG 4 target on child survival (Ruducha *et al.*, 2017:1142). In 1990, the under-5 mortality rate was one of the highest in the world, at 204/1,000 live births. By 2012, this rate had been decreased to 68/1,000 live births through the upscaling and strengthening of MCH services. The promotion of preventive new-born care practices through home visits by community health workers and community mobilisation has been shown to reduce new-born deaths and improve new-born care and new-born health outcomes in Ethiopia. Similar community educational approaches for reducing under-five mortality have shown to be effective in Northern Ethiopia (Callaghan-koru, 2013:10).

According to Penfold (2010:11), conducive environments and facilitation of hygienic delivery practices for women should present an opportunity to improve and expedite exclusive breastfeeding counselling. A study revealed that nursing practice and the opinions of nurses were fundamental to working together and understanding the implementation of nurse-family partnership approaches in rural communities (Campbell, 2019:12). Another study revealed that other positive health outcomes were influenced by women's happiness and appreciation for the continuous presence of a supportive person during childbirth (Kabakian-Khasholian & Portela, 2017:10-11).

A United States (US) study revealed the need to consider sociocultural and structural determinants of health that exert a differential protective effect on women before, during, and after pregnancy in special circumstances (Sufrin, 2019:803). It was also emphasised that advanced nursing practice should not depend on the individual nurse, but also on the organisational context in which the presence of a professional MCH practitioner is established. Hence, the nurses in the rural districts of Kenya districts were able to exercise their professional practices perfectly, particularly when working as midwives using networks and libraries; while others depended on the support of senior medical

colleagues and managers to advance their practice (East, Arudo, Loefler & Evans, 2014).

According to the study conducted on intimate partner violence screening, the context of home visiting is more appropriate to develop trust and the need to shift nurse home visiting practice from using short, structured screening tools to a more comprehensive assessment process that engages clients in parenting and safety (Jack, 2017:2224). In fact, the home delivery of nursing care is an opportunity for nurse to learn their patient's norms and culture, which is the best strategy to engage patients insightfully in care practices and also provide insights about quality nursing care for victim women. The WHO (2015:12) recommended vaginal examination at intervals of four hours on assessment of the active first stage of labour, vaginal cleansing with chlorhexidine, intrapartum antibiotic administration for preterm labour and premature rapture of membrane, manual removal of placenta and STIs syndromic management.

The WHO (2018b) global health policy has recommended supplementation of iron, depending on the local context of needs for 4-23 months, 24-59 months and school ages following the monitoring and evaluation using appropriate indicators. Also recommended for iron supplementation is 10–12.5 mg of elemental iron (equivalent of 50–62.5 mg of ferrous sulphate heptahydrate), and 30–37.5 mg of ferrous fumarate, alternatively, 83.3–104.2 mg of ferrous gluconate in the 6-23 age group; as well as 30 mg of elemental iron (i.e., 150 mg of ferrous sulphate heptahydrate) as well as 90 mg of ferrous fumarate (i.e. 250 mg of ferrous gluconate in the 24-59 year age group for three months of the year (WHO, 2016:10).

Despite the preponderant literature MCH nursing, less is known about the actual application of nursing practices in every aspect of the lives of the mother and newly born infant (Lee et al., 2002:11). A study by Ogbo (2016:176-179) showed that the low level of optimal breast feeding (early start and exclusive breastfeeding practice of 0-5 babies) worsens the health condition of mothers and their children. The reasons related to a range of factors, including: poor health policy, dietary diversity and socio-economic status, low levels of education, poor health promotion and health education; poor health communication and professional-family relations, lack of stakeholder collaboration, poor women empowerment, as well as dominant beliefs and customs concerning breast feeding during children's developmental ages of children (Ogbo, 2016:176-182).

According to Mekonnen (2019:12), factors that determine the use of contraception and antenatal visits include, but not limited to: maternal perceptions; status of education and employment; access to health facilities and health professionals; access to information; lifestyle and livelihood (rural or urban). According to a study by Adinew (2017:8), professionals should possess and use all competencies desirable to improve the health of citizens and society in their professional practice. In that regard, it is important to consider the individual and collective healthcare rights to which people are entitled, namely: quality, equity, relevance and effectiveness. Therefore, political, social, attitudinal, cultural, economic, and environmental factors (e.g., ventilation, sanitation and water supply) are salient determinants of the health outcomes of MCH practices in the community (Adinew, 2017:8).

The involvement of family in maternal and child health nursing practice related issues including breastfeeding reduces the risk of childhood malnutrition, diarrheal diseases, upper respiratory tract infections, prevent obesity, improve childhood innate immunity, increase intelligence and reduce childhood mortality. Additionally, mothers who optimally breastfeed their babies are more likely to lose weight postnatally, to have low risk of breast cancer, low risk of ovarian cancers, increase self-confidence, have better bond with their babies, reduce risk of type-2 diabetes mellitus (Babalola & Fatusi, 2009:11; Deller, 2015:S25).

Not every illness has an environmental aetiology (Butler & Cabello, 2018:13). However, health problems related to the environment are an integral part to the assessment, diagnosis, intervention, planning, and evaluation components of nursing practice. Additionally, housing-related environmental stress can affect the health of children, and such factors are often overlooked in routine patient assessments (Butler & Cabello, 2018:13). Proper referral linkage for sick mothers and children strengthened health education and awareness promotion through community-based support groups or women's groups for reducing morbidity and mortality by involving family members and community strengthening (ODPHP, 2019:42).

According to the USAID (2014:53), the quality of care provided to mothers and children is supported by factors such as: the availability of medicine, supplies, equipment and infrastructure; staff deployment and the presence of community health workers. According to the United Nations' micronutrient preparation, iron, folic acid as well as other vitamins and minerals should be provided to all lactating women with active TB in order to complement the maternal micronutrient needs. In addition to the above, it is also recommended that IV/IM oxytocin (10 IU) should be used for PPH prevention in

conjunction with controlled cord traction if manual removal of the placenta is practiced (WHO, 2018:16). The guidelines also recommend the use of “injectable uterotonics … or oral misoprostol” for preventing PPH in facility settings (WHO, 2018:34).

In terms of the Ethiopian maternal and child survival strategy, the eradication of preventable child and maternal deaths requires a comprehensive equity-based approach that includes family planning and service enhancement and reaching those who could not be reached, limiting missed opportunities; as well as reducing dropout rates (USAID, 2016:27).

2.3.8 Infection Prevention Care Practices

The guidelines recommended by the WHO (2018:104) emphasise that infection prevention should principally focus on hand washing, use of safe and sufficient water, safe environmental sanitation and ablution practices, as well as personal hygiene and use of sterile techniques. These guidelines require collective responsibility and ownership of individual accountability in MCH nursing practices (Agreli et al., 2019:7). It was found that the service utilisation and care practices on exclusive breast feeding, child immunisation and child feeding practices among model and non-model families visiting the health centre were uniform, regardless of the family type (Agreli et al., 2019:7) However, the model families were better in the use of HIV testing and counselling as well as Vitamin A and mineral supplement, largely due to their educational levels and the special attention provided by health extension workers.

Busch (2019:12) assert that the National Association of Paediatric Nurse Practitioners has unambiguously endorsed breastfeeding as an integral component of paediatric health care and essential in daily provision of maternal and childcare. As such, other infection prevention strategies recommended were, amongst others: providing family-centred care; supporting maternal self-efficacy lactation; serving as an educational resource for others; as well as employer/employee advocacy and protecting breastfeeding in order to reduce infant morbidity and mortality (Busch, 2019:12).

A comprehensive review of global qualitative evidence has identified crucial commonalities and implementation dissimilarities of task shifting for midwifery in various contexts (Colvin, 2013:1219-1220). As such, it has been strongly recommended that there should be multi-professional connections across different areas of nursing and midwifery practices and other PHC teams (Colvin, 2013:1220). Such an approach enables professionals in a team to provide dignified and evidence based care to women,

new-borns and their families in a manner that is consistent with a culture of human rights (Moxon & Zaka, 2019:17).

The current health policy of Ethiopia, in collaboration with the USAID, demonstrates packages of evidence-based interventions delivered across a continuum of care at family, community and facility levels by increasing availability of services such as skilled birth attendance and essential new-born care/treatment (USAID-Ethiopia News, 2019: 2). Also included is under-five illness management to improve maternal and child health practices and community care-seeking behaviours aimed at increasing the provision of quality community-based new-born care services with a focus of woreda capacity building (USAID-Ethiopia News, 2019:2).

2.4 ROLE OF STAKEHOLDERS IN MATERNAL AND CHILD HEALTH NURSING PRACTICES

Community-based task forces such as mothers, HEWs, TBAs, volunteer health promotors, community leaders, religious leaders and elders can effectively enable women to take care of children appropriately (FMOH, 2015:16-19). It is in the latter regard that the WHO (2017:26-27) clarifies that:

- a nurse is any individual who has completed a programme of basic nursing education and is qualified and authorized in her country to provide the most responsible service of nursing for the promotion of health, prevention of illness and care of the sick; and
- a midwife is any individual who is qualified to practice midwifery nursing and provide the necessary care and advice to women during pregnancy, labour and the postnatal period on her own responsibility and take care for the **newly born infant.**

2.4.1 Role of Nurses and Midwives

The principle of universal coverage plays a central role in health service intervention by midwives and nurses (Wardrop et al. 2019:101). Equally, the future of nursing and midwifery workforce will have key roles of application of global norms and standard guidelines and tools (World Health Organisation (WHO) and WHO, 2017:65-68). The roles of nurses and midwives in maternal and child health nursing practices include: emergency obstetric new-born and child care; networked communication and collaboration; exchange of knowledge, skill and practice through continuous health education, on-the-job support training of staff; participatory service provision; as well as evaluating effectiveness and regular enhancements of knowledge and practices (Ameh & Van Den Broek, 2015:2).

Nurses, midwives and allied health workers have a critical role as patient advocates, protectors of the human and legal rights of patients, including pregnant and postpartum women and their children, including the vulnerable populations in rural area (Jessup *et al.*, 2019:201; McCandlish, 2020:46). Amongst other duties, nurses and midwives also visit patients at home and offer health education on contraceptive use, sanitation, nutrition, vaccination, HIV/ AIDS, malaria, tuberculosis and other infectious diseases and promote human maternal and child health rights (Gerein & Pearson, 2006:7).

Nurses and midwives also play key roles in controlling the spread of disease by conducting rapid needs assessment, and are vital to the attainment of all strategic health policy goals (WHO, 2015:11-12). Currently, the SDG-3 considers nurses and midwives as active and multi-dimensional actors in the SDG 3 achievement of maternal and child health and well-being. The goal, when maintained accordingly, could assist in reduction of maternal mortality up to 75/1000 livebirth, new born death reduction up to 12/1000 livebirth and under-five mortality reduction up to 25/1000 livebirth by the year 2030 (WHO & UNICEF, 2017:9).

The nurses and midwives play a vital role in the maternity care workforce in rural area settings and interprofessional collaboration among staff working in MCH nursing contexts (Kozhimannil, Henning-Smith & Hung, 2016:417).

2.4.2 Role of Health Extension Workers/ HEWs

The role of HEWs includes the provision of care to women throughout pregnancy, childbirth and postnatal period, and timely referral of pregnant women to the nearby health centres in rural communities (Hill, 2019:5). In Ethiopia, the predominantly female HEWs account for almost 50% of the entire health workforce, and are entrusted with improving the health of mothers and new-borns by reaching every household, which recognises women's traditional roles as care providers in an acceptable way (Jackson & Jackson, 2018:2).

2.4.3 Role of Traditional Birth Attendants

Traditional birth attendants play critical role in improving health care seeking behaviours of mothers during pregnancy and lactation (Adatara, Afaya, Baku, Salia & Asempah, 2018:8). Furthermore, they play an instrumental role in ensuring and optimising lay health worker roles for working with individuals, families and communities for MCH by recognising and acknowledging their cultural and social acceptability in supporting the health of women and children, linking them with formal health services (Miller & Smith, 2017:3). In addition, TBAs played a significant role by providing psychological support,

facilitating referral linkage and supporting mothers in labour, although they were not adequately compensated or incentivised (Adatara et al., 2018:8).

2.4.4 Role of Community Members

Lack of respect from skilled birth attendant was viewed as a reason that negatively affects maternity service utilisation. In this regard, the role of community members then becomes a panacea for improving the supervision, education, community participation and capacity building for the wellbeing of women (Dawson, 2012:74).

2.4.5 Role of Women/Family Members

Traditionally, women, especially the elder woman in the family, are believed to be primarily responsible for family health. On the other hand, the roles of family members and siblings are a crucial determinant for influencing a woman's decision on her health (Morris, Short Robson & Andriatsihosena, 2014:14). Non-family members (e.g., religious leaders) are also involved in ceremonial activities of marriage and post-delivery situations (Morris et al., 2014:14). A study revealed that mothers are aware of their roles and responsibilities of caring for children and recognise the stakeholders and social supporters who participate in caring mothers and children during child bearing and child rearing (Arcos, 2018:184).

2.4.6 Role of Volunteer Health Promotors

The role of community volunteers includes the promotion of the health of the infant and young child, as well as improving child feeding practices and exclusive breastfeeding practices *(*Doherty*,* 2019:5). The volunteer women are required to conduct household visits and share what is commonly expressed by religious leaders and other elders in the village. The volunteer community health workers recognise symptoms or danger signs, and refer patients to the nearest sufficiently staffed and equipped health facility (Glenton & Javadi, 2013:6). The volunteer community health workers are responsible for operationalising the health promotion activities, as well as support programme effectiveness (Ludwick, 2018:7).

2.4.7 Role of Religious Leaders

Muslim religious leaders' play a role in promoting health to fight against misguidance and misdirection. It was reported that the health status of the future leaders and workers is directly linked to the health status of their mothers today (MAIWADA, 2020:6). According to one of the study findings, religious teaching could help shaping the ideation related to family planning and could contribute to increase contraceptive uptake *(*Doherty*,* 2019:5).

2.5 CHALLENGES IN MATERNAL AND CHILD HEALTH NURSING PRACTICES

A woman's experience is related to factors that hinder health-seeking behaviours, such as the abusive character of some caregivers, use of degrading language, insulting and shouting , poverty, fatigue and poor availability of medicines. Other MCH challenges include: lack of awareness, shortage of food, as well as religious practices such as fasting during pregnancy and avoiding certain food types associated with taboos (Bezabih et al., 2018:9).

It is recommended that current public policy should entail the participation of nurses and midwives in research initiatives and exploration of indigenous knowledge relevant to MCH nursing (FMOH, 2015:103). According to Turkmani (2013:1170), lack of research-based evidence with local context and content also contributed to some of the MCH challenges.

The foremost gap in MCH care was the mismatch between principles and actual care practices. For instance, the lack of compliance in the minimum requirement of the facility, poor clinical procedures and poor application of infection prevention principles (Turkmani, 2013:1168). In another study shortage of infrastructural and equipment challenges were mentioned as an indication of inadequate physical resources (Baffour-Awuah et al., 2015:62).

2.5.1 Health System Challenges

In many instances, health system challenges in maternal and child health nursing practices were linked to inadequate resources in health facilities, lack of engagement in policy making, as well as lack of participation in research with timeline suited to policy activity (Turkmani, 2013:1169). According to a study by Jackson and Hailemariam (2020:4), health systems challenges also included: illiteracy/ lack of information; poor health status of women; absence of a well-trained cadre; inadequate referral system; socio-economic barriers; poor health service coverage, geographical barriers, and limited capacity of health workers to provide services (Jackson & Hailemariam, 2020:4). The lack of expected outcome in this regard is due to challenges of mothers delaying to seek timely healthcare, transportation barrier to reach mothers and their children, poor quality health care, as well as unethical behaviour of care providers in the facility (Uneke, Sombie, Keita, Lokossou, Johnson, Ongolo-Zogo, 2016:125).

Other reported challenges were: The socioeconomic status of women, their educational levels, poor demand and supply management, lack of service utilisation, as well as personal interest or professional negligence (Betemariam, 2017:11).

2.5.2 Access Challenges

According to UNICEF (2014:16) access challenges to implementation of maternal and child health service delivery were related to aspects such as: the lack of area-specific research (UNICEF, 2014:16). Despite the substantial increase of health service coverage in Ethiopia, there are still access challenges to quality services due to insufficient resources for skilled birth attendants in rural populations (Betemariam, 2017:14; Zerfu et al., 2019:5). Other barriers were identified as: the lack of evidence-based decision-making, poor preconception care practices, short inter-birth interval, and insufficient screening services in maternal and child health nursing practices.

2.5.3 Attitudinal and Perceptual Challenges

The attitudes of certain nurses and midwives were negatively influenced by the challenges they faced in rural areas, in addition to the lack of a conducive environment, resources, and incentives; workload and waiting time pressures; as well as inadequate personal requirements of patients (Baffour-Awuah et al., 2015:61-62).

2.5.4 Socio-Cultural and Religious Aspects

In maternal and child health services, socio-cultural factors such as acceptability of services, education, cultural factors such as language taboo and religious beliefs were noted as influencing health outcomes (Desta et al., 2017:7). The study revealed that some types of nourishing foods and abdominal massage were prohibited due to cultural practice and traditional beliefs that are challenges in maternal and child health nursing practices, which in turn contributes to hardships and pregnancy related complications (Mesele, 2018:298-299). The perceptions of people might negatively impact the mothers and result in poor health seeking behaviour and early marriage practices may create barriers to the uptake of MCH care services (CDPF, 2010:48-49).

2.5.5 Resource Related Challenges

According to Morgan (2017), shortage of resources constituted a major challenge in MCH care services delivery, in addition to poor demand and supply management, poor participation of stakeholders, and lack of basic delivery supplies. According to Deller (2015:S30) other resource-related challenges were linked to frequent turnover, lack of electricity, shortage of water, limited HIV/AIDS treatment services, and poor communication.

2.5.6 Institutional Challenges

Some of the institutional challenges linked to MCH nursing practices include: lack of health insurance throughout the population, home-birth preference, budget constraints

and poor implementation of maternal knowledge (WHO Recommendation, 2015:644). Poor inter-professional and inter-institutional collaboration were also linked to maternal and child health nursing practices (DiMaria-Ghalili, Mirtallo, Tobin, Hark, Van Horn, & Palmer, 2014:7-8). In the current study, institutional challenges and limited collaboration between health facilities were also observed (Goossens & Beeckman, 2018:7).

2.5.7 Environmental Challenges

Lack of safe and sufficient water, lack of transportation, distance to facilities, lack of transportation and the constant mobility of pastoral communities were found to be consistent environmentally induced challenges (United Kingdom Report, 2018:99).

2.5.8 Coping Mechanism to Maternal and Child Health Challenges

Agyepong (2017:46) intimates that coping mechanisms to MCH challenges could be enhanced by, *inter alia*, conducting focused research, mobilising resources, collaboration, community participation, as well as innovation at all levels of the system. Some of the helpful mechanisms for overcoming challenges involve the practitioners' knowledge of their professional values and application of individual and collective accountabilities, as well as collaborating and negotiating with others challenges (Aderemi et al., 2016:74).

Health extension workers and religious leaders have increasingly accepted the communities as avenues for overcoming barriers and enhancing coping mechanisms that improve the health outcomes within their scope of practice (Desta et al., 2017:8). Such coping mechanisms also entail issues of accountability, devoted decision-making, community participation and women empowerment (United Kingdom, 2018:185). In addition, strengthened health care practices, collaboration among caregivers and care seekers could benefit women for better health outcomes (King *et al.*, 2015:545). Poor leadership and quality of access, inadequate resource allocation, and stakeholders' concerns also pose barriers to provision of health services (Plough et al., 2011:14).

2.6 MISSED OPPORTUNITIES IN MATERNAL AND CHILD HEALTH NURSING PRACTICES

Missed opportunities for contraceptive and immunisation use were high among pregnant people living with HIV and AIDS, and above average in rural health facilities (Edet & Edet, 2013:1155). Very notably, the application of principles of adult education and integration of antenatal education were also missed opportunities in maternal and child health care (Renkert & Nutbeam, 2001:385-386). In a study by Houghtaling (2018:86), it was revealed that lack of involvement of family elders such as grandmothers was a major

missed opportunity in MCH nursing practice. Thus, integration of volunteer grandmothers with health care providers would be advantageous to improving the best breastfeeding practices for mothers (Houghtaling, 2018:86). On the other hand, aspects such as the demand for care provision, technology, health resources and collaboration presented opportunities for increasing maternal and child health nutrition practices (DiMaria-Ghalili et al., 2014:6).

At community level, some of the missed opportunities included: decentralisation of MCH services, communication feedback, appropriate supply management, as well as intervention supervision and scaleup (United Kingdom, 2018:217). The lack of an effective health education curriculum and appropriate skills and clinical practices were other missed-opportunities in improving MCH care practices (Desta et al., 2017:8).

2.7 BEST PRACTICES IN MATERNAL AND CHILD HEALTH NURSING SERVICES

Some of the best practices in maternal and child health nursing practices are: adherence to standard professional and ethical guidelines; systematically evaluating client satisfaction; community/ civil involvement and dialogue in health care practices; as well as fulfilling basic requirements for maternal and child health in rural facilities (Hackett, 2016:188-189; WHO, 2015:24). Furthermore, conducting participatory research at community level was viewed as a means to explore and evaluate best practices in the context of the local community (Bezabih et al., 2018:1).

It was also established that encouraging demand, providing free of charge services, implementing evidence-based interventions and needs assessment based action planning were viewed as some of the contributory factors and tools to alter and sustain maternal and child health care practices (Paul, 2011:346). For the government of Kenya, using best practices as benchmarks (e.g., birth and death registration through mobile phones) were found to be significant insofar as advancing MCH care practice is concerned.

In respect of Ethiopia maternal and child health care practices were implemented through the strategy of increasing access by training health extension workers, traditional birth attendants, and also scaling up the three-tier health system of primary care levels (FMOH, 2015:8). The engagement of traditional leaders, participation of women through mobilisation and advocacy, as well as the use of solar energy at rural health facilities were also found to be positive MCH contributing factors (UN Women, 2015:24). In addition, the WHO (2012:118) proposed that the enhancement of collaborative and sustainable relationships, incentives to facilitate recruitment, as well as motivation and

resilience of front-line staff were some of the shared best practices in maternal and child health improvement.

From the perspective of the Centers for Disease Control and Prevention (CDC) and the World Health Organisation (2016:41-42), best practices in maternal and child health care were achievable by means of some of the following: sharing experience and exploring effective implementation; and improving compliance by providers, performance evaluation standards and coverage; as well as strengthening capacity to assess implementation and effectiveness of interventions and child survival intervention packages.

From the government of Sierra Leone's perspective, the expected outcomes of best practices in maternal and child health care encompassed: involvement of all nursing and midwifery care stakeholders, including communities as health care consumers accountable for the general quality of services and access; as well as regulatory and service provision based on globally and locally standardised and accepted and implementable legislation (Jalloh, 2019:1-2). It was also found that MCH enhancement involved addressing health inequality and inadequacies, and engaging diverse partners in health care (Franklin, 2016:32-33; Taft, 2015:2-3).

That nurses and midwives were both active participants and major role players and instrumental in improving MCH outcomes is not in dispute (WHO, 2017:58). To that effect, their contribution is most relevant in terms of the transformative SDG agenda insofar as the elimination of any form of mistreatment is concerned (Bohren, 2018:16); encouraging more parental responsibility for identifying problems and outlining milestones for monitoring children's growth (Nicogossian, 2015:19); as well as advocating for the use of mobile health services to improve MCH access in areas such as preconception care, antenatal care, perinatal care, postnatal care and care of under-five children in rural and remote areas (Nicogossian, 2015:19).

2.8 CONCLUSION

The review of literature from a variety of data sources and perspectives enabled the researcher's exposure to, and understanding of pertinent issues relating to maternal and child health care practices. It was in this regard that the current chapter presented discussions that included both the positive attributes and challenges attendant to this field of health practice in the global and Sub-Saharan African context.

Finalizing the reviewing of literatures prior to data collection in qualitative approach was found to be problematic when an area-specific situation of community health care practice is being studied qualitatively, because what works best in one situation or population may not be contextually applicable in another. It is in this regard that the particularities of the research problem necessitated an on-going review of the literature. The next chapter focuses on the theoretical and conceptual framework of this study.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The previous chapter presented a detailed literature review in respect of maternal and child health nursing practices. The current chapter basically presents the theoretical framework in terms of which an in-depth understanding is provided regarding the nature of maternal and child health service practices. Therefore, the theoretical framework articulates the scientific or conceptual boundaries or sphere of the study within the parameters of a particular theory or theories chosen by the researcher (Thomas, 2016:46; Welman, Kruger & Mitchell, 2012:29). Moreover, it is on the basis of the theoretical framework that the study's philosophical premises, structure and scope were derived, which enabled the process of generalisations for exploring, describing or explaining the core phenomenon of investigation and its associated variables (Ruppel & Mey, 2017:42; Welman et al., 2012;29).

According to Rani (2016:1) and Ruppel and Mey (2017:47), the theoretical framework serves as an influential mechanism to guide the structure of the study, while it also enables a coherent conceptual linkage to support various aspects of the self-same study. The theoretical framework helps the researcher by providing a background for identifying research focus areas, the formulation of research questions and data collection processes, and better understanding of the analytic and interpretation of maternal and child health nursing practices (Ridgeway, 2012:46). In this regard, the researcher viewed the Normalisation Process Theory (NPT) of implementation as a seminal theory for supporting healthcare intervention practices.

According to May (2006:8-9), the NPT is a prospective framework for ethnographic research, and thereby focuses on individuals and groups of key stakeholders in primary care services within an organisational or professional setting (May, 2006:8-9). In this regard, the current chapter's structure reflects two essential aspects: attributes of the NPT and their applicability or relevance to maternal and child health intervention practices.

3.2 THE NORMALISATION PROCESS THEORY

The Normalisation Process Theory (NPT) provides a framework for identifying and implementing programmatic interventions and improvements (May, Cummings, Girling, Bracher, Mair, May Murray, Myall, Rapley & Finch, 2018). According to the NPT, evaluation is helpful to identify both inhibitors and enhanced intervention effectiveness, and also improving links with these services and overcoming the barriers identified

(Leesa Hooker, Rhonda Small & Angela Taft, 2015:11). Furthermore, the Normalisation Process Theory (NPT) underpins three main problems: bridging practice (implementation), incorporating practice into routine individual or group work (embedding), and sustaining the social context of an organisation or (Mckinnon and Finch, 2018:4; Fox et al., 2014:1).

Normalisation is a vital tool for identifying and directing resources and training factors for integration into practice, and for training all human service workers, such as nurses and midwives and other individuals in the human services at grassroots level. In this regard, the NPT entails or suggests that all human beings are valuable, and further assists the researcher to understand the expected MCH health outcomes based on the existing nursing practices for possible suggestions and improvements (Gillespie, 2019:2-3).

3.2.1 What is Normalisation Process?

Normalisation is a continuous process which ought to be continuously refreshed to prevent any current or future misunderstanding of the healthcare in relation to location of the required human service; the nature of the demand and speed of its acquisition; human relations, communication, affordability, attractiveness, functional community resources; and use of new opportunities (May et al., 2018). For purposes of this study, normalisation is an ongoing activity for accommodating the evolving physical, emotional, and social needs of the mother and child by individuals, family and community. Figure 3.1 below is a depiction of the theoretical approaches of implementation science, of which the NPT is a component.

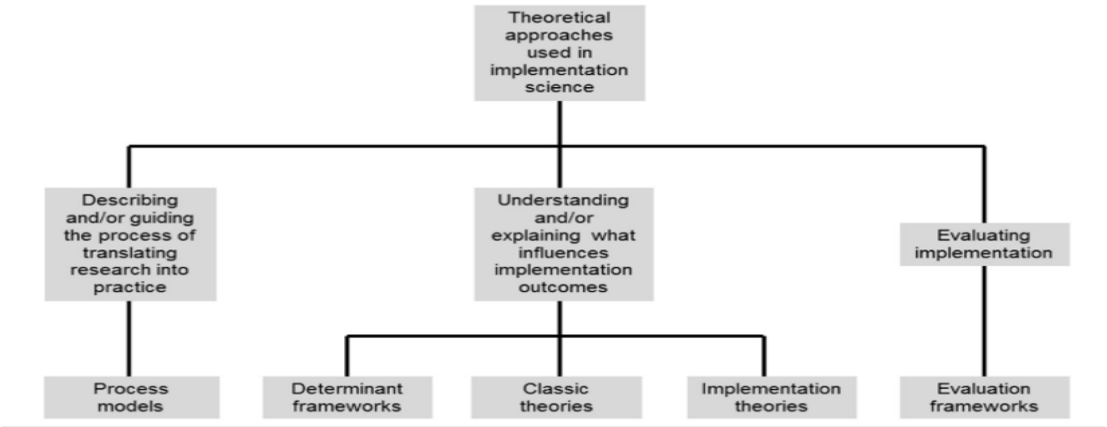

Figure 3.1: Theoretical approaches of implementation science
Source: Nilsen, 2015:5

Extrapolated from Figure 3.1 above is that the implementation science/theories are underpinned by three purposes, and five categories of theories, models and frameworks (Nilsen, 2015:5).

3.2.2 Normalisation Process Theory Framework

Different theories were reviewed by the researcher in relation to healthcare intervention practice and service implementation. Progressively a theory of implementation was identified from studies of practice in different healthcare settings. Figure 3.2 below is an illustration of the normalisation process theory framework, in terms of which complex organisational factors are shown and their interpersonal relationships within social networks that guide practice (McEvoy et al., 2019:28).

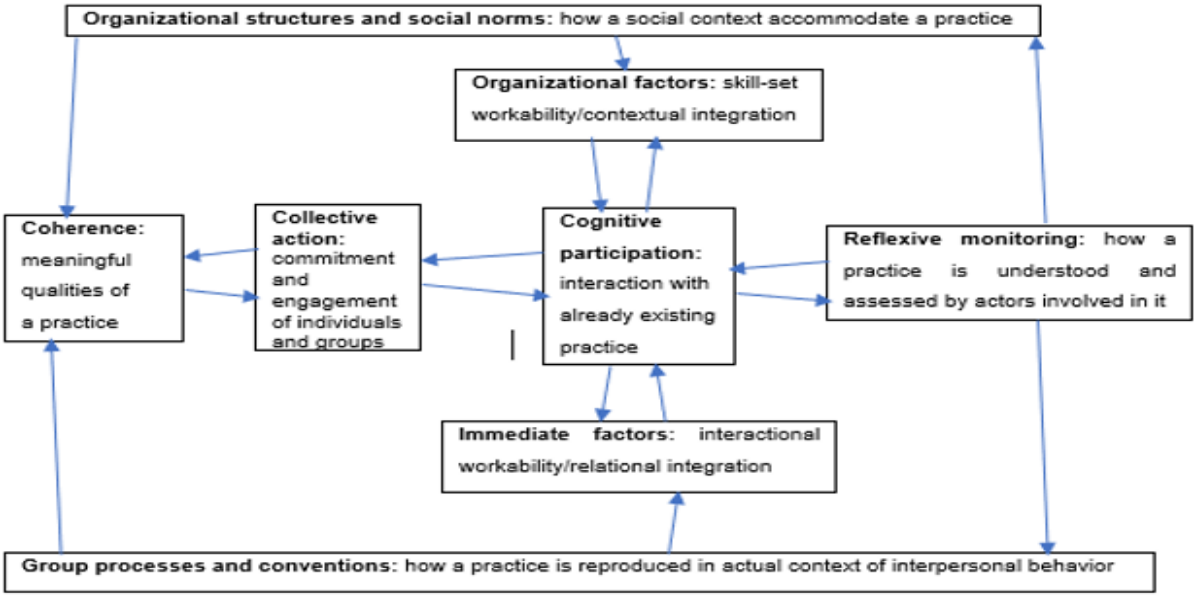

Figure 3.2: Normalisation process theory framework
Source: Adapted from May, 2006:542

3.2.3 Interaction Between Mechanisms of Normalisation Process Theory

In the mould of the Normalisation Process Theory, the four non-linear variables or domains interact dynamically to provide a detailed explanation of the implementation or interventions for practice (Asiedu, Fang, Harris, Colby & Carroll. 2019:3; May et al., 2018:15). Figure 3.3 (overleaf) is an illustration of the interactions between NPT mechanisms and obligatory points of passage.

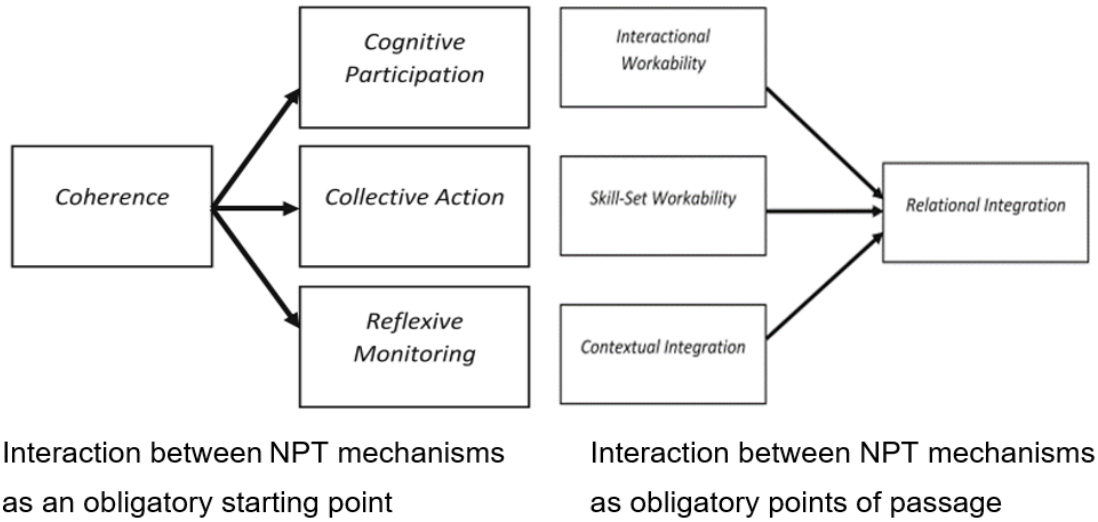

Figure 3.3: Interactions between NPT mechanisms and obligatory points
Source: Adapted from May et al. (2019:15).

On the one hand, the three factors of interactions between NPT mechanisms as an obligatory starting point (cognitive participation, collective action, and reflexive monitoring) are cohesively linked to coherence. On the other hand, relational integration is the cohesive factor linking interactional workability, skill-set workability, and contextual integration with the NPT obligatory points of passage.

Interactional workability means the work that people do together with other elements of a set of practices. Relational integrity refers to knowledge that people do to build confidence. Skill workability refers to allocation of duty around a set of practices operationalised. Contextual integration refers to allocation of resources and managing a set of practices (Morden& Brooks, 2015:801).

3.3 CORE CONSTRUCTS OF NORMALISATION PROCESS THEORY FRAMEWORK

The core constructs in a Normalisation Process Theory framework consist of four generative mechanisms, namely: coherence, cognitive participation, collective action and reflective monitoring. Coherence relates to how people make sense of intervention or its value (May et al., 2019:15). Meanwhile, cognitive participation is premised on the way people are involved and remain committed to their contribution to health care interventions. On the other hand, the mechanism of collective action basically implies how people perform their practice-related work, as well as the wherewithal to make such performance to happen fruitfully (May et al., 2019:15). Reflective monitoring, furthermore, relates to the extent of people's assessment of the work in order to understand the conditions of the intervention and to determine whether or not it was possible for improvement to occur (Adom & Hussein, 2018:440). Table 3.1 below is a tabular

depiction of the four generative mechanisms of the NPT and a synoptic description of their inter-related variables.

Table 3.1: The four generative mechanisms of the NPT and description

Generative mechanisms	Description
Coherence	The sense of making work that people do individually and collectively
Cognitive participation	The relational work that people do to sustain the community of practice in health care intervention
Collective action	The operational work that people do to enact a set of practices
Reflective monitoring	The appraisal works that people do to assess the way a set of practices affects them and others around them.

Source: Adapted from Lloyd, 2013:4

The NPT framework also includes institutional mechanisms for surveillance and regulation, evaluation and clinical governance upon which judgments about the intervention practice are made (May & Finch, 2019:31). Following below, are discussions concerning the for generative mechanisms of the NPT.

3.3.1 Coherence

Coherence proceeds from the notion that organisations are constituted by different individuals, approaches, practices and systems that all work coherently or synergistically towards achieving the same organisational goals (Morden & Brooks, 2015:3). Therefore, differentiation is not viewed antagonistically, but positively as “a communal specification” for the internalisation of individual tasks (Morden & Brooks, 2015:3).

3.3.2 Cognitive Participation

Cognitive participation deals with investigation to assess how stakeholders are oriented to engage themselves in MCH work and how they are prepared to diligently take part in initiation (modification of a set of practice-related work); legitimation (participatory relational work); and activation (collective definition of action and procedures for practice sustenance (Morden & Brooks, 2015:800).

3.3.3 Collective Action

Collective action relates to how the practice-related work, roles and services are organised and performed; people’s involvement and inter-connectedness; as well as skills to complete the work (Morden & Brooks, 2015:800). Collective action is diametrically opposite to individualisation, and could also be viewed as appositional to the aspect of coherence, insofar as different initiatives being undertaken to achieve a single or coherent purpose.

3.3.4 Reflective Monitoring

In the NPT mould, reflective monitoring pertains essentially to the profound or introspective observation of the sequence and speed with which (MTC) services are rendered (Morden & Brooks, 2015:801). Such monitoring reflects on the appraisal of work that people do to assess the way a set of practices affects them and others around them. The likely outcomes and areas that require timely correction or improvement are appraised individually or communally in order to evaluate the worth of a set of practices. Individual appraisal refers to individual work to a new set of practices. Agreli (2019:1-2) and Bamford (2012:3) contend that it is on the basis of reflective monitoring that challenges and opportunities for providing health and social services to a particular target of needy community could be understood more holistically.

3.4 IMPORTANCE OF NORMALISATION PROCESS THEORY FRAMEWORK

The NPT has been applied to study many health care practices in primary healthcare settings (Lloyd, 2013:5-6). Furthermore, the NPT is relevant to offer a conceptual framework about the implementation processes and is, therefore, a grounded theory rather than a theory that has drawn on constructs in existing theories: higher level theories of socio-technical change, higher level theories of structure and action, higher level agentic perspective in social cognitive psychology, formal grounded theory of normalisation process (capacity), middle-range theories of social structure, resources and mobilisation (capability), middle-range normalisation process theory (contribution), middle-range theories of individual and collective readiness (potential) and extended normalisation process theory (implementation theory) (May & Finch, 2019:540).

The normalisation process theory is relevant for investigating the implementation and maintenance of the interventions undertaken to inform the likely health outcomes (Nordmark et al., 2016: 8-9; McIntyre, 2018:174-175). The Normalisation Process Theory framework appears to be a direct alternative to the actor–network theory, which insists on the agency of human actors, seeks to be explanatory and also specifies a set of mechanisms for investigation of healthcare intervention practices that contextually fit well with the interpretive approach of ethnography, phenomenology and other qualitative research methods (May & Finch, 2019:540).

Furthermore, the NPT coheres with the social organisation of the work of making practices routine elements of everyday life (embedding), and sustaining or integrating embedded practices in their social contexts, while also expressing an empirically observable set of social processes that can be modelled (Finch, 2009:4). Notwithstanding that such forecast is subject to a range of unknown contingencies, emergence and

complexity are significant constraints on predicting the outcomes of social processes (May & Finch, 2019:15).

3.4.1 Qualitative Methodological Approaches in Normalization Process Theory

Qualitative study design is important for in-depth investigation and understanding of MCH nursing issues in the context of rural settings provided at individual, family and community levels (Jirojwong & Welch, 2011:10). Therefore, different qualitative study approaches could be applied even in the context of the NPT. For instance, phenomenology - for gaining insights into the lived experiences of participants about a particular condition (which reinforces both cognitive participation and collective action), and ethnography - for exploring social organisation (which also reinforces understanding of outcomes of social interaction).

Additionally, the Normalisation Process Theory was designed to be applied flexibly for adaptation to one or more points in a qualitative study, and provides a convincing theoretical framework to understand the intricacies of implementing and operationalising concepts in consistent ways (May et al., 2014:299).

3.4.2 Normalisation Process Theory Toolkit

The NPT offers a valuable set of conceptual tools for understanding the complexities of implementation processes within clinical practice (May et al., 2014:299). It is therefore important to link collective action to context in implementation studies, which encourages greater effort towards addressing challenges, including the use of frameworks, theories and models, as well as psychometric attributes of the instruments being developed (Rapley et al., 2018:14). Figure 3.8 below depicts the NPT tools related to constructs and sub-constructs.

Table 3.2: NPT tools related to constructs and sub-constructs

Constructs	Coherence	Cognitive Participation	Collective Action	Reflexive Monitoring
Core Construct	The process and work of sense making and understanding that individuals and organisations undertake that promote or inhibit the routine	The process and work that individual undertake to promote engagement with the new practice	The work done by individuals and organisations to enact the new practice.	The work inherent to formal and informal appraisal of new practice, to enable assessment of advantages and disadvantages, developing user's comprehension of the effects of a practice

Constructs	Coherence	Cognitive Participation	Collective Action	Reflexive Monitoring
	embedding of a practice			
Sub-constructs	Differentiation How do stakeholders see this way working?	Enrolment How do the stakeholders believe they are the correct people? to drive forward the implementation?	Interactional workability How does the intervention make it? easier or harder to complete tasks?	Systemisation How can the stakeholders be able to judge the effectiveness of the intervention?
	Individual specification How do individuals understand tasks the intervention requires of them?	Initiation How are their willingness and ability to engage others in the implementation?	Skill set workability How correct are the skills and training for the job?	Individual appraisal How will individuals judge the effectiveness of the intervention?
	Communal specification How do all those involved agree about the purpose of the intervention?	Activation How can stakeholders identify what tasks and activities are required to sustain the intervention?	Relational integration How do those involved in the implementation have confidence in the new way of working?	Communal appraisal How will stakeholders collectively judge the effectiveness of the intervention?
	Internalisation How do all the stakeholder's grasp the potential benefits and value of the intervention?	Legitimation How do they believe it is appropriate for them to be involved in the intervention?	Contextual integration How do local and national resources and policies support the implementation?	Reconfiguration How stakeholders be able to modify the intervention based on evaluation and experience?

Source: Adapted from Finch, 2020:31

However, what is still unknown is the NPTG's potential to predict the likely outcome of implementing an intervention, and whether NPT-based instruments can be used to enhance implementation in the development of instruments (Rapley et al., 2018:13). Therefore, further testing is still required for larger samples in implementation activities. The following questions are the normalisation process theory tool items intended for universal use: When to use the intervention? How familiar does it feel? Do you feel intervention is the normal part of your work? Do you feel the intervention will become the normal part of your work? (Rapley et al., 2018:11).

3.4.3 Dynamic Sustainability Framework for Health Intervention

Translation science is rapidly growing field in healthcare practices (May et al., 2019:21). However, it is not routinely used in testing implementation interventions for improving uptake and use of evidence in patient outcomes, which would illuminate on why some implementation strategies work in certain situations and not in others (Titler, 2018:9). Sustainable MCH nursing practices and outcomes are achievable in an environment of comprehensive, nurse-designed, and theory driven implementation, with long-term implications for the care of women and children (Titler, 2018:9). Similarly, the use of implementation theory in the design and analysis of work and organisations strengthens its value insofar as understanding the contextual sustainability factors (Hooker, Small & Taft, 2016:542; Malone, 2012:19).

In the dynamic sustainability framework, there are three essential constructs (intervention, practice setting/ context, and the ecological system), each with its own variables, as shown in Figure 3. 4 below.

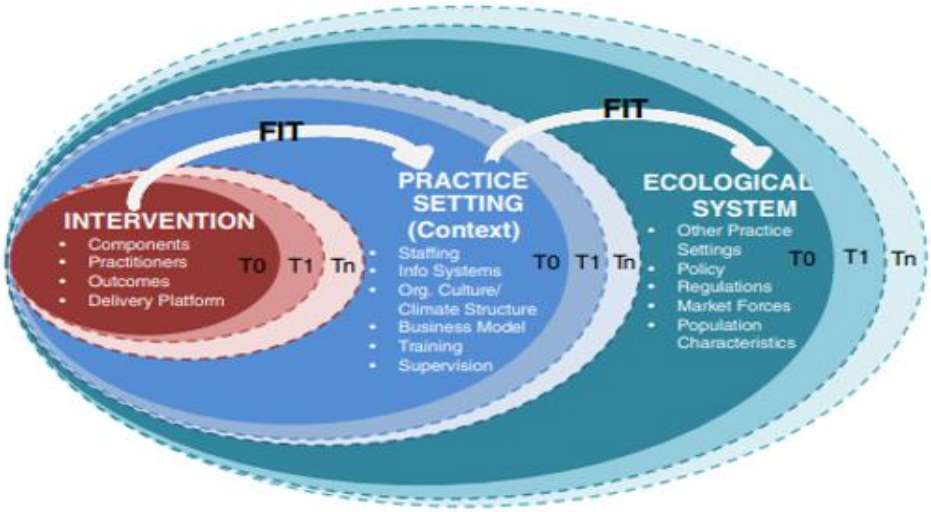

Figure 3.4: The dynamic sustainability framework
Source: Adapted from Chambers, Glasgow and Stange, 2013:4

As shown in Figure 3.4 above, the dynamic sustainability framework's goal is to maximise the fit between interventions, practice settings, and the broader ecological system over time (Chambers et al., 2013:4),and serves as a basis for the subsequent analysis stage by stage (represented by T0, T1, Tn), each with its own DSF constituent components (Klinga et al., 2018:5).

In conjunction with the above-cited DSF, the Clinical Sustainability Assessment Tool (CSAT) serves as a reliable mechanism for assessing the organisational capacity for sustainable clinical settings (McCreighgt, 2019:1002). In this study, the CSAT is considered relevant to the extent that it enables enhanced planning of research and

evaluation work regarding sustainable clinical settings, determining its (CSAT's) operational capacity within broader studies of implementation, and assessing its validity for outcomes of implementation in healthcare systems and clinical settings (Urquhart, R., Cynthia Kendell, Evelyn Cornelissen, Laura L. Madden, Byron J. Powell, Glenn Kissmann, Sarah A. Richmond, Cameron Willis and Jackie L. Bender, 2020:4).

Figure 3.5 (overleaf) is a representation of the clinical sustainability assessment tool framework and its co-constructs: programme or intervention design; external environment; implementation and sustainability infrastructure; recipients' influence on programme adoption, implementation, and maintenance; as well as the reach and effectiveness of programmes or interventions.

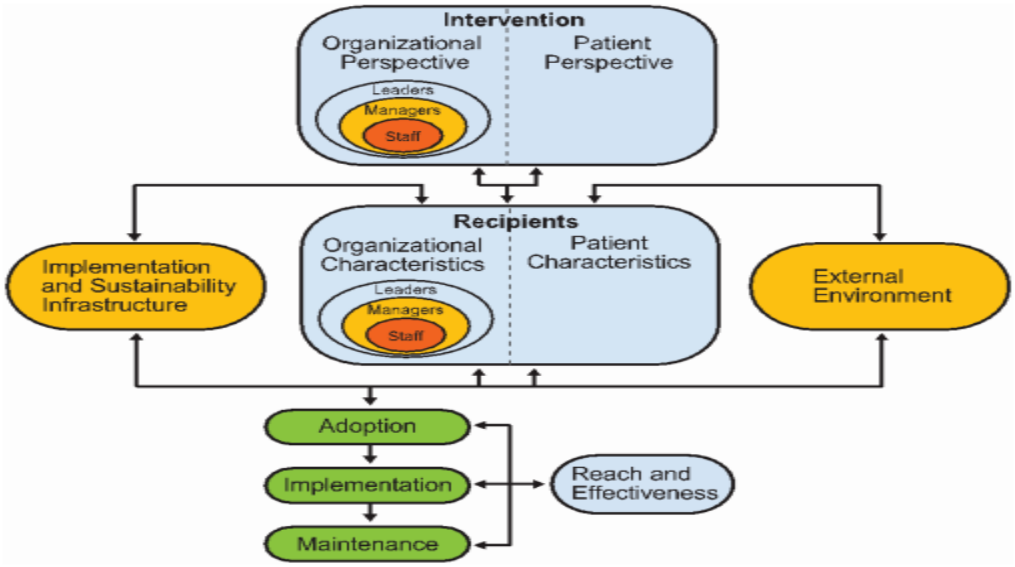

Figure 3.5: The clinical sustainability assessment tool (CSAT) framework
Source: Adapted from McCreighgt, 2019:1002

Figure 3.5 above indicates that the CSAT basically considers how the programme or intervention design, the external environment, the implementation and sustainability infrastructure, and the recipients influence programme adoption, implementation, and maintenance. used to guide planning, implementation, and evaluation of the research projects (Malone, 2012:14; McCreight, 2019:1002). For its applicability or operation, it is important to note the following key concepts and important conditions:

- continued capacity for innovative delivery in the absence of a champion or person/ team who introduced such innovation, given that sustainability is only relevant for innovations that are still required; and
- continued benefits for the patient, provider and/or health system, given that adaptation is critical to ensuring sustainability, relevance and fit/ appropriateness of demonstrable benefits (Urquhart, Kendell, Cornelissen, Laua, Madden, Powell, Kissmann, Richmond, Willis & Bender, 2020:3).

In the case of Ethiopia, both the dynamic sustainability framework and clinical sustainability assessment tool are relevant, especially to the extent that they advance the goals of MCH partnerships and inter-professional teamwork with other stakeholders in rural areas, such as the community health workers, traditional birth attendants, family members, religious leaders, community leaders and non-governmental organisations concerned with women affairs (Dynes, 2014:39-40; FMOH, 2015:114).

