ACCESS: ETHIOPIA OVERALL PROGRAM BRIEF

I. Strengthening pre-service education of health officers with a focus on clinical skills in maternal and newborn care to improve maternal and newborn survival;

II. Designing and implementing an in-service training program for health extension workers (HEWs), to update them in evidence-based maternal and newborn care.

Ethiopia has one of highest maternal mortality ratios in the world, with nearly 673 maternal deaths per 100,000 live births (DHS, 2005). The immediate causes of maternal deaths in the country are hemorrhage (25%), sepsis (15%), unsafe abortion (~ 40%), hypertensive disorders of pregnancy (12%), obstructed labor and other direct causes (8%). These occur as a result of one or more of the following three delays: 1) delay in identification of the problem by the woman and her family, 2) delay in transport to an appropriate facility, and 3) delay in getting proper care once at the facility. In addition, the overall rate of skilled attendance at birth is 6% (or lower in some rural areas) and is one of the worst in Africa (DHS 2005).

KEY INDICATORS FOR ETHIOPIA

- **Neonatal mortality rate (per 1,000):** 37
- **Skilled attendance at birth:** 11% Sylhet, 18% (Nat.)
- **Modern contraceptive prevalence rate:** 32% (Sylhet), 56% (Nat.)
- **Unmet need for family planning:** 26% (Sylhet), 18% (Nat.)
- **Total fertility rate:** 3.7 (Sylhet), 2.7 (Nat.)
- **Antenatal care attendance with trained provider:** 47% (Sylhet), 52% (Nat.)

In Ethiopia, an overwhelming majority of births (94%) occur at home. Further, only 5% of births occur in a public facility and less than 1% of births take place in a private facility. There are also huge gaps among the regions in the source of antenatal care (ANC). For example, 88% of mothers in Addis Ababa received ANC from a health professional, compared with less than 10% of mothers in the Somali Region.

International experts agree that the optimal strategy to reduce maternal mortality is to ensure that all pregnancies are wanted, all births are attended by skilled attendants either at home or in health centers, and all women with complications have access to emergency obstetric care. To ensure sustainability of activities, the program has worked closely with local institutions such as the Ethiopian Nurses and Midwives Association (ENMA) and the Ethiopian Society of Obstetricians and Gynecologists (ESOG) to strengthen their capacity to develop learning materials, conduct competency-based training and conduct supportive supervision.

PROGRAM STRATEGIES, INTERVENTIONS AND RESULTS

I. Accelerated Health Officer Program

The government of Ethiopia has set new targets for training health officers under a program called the Accelerated Health Officer Training Program (AHOTP). The plan is to train 5,000 health officers by 2010 using the approved three-year degree program currently offered in five national universities. With intakes of 1,000 nurses per year returning for further study, the plan recognizes that existing clinical facilities used by the universities will not be able to absorb all of them. As a result, 21 hospitals around the country were designated as affiliated hospitals for the purpose of this program (roughly four hospitals per university).

The Carter Center has provided financial and material support to these 21 hospitals, and has invited selected staff from the hospitals to participate in workshops on clinical training skills and learning methodology. Building upon these efforts, ACCESS has worked in eight of these hospitals to create enabling environments for the health officer trainees to acquire knowledge and skills in the clinical care of mothers and newborns.

