How conversations over coffee reduced maternal mortality rates

Bringing intimate rituals into hospitals throughout Ethiopia

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All over Ethiopia, a ritual known as the coffee ceremony is deeply ingrained in the social fabric. When I was a child, my mother would send me round to tell the neighbours she had lit the charcoal to roast the coffee beans. They would come to our house, sit, drink coffee, and exchange neighbourhood gossip. The ritual even has its place in childbirth. When a woman is in labour, her neighbours will often come by and make coffee as they offer encouragement and support.

Back in 2002, for every 100,000 live births in Ethiopia, 960 mothers tragically died. This was worse than the overall average for sub-Saharan Africa, which was 773. Fast-forward to 2020, and the picture looked very different. Sub-Saharan Africa as a whole had made progress, reducing maternal mortality rate to 536 per 100,000. But in Ethiopia, that number had come down to just 267, less than half the regional average (World Bank Group, 2023).

How did Ethiopia do it? For much of that period, I worked for the Ministry of Health, including as Minister of Health from 2012 to 2016. But I want to start the story long before that, back in the 1970s.

Before that time, the Ethiopian health system had focused primarily on big hospitals. As the majority of Ethiopians lived – and still live – in rural areas, they found medical services difficult to access. In the 1970s, we saw the first attempts to introduce a more community-based health workforce. But most services were focused on single issues, such as malaria or HIV, and they all relied on donor money or getting local people to volunteer. The principle of community health workers was good, but this was the wrong model. Once the donor money dried up, the programmes collapsed.

In 2003, the government assembled a team of experts to think about what would make a community-based healthcare programme work. We looked at examples in other countries, including India, Pakistan, Bangladesh, Ghana and Malawi. We made the decision that any programme had to be government funded, and the community health workers would receive government salaries. You can't ask people to do a full-time job on a voluntary basis – they need to be properly compensated.

We also decided that the programme needed to be general, not focused on one particular disease

or condition, and with the emphasis on preventive health, because most health problems in Ethiopia were preventable. The workers would also provide basic services such as family planning and treating common childhood illnesses. They would be the closest thing to a senior health professional in their village.

Over the next few years, we rolled out the Health Extension Programme throughout the country, training 30,000 community health workers. They were all women, for two important reasons. First, men in the villages spend much of their time working in the field, and they would not feel comfortable with us sending another man to their house while they were out. Second, we wanted to provide role models for girls. In many communities, fewer girls than boys completed their schooling. We wanted parents to see female health workers earning a good salary, giving them an incentive to send their own girls to school.

The programme had a transformational effect. It gave Ethiopia one of the best-performing health systems on the continent, by all kinds of metrics: child mortality, HIV prevention, malaria, sanitation, and so on. But there was one big exception: maternal mortality. Yes, the rate was coming down. But, frustratingly, it wasn't making the same kind of rapid progress as we saw in other indicators.

Connecting with communities over coffee

We had excellent health facilities for women to give birth in. We had ambulances, skilled midwives, surgeons, and blood transfusion services. But, despite all that, most women were not going to these facilities to give birth. Instead they were staying at home, where the risks of childbirth were much higher. Why?

To find out, we leveraged the cultural practice of the coffee ceremony. Beginning in 2010, we invited women in communities to have coffee, and chatted to them about why they preferred to give birth at home rather than in health facilities. These informal discussions brought up things that hadn't emerged in earlier, more formal community consultations. I learned things I had never previously thought about in my office in the Ministry of Health, leading me to

↑ Traditional coffee ceremony at a maternal health facility

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realise how many blind spots we had when it came to the needs and desires of pregnant women and birthing mothers.

The women told us, for example, that they did not want to go somewhere to give birth where they could not get anything to eat. Most rural areas are served by primary health centres, rather than a hospital. As these centres are designed to provide only outpatient services, they do not offer on-site food facilities, and often there are no restaurants nearby. Also, in these centres, their neighbours could not come round to drink coffee during labour, nor could they eat the porridge that is traditionally given to new mothers once the baby has arrived.

Some women told us that they preferred to give birth at home so they could have a religious leader in the room with them. Those who were members of the Orthodox church said they wanted the room to be blessed and sprayed with holy water.

Photo: Kesete Admasu

> "We learned that being physically looked after as they gave birth was not enough – they also wanted to be looked after emotionally and spiritually."

Other women said it was traditional in their culture for fathers or mothers-in-law to be present at the birth. They did not like how health facilities insisted on only professionals being in the delivery room, for hygiene reasons.

Some women told us that when a pregnant woman went from the village to the health centre to give birth, she would be taken away on a stretcher in an ambulance. This had a negative association for them. They were used to the idea that when someone went on a stretcher into an ambulance, they often didn't come back alive.

Equipped with this knowledge, we could start to ask ourselves questions. How could we make space in health facilities for family and friends to come in for coffee, and to make porridge? How could we bring religious leaders into the delivery room, while also ensuring that infection control measures would be upheld? Could we design a distinctive kind of stretcher for pregnant women, to break the mental association with the stretchers that carry gravely ill people into ambulances?

In two regions of northern Ethiopia, we trialled reforms to create a more relaxed, home-like environment in health facilities. This included allowing family and religious leaders into birth centres, providing spaces to cook their own food and making time for coffee ceremonies. Soon the idea had been adopted up and down the country, adapted by communities according to their own cultural practices. The number of women choosing to give birth in health facilities rose quickly, in some areas from as low as 20% up to as high as 73% (Bill & Melinda Gates Foundation, 2017).

It wasn't only the mothers who benefited, though. So did the health workers. It is a very stressful job, and the presence of friends and family encouraging pregnant mothers also provided emotional support for the nurses. Instead of the sterile smell of disinfectant, there would be the aroma of roasting coffee. When the nurses had a moment, they would sit down for a drink with the community members. It helped with stress and increased their sense of connection with mothers.

Government should be open to new ideas and older customs

For these Ethiopian mothers, we learned that being physically looked after as they gave birth was not enough – they also wanted to be looked after emotionally and spiritually, in line with their traditions and rituals. But our engagement was broader. Health extension workers led women's groups in every village, to support productive consultations on all aspects of the health system. Up to three million women have participated in these groups at any one time.

The broader lesson, applicable to all kinds of health services and settings, is this: if you genuinely engage and listen to community members – giving them the knowledge and the power to make decisions – they will be innovative in finding ways to ensure their own wellbeing. The keys to success are creating a sense of ownership, and being open to new solutions.

↗ **Find this article online at earlychildhoodmatters.online/2025-7**

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