3.5 CONCEPTUAL MODELS IN NURSING PRACTICE

A conceptual framework is developed from theory, identifies the concepts included in a complex phenomenon and shows their relationships by meaningful integrating into a pattern (Edmonds & Kennedy, 2012:4). In nursing, conceptual models are based on observations, insights, and deductions that combine ideas from several fields of inquiry, such that they provide a frame of reference and coherent mechanism to think about nursing phenomena (Allen, 2018: 41; Hanson et al., 2005: 71). For the purpose of this study, community health and maternal, child and family health nursing are highlighted as conceptual models in nursing practice.

3.5.1 Community Health Conceptual Framework

The continuum of care for reproductive, maternal, new-born, and child health care begins before pregnancy, and extends through pregnancy, childbirth and to childhood (Sudhinaraset *et al.*, 2018:5). Such care is provided by families and communities, through outpatient services, clinics, and other health facilities (African Union, 2013:40). Figure 3.6 below is indicative of the community nursing framework as an example of the assertion above.

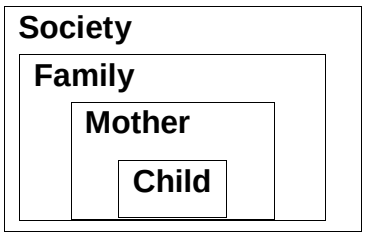

Figure 3.6: Community health nursing framework
Source: Adopted from Hemsing et al., 2017:30

The community health nursing framework depicted in Figure 3.6 above integrates mutually interdependent factors to explain potential sources of health care, and can also be used for solutions that may influence health-seeking behaviours (Sudhinaraset et al., 2018:6). This conceptual framework is important for understanding nursing work in managing healthcare services at all levels, and also offers an alternative for collective action to systematically analyse healthcare paths (Allen, 2018:41).

The rationale and effectiveness of community-based interventions on maternal and child health involve the use of lay people as community motivators, community health agents, and community health workers (Hemsing et al. et al., 2017:30).

3.5.2 Maternal, Child and Family Health Nursing Conceptual Framework

Family health care nursing is central to the nursing of families today. It is in this regard that existing family therapy theories have been reformulated to fit the nursing paradigm, while the evolving development and implementation of nursing care of families is based largely on the assumption that families are the basic unit of society in which the mother and children are the nucleus (Fraser et al., 2016:2559; Silali & Owino, 2016:3). In this study, the notion of maternal and child health nursing practices was organised and conceptualised in the context of rural communities in tandem with the logic of the research problem, for the purpose of achieving the desired aim and objectives. Figure 3.7 below is an illustration of the maternal, child and family nursing conceptual framework.

Figure 3.7: Maternal, child and family health nursing conceptual framework in the continuum of care
Source: WHO, 2006

The above framework highlights two primary MCH focal areas, the external (characterised by the household, health facilities, and community and outreach), as well as the internal environment (characterised by continuum factors from adolescence and to birth and childhood). The interaction between the external and internal environmental factors are viewed as providing a 'fit' in the healthcare system as a whole. Therefore, in the context of this study, the various conceptual factors in the continuum were deemed to be relevant for the improvement of MCH practices in rural Ethiopia in particular.

3.5.3 Conceptualising MCH Nursing Practice

In this sub-section, the researcher highlights his own schematic conceptualisation of MCH nursing practice, derived largely from the seminal Normalisation Process Theory and its attendant conceptual models and frameworks mentioned in the current chapter. Accordingly, Figure 3.8 below is a representation of the researcher's own conceptualisation of MCH, eclectically derived from the various NPT conceptual frameworks.

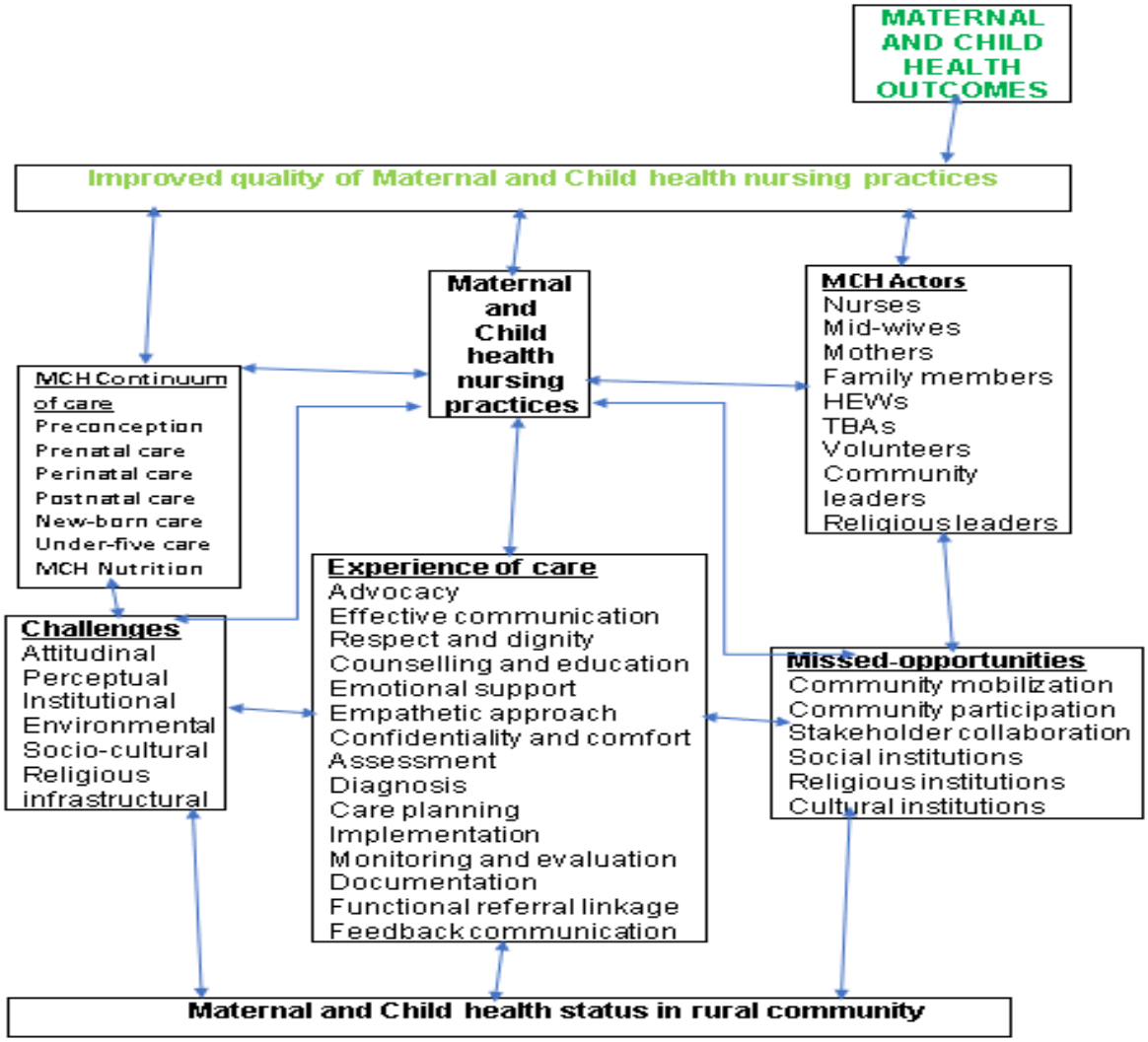

Figure 3.8: Conceptualised framework of MCH nursing practice
Source: Researcher's own adaptation from various sources on maternal health and the NPT

The Normalisation Process Theory characterises core elements of implementation processes and the factors that shape these elements to enable researchers to assesses the relative effectiveness and workability of practice (Gould, 2016:4; May et al., 2019:5). The workability and integration are important factors, considering how a complex intervention interacts with existing patterns of service organisation to explain the work that is involved in implementation and interactions between mechanisms and contexts (May et al., 2019:5). In that regard, the researcher considers all the elements of the

conceptualised MCH practices to be applicable in contexts such as the rural communities in Ethiopia.

3.6 CONCLUSION

It is accepted that the conceptual framework would not be able to provide a complete and comprehensive explanation to nursing and midwifery practice. Therefore, the Normalisation Process Theory frameworks afforded some degree of flexibility as there is no ‘one best way’ to operationalise its integrated constructs that explain implementation processes (Ajuebor *et al.*, 2020:8; May & Finch, 2019:546).

The Normalisation Process Theory constituted the core tenets of the present chapter, its associated constructs of coherence, cognitive participation, collective action and reflective monitoring, enabled the researcher’s understanding and association of these tenets with the core aspects of the research topic itself. In this regard, the chapter achieved its main purposes of identifying the association of NPT as a relevant and applicable for this study.

The following chapter focuses on the actual process of research design and methods as a data collection framework of the study.

CHAPTER FOUR

RESEARCH DESIGN AND METHODODOLOGY

4.1 INTRODUCTION

The previous chapter provided a synoptic overview of the study's theoretical framework. The current chapter on the other hand, mainly describes the research design and methods as outlined and mentioned earlier in Chapter One of this thesis. In that regard, the current chapter constitutes a pivotal link between various aspects of the abstract and practical domains of the study insofar as both the research problem and study objectives are concerned (Berg & Lune, 2012:26; Efron & Ravid, 2019:33). To this effect, the present chapter is appropriately structured to reflect the research design and methodology; setting and study population; sampling, data collection and analysis; as well as the quality and rigour of the study. It is also worth noting that the current chapter's structure also presages the evidential context of the study, whose details are fully presented and discussed in the ensuing chapters.

4.2 RESEARCH DESIGN

The research design pertains largely to a systematic process in terms of which the researcher articulates a summary of the important aspects to be reviewed before undertaking the research as a basis to consider from the philosophical perspective, research approach, research strategies, the research time lines; as well as the data collection and analysis techniques (Butterfield, 2012:19; Walliman, 2017:108). The research design is reflective of the choice that the researcher makes to conduct study in a structured and effective manner, such that the research question are answered confidently (Chenail, 2011:8). To that effect, Figure 4.1 below is a depiction of the critical research aspects or variables that should be considered during the design process (Kennedy & Montgomery, 2018:28).

The purpose of the research design is to ensure that the evidence obtained enables an effective resolution of the research problem with unambiguous research questions on the basis of a recognisable theory and its assumptions (Shanti et al., 2019:7-8). In addition both theoretical (literature review/ secondary data) and empirical (primary data) perspectives provide credible frameworks for the participation of individuals through cogent sampling strategies (Shanti et al., 2019:7-8).

Figure 4.1 (overleaf) is reflective of the research design continuum from the conceptualisation stages during which the idea of the study was still being incubated (Whitley & Kite, 2012:83), until its completion in the form of the final research report.

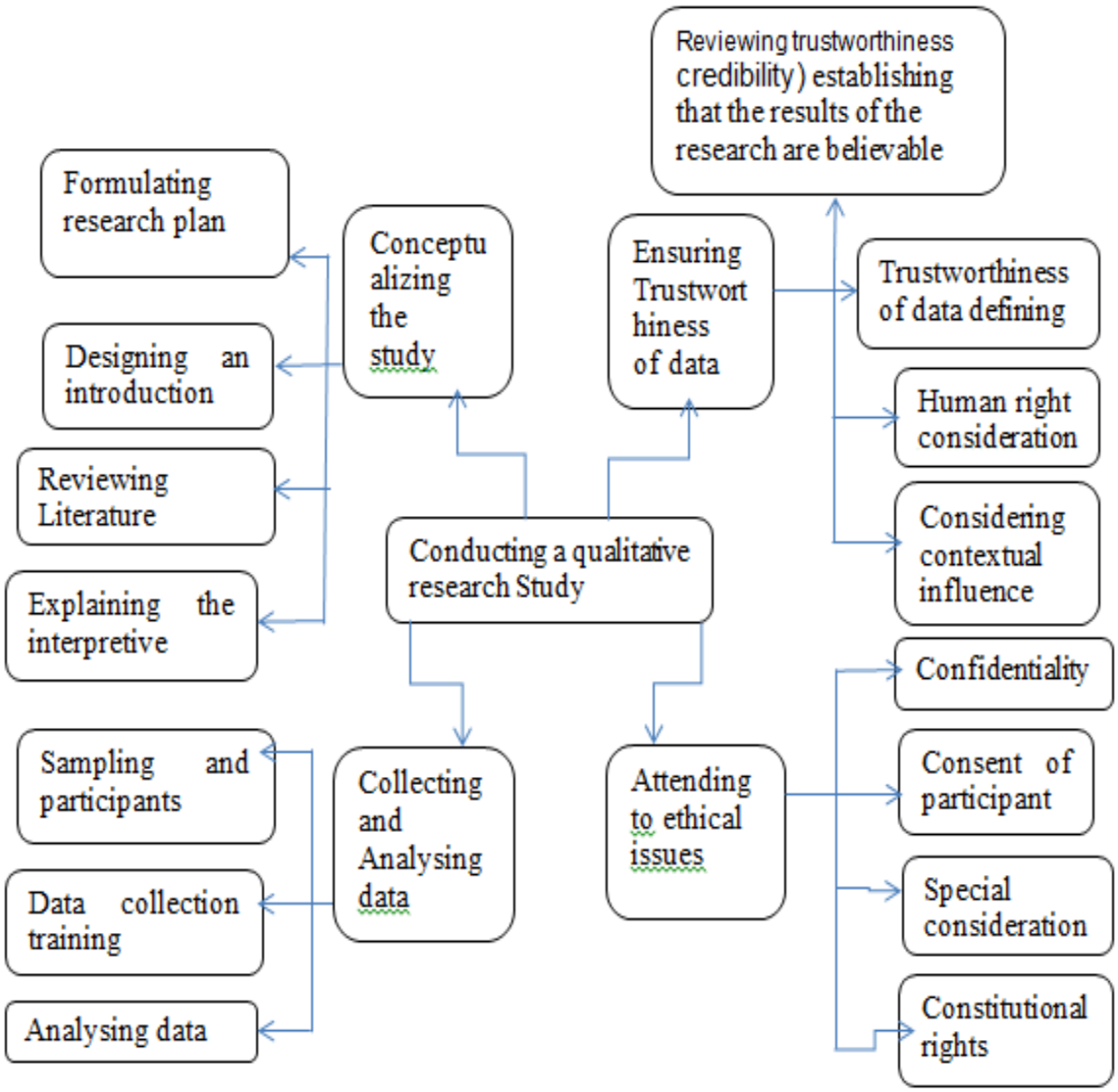

Figure 4.1: The research design process
Source: Researcher's own eclectic adaptation from various research methodology sources

Chenail (2011:1721) illuminates that the following steps are helpful in determining an appropriate research design for qualitative researchers:

- reflecting/ incubating the area of interest;
- justifying the practical relevance or importance of the preferred interest;
- refining the research topic;
- developing the preliminary research questions;
- defining goals and objectives;
- conducting a protracted review of literature;
- developing strategies for the research design itself;
- conducting self-assessment for determining the strengths and the skills needed for completion of the study;
- planning, conducting and managing the research process; and

- tenth is composing and submitting report (Chenail, 2011:1715-1716).

4.2.1 Qualitative Research Design Approach

In this study, the researcher opted for the qualitative exploratory and descriptive research design approach largely due to the collective influence of the ethnographic, phenomenological, and narrative philosophical perspectives (worldviews or paradigms) adopted by the researcher. Figure 4.2 below is an illustration of these three research perspectives and their interstitial link to the qualitative objective of providing in-depth understanding of the subject or phenomenon under investigation.

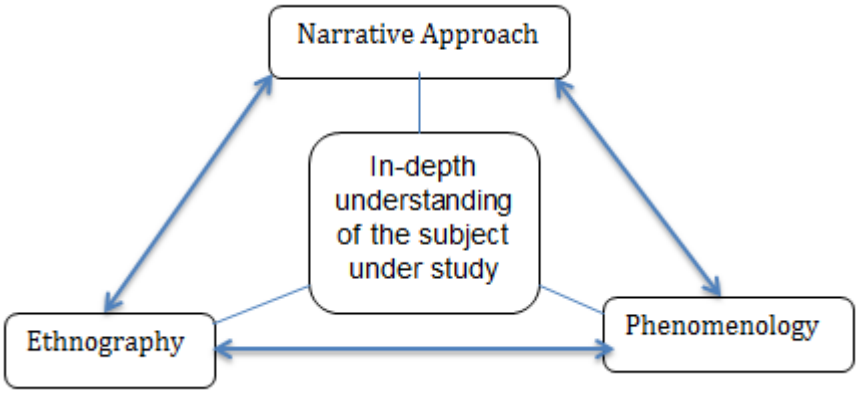

Figure 4.2: Qualitative research perspectives adopted in the study
Source: Researcher's own adaptation from various sources

Ethnography is used when the subject involves an entire cultural group and focuses on describing the cultures and customs of peoples in a particular social context or natural setting, in terms of which cultural references or constructs serve as a the primary medium to interpret results (Mohajan, 2018:15). Also, ethnography is most helpful for identifying and understanding patterns of behaviours, interactions, attitudes, and/or perceptions of certain groups and cultures (Thompson & Hickey, 2016:76). On the other hand, phenomenology is premised on clarifying how individuals make sense of their life experiences relative to the social phenomenon being studied (Jameel, Shaheen & Majid, 2018:3). Meanwhile, narrative inquiry premises on hearing and understanding stories of certain events and/or the experiences of individuals as told by the individuals themselves in their own words.

According to Mohajan (2018:8), narrative research has the potential to provide unique insight into procedural and unobservable aspects of participant experiences, revealing how changes evolve from a personal dimension to an psycho-social embodiment of those strongly held beliefs and perceptions for addressing causal complexity (Mohajan, 2018:19).

4.2.2 Rationale/ Justification for the Qualitative Research Design Approach

Qualitative research is a method of inquiry aimed at gathering in-depth understanding of human behaviour and its subjective contextual factors of daily life activities (Altman, 2019:3; Denscombe, 2014:27-28). Furthermore, qualitative research is dependent on the meticulous definition of the meanings of words, concepts, variables and the interrelationships between them, which enables the investigate of difficult issues that are not easy to record without any observation or other empirical engagement (Hammarberg, Kirkman & Lacey, 2016:500; Walliman, 2017:73). The qualitative research design was helpful in resolving the research problem and addressing the identified gap in maternal and child health nursing practices, and for exploring the barriers and enablers, as well as innovative ideas, so as to suggest ways for improving MCH care intervention practices in the rural settings of the study (McEvoy et al., 2019:9-10; Pope, Royen & Baker, 2019:8).

Overall, the (non-statistical/ non-numerical) qualitative research design was useful for facilitating the exploration of empirically-based information and data from the sampled participants regarding social service intervention practices in maternal healthcare in rural health centres of Eastern Ethiopia. The researcher's ethnographically inspired engagement with the participants enabled the exploration of the phenomenon of maternal healthcare practices by means of the participants' explanation of 'why' and 'how' a particular health service programme operates or does not operate in a particular context (i.e., the twelve rural health centres selected from six districts of the East Hararghe Zone, Oromia Region, Ethiopia.

The qualitative research design approach is advantageous for making it possible for gathering and analysing data that is pertinently linked to the innermost feelings and emotions of the affected stakeholders, which cannot be easily attained by quantitative means (Rahman, 2017). On the other hand, the self-same qualitative research design approach could be disadvantageous for its exclusion of "contextual sensitivities, and focusing more on meanings and experiences" (Rahman, 2017:105). This approach is also financially demanding and time consuming.

4.2.3 Contextual Aspects of Design

Context continuously influences the perspectives, feelings and opinions those who are directly affected by the material effects of the context itself, as well as their interpretation of the meanings of the investigated phenomena in their realistic experiences (Donley & Graueholz, 2012:26; Fink, 2010:19). Therefore, the contextual aspects in this study are closely linked to the physical environment (natural or ecological surroundings) and the

demographic particularities of the sampled participants in the context of the inclusion criteria. As such, the rural context of the study necessitated that the researcher should consider the social, cultural and religious values of the participants in the naturalistic Ethiopian setting.

The contextual aspects or factors of the research also extend to a range of material circumstances encompassing socio-economic, historical, cultural and other dynamic factors that relate directly to the study at the time that it was being conducted (Epstein & Carlin, 2012:27; Harding, 2013:19). In this case, the study was held at a time when maternal morbidity rates were found to be very high among the rural populace in Ethiopia, whose socioeconomic situation and cultural views had a direct bearing on their understanding of maternal and child health care.

4.3 RESEARCH SETTINGS

The research setting is the actual geographic location at which the study is undertaken, as well as the contextual factors that prevail during the period of the study's undertaking. This study was held at six purposively selected districts in the eastern Haraghe Zone of Oromiya Region, Eastern Ethiopia (see Figure 1.1). Meanwhile, Figure 4.3 below indicates the six districts and their zonal location.

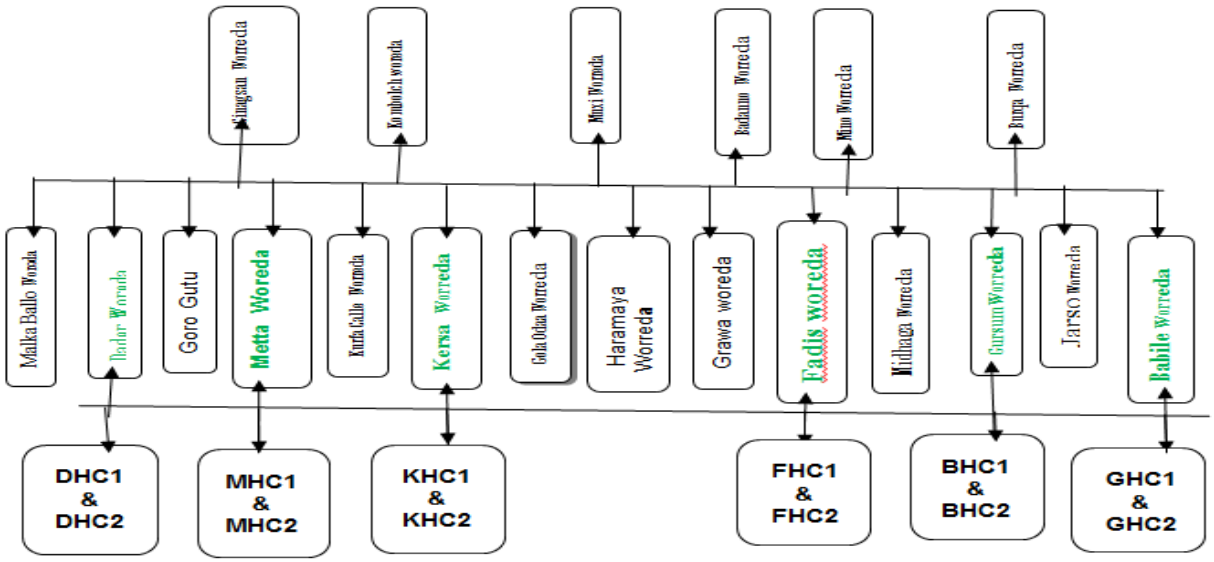

Figure 4.3: Schematic sampling of research sites and coded selected health centres.

The six districts are: Dadar, Meta, Karsa, Fadis, Babile and Gursum. The researcher obtained a list of rural health facilities from the health offices at the six districts from the heads of departments based on the assumptions of functional service years of minimum six years and above. Based on the above assumption criteria, twelve rural health centres were selected.

4.3.1 Study Population and Sample Size

The study population is the larger group from which the researcher choses a sample (Padgett, 2012:44). In fact, the study population is a pivotal reference frame since they possess the homogenous qualities or traits that enable the researcher to identify participants who qualify for inclusion in the study and those who are ineligible (Richard et al., 2015:34). Therefore, the population in this study included: pregnant mothers, facility managers, health extension workers, nurses, community leaders, midwives, volunteers, family members, traditional healers, religious leaders, and traditional birth attendants.

From the study population, the researcher eventually obtained a total number (sample size of 114 participants on the basis of their possession of the representative characteristics or qualities that the researcher pre-determined prior to undertaking the study (Polit & Beck, 2010:38). The total sample size comprised 72 FGD participants (health extension workers; women volunteer health promoters (haadha-garee); traditional birth attendants; local community leaders (abbaa-aradda); religious leaders; and elderly women). The other 42 sample category comprised 6 (six) key informants and focal persons 1 (one) from each district maternal and child health offices; 12 clients (women visiting health centres during data collection); 12 managers of health centres; and 12 midwives working in the rural health centres. Totally, 42 in-depth interviews and 12 focus group discussions were conducted. Among Key informant interviews, 24 (57.1%) were female participants and 18 (42.9%) participants were male. Each focus group discussion involved 6 individual participants in which 8 Fucus Group Discussions purely involved 48 (66.7%) female participants and 4 Fucus Group Discussions purely involved 24 (33.3%) male participants.

It should be mentioned, however, that sample size is not the only determinant of sufficient representativity in a research study. Data saturation is also very influential in this regard, since it is not only the number of people, but the quality of the information that enables the researcher's acquisition of information that is helpful to answering the research questions and resolving the problem under investigation (Patten & Galvan, 2019;33).

4.3.2 Sampling Procedures

Sampling is the process of systematically selecting participants for inclusion in the study, which is informed by the fact that it is not always to involve all population members in a study due to financial, logistical, or other constraints (Leedy & Ormrod, 2015; 37; Neuman, 2011:39). Both non-probability purposive sampling and snowball sampling

(referral sampling) methods were used for selection of the various participant categories in this study.

In the current research, the sample frame is understood as the information source from which the sample is selected. Accordingly, the researcher targeted a mixture of information sources. These were modern health practitioners such as health office managers, health extension workers as well as informal care providers such as traditional birth attendants, mothers/family members, religious leaders, volunteer health promoters and community leaders. Two types of sample frames were used to recruit research participants from the identified sample frames. For example, to involve health practitioners and health office managers, the available lists of such practitioners were used as information sources. To recruit community-based research participants (including mothers), the sample frames required for the research was generated by visiting health centres where such potential participants were found as informal and formal community-based task force agents in MCH nursing practice. In all cases, attempts were made to ensure that the sample frame used would also serve as a comprehensive and inclusive basis from which to select representative, samples for each category of participants (Khaldi, 2017;22).

In the context of current research, data were collected from health practitioners, health service managers, mothers and relevant family members, traditional birth attendants, volunteers, religious leaders, and community leaders. Figure 4.4 (overleaf) is an indication of the actual participants involved in this study.

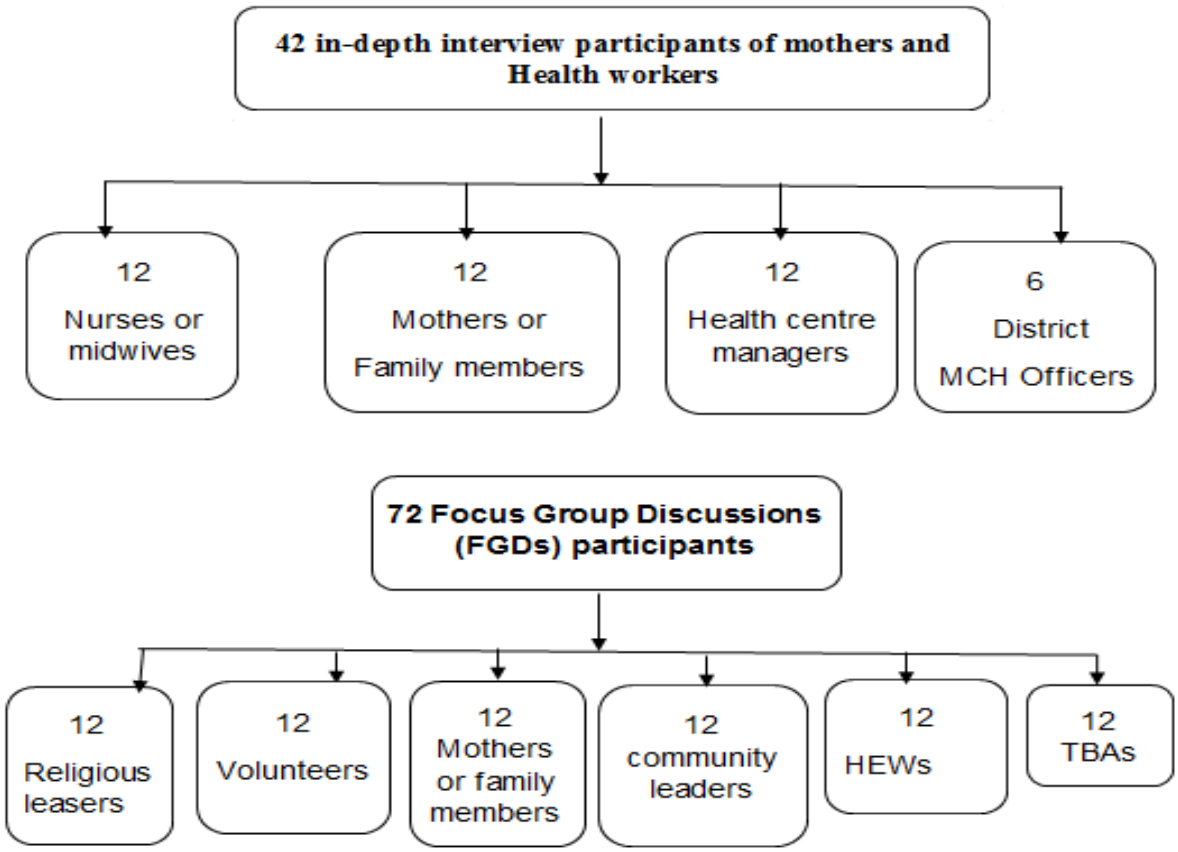

Figure 4.4: Schematic presentation of the sampled participants

The recruitment of study participants from the community included health officers, nurses/midwives, mothers/family members, religious leaders, community leaders, volunteer health promoters, HEWs and TBAs through the sample frames required for the research, which was generated from the supporters and companions visiting health centres and the nearby villagers, where such potential participants were found. However, the medical doctors were not included in the study. Because the current policy of the country does not allow assigning them to rural health centres. Only mid-level health professionals are assigned to the health centre. In all cases, attempts were made to ensure equitable inclusivity from which the samples were selected for each category of participants.

4.3.3 Inclusion Criteria and Exclusion Criteria

The inclusion or exclusion criteria is the unbiased standard or set of considerations in terms of which the researcher determines the participants who 'qualify' for involvement in the study, and those who do not (Grove et al., 2013:12; Kumar, 2015:106). In this study, the following factors constituted the researcher's selection criteria:

All participants were 18 years of age, and above, and were willing to be involved in the study. The health professionals who served for a minimum of five years in the respective health centres were also involved. Traditional birth attendants, religious leaders,

community leaders, mothers/family members, volunteer health promotors and HEWs who were 18 years of age and above.

The selection criteria for health practitioners and managers of health institutions were based on the consideration of those with direct experience of five years and above in which they dealt with maternal and child health problems. The selection criteria for recruiting mothers considered minimum of four MCH care visits for childbearing and child caring purpose. The criteria for recruiting traditional birth attendants include serving as traditional health supporters. In addition to the human-based sources of information, the researcher used relevant administrative and statistical documents available in the target health institutions to get insights on the nature, magnitude and intensity of maternal and child health problems in the study area. The selection criteria for recruiting mothers included regular health care visits at the local centres.

Any prospective participant who was younger than 18 years was not considered for participation in the study. Furthermore, any participant who was not resident in any of the six districts of the Eastern Haraghe Zone in Oromiya Region, Eastern Ethiopia, were also not included in the study.

4.4 DATA COLLECTION

Qualitative data collection and analysis were conducted concurrently in this study. Each day, summaries were made and attached to the corresponding field notes. Data analysis was conducted by manually coding the responses into themes first. These were analysed by content analysis to generate emerging relevant themes in respect of the research questions (Khaldi, 2017:43). These themes were then categorised and summarised according to these research questions.

4.4.1 Data Collection Process

The data collection process was undertaken by in-depth interview of key informants and FGDs with study participants from May to June in 2018 for the first round and from September to November for the second round and from January to March in 2019 for the third round, by beginning with detailed verbal explanations of the applicable ethical principles to the sampled participants and signing of the informed consent forms after reaching consensus (see Annexure B). Additionally, observation checklist was used about real phenomenon of facility environment, requirement and procedures that supported by photographic evidence. The researcher personally collected the data with other data collectors by physically travelling to all selected sites and health facilities.

4.4.2 Data Collection Instrument

Open-ended semi-structured interviews, focus group discussions and standard observation checklists were used as triangulated data collection instruments (see Annexure D). Broadly based on interactions between the researcher and research participants and the pilot study, data collection instruments were flexibly modified. This enabled the research to probe into what research participants think and believe. In this regard, they were effective tools for generating abundant data regarding the issues under study to generate the social, cultural, attitudinal, environmental, perceptual, institutional and infrastructural factors that affect maternal and child health nursing practices.

Generally, 42 key informant interviews and 12 FGDs were conducted for this research. The total number of 114 participants were recruited. The number of females were 72 (63%) and the number of males were 42 (37%). Among these, 24 (21.1%) females and 18 males (15.8%) participated in the Key Informant Interviews (KII). While 48 (41.1%) females and 24 (21.1%) participated in FGDs. Each FGD involved 6 individuals of the same sex group. An in-depth interview took 1hour and 15 minutes up to 1 hour and 30 minutes. But the first FGD took 3 hours, the second one took 2 hours and 30 minutes and the rest took only 2 hours. Initially, the interview questions focus group discussion guides were translated from English to Afan Oromo by me and another language expert in the context of local community for data collect. Then, immediately after every data collection, the collected data was first transcribed and then re-translated to English. Additionally, the recorded audio was transcribed verbatim in Afan Oromo and the transcribed verbatim data was again translated to English by me first and finally audited and edited by an expert of Afan Oromo and English languages.

The focus group discussion provided an opportunity to also observe the nature of the participants' interaction with each other while sharing their experiences. The semi-structured interviews allowed for the participants to express their feelings and thoughts freely without the researcher's constant interruptions (Jameel *et al.,* 2018:3). Only one focus group discussion was being conducted every day during field work due to distance and effort of gathering people of research interest in the rural community. However; the Focus Group Discussions produced a broad range of information and experiences of participants on maternal and child health. Finally, there was no further new information emerged and the data saturation was reached.

This study applied triangulation of data sources in examining the consistency of data from different sources within the same method, but different approaches at different points in time by comparing views of different people involved in the study. The process of

triangulation of data strengthens the overall validity and credibility of qualitative study (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014:545; Gale, 2015:94. The main reasons for triangulated data collection is based on the fact that a single method of data collection is not always adequate to shed light on all the aspects of a phenomenon, and enables a variety of information on the same issue to achieve a higher degree of validity and reliability (Honorene, 2017:91-92).

4.4.3 Qualitative Data Analysis Approaches

Based on the need for triangulation in this study and its vast sample size, both inductive and deductive analytical approaches were applied to analyse and interpret the collected data from these varied categories of research subjects (McEvoy et al., 2019:16-17).

4.4.3.1 Inductive Analytical Approach

The inductive approach was applied through the preparation of qualitative data and its thematic categorisation based on the relationships among the respective variables. This process includes open coding, creating categories and abstraction. Open coding means that notes and headings are written in the text while reading it. The final step is based on reporting the findings and linking them to the themes generated(Elo & Kyngäs, 2008:109).

4.4.3.2 Deductive Analytical Approach

The deductive approach enabled the analysis of data by linking the general statements of the participants to specific research questions as the basis to generate and develop individual and global themes from which to make convincing conclusions derived from the findings (Elo & Kyngäs, 2008:111). The following figure illustrates an inductive and deductive approach analysis.

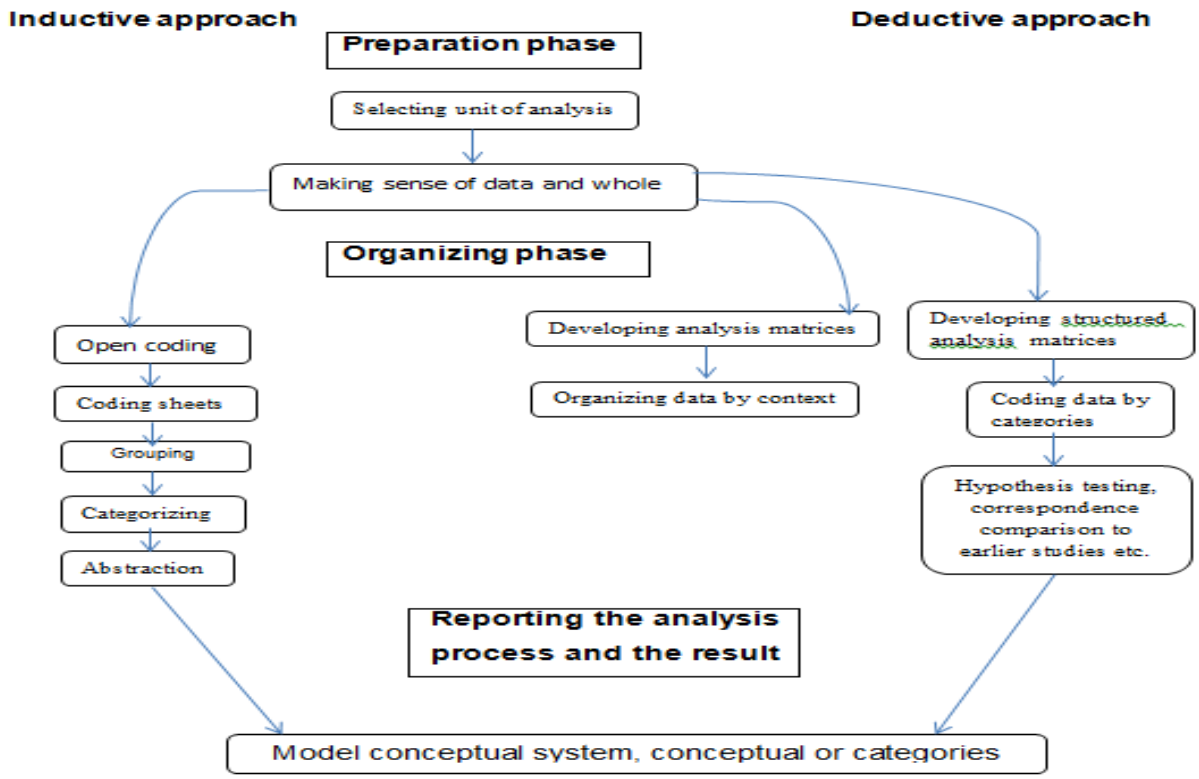

Figure 4.3: Preparation, organising and resulting phases in the content analysis process
Source: Adapted from Elo and Kyngäs, 2008:110

4.5 DATA ANALYSIS PROCESS

Data analysis involved the processes of making sense of data by uncovering themes, concepts, insights, patterns, categories, understanding and categories for interpretation of such meanings (Ehrlich & Joubert, 2014:38). The data generated vary according to the type of design being used. However, the data were generally subject to the same principles of analysis, which began with coding a number of thematic categories of description based on theoretical constructs (Efron & Ravid, 2019:27; Saldanha & O'Brien, 2013:19). In this regard, data analysis was actually a dynamic process weaving together recognition of emerging themes, identification of key ideas or meaning acquired.

Transcripts were first read thoroughly to gain a sense of the whole content of discussions and for the researcher's familiarisation with the data. For each transcript, significant statements were identified and highlighted; these were then extracted for each participant group and appropriate meanings formulated, which were then further categorised into themes which enabled the study findings to be described (Ehrlich & Joubert, 2014:38).

Data analysis included narrative analysis to address the participants' lived experiences. The phenomenological con text of the data analysis focused on the personal experience in texual description by open coding and building an idea that connects the categories by selective coding with a discursive set of theoretical propositions (Mohajan, 2018:42-43).

Ethnographic data considered three aspects of data: description analysis, interpretation of data and triangulating the data by comparing one source of data to another (Mohajan, 2018:43).

Thematic analysis process was applied in this study, in terms of which a number of themes were identified in the textual data (Penn-Kekana, 2017:5). Thematic analysis is more flexible than other specialised qualitative data analysis techniques, and is frequently used in the health and social sciences to analyse narratives, often in the form of interview transcripts, to identify patterns or trends in the form of themes. The use of themes guided the thematic analysis in terms of exploring the perceptions of various stakeholders and barriers and facilitators for implementation MCH care practices (Penn-Kekana, 2017:5).

Thematic analysis is the dominant method which has been used to analyse data in primary qualitative research in recent years (Fink, 2010:22; Thomas & Harden, 2008). Coding is one of the most central processes in qualitative data analysis. The researcher identified themes from each interview, and then compared them across the interviews and rechecked for concurrences (Butterfield, 2012:34; Patton, 2002:453). In the beginning, the researcher identified possible patterns, categories and themes based on interview transcriptions as proposed by Corbin and Strauss (1998).

Accordingly, the interview transcripts were read to understand their true meaning. In the initial stage, the researcher developed themes for translated data. For instance, culture, and gender, individual and community perceptions using transcripts of interviews. In the second stage, the researcher identified sub-themes and classified these into categories and labelled them. Finally, the main themes emerged, and the qualitative data were analysed and categorised accordingly. The above three stages were followed to generate the main themes and sub-themes. The Atlas ti 8.2 computer programme assisted the researcher using Microsoft Word documents and options such as bold, highlighting and track changes, italics and underlining the main themes, sub-themes and categories (Charmaz & Belgrave, 2018:12). The researcher created a file for each different theme and category as word documents (Microsoft word file) and moved relevant themes to the main themes using appropriate copying and pasting methods (Patton, 2002).

4.6 QUALITY OF DATA AND RIGOUR

After granting of the ethical clearance certificate by the UNISA Research Ethics Committee (see Annexure A), a pilot test was conducted in Haramaya district from May-June 2018, and the findings highlighted certain issues that should be modified. The

purpose of the pilot study was to check the study tools relevance in the context of rural community health centres of East Hararghe Zone, and to investigate the nature of the current maternal and child health nursing practices as a pre-test for the likely health outcomes of mothers and children before starting the main study data collection procedures as critical thinking in selecting and using evidence for research is important (Profetto-McGrath & Smith, 2019).The pilot study results were compared to the draft literature review and found to be totally different from what was really found on the ground. The researcher discussed this issue with a professor during qualitative software consultation workshop in Addis Ababa, Ethiopia.

The study specifically tested the existing gaps, challenges, coping mechanisms, missed opportunities and innovative ideas related to maternal and child health nursing care practices in rural health centres in Eastern Ethiopia. The methods of data collection include focus group discussion, in-depth interviews and observation of the facility and nursing care procedures and practices in each continuum of maternal and child health care in rural contexts (see Annexures C and D).

The researcher further consulted with his supervisor and confirmed that it was in the nature of qualitative studies to encounter pilot study results that were incongruent with most literature perspectives. The researcher then realised that reviewing of relevant literatures is a continuous process, based on the findings along with data processing and analysis. Additionally, based on the pilot study experience, certain interview guides were modified and translated to the local language (Afan Oromo). The translated interview guides and proposal document with the letter of support from UNISA office were submitted to the Oromia region Research Ethical Committee Office. The letter of permission and support was then submitted to East Hararghe Zone Health Office. The Zonal Health Office also wrote letters to six districts to support data collection activity.

The letters were also collected from each district health offices to Rural Health Centres which were purposely selected based on the years of establishment/ foundation and years of services among other health centres in rural areas. The letters were distributed to the targeted areas in the six districts, namely: Dadar, Meta, Karsa, Fadis, Babile and Gursum in the East Haraghe Zone, Oromiya region, Eastern Ethiopia. The ethical letters and letter of cooperation were distributed among twelve rural health centres in the selected districts. Prior to commencement of the data collection process, written and verbal consent were explained to the participants for their voluntary participation (see Section 1.12 in Chapter One). Finally, the data collection was carried out in twelve rural health centres in the six districts from 2019-2020.

In this study, credibility was applied through the researcher's prolonged engagement and sustained dialogue and conversations throughout the focus group discussions, observations and interviews (Abayneh, Lempp & Hanlon, 2020:11).

4.7 CONCLUSION

This chapter mainly provided an overview of the research design and methods used in the study. In this regard, the chapter Has highlighted the most essential pre-data collection framework according to which the processes, instruments and approaches to the acquisition and analysis of the triangulated data were applied in this study. Most importantly, the chapter also integrated the crucial aspect of maternal and child healthcare practices into the researcher's preferred pre-data collection framework.

The next chapter contains a detailed description and analysis of the collected data, which served as the ultimate findings of this research finding study.

CHAPTER FIVE

PRESENTATION AND ANALYSIS OF THE FINDINGS

5.1 INTRODUCTION

The previous chapter addressed aspects of the research design and methodology of the research. This chapter, on the other hand, presents the findings that emerged from qualitative data gathered from participants in the health centres of the six districts in the Eastern Haraghe Zone of Oromiya Region, Eastern Ethiopia, namely: Dadar, Meta, Karsa, Fadis, Babile and Gursum as shown in Figure 4.3 in Chapter Four. Therefore, the data presented in this chapter was generated from 114 participants, 72 of whom participated in the focus group discussions, and 42 in the semi-structured interviews.

The structure of this chapter is reflective of three prominent aspects of the collected data, namely: the participants' sociodemographic/ bibliographic characteristics or profiles; findings accruing from the focus groups and interviews; as well as findings accruing from the observation of the maternal and child health care facilities in the rural areas of the six districts reflected in Figure 4.3.

5.2 SOCIO-DEMOGRAPHIC PROFILES OF STUDY PARTICIPANTS

The study investigated maternal and child health care practices at the selected rural health centres of Ethiopia. The participants involved in the study were Amhara and Oromo by ethnicity. The majority of participants in the local community was Oromo (n=110, 96.4%). The rest (n=4, 3.5%) were Amhara. Additionally, the majority of the participants (n=103, 90.3%), were Islamic, followed by the Orthodox (n=7, 6.1%), and Protestant (n=4, 3.5%). The health care workers' lowest number of years in service was 5 (five) years, and the maximum was 20 years in service.

5.2.1 Gender Distribution of the Participants

The total number of 114 participants. The number of females were 72 (63%) and the number of males were 42 (37%). Among these, 24 (21.1%) females and 18 males (15.8%) participated in the Key Informant Interviews (KII). While 48 (41.1%) females and 24 (21.1%) participated in Focus Group Discussions.

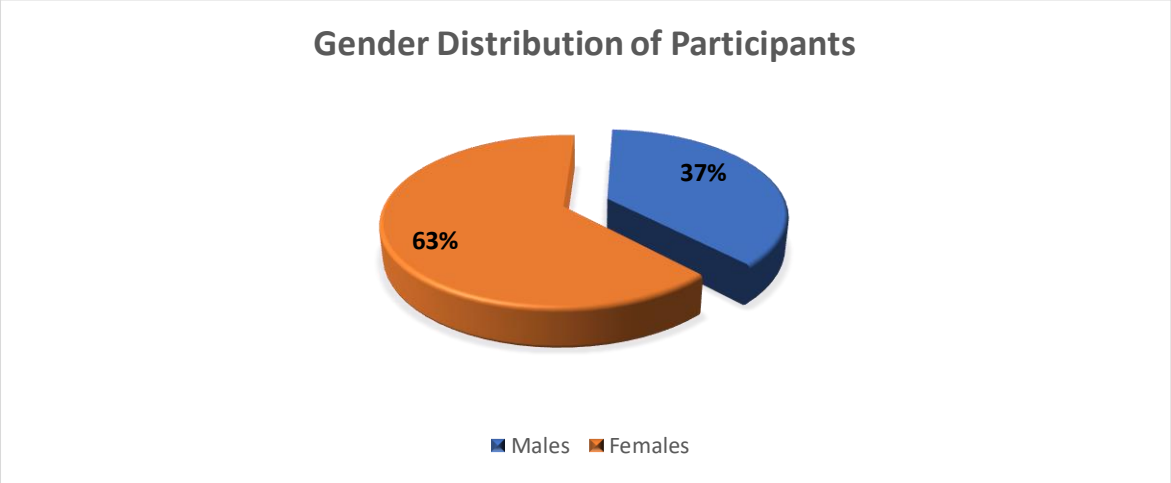

Figure 5.1: Gender distribution of participants

From the researcher's point of view, the fact that female participants were in the majority (by default rather than by design), is logically situated in the fact that they are mothers themselves who have given birth to children. As such, they would naturally be more versed and interested in all, or any maternal and childcare issues than their male counterparts (Abrandt-dahlgren, 2017:70-71; Carminati, 2018:2095-2096).

5.2.2 Age Distribution of the Participants

Figure 5.2 below is an illustration of the age distribution of the participants.

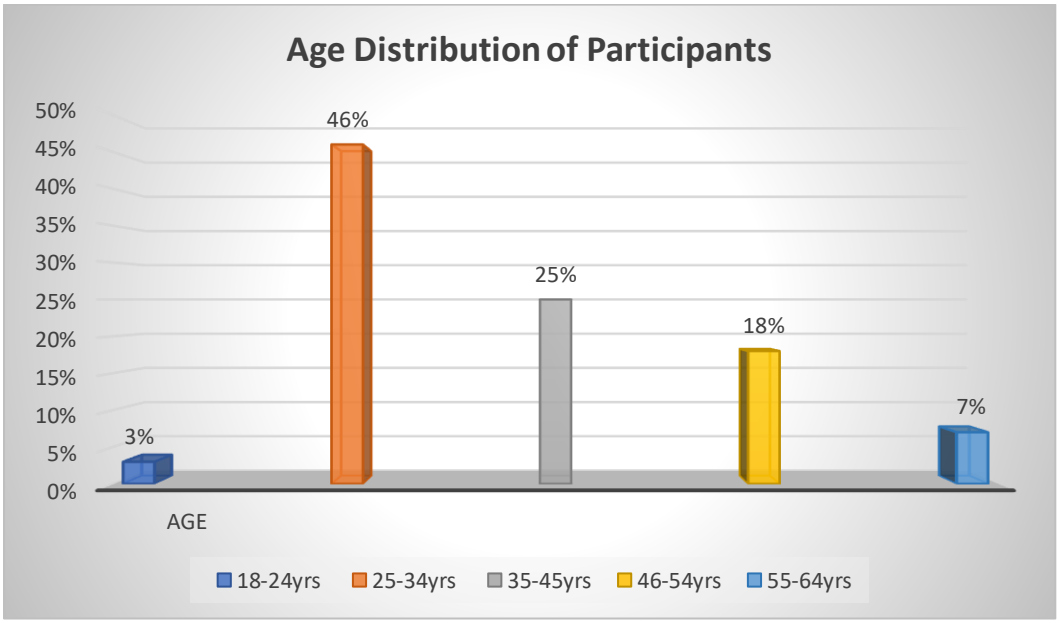

Figure 5.2: Age distribution of participants

The participants were categorised into 5 (five) age groups as follows: 18-24 years; 25-34 years;35-45 years; 46-54 years; and 55-64 years. The median age of these five participant categories was 35 years. The majority of the participants (n=52, 46%) were those in the 25–34-year age cohort, of whom 30 (58%) participated in the key informant interviews, and 22 (42%) participated in the focus groups. The second largest group (n=29, 25.4%) were those in the 35–45-year age group, followed by those in the 46–54-year age cohort (n=21, 18.4%); and those in the 55-64 age group (n=8, 7%) who all participated in the focus group discussions. The most minimal number of participants (n=4, 3%) were in the 18–24-year age cohort.

From the researcher's own perspective, the fact that the 18–24-year-old participants are in the minority (n=4, 3.2%) does not augur well for the current state and future of MCH practices in the rural Ethiopian populace. Such an assertion emanates from the view that the youth (including those in the 18–24-year age category) were the most at-risk group among whom the message of health-seeking behaviours needed to be endorsed and disseminated with the uttermost emphasis (Abrandt-dahlgren, 2017:70-71; Dean ,2014:3-4).

5.2.3 Educational Status of Participants

Figure 5.3 below reflects the educational status of the participants.

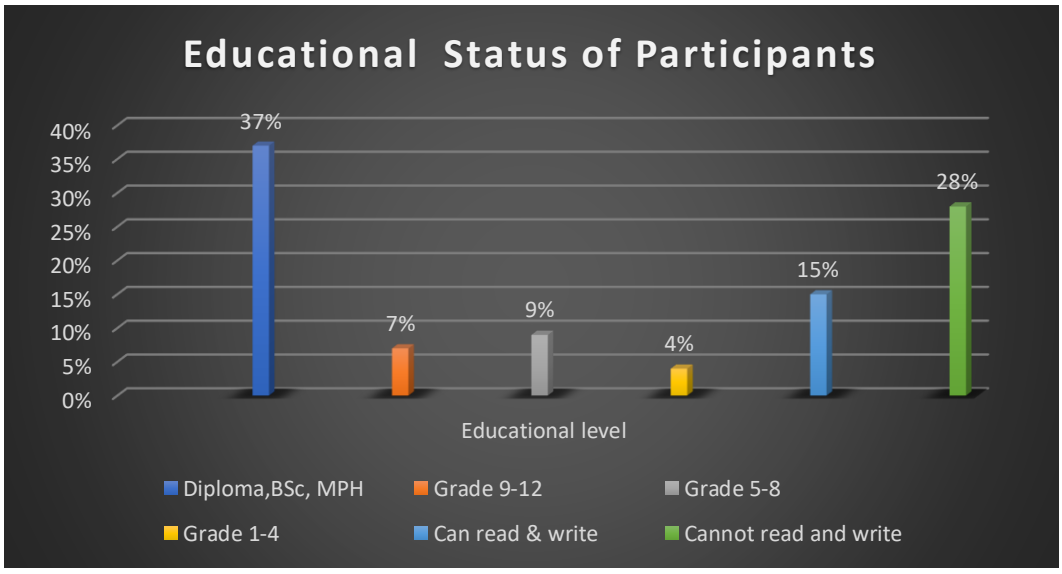

Figure 5.3: Educational status of participants

Generally, the state of affairs reflected in Figure 5.3 above is reminiscent of a metaphorical 'tale of two cities' in the sense of the polarities shown, on the one hand, by the majority of highly qualified participants (n=42, 37%) who have Diploma, BSc and Master of Public Health (MPH) qualifications. On the other extreme is the second highest proportion of participants (n=37, 32.4%) who could neither read nor write. These were

followed by 17 (15%) of the participants who could at least read and write, while the educational background of the rest (n=18, 16%) ranged between grade 1-4 (n=4, 3.5%); grade 5-8 (n=10,8%); and grade 9-12 (n=4, 3.0%).

It is the view of the researcher that, at the MCH practitioner level, the provision of the required institutional services was most likely to succeed, given the cadre of professionals entrusted with such responsibility. However, the illiteracy level could pose a risk to the continuum of care, especially in a rural context - where resource constraints could further compound the cultural rootedness of certain sectors of the rural populace (Lee et al., 2019:17; Renkert & Nutbeam, 2001:385-385).

5.2.4 Employment Status of Participants

Figure 5.4 below is a depiction of the employment status of the participants.

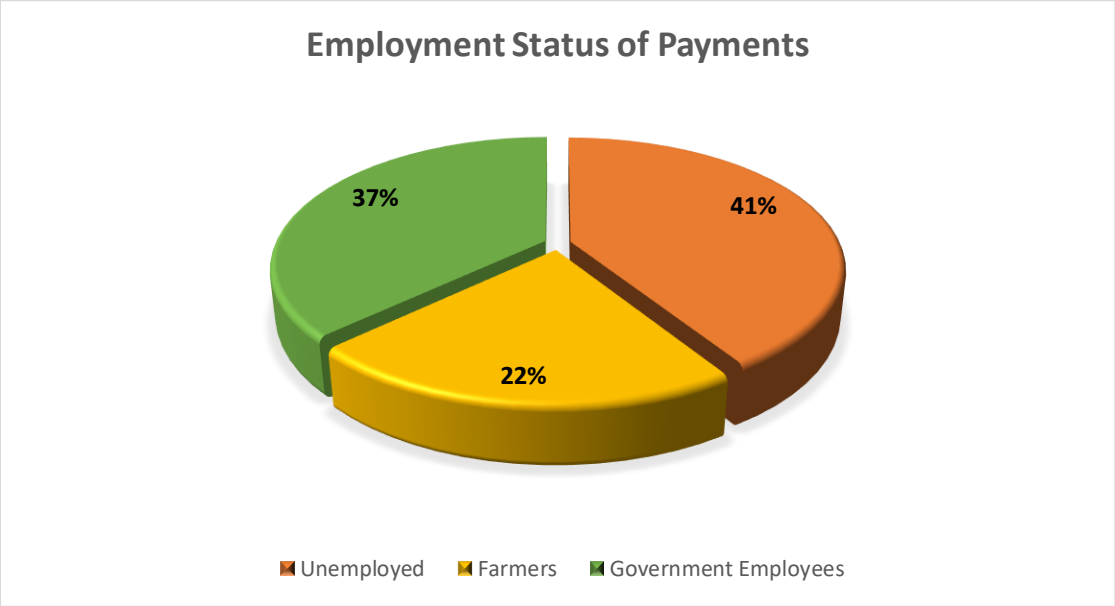

Figure 5.4: Employment status of participants

Extrapolated from Figure 5.4 is that the majority of participants (n=47, 41.0%) were unemployed housewives, followed by government employees (n=42, 237.0%), and farmers (n=24, 22.0%).

It is the researcher's considered view that, the fact that women (who constitute the majority of participants as shown in Figure 5.1) are also the majority of the unemployed, could also be an indication of the combined effect of socio-cultural and economic dynamics on rural communities, where the role of women is still largely confined to childbirth and rearing responsibilities.

5.3 FINDINGS ACCRUING FROM INTERVIEWS AND FOCUS GROUPS

In this study, the researcher converged views of participants from both the key informant interviews and focus groups in order to identify critical issues in the process of intervention and possible future options and alternatives to address the gaps in health outcomes. Based on the qualitative data obtained, four main themes and associated sub=themes emerged in respect of aspects of MCH care practices in rural health centres of Ethiopia, namely:

- Contemporary situation of MCH care practices;
- Barriers to MCH care practices;
- Enablers for MCH care practices; and
- Innovative ideas for improving MCH care practices.

Important sub-themes were also identified in the analysis. The other important six sub-themes, were also identified in the analysis of the first major theme which is Existing situation of MCH care practices and presented as follows.

5.3.1 Theme 1: Contemporary Situations of MCH Care Practices in Rural Health Centres

The qualitative findings of Key Informants Interviews conducted in six districts involved MCH Focal Persons, health centre managers, midwives and mothers visiting HCs focusing on the research question related to how is the existing MCH care practices brought about six sub-themes as: rationales for MCH care practices, purpose of MCH care practices, Components of MCH Care Practices, Task performance Activities in MCH Care Practices, Interactions in MCH care practices and satisfactory and/or unsatisfactory aspects of MCH care practices outcomes.

5.3.1.1 Rationales for MCH Care Practices

Different issues related to the rationales for MCH care practices were detailed. There were different reasons described in the analysis of the research findings as follows.

Table 5.1: Thematic representations of analytical findings related to rationales for MCH care practices

Major theme	Sub-theme	Categories
Contemporary situation of MCH care practices	Rationales for MCH care practices	MCH is a global priority issue and major concern of the national health policy; MCH is a determinant for survival of mothers and children; Reduces death of mothers and children; Address the health problems, complication and death; Priority of area of research for evidence-based intervention; Maternal value for survival of baby as food, shelter and clothes;

Major theme	Sub-theme	Categories
		MCH care is determinant for health of generation; MCH is obligatory principle in the religious teaching of Islam from couple screening to proper breastfeeding; Poor health care seeking practice; Health problem of a mother certainly affects the livelihood of a family in the community; MCH is the major component of health extension programme packages; Maternal and child mortality was considered as the cause for destruction of a family in a society; Maternal death results in serious negative socio-economic outcomes; MCH issue was underlined as lack of prevention of contributes to the loss of life to mothers and children; Importance of addressing preventable causes of death; The need for prevention of unwanted pregnancy before marriage through abstinence; The health of a mother was the backbone of a productive labour force; In the culture of the community, a woman was a cornerstone for construction of a family; Missed-opportunities, such as ignored indigenous knowledge and supportive religious teaching; Primary care importance for saving health expenses; The rural community mothers and children were marginalized; Breastfeeding importance for the prevention of physical, mental, social, emotional and psychological health problem was neglected; Maternal and child health promotion, prevention and maintenance needed both formal and informal care practices

Initially, why MCH care practice was an issue that was explained by the MCH focal persons as: “a global priority issue which was a primary goal of SDG 3; and, the major concern of the national health policy in Sub-Saharan countries including Ethiopia” (**KII1/MCHFP/M & KII3/MCHFP/M**). “MCH care practice was also crucial issue in the society as prerequisite for the health of family members in the society; and, fundamental for social and economic activity in the community” (**KII2/MCHFP/M & KII4/MCHFP/M**). “MCH was an issue was described as the existing situation of MCH care practices were determinant for the health of future health outcomes” (**KII5/MCHFP/M & KII6/MCHFP/M**).

The views of the majority of health centre managers about rationales for maternal and child death were similar with the responses of districts’ focal persons and other professionals in the study area.

However, one of the managers mentioned:

“Mortality due to preventable causes was the reason for MCH care practices and it was a priority need as well as the cost of health expenditure that can be saved by prevention; MCH care was priority need of the family health; bases for the health of society and public health issue of national health policy strategy in the country” (**KII7/DHCMgr/M, KII8/DHC2/Mgr/F, KII9/MHC1/Mgr/M & KII10/MHC2/Mgr/M**).

Two of the participants responded:
“The health of mothers and children was interdependent and today’s health care practices determine tomorrow’s health of children” (**KII12/KHC1/Mgr/M & KII12/KHC2/Mgr/M).** The managers of the health centres in Fadis health centres mentioned the same idea as: *“basis for social and economic development determinant in the community*” **(KII13/FHC1/Mgr/M & KII14/FHC2/Mgr/M**).

The Babile health center 1, 2 & Gursum health center 1 managers reported:
“The health of mothers and under-five children equally important at local, national and international in the society” **(KII15/BHC1/Mgr/M, KII16/BHC2/Mgr/M & KII17/GHC1/Mgr/M**). The manager of the health centre 2 in Gursum district differently stated: “It is fundamental human rights to provide basic and standard care for mothers and children in every part of the globe” **(KII18/GHC2/Mgr/F).**

From the midwife’s perspective, the responses to the question why MCH care practice was an issue was reported as: A means to address the MCH problems in rural health centres (**KII19/DHC1/MW/F).** A midwife working in one of the health centres stated:
It is a life-saving practice for mothers and children under the age of five years (**KII20/DHC2/MW/M).** Another midwife mentioned: It was an instrument for the reduction of maternal and under-five mortality for achievement of sustainable development goal 3 (**KII21/MHC1/MW/F)**. It was also described as: A priority needs for promotion of health and prevention of diseases **(KII22/MHC12MW/F).**

The majority of midwives reported that the global health policy that intended to enhance coverage and address the rural marginalized community free of charge for antenatal women, perinatal woman, postnatal woman and under-five children in the rural health centres, as:

“A determinant for survival of mothers and children and reduction of death of mothers and children for ensuring health and well-being of community” **(KII23/KHC1/MW/F, KII24/KHC2/MW/F, KII25/FHC1/MW/F and KII26/FHC2/MW/F).** One of the professional practitioners reported: “A priority of area of research for evidence-based intervention, as a part of their basic needs in one’s family and as corner stone for the existence of family

well-being" (**KII27/BHC1/MW/F).** Many rural mothers in the eastern Haraghe zone community believe that the rationale for MCH care practices was: "The need for address the health problems, serious complication and death in the country" **(KII28/BHC/MW/F, KII29GHC1/MW/F and KII30/GHC2/MW/F)**.

In the same way, a woman mentioned: "MCH care practice was the national and global health policy strategy" **(KII31/DHC1/Mthr/F, KII32/DHC2/Mthr/F and KII33/MHC1/Mthr/F).** Another woman responded: "There was no happiness and joyful life without the health and well-being of mother and children in one's family" **(KII34/MHC2/Mthr/F, KII35/KHC1/Mthr/F and KII36/KHC2/Mthr/F)**.

It was reported that: *"The health of mother was a pillar for the health a family"* **(KII37/FHC1/Mthr/F, KII38/FHC2/Mthr/F and KII39/BHC1/Mthr/F)**. Two mothers reported that: "The MCH outcome was the result of MCH care practices that answer the question of MCH rights and save them from all preventable causes of morbidity like bleeding and infection" n **(KII41/GHC1/Mthr/F and KII19/GHC2/Mthr/F)**.

One of the HEWs in Dadar averred:
The reasons for why MCH care was an issue were described by discussants as global priority issue of the country **(FGD1P1);** The second focus group participant stated: "Thank you for asking us about MCH care practices which is our issue. It was an obligatory principle in the religious teaching of Islam the health care of mother needs to be given attention starting from premarital period" (**Dadar religious leader FGD1P2**).

The community leader in Dadar averred: "The health of mother and her child health care practice would be determinant for the health status of a family" **(FGD1P3)**; Dadar TBA also mentioned: "Poor health care seeking practice of mothers was endangering a family health in the community" (**FGD1P4**). A health promotor woman mentioned: "The health of mother and health of children were inter-dependent that require continuous process of care" **(FGD1P5)**.

An elder woman and health extension worker stated: "The fact that a mother is the backbone of a family, the health problem of a mother certainly affects the livelihood of a family in the community. The reason for MCH care practices was mentioned as the major component of health extension programme packages by HEW in Dadar" (**FGD1P6 & FGD2P1).**

Religious leader also intimated: "The religious health rights of mother and children have to be protected by fathers, mothers, community members, religious leaders, community

leaders, teachers, traditional care givers and health professionals in the community" **(FGD2P2**).

A community leader mentioned: "Mother is the farmland on which seed of human being is grown sewed in the womb of mother to sustain human generation in a society" **(FGD2P3)**.

A traditional birth attendant stated: "Maternal and child mortality was considered as the cause for destruction of a family in a society" **(FGD2P4).**

A volunteer health promotor woman declared:
"Maternal and child health problems have public health importance in a community for their serious consequences" **(FGD2P5).** Similarly, an elder woman stated:
"The consequences of a maternal death result in serious negative socio-economic outcomes" (**FGD2P6**).

According to the responses of participants in FGDs conducted in Meta district, the HEW stated: Mothers and children are the largest proportion of population in the country. (**FGD3P1**).

A religious leader stated:
"In the religious belief of the community, the prophetic teaching stated that children have three rights upon their fathers. The first was checking the health mother before marriage (physical, mental, behavioural, social, emotional and psychological). The second was publicizing the birth of the baby by slaughtering goats or sheep for sacrifice and declaring nomenclature of the new-born baby as a blessing and socialization based on cultural and/or religious context of the community. The third was bringing up of a child in the best manner throughout developmental ages and stages until they are capable of independent life" **(FGD3P2).**

A community leader averred: "Maternal mortality was mostly associated with pregnancy related problem like bleeding after birth that can be prevented by proper MCH care practices" **(FGD3P3).**

On the other hand, a traditional birth attendant reported: "The value of health of mother was expressed as the first shelter and food-source of the baby both in the womb and after birth" **(FGD3P4).**

Similarly, a group leader of women who was serving the community as a volunteer health promoter indicated:

“The mother was known as *‘jaartuu-bultii’* which means founder of the family and if the health of mother is at risk, the health of all family members is at risk. The health problem of mother was dangerous for stability of the family life” **(FGD3P5).**

Additionally, an elder woman commented: “Community believed as the life of mother was the base for the life of the baby and as founder of a family life. If health problem of a mother is not protected the health of children is not protected in a family” **(FGD3P6)**.

A health extension worker in another group discussion mentioned: “Two-third of family size in a community was a mother and under-five children at minimal level” **(FGD4P1).**
A religious leader mentioned: “The maternal and child health issue has been mentioned in Qur’an and Hadith as a commandment in the contract agreement during marital ceremony for a couple partners mutual respect and taking care of each other as long as they live together “(**FGD4P2)**.

Another participant stated: “The mother was valued as the first medicine for her baby and the breastmilk is not only nutrition, but also medicine for the baby” **(FGD4P3).**
The reason for MCH care practices was reported by TBA in Meta as: “The reason for MCH issue was underlined as lack of prevention of preventable causes of maternal and child death that contributed to the life loss mothers and children in the rural area **(FGD4P4**).

Another woman commented: “The health of mother was the root for generation sustenance ‘*hunde biqilchituu shanyii ilma-namaa’* as we know that means source of generation production and reproduction” **(FGD4P5).** The woman (biting her finger) mentioned painfully that: “Though the maternal loss can be compensated for a husband in a family, there was no possibility for equivalent compensation of her life loss consequences for her children. Therefore, saving the life of the mother would be crucial for the health and survival of children” **(FGD4P6).**

The responses of participants in FGDs conducted in Kersa district reported as follows. A HEW stated: “Primary healthcare of mothers and children was important for addressing preventable causes of death in the rural community**” (FGD5P1);** In the same way, religious leader commented: “Islamic teaching was instrumental for sexual health in-depth about prevention of unwanted pregnancy before marriage through abstinence and fasting to prevent serious health, social and economic consequences in the community” **(FGD5P2).**

The community leader commented: “The health of mother was valued as the first school for her baby which serves as a base for complete health of the baby and shaping citizen” **(FGD5P3)**. A Traditional Birth Attendant (TBA) illuminated: “Morbidity and mortality of mothers and children in a family were directly interconnected with negative productivity outcomes in a society” **(FGD5P4).** The volunteer health promoter woman **(VHPW)** said: “Health of mother was a backbone of labour forces for productivity in the daily life activity of rural community” **(FGD5P5).** An elder woman “Maternal life loss consequences on the health of her children and family in a society can be observed by human-brain-minded person how orphans in the village behave and their hopelessness feeling that can be read from their faces” **(FGD5P6).**

According to the response of one of the participants, “The maternal and child health was a base for social transformation and development in the community” **(FGD6P1).**

The missed opportunity of Islamic teaching about importance childbirth spacing was: “Priority issue to be included in MCH care practices as a teaching tool. Lack of childbirth spacing by average of three years was lack of carrying out responsibility of defending child health rights primarily by parents as a violation of the health rights of children in the family” **(FGD6P2);** The mother is the nucleus of a family where generation make up is established (**FGD6P3**). “The maternal health problem negatively influences the general health status of a family in the community” (**FGD6P4**); “If the health of mothers and children were at risk as vulnerable group, all family members were at risk due to stressful situations” (**FGD6P5)**; “In the culture of the community, a woman was a cornerstone for construction of a family and similarly, maternal life loss was also equal to destruction of the family in a society **(FGD6P6)**; and, The other reasons for MCH care practices reported were addressing all preventable causes of maternal and child health problems in the community” (**FGD7P1**).

The use of indigenous culture of the community such as new-born socialization is: “Mandatory by shaving, naming and slaughtering of goat or sheep though blessing and parenting is the religious ceremony which is conducted on the seventh birthday of the baby regardless of gender specificity in the community (**FGD7P2**). The importance of the health of mother for family health in a society was also another reason for MCH care practices a community leader **(FGD7P3).** Similarly, maternal and child health problems’ negative health outcomes in a society was mentioned by TBAs” **(FGD7P4).**

Another participant also reported: “The healthy baby was born to a healthy family **(FGD7P5**); and, the health of mother was determinant for bringing up of physically,

mentally, socially, emotionally, sexually, spiritually and intellectually healthy children in a society" (**FGD7P6)**. A focus group discussion participant mentioned: "Prevention and maintenance of maternal and child health problems was the major reason for MCH care practices" **(FGD8P1**)

A religious leader uttered: "The use of available opportunities like supportive religious teaching about villagers' responsibility to protect environmental sanitation was mentioned. For instance, in the prophetic teaching it is said that spitting on the road or open field without burying it is sufficient for the sinfulness of human being" **(FGD8P2**).
A community leader commented: "The health of mother is the power for development of one's family in a society" **(FGD8P3).**

A TBA commented: "The preventable maternal and child health problems were critical issue for the health of a family in the society" **(FGD8P4).** A volunteer woman reported: "The need for shaping health citizens begins with the healthcare of mothers and children in a society. Consequently, shaping citizen was founded in the early life childhood developmental ages and stages" **(FGD8P5**).

An elder woman also commented: "The health problems of mothers that affected the health of children and the health of all family members in the rural community was major reasons for MCH care (**FGD8P6**). The majority of the rural community mothers and children were marginalized that would be reached by health service coverage" **(FGD9P1**).

A religious leader commented: "The best prophetic teaching in child feeding practices was mentioned as avoidance of blowing into a dish or a cap containing hot diets to cool was prohibited for introducing the pathogenic micro-organisms **(FGD9P2**); The health of mother was the base for economic development in any society **(FGD9P3)**; Majorly, the maternal and child life threatening condition could be prevented by promotion of health and prevention of disease effectively and efficiently **(FGD9P4**).

The health of mother and children was better protected by primary and secondary prevention from occurrence of serious complication and death **(FGD9P5**); and, the maternal and child disease and death mainly resulted in negative social, economic and health outcomes in the rural community" **(FGD9P6**).

The community of Babile district also affirmed: "The reasons as most of emergency maternal and child health problems in rural community could be addressed easily by prevention as early as possible" (**FGD10P1**). Another religious leader in the community

member stated: “Cutting things from the throat of new-born as a healing practice was a killing practice; while, the religious teaching protected people from cutting things from the throat and advised use of alternative medicine through nasal route of administration by sniffing the yellowish bitter fluid of Aloe Vera plant for all infections in any part of the throat (**FGD10P2)**; and, the health of mother and child was priority issue of community health needs” (**FGD10P3)**.

A TBA averred: “Awareness of the community about maternal and child health rights was limited and one of contributing factors for poor health seeking behaviour in a society **(FGD10P4**). The maternal life was the base for the life of the baby and serious maternal health problem resulted in dangerous circumstances for their future life of children” **(FGD10P5**). An elderly women commented: “The cultural belief of this society about avoidance of maternal anger, disappointment and psychological distress during pregnancy and breastfeeding importance for the prevention of physical, mental, social, emotional and psychological health protection and promotion was neglected **(FGD10P6**); and. the rural community believes that maternal and child health care practice was most important in a society” (FGD11P1).

A religious leader commented “Addressing maternal and child health problems was the responsibility of all adults and adolescents in the rural community. Culturally, it was mentioned that a child’s behaviour takes after its village. In the process of raising a child in the community, taking care of words and actions is very important for building up of life long social, mental, emotional and sexual health of a baby. as it has been adopted from Islamic scholars’ teachings in many rural places during the well coming of the new-born baby ceremony on the 7th day after child was born to inform the responsibility of community members and socialization of the baby” (**FGD11P2).**

A community leader also mentioned: “The health of mother is the basic needs of the baby as the first home of the baby, the firs food and the first cloth of the baby as a kangaroo mother care practice” (**FGD11P3**). One TBA commented: “The pregnancy and breastfeeding period were the time in which a mother seeks support of traditional health, family members and health care providers in the rural community” (**FGD11P4);**

On the other hand, “lack of advocacy of available health services and their benefits was contributing to stagnation of health care seeking practice in a society **(FGD11P5**). and, disability and death of mothers and children have serious social, economic and health consequences in the rural community” **(FGD11P6).** Another HEW mentioned: “The

support of maternal and child health promotion, prevention and maintenance was in need of both formal and informal care practices" (**FGD12P1**). A religious leader commented: "Prevention of maternal and child sickness and promotion of their health was responsibility of all adults and adolescents in the rural community that would be integrated with MCH care practices. Likewise, making use of engagement in religious assembly as an opportunity for obligatory teaching of Qur'an that commands minimum of regular and consistent breastfeeding for two years in Islam" (**FGD12P2**).

The mother was central part of family foundation as a component of the basic unit of a society (**FGD12P3**). A TBA commented: "The lack of community mobilisation for enhancing participation in maternal and child health service provision was a missed opportunity to drive the care seekers to the health facility in rural community" (**FGD12P4)**. In this regard, a task force member woman in the rural community mentioned:
"The maternal and child life loss cannot be prevented without contribution of mothers, family members, teachers, traditional birth attendants, volunteer health promoters, community leaders, religious leaders and health extension workers in the rural community. Sustainability of improved maternal and child health outcome was in need of mother's self-care and child care practices with support of family members, traditional birth attendant's consultancy service, volunteer health promoter's collaboration, of community leader's participation, religious leader's guidance and health extension workers care practices in the rural community" **(FGD12P5**); and,
The maternal sickness and life loss affect the livelihood of a family in the rural community as reported by elder woman in the community of Gursum district (**FGD12P6)**.

5.3.1.2 Purpose of MCH Care Practices

The analysis result of MCH care practice purpose was emerged with the details of description illustrated in the following representations.

Table 5.2: Thematic representations of analytical findings related to purpose of MCH care practices

Major theme	Sub-themes	Categories
Contemporary MCH situation	Purpose	To protect all mothers and under-five children from preventable causes of diseases' complication and death; Empowering clients for self-care and for baby care through training, health education, counselling and follow up to improve and sustain their health and well-being; Achieving Sustainable Development Goal 3; Reducing the death of mothers and under-five children in the community; Addressing all health needs of mothers and children;

Major theme	Sub-themes	Categories
		Enhancing community participation; Provide routine care service; Providing fundamental basic health service to all mothers and under-five children equally; Reducing the death of mothers and children; Improve breastfeeding practice; Prevent harmful traditional practices; Reducing maternal and child death; Enhance facility-based child birthing; Providing free of charge services; Promoting contraceptive use; Provide immunisation services for all mothers and under-five children in the rural community; Improve maternal health seeking behaviour; Initiating premarital health screening; Prevent delay from seeking healthcare; Reduce number of orphan children that have no mothers in the rural community; Improve survival of mothers and under-five children in the rural community; Improving community participation in informal MCH care practices such as social support by villagers; Enhance awareness of all mothers about dangers signs of pregnancy and labour; Improve access to maternal and child health service; and Improve antenatal care attendance.

The selected study participants' views about the purpose of MCH care practices were expressed as follows.

All participants working as focal persons in the districts of Dadar, Meta and Kersa responded to KII with regard to the question of purpose of MCH care practices, similarly answered and reported that: "Decreasing the death of mothers and under-five children is the purpose of MCH care; addressing all preventable to decrease death from attacking mothers and children is the aim of MCH care practice; preventing all mothers and under-five children from preventable causes of diseases, complication and death" **(D/M/K/MCH/FP/1F:2M**).

In the same way, the MCH focal persons of Fadis, Babile and Gursum districts commented: "To empower clients for self-care and baby care through training, health education, counselling, and follow up to improve and sustain their health and well-being; to address the health needs of mothers and under-five children equally in the rural areas; and to contribute to the achievement of sustainable development goal 3 by the year 2030"

(F/B/G/MCH/FPs/1F:2M). Similarly, the managers of HCs responded as "Reducing the death of mothers and under-five children in the community" **(KII7/DHC1/Mgr/M).**

"Addressing all preventable diseases and death from attacking mothers and children" (**KII8/DHC2/Mgr/F);** "Preventing mothers and children from all preventable causes of death **(KII9/MHC1/Mgr/M);** "Enhancing community participation in MCH health care practices through training, health education, counselling about self-care and childcare giving" (**KII10/MHC2/Mgr/M**); "Increasing the well-being of mothers and children progressively from time to time" **(KII11/KHC1/Mgr/M**); "Improving MCH service utilisation equally in the rural health centre" (**KII12/KHC2/Mgr/M);** "Realising health policy of the country translation in to practice so as to reduce the maternal and child death as per the sustainable development goal in the locality" **(KII13/FHC1/Mgr/M** and **KII14/FHC2/Mgr/M);** "Enabling mothers to address prevention of maternal and child health problems by training, health education, counselling, care giving and follow up at community level" **(KII15/BHC1/Mgr/M**) and **KII16/BHC2/Mgr/M**); "Enhancing the health status and well-being of mothers and under-five children in the community" **(KII17/GHC1/Mgr/M** and **KII18/GHC1/Mgr/M**).

According to the responses of midwives, the purpose of MCH care practices were enhancing MCH service coverage and equally provide routine care services; reducing the death of mothers and under-five children in the community by:
"Addressing all preventable diseases and death from attacking mothers and children" **(KII/19/20/21/HCs/MW/2F:1M**).

Others also added: "Preventing mothers and children from all preventable disease and death; making joint collaboration with community members in health care provisions through training, health education, counselling, care giving and follow up to prevent all preventable causes of death". Others mentioned the following: "Increasing the well-being of mothers and children progressively from time to time sustainably" (**KII22/MHC2/MW/M, KII23/KHC1/MW/F and KII24/KHC2/MW/M**).

Moreover, some of the key informant interviewees averred: "Providing fundamental basic health service to all mothers and under-five children equally in the rural health centre; translating the health policy of the country in to practice so as to reduce the maternal and child death as per the sustainable development goal in the locality; reducing the death of mothers and children progressively from time to time sustainably were purposes of Babble MCH care practices" **(KII25/FHC1/MW"/F, KII26/DHC2/MW/F and KII27/BHC1/MW/M)**

Similarly, others also reported: “Enabling mothers to address prevention of maternal and child health problems through training, health education, counselling on self-care giving and child care at community level and translating the health policy into practice so as to reduce the maternal and child health problems in line with the sustainable development goal in the locality” **(KII28/BHC2/MW/F, KII29GHC1/MW/F and KII30/GHC2/MW/F).**

Overall, as informed by the understandings of mothers interviewed in different rural HCs, the purpose of MCH care practice was described as: “To help mothers and children before getting sick and during their sickness, to assist mothers during pregnancy and child birth in the rural health facility, to enhance immunisation coverage, child delivery assistance and prevention and treatment of childhood illness, to manage the health problem of mothers and children in the rural health centres and to improve the health status of mothers and children in the rural community” (**KII31-35/D/M/K/HC1&2/Mthrs**).

Similarly, according to the responses of mothers interviewed in rural HCs, “The purpose of MCH care practice were to improve breastfeeding practice by supporting the mothers and family members after child birth in the rural health facility, to prevent harmful traditional practices that affect the mothers and children in the community, to realise MCH rights and save mothers and children by accessing them basic primary health care service in the facility, to monitor the health status of mothers and children in the rural community before their health condition is deteriorated, to reduce maternal and child death that happens due to lack of health services in the rural community, to enhance facility based child birth and provide referral service by facilitating ambulance and to provide free of charge services like antenatal care, perinatal care, postnatal care and care of under-five children in the rural health centre” **(KII36-42/F/B/G/HC1&2/Mthrs).**

The purpose of MCH care practice was reported community members in Dadar districts as: “To increase maternal and child health service coverage in the rural community **(FGD1P1**); To improve initiation of maternal and child health care intervention practice before marriage in the community; **(FGD1P2);** To address the health needs of mother and children (FGD1P3); To promote contraceptive use in the rural community **(FGD1P4**); To improve health seeking behaviour of mothers during pregnancy labour and postnatal care of mothers and children in the rural community **(FGD1P5**); and, To improve maternal health status in the rural community” **(FGD1P6).**

Additionally, the purpose was indicated as: “To prevent maternal and child illness causing factors in the rural community” (**FGD2P1**); “To improve sharing responsibility among stakeholders to contribute to maternal and child health care practice in the community”

(FGD2P1); "To prevent maternal and child sickness **(FGD2P3);** To improve use of immunisation service in the rural area" (FGD2P4) "To reduce disease and death occurrence of mothers and under-five children in the rural area" (**FGD2P5)**; and, "To improve maternal and child health status in the rural community" **(FGD2P6).**

The purpose of rural community members in the Meta district was also: "To provide immunisation services for all mothers and under-five children in the rural community" **(FGD3P1);** "To prevent and maintain the health of children at their early stages of life for the better health outcomes of their future" **(FGD3P2);** "To improve maternal and child health condition" **(FGD3P3**); "To improve maternal and child health awareness **(FGD3P4)**; To enhance facility based childbirth in the rural community (**FGD3P5);** and, to reduce maternal sickness in the rural community" **(FGD3P6).**

Moreover, another FGD participants also reported as: "To improve the maternal health seeking behaviour through the efforts of health extension workers in the rural community" (**FGD4P1)**; To apply principle of couple health screening before marriage to prevent the health of parents and their future children" (**FGD4P2**); "To reduce maternal and child death" **(FGD4P3);** "To enhance understanding of preventable maternal death in the rural community" **(FGD4P4**); "To empower pregnant mothers to consult the nearby health care providers in time of need in the rural community" **(FGD4P5)**; and, "To reduce child sickness in the rural community" **(FGD4P6**).

The Focus Group Discussants in the district of Kersa community responded about the purpose of MCH care practice as:"To enhance maternal breastfeeding practice (**FGD5P1**); To avoid occurrence of unwanted pregnancy (**FGD5P2**); To increase service utilisation" (**FGD5P3)**; "To increase awareness of preventable causes death" **(FGD5P4**); "To improve access to health information (**FGD5P5);** and, to reduce maternal and child death in the rural community" **(FGD5P6).**

Another group participant in the area also reported that the purpose of MCH care was: "To prevent maternal delay from timely seeking health care" **(FGD6P1**); "To improve child birth spacing in the rural community" **(FGD6P2**); "To reduce number of orphan children that have no mothers in the rural community" (**FGD6P3**); "To reduce maternal exposure to health risks in the rural area" **(FGD6P4);** "To improve survival of mothers and under-five children in the rural community" (**FGD6P5)**; and, "To reduce maternal and child death in the rural community" (**FGD6P6).**

According to the community of Fadis district residents' response, the purpose of MCH care practice was: "To screen the health status of mothers and under-five children in the rural community" (**FGD7P1**); "To improve community participation in informal MCH care practices like social support by villagers" (**FGD7P2**); "To improve the health of a family members in the rural community" (**FGD7P3)**; "To reduce exposure of children to health risks in rural area (**FGD7P4**); To reduce maternal and child death" (**FGD7P5**); and, "To maintain health and well-being of mothers and children in the rural community" **(FGD7P6).**

Additional purpose was: "To enhance awareness of all mothers about dangers signs of pregnancy and labour" (**FGD8P1**); "To mobilise the community members to participate in maternal and child health promotion and prevention" (**FGD8P2)**; "To provide routine maternal and child health services" (**FGD8P3**; "To increase maternal health service utilisation" (**FGD8P4**); "To positively contribute to maternal and child health care practices" (**FGD8P5**); and, "To save the lives of mothers and under-five children in the rural community" (**FGD8P6).**

The community of Babile district described the purpose of MCH care practice as:
"To improve community based environmental and personal hygiene practice" (**FGD9P1**); "To improve understanding of the community members about preventive measures of maternal and child health risks" (**FGD9P2);** "To prevent maternal and child sickness from preventable causes of diseases" (**FGD9P3)**; "To increase quality of maternal and childcare practices" **(FGD9P4**); "To increase involvement of family members in maternal and child health care practice" (**FGD9P5);** and, "To improve the survival of mothers and under-five children in the rural community" **(FGD9P6**).

Moreover, in the same area, the community members responded about the purpose of MCH care practice as "To improve nutritional status of mothers and under-five children (**FGD10P1**); To improve avoidance of harmful traditional practices like FGM and uvulectomy (**FGD10P2**); To decrease maternal and child death **(FGD10P3**); To enhance breastfeeding practices (**FGD10P4**); To reduce maternal and child health hazards **(FGD10P5**); and, to enhance maternal and child health service coverage in the rural community" (**FGD10P6).**

As per the community members of GURSUM district, the purpose of MCH care practice was: "To improve access to maternal and child health service" (**FGD11P1**); "To inform all community members about maternal and child health problems and ways of prevention" (**FGD11P2);** "To improve health facility based child birth in the rural health centres"

(FGD11P3); "To improve antenatal care attendance throughout pregnancy" (**FGD11P4**) "To improve access to health information by bridging the gap of communication between mothers and health professionals" (**FGD11P5);** and, "To enhance trust of the community members in utilisation of MCH services in the rural health centres" (**FGD11P6**).

Furthermore, the reported purpose was overlapping as: "To reduce maternal and child death" (**FGD12P1)**; "To prevent maternal and child sickness" (**FGD12P2**); "To increase use access to family planning services" **(FGD12P3**); "To increase skilled delivery service attendance by support of TBAs" (**FGD12P4**); "To improve community participation in maternal child health care practices" (**FGD12P5**); and, "To improve the health status of mothers and under-five children in the rural community" (**FGD12P6).**

5.3.1.3 Components of MCH Care

The analysis result of MCH care practice purposes has been illustrated in the following representations as encapsulated in Table 5.3 (overleaf).

Table 5.3: Thematic representations of analytical findings related to components of MCH care practices

Major theme	Sub-theme	Categories
Contemporary situations of MCH care practices	Components of MCH care practices	Awareness creation, health education, FP, ANC, delivery and PNC, as well as care of new-born and care of under-five children, screening services, PMTCT, Zink, Iron and Vit A supplements, prevention and management of STDs; maternal and child immunisation; Treatment of childhood illnesses; Prevention and management of TB; provision of youth friendly services; Choice-based contraceptive services, post abortion care, malaria prevention and management; Growth monitoring, safe water supply, nutrition, provision of mosquito net; Support of breastfeeding, exclusive breastfeeding, complementary feeding and provision of homemade ORS, and; Baby washing and massaging.

With regard to components of MCH care services, the responses of participants were explained as follows.

The focal persons of MCH in the districts located in the high lands of the study area reported as indicated below:

"Health education, FP, ANC, Delivery service, care of new-born and care of under-five children, screening services, PMTCT, Vit A prevention and management of STDs; maternal and child immunisation, FP service, ANC, PMTCT, prevention of HIV and STDs, child delivery care, PNC, care of new born, emergency care of under-five children,

Treatment of childhood illness, Child protection, breastfeeding, child washing, child feeding, child immunisation, provision of mosquito nets for prevention of malaria, prevention and management of TB, health promotion, deworming, prevention of complication and referral services were mentioned as routine MCH care services that are freely provided for mothers and under-five children in rural health facilities; screening, nutrition, FP, ANC, Delivery service, care of new-born and care of under-five children, screening services, PMTCT, Vit A, provision, malaria prevention, TB management, immunisation and health education services" were reported as routine MCH care services provided in all HCs in the districts **(KII1/D/MCH/FP/M, KII2/M/MCH/FP/M and KII3/K/MCH/FP/M)**.

In addition to the above mentioned routine MCH care, the focal persons working in the low land districts of the study area mentioned: "Youth Friendly Service (YFS) was provided as a component of MCH care services in the area; sanitation, hygiene, breastfeeding, FP, ANC, Delivery service, care of new-born and care of under-five children, STDs prevention and management, PMTCT, giving Zink, Iron and Vit A supplements were types of MCH care; and provision of mosquito nets for all pregnant women, malaria prevention, TB management, immunisation and health education services" **(KII4/F/MCH/FP/F, KII5/B/MCH/FP/M and KII6G/MCH/FP/M).**

From perspective of health centre managers, components of MCH care practices reported were inter-related and overlapping, as shown below:
"Health education, FP, ANC, Delivery service, care of new-born and care of under-five children, screening services, PMTCT and provision of Vit A that were routine MCH care services" **(KII7/DHC1/Mgr/M)**;"Provision, malaria prevention, TB management, immunisation and health education services" **(KII8/DHC2/Mgr/F**); "Awareness creation about latrine construction and proper utilization (**KII9/MHC1/Mgr/M**); Home-based counselling, breastfeeding, complementary diet feeding, FP, ANC, Delivery service, care of new-born and care of under-five children, screening services, PMTCT, provision of iron, Zink and Vit A provision" (**KII11/MHC1/Mgr/M**).

In addition to routine MCH care "Youth Friendly Service (YFS) was mentioned to be given in a rural HC" **(KII11/KHC1/Mgr/M**); "Provision of mosquito nets, malaria prevention, TB management, immunisation and health education services were mentioned" **(KII12/KHC2Mgr/M, KII13/FHC1Mgr/M and KII14/FHC2/Mgr/M, KII15-16/BHC1/ HC2/M and KII17-18/G/HC1-2/Mgr/M).**

From the perspective of midwives, components of MCH services were reported as: "Women empowerment, awareness building, training, screening STDs" (**KII19/DHC1/MW/F);** "Provision of health education, choice-based contraceptive services, post abortion care" (**KII20/DHC2/MW/M**); "Delivery service and immediate post-delivery care and postnatal care including care of mothers, care of new-born and care of under-five children" (**KII21/MHC1/MW/F**); "PMTCT, provision of Vit A, provision, malaria prevention, and health education services" **(KII22/MHC2/MW/F**); "Personal hygiene, environmental sanitation, counselling, breastfeeding, service, care of new-born and care of under-five children, screening services", **(KII23/KHC1/MW/F)**; "Safe water supply, nutrition, provision of mosquito nets, malaria prevention, TB management, immunisation and provision of health education services" (**KII24/KHC2/MW/F**); "Awareness creation, health education, counselling, care of new-born and care of under-five children, growth monitoring, and nutrition" (**KII25/FHC1/MW/F & KII26/FHC2/MW/F)**; "Awareness creation,, care of new-born and care of under-five children", **(KII27/BHC1/MW/F & KII28/BHC2/MW/F**); "Preconception, care of under-five children and screening services" **(KII29/GHC1/MW/F**); and, "provision of mosquito nets, TB management, immunisation, health education and laboratory services" **(KII28/MGHC2/MW/F**).

The rural mothers also reported the types of MCH services as: FP, ANC, Delivery, exclusive breastfeeding, complementary feeding, immunisation, child nutrition '*nyaata joollee'* and treatment of diarrhoea, health education, FP, ANC, Delivery, *kiniina qiwwaa, Kinina raammoo, Vitamina joolleetii fi kinina Dhiigaa kannu*; which means provision of Zink, iron, vitamins, anthelmintics and child nutrition as well as Treatment of childhood illness" **(KII31&32/DHC1-2/Mthrs & KII33&34/MHC1-2/Mthrs**).

In the same way,
"Maternal and child immunisation, FP service, ANC, PMTCT, prevention of HIV and STDs, child delivery care, PNC, care of new born, emergency care of under-five children, Treatment of childhood illness, breastfeeding practices and provision of mosquito nets" **(KII35&36/KHC1-2/Mthrs).** Almost half of the mothers who were seeking health care from HCs reported the components of MCH care services as: "Education, FP, ANC, child delivery service, care of new-born and care of under-five children, provision of iron (kiniina dhiigaa), breastfeeding, immunisation, provision of homemade oral rehydration salt, management of childhood illnesses and provision of mosquito nets" **(KII37-42/F/B/G/HC1-HC2/Mthrs).**

The rural community reported the types of MCH services as: "FP, ANC, child delivery, exclusive breastfeeding, complementary feeding, immunisation, child nutrition '*deydayaa*

fi waan joollee' which means pregnancy related disorders and treatment of childhood illnesses" **(FGD1,2,3&4/P1-6**); Growth monitoring, health education, FP, ANC, delivery assisting, new born care, deworming and child nutrition as well as treatment of childhood illnesses" **(FGD5&6/P1-6).**

In the same way,
"Maternal and child immunisation, FP service, ANC, PMTCT, prevention of HIV and STDs, counselling, child delivery care, PNC, care of new-born, care of under-five children, breastfeeding practices and provision of mosquito nets" (FGD7&8/P1-6);
the components of MCH care services were "Health education, FP, ANC, child delivery service, care of new-born and care of under-five children, provision of iron breastfeeding, complementary feeding, provision of homemade oral rehydration salt, management of childhood illnesses, baby washing, massaging and provision of mosquito nets" **(FGD9,10,11&12/p1-6).**

5.3.1.4 Task Performance Activities in MCH Care Practices

The analysis result of MCH care task performance activities has been illustrated in the following representations.

Table 5.4: Thematic representations of analytical findings related to activity performance

Major theme	Sub-theme	Categories
Contemporary situations of MCH care practices	Task performance activities	Facilitating, planning, coordinating, directing; Assigning duties and supervision; Attending to the care processes and supporting actors through empowerment and motivation; Planning the right intervention; Evaluation of implementation regularly; Giving direction on resources utilisation, ethical issue and supervision of performance of their duties; Sharing experience of work planning to support others in facilitating improvement of culture of MCH care practice in every set up; Adherence to use of guidelines; Assigning duties to nurses and midwives to provide twenty-four hours service in the health centre; Delegating managerial responsibility to team members and unit leaders in the health centre; Management of resources and capacity building of midwives and nurses through regular training and motivation depending on their commitment and performance of their duties; Preparing equipment, managing demand and supply, encouraging staff, providing services, referring legible cases and communicating feedbacks; Involving community members;

Major theme	Sub-theme	Categories
		Sharing knowledge of culture and context in a complex and dynamic MCH nursing practices with staff and community members; Seeking information from elders, TBAs, family members, religious leaders, community leaders, HEWs, volunteer women support group leaders (haadha garee) and social-supporters about danger signs of pregnancy, labour and childhood diseases; Teaching and behavioural change communication; and Teaching about child health rights, child spacing through proper breastfeeding and use of contraceptive methods.

According to the responses of MCH focal persons from six districts, the activity performance was carried out by:

"Facilitating, planning, coordinating, directing, supervising and evaluating activities; exercising managerial responsibility assigning duties and supervision; attending the care processes and supporting actors through empowerment and motivation; planning the right intervention and evaluation of implementation regularly; giving direction on resources utilisation, ethical issue and supervision of performance of their duties; sharing experience of work planning to support others in facilitating improvement of culture of MCH care practice in every set up and involving the community and making people use the guidelines properly for MCH planning, promoting, preventing and treating services as well as follow up of the progression" **(KII1-6D/M/K/F/B/G/MCH/FP).**

The rural health centre managers also reported the task performance activities as done by:

"Assigning duties to nurses and midwives in the way they can provide twenty-four hours service in the health centre" **(KII7/D/HC1Mgr/M)**; "By delegating managerial responsibility to the team members and unit leaders in the health centre" **(KII9/D/HC2Mgr/F)**; "By attending nurses and midwifery work activities as well as helping during overburdening and maintaining management of supply and demand in the health centre" **(KII9/M/HC1/Mgr/M**); "By understanding proper need of mothers and children through need assessment, planning, intervention and evaluation of implementation regularly" **(KII10/M/HC2/Mgr/M);** "By managing resources and empowering midwives and nurses through regular training and motivation depending on their commitment and performance of their duties" **(KII11/K/HC1/Mgr/M**); "By assessing, planning and implementation of maternal and child health promotion, disease prevention and evaluating the progression in the health centre" (**KII12/K/HC2/Mgr/M**);

The health managers in the low land districts of the health centres reported performance of activities as:

"By working in collaboration with others by resource mobilisation, monitoring and evaluation of activities in the health centre and outreach programmes" (**KII13/F/HC1/Mgr/M**); "By assigning duties to nurses and midwives in the way they can provide twenty-four hours service in the health centre" **(KII14/F/HC2/Mgr/M**); "By delegating managerial responsibility to unit leaders in the health centre" **(KII15/B/HC1/Mgr/M**); "By attending nurses and midwifery work activities as well as helping during overburdening and maintaining management of supply and demand in the health centre" (**KII16/B/HC2/Mgr/M**); "By understanding proper need of mothers and children through need assessment, planning, intervention and evaluation of implementation regularly" (**KII17/G/HC1/Mgr/M**); and, "By management of resources and capacity building of midwives and nurses through regular training and motivation depending on their commitment and performance of their duties" **(KII18/D/HC2/Mgr/M**).

According to the responses of health centre managers, task performance activities were performed by:

"Diagnosing, planning, implementing and evaluating and documenting MCH care practices" **(KII19/D/HC1Mw/F);** "Preparing equipment, managing demand and supply, encouraging staff, providing services, referring legible cases and communicating feedbacks" **(KII20/D/HC2/Mw/M**); "By involving community members, educating health and illnesses, discussing concept of maternal and child health nursing practice with regard to cultural context of the community" **(KII21/M/HC1 Mw/F**); "By assessment, diagnosis, planning, implementing and evaluating based on informed choices of customers" **(KII22/M/HC1 HC2Mw/M);** "By using guidelines and policy translation through sharing information about MCH nursing requirement in the context of the rural community" (**KII23/K/HC1/MW/F**); "By sharing experiences of knowledge, beliefs and best MCH nursing practices" **(KII24/K/HC2MW/M);** "By giving directions, supporting, supervising and collaborating with stakeholders" **(KII25/F/HC1/MW/F);** "By sharing knowledge of culture and context in a complex and dynamic MCH nursing practices with staffs and community members" **(KII26/F/HC2MW/F);** "By actively participating in information sharing about MCH nursing practices and tasks to be carried out at home level, community level and facility level in the rural area" **(KII27/B/HC1/MW/M);** "By sharing experience of success factors for improving maternal and child health nursing practice among care givers in the rural community" **(KII28/B/HC2MW/F);** "By assigning accountability among frontline staff members and sharing responsibility based on shared-decision making with mothers, traditional birth attendants, family members, volunteer

health promoters, community leaders, teachers and religious scholars in the rural community; and by involving influential community members and improving their understanding about MCH care practices to build sense of ownership in the rural community" **(KII29-30/G/HC1 HC2MWs/Fs).**

The rural mothers who participated in this study reported how tasks were performed by means of: "Breastfeeding, child caring, keeping proper sanitation and hygiene as well as timely seeking services for myself and for my baby; by proving care for family members using homemade medicine like water, common salts, honey, aloe-vera, blackseed as natural medicine that inherited from elders for common illnesses including common cold, diarrhoea and wound care" **KII31-3/D/HC1-HC2/Mthrs.** For child birthing processes, about half of participant mothers in local community reported as the work was being done pleasantly by: "Being assisted by TBAs, family members, social supporters and spiritual healers in the home and by female midwives and nurses in the health centres" **(KII32-34/M/HC1-HC2/Mthrs).**

On the other hand, the maternal and child health care practices were done by: "Seeking information from elders, TBAs, family members, religious leaders, community leaders, HEWs, volunteer women support group leaders (*haadha garee*) and social-supporters, about danger signs of pregnancy, labour and childhood diseases as well as solution. Salutation was also mentioned as the right guidance and support for their seeking solution throughout task as the core of task performance activities in the process of MCH care practices of routine MCH care and traditional care practices **"(KII35-39/K/F/B/HC1-HC2/Mthrs).**

The rest participants also, reported as it was done by:
"Proper utilisation of routine MCH care for myself and child caring, child feeding, child washing and child protecting, breastfeeding, complementary diet feeding, collaborating with stakeholders in the facility and in the village, using FP, immunisation, prenatal care, perinatal care and postnatal care in the rural area" **(KII40-42/G/HC1-HC2/Mthrs).**

As per the community responses task performances activities of health extension workers were "By enhancing exclusive breastfeeding practice for the minimum of two years, reducing maternal and child illness causing factors, improving access to immunisation services, increasing maternal health seeking behaviour, preventing the primary delay of labouring mothers in the rural community, increasing maternal and child health coverage, in the rural community" **(FGD1P1, FGD2P1, FGD3P1, FGD4P1, FGD5P1 and FGD6P1).**

The task performances activities of religious workers were

“By teaching to encourage premarital/preconception care intervention practice, teaching about maternal respect as a merciful service, teaching about child health rights fulfilling obligation of child birth spacing during early life of the baby through proper breastfeeding and abstinence as the natural contraceptive methods, application of principle of couple health screening before marriage to prevent the health of parents and their future children as an obligatory action, teaching prohibiting occurrence of unwanted pregnancy that ultimately result in unwanted children before and after marriage and prevent risk of abortion and serious health consequences of mothers and children in the community” **(FGD1P2, , FGD2P2, FGD3P2, FGD4P2, FGD5P2 and FGD6P2)**

The task performances activities of the community leaders were reported as*:*

“By the side of health task forces during campaign, mobilising latrine construction, accessing safe and sufficient water, supporting mothers to timely reach health facility during child birth, improving facility based child delivery service utilisation, facilitating conditions for health promoters in the community, enhancing health seeking behaviour of mothers, supporting road construction and managing occurrence of disease outbreaks and epidemics by working with health extension workers in the rural community” **(FGD1P3, FGD2P3, FGD3P3, FGD4P3, FGD5P3 and FGD6P3).**

The task performances activities of health promoters were reported:

“By promoting contraceptive use, improving use of immunisation service, improving community health awareness, enhancing understanding of preventable maternal death, increasing awareness of preventable death of mothers and under-five children and reducing maternal health risks in the rural area” **(FGD1P4, FGD2P4, FGD3P4, FGD4P4, FGD5P4 and FGD6P4).**

The task performances activities of traditional birth attendants were reported as

“Improving the health seeking behaviour of mothers during pregnancy labour and postnatal care, advertising appropriateness of modern health services, empowering pregnant mothers to consult the nearby health care providers in time of need by coordinating, improving access to health information about available services, giving advices for mothers and supporting mothers to visit health facility” **(FGD1P5, FGD2P5, FGD3P5, FGD4P5, FGD5P5 and FGD6P5)**

The task performances activities of elder women(grandmothers) were reported as:

“Improving maternal child care practices by sharing experiences, supporting proper provision of self-caring and care of children in time of need, improving informal health

care practices for mothers by fumigation, improving the health status of children by proper breastfeeding, preventing infection by hygienic practices, staying home with sick mothers and children during illness, encouraging proper attending of antenatal care services in the rural community" **(FGD1P6, FGD2P6, FGD3P6, FGD4P6, FGD5P6 and FGD6P6)** The responses of stakeholders in the community with regard to task performances activities were almost similar in all study areas.

However, "Provision of mosquito nets, seasonal provision of food items and involving clan leaders in supporting heath care provision by using animals for transportation and using loud speakers for calling marginalized rural pastoralists were limited to the catchment areas of selected low land districts" (**FGD7-12P1-6).**

5.3.1.5 Nature of Interactions in MCH care practices

The result of analysis that shows components of MCH care has been illustrated in the following representations.

Table 5.5: Thematic representations of analytical findings related to interactions in MCH care practices

Major theme	Sub-theme	Categories
Contemporary situations of MCH care practices	Interactions in MCH care practices	Communication was means for interaction; Using oral and written conversation; Coordinating services and physical interaction; Communication and making regular assembly through community participation; Interaction through awareness creation, contact and communicating; Networking with customers for regular communication and training; Inter-connecting and involving the community members; Culture of the community allows best inter-personal communication daily with family members, neighbours, community leaders, neighbours, religious leaders and health extension workers during coffee ceremony; Reality in other rural area revealed through interaction by exchanging information with HEWs in utilisation of immunisation and family planning for child birth spacing and with nurses and midwives in using skilled delivery service and continuous discussion with family members, traditional birth attendants, health extension workers, health professionals, religious leaders, community leaders, community based health team agents about personal experience during pregnancy, child birth and postnatal, antenatal visits, child birth and child care services through communication, and through communication by using mobile phones for getting advices from HEWs in the community.

As per the responses of district MCH focal persons to the question related to inter-personal interaction, the findings were reported thus:
"Communication was means for interaction with subordinates, using oral and written conversation was helpful to interact, regular discussion with staff was the way of interaction in MCH care practices, stretching networks with staff and coordinating services regularly contact interaction, linking sectors and regularly interacting by using information technology; harmoniously collaborating by timely communicating daily routine activities and emergent issues for timely addressing the problem" **(KII1-6/D/M/K/F/B/G/MCH/FP).**

The managers of health centres also reported the nature of personal interaction in MCH care practices as done through: Communication to maintain trust (working relationship and confidence **(KII1/D/HC1Mgr/M).** In connection with this, it was also reported as "Communication and physical interaction with stakeholders" (**KII2/D/HC2/Mgr/F**); Through sharing information and regular assembly, sharing responsibility and communication activity report **"(KII9-10/M/HC1-HC2/Mgrs/M**).

The majority of participants also reported that their personal interaction was by:
"Communication, making regular assembly with all stakeholders and interact through telephone communication in day-to-day activities; Continuous communication vertically with policy makers to pave the way for timely getting support and horizontally with health staffs and community members to improve their confidence, participating community interaction and social affairs as well as using opportunity to interact with family members and community members in the facility; By communicating with governmental and non-governmental organisation as well as staffs and community members and interact through continuous communication with beneficiaries about MCH problems and solutions" **(KII11-16/K/F/B/HC1-HC2/Mgrs/M).**

One of the health centre managers also reported as his inter-personal interaction was carried out by: "Harmoniously interacting internally and externally with customers and care givers in the area along with enhancement of community participation in MCH care practices" **(KII17/G/HC1/Mgr/M).** Another report also showed as the interaction was by:
"Awareness creation and behavioural change communication with mothers, family members and community members to build confidence in their heart and improve their health seeking behaviour" (**KII18/G/HC1/Mgr/F**).

The fact that certain midwives in the rural MCH care facilities reported that their inter-personal interaction was done by:

“By contacting and communicating with community health agents and care providers in the rural health facility” (**KII19-22/D/M/HC1-HC2/2M&2F).**

The majority of midwives in the rural health facilities also reported in the same way as inter-personal interaction was done by: “Communication with mothers, community leaders, traditional healers, religious leaders, role model family members and health extension workers for accessing information in real time about real world, networking with care providers for regular communication and awareness creation based on the need questions, through human-to-human networking and conversation among community members, care providers and clients being part of role players in the community, through training and community empowerment by awareness creation, health education and community mobilisation and self-engagement in the community affairs” **(KII23-28/K/F/B/HC1-HC2/2F.4M).**

The midwives reported further that:
“Contacting and informing well about the details of MCH care practices required from each partner in the network; communicating and visiting clients, family members and community members regularly, care giving supervising, supporting, inter-connecting and involving the community members to continuously interact” **(KII29-30/G/HC1-HC2/F).**

The rural mothers interviewed in the health centres reported an inter-personal interaction as done by: “(*Allah ja’ani, ollaa ja’an*) which means who is called next to Allah is neighbour. for discussing about their health issues and for seeking advices and support in maternal and child health care practices; communicating about health issue with family members, neighbours, traditional birth attendants, health extension workers and community leaders in the village and with nurses and midwives in the health centre; continuously contacting and communicating with health extension workers by communication about health information with family members, neighbours, religious leaders and health extension workers; regularly contacting and discussing with health extension worker about immunisation, family planning and certain childhood illness management like diarrhoea and common colds; interacting with trained traditional birth attendants and health extension workers by face-to-face communication” **(KII31-36/D/M/K/HC1-HC2/Mthrs**). “The culture of the community allows best inter-personal communication daily with family members, neighbours, community leaders, neighbours, religious leaders and health extension workers during coffee ceremony” **(KII37-38/F/HC1-HC2/Mthrs).**

The reality in other rural area revealed as: “They interact by exchanging information with health extension workers in utilisation of immunisation and family planning for child birth spacing and with nurses and midwives in using skilled delivery service and continuous discussion with family members, traditional birth attendants, health extension workers, health professionals, religious leaders, community leaders, community based health team agents about personal experience during pregnancy, child birth and postnatal, antenatal visits, child birth and child care services through communication in the rural area primary healthcare” **(KII39-42/ B/G/HC1-HC2/Mthrs).** “The community members responses to the question of interaction were reported as common thing in daily life of local community” **(FGD1P1);** “As a tool for discussing about their health issues **(FGD2P1&6);** As a mean for seeking advices and support in maternal and child health care practices through communication” (**FGD3/P2&3**);

“Similarly, inter-personal interaction was done by communicating about health issue with family members, neighbours, traditional birth attendants, health extension workers and community leaders in the village and with nurses and midwives in the health centre” **(FGD4/P4&5);** “In certain circumstances where communication technology was available, inter-personal interaction was done through communication by using mobile phones for getting advices from HEWs in the community” **(FGD5/P1-6).**

“As per rural community experiences reported by group discussants, inter-personal interactions in MCH care practices were carried out while visiting health facilities for pregnancy check-up, child birth and postnatal services, antenatal visits, childbirth and child care services including nutritional services through physical contact and communication in the rural area primary healthcare” **(FGD6/P1-6).**

Other group participants also agreed upon that inter=personal interaction was
“By physical contact and communication with health extension workers, family members, neighbours, religious leaders and health extension workers in time of needs” (**FGD7/P1-6).** “Again, a common sense of community about inter-personal interaction in MCH care practices was reported as regularly done with health extension worker during immunisation, family planning and childhood illness management like diarrhoea, malnutrition, common colds, etc”. (**FGD8/P1-6).**

“Moreover, interacting persons by face-to-face communication within a family and community members about MCH problems and care practices in occurrence of any sickness situation of mothers and children was common in the local community” **(FGD9/P1-6**). “The culture of the community also allows best inter-personal

communication daily life activities with family members, neighbours, community leaders, neighbours, religious leaders and health extension workers while coming across and during coffee ceremony" **(FGD10/P1-6**). "The reality in other rural area revealed as certain community member interact by exchanging information with health extension workers during immunisation, family planning, childbirth spacing with nurses and midwives" (**FGD11/P1-6)**. "Over and above, inter-personal and inter-group interaction were mostly done during social, cultural and religious assemblies as well as childbirth, festival, marriage and mourning ceremonies traditional birth attendants, health extension workers, health professionals, religious leaders, community leaders" **(FGD12/P1-6).**

5.3.1.6 Satisfactory/ Unsatisfactory Aspects in MCH Care Practices

Two sub-themes were generated in this case, namely: satisfactory factors in MCH care practices and unsatisfactory factors in MCH care practices.

5.3.1.6.1 Satisfactory things in MCH care practices

The analysis result of the study related to satisfactory factors or aspects in MCH care practices were shown in the following illustration.

Table 5.6: Thematic representations of analytical findings related to satisfactory aspects in MCH care practices

Major theme	Sub-theme	Categories
Contemporary situations of MCH care practices	Satisfactory aspects in MCH care practices	Access to free of charge services was satisfactorily done; Enhanced community participation in MCH nursing practices; Access to preventive care of mothers and children through immunisation and screening services; Improved follow up of clients and timely reporting activities; Improved referral networks and referral services; Improved community participation; Improved collaboration with HEWs; Enhanced utilisation of FP services; Increased number of skilled-child birthing users; Improved MCH service utilisation in the rural health centre; Improved community awareness and social support; Access to contraceptive methods; Access to malnutrition management services; Support of TBAs and maternal interest and readiness for self-preparation of birth preparedness, childbearing and child rearing; Improved normal pregnancy assisting; Cultural food preparation for PNC; Improved participation of women support group; Improved coverage of 18 primary care packages; Home-based MCH care practices by HEWs addressed the majority of MCH problems in the community;

Major theme	Sub-theme	Categories
		Improved the interaction of teamwork in the facility; MCH care practice have improved access to transportation for referral services; Latrine construction was improved and improved prevention of diarrhoea by increasing proper utilisation of latrine in the rural community; Improved maternal understanding about certain danger signs of pregnancy, labour and childhood illnesses and has elevated level of satisfaction, and; Improved information exchange between care givers and care seekers throughout pregnancy attendance and child birth and improved information seeking behaviour of the community were satisfactory aspects in MCH care practices.

5.3.1.6.2 Unsatisfactory factors in MCH care practices

Similarly, the analysis result of the study related to unsatisfactory factors in MCH care practices were shown in the following Table 5.7 illustration.

Table 5.7: Thematic representations of analytical findings related to unsatisfactory aspects in MCH care practices

Major theme	Sub-theme	Categories
Contemporary situations of MCH care practices	Unsatisfactory factors in MCH care practices	Satisfaction limited due to barriers such as cultural beliefs and lifestyle of pastoral community; Satisfaction limited due to lack of access to mobile MCH care services; Referral service in rural health facility not fully satisfactory due to inconsistency of ambulance availability; Incompleteness of facility requirement readiness was unsatisfactory; Using unsavoury language was unsatisfactory; Unsatisfactory greeting from health professionals; Unsmiling male midwives (fuulli ogeeysaa fuula ililli maawardi odoo tahuu qabuu, fuula qajjeebbuu tahee arkame) which means the face of professional that should be bright like a rose flower was found to be disgusting; Lack of professional, clear communication with clients and family members obscured wisdom and freedom of customers; Population growth was widening gaps between the standard and the existing MCH care practices and workloads in the rural community; Lack of using indigenous knowledge created gap for poor satisfactory condition; Poor relationship and interaction between community members and caregivers was unsatisfactorily; Access to communication technology was limited to call for emergency; Unmet need and the focus of health education and counselling about contraceptive methods promotion were problematic;

Major theme	Sub-theme	Categories
		Physical attack, coercion and violence against women were the real causes of unmet needs (wal quba hin qabduun, waliif dawaa hin qabdu) which means lack of insights about the root cause might have led to mismanagement; Food security was not satisfactory, and ladies have no power of making decision; Lack of compensation/ payment for informal care givers (e.g., TBAs) in the community; Availability of resources was not promising, there was no satisfactory childbirth spacing; Poor satisfaction with drug shortages in the health facility; scale up of family health recording that has been preached to be practical remained unsatisfactory; disappointing behaviour of certain care givers; distance, bad behaviour of certain care givers, hills, mountains, rivers and lifestyles of the community was affecting access to health centres in the rural community; I was at sub-optimal level than it should be due the nature of complexity of culture that requires several issues to be addressed in the process of care practice such as culturally sensitive language taboo and female midwife gender preference in delivery care services due to belief of the community; purchasing certain prescribed drugs from private drug venders deducted the level of satisfaction with MCH care practices; cultural gender preference of the local community for midwifery service was neglected; feedback communication was not done practical and access to referral linkage and ambulance service sometimes limited; clients' complaint handling was not responsive to satisfy customers; communication among stakeholders was unsatisfactory; access to house-to-house service was insufficient due unequal attention for every household in the community; rural women mostly complain about side effects of artificial contraceptive methods such as headache, nausea, excessive menstrual bleeding and dizziness rather than satisfaction; culturally sensitive issue was not addressed by addressing specific gender preference need of women in the community; service that was provided by male midwife was unsatisfactory; when the health rights were violated, there was no mechanism of handling the problem in case of decision making which was not customer-centred; improper utilisation was due to shortage of water in the rural community; unequal coverage, demographic issues scarcity of resources and poor access to MCH care practice; lack of using guidelines in all intervention areas of the care practices, and; lack of greeting and self-introducing of care givers were unsatisfactory factors/ aspects.

As per the district MCH focal person mentioned: “The care practice improved health insurance and access to free of charge services done. But satisfaction was occasional or inconsistent” **(DMCHFP).** Another focal person averred: “Enhanced community participation in MCH nursing practices encouraging, but there was no satisfactory satisfaction due to shortage of resources to fulfil the needs” **(MMCHFP).**

A focal person in a local district commented: “Improved access to preventive care of mothers and children was satisfactory, but satisfaction was low due to surpluses of population size compared to the standards of the country” **(KMCHFP)**; “Another satisfactory thing was improved cost-free services enhanced timely health seeking behaviour; But the community satisfaction was limited due to lack of access to mobile MCH care services” **(FMCHFP).**

Another focal person stated: “Improved monitoring and evaluation of the work of maternal and child health care practices enhanced level of commitment and participation of stakeholder; however, satisfaction was limited due to barriers like cultural beliefs and lifestyle of pastoral community” **(BMCHFP).** The MCH care practices improved follow up of clients and timely reporting activities, but availability of drug was below expectation **(GMCHFP).** The managers of rural health centres responded to the question of what satisfactory and/ or unsatisfactory aspects were in MCH care practices as follows.
A manager stated: “In MCH care practices improved referral networks and referral services in the rural health facility, but it was not fully satisfactory due to inconsistency of ambulance availability” **(DHC1Mgr).**

Another manager also stated: “In the care practices again improved community participation in the rural community was satisfactory, but incompleteness of the health facility requirement made it unsatisfactory (**DHC2Mgr**); Access to MCH care practices was also improved, but unethical behaviour of certain care givers and lack of timely corrective measure in the health centres were disgusting” **(MHC1Mgr);**

“In addition, the care practice improved continuous monitoring and evaluation of the routine care work in maternal and child health services in the health centre. But lack of using soft words was affecting satisfaction” **(MHC2Mgr).** There was also improved collaboration with HEWs in the community, “But effort of collaboration from professional sides with community in the rural facility was not as such satisfactory due to lack of greeting from health professional sides **(KHC1Mgr);** Again, MCH care practices satisfactorily enhanced utilisation of FP services, but there was non-smiley face from male midwives mostly (*Fuulli ogeeysaa fuula ililli maawardi odoo tahuu qabuu, fuula*

qajjeebbuu tahee arkame) which means the face of professional that should be bright like rose flower was found to be the face of scorpion" **(**KHC2Mgr).

Other managers also reported: "improved care seeking behaviour due to health promotion within community, but certain health care givers had ill-behaviour that affect customer satisfaction in the health centres" **(FHC1Mgr);** and, "There was again improved mobilisation of resources for porridge preparation for postnatal mothers in the health centre, but lack of professionals' clear communication with the clients and family members was an obscure to wisdom and freedom of customers" **(FHC2Mgr**). "Furthermore, there was improved implementation of routine maternal and child health care practices in the rural health facility, but there was lack of face-to-face listening and talking **(BHC1Mgr**); and, besides there was improved maternal and child health service coverage in the rural area, but lack of empathy was problematic" **(BHC2Mgr).**

Other stated that*:* "There was improved quality of maternal and child health care practices in the rural health facility, but there was lack of respectful interaction **(GHC1Mgr);** and also, "MCH care practice improved access to FP service, but provision of condom to adolescents in the community was not culturally congruent" **(GHC2Mgr).**According to the responses of midwives in the rural health centres: "there was increased number of skilled-child birthing users, but lack of proper leadership made the existing MCH care practices meaningless|" **(DHC1Mw/F);** "There was improved MCH service utilisation in the rural health centre, but lack of using indigenous knowledge created gap for satisfactory achievement" **(DHC2Mw/M**); "There was increased cost free services, but at the same time the population growth doubling was widening the gap between the standard and the existing MCH care practices and over burdening and overloading the work in the rural community of the country" **(MHC1Mw/F);** "The MCH care practices also improved community awareness and social support, but there was huge gap between the community members and care givers to interact satisfactorily due to personal characteristics and the working environment" **(MHC2Mw/M).**

In the rural community, "MCH care practice enhanced understanding of the community about danger signs of pregnancy, labour and childhood diseases, but access to information technology was limited to call for emergency" **(KHC1Mw/F);** "Even though addressing unmet need for FP was primary issue of MCH policy in the country and improved access to contraceptive methods, but the root problems of unmet need and the focus of health education and counselling about contraceptive methods promotion were on different sides of the river as physical attack, coercion and violence against woman were the real causes of unmet needs *'wal quba hin qabduun, waliif dawaa hin qabdu'*

which means lack of insights about the root cause might have led to mismanagement" **(KHC2Mw/M).**

Additionally, the midwives reported that: "There was improved access to acute severe malnutrition management services at rural facility level, but food security was not satisfactory for prevention of malnutrition" **(FHC1Mw/F);** "Similarly, the rural MCH care practices brought behavioural change to some extent; but woman empowerment and gender equality that have been announced several times on mass media remained unrealised dreaming" **(FHC2Mw/F);** "MCH care practices also improved primary and secondary delay of pregnant mothers in labour; but the care givers were not communicative as to be" **(BHC1Mw/M);** "Locally, service utilisation in MCH care was also improved to some extent in rural health centres, but it was not encouraging due to lack of consistency as a result of lifestyle of pastoral community seasonal displacement" **(BHC2Mw/F).** "Over and above, community participation and quality of care was improved in the rural health facility, but nature of existing population number was overloading the work of MCH care practices in the area" **(GHC1Mw/F);** and, "There was improved avoidance of under-five FGM; but rarely it was not abandoned and it has been performed in the cave out of public sight" **(GHC2Mw/F).**

The women in the rural community reported: "The majority of mothers' satisfaction was improved by health extension workers support and skilled delivery assistance; but postnatal visit was still uncovered due to shortage of human resources" **(DHC1Mthr);** "Advocacy of MCH care practices improved access to health information communication from health extension workers; however, lack of technology affected to satisfactorily access health information" **(DHC2Mthr);** "Access to prenatal care, perinatal care and postnatal care was improved well; but preconception care was neglected in the health centre (**MHC1Mthr)**; "Childhood disease management was improved, but free of charge service was not free for all in the rural health centre" **(MHC2Mthr);** "MCH care service availability improved interest of the community members to participate in the care practices; but it was not encouraging situation due to lack of committed professionals to attract participants" **(KHC1Mthr);** "MCH care practices again improved information and experience sharing between people about contraceptive options; but ladies have no power of making decision on using contraceptive methods without permission of their husbands" **(KHC2Mthr);** "Health education also improved child care and child protection from certain harmful traditional practices; but in most marginalized area, HTP like cutting things from the throat was going on publicly" **(FHC1Mthr);** "On the other hand, though understanding of self-care practice and baby care practice was improved in the rural

area, there feeding habit was not changed due to food scarcity and lack of diversity" **(FHC2Mthr);**

The support of TBAs was appreciated by mothers in MCH care practices; "But from time to time, the commitment of TBAs was becoming poor due to lack of energizer or compensation" **(BHC1Mthr);** "The MCH care practices again improved maternal interest and readiness for self-preparation of birth preparedness, childbearing and child rearing as well as proper breastfeeding and complimentary diet feeding; "But availability of resources was not promising there was no fruitful outcome satisfaction in childbirth spacing" **(BHC2Mthr);** "The satisfaction of service users with quality of care by skilled birth attendant was appreciated mostly in MCH care practices, but sometimes it was disgusting due to professional's unethical manner and malpractice" **(GHC1Mthr);** and, "improved health promotion and disease prevention practices, but there was poor satisfaction, due to lack drugs in the health facility, lack of dignity and poor communication skills of health care givers" **(GHC2Mthr).**

Some of the group discussion participants reported: "The impacts of MCH care practices were reported as improved normal pregnancy assisting service provision and as satisfactory from the perspective of health extension workers" **(FGD1P1). "**Access to free of charge service was improved, but scale up of family health recording that has been preached to be practical remained unsatisfactory" **(FGD1P3).** "The skilled child birth assisting in maternal and child health care practice outcome was good and also satisfied certain cultural needs like preparation of cultural food (known as '*shuuroo' or 'marqaa*) porridge prepared from different cereals for mothers after child birth in the health centre" **(FGD1P4**). "The participation of women support group at community level was good initiative, but lack of incentives and communication technology for interacting with community and care givers was disappointing" **(FGD1P5).** "There was also improved delivery service that was assisted by midwives, although the feminine midwife preference than the masculine midwives in the cultural and belief context of the local community was unaddressed issue" **(FGD1P6).**

Other participants stated further that: "An improved coverage of 18 primary care packages majorly associated with MCH care practices, appraisal of health posts to health centre level may make it more satisfactory in the rural community" **(FGD2P1**). "Bringing home, the MCH care practices by HEWs addressed the majority of MCH problems in the community, but it required integration of conducting research with the daily MCH care activities and follow up in the rural community for realisation of further satisfaction" **(FGD2P2).**

Other group discussion participants reported that: “Access to the nearby HPs improved the first delay that was caused by poor health seeking behaviour in the rural setups; however, the distance, bad behaviour of certain care givers, hills, mountains, rivers and lifestyles of the community was affecting access to health centres in the rural community” **(FGD2P3**). “The community-based maternal and child health care practices improved provision of routine care practices like FP, ANC, Delivery, care of new-born and care of under-five children, but is was at sub-optimal level than it should be due the nature of complexity of culture that requires several issues to be addressed in the process of care practice like culturally sensitive language taboo and female midwife gender preference in delivery care services due to belief of the community” **(FGD2P4).** “Free of charge health maternal and child service has been realised by strengthening network between women support group and care providers in the rural health centre, but purchasing certain prescribed drugs from private drug venders deducted the level of satisfaction with MCH care practices” **(FGD2P5).**

A woman in the rural community commented:
“The major impact of MCH care practice was improved access to midwifery services in the nearby facility. However, professional development for local health service in MCH would have been learnt from earlier existing traditional birth assisting care practices before the era of modern health service coverage was expanded”. On further probing, the woman augmented that: “In the history of the local community, there was no male TBAs. So, as for the health extension packages female HEWs were selected and trained, the cultural gender preference of the local community for midwifery service was neglected. If improving and sustaining of women preference to facility-based delivery of the baby in in the area, increasing number of female midwives and retaining them would be mandatory” **(FGD2P6).**

According to the community of Kersa district, “Access to referral services was improved to some extents; however, feedback communication was not done practical and access to referral linkage and ambulance service sometimes limited” **(FGD3P1)**. “The effects of maternal and child health nursing practice in the facility improved the interaction of teamwork in the facility, but clients’ complaint handling was not responsive to satisfy customers” **(FGD3P2).**

Access to MCH routine care was good in the facility due to proper provision of available services in the health centre. In this regard, it was mentioned: “the site of health centre construction was not community-centred and not satisfactory in the locality” **(FGD3P3).**

The maternal and child health nursing practice outcome was different in different units. For instance, they described: “The maternal and child health in the delivery room is appreciated by many users. But, the use of artificial contraceptive methods was condemned by a majority of the users in the community for the side effects” **(FGD3P4).** “The efforts of sharing responsibility with mothers, family members and community members improved their participation; but there was no satisfactory practice to due to lack of continuity of professional support and communication as expected to be by beneficiaries” **(FGD3P5).** “An impact of MCH care practice increased nutrition, screening, diagnostic service and treatment of common MCH problems; but certain services were exhaustive and financially demanding due to unavailability of supplies and drugs in the locality” **(FGD3P6**). “In the community of Fadis district, there was improved responsiveness in assisting normal labour in the facility. However, level of satisfaction was dependent on positive and negative attitudes and behaviours of individuals. Positive attitudes or behaviour was satisfactory while the negative one was disgusting” **(FGD4P1).** “At community level health service utilisation was improved, but mutual respect in communication among stakeholders was not satisfactory” (**FGD4P2)**.

Views on access to HEWs indicated that: “Access to house-to-house service was insufficient due unequal attention for every household in the community” **(FGD4P3**). “The coverage of FP and the contraceptive use were improved. But the rural women mostly complain about side effects of artificial contraceptive methods like headache, nausea, excessive menstrual bleeding and dizziness rather than satisfaction” **(FGD4P4**). “Child immunisation was routinely given for under-five children satisfied the community members. But the postnatal follow up after discharge was not given attention” **(FGD4P5).**

Another woman in the rural community mentioned “Provision of routine MCH care improved health seeking behaviour. But it did not include gender issue”. When probed further by the researcher, she stated: “ … the gendered community were not taught about equality of male and female babies. Immediately, after birth people have been alarming using their mouth loudly ‘ililililililili…. Ililil’ for welcoming of the male baby and have been keeping quite when the sex of new-born baby was reported to be female” **(FGD4P6).**

The responses of the community of Kersa district to the guiding question on impacts and satisfaction in MCH care practices were reported as the care practice in delivery setup was technically good by assisting delivery and facilitating referral linkages that significantly decreased maternal and child mortality than before. But their approach was not satisfactory.

Additionally, in response to a probing question for clarity, she replied: “Respect begins by cultural greeting ‘peace be upon you. However, the fact was that the majority of health professionals did not start their communication with clients by greeting and self-introducing. They were directly asking what did the customers need. Their communication style did not allow the customers to feel free and express feelings in-depth” **(FGD5P1-6)** and all participants agreed.

Similarly, another group participant replied: “During immunisation campaign like polio vaccination workers were happy due to incentives. But their motivation was not this much during routine immunisation service provision. The maternal and child health nursing practice outcome is good when the community members are actively involved as it overcomes delay and provide emotional support of mothers” **(FGD6P1-6)**

The rest participants nodded to confirm their agreement. “The community Fadis district reported that the MCH care practice have improved access to transportation for referral services. But the midwifery service that was provided by male midwife was not satisfactory” **(FGD7P1&2**). “The latrine construction was improved by efforts of HEWs. But improper utilisation was due to shortage of water in the rural community” **(FGD7P3&6**).” The MCH care practice also encouraged the culture of social support and labour companions. But lack of access to waiting area in the health centre negatively affected their satisfaction and agreed upon by all participants" **(FGD8P1&2**). “In the same way, maternal confidence was increased due understanding of maternal and child health rights. But when the health rights were violated, there was no mechanism of handling the problem in case of decision making which was not customer-centred” **(FGD8P5&6)**. Others raised their hands to signal agreement.

The responses of the community of Babile about impacts of MCH care practice were: “Improved prevention of diarrhoea by increasing proper utilisation of latrine in the rural community. But due to the work overload during disease outbreak, the care practice was not satisfactory as to be” **(FGD9P1&2**). “It also improved maternal understanding about certain danger signs of pregnancy, labour and childhood illnesses and has elevated level of satisfaction” **(FGD9P3&4**). “There was improved information exchange between care givers and care seekers throughout pregnancy attendance and childbirth, but there was no equal satisfaction due to lack of communication technology like mobile phone” **(FGD10P1,2&3).** “The MCH care practice decreased mortality of mothers and children in rural community and it was satisfactory. In the same way MCH care practice also improved delivery services assisted by midwives and it was satisfactory” **(FGD10P4,5&6)**

The community of Gursum district reported that: “MCH care practice improved access to routine care services like FP, ANC, Delivery Service and PNC; That was true. But it did not consider cultural context” **(FGD11P1&2).**

The interviewer asked for further explanation and other group members reported: “Professional development for local health service provision in MCH care could have been learnt from earlier existing cultural context of traditional birth attendant’s experience for contextualising health service coverage was expanded” **(FGD11P3&4).**

The interviewer asked for additional clarification and the rest two participants reported: “In the history of the local community, there was no male TBAs. So, as gender sensitive issue that might affect home-to-home visiting by HEWs was taken into account and decided selection of feminine HEWs and trained, the preference of feminine midwives rather than masculine midwives would have been culturally congruent in the local community. Lack of increasing number of female midwives and retaining them was one of the factors for dissatisfaction” **(FGD11P5&6)**

Others supported the idea thus: “The continuity of the existing routine MCH care practices has been realised in the rural health facilities of Gursum district due to proper use of guidelines in all intervention areas of the care practices” **(FGD12P1**). “Similarly, it has improved information seeking behaviour of the community” **(FGD12P2**). “But access to feedback communication was limited. The MCH care practice also increased awareness of mothers about danger signs of pregnancy and labour and their complications” **(FGD12P3&4**). “In the same way, its improved awareness of importance of breastfeeding and complementary feeding practices” **(FGD12P5**). “All these improved the health outcomes of mothers and children to some extent. But due to unequal coverage, demographic issues scarcity of resources and poor access to MCH care practice did not equally increased nutritional status, maternal and child screening, diagnostic service, treatment of common MCH problems and demanding in the locality” **(FGD12P6).**

5.3.2 Theme2: Barriers to MCH Care Practices

The analysis of the research findings related to barriers to MCH care practices was shown in the following illustration.

Table 5.8: Thematic representation of the analysis findings related to barriers for MCH care practices

Major theme	Sub-themes	Categories
Barriers MCH nursing practices	Access barriers	lack of access to transportation, moutainous condition, lack access to roads and vehicles were barriers to maternal and child health in rural areas
	Lack of technology	lack of means of communication, Shortage of medical equipment
	Lack of sufficient resources	lack of availability of medicines, lack of sufficient financial resource in the health centre for availing the medical supplies and drugs timely in the facility, lack of access to ambulance during emergency, lack of sufficient workers and professional turnover who have been trained in maternal and child health services, lack of rooms and beds in the health centre
	Lack of education	lack of knowledge about maternal and child health rights, lack of awareness about available services and lack of knowledge to answer the questions raised by the community about side effects of artificial contraceptive methods
	Socio-cultural and religious beliefs	preference of female midwife, language barrier due to contextual difference, misbelief (as if intake of nutritious diet during pregnancy causes big baby size that endangers child birth),
	Attitudinal barriers	lack of concern, lack of empathy, lack of commitment, bad behaviours of care givers and views of care seekers due to misperception about availablity and quality of diagnostic and treatment services
	Lack of research	lack of conducting specific research in the local context;
	Lack of conducive environment	lack of conducive environment for health professional, lack of certain diagnostic facilities and lack of waiting area for companions in the health centre
	Lack of peace and security	risky condition near the health centre environment at night due to intoxicated robbers in the area and tribal conflict
	lack of capacity building	lack of empowerment through training and educational opportunity, lack of motivation and lack of incentives
	Lack of policy implementation	lack of decentralization of resource, Poor management of demand and supply chain, lack of retaining senior experienced staff in the rural health centre

According to the responses of district MCH focal persons, barriers for MCH care practices were: “lack of conducting area specific research in the local context is one of the barriers to influence MCH care in rural community; Poor management of demand and supply chain is another barrier for MCH in rural area; mountainous environment and lack access to roads is one of the barriers to maternal and child health in rural areas; distance of the health centre from the community is one of the barriers for MCH in rural community; lack of sufficient financial resource is barrier to MCH in the rural health facility; lack of access to information and lack of means of communication in the locality; lack of capacity building

due to insufficient budget is barrier to maternal and child health nursing; Lack of sufficient workers and professional turn over are also other barriers for MCH in the rural area; and, the geographic location and lack of reliable roads and access to transportation are barriers to MCH at rural community level" **(D/M/K/F/B/G/MCH/FPs).**

According to health centre managers in high land, barriers for MCH care practices, the reported findings were: "Lack of decentralization of financial resource to health centres that resulted in the delay of accessing the medical supplies and drugs timely in the facility; challenge in the facility due to professionals turn over who have been trained in maternal and child health service delivery due to lack of conducive environment in the rural area; Lack of information in local language how the implementation process interacted and interconnected in relation with local context; lack of conducting maternal and child health nursing practice research at rural community level and preparing each stakeholders responsibility in local language was hindering the implementation process; lack of sustained availability of necessary medicines in the health centre for mothers and children is the major barriers that created bad image in the community and affected the health seeking behaviour from public institution; lack access to roads and vehicles are barriers to maternal and child health in rural areas; the geographic mountainous condition is hindering women in rural areas from accessing transportation and getting to health centre in the area" **(D/M/K/HCMgrs/1F&5M).**

The managers of health centres in the low land districts described the same barriers and reported: "the barriers in maternal and child health nursing practices are lack of sufficient financial resource in the health centre for availing the medical supplies and drugs timely in the facility; lack of collaboration with others in the management of maternal and child health nursing practice is the main challenges in the rural health centre; lack of sustained capacity building through training and educational opportunity for professional in the rural health centre is affecting professional retaining and thereby hindering the maternal and child health nursing practices in rural health centre; lack of sufficient workers and professional turn over who have been trained in maternal and child health service delivery due to lack of conducive environment in the rural area; and' the geographic location and lack of reliable roads and poor access to transportation **(F/B/G/HCs/Mgrs/2Fs&4Ms).**

According to responses of midwives in the rural health centres to the question of barriers for MCH care practices, the reported findings were: "Lack of commitment and turnover, "lack of roads due mountainous condition, lack of budget decentralisation and shortage of resource to address the need of the community for example the budget allocated yearly for rural health centre is 180,000 Birr that resulted in lack of medicine and supplies in the

centre and purchased from private centres which is not good for the image of public health institution; bad behaviours of care givers, misperception of healthcare seekers about availability of diagnostic and treatment services related to MCH nursing practice, lack of incentives, lack of conducive environment for health professional, lack of certain diagnostic facilities in the health centre, lack of respect, lack of motivation and lack of transportation facility in the locality, lack of concern and humanity, lack of proper communication and lack of proper complaint handling of intervention practice in the health centre" **(DHCs/MWs/1Ms&1Fs)**

The midwives of meta also responded the barriers as: "Distance and lack of roads due to construction of the health centre out of the reach of the community catchment area, professional turnover, lack of comfortable residences, lack of access to information, lack of information communication technology, lack of empowerment through training and educational opportunity in the health centre; lack of roads due to mountainous condition, distance due to construction of the health centre out of the reach of the community" **(MHCs/MWs/1Ms&1Fs).**

The Kersa district midwives also reported the barriers as: "Lack of incentives and motivation, lack of peace and security near the health centre environment at night, lack of backup generator for power supplies, lack of sufficient laboratory facility, lack of educational opportunity for professionals and health centre distance from community; lack of sufficient skills like doing episiotomy before head engagement" **(KHCs/1Ms&1Fs).**

The responses of midwives in the health centres of a low land district reported the barriers as: "Lack interest to work in the rural health facility, lack of access to roads, lack of access to transportation, lack of rooms and beds in the health centre; lack of using guidelines, lack of informed choice treatment, lack of respect for the customers and family members and lack of responsiveness and poor communication skills in the health centre; cultural barriers such as preference of female midwife professionals, language barrier due to contextual difference, misbelief (as if intake of nutritious diet during pregnancy causes big baby size that endangers child birth), lack of using opportunities to entertain with the community (engagement in marital ceremony and mourning ceremony) and lack of community involvement in maternal and child health nursing practice" **(FHCs/1Ms&1Fs).**

In another low land district, the midwives in the two health centres reported the barriers as: "Lack of proper policy translation, lack of using practical guidelines, lack of sufficient infrastructure facility to accommodate all customers and work overload in the health

centre; misbeliefs about contraceptive use, lack of breastfeeding knowledge, lack of client follows up after discharge, lack technology to communicate with mothers in time of need and lack of commitment of certain health workers in the health centre; lack of research to identify the real phenomenon of existing problems which are beyond eye sights in the process of health care intervention practice, lack of considering cultural context, lack of involving influential community members in preventive and promotive care practices; lack of transportation facility in the rural area and improper use of maternal and child health resources (selling formulated supplementary diets for shop keepers in the area, eating of child nutrition by health professionals in the health centre and use of 40% glucose by care providers as energizer) in the rural health facility **(BHCs/MWs/2Fs).**

The midwives in the two health centres of Gursum reported the barriers as: “shortage of ambulance for referral service, lack of proper resource utilisation such as use of ambulance for personal benefits (e.g., collection of coins by the driver from non-patient passengers on his way to serve mothers in labour; lack of using guidelines, lack of proper documentation, lack of feedback communication, poor referral report feedback communication, lack of retaining senior experienced staff in the rural health centre and poor coordination and networking in the rural community” **(GHCs/MWs/2Fs).**

In the rural health centres, the responses of mothers to the question of barriers for MCH care practices were reported as: “Lack of access to service was common in rural maternal and child health setup in the health centre. For most of the maternal and child health problems in the area, clients were referred to the hospital for the reason of shortage of diagnostic facility in the centre; lack of respect due to disgusting behaviour of health professionals and lack of commitment” **(DHC1/Mthr).**

Another mother who was not selected as a key informant, added in agreement: “I am a mother of labouring mother and I have been pushed out and insulted to be protected from entering to delivery room by a male midwife who was giving service unethically in this health centre. I reported my complaint to the head of the health centre and she has reassured me. But there is no corrective measure and it is difficult to revisit this centre in this manner”.

This undesirable character of such health care provider can be mentioned not only as a barrier, but also as a crime. But lack of access such as the location of the health centre on the top of the mountain along the main road from Addis Ababa to Harar or Dire Dawa is common. Thus, the majority of the residents supposed to be served by this health

centre were in low land areas and on the other side of another mountain and far away to access the service provided in the health centre.

“There was no access to roads for transporting clients to the health facility” **(DHC2/Mthr**). “Similarly, the site of health centre construction was not considered benefit of customers. Rather, the advantage of constructor was facilitated along the main road, neglecting the areas catchment area**” (MHC1 /Mthr).**

Therefore, the distance, lack of roads, geographic barrier and lack of decentralization of service to health centres were barriers in the locality; the first barrier, in this area was access barriers to health services due to lack of safety and security near the health centre, mountainous streets hard to go on safely up and down to the health centre.

To this effect, the participant stated: “I was brought to the health centre with difficulties after midnight from lowland on the shoulder of the villagers on foot, which is about 10 km from the health centre. It takes 3 hours to climb up to the heels and mountains to reach to here on the other side of the mountain. The health centre was constructed at the boarder of the town on another age of the mountain. My husband was sent to purchase the prescribed drug from private drug shop in the Qullubbi town. As he was going to the centre of the town to buy medicine, he was attacked and robbed by thieves who have been intoxicated. He was seriously injured and found falling on the ground along the roadside. The policemen saw him and called an ambulance from Chalanko hospital and saved his life. So, the location of the health centre is barrier for serving and saving the life of the majorities in the catchment area” **(MHC2/Mthr).**

Other barriers were lack of waiting area for labour companion; lack of ambulance service from our residence to the health centre, flood during rainy season; mobility of the local community, insufficient beds for postnatal mothers. For example: “There were only three beds in postnatal care unit. The available beds were occupied. Among five delivered mothers in this night, two of us have been discharged within two to three hours and we are going to look for our relatives in this area to stay up to morning because of darkness, lack of transport and distance to go back to our home” **(MHC2/Mthr).**

Lack of freedom to decide on treatment option due to judgemental character of professionals. For instance, “I came to antenatal care unit to follow up for the third time antenatal visit before a week. I was respectfully served by one of the care providers in the health centre and given tablets for anaemia treatment to continue for a month. But, at this moment, as I have seen fever and exhaustion on myself, I am just here for getting service as per an advice of the previous respectful health professional. I explained to the

new health care provider who has been serving in outpatient department about my health condition and previous follow up as well as the emergency signs I have been experiencing that forced me to comeback before scheduled visit. The care provider ordered the drug without telling me what has been diagnosed. The druggist was familiar to me and when I asked him what type of drug was prescribed, he told me as it is diclofenac injection. Then, I went back to prescriber and told him that I am sensitive to this drug and due to what happened to me before, even I have developed phobia against any injection form of other drugs. He torn out the prescription and ordered me to go out and treat myself. That is why I am crying. Hence, negative attitude and bad character of individual health professional and lack of freedom for treatment option are barriers for me. I am neighbouring this health centre. But, this phenomenon, silence of other people around and lack of support to defend for my health rights except my sister are making me hopeless not to come again" **(KHC1/Mthr).**

Other barriers were lack of access to ambulance service to bring labouring mother to the health centre, lack of financial resource to use public transport, lack of skilled labour assistant in the village and shortage of female midwives in the health centres for cultural and religious belief preference of mothers. The mother stated: "In our culture, there is no male traditional birth attendant. Similarly, according to the religious beliefs of our community, let alone the private part of the body, even exposure of any other part of the body to an eye of male person other than our husband is not allowed" **(KHC2/Mthrs).**

Thus, lack of getting female midwives in maternal and child health service in the health centre in the context of the local community. Another participant particularly stated: "As far as I know, the health professionals' turnover and language barrier due to contextual meaning difference are what I personally experienced as barriers in the health centre. For example, I have been using family planning for the last three years. The current head of the health centre was serving me well as she knows the language taboos and culture in the local community context. Recently, after she was taken to the position of health centre administration, another male care provider whose mother tongue is the same with mine has been serving in the family planning unit. I told him what type of contraceptive I have been using and explained my problem by stating: '*xuriitu anatti turee jannan, akka diqachuun dirqama kiyya tahee fi akka kan isaa hin tahin na gorsee'*, when I informed the male midwife in the health centre about menstrual disorder, I personally faced using avoidance of language taboo as stating that I am dirty for more longer than a month, he advised me as self-cleaning and self-washing was my responsibility and not the responsibility of health care provider. I looked for the head of the health centre and informed her as the guy could not understand me. She told me as this cultural explanation

of the thing is specific to the local context the language taboo to explain culturally sensitive issue is not understandable by the newly recruited person to the locality and gave me the solution" **(FHC1 /Mthr).**

Other barriers to MCH care practices were professional work overload, shortage of health workers and lack of essential medicines for both mothers and children. For example, a single nurse serving in three or more maternal and child health setups in the rural health facility is sometimes seen in the health facility. Additionally, "My baby is now referred to hospital due to lack of intravenous infusion for managing complication of diarrheal disease in the rural health facility; lack of mobile HEWs in pastoralist community, shortage of food for proper feeding practice, unequal access to maternal and child health service, lack of essential drugs in the health centre and tribal conflict are the major barriers for this local community; lack of getting HEWs in the village during night when labour begins, lack of trained TBAs to assist delivery, lack of beds for malnutrition service and distance from the health centre are the major barriers in the area; and, lack of access to ambulance during emergency, lack of complaint handler in the health centre, distance and lack of access to roads in the local community are main barriers for mothers in maternal and child health nursing practice" **(FHC2/BHCs/GHCs/Mthrs).**

The FGD participants' responses of the community of Dadar with regard to barriers to MCH care practices were reported as: "Lack of technology for information dissemination **(FGD1P1)**; Lack platform to carryout religious responsibility in MCH care practices **(FGD1P2)**; Certain negative health outcomes created bad image in the community about contraception after a woman in the village used it in postnatal period of the first childbirth **(FGD1P3);** Lack of access to technology for advocacy **(FGD1P4).** Misperception of the community members about professional knowledge and skill (FGD1P5); and, Lack of knowledge about maternal and child health rights and unnecessary referral of many mothers from health centres to hospital without indication" **(FGD1P6).**

Additionally, the community members reported barriers as: "Lack of residence for HEWs" **(FGD2P1);** "Lack of professional collaboration with religious leaders" **(FGD2P2);** "Lack of commitment to participate" **(FGD2P3);** "Lack of access to the local legal body for accusation care giver who seriously abused mothers and family members" **(FGD2P4);** "Communication barrier during conversation between clients and health professionals **(FGD2P5);** and, Lack of respect from certain midwives in the health centre" **(FGD2P6).**

According to the responses of the community of Meta district, barriers were the negative attitude of the community about artificial contraceptive method particularly condom that

was perceived as: “An instrument that attracts adolescents toward prostitution **(FGD3P1);** Lack of community health service integration with religious institution **(FGD3P2);** Lack of Incentive for motivation **(FGD3P3);** Lack of roads for reaching health centre easily **(FGD3P4);** Lack of empowerment to assist delivery **(FGD3P5);** and, Lack of access to roads and transportation in the locality” (**FGD3P6**).

In addition, the community listed: “Lack of transportation facility” (**FGD4P1**); “Lack of using supportive religious teaching in health education” **(FGD4P2);** “Lack of dignity and respect” **(FGD4P3);** “Non-community centred site of health centre construction which was out of the reachable area for the majority rural community in the catchment area” **(FGD4P4)**; “Lack of incentives for traditional birth attendants (**FGD4P5**); and, Lack of access to the health centre due to distance and topography of the land in the locality” **(FGD4P6).**

The responses of Kersa district community about the barriers for MCH care practices were listed as: “A hidden performance of harmful traditional practice” **(FGD5P1);** “Lack of facilitators for using available opportunity like ceremony in the community” **(FGD5P2)**; “Lack of technology for communication” **(FGD5P3)**; “Lack of education for writing activities done” **(FGD5P4)**; “Lack of compensation for the lost benefits” **(FGD5P5**); and, “Bad characteristic of health service providers and poor communication skill that unfit with Cultural context of the community about sensitive issue” **(FGD5P6)**.

Over and above, the participants added: “Lack of electricity and backup generators for refrigerator of vaccines in the health post and health centres” **(FGD6P1**); “Lack of coordination of maternal and child health service with religious teaching” **(FGD6P2**); “Political instability” (**FGD6P3)**; “Uncertainty of political situation in the locality takes much more time of community than health information communication” **(FGD6P4)**; “Lack of respect from health professionals” **(FGD6P5)**; and, “Lack of sufficient beds for postnatal service in the health centre when delivered mothers are greater than three in number” **(FGD6P6)**.

As per the responses of the community of Fadis district the barriers in MCH care practices described as: “Lack of access to water supply in the health post” (**FGD7P1**); “Lack of commitment of religious leaders” **(FGD7P2);** “Protesters’ Road blocking” **(FGD7P3);** “Frequent domestic violence in the rural community” **(FGD7P4)**; “Lack of mobile phone for calling ambulance during emergency” (**FGD7P5);** and, “Lack of access to gender preference for midwifery service with regard to cultural and religious beliefs” (**FGD7P6**).

In addition, the community members who were a FGD participants commonly listed misperceptions of husbands about contraceptive use as: “A causal factor permanent infertility; Lack of participation in maternal and child health care practice; Tribal conflict that dismantled the community from their residence; Lack of legal power to stop domestic violence due to contraceptive use; Lack of motivation and encouraging words from midwives and nurses); and, Frequent turnover of health service providers who were accustomed to the local community (**FGD8P1, FGD8P2, FGD8P3, FGD8P4, FGD8P5** and **FGD8P6**).

The discussants in Babile district sequentially listed down the barriers for MCH care practices as: “Frequently occurring public and political protests that affected mobility of people from place to place; Religious scholar’s negligence to preach about religious obligation of peace building practices; Lack of supervision in-depth; Lack of equal access to health information; Prohibition of traditional birth attendants from assisting homebased child delivery; and, Prolonged waiting time to get service due to work overload in the health centres” **(FGD9P1,2,3,4,5&6).**

Furthermore, the challenges were described as: “scarcity of food in the locality; Giving priority for personal interest like uvulectomy for income generation against religious teachings and obligation; Lack of taking corrective measures against misconduct and malpractices; Border related tribal conflict in the locality; Lack resource for mobile health service provision in the rural pastoralist community; and, Tribal conflict that resulted in destruction of health facility and dismantling of health professionals as well as serious socio-economic and political consequences **(FGD10P1,2,3,4,5&6**).

In the same way, the community of Gursum district reported the barriers as:
“Tribal conflict between Oromo and Somali people; Lack of respect for mothers from the majority of the community members; Lack of roads and other transportation facilities; Lack of knowledge to answer the questions raised by the community about side effects of artificial contraceptive methods; Lack of recognition for participation in maternal and child health care practices; and, Lack of drugs in the health centre” (**FGD11P1,2,3,4,5&6).**

They also listed the barriers as: “Lack of incentives for off days duty in the community; Political instability; Lack of response to urgent call for ambulance; Lack of response to handle community complaint; Lack of response from ambulance service coordinators and drivers during emergency call; and, Lack of homebased skilled delivery service in the nearby health posts of the rural community” **(FGD12P1,2,3,4,5&6).**

5.3.3 Theme 3: Enablers for MCH Care Practices

The analysis of the research findings related to enabling factors for MCH care practices was shown in the following illustration.

Table 5.9: Thematic representation of the analysis findings related to enabling factors for MCH care practices

Major theme	Sub-themes	Categories
Enabling factors for MCH care practices	access to MCH care	Access to transportation, access to roads, access to competent care givers, access to quality of care and access to health facility.
Enabling factors for MCH care practices	Proper Health policy application/operation	Health insurance, free of charge service, collaboraation with stakeholders, community participation, protection and promotion of maternal and child health rights, use of social, cultural and religious institutions, motivating care givers and customers, health information communication, respecting customers and colligues, good behaviour, availability of service and quality of care, inducing willingness of mothers, community interest, personal commitment and socio-cultural support, communication skill, understanding of cultural context and support of TBAs and collaboration of HEWs.
	Use of available opportunity	Use of Effective communication, indigenous knowledge, supportive religious teachings, community participation, family support, health policy implementation, use of technology such as mobile phone and utilisation of available services
	Availability of resources	availability of resources including human, physical (infrastructural), financial and material, availability of drug and supplies, availability of competent professionals, safety net programme to address food scarcity and availability, of health extension workers
	Capacity building	Improving individual positive behaviour and positive attitude through health education, counselling and responsiveness and relevance of health services, building sense of ownership in the community, awareness of health rights,
	Peace building	Tribal conflict management and love and harmonious interactions

According to the responses of MCH focal persons in the rural districts of Hararghe community, enablers for MCH care practices were:

“Health insurance; free of charge services; use of mobile phone; collaborative and participatory supervision; indigenous knowledge, supportive religious teachings; maternal and child health rights policy; commitment of mothers” **(Ds/MCH/FPs/1F&5Ms).**

According to health centre managers, responses to the question what enablers for MCH care practice were: “Health policy; expansion of rural health facility; taking service to the community through various health agents such as health extension workers, volunteers, family members and community leaders; the current health insurance programme that created platform equally for health service users in rural health facility in time of need; health education package; interest of rural community; collaboration of stake holders and community participation; and, social support in the community culture labour companions that accompany the labouring mothers and contribute all necessities for positive pregnancy outcomes; collaborative supervision; availability of all resources including financial material and human in the rural health centre; maternal and child health rights; social institution; sustainable development goal 3 and global partnership programme; and, use of available opportunities timely **(Ds/HCs/Mgrs).**

According to the responses of midwives:
“Enablers for MCH care practices were individual factors like health seeking behaviour, social support, supportive religious beliefs, community participation and family support, health policy, peace and security and availability of resources including human, physical (infrastructural), financial and material **(DHC1Mw/F);** Social support, community association, supportive religious teachings and access factors **(DHC2Mw/M);** Access to MCH service, volunteer health promoters, family members, trained traditional birth attendants, health extension workers and community leaders in the locality **(MHC1Mw/F);** Community participation, stakeholder collaboration, capacity building and availability of resources in the health centre **(MHC2Mw/M);** Professional commitment, availability of drug and supplies, availability of competent professionals, respectful service provision and health seeking behaviour of customers **(KHC1Mw/F);** and, Seasonal factors like dry season, motivational factor like incentives, attractive facility environment, health information communication, community awareness and interaction with clients, family members, community members and health professionals in the community” **(KHC1Mw/M).**

In addition, the midwives in Gursum district reported: “Individual positive behaviour, positive attitude, health education, counselling and responsiveness and relevance of health services **(FHC1Mw/F);** Social support, community participation, access to transportation, access to information, training, capacity building, **building ownership and transferring responsibility and accountability to all stakeholders (FHC2Mw/F**); Access to transportation, community participation, stakeholders collaboration, family support, training, access to roads in the locality **(BHC1Mw/M);** Customer respect, awareness of health rights, capacity building and availability of resources in the health

centre **(BHC1Mw/F);** Individual commitment, availability, affordability, acceptability of services **(BHC2Mw/F**); Community participation, safe and sufficient water, incentives, attractive facility environment, information access, good communication, community awareness, good governance and harmonious interaction" **(GHC1Mw/F and (GHC2Mw/F).**

According to the responses of mothers in the rural health centres, enablers for MCH care practices were: "Maternal and child health nursing enablers are existence of health centres, health posts, support of family members, efforts of community health workers and collaboration of community members **(DHC1Mthr);** Good behaviour, availability of service and quality of care **(DHC2Mthr**); Support of health extension workers, free of charge service and availability nutrition **(MHC1Mthr);** Facility readiness, power of women to decide and awareness maternal and child health rights **(MHC2Mthr);** Commitment of health professionals, communication skills, health policy, accessibility, availability and affordability of service **(KHC1Mthr);** and, Use of technology, support of traditional care providers, concern of religious leaders and community leaders in the locality" **(KHC2Mthr).**

Moreover, two mothers also reported: "Mobile health care, constructed roads, availability of ambulance service, access to emergency call, responsiveness, community dialogue, attractive environment, supportive religious teaching and sense of ownership were enablers for MCH care practices" **(F/B/G/HC1&2Mthrs).**

A group discussant described enablers for MCH care practices and reported:
"Health policy, leadership, availability of guidelines, interest care seekers, commitment of care givers, free of charge services, efforts of TBAs, social support and community participation **(FGD1P1-6).** Similarly, the community members reported: "enablers as willingness of mothers, religious institution, awareness of people, community interest, personal commitment and cultural associations called afoosha" **(FGD2P1-6).**

The group discussants again reported: *"Enabling factors as maternal health rights, child health rights, indigenous knowledge (tan biliga ananii, tan qoma furri)* which means milky groin and mucoid chest) that implied fertile pelvic and productive breasts that teaches importance of breastfeeding, existence of health centre in the community and mutual respect" **(FGD3P1-6).** "Additional enablers listed were: *Best manners, good approach, community support and health insurance"* **(FGD4P1-6).**

The rural community responses about enabling factors indicated: "*Health extension packages, indigenous teaching (ulfaa fi hoosiftuu hin aarsan ykn hin mufachiisan)* which

means postnatal hygiene prevents evil attack, communication skill, understanding of cultural context and support of TBAs" **(FGD5P1-6).** Other enabling factors were "Collaboration of HEWs, indigenous teaching *(qulqullini ulmaa, ibliis fageeysa)*, health service utilisation, existence of HEWs in the village" **(FGD6P1-6).**

The participants also discussed that enablers of MCH care practices were: "Partnership, community-based health task forces, spiritual psychological support, nutritional advice, relationship and interaction with mothers and support of husbands" **(FGD7P1-6);** "Transportation facility, peace and security, safety net programme to address food scarcity, responsiveness of service, community dialogue, technology and education were enabling factors" **(FGD8P1-6);** "and, enabling factors were peace building, conflict management, clan leaders, and religious leaders" **(FGD9P1-6).**

The community again reported the same thing and added other enablers, such as: "Training, access, availability, of health extension workers in the rural community. Use of religious ceremony as an opportunity, for support of women, woman empowerment and mobile health services" **(FGD10P1-6);** "Enabling factors were collaboration of stakeholders, community participation, engagement in social affairs, cultural assembly and religious institution" **(FGD11P1-6**); and, "major enabling factors were roads, ambulance, health seeking behaviour and use of guidelines" **(FGD12P6).**

5.3.4 Theme 4: Innovative Ideas to Improve the MCH Care Practices

The analysis result of MCH care practice was illustrated in the following representation.

Table 5.10: Thematic representation of analysis findings related to innovative ideas for improving maternal and child health care practices

Major theme	Sub-themes	Categories
Innovative ideas for improving MCH care practices	Capacity building	Women empowerment, health education, improving allocation of budget, providing continuous support for care givers and care seekers, continuous training, counselling and communicating on ethical issues and avoidance of unethical behaviour, community sensitisation, construction of roads for connecting all villages with rural health facility was instrumental for maternal and child health care practices, comprehensive coverage of maternal and child health service, scale up of health extension workers to midwives and appraisal of HPs to HC level, community participation and stakeholder collaboration, facilitation of coping mechanism with seasonal factors, incentives, attractive facility environment communication and interaction with clients, family members, community members and building ownership and transferring responsibility and sharing knowledge and experiences, awareness creation about

Major theme	Sub-themes	Categories
		health rights, physical facility construction, capacity building of human resources, involvement of religious leaders in sharing responsibility of MCH care practices, continuous on job training for health professionals to scale up their knowledge and skills, strengthening complaint management service in the rural health facility, continuous awareness creation, integration of health education with adult education and community development programme, construction of waiting area and compensation payment for TBAs as well as integration of legal service with MCH care in rural community to stop domestic violence
	Development of guidelines	development of relevant guideline for all continuum of care, development of guidelines by considering local context and assessment of both clinical and non-clinical care practices, incorporation of supportive religious teachings in the guidelines.
	Adoption of best practices	Adoption of best practices through experience sharing and use of appropriate technology, transferring responsibility and sharing knowledge and experiences as well as enhancing access to information technology.
	Proper policy translation	Provision of friendly service in collaboration with local context, improving individual positive behaviour, positive attitude, and continuous health education, rewarding task force members, strengthening networks between community members and health care providers in the rural area, strengthening networks between community members and health care providers in the rural area and retaining of skilled health workers in the rural facility.
	Provision of culturally congruent services	developing and assigning gender specific midwives for MCH care practice, orientating culturally sensitive issues for all staff, ensuring access to female midwives for maternal gender preference in the health centre, assigning gender specific midwives for MCH care and upgrading of HEWs to midwives level, health service provision in cultural and religious contexts and orienting language taboo in the area.
	Rethinking of Mobile health service	rethinking of mobile MCH care practices for addressing marginalized pastoralist community and reconstruction of health centres to enhance coverage.
	Peace building	tribal conflict timely management, avoidance of tribal conflict and enhancement of conflict management practices in the health centres.

The responses of respondents to the question of suggestions for improving MCH care practices were: “Girls and women empowerment through health education and training” **(D/MCH/FP/M);** “Income generation to fill the gap of financial shortage” **(M/MCH/FP/M);** “Continuous behavioural change and communication using community-based available technology” **(K/MCH/FP/M**); “Improving allocation of budget, building alliance with stakeholders to strengthen staff development and capacity building” **(F/MCH/FP/F);**

“Constructing roads, increasing transportation facilities in rural community, comprehensive coverage of maternal and child health services according to the standard” **(B/MCH/FP/M);** and, “Providing continuous support for care givers and care seekers and development of relevant guideline for all continuum of care” **(G/MCH/FP/M).**

In their responses to the question*: What do you suggest for improving MCH care practices?,* the health centre managers mentioned: “Educational campaign to inform the community members about the maternal and child health care practices” **(DHC1Mgr/M);** “Continuous training, educating, counselling and communicating on ethical issues and avoidance of unethical behaviour” **(DHC2Mgr/F);** “Appropriate technology, guidelines, resources, interconnection and continuous interaction with community members and clients in rural area” **(MHC1Mgr/M);** “Improving access to information and extending audio-visual training facilities opportunity for community sensitisation” **(MHC2Mgr/M**); “Mobilisation of resources for income generation and proper use of resources” **(KHC1Mgr/M);** and, “Building alliance with stakeholders on maternal and child health care practices” **(KHC2Mgr/M).**

In addition, other health service managers also reported: “Construction of roads for connecting all villages with rural health facility was instrumental for maternal and child health care practices” **(FHC1Mgr/M);** “Comprehensive coverage of maternal and child health service” **(FHC2Mgr/M);** “Convincing and distributing tasks among task forces for both clinical and non-clinical care practices in rural community” **(BHC1Mgr/M);** “Providing continuous training for all clinical care providers and non-clinical care givers **(BHC2Mgr/M);** Development of guidelines by considering local context and assessment of both clinical and non-clinical care practices” **(GHC1Mgr/M);** and, “Allocation of sufficient budget and friendly service provision in collaboration with local context” **(GHC1Mgr/F).**

The suggestions of midwives working in rural health centres to enhance MCH care practices were: “Social support, supportive religious beliefs, community participation and family support, health policy, peace and security and sufficient resources” **(DHC1Mw/F);** “Social support, community participation, supportive religious teachings and use of indigenous knowledge” **(DHC2Mw/M);** “Platform to MCH service access, commitment of volunteer health promoters, support of family members, scale up of health extension workers to midwives and appraisal of HPs to HC level” **(MHC1Mw/F);** “Community participation, stakeholder collaboration, capacity building and enough resources” (**MHC2Mw/M**); “Professional commitment, availability of drug supplies, availability of competent professionals, respectful service provision and good health seeking behaviour

of customers" **(KHC1Mw/F);** and, "Facilitation of coping mechanism with seasonal factors, incentives, attractive facility environment communication and interaction with clients, family members, community members" **(KHC2Mw/M).**

Additionally, other participants described: "Individual positive behaviour, positive attitude, continuous health education, counselling and responsiveness" **(FHC1Mw/F**); "Social support, community participation, access to transportation, training, capacity building, building ownership and transferring responsibility and sharing knowledge and experiences" **(FHC2Mw/F);** "Organising community members, volunteer health promoters, social support, training traditional birth attendants and development of health extension workers" **(BHC1Mw/M);** "Dignity, awareness of health rights, use of technology, mobile health care services and area-specific research in the health centres **(BHC2Mw/M);** and, Sufficient ambulances, proper supervision of care and strengthening coordination and communication with local stakeholders **(GHC1Mw/M);** and, considering culture of community in development of guidelines and planning services, incentives for TBAs and volunteer health promoters, shared-decision making and sharing responsibilities among responsible bodies in MCH care practices" **(GHC2Mw/F).**

According to the responses of woman about opinions or suggestions to improve MCH care practices, "Innovative ideas of rural mothers were construction of physical facility and upgrading of service quality" **(DHC1Mthr);** "Developing and assigning gender specific midwives for MCH care practices" **(DHC2Mthr);** "Reconstruction of the health centre in the centre of community catchment area" **(MHC1Mthr);** "Upgrading of HP to HC level and enhancing access roads" **(MHC2Mthr);** "Legal enforcement on ethical practice and awareness building on MCH rights in Implementation of MCH care in the rural community" **(KHC1Mthr);** and, "Physical facility construction, capacity building of human resources and woman empowerment" **(KHC2Mthr).**

Above all, orientating culturally sensitive issues for all staff: "Ensuring access to female midwives for maternal gender preference in the health centre, assigning gender specific midwives for MCH care and upgrading of HEWs to midwives' level" **(FHC1Mthr);** "Improving road access and upgrading of service quality" **(FHC2Mthr);** "Ensuring food security" (BHC1Mthr); "Upgrading HPS to HCs, peace and security, love and harmony, patience, tolerance and tribal conflict management **(BHC2Mthr);** Properly complaint handling, physical facility construction, availing resources, social networking and coordination" **(GHC1Mthr);** and, "Enhancing access to ambulance service, application of health rights principles, use of appropriate technology and sharing experiences of best

practices in the context of rural community by collaborative supervision and monitoring" **(GHC2Mthr).**

The suggestions of community members in Dadar district for improving MCH care practices were reported as: "Enhancing access to information technology", **(FGD1P1);** "Involvement of religious leaders in sharing responsibility of MCH care practices" **(FGD1P2);** "Continuous behavioural change activity **(FGD1P3);** Improving access to information technology" **(FGD1P4);** "Continuous on job training for health professionals to scale up their knowledge and skills" **(FGD1P5);** and, "Scaling up of health professionals in the rural community through education and training" **(FGD1P6).**

In addition to the above ideas, another group members also reported as: "Creating platform for HEWs in the rural community" **(FGD2P1);** "Strengthening relationship between health professionals and religious leaders" **(FGD2P2);** "Conflict management and timely taking corrective measures" **(FGD2P3);** "Strengthening complaint management service in the rural health facility" **(FGD2P4);** "Enhancing information communication between community members and health professionals in the rural community" **(FGD2P5);** and, "Respectful practice in the rural health centre" **(FGD2P6).**

The suggestions of community members in Meta district for improving MCH care practices were reported as: "Continuous awareness creation" **(FGD3P1**); "Use of supportive indigenous knowledge of the rural community in health MCH care practices" **(FGD3P2);** "Community mobilisation for participation" **(FGD3P3);** "Construction of roads in the rural community" **(FGD3P4),** Community empowerment (FGD3P5); and, "Improving access to transportation facility in the rural area" **(FGD3P6).**

The following innovative ideas were also explored as: "Improving access to transportation facility; Using supportive religious teaching in MCH intervention; Rewarding task force members for motivation; Reconstruction of health centre in the reachable area in the centre of catchment area for the rural community; Positive re-enforcements of health task forces in the rural community; and, Scaling up health posts to health centre level in the rural community" **(FGD4P1,2,3,4,5&6).**

The suggestions of community members in Kersa district for improving MCH care practices were reported as: "Community collaboration on harmful traditional practice avoidance; Using available missed-opportunity by engagement in the rural community social, cultural and religious affairs; Dignity and respect in health services provision; Integration of health education with adult education and community development programme; Compensation payment for TBAs as an alternative of opportunity for TBAs'

the lost benefits; and, Application of ethical principles by care providers in the rural community. Another group discussants' suggestions were securing power supply and medical equipment in the rural health facilities; Strengthening networks between community members and health care providers in the rural area; Enhancing access to communication technology; Working on peace building; Strict follow up MCH care practices in the rural community; and, construction of waiting area for companions in the health centre" **(FGD6P1,2,3,4,5&6).**

The suggestions of community members in Fadis district for improving MCH care practices were reported as: "Improving access to safe and sufficient water supply in the rural area; Participation of the religious leaders in shared-decision making, Collaboration of all community members in sustaining peace and security in the rural community Strengthening domestic violence screening service in the rural community; Improvement of access to communication and transportation technology; and, Adjusting health service provision of with cultural and religious contexts of the rural community **(FGD7P1,2,3,4,5&6).**

Additionally, the community suggested that: "Encouraging involvement of husband in MCH care practices; Encouraging religious leaders' participation in maternal and child health care practice; Immediate response of the government to the needs of rural community; Integration of legal service with MCH care in rural community to stop domestic violence; Motivational rewarding of care providers and supporters of mothers in the rural community; and, Retaining of skilled health workers in the rural health centre **(FGD8P1,2,3,4,5&6).**

The suggestions of community members in Babile district for improving MCH care practices were reported thus: "Strengthening peace and security in the area; Integration of indigenous and religious knowledge with MCH care practices in the rural community; Tribal conflict timely management and prevention; Improving equal access to health service coverage; Special consideration for empowerment of HEWs and TBAs in the rural pastoralist community; and, rethinking of mobile MCH care practices for addressing marginalized pastoralist community" **(FGD9P1,2,3,4,5&6).**

In this area, additional ideas were reported thus: "Improving productivity of different variety of food in the locality; Avoidance of making benefits at the expense of community, for individual profit achievement in a way that might cause the community harm; Enhancing access to information communication facility in the rural community; Avoidance of tribal conflict in the rural community; Project designing for mobile health

service provision in the rural pastoralist community; and, Development human resource based on the local community needs and cultural context in the rural community" **(FGD10P1,2,3,4,5&6).**

As per the responses of community members participated in FGDs in Gursum district, opinions of group discussants for improving MCH care practices were reported as:
"Integrating research with MCH care practices; Development of guiding principles for both formal and informal MCH care practices in the rural community; Strengthening social networking; Facilitating conducive platform for care givers and care seekers in the rural health facility; Encouraging active participants based on performance and contribution for rural community motivation; and, improving drug supply and management in the rural health facility based on demand" **(FGD11P1,2,3,4,5&6).**

Over and above, others reported as:
"Income generation by community mobilisation and partnership; Enhancement of domestic violence preventive service in the rural community; Improving access to ambulance service and follow up; Enhancement of conflict management practice in the rural health facility; Improving access and responsiveness of ambulance service for emergency call in the rural area; and, Establishment of community based skilled delivery service in the rural health posts were suggested as best ideas for MCH care practices **(FGD12P1,2,3,4,5&6).**

5.4 OBSERVATION FINDINGS IN RURAL MCH CARE PRACTICES

The observation was started by exploring the facility environment of rural health centres. The observation was guided by checklists adopted from the standard guidelines of MCH care practices. The range of observation was supported by photographic evidence are described and presented. The observations involved the exploration of the general situations of the existing realities in rural health care centre including completeness of minimum requirement and MCH service provisions with the reflection of customers' feedback. From an external view of the layout of the observed facilities, the most prominent observations ranged from clearly marked logos in some parts (for instance, gates of health centres) and some unclearly marked logos as well. There were also direction markers (indicators) in some parts, while a noticeable absence of these markers was also made in other parts.

5.4.1 Pictorial evidence illustrating the realities of twelve health centres gates.

Image D1: Dadar HC1

Image D2: Dadar HC 2

Image D3: Meta HC 1

Image D4: Meta HC 4

Image D5: Kersa HC5

Image D6: Kersa HC6

Image D7: Fadis HC1

Image D8: Fadis HC2

Image D9: Babile HC1

Image D10: Babile HC2

Image D11: Gursum HC1

Image D12: Gursum HC2

Generally, among the 12 rural health centres observed. Only three (3) of them were well fenced. In certain health centres the security personnel's house, main gate door, logos, pictorial directions and indicators were visible to the public. Others were not. These health centres were **KHC2, FHC2 and GHC1** that were also constructed in the centre of the catchment areas and relevant to the standard of the rural health facility of the country as observed on the map that was posted on the wall of head office of the HCs (**FMHACA** Facility Standard, 2012).

5.4.2 Standard Check Lists and Observation Findings

Table 5.11 (overleaf) is an illustration of the findings from the researcher's on-field observations during the interviews with various categories of selected participants. In a number of instances, the researcher's empirical observations are supported by images that provide relevant pictorial evidence.

Table 5.11: Observation findings

Standard 1: Check List Every woman and child received evidence-based routine care and management of complications.
Observed Realities
The majority of women and children were observed that being served in receiving routine care. But, the management of complication was not properly handled as to be.
The woman came to the health centre and complained about irregular menstrual bleeding for an abnormally long period of time. She also indicated that she has long-term contraceptive device inserted on her left upper arm. She was eventually advised that she must keep the device on the heavy bleeding will resolve on its own. The woman responded that the device has been in situ for over a period of three (3) months and she cannot tolerate it anymore. The woman was referred to the midwife, who arrived with a piece of clean glove, surgical blade and bandage. The woman was taken to FP and ANC unit which was on the corridor corner of the delivery room. The patient lied on the couch which served as the examination bed. The midwife disinfected the site and injected the woman with lidocaine and made a small incision to remove the device on the woman's upper arm. The wound was bandaged by the midwife using her single hand wearing clean glove.
Similarly, in another health centre many women were seen receiving routine care such as FP, ANC, Delivery services and neonatal care in the same room from the same health professional. A male midwife was observed quarrelling with other care givers, family members and labour companions during the consultation. The head nurse was observed saying the following furiously: *He left the labouring mother on the couch and left for Kobo town to visit his wife and came back after 4 hours*. On the other hand, the corrective measure taken was not observed. The husband said*: We are so sorry for asking the question that has no answer.* An old man in neighbouring health centre was observed saying: *It is clear that all women coming to the centre were saying that they got relief whenever they were served by Mrs. X the midwife. When they came across with Mr. Y midwife they were more diseased than ever. Had I been those women, I would have not come to that health centre as long as Mr. Y midwife was there.* The implication is that the female midwife gives service respectfully while the behaviour of male midwife and lack of conducive environment were not attracting the customers.
Every woman coming to the health centre was also observed complaining abut the distance they travelled climbing up the mountain to reach the health facility for receiving the routine MCH care. However, a lady was observed complaining about a prolonged menstrual bleeding after three (3) months use of contraceptive pills while breastfeeding. The health care provider gave another type of contraceptive pills and advised her to call for consultation regarding her reproductive health in time of need. The care giver wrote his number and gave it to her. The client also gave the phone number of her husband to inform care giver the number she used to call him. The client was satisfied and finalised her communication happily by blessing the guy. During observation, a majority of care seekers were found to be given routine care in MCH units of the health centre. What was learnt from this observation was that despite exaustive long distance, the best practice that was going on in the health centre provided relief and satifaction to the customers.
Furthermore, a lady who was pregnant and appeared to have reached full term, came to ANC with complaint of high body temperature and cough. A nurse working in ANC unit took her vital

signs and auscultated over her chest. He prescribed certain drugs and sent her to the pharmacy in the health centre. She was given 2 strips of amoxicillin 500mg and Diclofenac injection. She asked for oral analgesics instead of injection by mentioning her previous history of allergic reaction to injection. She was asked what happened. She commented: *The druggist commanded me to do what I was commanded to do and refused to change it.* The lady went back to prescriber and asked for the injection to be changed to paracetamol. The prescriber rejected the request again. The lady was disappointed and went back to the head office again. Unfortunately for her nobody was there to attend to her complaints. Her sister begged the prescriber again. He refused again. In the meantime, another person tried to help them, she eventually received paracetamol. She stated: *I cried and my younger sister also cried with me. I cried to say 'praise is for Allah', who created both Devils and Angels and allowed them to exist together on the earth*. she turned her face toward her younger sister and said: *I wish a very kind and respectful professional husband for you like the one who tried to build up my broken heart*. The younger sister repeatedly said three times: *Ameen, Ameen, Ameen*. She went back to the man who solved her problem and said: *Thank you, would you please accept, if I make you marry to my younger sister standing behind me*? The guy replied: *I am extremely grateful for your making me a part of your family members. But I cannot decide at this moment on what you have said, without discussing an issue with my family*. Finally, he accompanied them to the main gate of the health centre and gave them his phone number to contact him in time of need.

This indicated that unrthical behaviour of health worker injures the heart of people. But the work of disciplined worker dresses the bad image of others in community services.

In one of the health centres, a pregnant woman was observed coming to the health centre. She sat in front of the ANC unit on the bench and asked another woman coming out of ANC unit if she aware of the care giver serving there. She responded by saying that she only knew that it was a male nurse was giving service. She moved to a female staff in a white gown standing on a corridor in front of pharmacy. She asked: W*hen a female midwifery nurse so and so would be available*? She was informed that her preferred midwife would come the next day. She then thanked the nurse and replied that she came for the third time for ANC visit. The druggist tried to brief as an expert was giving service in ANC unit. The client said: *I do not know him. But I disliked being served by male*. She closed her eyes and moved her head to the left and right several times and ended with blowing out air from her mouth. Many women were also seen complaining receiving routine care from the male nurses or midwives.

What was learnt from the observation was that the local community preference was female health workers due to cultural and religious beliefs.

In one of the health centres, there were no provision of routine care services on Friday. It is informally considered as weekend the staff's weekend. This is what makes that locality different from other areas of Eastern Hararghe zone was the uniqueness of the market day. The market day is Sunday which is commonly formal weekend from the government side. For this reason, many people were observed when they come to the market visiting the rural health facility for seeking routine care on Sunday. But, on Sunday there was not routine care given which is normally given on working days and hours except emergency services. In contrast, on Friday, nobody was observed coming to MCH units except for emergency case.

This shows that there is mismatch between the local community socio-cultural context and days of routine care provision.

In another MCH setup, there was a breastfeeding woman who came seeking assistance at the under-five health care facility. The baby had diarrhoea and vomiting. A nurse examined the baby for signs of mild dehydration and gave ORS. She was advised to continue breast feeding.

The baby was given ORS several times. But the baby continued vomiting and passing watery diarrhoea. Gradually, the baby failed to suck the nipple of the breast of his mother. Then the nurses tried to secure IV infusion on the scalp veins. But they couldn't gain the vein and the baby was severely dehydrated. Finally, the baby was referred to hospital was taken by ambulance to hospital.

The implication is lack of skilled professionals and shortage of resources to make a cut down procedure for securing intra-venous fluid

Image D13: Staff writing referral notes

Image D14: examination bed in the facility

Standard 2: Check List

The observation was to see how health information system enabled the use of data for early and appropriate action to improve care for woman and child.

Observed Realities

An enabling environment for health information that could help early and appropriate action was not observed.

For instance, the woman delivered a baby that cried once and died after an hour as a result of improper neonatal care and negligence by the midwife due to lack of enabling health information data for early and appropriate action.

There was no the health information system in the centre except patient cards on the shelf

Even proper use of patient card and keeping records on the shelf was not observed giving proper function in ANC and FP unit including the one illustrated in the above.

For example, a woman came to the health centre holding patient card number.

The patient card was not found on the shelf of card room as the image depicted below

Image D15: Card room of a health centre

Image D16: Head office of a health centre

There was no computer-based patient record. The new card was given for the client.

Previous history of the patient was lost due to negligence. That loss became a barrier to the data for early management of women and children.

Similarly, it was observed that the health centre had HISM professional working in one corner of director office keeping desktop computer on the table. But what was being documented was daily activity report. There was no digitalised patient record keeping. Data was not utilised for early and appropriate management of women and children. FP, ANC and immunisation including common childhood disease management and severe acute malnutrition management were observed being given only during working hours. But emergency service and skilled birth attendance were given 24 hours throughout the week.

The implication is that there was no enabling health information system observed to use data for early and appropriate action. Additionally, digitalization of clinical services is a big agenda that is left as an assignment for the government of the country.

The case of Gursum health centre had HISM professional working in his office. There was computer-based record keeping that enable use of data for early and appropriate action to improve care for woman and child. Relatively, the health centre was found to be better than all other health centres observed. However, the researcher observed a mother who was preparing a liquid diet for malnourished baby was observed in nutrition centre. She was trying to cool the hot soup by blowing into the cap several times until the soup became lukewarm and suitable to feed the baby. A nurse was also observed walking through without advising the mother, as if she was doing the right thing.

The implication was that there were more best practices and a few bad practices observed the facility.

Standard 3. Check list:

The researcher was to observe the effectiveness of the health centre on women and children whose condition(s) cannot be dealt with effectively due to limited resources and services as well as access to referral services.

The pregnant woman who was in labour came to the health centre. The midwife arrived and took her to the delivery room. She examined and confirmed that it was the first stage of normal labour, subsequently the woman was advised to go to hospital without any abnormal detection in the absence of ambulance service. The husband was called to accompany her to hospital, he used public transportation to take the wife to hospital. On the other hand, the head of the health centre ordered the ambulance to refer the labouring mother who stayed in the second stage of labour. The officer reported that an ambulance has gone to another health centre for the same case and told the staff to tell the family members to look for public transportation.

During observation, the researcher discovered that access to referral service was very limited. On the other hand, access for referral service from health centre to hospital was observed through an on-call Ambulance service in the health centre. The pregnant women were observed coming to the centre for delivering the baby by 'Bajaj' and public transportation.

A labouring mother was also observed coming to the health centre by stretcher on the shoulder of the community during observation. Many labouring mothers were observed coming to the health facility late in the second stage of labour. The ambulance and referral linkage communication were observed being facilitated by health care provider call when necessary.

The referral linkage from the health centre to hospital was observed to be good. However, referral service from the community to the health centre was not observed. Access for referral service from health centre to hospital was appreciated by the researcher.

Furthermore, access to referral from rural remote area of pastoralist community was not observed during observation period. A pregnant lady with pushing down sensation was observed coming to the health centre on foot from a distance. Her family was complaining about the lack of access to transportation and lack of response from ambulance driver. They alluded to the fact that the community leader, the religious leader, the women group team leader and family members tried to call the ambulance service but it was all in vain.
They were observed reporting the problem to the head of the health centre and the district health office manager.
Access to referral service was not timely from the remote rural area.
For evidence, a woman was observed arriving late in the second stage of labour to the health facility and delivered in 30 minutes after arrival from the rural village.

Standard 4. Check List:

The researcher was to observe how effective was the communication between women and their families and the health personnel in response to their needs and preferences.

Observed Realities

The communication was not satisfactory to convince the mother and family member during the referral services. The mother of the woman in labour ward was disappointed and cried as if she was neglected due to lack of reassuring words from professional side.
In one of health centres a lady was observed. She was a victim of the domestic violence who came to seek assistance from the centre and she felt that the communication was improper. She was directed to the court. Nurses were laughing. But the client was crying.
This shows lack of humanity, unethical approach and lack of professional accountability.

In one of the health centres, due to poor communication and attention of the midwife, clients and the family members were found to be at risk due to unsafe the environment.

In another health centre, though the nature of communication between care givers and customers, appeared to be good, however, there was insufficient communication between health service providers, clients and family members.

This observation indicated that lack of proper communication and unethical behaviour made the pregnant woman ill rather than healing her.

In another rural area, the major observed issue was the language barrier within the same language speaker due to contextual difference. For instance, the mother was observed describing that she was earlier given iron and instructed to take 1 tab per day, but the prescription documented on the patient card was observed as 1 tab twice in a day after meal.
The communication between health professionals was good in many environments.
In fact, in certain facilities, the communication between care giver and patient as well as between care giver and family members was not as such satisfactory. For instance, the mother who came to receive contraceptive pills was asked what she inquired and was given the pills without further communication about her health condition and comfortability of the drug to the patient.

In the low land health centre, lack of response to call and language barrier between health service providers and patients and family members was seen in the pastoral areas. For evidence, there was observed gap in communication while the family members were complaining about the lack of response to ambulance call for the facility-based child nearing in the rural community. Similarly, doe communication gap, the community misperceived use of condom as a mean to teach adolescents to learn prostitution against the culture of the community.

Mostly, in certain health centres the communication between care givers and care seekers was found to be good; however, the gap of clear communication and understanding was observed. This implies the need for training on communication skills.

Standard 5: Check List

Observation was to see how woman received care with respect and dignity.

Observed Realities

Dignity and respect reflecting communication was seen to be limited in MCH units.
But few health care providers were not behaving according to the rules and regulations.
For instance, there was poor communication between the mother and care provider.
The third person in the health centre whose responsibility was record keeping, was observed asking the need of the mother and tried to send the mother back without assistance.
The mother was complaining as she was coming for the third time.
The record handler issued her card and went to the residences of midwife and reported the matter.
Furthermore, the midwife came and started serving the mother without communicating to her, expressing her silent anger because the mother reported her.
Most of MCH service seekers were observed receiving care with dignity and respect.
But, in almost all cases no one was observed greeting women at the beginning of their contact with them.
There was respect service in a majority of cases during routine care services.
But certain extra ordinary case was not given attention.
For instance, one of the cases was, the case of a grade 10 girl student whose abdomen was gradually distended and the family suspected that she might be pregnant.
The family members tried to investigate her history of exposure to unprotected sex.
The girl denied confessing her exposure even to male clothes in any circumstance.
She was virgin and was examined by traditional birth attendant in the locality and informed her mother and her elder sister's suspicions.
Her father was lately informed after other family members exhausted the issue.
She was seriously beaten by her father due to lack of getting information from her and lastly brought to the health centre after she attempted to commit suicide. The family reported the matter at the centre as they suspected unwanted pregnancy while her hymen was intact as observed by TBA. The midwife asked the girl to be on the delivery couch and observed into vaginal orifice. She confirmed as the hymen was intact and tested the urine, confirmed the pregnancy and informed the result without going far with that sensitive issue. The health staff were observed starting the communication by asking what would be needed from her. But, in no situation, greeting patient was not observed in their communication.

The observed reality shows occurrence pregnancy without coitus by external ejaculation.

Mostly, many women were observed for receiving care with respect and dignity. But, on and off, the women were observed being treated without respect and dignity against their health rights. For evidence, the woman who was complaining about violence against woman was not given attention by care givers was observed in a facility. She was told that the case was not the concern of the health centre. But the health policy of the country stated domestic violence prevention and management were one of the major duties of health workers as a legal protection of women's health rights in the country.

Access to referral service timely from remote rural area was not seen. For evidence, one post-partum mother was brought on the shoulder of the community by improvised stretcher on the shoulder of the villagers. The patient appeared to be severely anaemic. The health officers and midwives confirmed as she delivered in the health centre before three weeks from the recorded document. The staff immediately examined and diagnosed her for postnatal sepsis. The head

of the health centre called an ambulance from the district health office. The health professionals quickly secured iv lines and gave iv antibiotic drug (ceftriaxone). In 45 minutes, the ambulance arrived and picked the patient to hospital. However, sadly the patient passed away before reaching the hospital. Then, the dead body was observed being brought back by ambulance to the health centre for reporting the outcome and took the deceased mother to the rural village.

This showed lack of postpartum visit at home level and lack of follow up ended up with lack of postpartum infection prevention and the patient died due to puerperal sepsis.

In a health facility, dignity and respect with good communication was seen while giving service in delivery room by female midwives during observation. Respect and dignity were observed throughout participant observation in the facility. All the staff were observed giving routine care services in MCH units with respect. All the women coming to MCH units were observed while they were receiving care with respect and dignity. All women and their family were observed being served by good communication skill and their expression of gratitude. Communication among care givers, clients and their family were observed to be good internally.

The best experience of communication skill was observed in the health facility.

Standard 6: Check List

Observation was to see how every woman and her family were provided with emotional support that is sensitive to their needs and strengthens her own capabilities.

Observed Realities

The researcher observed the emotional support between the family and professional sides of labouring mother. They were saying *Abshir, rakko hin qabduu, amma dhalta* which means, be sure, you have no problem and you will deliver soon. Many family members and mothers were observed being supported by health care givers.

In another health centre, one of the care givers was observed as he was disgusting them rather than reassuring them. The grandmother was seen being attacked verbally and physically by the midwife.

In one of the health centres, all women coming to the health centre were observed being provided with emotional support except the one who was mentally disturbed due to domestic violence in the family. A nurse asked the women who came to the health centre whether the woman had lack of sleep. She was in need of sleep-inducing drug for correcting her sleeping pattern disturbance. Many staff knew her for being their customer for many years. But nobody observed her feeling of pain except laughing at her due to her speech inconsistency. Certain women were receiving care with respect and dignity from certain individual care givers.
Others were found to be neglected by certain care givers.
The observer noted that the Ethical issue was not equally attended to by all staff in the health centre.

Two similar cases arrived at the health centre at the same time. One was treated and the other was sent to hospital for the same service seeking. The person who was involved in partiality commented that she has no respect for health professionals.

The health worker is against ethical principles of health profession.

Many women and their families were observed being provided with emotional support care.
But, a very few women and their families were observed lacking emotional support from health care providers.

Mothers and family members were emotionally supported specially, labouring mothers and their families. In all setups of MCH services emotional support of mothers and their families were appreciated in the facility during observation. The family members and community members who accompanied the labouring mother were observed while staying in the compound of the health centre and praying for the positive outcome of the pregnancy. The clients and their family members were observed while they were getting emotional support from the staff. All women were observed receiving care with respect and dignity.
All health workers were observed supporting mothers and keeping privacy of the patient.

Here there was appreciable experience of companionship and culture of emotional support.

Standard 7 check list
Observation was to see if the competent and motivated staff was consistently available for every woman and child to provide routine care and manage of complications.

Observed Realities

Some of the present staff were competent and committed to serve the community.
Some of them were simply there.
In the health centre, clients mostly call care givers from their residences during observation.
During observation the mother was observed being referred to another health centre for checking blood sugar due to lack of the glucometer and laboratory technician in the health centre. Certain staff were motivated staff while others were simply there for painless purpose to deal with trouble free works not for management of complication.

The centre was visited on several occasions. The presence of staff was not consistent. Many health staff were not found around due to campaign for mobilisation of the community to accomplish annual health insurance payments. The family members and delivered woman were under distress due to lack of emotional support due to husband's disappearance. The majority of health workers were observed as they were competent and motivated. But certain individuals were not competent enough in their professional practice as observed on a male nurse in ANC unit that refused providing choice-based care for a woman.

This indicated lack of commitment and competency of health professionals in the facility.

All women coming to MCH units were observed receiving care with respect and dignity.
All staff in delivery room were competent and committed to serve skilled birth attendance.
The care givers in MCH setups were found to be competent and motivated.

Though they were not competent enough professionals in skill, they were not highly motivated staff due to lack of incentives and other benefits like well stablished residence.
.
All staff were observed for their existence in the facility working with motivation. However, they were motivated to work in a very remote area where tribal conflict frequently occurred.
All health workers working in the FP unit, ANC unit, delivery room and PNC unit were observed providing services by motivation. Staff were available consistently as observed during working hours.

Best experience observed in this case.

Standard 8: Check List
Observation was to see whether the health facility had an appropriate physical environment with adequate utilities, medicines, supplies and equipment for maternal and child complications handling.

Observed Realities

Infrastructure is not sufficient for service.

There was no waiting area for companions and family members as reflected in the image below.

Image D17: ANC unit

Image D18: Multi-purpose room in the facility

Both FP, ANC and PMTCT were observed being given in the same room due to shortage of infrastructures. Water supply was good in the majority of health centre compound. But there was no pipeline connected in any room of the health centre including delivery room. Beds in both prenatal and postnatal units were observed without bedsheets as depicted in the image below.

Image D19: PNC Beds

Image D20: Newborn's corners of new-born

Image D21: Buckets

Image D22: Abortion set

Emergency Sets available to some extent in one corner of an OPD room due to shortage of physical facility. FP, ANC and Delivery were equipped well. In new-born care corner of the delivery room there was no warmer except ambo-bag and manual sucker.

All health workers working in FP unit, ANC unit, delivery room and PNC unit were observed providing emotional support for every woman and her family in the rural health centre. There was no waiting area for companions and family members. Infrastructures were constructed for certain health centres to the standard. Others were not. The fuel user refrigerators were available for cold chain in the facility. But, poor access to transportation was observed due to lack of road construction in the area. There were insufficient rooms, staff residences and waiting area for the community.

The observation revealed that the health facility was under rehabilitation after tribal conflict resolved.


Image D23: Beds without mattress & bed sheet

Image D24: Expired drugs scattered

5.5 CONCLUSION

The findings of the study show that a wide range of aspects of maternal and child health care practices in rural health centres of Ethiopia. These include contemporary situations of MCH care practices in rural health centres that involved rationales for MCH care practices, purpose of MCH care practices, components of MCH care services, task performance activities in MCH care practices, nature of interactions in MCH care practices and satisfactory and/ or unsatisfactory situation of MCH Care practices. The data also reveals those barriers to MCH care practices, enablers of MCH care practices and innovative ideas for improving MCH care practices. The identified experiences of participants in MCH care practices show both formal and informal MCH care practices and cultural and traditional beliefs affecting maternal and child health care practices. Furthermore, the findings of observational study show that real phenomena of maternal and child health service provisions that have either positive or negative influence on the care practices in the locality.

The next chapter is fundamentally a discussion premising on a discussion of the findings in respect of the various MCH nursing practices emanating from the findings in Chapter Five.

CHAPTER SIX
DISCUSSION OF FINDINGS

6.1 INTRODUCTION

The previous chapter primarily focused on the analysis of the collected qualitative data which served as the basis upon which the true value and weight of the research findings could be supported as having practical and meaningful implications for the study and it's relevant for stakeholders (Fox et al., 2014:1. This chapter is based on the presentation of the maternal and child health care practices in rural health centres, Ethiopia. The research examined the viability of this study in comparison to the literature on evidence-based practices of maternal and child health care practices in rural health centres. Furthermore, the research is intended to objectively broaden the study's practical implications and meaningfulness by presenting the discussions, conclusions and recommendations in the ensuing chapter.

According to previous international protocols, the 1978 Alma Ata declaration number VIII: "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors". This was confirmed by subsequent international MDGs 4 & 5 thus: *To promote women health and safe motherhood: to achieve a rapid and substantial reduction in under-five and maternal mortality by two-third and by three-fourth respectively, and improve the health and nutritional status of under-five children and women*.

However, despite Ethiopia being a successful country with regards to MCH care performance and achievement of MDG 4 and MDG 5 in 2015. Furthermore, there was an unfinished agenda of sustainability in maternal and child health care well-being and having responsibility to implement MCH intervention and utilisation of health services which is meant to support all women equally with quality of services delivered through coping mechanisms of challenges negatively influencing women and making use of enabling factors or missed opportunities on facility based maternal and child health services. The implication of this shortfall is the fact that Ethiopia could have challenges to ensure healthy lives and promote well-being for all at all ages as stipulated in Sustainable Development Goal (3) (WHO & UNICEF, 2017:9). Furthermore, WHO and UNICEF (2017:9) mention that the global maternal mortality ratio should be reduced to less than 70/ 100,000 live births by 2030, as well as the reduction of neonatal mortality by at least 12/ 1,000 live births and under-5 mortality to at least as low as 25/1,000 live births, and the reduction of premature mortality by 1/3 from non-communicable diseases through prevention, treatment and promotion of mental health and the well-being.

Furthermore, the universal access to sexual and reproductive health-care services should be ensured, including family planning, information and education, and the integration of productive health into national strategies and programmes.

Universal health service coverage included access to quality, safe, effective, quality and affordable essential medicines and vaccines for all. Hence, the findings of this study presented with realities of rural MCH care practices that need to be addressed and generate innovative ideas from important stakeholders that would be helpful in guiding the policy makers for improving the practical guidelines with suggestions for prospects of health outcomes for accelerating the progress toward achievement of SDG 3 by 2030.

The researcher identified themes from each interview by comparing them across interviews and rechecked for concurrences as mentioned in other studies (Butterfield, 2012:34; Patton, 2002:453).Basically, Normalisation Process Theory was designed for formulating research questions, data collection, data presentation with interpretation and data analysis in this qualitative study as pointed out by another study (Penn-Kekana, 2017:5).

This Theoretical foundation was the base for building the conceptual framework on the specific assumptions of maternal and child health. The framework was implemented in four stages. The first two stages involved formulating research question with data collection and analysis. The third and fourth stage involved the presentation and interpretation of the research findings with forming the core of conclusion which is in agreement as indicated by another study (Ridgeway, 2012:46). The framework really served to guide the structure of the study and enabled a coherent conceptual linkage of various aspects of maternal and child health as described by Rani (2016:1) and Ruppel and Mey (2017:47).

In this regard this qualitative study attempted to explore the broadly diversified factors and also involved observed data into synthesis, hypothesis and generalization of identified phenomena with regard to aspects of MCH nursing practices and associated factors to understand implementation and operationalization of concepts in consistent ways (May et al., 2014:299). The use of theoretical consideration increased awareness of health-related qualitative data analysis and presentation of findings which is in agreement with another study (Snyder, 2019: 334). This further justifies the relevance of the research method used in this study. The relevance of normalization process theory provided understanding for studying complex system and processes liked with aspects of MCH care practices, challenges, opportunities and generation of innovative ideas in

the context as realised by other studies (Fox, Gardner & Osborne, 2014:1; Nessun, 2020:3).

6.2 CONTEMPORARY SITUATIONS OF MCH CARE PRACTICES IN RURAL HEALTH CENTRES

To identify contemporary situations of MCH care practices in rural health centres, six (6) sub-themes were developed as indicated below:

- the reasons for MCH care practices;
- purpose of MCH care practices;
- components of MCH care services;
- task performance or activities of stakeholders;
- nature of interaction in MCH practices; and
- extent and nature of satisfaction in MCH care practices.

6.2.1 Rationale/ Reasons for MCH Care Practices

Different issues related to the rationales for MCH care practices are discussed in this chapter. Dadar, Meta and Kersa District's MCH focal persons explained the reasons why MCH care practices became a global priority issue as a primary goal of SDG 3 to address all preventable maternal and child deaths. This finding is similar to the study that conducted was conducted in Ethiopia using the delay framework that was indicated as a priority for the maternal health services action area (Kea, 2018:12)

Additionally, for the question: Why was MCH reported as an issue by Fadis, Babile and Gursum District's MCH focal persons?

The existing MCH care practices were determinant for the future of the health outcomes. The views of a majority of the health centre managers about rationales for maternal and child death were similar and overlap with the responses of districts' focal persons and other professionals in the study area (Addisse, 2003:47). However, one of the managers differently reported:

The cost of health expenditure that can be saved by prevention.

Similarly, the managers of the health centres in Fadis mentioned that the MCH is a fundamental issue for social and economic development determinant in the community. Hence, it is concordant with the study finding of Babalola and Fatusi, 2009:8 who mentioned that preventive care service is cost effective and promising for socio-economic development of the household. Furthermore, MCH Focal Persons mentioned the following:

MCH Focal Persons reported: MCH care is fundamental human rights to provide basic and standard care for mothers and children in every part of the globe.

The above-mentioned statement is similar to the vision of implementing global strategy by 2030 (UNAIDS, 2018:1)

From the midwife's perspective, the responses to the question 'Why is MCH?' was reported as: it an issue to address its problems as well as maternal and under-five mortality, Another major reason was: being global health priority to enhance coverage to the rural marginalized community by free of charge services and as a determinant factor for survival of mothers and children. This result is similar to the world health report as reasons for first contact care or primary health care (Kuruvilla, 2014:533). In that regard, one of the Professional Practitioners reported: It is a priority area of research for evidence-based intervention.

The importance of research in clinical practices for care quality improvement was also revealed in the same way in the study was conducted in rural South Africa (Chetty et al., 2018:9). With regard to the responses of rural mothers in the Eastern Haraghe zone community, many of them believed that the rationale for MCH care practices was pregnancy and childhood health problems that have been causing death.

One of the women reported: There was a need for enhancing care of mother and children as there is no happiness in daily life activities of the household whenever there is the health problem in one's family.

This implies that the livelihood of mother and child activities are in a disastrous situation with maternal and child health care's deterioration, as mentioned by Kuruvilla (2014:537), that it is imperative to increase support in reforming health care system. The healthcare impact (outcome) in the locality also indicated the necessity of MCH care practices to save mothers and children from all preventable causes of mortality. Similar to this finding, the research finding of Silali and Owino (2016:2) justified that the access to MCH care practices was the reason for morbidity and mortality reduction.

With regard to the HEWs' report:
The global health and country health policy as a component of HEPs was the reason for MCH care practices.

The above-mentioned statement is concomitant to the Ethiopian MCH care strategy study conducted by Bang (2018:228). The demographic reason was mentioned as:

Mothers and children are the largest proportion of population in the country.

The above-mentioned statement is in line to the study conducted by Betemariam (2017:14), which stated that the population of mother and child has increased and the health service coverage is very low.

Similarly, the support of maternal and child health promotion, prevention and maintenance was in need of both formal (professional nursing care) and informal care practices (non-professional care).

This finding is in line with a study that indicate an increase in the employment of mothers of preschool children for adequate childcare services (Squires & Dorsen, 2018:18).

The religious scholars understand the reasons for MCH care practice as obligatory action and religious teaching that should be given attention from the premarital period. Thus, the religious teaching stated that children have three rights upon their fathers. The first was checking the mother's health before marriage (physical, mental, behavioural, social, emotional and psychological). The second was publicising the birth of the baby by slaughtering goats or sheep for sacrifice and declaring the new-born baby as a blessing and socialization based on cultural and/or religious context of the community. The third was bringing up of a child in the best manner throughout developmental ages and stages until they are capable of independent life.

This was the reason for the betterment of physical, mental and social health of mothers and children in the society. However; indigenous supportive religious teaching was not paid attention in the teachings of MCH in the society except their negative impact as details of the study findings (UNFPA, 2011:48-50).

The teaching of Qur'an and Hadith again views marriage as a contractual agreement that is signed during a marital ceremony for a couple's mutual respect and taking care of each other as long as they live together. Turkman (2013: 1170) agrees with the above statement as being related to the maternal and child health nursing practices by mutual respect in order to ease the care practices and to address disrespectful challenges. Furthermore, the Islamic teaching of abstinence from sexual intercourse before marriage was one of the reasons mentioned as the missed opportunity of using indigenous knowledge. The implication is the importance of health care of mothers for productivity, socio-economic consequences, and consequences of health risks such as death and orphans who have lost hope. This finding collaborates with a study conducted by Hemsing, Greaves and Poole (2017), which revealed that unplanned pregnancies could

result in health risks and socio-economic losses. For instance, their religious teaching totally prohibits spitting on the open field as a sin. However, on the other hand, it implies that this finding is one of the best practices for the prevention of TB and other airborne disease transmission, which is in accordance with WHO recommendations for reducing infectious disease transmission. Similarly, the best religious teaching in child feeding practices was mentioned as avoidance of blowing into a dish or a cap containing hot food to cool. This was prohibited as it would introduce pathogenic micro-organisms and other participants agreed upon.

Meanwhile, a mother was observed while she was blowing into a cap due to lack of such indigenous Knowledge. That was the indication of swallowing normal flora that is blown into child's diet from one's oral cavity which might make children susceptible to the bacteria and/or infection. Similarly, the endogenous or exogenous flora ascending through the vaginal cavity might cause serious infection such as puerperal infection (Littleton & Engebretson, 2002:945). However, the other reason for MCH care was community engagement and participation.

The following statement was responded by a Maternity Health Practitioner (MHP):
On the seventh birthday of new-born, the cultural and religious belief of welcoming ceremony was also the reason for MCH care which done by advising breastfeeding for the minimum of two years as religious obligation in the community.

There is similarity of this finding and a report of FMOH (2015:9) which mentioned that as most communities have self-help traditions that could readily serve as a base for building or expanding support systems to help families in this regard (FMOH, 2015:9). On the other hand, making use of engagement in religious assembly is directly related with developing the state of the world's nursing report that stated the government officials' role with the support of WHO and partners for engaging relevant stakeholders (Nightingale, 2020:6).

The study also revealed the best reason for MCH care practice as:
Cutting things from the throat of new-born as a healing practice was a killing practice; while, the religious teaching protected people from cutting things from the throat and advised use of alternative medicine through nasal route of administration by sniffing the yellowish bitter fluid of Aloe Vera plant for all infections in any part of the throat and avoidance of annoying mother or disappointing her and importance psychological support during pregnancy and breastfeeding that was neglected.

The above statement implies that making use of such best teaching is instrumental for child protection and prevention of infection from harmful traditional practices due to lack of awareness while an alternative indigenous solution was there. The findings agree with the study conducted by (Sadik et al., 2014:7-9). The view of the community leaders for MCH reason was that health rights that should be protected. This finding differs from the researcher's finding which revealed that the reasons for poor access of the basic standard of health services is fear of being mistreated and loss of autonomy (Vedam, Stollb, Rubashkincd, Martina, Miller-Vedame, Hayes-Kleine & Jolicoeurf, 2017:201-210). Furthermore, the value of the life of mother is similar to the farmland on which the seed of a human being grows in the mother's womb to sustain human generation in a society. It is consistent with the importance of health promotion and disease prevention on mothers and children who positively impact on the health outcomes of a generation.

On the other hand, maternal mortality was the cause for destruction of a family in a society and, similarly, in the philosophy of nursing practices and the assumption that maternal health affects the health of all family members. One participant mentioned the value of mother as:

'Jaartuu-bultii' which means founder of the family and her health was determinant for stability of the family life and for the life of the baby too'.

The findings have similarity with the study conducted by (Saving New-born Lives in Nigeria, 2009:56) in Nigeria, furthermore, the study also revealed that health promotion and disease prevention on mothers and infants would positively impact the health outcomes. The value of mother was reported as the first for all: first to provide shelter for the baby; the first to provide food such as breastfeeding for the baby; as well as the first to provide medication for the baby; and the first to assist with the baby's mile stones.

From the perspective of TBAs:
Poor health care for mothers was endangering a family health in the community

The above mentioned response implies that the knowledge of health is imperative to the mother and is the reason for MCH care's utilisation which is similar to the study result conducted by Yared and M.Asnakech, 2003:8, and was based on factors influencing the use of MCH care services in Ethiopia. Additionally, the study reported that the importance of public health in the community, to eliminate serious health consequences and promote socio-economic outcomes. Furthermore, this study finding similarly shows the interdependence of socio-economic variables with maternal health outcomes (Colvin, 2013:193-198).

The reason for MCH care practice was irreversibility of the lost value of maternal life in a family as:

The maternal loss may be compensated for a husband in a family, there was no possibility for equivalent compensation of her life loss consequences for her children. Therefore, saving the life of the mother would be crucial for the health and survival of her children.

This implies that the wife can be substituted or compensated by the husband but the same cannot be said to the value of the mother and baby. This finding is inconsistent with the crucial importance of MCH promotion and prevention for successful health outcomes of mothers and children as well as to stop unrecoverable damage in a society (LifeInt-Opray, 2015:7). According to the responses of participants, the maternal and child health issue were the vulnerability of social transformation and development using missed opportunity such as influential people and supportive religious teachings about the obligation of child-birth spacing for producing healthy generation which is in accordance with the FMOH (2015:9) report. On the other hand, mothers and children and vulnerable group are at risk of contracting diseases as well as pregnant and lactating women.

Despite being a cornerstone for the family construction, a mother is exposed to preventable diseases. This was mentioned in another study conducted by (Dunlop, 2010:42) as a for future research as innovative practices and evidence-based approaches to prevent further loss of life in an on-going priority during preconception care practices such as maternal screening from nutritional status, STIs and HIV/AIDS as well as counselling about risk of pregnancy, infertility, chronic conditions, medications, and sexually-transmitted infections prevention.

The other reasons for MCH care practices were importance of contribution of community members:

The maternal and child life loss cannot be prevented without contribution of mothers, family members, teachers, traditional birth attendants, volunteer health promoters, community leaders, religious leaders and health extension workers in the rural community. The implication is that sustainability of improved maternal and child health outcome needed mother's self-care and childcare practices with support of local stakeholder in the rural community.

This idea is directly related with a study conducted in India that reported that women and their companions can help nursing to keep the woman and baby safe (Semrau, 2016:5),

and as WHO described social support and/or companion in labour was friendly supportive and welcoming environment that can make a huge difference to mothers' experiences of care and also reduce stress and their risks of complications (World Health Orgnization, 2018:11). Following is the statement by doctors and WHO guide for midwifery:

"The notion of safe motherhood expanded beyond the prevention of morbidity and mortality to encompass respect for women's basic human rights, including women's autonomy, dignity, feelings and choices and preferences, including the choice of companionship wherever possible" (WHO, 2017:2).

6.2.2 Purpose of MCH Care Practices

The primary purpose of MCH care practice that was revealed by this study from health workers' perspective was to decrease the death of mothers and children under-five from all preventable causes of death and the result is directly with SDG 3 (Lassi, 2016:2; WHO, 2018:6-7).

Similarly, the MCH purposes were to empower clients for self-care and baby care through training, health education, counselling, and follow up to improve and sustain their health and well-being; to address the health needs of mothers and under-five children equally in the rural areas; and to contribute to the achievement of Sustainable Development Goal 3 by the year 2030. This finding is in agreement with the national strategy of immunisation (FMOH, 2015:67-68).

The majority of the participants reported:
to equally provide routine care; to enhance community participation; to improve MCH service utilisation; to realise health policy; and to enhance the health status of mothers and under-five children in the community.

The results of this study cohere with the global strategy for women's, children's and adolescents' health, which is also fully aligned with the SDG targets and SDG3 (Assefa, 2017:2). Moreover, following is another important purpose as stated by a participant:

enabling mothers to address their health problems and the problems of their children through training, health education, counselling on self-care giving and childcaring so as to reduce deaths in line with the sustainable development Goal 3.

The above statement also indicates that the empowerment of women and strengthening of their participation is part of MCH purposes as indicated by the study conducted by

Berhe (2017:11) who also recommended the empowering of women to promote essential new-born care practice. Based on the perspective of mothers interviewed in different rural HCs, the purpose of MCH care practice was described as follows:

To help mothers and children before getting sick and assisting during their sickness, pregnancy and childbirth, to enhance immunisation coverage, to prevent and treat childhood illnesses, to improve breastfeeding practice, to prevent harmful traditional practices that affect the mothers, to realise MCH rights and save mothers and children, to enhance facility based childbirth.

The above-mentioned finding is similar to the objective of Ethiopia's health policy in enhancing service coverage equally to rural communities (Abebe, 2020:67-68; Nigatu, 2013:7-8). From the perspective of community members, the purpose of MCH care practice was to promote contraceptive use in the rural community and to improve health seeking behaviour. The aim is to avoid the occurrence of unwanted pregnancy and to improve childbirth spacing in the rural community, as well as to improve survival of mothers and under-five children in the rural community. Studies also show similar findings in relation to the avoidance of unsafe abortion and protection of health rights (Aderemi, 2016:71; Gross & Wydra, 2013:181). The result is also in agreement with the views of the issues such as contraceptive adoption and family formation. Furthermore, the other explored purposes are stated as improving and sharing responsibility among stakeholders, which was in line with a study that revealed that sharing roles and responsibilities was influential in maternal and child health care practices (Aderemi, 2016:71).

The unique purpose was identified as applying the principle of a few health screenings before marriage in order to prevent the health of parents and their future children. This is similar to the findings of a study conducted by Hooker et al. (2015:540-541) which demonstrated the importance of screening problems as well as the understanding of future required actions. The majority of the results from the community's perspectives were overlapping and converged with the results mentioned elsewhere; except to mobilise the community members through awareness creation. Furthermore, the study findings also revealed excellence in practices of collaborative partnership and improved participation with the internal and external task sharing in maternal and child health nursing practices, which was confirmed by Modi et al. (2019:32).

Another purpose was to improve hygiene practice, while the religious leader mentioned improvements in avoiding harmful traditional practices such as uvulectomy as the current health policy of Ethiopia majorly emphasises hygiene sanitation (FDRE, 2018:1). According to the volunteer health promoters, the purpose of MCH care practice is to improve access to health information and this was underlined by another study as a factor affecting use of contraception and antenatal visits (Mekonnen, 2019:9-12).

6.2.3 Components of Existing MCH Care in the Health Centres

With regard to components of MCH care services, the responses of the majority of the districts' MCH focal persons were health education, FP, ANC, Delivery service, care of new-born and care of under-five children, maternal and child screening services, PMTCT, Vit A prevention and management of STDs; maternal and child immunisation, FP service, ANC, PMTCT, prevention of HIV and STDs, child delivery care, PNC, care of new born, care of under-five children, prevention and treatment of childhood illness, prevention and management of TB, counselling on child protection, breastfeeding, child washing, child feeding, child immunisation, provision of mosquito nets for prevention of malaria, health promotion, growth monitoring, nutritional advices, deworming, prevention of complication and referral services. All of these factors were mentioned as routine MCH care services that are freely provided for mothers and under-five children in rural health facilities in the districts.

These findings are in agreement with the components detailed in other studies (Busch, 2019:12-12). What was specifically mentioned in certain districts is a component of MCH care practices such as Youth Friendly Service (YFS), which is part of a reproductive health programme in the current health policy of Ethiopia (Kereta *et al.*, 2021:74). From the perspectives of the managers of health centres, components of MCH care practices were inter-related and overlapping. However, the manager of Gursum HC1 offered a different response:

Home-based counselling on breastfeeding, complementary diet feeding and FP service a component of MCH care practices.

The above-mentioned statement is also in line with WHO strategic plan. Similarly, women empowerment, awareness building, post abortion care, and laboratory services were also mentioned in agreement with other study findings (Aderemi, 2016:71; United Kingdom, 2018:185). Community members who were also components of MCH care services mentioned:

Provision of homemade oral rehydration for babies such as salty water with sugar, as well as lemon and honey or sugar.

The above assertion is in agreement with the study indicating the first line of prevention and treatment of diarrhoea with improved sanitation facility. The current study revealed the types of MCH services. Special issues that were discussed in local language were '*tajaajila deydaya fi waan joolle'* which means, women's illness that is associated with pregnancy such as morning sickness and childhood disease prevention and management as discussed in an Ethiopian child survival programme (Kahrmann, 2019:7-8) and other studies (Wilson, 2018:532; Mesele, 2018:298-299).

6.2.4 Task Performance Activities of Role Players in MCH Care Practices

The districts' MCH focal persons activity performance was carried out by facilitating, planning, coordinating, directing, supervising and evaluating activities; exercising managerial responsibility assigning duties and supervision; attending the care processes and supporting actors through empowerment and motivation. They also manage demand and supply chain and give direction on resources utilisation, ethical issue and performance of their duties by facilitating community participation and availing guidelines.

This result is directly related to another study that revealed that managerial activities' health leaders of districts were in connection with change availability, quality and outcomes of MCH care practices (Kisakye, 2017:3-6).

The managers of rural health centres in Dadar district reported that task performance activities were conducted by means of assigning duties to nurses and midwives and by delegating managerial responsibility to the unit leaders in the health centre, which is similar to the finding in other previous studies (Ezeanolue, 2015:254; Jessup, 2019:201).

Furthermore, the current study revealed that the performance of activities by managers involved supporting staff and maintaining management of supply and demand through need assessment, planning, intervention and evaluation. In this regard, the importance management in all MCH continuum of care was mentioned as collaborating with others and mobilising resources. This finding is similar with a study finding that revealed collaboration of family and relatives and importance of resources in resource-constraint settings in rural communities (Darkwa, 2019:11-12).

With regard to the result of task performance activities from the perspective of midwives, it was "by assessing, diagnosing, planning, implementing and evaluating, referring, documenting and communicating feedbacks based on guidelines".

This finding is in agreement with the nursing processes related to maternal and child health issues (Ethiopian Standards Agency (ESA), 2012:42). Moreover, mechanisms of task performance activities were:
‘By assigning duty, sharing responsibility based on shared-decision making with mothers, traditional birth attendants, family members, volunteer health promoters, community leaders, teachers, religious scholars and other influential community members in the rural community”.

This finding is in agreement with that of the WHO (2018:30-34). From the perspective of rural mothers, task performance activities were carried out by:
“Assisting breastfeeding, child caring, timely seeking health services and using homemade medicine like water, common salts, honey, aloe-vera, blackseed as natural medicine that inherited from elders for common illnesses by support of TBAs, family members, social supporters and spiritual healers in the home and by female midwives and nurses in the health centres”.

This finding is similarly related with the role of woman/family members in MCH care practices (Morris et al., 2014:14). Additionally, the majority of the participants stated:
“By proper utilisation of routine MCH care, child washing and child protecting, breastfeeding, complementary diet feeding, collaborating with stakeholders in the facility and in the village.

This related to the importance of community participation and collaborative efforts for MCH care participation of MCH care (Arcos, 2018:184). According to the community’s perspective, task performance activities were conducted as follows:

Enhancing exclusive breastfeeding practice for the minimum of two years, teaching importance of premarital/preconception care intervention practice, teaching about maternal respect as a merciful service, teaching about child health rights fulfilling obligation of child birth spacing during early life of the baby through proper breastfeeding and abstinence from unprotected bed-sharing or making love (avoidance of unsafe sex practice) as natural contraceptive methods, mobilisation on application of principle of couple health screening before marriage as an obligatory action.

According to community members, it is their role to support women and their families in order for those women to be enabled to advocate for hand their families' hygiene practice (Dawson, 2012:67). Other participants mentioned that task performance activities are conducted as follows:

Teaching to prohibit the occurrence of unwanted pregnancy that ultimately result in unwanted children before and after marriage and prevent risk of abortion and serious health consequences of mothers and children in the community.

The above study finding coheres with other studies that have demonstrated that family planning messages that are passed through religious leaders to adherents of different faiths could help in shaping their ideation related to family planning and thereby contribute to increased contraceptive uptake (FMOH, 2015:9). Religious leaders can influence and shape people's ideas and views about issues such as contraceptive adoption and family formation. The implication is that, it is the best practice of modern MCH policy of Ethiopia that recommends participation of nurses and midwives in research initiatives to explore indigenous knowledge relevant to MCH nursing, which would inform policymakers and educating populations through communication on key MCH priorities and the national health strategy of the country (FMOH, 2015:9).

In principle, the care giver was expected to be on the frontline in any of the MCH unit. However, the midwife was not available in the ANC unit. She had to be called from home during working hours. Upon her arrival, she only had one handed glove and performed the incision using surgical blade without the blade holder, she put the gauze on the table and applied after removal and bandaged. In principle she should have greeted the client and apologised on her arrival. The procedure for removal of indopanolol should have begun with hand washing, preparation of equipment of sterile field, avoidance of cross contamination, client-centred decision making and discussion on alternative contraceptive methods and allowing informed choice (.

Similarly, the gaps observed were lack of punctuality, poor sterile procedural techniques applied and poor communication skill was observed. There were professional malpractice and misconduct observed as gaps in MCH care practices. The care giver was observed while he was shouting, pushing the grandmother forcefully away out of the delivery room, calling for the security guards to force all relatives out of the compound in the rain, the community reported the condition to the head nurse who was equally scared and resorted in keeping quiet and continued to assist with the delivery. The husband stated: *We are so sorry for asking the question that has no answer*.

The implication was that there were no mechanisms to handle the complaints as well as giving solutions to the problems that occurred in the health facility. The gaps observed were lack of obedience for the rules and regulations of the health policy of the country, lack of corrective measures due to undermining of woman participation in leadership,

gender discrimination, use of muscle for his masculinity, violation of human rights, lack of dignity and respect, bad behaviour and unethical practice as well as abuse of clients and community. In these cases, an observed gap was the site of construction of the health centre at a border of catchment area. The majority of the community members were far away from the centre.

The health centre was on the other side of the mountain which is also a challenge for pregnant and lactating women to reach the centre. However, the communication skill of a care provider and interaction with clients was supposed to be the best practice. Lack of proper communication, lack of respect, lack of shared-decision making, lack of corrective measures, violation of human rights, lack of dignity and respect, improper handling of patient, lack of empathy, bad behaviour and unethical practice as well as abuse of client and family members were also observed. Culturally, that behaviour was observed as inhuman. That was according to the cultural belief of the community, the male midwifery service was not acceptable in the community.

The seriousness of the issue was observed from repeatedly coming from women on everyday basis to request for female midwives to request for services. The gap observed was the mismatch between gender sensitive cultural context and biological gender of midwives available in the health centre. When the other pregnant woman was advised to visit the good expert in the centre, she closed her eyes and moved her head to the left and right several times and ended with blowing out air from her mouth and uttered: *I hate the maleness of midwife nothing else*.

Similarly, there was a difference between the formal off days of the country and informal off days of the local community. In other words, the off day of the week and the market day of the local community coincided. The implication is that the nature of MCH care services provided in the locality was not culturally congruent and not fit with local context. Therefore, it needs adjustment.

6.2.5 Nature of Interactions in MCH care practices

The current study finding related to the nature of interaction in MCH care practices were reported as conducted by:

Communication using oral and written conversation, regular discussion with staff, stretching networks and coordinating services, linking sectors and feedback communication by using information technology; awareness creation and behavioural change communication through health education and training and regular meetings in all circumstances.

There is similarity with the current finding and global observatory report that shows The cost-effective nursing and midwifery care for all, women using client-centred, family centred and community-centred approaches supported by information technology and communication platform in response to the needs of community through excellence interactional practices, collaborative partnership, and improved participation with internal and external harmonious relation in maternal and child health nursing practices were similar to the global observatory report (Modi et al., 2019:32)..

The observed realities in MCH setups were lack of proper reception of the client, lack of ethics and lack of respect were observed from professional sides, unequal access to ambulance service, lack of attention to domestic violence against woman, lack of communication about availability essential drugs in the facility, lack of communication about peace near the surrounding heath centre, unwanted behaviour in the communication of care givers was observed that revealed an arrogance of health professionals and pride, lack of greeting between clients and care givers, lack of using communication technology in the unique lifestyle of pastoral community, lack of mutual cooperation on communication and lack of using standard guidelines.

The fact that the result related to the nature of interaction in MCH care practices from perspective of community members who participated in FGDs mainly revealed as usually done by using inter-personal and public communication, participation and engagement in socio-cultural and religious affairs of the local community. This finding is also in agreement with another study result that demonstrates communication, participation and engagement of stakeholders could enhance knowledge and practice of MCH by researching what works and evaluating effectiveness of the best practices at community and facility level (Ameh & Van Den Broek, 2015:2). All in all, an observed gap in all rural health facilities selected for study was lack of greeting. Greeting was important for opening conversation on welcoming and client reception.

People were observed while they were talking about greeting as it was the key to love and respect for human harmony of relation and interaction. That was greeting at the beginning of joining individuals or groups on the way or at some place and certain point in time. On the other hand, the greeting in between discussion is culturally believed and used as a request of greeter to ask permission for getting chance to talk and calling attention of all individuals around there. In this regard, the response of individuals or groups to the greeting in that occasion or circumstance was allowing the greeter to go ahead or expressing their readiness to pay attention to the speech of the greeter and confirmation of agreement upon listening.

So, greeting is crucially important for conducting any human services in the culture and belief of the community. In the process of provision of care the mismatch between principles and practices was observed. For instance, lack of postnatal home visits and follow up to prevent maternal and new-born complications and death can be mentioned.

6.2.6 Nature of Satisfaction in Rural MCH Care Practices

Comparatively, this study revealed that there were more aspects in MCH care practices that were more satisfactory, with mina few could be categorised as poorly or not sufficiently satisfactory.

6.2.6.1 Satisfactory Aspects in MCH Care Practices

According to the current study findings, what made MCH care practice satisfactory was access to free services, enhanced community participation, improved timely health seeking behaviour of women, improved monitoring and evaluation, improved referral linkage, improved access to MCH care service, improved skilled-delivery services, understanding of danger signs of pregnancy and labour, improved access to contraceptive methods and acute severe malnutrition management service. This agrees with a study finding that illustrated factors that determine the MCH outcome satisfaction as availability of supplies, decision making power of woman, organisational factor, inter-personal factor, intra-personal factor, attitudinal factor, managerial, economic factors, environmental factors, burnout and contextual factors in maternal and child health nursing practices (Ayivi-Guedehoussou, 2017:42-56).

Additionally, the primary and secondary delay was addressed due to awareness of contraceptive use that indirectly improved satisfaction and community participation. Similarly, Buynder (2019:2819)revealed the importance of public health education, client and community participation in awareness creation, increasing health service coverage, vaccination of mothers during pregnancy for the benefits of their health and their children health outcomes in maternal and child health care practices (Deller, 2015:S30). Another satisfactory issue was the stakeholders' collaboration which is supported by another study finding that found out the voices of nurses as fundamental in understanding and working together to implement nurse-family partnership approach in rural communities (Campbell, 2019:12).

In addition to the above, improved health service coverage, awareness of breastfeeding and complementary feeding practices, support of traditional birth attendants, access to management of childhood illnesses, encouraging culture of social support, accompanying of labour companions and their contribution to cultural porridge

preparation for postnatal mothers were satisfactory conditions for a healthy mother and baby. There is a very strong evidence that the presence of companions of the woman's choice during labour and birth has a positive influence on women satisfaction and great benefits with the birth process and dissemination of infection prevention information and health education messages at the community level and in health facilities focusing on clean and safe birth practices which are essential to raise the hygiene awareness of women and their families that would enable women and their families to advocate for hand hygiene practices (Dawson, 2012:67).

Over and above, supportive religious teachings related breastfeeding and child-birth spacing as satisfactory aspects. However, the current study finding is at variance with another study finding that revealed the use of ethical guidelines, respectful service provision, confidentiality, systematic evaluation of client satisfaction, alliance of maternal action, adherence to standard guidelines, use of technology and considering context were described as satisfactory (Hackett, 2016:188-189).

6.2.6.2 Unsatisfactory Aspects in MCH Care Practices

The current study finding with regard to unsatisfactory factors or aspects in MCH care practices were inconsistent or shortage of resource, lack of access to mobile MCH care service, unavailability of drug, insufficiency of ambulance service, lack of readiness of requirement for instance glucometer, unethical approach of certain care givers, such as lack of respectful interaction, lack of considering cultural context, such as preference of female midwives, lack of greeting, poor complaint handling. For instance, what one of the participants painfully reported was:

"non-smiling face from male midwives mostly that of male midwives 'Fuulli ogeeysaa kan fuula ililli maawardi odoo tahuu qabuu, fuula qajjeebbuu tahee arkame'. Which means the face of professional that should be bright like rose flower to attract customer was found to be the face of scorpion.

There is similarity with the literatures reviewed based on contextual factors including socio-economic and cultural, geographical, healthcare cultural, religious and other factors affecting maternal and child health nursing practices including satisfaction (Singh *et al.*, 2016:10-11). Another unsatisfactory situation was lack of knowledge. For example, one of respondents specially reported that:

"unmet need to contraceptive use due to husband's fear of drug side effect as if it causes infertility 'wal quba hin qabduun, waliif dawaa hin qabdu''which means lack of insights may lead to loss.

The above-mentioned is in agreement with the Ethiopian health policy strategies and programmes which are basically preventive and supportive to take intervention to the community regarding maternal education through mass media was used to improve the women's awareness of maternal health, family planning, safe delivery, postpartum care, child care intervention patterning participation in health care delivery (Bang, 2018:228). Generally, among the twelve (12) rural health centres observed, only three were well fenced, had a guard house, main gate door, logos, pictorial direction indicators and an attractive environment.

These health centres were KHC2, FHC2 and GHC1, and were also constructed in the centre of the catchment areas and relevant to the standard of rural health facility of the country as observed on the map posted on the wall of the head office of the HCs (FMHACA Facility Standard, 2012). The researcher noted as unsatisfactory the aspects of poor handling of records, lack of HIMS office in the centre, lack of HIMS in the centre, lack of proper neonatal care facility, negligence of midwife, lack of enabling environment to use data for appropriate management, poor communication between mothers and nurses in the facility, lack of knowledge about causative factors for food contamination (while a mother was blowing into the cup to cool liquid diet for feeding baby).

The implication was both the mother and the nurse in the nutrition centres were ignorant of the health consequences of introducing the normal flora from one’s throat to drinkable or edible substance that could transmit pathogenic micro-organisms to the one who consumes it in the gastro-intestinal tract.

6.3 BARRIERS TO MCH CARE PRACTICES

According to the current study findings as originating from Annexure D, one of the barriers for MCH care practices was the lack of conducting area specific research. There is a link between this finding and the finding in another study that revealed lack of using research evidence to sustain in practices as challenges (Turkmani, 2013:1170). In connection with this, current public policy recommends participation of nurses and midwives in research initiatives in exploration of indigenous knowledge relevant to MCH nursing for evidence-based practices (FMOH, 2018). Lack of seriously taking the sexual and reproductive health issues of unwanted pregnancy that resulted in school dropout of the girl, psychological stress/depression, domestic violence and discrimination of the victim in the family were also observed.

Consequently, the following were further observed: poor management of demand and supply chain; mountainous environment, lack of roads; distance, shortage of resource, lack of access to information technology; lack of capacity building, lack of sufficient workers, professional turn over, lack of resource lack of conducive environment; lack of understanding language; lack of educational opportunity and poor access to transportation. This finding is also in agreement with a study that illustrated multi-factorial systems related challenges, such as poor health status of women, illiteracy lack of information, absence of well-trained cadre, inadequate referral system, poor linkages of health centres with community, health service coverage, socio-economic barriers, geographical barrier and limited capacity of health workers to give delivery services in maternal and child health (Jackson & Hailemariam, 2020:4).

Other observed factors were: referral of normal labour without consideration of financial burden for transportation, referral of illegible person that could be managed by available services, use of ambulance for personal interest while people were looking for public transportation for mothers in labour; poor handling of patient data, lack of follow up planning and feedback communication between care givers and postnatal mothers on discharge, and shortage of ambulance.

From the perspectives of midwives, the barriers to MCH care practices related to: insufficiency of budgets; bad behaviours of care givers; misperception of healthcare seekers; lack of incentives; lack of respect and motivation; lack of concern and humanity and poor communication; lack of proper complaint handling; population density in the catchment area; lack of training and security; lack of backup generator for power supplies, lack of sufficient laboratory facility, lack of sufficient skills (such as performing episiotomy before the head engagement was observed in one of the health centre); lack of interest to work in the rural health facility; poor use of guidelines; as well as ack of informed choice treatment and lack of responsiveness.

Cultural barriers observed included: preference of female midwife professionals, lack of greeting, language barriers, misbelief (as if intake of nutritious diet during pregnancy causes big baby size that endangers child birth), lack of using opportunities to interact with the community (poor engagement in marital ceremony and mourning ceremony) and lack of using practical guidelines; poor infrastructure to accommodate all customers; work overload; misbeliefs about contraceptive use, lack of breastfeeding knowledge, lack of client follow up after discharge and lack technology to reach mothers in time of need, and improper use of maternal and child health resources.

These findings are similar to the findings of a study conducted in rural Ethiopia (Betemariam, 2017:11); and, another study that illustrates challenges to the desired outcome of MCH (Uneke et al., 2016:125). In the rural health centres, the MCH care practice barriers were reported as lack of access to service due to lack of desire of care giver to serve. For instance, a mother who was in the first stage of labour was observed sent to hospital without referral documents. This demonstrates that lack of respect due to disgusting behaviour of health professionals and lack of commitment were barriers to MCH care.

One of the mothers reported:
I am a mother of labouring mother and I have been pushed out and insulted to be protected from entering to delivery room by a male midwife who was giving service unethically in this health centre. I reported my complaint to the head of the health centre and she has reassured me. But there was no corrective measure and it is difficult to revisit this centre in this manner.

The implication is that the bad behaviour and attitude of such a health care provider is not only unethical, but also, criminal. The result is once again in agreement with a study finding that explored the health system challenges in MCH care practices (Turkmani, 2013:1169). Furthermore, another mother reported:
“I was brought to the health centre with difficulties after midnight from lowland on the shoulder of the villagers on foot, which is about 10 km from the health centre. It takes 3 hours to climb up to the heels and mountains to reach to here on the other side of the mountain. The health centre was constructed at the boarder of the town on another age of the mountain. My husband was sent to purchase the prescribed drug from private drug shop in the Qullubbi town. As he was going to the centre of the town to buy medicine, he was attacked and robbed by thieves who have been intoxicated. He was seriously injured and found falling on the ground along the roadside. The policemen saw him and called an ambulance from Chalanko hospital and saved his life. So, the location of the health centre and peace and security issues were barriers to serve and save the life of the majorities in the catchment area”.

In this regard, the above statement indicates that barriers in the study area were primarily linked to access (geographical, distance and unavailability of resources such as medicine), risk environment (lack of security during the night), poor communication skills and improper use of resources (unnecessarily prescribing items to be purchased from private health centre), mistreatment and carelessness of care givers. The WHO recommendations revealed similar barriers and recommended networking and

communication (World Health Organisation, 2018c:72-79). Geographic barriers also included knowledge and skill, lack of using guidelines and the location of the health centre situated on the top of the mountain along the main road from Addis Ababa to Harar or Dire Dawa.

The majority of the patients who were supposed to be served by this health centre were in low-lying areas and on the other side of another mountain and far away to access the service provided in the health centre. This implies that the site on which the health centre was constructed did not consider the benefit to the beneficiaries and neglected the central catchment area. Another study result is in accord with this finding, and indicated that lack of conducive environment and neglecting the use of guidelines were the major barriers (Biza, 2019:9). Improper use of resources included formulated supplementary diet that was sold by the shop keepers in a private shop and was being taken with 40% glucose orally by care providers without any reason) in the rural health facility.

Despite shortage of ambulance for referral service, improper use of ambulance for personal benefits (e.g., collection of coins by the driver from non-patient passengers on his way to serve mothers in labour and use of ambulance as personal vehicle by district health officers) were observed in different study areas. Other observations included: misperception and myth-making about condoms as if the thing was presented to teach adolescents practicing prostitution, lack of proper documentation, poor referral report feedback communication, lack of retaining senior experienced staff in the rural health centre and poor coordination and networking in the rural community. Similarly, Kusena (2017:7) reveals that lack of using locally available and implementable resources as a challenge.

Therefore, the first and leading barrier to health services were due to lack of safety and security near the health centre, mountainous streets preventing easy access to health centres. Other barriers observed were lack of waiting area for labour companion; lack of ambulance, lack of residence in and/or near the health centre, flood during rainy season; mobility of the local community in pastoralist area, insufficient beds for postnatal mothers. One of the postnatal mothers reported:

There were only three beds in postnatal care unit. The available beds were occupied. Among five delivered mothers in this night, two of us have been discharged within two to three hours and we are going to look for our relatives in this area to stay up to morning because of darkness, lack of transport and distance to go back to our home.

In practice, the researcher observed the above while postnatal mother was being discharged in an hour to leave the bed for the next mothers who were in delivery beds. This situation is in accordance with another study report that shows that there is evidence of the results which are described as incompleteness of requirement and inadequate physical facility in maternal and child health care (Turkmani, 2013:1168; Baffour-Awuah et al., 2015: 62).

A mother painfully reported her feeling by shaking her head sideways and stated: lack of freedom to decide on treatment option due to judgemental character of professionals The care provider ordered the drug without telling me what has been diagnosed. The druggist was familiar to me and when I asked him what type of drug was prescribed, he told me as it is diclofenac injection. Then, I went back to prescriber and told him that I am sensitive to this drug and due to what happened to me before, even I have developed phobia against any injection form of other drugs. He torn out the prescription and ordered me to go out and treat myself. That is why I am crying. Hence, negative attitude and bad character of individual health professional and lack of freedom for treatment option are barriers for me. I am neighbouring this health centre. But, this phenomenon with silence of other people around and lack of support to defend for my health rights except my sister are making me hopeless not to come again.

The interpretation is that such a care giver is abusive and disgusting to the care seeker. Such bad behaviour or unethical approach of care providers was similarly underlined as a challenge in another study result (Uneke et al., 2016:125).

One of the cultural challenges identified in this study as reported by a mother was the religious and cultural norms of the community, let alone the private part of the body, even exposure of any other part of the body to an eye of a male person other than one's husband is not allowed. This finding is in agreement with a study that reveals trust on TBAs in delivery assisting preference due to their femininenes (Hill, 2019:7). Furthermore, another participating woman mentioned the following:

As far as I know, the health professionals' turnover and language barrier due to contextual meaning difference are what I personally experienced as barriers in the health centre. For example, I have been using family planning for the last three years. The current head of the health centre was serving me well as she knows the language taboos and culture in the local community context. Recently, after she was taken to the position of health centre administration, another male care provider whose mother tongue is the same with mine has been serving in the family planning unit. I told him what type of contraceptive I have been using and explained my problem by saying 'xuriitu anatti turee

jannan, akka diqachuun dirqama kiyya tahee fi akka kan isaa hin tahin na gorsee', when I informed the male midwife in the health centre about menstrual disorder I personally faced using avoidance of language taboo as saying I am dirty for more longer than a month, he advised me as self-cleaning and self-washing was my responsibility and not the responsibility of health care provider. I looked for the head of the health centre and informed her as the guy could not understand me. She told me as this cultural explanation of the thing is specific to the local context the language taboo to explain culturally sensitive issue is not understandable by the newly recruited person to the locality and gave me the solution.

The above-mentioned statement confirmed the barriers to maternal and child health nursing practices (DiMaria-Ghalili et al., 2014:7-8). Other barriers were work overload and shortage of medicine. For evidence, a nurse was observed attending to more than one MCH unit (FP and ANC) at a time and a dehydrated baby being referred to hospital due to lack of intravenous fluid in the rural health facility. The current finding is in line with the study that reported economic factors as resource related barriers (Goossens & Beeckman, 2018:7). Moreover, side effects of artificial contraceptive method caused misperception after a woman in the village used OCP during postnatal period of the first childbirth remained infertile for the past 20 years in the community. This resulted in low utilisation of contraceptive methods in the area.

Similarly, the fact that unnecessary referral of a mother who was in the first stage of labour from rural health centres to hospital without indication was observed as evidence of the mismatch evidence between principles and practices. What was specially mentioned in another study areas as barriers to MCH care practices were lack of safe and sufficient water, tribal conflict, lack of trained TBAs that move with seasonal mobility of pastoralists, lack of professional collaboration with religious leaders, political instability, negative attitude toward condom use that was perceived as an instrument that pushes adolescents toward prostitution and topography of the land.

The current finding is in agreement with another study that revealed the life style and environmental challenges of MCH (United Kingdom Report, 2018:99). The majority of women visiting the health centres in the current study were provided with emotional support, except one who was mentally disturbed due to domestic violence in the family. She needed sleep-inducing drug for correcting her sleeping pattern disturbance. Many staff members knew her as a client for many years, but she was being laughed at due to her speech inconsistency. In this regard, the researcher noted that ethical issues were not given equal attention by all staff in the health centre. Two similar patients arrived at

the health centre at the same time. One was treated and the other was sent to hospital for the same service. The staff member involved in this selective treatment mentioned the following about this particular patient: "*she has no respect for health professionals*".

The implication is partiality in provision of care. There was a gap in application of ethical principles in the provision of MCH care in the facility and lack of handling the domestic violence as a routine MCH care practice; as well as unequal responses to the need of clients in the health centre. For instance, impartiality was written and posted as a rule of health service provision, but painful partiality was observed while providing services to two different clients on the same diagnosis. Other barriers observed in the area were insufficiency of infrastructure, water and power supply, as well as medical instruments and supplies.

Other observations were: lack of a conducive environment and adequate facility, shortage of beds, incompleteness of new-born care facility including, warmer, oxygen supplier and weighing balance cover sheets, lack of guidelines on the tables and on the shelf throughout observation, lack of immediate cleaning, disinfecting and sterilising medical equipment in the daily preparation of medical equipment for reuse, shortage of post abortion care facility in the health centre, lack of giving attention to weather condition, seasonal variation and lifestyle of the community to fulfil the necessary requirement for action.

For example, cold conditions throughout the year, poor bedmaking in the majority of rural health facilities, poor infection prevention facilities in the health centres due to poor condition of the pipelines, scarcity of water supplies and shortage of protective personal equipment, destruction of resources due to tribal conflict and fear of rehabilitation in the area, insufficiency of resources, improper disposal of expired drugs stored in one of the rooms constructed for storage.

Regarding health service provision, the following were observed: lack of motivated staff, poor leadership in the management of resources in the facility (e.g., lack of a simple test of glucometer that could be made available at a very low cost for which a care seeker was observed being sent to long distance during ANC visit), inconsistency of access to care givers at the frontline for routine care, health professional enrolment to non-professional work that could be done by other development agents; for example, health insurance collection, lack security in the area due to robbers attacking client; husband ordered by a health care giver to purchase drugs from private dealers after mid-night, lack of mother-centred care in the facility, lack of knowledge and skill and lack of area

specific and lifestyle related service provision approach. For instance, lack of mobile health service for pastoral community were observed.

6.4 ENABLING FACTORS FOR MCH CARE PRACTICES

According to this study finding, enablers for MCH care practices are health insurance; free data services for mobile phones, supervision, use of indigenous knowledge such as supportive religious teachings, maternal and child health rights policy and commitment. This finding is consistent with another study that is situated in the informed, nurse-designed consensus model that enables formation of relationship (May et al., 2018:19).

From the perspective of health centre managers to the question of the enablers for MCH care practice the following were observed: expansion of rural health facility; health extension workers, volunteers, family members and community leaders; health education package; interest of rural community; collaboration of stake holders and community participation; and, social support in the community culture labour companions, maternal and child health rights; social institution; Sustainable Development Goal 3 and partnership and use of available opportunities. The result of the current study is related to another study result that illustrates collaborative practices as enablers (Turkmani, 2013:1168).

With regard to midwives' report, enablers for MCH care practices were: individual factors, for example: health seeking behaviour, social support, supportive religious beliefs, community participation and family support, health policy, security and availability of resources including human, physical (infrastructural), supportive religious teachings and access to MCH service, efforts of volunteer health promoters, family members, trained traditional birth attendants, health extension workers, clan leaders and community leaders; community participation, stakeholder collaboration, capacity building, respectful service provision, motivational factor such as incentives, attractive facility environment, health information communication, community awareness building and interaction with clients.

This finding is in agreement with the WHO's broad themes such as structure and process (World Health Organisation, 2018:24); and, the quality of care considered punctuality, cleanliness and informal payments (Saxena, 2018:13). In addition, individual positive behaviour, positive attitude, health education, counselling, responsiveness, training, capacity building, building ownership, availability, affordability, acceptability, good governance and harmonious interaction were also observed. This result is related with one of the reports of FMOH (FMOH, 2004:16-19).

Other enabling factors explored by this study were existence of health centres, health posts, support of family members, efforts of community health workers and collaboration of community members, good behaviour, availability and quality of care and availability nutrition, facility readiness, power of women to decide, good communication skills, health policy, use of technology, support of traditional care providers, concern of local leaders. This finding is also related with another study finding that demonstrated a positive influence on women's satisfaction (Dawson, 2012:67).

Other observations included: mobile health service task force, roads, ambulance service, access to emergency call, responsiveness, community dialogue, attractive environment, supportive religious teaching and building sense of ownership in women were enablers for MCH care practices. This finding is in line with the philosophy of the midwife that aligns with health right of each woman and her child to provide the highest attainable standard as a fundamental human right and collective responsibility in the context of community (Marsh, 2015:68). The findings related to enablers of MCH care practices were health policy, leadership, availability of guidelines, interest care seekers, commitment of care givers, free of charge services, efforts of TBAs, social support and community participation.

This study also identified use of social, religious institutions and cultural associations such as schools, Masjids and '*afoosha'* as opportunity. This finding is also among the listed enabling factors for maternal and child health in rural facilities as reported by WHO (2015:24). The study also reported enabling factors as maternal health rights, child health rights, good manners, indigenous blessing (*tan biliga ananii, tan qoma furri*) in local language which means 'May Allah make a lady fertile and fruitful' that imply praying for the Will of God to teach importance of fertility and breastfeeding in the culture of the community. This result is in agreement with a study that reveals enabling process, involving parents and grand-parents in responsibility for their mothers' and children's health services (Barnes, 2003:5).

Other enabling factors identified were: health extension packages, indigenous teaching (*ulfaa fi hoosiftuu hin aarsan ykn hin mufachiisan akkasumatti qulqullinaas ni eegan*) which means sanitation and hygiene prevents evil attack as the community believes in indigenous teachings such as '*qulqullini ulmaa, ibliis fageeysa'* (the assumption is infection prevention), communication skill, understanding of cultural context and support of TBAs. This result is again affirmed by another study that mentioned partnership, community-based health task forces, spiritual psychological support, nutritional advice, good relationship with a partner and harmonious interaction, transportation facility, peace

and security, food scarcity, responsiveness of service, community dialogue, technology and education (Marsh, 2015:68)..

In this regard, the current study finding is also in line with the study finding that revealed that resources, technologies, effective coverage and integration were recommended as enabling tools for maternal and child health (Grove *et al.*, 2015:4). The current study finding revealed enabling factors as peace building, conflict management, clan leaders contribution, and support of religious leaders, training, access, woman empowerment and mobile health services which is in agreement with another study insights that showed the use of all implementable opportunities of the best frame work that effectively assist in the explanation of the success or failure of specific project implementation that lies in the theory of informed, nurse-designed consensus model, which enhanced ownership, participation and potential sustainability of the intervention and sharing experiences and enable formation of relationship (May et al., 2018:19).

Moreover, this study identified collaboration of stakeholders, community participation, engagement in social affairs, cultural assembly and religious institution as enabling factors. This finding is directly linked to what the realisation of maternal and child health policy implementation reveals as opportunities to impact the health of the community (Franklin, 2016:32-33). Moreover, enabling factors mentioned in this study were access factors such as roads, ambulance, health information and services which similar with policy that recommends access to maternal and child health care, quality of care and stretching networks between facility and community level (PCMCH, 2018:35). Good behaviour and best communication skill were also observed as a best practice in the interaction between care giver and customer.

6.5 INNOVATIVE IDEAS TO IMPROVE THE MCH CARE PRACTICES

The result of the current study explored innovative ideas as women empowerment by continuous health education and training, income generation, behavioural change communication using community-based available technology, improving allocation of budget, building alliance with stakeholders, strengthening staff development, constructing roads, increasing transportation facilities, comprehensive coverage, providing continuous support for women and development of relevant guideline for all individuals. This is in agreement with investing in innovative community-based healthcare services (Acharya *et al.*, 2017:6).

From the perspective of health centre managers, the key findings related to innovative ideas were continuous training, health educating, counselling and ethical approach, appropriate technology, use of guidelines, proper use of resources, interconnection and harmonious interaction with community members and clients in rural area, improving access to information and extending audio-visual training facilities, use of missed opportunity, income generation and proper use of resources, task sharing, considering local context and friendly service provision in collaboration with partners and stakeholders.

This study finding is in accordance with innovative approaches to implementing maternal, neonatal, and child health and nutrition interventions in changing behaviours and empowering women and their communities (Perry, 2015:367-368). From the perspective of midwives working in rural health centres, explored innovative ideas were providing woman centred approach, social support, use of supportive religious teachings, encouraging community participation and family support, peace building, attractive facility environment securing privacy and harmonious interaction with clients. This result is similar to the study finding that shows appropriate ways to engage with the partner to reduce discomfort and maintaining privacy and confidentiality for women (Martínez-Serrano, 2018:131-132).

In addition, individual positive behaviour, positive attitude, sharing knowledge and experiences, organising community members, conducting area-specific research, strengthening coordination and communication shared-decision making and sharing responsibilities among responsible bodies in MCH care practices. This finding is related to the need-based design of relevant innovative interventions to improve maternal and child health intervention in rural Ethiopia in the SDGs era (Zerfu *et al.*, 2019:5).

The rural women's critical opinions or suggestions to improve MCH care practices included: construction of physical facility and upgrading of service quality, developing and assigning gender specific midwives (feminine), reconstruction of the health centre in the centre of community catchment area, upgrading of HP to HC level and awareness building on MCH rights, upgrading of HEWs to midwives' level, mobilisation of resource, use of appropriate technology and adoption of best practices. This study finding is in agreement with the CDC's global health MCH strategy goals and objectives that seek to take advantage of identifying and applying new intervention within old intervention in innovative way in the context of local situations.

From the community members perspective, innovative ideas suggested were scaling up of health professionals, upgrading HEWs to midwives' level, strengthening relationship between health professionals and community members, enhancing information communication and task sharing among stakeholders. The current finding is in accordance with what World Health Organisation recommended about different interventions that have an impact on health and that have consequences for the use of resources (WHO, 2016:9).

In the same way, mutual respect in practices, use of supportive indigenous knowledge of the rural community, avoidance of harmful traditional practice avoidance, using missed-opportunity, compensation payment for TBAs as an alternative income for the lost benefits, application of ethical principles and use of guidelines. The current finding is directly related with Ethiopian HEP that efficiently and effectively addressed the MCH problems with high impact including prevention from mother-to-child transmission (Zerfu *et al.*, 2019:5). Other observations were: securing power supply in the facility, enhancing access to communication technology, working on peace building and conflict management and construction of waiting area for companions in the health centre.

The current finding is supported by another study finding that shows the use of creative and innovative approaches that would contribute to better health outcomes for most vulnerable women, new born and children (Kuruvilla, 2014:536). Other innovative ideas were impacting woman self-efficiency, involving of husband in all woman affairs, stopping, violence against woman, special consideration for upgrading of HEWs and TBAs, rethinking of mobile MCH care practices. This finding shows woman empowerment and self-efficiency to put knowledge into operation, which is in accordance with empowerment of learners in education (Barbour & Schuessler, 2019:4). Another innovative idea explored by this study was integrating research with MCH care practices and development of guiding principles for both formal and informal MCH care practices.

This finding is also in agreement with another study that reflects evidence of self-appraisal and the value of research evidence for practice (Victoria Association of MCH Nurses, 2015:12-14). Similarly, strengthening social networking, performance-based motivation, improving demand and supply management, improving responsiveness, applying proper communication skill and addressing delays in the community by the community and feedback communication were observed factors in the current study. The feedback at each and every step of practice was the major innovative idea in this finding and in agreement with another study finding which indicates that the feedback provides

valuable evidence against a set standard and then enable identifying the knowledge and practice gaps (Lengetti, 2018:162-163).

6.6 CONCLUSION

This chapter presents a discussion of maternal and child health nursing practices in rural health centres of Ethiopia. The findings included: contemporary situations of MCH care practices in rural health centres that involved the rationale for MCH care practices; purpose of MCH care practices, components of MCH care services, task performance activities in MCH care practices, nature of Interactions in MCH care practices and satisfactory and/or unsatisfactory situations in MCH care practices.

The data also reveals those barriers to MCH care practices, enablers of MCH care practices and innovative ideas for improving MCH care practices. The identified experiences of participants in MCH care practices show both formal and informal MCH care practices and cultural and traditional beliefs affecting maternal and child health care practices. Furthermore, the findings of the observational aspect of the study show that the phenomena of maternal and child health service provisions have either positive or negative influences on the care practices in the locality. The next chapter reveals the discussion, conclusion and recommendation parts of the study.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

7.1 INTRODUCTION

The previous chapter presented a detailed discussion in respect of the core thematic aspects of the research findings. The current chapter concludes the entire study, and emphasises on the extent to which the findings meaningfully contributed to the very reasons for which the study was undertaken (Carminati, 2018:2096; Creswell, 2014:17). In this regard, the main conclusions reached in this chapter have relied on both the research findings, as well as the research aim and objectives. Following a synopsis of the conclusions, the recommendations are then outlined as drawn from the findings themselves, after which the contributions and limitation of the are highlighted as well.

7.2 MAIN CONCLUSIONS

The study initially sought to explore, describe and analyse the existing MCH care practices, challenges/barriers, and opportunities/enablers in selected Ethiopian health facilities and recommend suggestions to inform stakeholders in respect of better MCH outcomes. Based on this broad aim, the corresponding main research question was:
Do maternal and child health nursing practices improve the health outcomes of mothers and children in rural health centres?

Based on both the research aim and its corresponding main research question, the specific objectives were then articulated thus:
Research Objective 1: To understand existing realities of MCH nursing practices in selected rural health centres in Ethiopia;
Research Objective 2: To examine the barriers affecting MCH nursing practices;
Research Objective 3: To identify enablers/ opportunities to improve MCH nursing practices;
Research Objective 4: To explore innovative ideas for improving rural MCH nursing practices.

Based on the above-stated specific objectives, the corresponding research questions were then articulated thus:
Research Question 1: What is the existing nature of MCH nursing practices in Ethiopian rural health centres?
Research Question 2: What are the barriers affecting MCH nursing practices in the rural health centres?
Research Question 3: What enablers/opportunities are there to improve MCH nursing practices?

Research Question 4: Which innovative ideas could be explored and implemented to improve and sustain MCH nursing practices?

In the view of the researcher, both Research Objective 1 and its attendant Research Question1 were adequately achieved, as demonstrated in Sub-sections 7.2.1 to 7.2.4. Research Objective 2 and its attendant Research Question 2 were also adequately achieved, as demonstrated in Sub-section 7.2.7. Similarly, both Research Objective 3 and its attendant Research Question3 were sufficiently addressed, the proof of which is shown in Sub-section 7.2.8. On the other hand, Research Objective 4 and its Research Question 4 were also sufficiently addressed, the evidence of which is shown in Sub-section 7.2.9.

7.2.1 Reasons for MCH Care Practices

In this regard, the reasons for MCH care practices were the value of healthy mother in the community, the need for addressing the health needs of high proportion of the target group (women and under-five children), MCH rights, religious and cultural concern, existence of MCH problems, the need for maternal and child mortality reduction, priority issues of the country and the world at large, the need for social support and generation well-being, public health importance of preventable causes of death, the opportunity for marginalised rural community, socio-economic importance of MCH and continuity of child bearing and child rearing processes in a society.

Similarly, other major reasons were national and international health policy, public health importance, supportive religious teaching, value of mothers, the need for socio-economic development, SDG-3, the need for healthy generation, maternal and child health rights and importance of shaping citizen. Over and above, public health importance of MCH care services and deaths due to preventable causes were the major reasons for why MCH was an issue.

7.2.2 Purpose of MCH Care Practices

The purposes of the MCH care practices revealed in this study is to increase awareness of mothers on self-care and care of under-five children, to enhance service coverage and increase quality of MCH care. Similarly, the enhancement of facility-based child birthing, immunisation coverage as well as the improvement of the use of contraception, increase community participation, address MCH needs, achieve SDG-3 and encourage collaboration of stakeholders to address pregnancy related complications. Furthermore, the empowerment of women, increase ANC follow up, initiation of screening woman from

premarital age and stage to improve health seeking behaviour and encourage social support are vital to MCH practices.

7.2.3 Components of Rural MCH Care Practices

Components of MCH care practices in this study were described as different services as health education, Family Planning, ANC, delivery service, mother and child care, care of new-born and care of under-five children, maternal and child screening services, PMTCT, Vit A prevention and management of STDs; maternal and child immunisation, FP service, ANC, PMTCT, prevention of HIV and STDs, child delivery care, PNC, care of new born, care of under-five children, prevention and treatment of childhood illness, prevention and management of TB, counselling on child protection, breastfeeding, child washing, child feeding, child immunisation, provision of mosquito nets for prevention of malaria, health promotion, growth monitoring, nutritional advices, deworming, prevention of MCH complication, screening, training on breastfeeding and complimentary feeding practices, youth friendly services and referral services.

7.2.4 Task Performance Activities in MCH Care Practices

Tasks performed by agents of MCH care were regular communication, monitoring and evaluation, management of supply and demand, supervision and sharing of knowledge and experience to subordinates. Furthermore, MCH agents promoted MCH rights as well as teaching and behavioural change communication, assigning duties, providing training and services, encouraging breastfeeding practice, encouraging participation and mobilising community and resources, using guidelines and resources, collaborating with others, networking, coordinating, by delegating managerial responsibility, assisting childbirth and promoting use of contraception.

In general, health professionals' and non-health professionals' task performance activities were carried out without using guidelines but through sharing information in the context of the rural community as observed in reality. This finding is opposite to a study result that revealed importance of use of standard guidelines (Mulenga et al., 2018:10); and another study also mentioned the importance of sharing up-to-date information and experiences to fill the gap of MCH nursing practices (PCMCH, 2018:31-33).

7.2.5 Nature of Interaction Among Actors

The interactions among task force members and customers as well as other stakeholders were being carried out by communication using oral and written conversation. Furthermore, interaction through regular discussions with staff, stretching networks and coordinating services, linking sectors and feedback communication by using information

technology; awareness creation and behavioural change communication through health education, training, regular meeting and feedback communication.

7.2.6 Satisfactory and Unsatisfactory Aspects in MCH Care Practices

The nature of satisfaction in rural MCH care practices revealed moderate satisfaction with minimal dissatisfaction as the lists of satisfactory aspects compared with the unsatisfactory variants described in this study.

7.2.6.1 Satisfactory aspects in MCH care practices

Access to free of charge service, enhanced community participation, improved timely health seeking behaviour of women, improved monitoring and evaluation, improved referral linkage, improved access to MCH care service, improved skilled-delivery services, understanding of danger signs of pregnancy and labour, improved access to contraceptive methods and acute severe malnutrition management service (Degu & Wolpe, 200614). This agrees with a study finding that illustrated factors that determine the MCH outcome satisfaction as availability of supplies, decision making power of woman, organisational factor, inter-personal factor, intra-personal factor, attitudinal factor, managerial, economic factors, environmental factors, burnout and contextual factors supportive religious teaching related breastfeeding and child-birth spacing were also mentioned as satisfactory aspects or factors.

7.2.6.2 Unsatisfactory factors or aspects in MCH care practices

With regard to unsatisfactory factors or aspects in MCH care practices were inconsistent or shortage of resource, lack of access to mobile MCH care service, unavailability of drug, insufficiency of ambulance service, lack of readiness of requirement for instance glucometer, unethical approach of certain care givers, such as lack of respectful interaction, lack of considering cultural context, such as preference of female midwives, lack of greeting, poor complaint handling.

7.2.7 Barriers in MCH Care Practices

The major barriers were majorly access factors, resource related factors, environmental factors, geographic barrier, attitudinal barrier, service-related barriers such as poor access to technology, availability issues, bad behaviour of professionals, lack of using guidelines, tribal conflicts, poor capacity building and lack of scaling up of facilities and HEWs in the communities.

7.2.8 Enabling Factors in MCH Care Practices

The major enabling factors were peace and security, capacity building, motivating, health policy, accessibility of MCH care services, availability of resources and use of available

opportunities, capacity building, peace and security, commitment of mothers and care givers and accessibility of services. Generally, what constituted barriers to MCH care practices were the opposite issues of enabling factors. In contrast, the enabling factors for MCH care practices were found to be the opposite of barrier factors in this study finding.

7.2.9 Innovative Ideas for Improving MCH Care Practices

Explored innovative ideas suggested by participants of the study were based on the existing realities and the likely outcomes of MCH care practices in rural health centres were concluded as follows. These are developments of relevant guidelines, adoption of the best practices, evidence-based practices, proper communication skills, proper policy translation, provision of culturally congruent services, continuous empowerment, use of indigenous resources, awareness building, income generation, community participation, collaboration with stakeholders, enhancing partnership, creating conducive environment, strengthening responsiveness, fulfilling minimum standard requirement, scaling up of services and upgrading of HEWs to Midwifery nurse level, performance-based motivation, feedback communication, proper complaint handling, proper monitoring and evaluation, timely referral services, establishing mobile MCH service wing and proper documentation.

The result implies importance of cost effectiveness of MCH preventive services and sustainability of maternal and child health well-being which is important for economic development of the country. Therefore, when the healthy baby is born to a healthy mother, implications are that the health of mother (physically, mentally, socially, emotionally, sexually, spiritually and intellectually) was determinant for childbearing. However, another study found out that prevention of maternity related problems and sustaining proper care of mothers throughout preconception, gestational ages and stages, child delivery and postpartum period were for the better health outcomes of mothers and children (Wilson, 2018: 532).

7.3 RECOMMENDATIONS

Based on the discussion and conclusions of this study, the following important points are recommended for sustainable improvement of MCH care practices and better health outcomes in the rural community. To make optimally effective MCH care intervention, there needs to consideration for the results, discussion and conclusion of this study and recommend what should be done by each responsible body at individual level, family level, community level, health sector level and government level. In this regard, the study would particularly recommend the following (Fuemmeler, 2016:19):

7.3.1 Recommendation for the Government of Ethiopia

All local, regional and national administrators of the country are responsible for carrying out the recommended points of this study. To strengthen Ethiopia's maternal and child healthcare services provision in compliance with its rights and obligations, the government should take the followings into considerations:

a) To provide free services to all maternal and under-five children;
b) To improve the constitution of FDRE by including mother and childcare;
c) Allocating sufficient budget to make all rural Ethiopians have access to public health and education;
d) Provision of food, clean water, housing and social security to scale up and sustainably; and
e) Implementation and provision of maternal and child health service packages

The government should encourage cooperation with different ministries for mainstreaming MCH care practices among the Ministry of Health, Ministry of Agriculture, Ministry of Education, Ministry of Women and Children Affairs, Ministry of Labour and Social Affairs, Ministry of Peace and security, Ministry of Transportation, Ministry of Justice and Ministry of External Affairs in an efficient manner. The government need to increase awareness about patients' rights, particularly the MCH rights, RH rights, the right to informed consent, amongst potential patients and healthcare workers by ensuring this information is visible in all health facilities by all relevant languages as a part of the pre-test counselling process in the Guidelines for Maternal and Child Health Care Practices in Ethiopia.

In this regard, the government should ensure that women's and girls' access to safe, effective, affordable and acceptable methods of family planning and full range of contraceptive services. The government should adopt all necessary measures to prevent, combat and punish violence against women, FGM and harmful traditional practices applied on under-five children by undertaking area-specific research and establish awareness raising campaigns on human rights violation issues.

7.3.2 Recommendation for the Ministry of Health

Policy makers are recommended to consider research findings and implement shared decision making on planning MCH care practices (Solomon, 2015:2). Development of relevant guidelines for MCH care practices should be implemented. Allocation of sufficient budget and follow up of proper health care service provision and utilisation. MOH should facilitate conducive environment and provide incentives for health workers in rural health facilities. Adequate and proper roads and infrastructures. Furthermore,

Ministry of Health should also ensure that all service-users, especially women and children are treated properly with full respect and dignity by properly applying ethical principles in provision of health services.

It is imperative to develop indicators and benchmarks for monitoring activity performance and measuring progress towards ensuring all women and children have sustainable access to early and consistent maternal and health care services under consideration of MCH rights. Development of proper MCH care practical guideline based on area specific research evidence and provide on-going training for customers and care givers on the human rights and special needs of rural communities, such as gender specific preference in MCH care services provided by midwives and nurses. FMOH should develop fund raising mechanisms including health insurance and educate the population about the importance of early and continuous maternal and child healthcare services and the associated health benefits.

FMOH should raise awareness and capacity of healthcare workers by providing on-going professional training and educational opportunity on MCH care practices to successful implementation of health policy (Solomon, 2015:16). MCH care should be adopted as well as intervention of best practices such as application of normalisation process theory of health service intervention that helps as a practical guideline and check-lists for each MCH continuum of care to full respect of MCH rights, privacy and confidentiality. Barriers to accessing health facilities for women and children should be addressed by increasing the number of obstetric ambulances and vehicles for outreach programmes conducting of maternal and child health check-ups.

National standards on staffing patterns, norms, standards and training requirements for all cadres of rural health care providers should be established and applied. Enhance partnership with stakeholders to improve safe and affordable access to maternal health services for pregnant women and children. Recommendation with regard to Ministry of Women, Youth and Children Affairs. The Ministry should urgently develop protocol of women's army and model family to address the information and knowledge gap of maternal and child health services at grass-root level and create job opportunity to enable accessing income generating activities for women empowerment.

7.3.3 Recommendation for the Ministry of Transport

Lack of safe, reliable, affordable, convenient and adequate transport should be addressed urgently by the Ministry of Transport, particularly for marginalized

communities at national, provincial and local levels by providing free transport services for pregnant women and under-five children to be able to access MCH care services.

7.3.4 Recommendation for the Ministry of Education

The Ministry should ensure that all young people, both in school and out of school, could access age-based appropriate reproductive and sexual health education. Health education should include information on unwanted pregnancy, family planning and use of contraceptives and prevention and treatment of sexually transmitted infections. Research is recommended to be conducted on improving educational quality of health and medical colleges are recommended.

7.3.5 Recommendations for the Ministry of Labour and Social Affairs

The Ministry should consider extending the system of maternal and child support in the period of pregnancy, to enable pregnant women to cope up with the increased financial needs and pressure of pregnancy. The Ministry should also seek to investigate the impact of barriers to maternal and child health services related to social affairs in rural or disadvantaged communities in Ethiopia and plan for addressing problem in collaboration with MOH.

7.3.6 Recommendations for the Ministry of Agriculture

Women empowerment should be prioritised by providing easily harvestable and highly nutritious seeds and breeds and facilitate platform for availing locally produced complementary diet for mothers and under-five children in collaboration with MOH.

7.3.7 Recommendations for Peace and Security

The Ministry should work on peace building and management of conflict at all levels of the community by involving all stakeholders and sharing responsibility through shared-decision making.

7.3.8 Recommendations for the Ministry of Justice

The Ministry should work on implementation of MCH Rights and protection of violence against women and child abuse.

7.3.9 Recommendations for the Regional Health Offices

The regional health office should adopt the national and international MCH policy and adjust to the regional and local context using different languages and encourage policy translation by strict follow up and support. Designing proper follow up mechanisms at all levels of MCH care services. Proper leadership and Management training and capacity building. Enhancing global partnership with different organisations. Formulation of code

of conduct for controlling application of ethical principles. Proper strategic planning for scale-up of services are recommended.

7.3.10 Recommendations for the Zonal Health Offices

The zonal health office should provide up-to-date guidelines and training on MCH care provision and communicate directly with district MCH officers and rural health facility leaders about health service situations regularly.

7.3.11 Recommendations for the District Health Offices

The district MCH officers should decentralise financial resources and regularly scale up of MCH services to the standard by fulfilling requirement and paying attention to empowering women, community-based task forces and care givers through training, motivational rewarding and incentives.

7.3.12 Recommendations for the Health Sector

Strengthening teamwork with community-based task forces and organising committees for each and every continuum of MCH care and staying in touch at all times for responding to the need of the community. Proper policy translation and proper use of guidelines for providing services through applying ethical principles in the practices. Health staff should empower individuals, family members and community members through continuous communication, training, capacity building, encouraging participation and building harmonious relation and interaction. Provision of family health folders with improved guidelines and making use of them by strict supervision for improving and sustaining MCH care practices in the rural community should be additional responsibilities of health workers.

On the job training for all professionals working in each continuum of care based on practical and procedural issues should be made available. Enhancing access by formulating alternative means and mechanisms (improving MCH practical guidelines and making use of it) for addressing the gap in each continuum of MCH care including preconception care (adolescents RH services and pre-marital screening services,) prenatal care (ANC visits), perinatal care (addressing all three delays), PNC, new-born care and care of under-five children in the rural community. Bridging the gap between of MCH care practices by fulfilling basic requirement and standardising or upgrading the services regularly.

Protection of MCH rights should be confirmed by saving mothers and under-five children from all the preventable causes of death. Awareness building and understanding of health problems and solutions associated with mothers and under-five children in the

locality should be considered. Creating peace building mechanisms for harmony among individuals and groups in the society should be undertaken. Ensuring individuals and tribal conflict management practices are recommended by collaborating with community members and local administrators. Creating trust in the community and building ownership among all stakeholders in the area is recommended, as well as enabling women and their husbands to pave the way for mutual support in MCH care practices.

Special attention should be given to health promotion and disease prevention in any primary care services by strengthening community participations. In this regard, due consideration should be given to: feedback collection mechanisms; proper structuring and coordination, networking and communication; adequate demand and supply management; developing proper MCH practical guidelines for all task-force members; conducting area-specific research and providing evidence-based MCH care practices; and adopting best-fitting frameworks by shaping with local context and using as a checklist for MCH care practices. Also recommended is the use of all available self-engagement opportunities in socio-cultural, economic and religious affairs related to MCH issues in the local community; as well as empowering both formal and informal MCH care practices in the area. Moreover, the researcher recommends the use of checklists that should be adapted from normalisation theory of practices and adjusted to the local context through continuous sharing of knowledge and best practices.

7.3.13 Recommendation for the Community

The community members are important for improving and sustaining MCH care practices in rural area. It is important that the concern of the community members for MCH care practices should be considered in their day-to-day activities as long as continuity of childbearing and child rearing is there. The community members should have area-specific and improved guidelines to be guided by for improving and sustaining MCH care practices in the rural community. There must be social structures and networks for regular communication and dialogue with other stakeholders in the area.

7.3.14 Recommendation for the Family

Family members have a great responsibility to support mothers and giving care to under-five children at home, and encouraging women to seek proper promotive preventive and curative care at the proper time. They should have a family health record and guidelines for carrying out their responsibilities. All family members should have means of communication for timely informing emergency cases and receiving information for up-to-date MCH knowledge and practices from knowledgeable people in the area.

7.3.15 Recommendations for the Individual

Each and every individual must have insight regarding what he/she is expected to do based on the MCH care practices, including preventable causes of maternal and child diseases and deaths as well as means and mechanisms of prevention. They should be well-informed and must have detailed job descriptions of individuals and group rights, roles and responsibilities relevant to rural MCH care practices. Individuals should have means of health information communication for timely informing emergency cases and up-to-date MCH information from knowledgeable people in the area. The responsible bodies for implementation of these recommendations are the mothers, who should be able to provide self-care for their children, as well as proper utilisation of available services.

7.4 CONTRIBUTIONS OF THE STUDY

The current findings have important contributions for MCH policy in Ethiopia. The study result reveals that the existing maternal and child health services in the rural health facilities are by far lower than the national standard. The findings have further contributed to the corpus of knowledge regarding the unfinished agendas of prioritisation of MCH care practices in the context of gaps in MCH care practices, particularly in the areas of application of ethical principles; communication skills among care providers and care recipients; enhancing coverage and improving access; upgrading of health facilities; addressing underlying socio-cultural determinants such as preference of feminine midwife, upgrading of health posts to health centre level; as well as upgrading of health extension workers to midwife level.

The purpose of MCH care practices identified by this study is consistent with the national and international Sustainable Development Goal 3 strategy. With regard to the components of MCH care practices, the most neglected preconception care is another priority problem identified by this study. Lack of preconception and premarital care contributes to the occurrence of unwanted pregnancy that can cause serious health and social consequences.

Consistent with its fourth research objective (Research Objective Four), the study has explored innovative ideas for improving MCH care practices in ways that are relevant to the local communities' contextual factors (see Sub-section 7.2.9). Generally, these ideas may not be wholly novel, but they contribute towards prospects for fundamental social, institutional and emotional support benefits for pregnant women under-five children and unseen difficulties that women experience during pregnancy, childbirth and breastfeeding period.

7.5 LIMITATIONS OF STUDY

Despite the fact that the necessary endeavours were made to minimize or avoid the possible shortcomings of this study, the following unavoidable limitations were limitations of this qualitative study. The qualitative study was time consuming, financially demanding and exhaustiveness), transportation problem during rainy season to reach the study area as needed. In addition, the data collection was carried out by redundant visits of research sites. But what challenging was the overlapping of some of data collection times with the lockdown due global outbreaks of COVID-19.

This study utilized data source triangulation study design which made the findings possible to establish causal relationship between the existing observed realities and the information gained from different sources with the likely health outcomes. The possibility of getting the right key informant at a time was another challenge in a particular study area due tribal conflict in the study site. The participants in FGDs in certain areas were found to be voluntary for participation only during night time as they were occupied by their daily life activities during the day time. There was no platform for facility-based maternal and child health nursing practice observation. Certain health workers in a few health centres were not comfortable to allow the data collector for observing each and every nursing procedure carried out in MCH setups. All these factors contributed to the limitation of the study.

For optimisation of its data and method triangulation, the study could have applied a quantitative aspect to ‘compensate’ for the shortcomings imposed by the need to physically visit the research sites (Dantzker & Hunter, 2012:27). However, this could not compromise the ultimate study results due to the various stakeholder involvement. Moreover, the massive observational findings (see Annexure D) testify to the amount of data that saturated this aspect of data collection.

Over and above, the limitation could not hinder the researcher from reaching the goal and coming up with the necessary research findings to suggest and contribute to better improvement of MCH care practices in the future.

7.6 CONCLUSION

In conclusion, patriarchy still influences all aspects of social life and relationships, particularly in many aspects of maternal and child health services by the women in rural Ethiopia. There are various socio-cultural underpinnings of the maternal and child mortality in East Hararghe, Oromia, Ethiopia. In general, important points explored by this study were linked to aspects of the existing MCH care practices that include the

rationale for MCH care practices, purpose, components, interactions, activity performance, nature of satisfaction, barriers, enabling factors and innovative ideas for improving MCH care practices are generated by the study.

In conjunction with the study's findings, the researcher's proposed recommendations are intended to address all pertinent institutional and systemic MCH aspects, particularly in rural Ethiopian contexts. The researcher reiterates that the real-life or grassroots contexts (e.g., socio-cultural, ethnic and religious backgrounds) of Ethiopia ought to be accorded the value which the indigenous communities attach. Therefore, the top-down 'one size fits all' approaches to maternal and child health care practices could become a catalyst for adversity, rather than a panacea or source of hope for rural populaces.

REFERENCES

Abayneh, S., Lempp, H. & Hanlon, C. 2020. Participatory action research to pilot a model of mental health service user involvement in an Ethiopian rural primary healthcare setting: Study protocol, *Research Involvement and Engagement*, 6(1): 1-14. https://doi.org/10.1186/s40900-019-0175-x

Abebe Alebachew, 2020. Improving health system efficiency in ethiopia Human resources for health reforms.

Abrandt-dahlgren, M. 2017. Health care providers and quality improvement co-producing interprofessional round work. *Qual Manag Health Care*. 26(2): 70–82. https://doi.org/10.1097/QMH.0000000000000133

Acharya, B., Maru, D., Schwarz, R., Citrin, D., Tenpa, J., Hirachan, S., Basnet, M., Thapa, P., Swar, S., Halliday, S., Kohrt, B., Luitel, N.P & Ekstrand, M. 2017 Partnerships in mental healthcare service delivery in low-resource settings: Developing an innovative network in rural Nepal. *Globalization and Health*, 13(2) https://doi.org/10.1186/s12992-016-0226-0

Adatara, P., Afaya, A., Baku, E.A., Salia, S.M. & Asempah, A. 2018. Perspective of traditional birth attendants on their experiences and roles in maternal health care in rural areas of Northern Ghana. *International Journal of Reproductive Medicine*, *2018*(2165627): 10. https://doi.org/10.1155/2018/2165627

Addisse, M. 2003 Maternal and child health care: in collaboration with the Ethiopia public health training initiative. Ethiopia: The Carter Center,

Aderemi, R. 2016. ethical issues in maternal and child health nursing: Challenges faced by maternal and child health nurses and strategies for decision making. *International Journal of Medicine and Biomedical Research*. (5): 67-76. https://doi.org/10.14194/ijmbr.5.2.3

Adinew, Y.M. 2017 Childhood mortality: Trends and determinants in Ethiopia from 1990 to 2015 — A Systematic Review. London: Chandler

Adom, D. & Hussein, E.M. 2018 Theoretical and conceptual framework: Mandatory ingredients theoretical and conceptual framework. Mandatory ingredients engineering *International Journal of Scientific Research, 7:* 93–98.

African Union, 2014. *Status report on maternal new-born and child health*. Available from https://au.int/sites/default/files/newsevents/workingdocuments/28074-wd-2014_status_report_on_mnch_-_english_1.pdf

Agreli H., Barry F., Burton A., Creedon S., Drennan J., Gould D., May C., Smiddy MP., Murphy M., Siobhan M., Savage S., Wills T. & Hegarty J., 2019. Ethnographic study using normalisation process theory to understand the implementation process of

infection prevention and control guidelines in Ireland, *BMJ Open, 9*(8): 1–8. https://doi.org/10.1136/bmjopen-2019-029514 .

Agyepong, I.A. 2017. The Lancet Commissions the path to longer and healthier lives for all Africans by 2030: The Lancet Commission on the future of health in Sub-Saharan Africa. *The Lancet, 6736*(17). https://doi.org/10.1016/S0140-6736(17)31509-X .

Ajuebor O., Giorgio Cometto, Carey McCarthy, Yin Li, Sumaya Mohamed Al-Blooshi, Nonhlanhla Makhanya and Giorgio Cometto, 2020. Are the global strategic directions for strengthening nursing and midwifery 2016 – 2020 being implemented in countries? Findings from a cross-sectional analysis, *International Journal of Nursing Studies*. 2(219): 1–10.

Akowuah, J.A., Agyei-baffour, P. & Asibey, B.O. 2018. A qualitative study on the pathways to evidence-based antenatal care in Periurban Ghana. London: Elsevier.

Allen, D. 2018. Translational mobilisation theory: A new paradigm for understanding the organisational elements of nursing work, *International Journal of Nursing Studies*. 36–42. https://doi.org/10.1016/j.ijnurstu.2017.10.010.

Altman, L. 2019. A qualitative study of health care providers perceptions and experiences of working together to care for children with medical complexity (CMC), *BMC Health Services Research*, 18(1): 1–18. https://doi.org/10.1186/s12913-018-2857-8.

Ameh, C.A. & Van Den Broek, N. 2015. Making it happen: Training health-care providers in emergency obstetric and newborn care, *Best Practice and Research: Clinical Obstetrics and Gynaecology*, 29(8): 1077–1091. https://doi.org/10.1016/j.bpobgyn.2015.03.019

Arcos, E. 2018. Motherhood inmigrant women in Chile: A qualitative study, *Midwifery, 66*(7): 182–186. https://doi.org/10.1016/j.midw.2018.08.008.

Asiedu, G.B., Fang, J.L., Harris, A.M., Colby, C.E. & Carroll, K. 2019. Health care professionals' perspectives on tele neonatology through the lens of normalisation process theory*, Health Science Reports, 2*(2): e111. https://doi.org/10.1002/hsr2.111

Assaf S., Horton L., Bornstein M. & Pullum T., 2017. Levels and trends of maternal and child health indicators in 11 Middle East and north African countries.

Assefa Y., Gelaw Y., Peter S., Taye B. and Damme W., 2019. Community health extension program of Ethiopia , 2003 – 2018 : successes and challenges toward universal coverage for primary healthcare services.

Assefa, Y. 2017. Successes and challenges of the millennium development goals in Ethiopia: Lessons for the sustainable development goals, *BMJ Global Health*, 2(2): 1–8. https://doi.org/10.1136/bmjgh-2017-000318.

Aston, M., Price, S., Hunter, A., Sim, M., Etowa, J., Monaghan, J. & Paynter, M. 2021. Second opinions: Negotiating agency in online mothering forums. *The Canadian*

Journal of Nursing Research 53(4): 327–339. https://doi.org/10.1177/0844562120940554

Ayivi-Guedehoussou, N. 2017. The determinants of job satisfaction among nurses, midwives, and auxiliary nurses in health clinics: The case of Bénin, West Africa, https://doi.org/10.7249/rgsd373 .

Babalola, S. & Fatusi, A. 2009. Pregnancy and childbirth beyond individual and household factors, *BMC* 13: 1–13. https://doi.org/10.1186/1471-2393-9-43 .

Babler, E. & Strickland, C.J. 2016. Helping adolescents with Type 1 diabetes figure it out, *Journal of Pediatric Nursing, 31*(2): 123–131. https://doi.org/10.1016/j.pedn.2015.10.007

Baffour-Awuah, A., Mwini-Nyaledzigbor, P.P. & Richter, S. 2015. Enhancing focused antenatal care in Ghana: An exploration into perceptions of practicing midwives', *International Journal of Africa Nursing Sciences*, 2: 59–64. https://doi.org/10.1016/j.ijans.2015.02.001

Bamford, C. 2012. Implementing nutrition guidelines for older people in residential care homes: A qualitative study using normalisation process theory, *Implementation Science*, 7(1): 1–27. https://doi.org/10.1186/1748-5908-7-106

Bang, K. 2018. Effects of a community outreach program for maternal health and family planning in Tigray, Ethiopia, *Asian Nursing Research*, 12(3): 223–230. https://doi.org/10.1016/j.anr.2018.08.007

Barbour, C. & Schuessler, J.B. 2019. A preliminary framework to guide implementation of the flipped classroom method in nursing education, *Nurse Education in Practice*, 34(2018): 36–42. https://doi.org/10.1016/j.nepr.2018.11.001

Barnes, M. 2003. Contemporary child health nursing practice: services provided and challenges faced in metropolitan and outer Brisbane areas, *Collegian*, 10(4): 14–19. https://doi.org/10.1016/S1322-7696(08)60071-2

Berg, B.L. & Lune, H. 2012. *Qualitative research methods for the social sciences*. 8th edition. USA: Pearson.

Berhe, M. 2017. Essential neonatal care utilisation and associated factors among mothers in public health facilities of Aksum Town, North Ethiopia, 2016, *PLoS ONE*, 12(4): 1–13. https://doi.org/10.1371/journal.pone.0175902

Betemariam, W. 2017. Effect of Ethiopia's health development army on maternal and newborn health care practices: A multi-level cross-sectional analysis, *Annals of Global Health*, 83(1): 24. https://doi.org/10.1016/j.aogh.2017.03.051

Bethell, C.D., Simpson, L.A. & Solloway, M.R. 2017. Child well-being and adverse childhood experiences in the United States, *Academic Pediatrics*, 17(7): S1–S3. https://doi.org/10.1016/j.acap.2017.06.011

Bezabih, A.M., Wereta, M.H. & Kahsay, Z.H. 2018. Demand and supply side barriers that limit the uptake of nutrition services among pregnant women. https://doi.org/10.3390/nu10111687

Bhutta, Z.A. 2010. Countdown to 2015 decade report (2000-10): Taking stock of maternal, newborn, and child survival, *The Lancet*, 375(9730): 2032–2044. https://doi.org/10.1016/S0140-6736(10)60678-2

Biza, A. 2019. Challenges and opportunities for implementing evidence-based antenatal care in Mozambique: A qualitative study, 16–18. https://doi.org/10.1186/s12884-015-0625-x

Bohren, M.A. 2018. Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: Labor observation and community survey, *BMC Medical Research Methodology*, 18(1): 1–15. https://doi.org/10.1186/s12874-018-0603-x

Bolin, J.N. 2020. Rural healthy people 2020. *New Decade*, 31(2015): 326–333. https://doi.org/10.1111/jrh.12116.

Borketey, P.E. & Borketey, P.E. 2017. A literature review on the challenges of eHealth implementation in developing countries among rural folks: A case of Ghana, *Arcada,* (7).

Busch, D.W. 2019. NAPNAP position statement on breastfeeding: National association of pediatric nurse practitioners, breastfeeding education special interest group, *Journal of Pediatric Health Care,* 33(1): A11–A15. https://doi.org/10.1016/j.pedhc.2018.08.011

Butler, S.M & Cabello, M. 2018. Housing as a hub for health, community services, and upward mobility. Available from:

Butterfield, J. 2012. *Problem-solving and decision making: Illustrated course guides* 2nd edition. Australia: Lengage Learning.

Buynder, P.G. 2019. Antigen specific vaccine hesitancy in pregnancy, *Vaccine*, 37(21): 2814–2820. https://doi.org/10.1016/j.vaccine.2019.04.021

Callaghan-koru, J.A. 2013. Newborn care practices at home and in health facilities in 4 regions of Ethiopia. New York: Elsevier

Campbell, K.A. 2019. Weathering the rural reality: Delivery of the nurse-family partnership home visitation program in rural British Columbia, Canada, *BMC Nursing*, 18(1): 1–35. https://doi.org/10.1186/s12912-019-0341-3

Carl, R.M., Cummings, A., Girling, M., Bracher, M., Frances, S., Mair, C.M.M., Elizabeth Murray, T.F. & Michelle, T.F. 2018. Using normalisation process theory in feasibility studies and process evaluations of complex healthcare interventions: A systematic review, *Implementation Science*, 13(1): 1–42. https://doi.org/10.1186/s13012

Carminati, L. 2018. Generalizability in qualitative research: A tale of two traditions. *Qualitative Health Research*, 28(13): 2094–2101. https://doi.org/10.1177/1049732318788379

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A.J. 2014. The use of triangulation in qualitative research. *Oncology Nursing Forum*, 41(5): 545–547. https://doi.org/10.1188/14.ONF.545-547.

Chambers, D.A., Glasgow, R.E. & Stange, K.C. 2013. The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change, *Implementation Science,* 8(1): 1–11. https://doi.org/10.1186/1748-5908-8-117 .

Charmaz, K. & Belgrave, L.L. 2018. Thinking about data with grounded theory, *Qualitative Inquiry*. 25(8): 743-753. https://doi.org/10.1177/1077800418809455

Chenail, R.J. 2011. Ten steps for conceptualizing and conducting qualitative research studies in a pragmatically curious manner, *Qualitative Report*, 16(6): 1715-1732. https://doi.org/10.46743/2160-3715/2011.1324

Cheng, C.Y., Fowles, E.R. & Walker, L.O. 2006. Postpartum maternal health care in the United States: A critical review, *Journal of Perinatal Education*, 15(3): 34–42. https://doi.org/10.1624/105812406x119002.

Chetty, T., Yapa, H.M.N., Herbst, C., Geldsetzer, P., Kevindra, K., Jan-Walter, N., De Neve, D., Herbst, K., Matthews, P., Pillay, D., Wyke S. & Bärnighausen, T. 2018. The Monarch intervention to enhance the quality of antenatal and postnatal primary health services in rural South Africa: Protocol for a stepped-wedge cluster-randomised controlled trial. *BMC Health Serv Res* 18, 625. https://doi.org/10.1186/s12913-018-3404-3.

Chigozie Jesse Uneke, Issiaka Sombie, Namoudou Keita, Virgil Lokossou, Ermel Johnson, Pierre Ongolo-Zogo, 2016. An assessment of maternal, newborn and child health implementation studies in Nigeria: implications for evidence informed policymaking and practice.

Clark K., Beatty S. & Fletcher T., 2016. Maternal and child health nursing services: perspectives of parents; *Australian Journal of Child and Family Health Nursing.* 13(1): 4

Colvin, C.J.J. 2013. A systematic review of qualitative evidence on barriers and facilitators to the implementation of task-shifting in midwifery services, *Midwifery*, 29(10): 1211–1221. https://doi.org/10.1016/j.midw.2013.05.001.

Corbin, J. & Strauss, A. 1998. Grounded theory research: procedures, canons, and evaluative criteria, *Qualitative sociology*, 13(1): 3-21.

Creswell, J.W. 2014. Research design: International student edition. Washington DC: Sage.

Dantzker, M.L. & Hunter, R.H. 2012. *Research methods for criminology and criminal justice*. 3rd edition. Sudbury MA: Jones & Bartlett Learning.

Darkwa, K.E., Sophia Newman, M., Kawkab, M., & Elahi Chowdhury, M. 2015. A qualitative study of factors influencing retention of doctors and nurses at rural healthcare facilities in Bangladesh. *Newborn and Child Health,* 1-16. https://doi.org/10.1186/s12913-015-1012-z.

Dawson, A. 2012. Quality of maternity care practices of skilled birth attendants in Cambodia. *Newborn and Child Health* https://doi.org/10.1111/j.1744-1609.2012.00254.x.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2012. *Research at grass roots: for the social sciences and human service professions*. 4th edition. Pretoria: Van Schaik.

Dean, S.V. 2014. Preconception care: Closing the gap in the continuum of care to accelerate improvements in maternal, *Newborn and Child Health*, 11(3): 1–8.

Degu, G. & Wolpe, J. 2006. Research methodology, *American Journal of Psychiatry*. https://doi.org/10.1176/ajp.135.8.998-b.

Deller, B. 2015. Task shifting in maternal and newborn health care: Key components from policy to implementation, *International Journal of Gynecology and Obstetrics*, 130(S2): S25–S31. https://doi.org/10.1016/j.ijgo.2015.03.005 .

Demisse, T.L. 2019. Utilisation of preconception care and associated factors among reproductive age group women in Debre Birhan town, North Shewa, Ethiopia, *Reproductive Health,* 16(1): 1–10. https://doi.org/10.1186/s12978-019-0758-x .

Denscombe, M. 2014. The good research guide for small-scale social research projects. 5th edition. England: McGraw-Hill.

Desta, F.A., Shifa, G.T., Dagoye, D.W., Carr, C. & Kim Y. 2017. Identifying gaps in the practices of rural health extension workers in Ethiopia: A task analysis study, *BMC Health Services Research*, 17(1): 1–9. https://doi.org/10.1186/s12913-017-2804-0.

DiMaria-Ghalili, R.A., Mirtallo, J.M., Tobin, B.W., Hark, L., Van Horn, L. & Palmer, C.A. 2014. Challenges and opportunities for nutrition education and training in the health care professions: Intraprofessional and interprofessional call to action, *American Journal of Clinical Nutrition*, 99(5): 1184–1193. https://doi/10.3945/ajcn.113.073536.

Doherty, T. 2019. Reduction in child mortality in Ethiopia: Analysis of data from demographic and health surveys, *Journal of Global Health*. 6(2): 1–10. https://doi.org/10.7189/jogh.06.020401

Donley, A. & Graueholz, L. 2012. Student handbook to sociology: research methods. New York: Facts on File Inc.

Drisse, Goldizen and Adair-Rohani, 2017: Atlas on children's health and the environment.

Dunlop, A.L. 2010. Sexual & Reproductive Healthcare Integrating reproductive planning with primary health care: An exploration among low-income , minority women and men, *Sexual & Reproductive Healthcare*, 1(2): 37–43. https://doi.org/10.1016/j.srhc.2010.01.001 .

Dynes, M.M. 2014. Factors Shaping Interactions Among Community Health Workers in Rural Ethiopia: Rethinking Workplace Trust and Teamwork. https://doi.org/10.1111/jmwh.12135.

East, L.A., Arudo, J., Loefler, M., & Evans, C.M. 2014. Exploring the potential for advanced nursing practice role development in Kenya: A qualitative study. *BMC Nursing*, 13(1): 1–11. https://doi.org/10.1186/s12912-014-0033-y.

Edet, O. & Edet, E. 2013. Missed Opportunities for Intermittent Preventive Treatment among Pregnant Women, in a Secondary Health Facility, Cross River State, Nigeria. *Journal of Life* 7(11): 1147–1158. Available at: http://www.davidpublishing.com/davidpublishing/Upfile/3/3/2014/2014030305083721.pdf.

Edmonds, W.A. & Kennedy, T.M. 2012. An Applied Guide to Research Designs: Quantitative, Qualitative, and Mixed Methods.

Efron, S.E. & Ravid, R. 2019. *Writing a literature review: A practical guide*. New York: The Guilford Press.

Ehrlich, R. & Joubert, G. 2014. *Epidemiology: A research manual for South Africa*. 3rd edition. Cape Town: Oxford University Press.

Elo, S. & Kyngäs, H. 2008 The qualitative content analysis process, *Journal of Advanced Nursing*, 62(1): 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x.

Epstein, I. & Carlin, K. 2012. Ethical concerns in the student/ preceptor relationship: A need for change. *Nurse Education Today*, 32(8): 897-902.

Ethiopia Mini Demographic and Health Survey 2019: Key Health Indicators

Ezeanolue, E. 2015. Why are children still being infected with HIV? Impact of an integrated public health and clinical practice intervention on mother-to-child HIV transmission in Las Vegas, Nevada, 2007–2012, *Annals of Medical and Health Sciences Research*, 5(4): 253. https://doi.org/10.4103/2141-9248.160189.

Federal Ministry of Health (FMOH), 2015. Health Sector Transformation Plan: Annual performance report. Available at: https://www.itacaddis.org/docs/2017_11_10_09_46_13_healthsectortransformationplan-iannualperformancereport(ARM_2016)compressed.pdf.

Fedral Ministry of Health (FMOH), 2015. ETHIOPIA NATIONAL EXPANDED PROGRAMME ON IMMUNIZATION COMPREHENSIVE MULTI- MULTI - YEAR PLAN 2016 - 2020 Federal Ministry of Health , Addis Ababa.

Fetene, N. Binyam, L., Hibret, F., Halima, F., Omer, M., Canavan, J., Smith, P. & Berman, Elizabeth 2016. The Ethiopian health extension program and variation in health systems performance : What matters ?, *PLOS ONE*, 11(5): 1–20. https://doi.org/10.1371/journal.pone.0156438 .

Finch, T. 2009. Implementing, embedding, and integrating practices: an outline of normalisation process theory', *Plosone*, 43(3): 535–554. https://doi.org/10.1177/0038038509103208.

Fink, A. 2010. Conducting research literature reviews: From the internet to paper. 3rd edition. California: SAGE.

Fox, A., Gardner, G. & Osborne, S. 2014. A theoretical framework to support research of health service innovation: A theoretical framework to support research of health service innovation, *Journal of the Australian Healthcare & Hospitals Association,* https://doi.org/10.1071/AH14031 .

Franklin, M.L. 2013. Understanding research coping with the quantitative-qualitative divide. United States of America: Routledge.

Franklin, P.K. 2016. Public health within the EU policy space: A qualitative study of organised civil society (OCS) and the health in all policies (HiAP) approach, *Public Health*, 136: 29–34. https://doi.org/10.1016/j.puhe.2016.02.034.

Fraser, S., Grant, J. & Mannix, T. 2016. Maternal child and family health nurses: delivering a unique nursing speciality, *Maternal and Child Health Journal*, 20(12): 2557–2564. https://doi.org/10.1007/s10995-016-2081-2.

Fuemmeler, B.F. 2016. Child and family health in the era of prevention : New opportunities and challenges, *Journal of Behavioral Medicine*. https://doi.org/10.1007/s10865-016-9791-1.

Gale, C. 2015 Research methodology applied to a comparative case study of the deinstitutionalisation of children in Bulgaria and Ukraine, *Scottish Journal of Residential Child Care* 14(3): 85–98.

Gebeyehu, W.Y. 2014. Factors affecting utilisation of postnatal care service in Amhara Region, Jabitena District, Ethiopia, *Science Journal of Public Health*, 2(3): 169. https://doi.org/10.11648/j.sjph.20140203.15.

Gebre, E., Worku, A. & Bukola, F. 2018 Inequities in maternal health services utilisation in Ethiopia 2000-2016: Magnitude, trends, and determinants. *Reproductive Health Matters* 9(6): 1–9. https://doi.org/10.1186/s12978-018-0556-x

Gebre, M. 2019. Ethiopia Reduces Maternal Mortality Though Numbers Still High. *Reproductive Health Matters*. 13(2): 5–9.

Gerein, N., Green, A. & Pearson, S. 2006. The implications of shortages of health professionals for maternal health in Sub-Saharan Africa, *Reproductive Health Matters*, 14(27): 40–50. https://doi.org/10.1016/S0968-8080(06)27225-2.

Getachew, T., Abebe, S.M., Yitayal, M. 2020. Assessing the quality of care in sick child services at health facilities in Ethiopia, *BMC Health Serv Res* 20: 574. https://doi.org/10.1186/s12913-020-05444-7.

Gillespie, B.M. 2019. Using normalisation process theory to evaluate the implementation of a complex intervention to embed the surgical safety checklist, *BMC Health Services Research*, 18(1): 1–17. https://doi.org/10.1186/s12913-018-2973-5.

Gilmore, B. & Mcauliffe, E. 2013. Effectiveness of community health workers delivering preventive interventions for maternal and child health in low- and middle-income countries : A systematic review, *BMC Public Health*, 13: 847. https://doi.org/10.1186/1471-2458-13-847

Glenton and Javadi, 2013. Community Health Workers' Role and Tasks within MCH.

Goossens, J. & Beeckman, D. 2018. Preconception lifestyle changes in women with planned pregnancies, 56. 112–120. https://doi.org/10.1016/j.midw.2017.10.004.

Gould, D.J. 2016. Promoting health workers' ownership of infection prevention and control: Using normalisation process theory as an interpretive framework, *Journal of Hospital Infection*. https://doi.org/10.1016/j.jhin.2016.09.015.

Grant, J.M., Mitchell, C. & Cuthbertson, L. 2017. National standards of practice for maternal, child and family health nurses in Australia. Available at: https://www.mcafhna.org.au/Portals/0/PositionStmt-PDF/NationalStandardsofPractice for MCaFHNA.pdf .

Gray, D.E. 2019. *Doing research in the business world*. 3rd edition. Los Angeles: SAGE.

Gross and Wydra, 2013. Maternal-Child Health Maternal-Child Health Interdisciplinary Aspects Within the Perspective of Global Health.

Grove, J. 2015. Maternal, newborn, and child health and the sustainable development goals-a call for sustained and improved, https://doi.org/10.1016/S0140-6736(15)00517-6.

Grove, S.K., Burns, N. & Gray, J. 2013. *The practice of nursing research: Appraisal, synthesis and generation of evidence*. 7th edition. St. Louis, MO: Elsevier Saunders.

Guest, G., Namey, E.E. & Mitchell, M.L. 2013. *Collecting qualitative data: A field manual for research*. Los Angeles: SAGE.

Hackett, K.M. 2016. 'Impact of a community-based smartphone intervention on maternal health service utilisation in rural Tanzania by maternal health service utilisation in rural Tanzania'. Doctoral Thesis, University of Toronto

Hammarberg, K., Kirkman, M. & Lacey, S.D. 2016. Qualitative research methods: When to use them and how to judge them, *Human Reproduction*, 31(3): 498–501, https://doi.org/10.1093/humrep/dev334

Harding, J. 2013. Qualitative data analysis from start to finish. Los Angeles: SAGE.

Hemsing, N., Greaves, L. & Poole, N. 2017. Preconception health care interventions: A scoping review, *Sexual & Reproductive Healthcare*, 14: 24–32. https://doi.org/10.1016/j.srhc.2017.08.004

Hill, Z. 2019. People have started to deliver in the facility these days: A qualitative exploration of factors affecting facility delivery in Ethiopia. *BMJ Open*, 1–9 https://doi.org/10.1136/bmjopen-2018-025516

Honorene, J. 2017. Understanding the role of triangulation in research Johnson Honorene, *SRJIS*, 5 (77): 91–95.

Leesa Hooker, Rhonda Small & Angela Taft, 2016. Using theory to design, implement and evaluate sustained nurse domestic violence screening and supportive care. *Journal of Research in Nursing*, https://doi.org/10.1177/1744987116649633.

Hooker, L., Small, R. & Taft, A. 2015 Understanding sustained domestic violence identification in maternal and child health nurse care: Process evaluation from a 2-year follow- up of the MOVE trial, *Journal of Advanced Nursing*, 72(3): 533–544. https://doi.org/10.1111/jan.12851.

Houghtaling, B. 2018. Grandmother and health care professional breastfeeding perspectives provide opportunities for health promotion in an American Indian community, *Social Science and Medicine*, 208(17): 80–88. https://doi.org/10.1016/j.socscimed.2018.05.017.

Health Sector Development Plan (HSDP), Federal Ministry of Health (FMOH), 2016. HEALTH SECTOR TRANSFORMATION PLAN I: ANNUAL PERFORMANCE REPORT

Hughes, H.K. & Kahl, L.K. 2018 *A manual for pediatric house officers*. London: The Harriet Lane Handbook.

Jack, S.M. 2017. Identification and assessment of intimate partner violence in nurse home visitation, *Journal of Clinical Nursing*, 26(15–16): 2215–2228. https://doi.org/10.1111/jocn.13392.

Jackson, R & Jackson, R. 2015. We prefer the friendly approach and not the facility: On the value of qualitative research in Ethiopia, *Ethiopian Journal of Health Sciences*, 28(5): 555–562. https://doi.org/10.4314/ejhs.v28i5.6.

Jackson, R. & Hailemariam, A. 2020. The role of health extension workers in linking pregnant women with health facilities for delivery in rural and pastoralist areas of Ethiopia. *Ethiopian Journal of Health Sciences*, 26(5): 471–478. https://doi.org/10.4314/ejhs.v26i5.9

Jalloh, M. B. 2019. Impact of the free healthcare initiative on wealth-related inequity in the utilisation of maternal & child health services in Sierra Leone, *BMC Health Services Research,* 19(1): 1–21. https://doi.org/10.1186/s12913-019-4181-3 .

Jameel, B., Shaheen, S. & Majid, U. 2018. introduction to qualitative research for novice investigator's introduction to qualitative research for novice investigators, *Undergraduate Research in Natural and Clinical Science and Technology (URNCST) Journal.* https://doi.org/10.26685/urncst.57.

Jessup, M.A. 2019. Pregnant and parenting women with a substance use disorder: actions and policy for enduring therapeutic practice, *Nursing Outlook*, 67(2): 199–204. https://doi.org/10.1016/j.outlook.2019.02.005.

Jirojwong, S. & Welch, A. 2011. The importance of research in nursing and midwifery, *Research Methods in Nursing and Midwifery Pathways to Evidence-Based Practice*, 3–13.

Johnson, K., Atrash, H. & Johnson, A. 2008. Policy and finance for preconception care opportunities for today and the future, *Women's Health Issues*, 18(6): S2–S9. https://doi.org/10.1016/j.whi.2008.09.006

Kabakian-Khasholian, T. & Portela, A. 2017. Companion of choice at birth: Factors affecting implementation, *BMC Pregnancy and Childbirth*, 17(1): 1–13. https://doi.org/10.1186/s12884-017-1447-9.

Kahrmann, D. 2019*. USAID contributes to reduction of maternal and child deaths*, pp. 7–8. Available at: https://www.usaid.gov/sites/default/files/documents/1864/MCHVision.pdf

Kassa, N., Berhane, Y. & Worku, A. 2012. Predictors of unintended pregnancy in Kersa, *Reprod Health* 9(1): 12-45, https://doi.org/10.1186/1742-4755-9-11-7 .

Kea, A.Z. 2018. Exploring barriers to the use of formal maternal health services and priority areas for action in Sidama zone, Southern Ethiopia, *Midwifery* 1–12.

Kennedy, L.A. & Montgomery, A. 2018. *Exploring Qualitative Research*, USA: Sage

Khaldi, K. 2017. Quantitative, qualitative or mixed research: Which research paradigm to use. *Journal of Educational and Social Research*, 7(2):15-24.

Kim, Y. 2019. Factors affecting complete and childhood immunisation coverage Pakistan: A secondary analysis of c sectional survey data, *Global Health Action* 1–22.

King R., Ruth Jackson, Elaine Dietsch and Asseffa Hailemariam, 2015. Barriers and facilitators to accessing skilled birth attendants in Afar region, Ethiopia, *Midwifery*, 31(5): 540–546. https://doi.org/10.1016/j.midw.2015.02.004.

Kisakye, A.N. 2017. Effect of support supervision on maternal and newborn health services and practices in rural Eastern Uganda, *Global Health Action*, 10(0). https://doi.org/10.1080/16549716.2017.1345496 .

Klinga, C. Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care, *Research Methods in Nursing and Midwifery Pathways to Evidence-Based Practice* 1–12.

Kozhimannil, K.B., Henning-Smith, C. & Hung, P. 2016. The practice of midwifery in rural us hospitals. Maternity, 411–418. https://doi.org/10.1111/jmwh.12474 .

Kumar, R. 2015. Research methodology: A step-by-step guide for beginners. 4th edition. London: Sage.

Kuruvilla, S. 2014. Success factors for reducing maternal and child mortality, *Bulletin of the World Health Organisation*, 92(7): 533–544. https://doi.org/10.2471/blt.14.138131.

Kusena, P. 2017. Understanding barriers to utilisation of maternal and childhood services through community dialogue in the context of result-based financing transport unavailability, *Texila International Journal of Public Health. 5*.: 348-355. https://doi.org/10.21522/tijph.2013.05.04.art034

Lassi, Z. S. 2014. Essential interventions for maternal, newborn and child health: Background and methodology, *Reproductive Health*, 11(1): 1. https://doi.org/10.1186/1742-4755-11-S1-S1.

Lassi, Z.S. 2018. Chapter 14 community-based care to improve maternal, newborn, and child health, *Repro*, 2(2): 1–23. https://doi.org/10.1596/978-1-4648-0348-2 .

Lee, D. T. F. F., Woo, J. and Mackenzie, A. E. (2019) 'The Cultural Context of Adjusting to Nursing Home Life : Chinese Elders Perspectives, *Gerontologist Repro Culture,* 1–25 https://doi.org/10.1093/geront/42.5.667 .

Leedy, P.D. & Ormrod, J.E. 2015. *Practical research: Planning and design*. 11th edition. England: Pearson Prentice Hall.

Lengetti, E. 2018. Nurse education in practice an innovative approach to educating nurses to clinical competence: A randomized controlled trial, *Nurse Education in Practice*, 159–163. https://doi.org/10.1016/j.nepr.2018.08.007.

LifeInt-Opray, N. 2015. Directed preconception health programs and interventions for improving pregnancy outcomes for women who are overweight or obese, *Cochrane Database of Systematic Reviews*, 4(7): 256 https://doi.org/10.1002/14651858 .

Littleton, L.Y. & Engebretson, J.C. 2002. Women's health nursing brief contents unit: Foundations of women across the life span. Taxas: Esperti.

Lloyd, A. 2019. Patchy coherence: Using normalisation process theory to evaluate a multi-faceted shared decision-making implementation program, *Methods,* 8(20): 1–17. https://doi.org/10.1186/1748-5908-8-102

Lori, J.R.R. 2013. Promoting access: The use of maternity waiting homes to achieve safe motherhood, *Midwifery,* 29(10): 1095–1102, https://doi.org/10.1016/j.midw.2013.07.020.

Ludwick, T. 2018. Supportive supervision and constructive relationships with healthcare workers support CHW performance: Use of a qualitative framework to evaluate CHW programming in Uganda. New York: Palsiva Publishers

Mabaso, M.H., Ndaba, T., & Mkhize-Kwitshana, Z.L. 2014. Overview of maternal, neonatal and child deaths in South Africa: Challenges, opportunities, progress and future prospects. *International Journal of MCH and AIDS*, 2(2): 182–189.

Macarayan, E.K. 2020. Articles assessment of quality of primary care with facility surveys: A descriptive analysis in ten low-income and middle-income countries, *The Lancet Global Health*, 6(11): e1176–e1185. https://doi.org/10.1016/S2214-109X(18)30440-6.

Maiwada, 2020. Maternal and Reproductive Health in Zamfara State of Northwest Nigeria : An Impact Evaluation of Health Promotion in the Community.

Malone, S. 2012. The clinical sustainability assessment tool: Measuring organisational capacity to promote sustainability in healthcare, Thousand Oaks: SAGE.

Mann, C. 2016. Measuring Efficiency of Public Health Centers in Ethiopia. London: SAGE.

Martha A. Jessup, Sarah E. Oerther, Bonnie Gance-Cleveland, Lisa M. Cleveland, Kim M. Czubaruk, 2019. Pregnant and Parenting Women with a Substance Use Disorder: Actions and Policy for Enduring Therapeutic Practice.

Marsh, C.A. 2015. Guilty until proven innocent? The assumption of care of a baby at birth, *Women and Birth*, 28(1): 65–70. https://doi.org/10.1016/j.wombi.2014.10.008

Marshall, C. & Rossman, G.B. 2011. Designing Qualitative Research. 5th edition. Los Angeles, CA: Sage.

Martínez-Serrano, P. 2018. Midwives' experience of delivery care in late foetal death: A qualitative study, *Midwifery*, 66(261): 127–133. https://doi.org/10.1016/j.midw.2018.08.010

Mason, J. 2014. *Qualitative researching*. 2nd edition. London: Sage.

Maureen E Canavan , Marie A Brault , Dawit Tatek, Daniel Burssa , Ayele Teshome, Erika Linnander & Elizabeth H Bradley, 2020. Maternal and neonatal services in Ethiopia: measuring and improving quality.

Maxfield, M.G. & Babbie, E. 2014. *Research method for criminal justice and criminology*. 7th edition. Boston: Thomson-Wadsworth.

May, C. & Finch, T. 2019. Evaluating complex interventions and health technologies using normalisation process theory: Development of a simplified approach and web-enabled toolkit, *Journal of Nursing Studies* 1–30.

May, C., Sibley, A. & Hunt, K. 2014. The nursing work of hospital-based clinical practice guideline implementation: An explanatory systematic review using Normalisation Process Theory, *International Journal of Nursing Studies*, 51(2): 289–299. https://doi.org/10.1016/j.ijnurstu.2013.06.019.

May, C.R., Mair, F.S. & Dowrick, C.F. 2019. Process evaluation for complex interventions in primary care: Understanding trials using the normalisation process model, *Maternity* 8(27): 1–24.

Mcarthur, J. W. *et al.* (2019) 'How many lives are at stake ? Assessing 2030 maternal and child health Can you help us ? Can you help us ?', pp. 1–12.

McCreight, M.S. 2019. Using the practical, robust implementation and sustainability model (PRISM) to qualitatively assess multilevel contextual factors to help plan, implement, evaluate, and disseminate health services programs, *Translational Behavioral Medicine*, 9(6): 1002–1011. https://doi.org/10.1093/tbm/ibz085.

McCandlish, 2020. MIDWIFERY 2020: Delivering expectation. Professional Leadership Team Department of Health Location 452C Skipton House 80 London Road London SE1 6LH 020

McEvoy, R., Tierney, E. & MacFarlane, A. 2019. Understanding the levers and barriers to the implementation of community participation in primary healthcare: A qualitative study using normalisation process theory, *BMC Health Services Research*, 19(1): 1–14. https://doi.org/10.1186/s12913-019-4331-7.

McIntyre, S.A. 2018. The use of theory in process evaluations conducted alongside randomized trials of implementation interventions: A systematic review, *Translational Behavioral Medicine. Oxford University Press*,7(89): 168–178. https://doi.org/10.1093/tbm/iby110

Mckinnon and Finch, 2018. police custody suites – qualitative evaluation from the HELP-PC study in London , UK.

Mekonnen, T. 2019. Trends and determinants of antenatal care service use in Ethiopia between 2000 and 2016, *International Journal of Environmental Research and Public Health*, 16(5). https://doi.org/10.3390/ijerph16050748.

Memirie, S.T. 2016. Inequalities in utilisation of maternal and child health services in Ethiopia : The role of primary health care, *BMC Health Services Research* 1–8. https://doi.org/10.1186/s12913-016-1296-7.

Mesele Damte Argaw, Binyam Fekadu Desta, Temesgen Ayehu Bele and Abebe Dagnew Ayne, 2019. Improved performance of district health systems through implementing health center clinical and administrative standards in the Amhara region of Ethiopia.

Mesele, H.A. 2018. Traditional Maternal health beliefs and practices in Southern Tigray: The case of Raya Alamata District, *Anatomy & Physiology*, 08(02): 1–12. https://doi.org/10.4172/2161-0940.1000298 .

Miller, T. & Smith, H. 2017. Establishing partnership with traditional birth attendants for improved maternal and newborn health: A review of factors influencing implementation, *BMC Pregnancy and Childbirth*, 17(1): 1–10. https://doi/10.1186/s12884-017-1534-y.

Mills, D. & Ratcliffe, R. 2012. After method? Ethnography in the knowledge economy. *Qualitative Research*, 12(2): 147-164.

Modi, D., Dholakia, N., Gopalan, R., Venkatraman, S., Dave, K. & Shah, S. 2019. mHealth intervention “ImTeCHO” to improve delivery of maternal, neonatal, and child care

services—A cluster-randomized trial in tribal areas of Gujarat, India. *PLoS Med* 16(10): e1002939. https://doi.org/10.1371/journal.pmed.1002939

Mohajan, H. 2018. Qualitative research methodology in social sciences and related. *Journal of Economic Development, Environment and People*, 7(1): 23-48. https://doi/10.26458/jedep.v7i1.571

Morden, A. & Brooks, L. 2015. Long term-change, and general practice, Available at: www.emeraldinsight.com/1477-7266.htm.

Morgan, R. 2017. Gender dynamics affecting maternal health and health care access and use in Uganda, *Health Policy and Planning*, 32: v13–v21. https://doi.org/10.1093/heapol/czx011.

Morris, J.L. Short, S., Robson, L & Andriatsihosena, M.S. 2014. Maternal health practices, beliefs and traditions in southeast Madagascar. *African Journal of Reproductive Health*, 18(3): 101–117.

Mouton, J. 2014. *Understanding social research.* Pretoria: Van Schaik.

Moxon, S.G. & Zaka, N. 2019. Every woman, every newborn scaling up quality care for mothers and newborns around the time of birth: an overview of methods and analyses of intervention-specific bottlenecks and solutions, *The Lancet Global Health* 1–26.

Mozambique Report, 2015. International Monetary Fund, Czech Republic: Staff Report for the 2015 Article IV Consultation.

Mugo, N. 2015. Maternal and child health in South Sudan, *SAGE Open*, 5(2): 215 https://doi.org/10.1177/2158244015581190.

Mulat, G., Kassaw, T. & Aychiluhim, M. 2015. Antenatal Care service utilisation and its associated factors among mothers who gave live birth in the past one year in Womberma Woreda, Northwest Ethiopia Epidemiology: *Open Access,* https://doi.org/10.4172/2161-1165.S2-003.

Murray, E., Treweek, S., Pope, C., MacFarlane, A., Ballini, L., Dowrick, C. & May, C. 2010. Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. *BMC Medicine*, 8(1): 1-11. https://doi.org/10.1186/1741-7015-8-63.

Mwale, M.W. 2004. *Infant and child mortality*, 123–132 Available at: https://dhsprogram.com/pubs/pdf/fr175/08chapter08.pdf

Nair, N. 2017. Effect of participatory women's groups and counselling through home visits on children's linear growth in rural eastern India (CARING trial): A cluster-randomised controlled trial, *The Lancet Global Health*, 5(10): e1004–e1016. https://doi.org/10.1016/S2214-109X(17)30339-X.

Necochea, E. 2015. Implementation of the standards-based management and recognition approach to quality improvement in maternal, newborn, and child health programs in

low-resource countries, *International Journal of Gynecology and Obstetrics*, 130(S2): S17–S24, https://doi.org/10.1016/j.ijgo.2015.04.003.

Neuman, W.C. 2011. Social research methods: Qualitative and quantitative approaches. Boston, MA: Pearson International.

Nicogossian, A. 2015. mHealth: Saving Lives with Mobile Technology. New York: Pearson

Nigatu, T. 2013. The status of desired maternal and child health practices and service utilisations of model families of the health extension program in SNNPR, Ethiopia, *Journal of Community Medicine & Health Education*, 04(01): 10. https://doi.org/10.4172/2161-0711.1000258.

Nightingale, F. 1985. Health Then and Now, *Public Health*, 75(2): 181–186.

Nilsen, P. 2015. Making sense of implementation theories, models and frameworks Making sense of implementation theories, models and frameworks, (10). https://doi.org/10.1186/s13012-015-0242-0.

Nordmark, S., Zingmark, K. & Lindberg, I. 2016. Process evaluation of discharge planning implementation in healthcare using normalisation process theory, *BMC Medical Informatics and Decision Making*, 16(1): 1–28. https://doi.org/10.1186/s12911-016-0285-4.

Notar, C.E. & Cole, V. 2010. Literature Review Organiser, *International Journal of Education*, 2(2): 1–17. https://doi.org/10.5296/ije.v2i2.319

Office of Disease Prevention and Health Promotion. 2019. *Maternal, infant, and child health data details | healthy people 2020', Healthpeople.gov*, pp. 1–104. Available at: https://www.healthypeople.gov/node/3492/data-details .

Ogbo, F.A. 2016. Infant and young child feeding practices in Nigeria: Epidemiology and policy implications, *PQDT - Global*, 1–266.

Onwuegbuzie, A.J. & Frels, R. 2016. Methodology of the literature review, seven steps to a comprehensive literature review: A Multimodal and Cultural Approach, *PLos* 48–64.

OXFORD Research, 2018. Community-Oriented Primary Health Care Community-Based PHC Approach and the Continuum of Care (MNCH).

Padgett, D.K. 2012. *Qualitative and mixed methods in public health*. Thousand Oaks, CA: Sage.

Paré, G. & Kitsiou, S. 2017. Chapter 9 Methods for literature reviews. In: Lau F, Kuziemsky C, editors. *Handbook of ehealth evaluation: An evidence-based approach [Internet].* University of Victoria; 2017 Feb 27. Available from: https://www.ncbi.nlm.nih.gov/books/NBK481583/

Patten, M.L. & Galvan, M.C. 2019. *Proposing empirical research: A guide to the fundamentals*. 6th ed. New York: Routledge.

Patton, A. 2002. Qualitative research and evaluation methods, 3rd ed Canada: SAGE.

Paul, V.K. 2011. Reproductive health, and child health and nutrition in India: Meeting the challenge, *The Lancet*, 377(9762): 332–349. https://doi.org/10.1016/S0140-6736(10)61492-4.

Pautasso, M. 2013. Ten simple rules for writing a literature review, *PLoS Computational Biology*, 9(7): 7–10, https://doi.org/10.1371/journal.pcbi.1003149

Penfold, S. 2010. A large cross-sectional community-based study of newborn care practices in Southern Tanzania, *PLosOne* 5(12): 1–6. https://doi.org/10.1371/journal.pone.0015593.

Penn-Kekana, L. 2017. Understanding the implementation of maternity waiting homes in low- and middle-income countries: A qualitative thematic synthesis, *BMC Pregnancy and Childbirth*, 17(1): 1–12. https://doi.org/10.1186/s12884-017-1444-z.

Perry, H., Morrow, M., Borger, S., Weiss, J., DeCoster, M., Davis, T. & Ernst, P. 2015. Care groups I: An innovative community-based strategy for improving maternal, neonatal, and child health in resource-constrained settings. *Global health, Science and Practice,* 3(3): 358–369. https://doi.org/10.9745/GHSP-D-15-00051.

Polgar, S. & Thomas, S.A. 2011. *Introduction to research in the health sciences e-Book*. 5th edition. London: Elsevier Health Sciences.

Polit, D.F. & Beck, C.T. 2010. *Nursing research: Principles and methods*. Philadelphia: Lippincott Williams & Wilkins.

Pope, C., Royen, P. Van & Baker, R. 2019. Qualitative methods in research on healthcare quality, *Medical Journal* 11(2): 1–14.

Price, S.L. 2018. Maternal knowing and social networks: Understanding first-time mothers' search for information and support through online and offline social networks*, Sage Journal*. https://doi.org/10.1177/1049732317748314.

Prism, S.M. & Feldstein, A.C. 2008. A practical, robust implementation for integrating research findings into practice, 34(4), England: Springer.

Profetto-McGrath J. & Karen Bulmer Smith, 2019. The Poster: A Critical Thinking and Creative Strategy in a Research Course.

Punch, K.F. 2014. Introduction to social research – quantitative & qualitative approaches. London: Sage.

Rafiki, A. & Medan, U. 2020. To support customers in easily and affordably obtaining titles in electronic format IGI global is now offering a 50 % discount on all e-books and e-journals ordered directly through IGI global online bookstore *Opportunities and Challenges of Social Me*, 1–6. https://doi/10.4018/978-1-7998-2257-8.ch011

Rahman, S. 2017. The advantages and disadvantages of using qualitative and quantitative approaches and methods in language. Testing and assessment research: A literature

review, *Journal of Education and Learning*, 6(1): 102–112. https://doi.org/10.5539/jel.v6n1p102.

Rani, V.J. 2016. Methodologies of translation. *IOSR Journal of Humanities and Social Science (IOSR-JHSS),* 1-2. Available at: https://www.iosrjournals.org/iosr-jhss.html (Accessed 19 March 2020).

Rapley T, Melissa Girling, Frances S. Mair, Elizabeth Murray, Shaun Treweek, Elaine McColl, Ian Nicholas Steen, Carl R. May and Tracy L. Finch, 2018. Improving the normalisation of complex interventions: Part 1-development of the NoMAD instrument for assessing implementation work based on normalisation process theory (NPT) 17 Psychology and Cognitive Sciences 1701 Psychology, *BMC Medical Research Methodology*. https://doi.org/10.1186/s12874-018-0590-y .

Raven, J. 2011. Methodology and tools for quality improvement in maternal and newborn health care, *International Journal of Gynecology and Obstetrics*, 114(1): 4–9. https://doi.org/10.1016/j.ijgo.2011.02.007.

Renkert, S. & Nutbeam, D. 2001. Opportunities to improve maternal health literacy through antenatal education: An exploratory study, *Health Promotion International*, 16(4): 381–388. https://doi.org/10.1093/heapro/16.4.381 .

Richard, M., Grinnell, J.R., Yvonne, A. & Unrau, A. 2015. *Social work research and evaluation: Foundations of evidence bases practice*. 11th edition. Oxford University Press.

Ridgeway, J.L. 2012. Building a measurement framework of burden of treatment in complex patients with chronic conditions: *A qualitative study*, 39–49.

Rosen, H.E. 2015. Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa, pp. 1–11. https://doi.org/10.1186/s12884-015-0728-4.

Ruducha, J., Carlyn Mann, Singh, N.S., Gemebo, T.D., Tessema, N.S., Baschieri, A., Friberg, I., Zerfu, T.A., Yassin, M., Franca, G.A. & Berman, P.A. 2017. How Ethiopia achieved millennium development goal 4 through multisectoral interventions: A countdown to 2015 case study. *The Lancet Global Health*, 5(11): e1142–e1151. https://doi.org/10.1016/S2214-109X(17)30331-5.

Ruppel, P.S. & Mey, G. 2017. *Grounded theory methodology*. From: http://www.communication.oxfordre.com/view/10.1093/acrefore/9780190228613.001.0001/acrefore-9780190228613-e-522 (Accessed: 10 May 2020).

Sadik, E.A. & Bezatu. A. 2013. Aspects of common traditional medical practices applied for under-five children in Ethiopia, Oromia Region, Eastern-Harargie District, Dadar Woreda, 2011 G.C. *Community Medicine & Health Education*. https://doi.org/10.4172/2161-0711.1000237

Saldanha, G. & O'Brien, S. 2013. *Research methodologies in translation studies*. London: Routledge.

Santos, R.B. 2017. *Crime analysis with crime mapping*. 4th edition. London: SAGE Publications, Inc.

Saxena, M. 2018. Is quality of care during childbirth consistent from admission to discharge? A qualitative study of delivery care in Uttar Pradesh, India. *PLoS ONE*, 13(9). https://doi.org/10.1371/journal.pone.0204607.

Schaffer, K. & Rashid, S. 2016. Improve maternal and new-born health and nutrition, *The Partnership for Maternal, New-born and Child Health*, 18(10): 399–417.

Scotland, J. 2012. Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9): 9-16.

Semrau, K.E.A. 2016. Effectiveness of the WHO safe childbirth checklist program in reducing severe maternal, fetal, and new-born harm in Uttar Pradesh, India: Study protocol for a matched-pair, cluster-randomized controlled trial, *Trials*, 17(1). https://doi.org/10.1186/s13063-016-1673-x.

Shetty, A.P. 2016. Florence Nightingale: The queen of nurses, *Archives of Medicine and Health Sciences*, 4(1): 144. https://doi.org/10.4103/2321-4848.183362.

Silali, M. & Owino, D. 2016. Factors influencing accessibility of maternal & child health information on reproductive health practices among rural women in Kenya, *Family Medicine & Medical Science Research*, 05(01): 1–7. https://doi.org/10.4172/2327-4972.1000198.

Singh, D., Negin, J., Orach, C. & Cumming, R. 2016. Supportive supervision for volunteers to deliver reproductive health education: A cluster randomized trial. *Reproductive Health*. https://doi.org/13. 10.1186/s12978-016-0244-7.

Smith, J., Flowers, P & Larkin, M. 2009. Interpretative phenomenological analysis: Theory, method and research. New York: SAGE

Smith, H.J., Portela, A.G. & Marston, C. 2017. Improving implementation of health promotion interventions for maternal and new-born health, *BMC Pregnancy and Childbirth*, 17(1): 2–7. https://doi.org/10.1186/s12884-017-1450-1.

Snyder, H. 2019. Literature review as a research methodology: An overview and guidelines, *Journal of Business Research*, 104(8): 333–339. https://doi.org/10.1016/j.jbusres.2019.07.039.

Solomon, B. 2015. Ethiopia's lessons from maternal, new-born and child health for non-communicable diseases. *Springer*, https://doi.org/10.13140/RG.2.1.2047.7520

Spies, L.A. 2015. Uganda nursing research agenda: A Delphi study, *International Nursing Review*, 62(2): 180–186. https://doi.org/10.1111/inr.12167 .

Squires, A. & Dorsen, C. 2018. Qualitative research in nursing and health professions regulation, *Journal of Nursing Regulation*, 9(3): 15–26. https://doi.org/10.1016/S2155-8256(18)30150-9.

Stockwell, F. 2010. A contemporary perspective on Florence Nightingale's writings in notes on nursing and Florence Nightingale to her nurses: Some personal reflections. London: Austin Macauley Publishers

Sudhinaraset, M., Patience Afulani, Nadia Diamond-Smith, Sanghita Bhattacharyya, France Donnay, Dominic Montagu 2018. Advancing a conceptual model to improve maternal health quality: The person-centered care framework for reproductive health equity, *Gates Open Research,* 1(0): 1–14. https://doi.org/10.12688/gatesopenres.12756.1 .

Sufrin, C. 2019. Pregnancy outcomes in US prisons, 2016-2017, *American Journal of Public Health*, 109(5): 799–805. https://doi.org/10.2105/AJPH.2019.305006

Susan, L. & Shelton, M. 2009. Unit one foundations in maternal, family, and child care London: Sage

Taft, A.J. 2015. Maternal and child health nurse screening and care for mothers experiencing domestic violence: A cluster randomised trial, *BMC Medicine*. 1–10. https://doi.org/10.1186/s12916-015-0375-7

Takele, M. 2018. College of health science school of public health improving the implementation status of nursing and midwifery care standard practice at medical, surgical and gynaecology wards in Dilchora hospital, Dire Dawa, Ethiopia. Ethiopia: Mulatu Takele

Thanh, N.C. & Thanh, T.T.L. 2015. The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science*, 1(2): 24-27.

Thomas, G. 2016. *How to do your case study.* 2nd edition. London: SAGE.

Thomas, J. & Harden, A. 2008. Methods for the thematic synthesis of qualitative research in systematic reviews, *Journal of Advanced Nursing,*10: 1–10. https://doi.org/10.1186/1471-2288-8-45

Thompson, W.E. & Hickey, J.V. 2016. *Society in focus: An introduction to sociology.* Leeds: Rowman & Littlefield.

Tierney, E. 2019. Interdisciplinary team working in the Irish primary healthcare system: Analysis of invisible bottom-up innovations using normalisation process theory, *Health Policy*, 123(11): 1083–1092. https://doi.org/10.1016/j.healthpol.2019.09.002

Titler, M.G. 2018. Translation research in practice: An introduction, *Online Journal of Issues in Nursing*, 23(2): 1–1. https://doi.org/10.3912/OJIN.Vol23No02Man01.

Trudel, M.C. 2015. Information & management synthesizing information systems knowledge : A typology of literature reviews, *Information and Management*, 52(2): 183–199. https://doi.org/10.1016/j.im.2014.08.008.

Turkmani, S. 2013. Midwives are the backbone of our health system: Lessons from Afghanistan to guide expansion of midwifery in challenging settings, *Midwifery*, 29(10): 1166–1172. https://doi.org/10.1016/j.midw.2013.06.015

Twinn, S. 1997. Methodological issues in the evaluation of the quality of public health nursing: A case study of the maternal and child health centres in Hong Kong, *Journal of Advanced Nursing,* 25(4): 753–759. https://doi.org/10.1046/j.1365-2648.1997.1997025753.x.

Uneke, C.J., Issiaka, S., Namoudou, K., Virgil, L., Ermel, J., & Zogo, J.P. 2016. An assessment of maternal, newborn and child health implementation studies in Nigeria: Implications for evidence informed policymaking and practice, *Tabriz University of Medical Sciences,* 6(3): 119–127. https://doi.org/10.15171/hpp.2016.20

UNF, 2015. *The MAPS Toolkit: mHealth assessment and planning for scale, World Health Organisation.* Available at: http://www.mobilemamaalliance.org/sites/default/files/9789241509510_eng.pdf

UNICEF, 2017: UNICEF Annual Report 2017. Addis Ababa, Ethiopia.

UNISA. 2020a. Covid-19 guidelines: Implication of alert levels for researchers and postgraduates' students. Pretoria. University of South Africa.

UNISA. 2020b. University of South Africa COVID-19 position statement on research ethics.

University of South Africa/ UNISA. 2016. *UNISA policy on research ethics.* Florida: UNISA.

United Kingdom Report, 2018. Inquiry into Perinatal Services. PARLIAMENT OF VICTORIA Family and Community Development Committee

UN Women, 2015. MONITORING GENDER EQUALITY AND THE EMPOWERMENT OF WOMEN AND GIRLS IN THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT: OPPORTUNITIES AND CHALLENGES. United Nations Entity for Gender Equity and Empowerment of Women.

Urquhart, R., Cynthia Kendell, Evelyn Cornelissen, Laura L. Madden, Byron J. Powell, Glenn Kissmann, Sarah A. Richmond, Cameron Willis and Jackie L. Bender, 2020*. Defining sustainability in practice: Views from implementing real-world innovations in health care*, New York: Elsevier.

USAID 2014 Ending preventable maternal mortality: USAID maternal health vision for action, *USAID Maternal Health Vision for Action*, (2): 1–56. https://doi.org/10.1007/s13398-014-0173-7.2

USAID 2016. *Acting on the call: Ending preventable child and maternal deaths*. New York: US Agency for International Development.

Van der Riet, M. & Durrheim, K. 2014. Putting design into practice. *Research in practice: Applied methods for the social sciences.* 2nd edition. Cape Town: UCT Press.

Vedam, S. 2017. The mothers on respect (MOR) index: Measuring quality, safety, and human rights in childbirth, *SSM-Population Health*, 3(1): 201–210. https://doi.org/10.1016/j.ssmph.2017.01.005.

Victoria, 2011. Using student assessment for professional learning focusing on students' outcomes to identify teachers' needs.

Vyncke, M. 2012. 'The Concept and practice of critical thinking in academic writing: An investigation of international students' perceptions and writing experiences'. MA Dissertation. King's College, London.

Walliman, N. 2017*. Social research methods*. 2nd edition. London: Sage*.*

Walugembe, D.R. 2015. Sustainability of public health interventions: Where are the gaps, *JMP Journal* 1–7.

Wardrop, R., Coyne, E. & Needham, J. 2019. Exploring the expectations of preceptors in graduate nurse transition: A qualitative interpretative study, *Nurse Education in Practice*, 34(33): 97–103. https://doi.org/10.1016/j.nepr.2018.11.012

Welman, J.C., Kruger, S.J. & Mitchell, B. 2012. *Research methodology*. 3rd edition. Cape Town: Oxford University Press.

WFP 2020. Executive board draft Ethiopia interim country. *Strategic Research*, 1–41.

UNICEF 2015. Water, sanitation and hygiene in health care facilities: Status in low-and middle-income countries and way forward question and answer. Geneva: WHO

Whitley, B.E. & Kite, M.E. 2012. *Principles of research in behavioural science* 3rd ed. New York: Routledge.

WHO & UNICEF. 2017. *Reaching every new-born national 2020 milestones country progress, plans and moving forward*. Available at: http://apps.who.int/iris/bitstream/10665/255719/1/9789241512619-eng.pdf?ua=1.

WHO. 2013. *Postnatal care of the mother and new-born*. Geneva: World Health Organisation, 1–72.

WHO. 2015a. Postnatal care for mothers and new-borns highlights from the World Health Organisation 2013 Guidelines, Geneva: WHO Library Cataloguing-in-Publication Data World.

WHO. 2015b. WHO recommendations for prevention and treatment of maternal peripartum infections Executive summary, *World Health Organisation*, 1–6. https://doi.org/10.1016/0140-6736(93)92727-B .

WHO. 2018. Delivering quality health services. Available at: http://apps.who.int/bookorders.

Widmer, M. 2011. The role of faith-based organisations in maternal and newborn health care in Africa, *International Journal of Gynecology and Obstetrics*, 114(3): 218–222. https://doi.org/10.1016/j.ijgo.2011.03.015

Williams, C. 2007. Research methods, *Journal of Public Health* 5(3): 65–72.

Willis, K. 2007. The essential role of social theory in qualitative public health research, *Australian and New Zealand Journal of Public Health*, 31(5): 438–443. https://doi.org/10.1111/j.1753-6405.2007.00115.x.

Wilson, R.D.l. 2018. Special reports guidelines for antenatal and preoperative care in cesarean delivery: Enhanced recovery after surgery society recommendations (Part 1)', *The American Journal of Obstetrics & Gynecology*, 219(6): 523.e1-523.e15. https://doi.org/10.1016/j.ajog.2018.09.015

Withrow, B.L. 2014. *Research methods in crime and justice*. New York: Routledge.

World Health Organization Report, 2008. Primary Health Care. Now More than Ever.

WHO Recommendations, 2015. World Health Organization Recommendations for maternal and interventions on health promotion newborn health.

World Health Organisation 2016. The WHO safe childbirth checklist collaboration, Available.at:http://www.who.int/patientsafety/implementation/checklists/childbirth_collaboration_engaging/en/.

World Health Organisation 2017. New guidelines on antenatal care for a positive pregnancy experience, *World Health Organisation*, 6(11): 1–4.

World Health Organisation 2018a. Standards for improving quality of maternal and newborn care in health facilities, *World Health Organisation*, 6(11): e1140–e1141. https://doi.org/10.1016/s2214-109x(18)30394-2

World Health Organisation 2018b. WHO recommendations: Uterotonics for the prevention of postpartum haemorrhage, Geneva: World Health Organisation.

World Health Organization, 2018c. The network to improve quality of care for maternal, newborn and child health, *Quality, Equity, Dignity*. https://doi.org/10.1053/jlts.2000.8508

Worknesh Kereta, Bekele Belayihun, Kidest Lulu Hagos, Yordanos B Molla, Marta Pirzadeh & Mengistu Asnake, 2021. Youth-Friendly Health Services in Ethiopia: What Has Been Achieved in 15 Years and What Remains to be Done.

Yared, M. & Asnakech, M. 2003. Factors influencing the use of maternal healthcare services in Ethiopia, *International Journal for Equity in Health*, 14(1). https://doi.org/10.1186/s12939-015-0162-2.

Yaya, S. 2019. Decomposing the rural-urban gap in the factors of under-five mortality in sub- Saharan Africa? *Evidence from 35 countries'*, (6): 1–10.

Zerfu, T.A. 2019. Reaching the unreached through trained and skilled birth attendants in Ethiopia: A cluster randomized controlled trial study protocol, *BMC Health Services Research*, 17(1): 1–11. https://doi.org/10.1186/s12913-017-2041-6

Zulawski, D.E. & Wicklander, D.E. 2016. Field interviewing*. Law and Order*. September: 111-115.

ANNEXURE A: UNISA ETHICAL CLEARANCE

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

6 December 2017

Dear Sadik Elias Ahmed

Decision: Ethics Approval

HSHDC/787/2017
Sadik Elias Ahmed

Student No.:6164-988-0
Supervisor: Prof ON Makhubela-Nkondo
Qualification: PhD
Joint Supervisor: -

Name: Sadik Elias Ahmed

Proposal: Challenges and opportunities in maternal and child health nursing practices in rural health centres in Ethiopia

Qualification: **DPCHS04**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 6 December 2017 to 6 December 2022.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 6 December 2017

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

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PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES

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ANNEXURE B: LETTERS OF PERMISSION TO RESEARCH SITES

1

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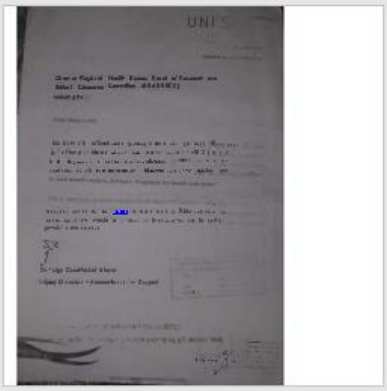

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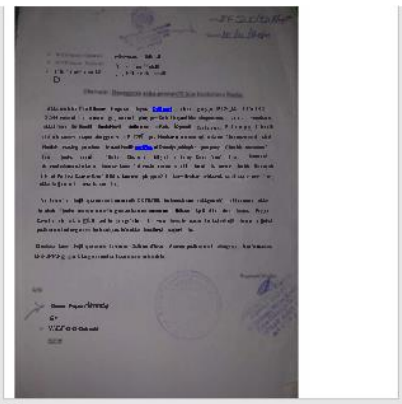

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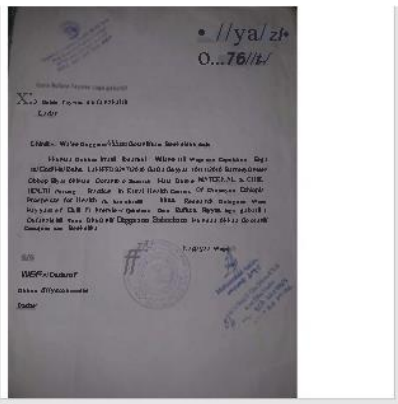

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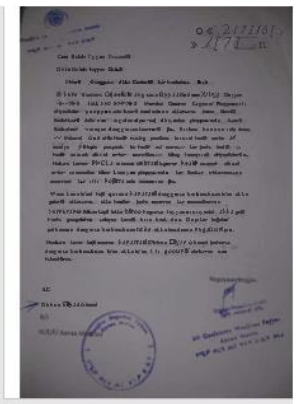

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ANNEXURE C: INFORMED CONSENT

Informed Consent Form

Healthcare professionals are daily faced with challenges regarding the protection of their patients and communities from diseases and death in the context of maternal and child health nursing care practices.

I hereby invite you to participate in my research study on “MATERNAL AND CHILD HEALTH NURSING PRACTICES TO IN RURAL HEALTH CENTERS ETHIOPIA: PROSPECTS FOR HEALTH OUTCOMES”.

The purpose of the study is to explore challenges and opportunities for maternal and child health (MCH) nursing in the context of East Hararghe Zone of the Oromia National Regional State in Ethiopia. The information obtained will benefit both the facilities, personnel and the community, as the results will be used to determine what can be done to improve the situation. There is no risk of discomfort in sharing your information and you need not attach your name, surname, address or telephone number.

To participate in the study, you will be required to respond to the questions that will be asked by the researcher. If you do not understand, please feel free to ask for clarification, and your questions and concerns will be addressed in a language of your choice.

Participation is voluntary; you are under no obligation to participate in the study. You have the right to refuse participation in the study, and you will not be penalised in any way.

Researcher: ELIAS AHMED SADIK	Date: ……/……/……

I confirm that I have received and understand all the information regarding the study. It was also explained to me that my participation is voluntary and that I may refuse to participate or give consent to the study without any penalty meted against me.

I hereby freely consent to take part in this research study.

Signature of respondent _____	Signature of witness _____	Date: _____

ANNEXURE D: INTERVIEW QUESTIONS

Part 1: Key Informant Interview Questions

District: ……Code of Health Centre: ……

Date: …… Time: .....

Code of Participant/s: ……

In-depth Interview: Open Ended Questions
Good morning/day. would you please tell me about your profile in respect of the following? 1. Demographic Profile Age, gender, educational status, marital status, ethnic group, job experience and religion 2. Aspects of MCH care practices A Rationale for MCH Why is MCH care practice an issue? Any more? What else? B. Purposes of MCH Care What is the purpose of MCH care practice? Any more? What else? C. Components of MCH care What services are there in MCH care? Any more? What else? D. Role of Stakeholders in MCH care What activities are carried out in MCH care practices? Any more? What else? E. Interactions in MCH Care How is social-networking in MCH care practices? Any more? What else? How effective is inter-personal communication? Any more? What else? F. Satisfactory and unsatisfactory things in MCH Care practices What are the details of your satisfactions? Any more? What else What are the details of your dissatisfactions? Any more? What else? 3. Barrier Factors in MCH Care Practices What are the major challenges in MCH care practices? •What Health Service-related barriers? Any more?

What else?
•What Socio-political factors?
Any more?
What else?
•What Access related barriers?
Any more?
What else?
•What Economic Factors?
Any more?
What else?
•What Cultural factors?
Any more?
What else?
•What Religious factors?
Ant more?
What else?

4. Enabling factors

What are enabling factors or available opportunities for MCH care?
•What Health Service-related barriers?
Any more?
What else?
•What Socio-political factors?
Any more?
What else?
•What Access related barriers?
Any more?
What else?
•What Economic Factors?
Any more?
What else?
•What Cultural factors?
Any more?
What else?
•What Religious factors?
Ant more?
What else?

5. Innovative Ideas

What do you suggest to improve MCH Care?
Any more?
What else?

Part 2: Focus Group Discussion Guides

District ……. Code of Health Center……

Date …… Time.....

Focus Group Discussion Session ……

Code of Participant:

1. **……..**
2. **…….**
3. **…….**
4. **……**
5. **……**
6. **…….**

Focus Group Discussion Guidelines
Good morning/day. would you please tell me about your profile in respect of the following? 1. Demographic Profile Age, gender, educational status, marital status, ethnic group, job experience and religion 1…….. 2……. 3……. 4…… 5…… 6……. 2. Aspects of MCH care practices A. Rationales/Reasons for MCH care practices B. Purposes of MCH care practices C. Components of MCH care practices D. Activities in MCH care practices E. Integrations in MCH care practices F. Satisfactory and unsatisfactory things 3. Barrier factors affecting MCH care practices •Health care factors •Socio-political factors •Access factors •Economic factors •Cultural factors •Religious factors •Others 4. Enabling factors for MCH care practices •Health care factors •Socio-political factors •Access factors •Economic factors •Cultural factors •Religious factors •Others 5. Innovative ideas to improve MCH care practice Opinions Suggestion Comments

Others

Part 3: MCH Facility and Nursing Practice Observation Checklist

District: ……. Code of Health Centre: …….

Date: ……. Time: .....

General Facility-based MCH Service Provision Observation Check Lists

Observation Check Lists
Standard 1: The way every woman and child receive evidence-based routine care and management of complications
Standard 2: The way health information system enables the use of data for early and appropriate action to improve care for woman and child
Standard 3: The way every woman and child with condition (s) that cannot be dealt with effectively with the available resources and services.
Standard 4: The way communication with women and their families is effective and in response to their needs and preferences.
Standard 5: The way every woman receives care with respect and dignity.
Standard 6: The way every woman and her family are provided with emotional support that is sensitive to their needs and strengthens her own capabilities.
Standard 7: The way competent and motivated staff is consistently available for every woman and child to provide routine care and manage of complications.
Standard 8: The nature of health facilities' appropriate physical environment with adequate utilities, medicines, supplies and equipment for maternal and child complications handling.
Observed Realities and Explanations

ANNEXURE E: EDITING LETTER

I, the undersigned, hereby confirm my involvement in the academic editing, language control, text redaction, research methodology compatibility and technical compliance for the manuscript of **Mr Elias Ahmed Sadik (Student Number: 61649880)** submitted to me in respect of his fulfilment of the requirement for the Doctor of Philosophy (PhD) in Nursing degree registered with the University of South Africa (UNISA), and entitled:

Maternal and child health nursing practices in rural health centres, Ethiopia: Prospects for health outcomes

As an independent academic editor, I attest that all possible means have been expended to ensure the final draft of **Mr E.A. Sadik's** thesis manuscript reflects both acceptable research methodology practices and language control standards expected of postgraduate research studies at his academic level.

In compliance with expected ethical requirements in research, I have further undertaken to keep all aspects of **Mr E.A.'s** research study confidential, and as his own individual initiative.

Sincerely.

TJ Mkhonto
BA Ed: North-West University, Mafikeng (1985)
MEd: School Administration; University of Massachusetts-at-Boston, USA, Harbor Campus (1987)
DTech: Higher Education Curriculum Policy Reform, Design & Management; University of Johannesburg, (2008)

All enquiries:

Email: mkhonto9039@gmail.com
Cell: +27(0)60 401 8279

Signed: _____ **Date:** _27 October 2022_

Dr TJ Mkhonto dd/mm/yyyy

Independent Academic Editor

Professional EDITORS Guild

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Associate Member

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ANNEXURE F: TURNITIN ORIGINALITY REPORT