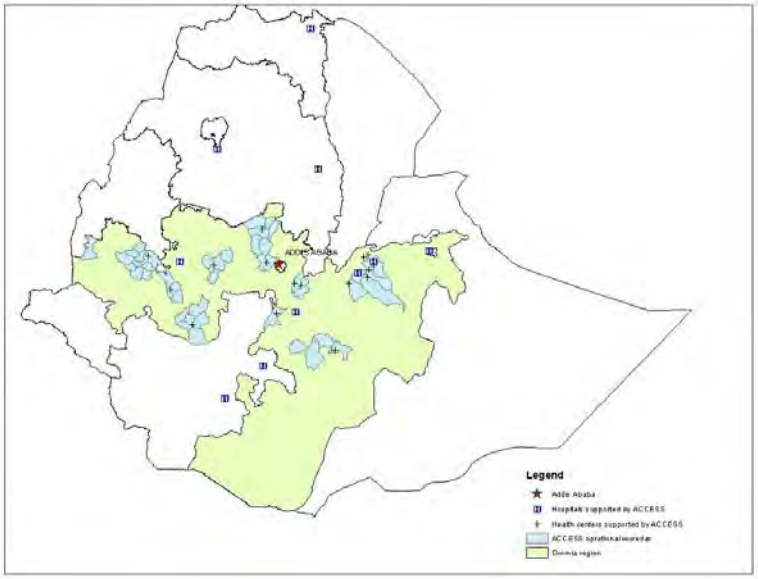
Based on gaps identified during an initial site assessment, action plans were developed, and clinical sites were strengthened to ensure adequate resources to support teaching and learning activities. A three-week BEmONC[1] training course was conducted in three sites for 52 participants from the eight selected hospitals and AHOTP-affiliated university representatives (e.g., university ob/gyn department representatives). Among the participants, 18 also participated in a six-day clinical training skills course to enhance their capacity to transfer knowledge and skills. It is estimated that more than 500 health officers have thus far benefited from the improved clinical learning environments.

In addition, focused antenatal care (FANC) is standard of care in seven of the eight hospitals, and all eight have markedly improved their infection prevention (IP) practices and women friendly care. AMTSL[2] and essential newborn care are now routinely carried out in all eight hospitals. Care and follow-up in the immediate postpartum has also improved and many women remain in the facilities for at least six hours before discharge.

To address remaining gaps in performance, ACCESS has selected four of the hospitals and oriented them to the Standards-Based Management and Recognition (SBM-R) approach, which uses agreed-upon performance standards as the basis for measuring performance and identifying gaps in quality of care, as well as rewarding compliance with standards through recognition mechanisms. The baseline assessment shows gaps in a number of areas in the provision of essential maternal intrapartum care. The hospitals identified plans to address the gaps in care, focusing initially on those gaps that can be closed easily. Internal assessments will now be carried out by the hospitals, with the expectation that there will be an improvement toward reaching desired performance standards.

A number of challenges remain including inconsistency in practices and non-availability of magnesium sulphate for treatment of pre-eclampsia and eclampsia. In the coming months, ACCESS will support ongoing efforts by the eight hospitals to improve the quality of care and focus on standardizing use of partographs in labor and administration of magnesium sulphate for eclampsia.

Figure 1: ACCESS supported facilities and operational Woredas



II. Health Extension Worker Program

The Federal Ministry of Health has developed a Health Sector Development Plan (HSDP-III), which includes the goal of accelerating the expansion of primary health coverage and increasing the number of health care workers. At the core of the HSDP-III is the Health Extension Program (HEP), introduced in 2004–2005, which has trained and deployed nearly 30,000 female HEWs, two per *kebele* (i.e., village) or approximately two per 5,000 people. These grade 10 graduates undergo an additional year of training and perform a variety of community-based services in rural areas, operating from a health post (HEP document, 2006). They conduct household visits, work with community volunteers and *kebele* administration to carry out 16 different health interventions,

[1]**Basic EmONC** services should include the following: parenteral antibiotics; parenteral uterotonics; parenteral anticonvulsants; manual removal of placenta; manual removal of retained products (preferably by MVA); assisted delivery by vacuum and newborn resuscitation. **Comprehensive EmONC** services at the district hospital level should include: all the above plus surgical capability (caesarean section), anaesthesia and blood transfusion.
[2]Active management of the thirst stage of labor

and are the government's "main vehicle for bringing key maternal, neonatal and child health interventions to the community."

ACCESS is working to build the capacity of the HEWs to provide essential maternal and newborn care using the following approaches:

A. Training of HEWs

ACCESS has worked to build the capacity of the ENMA to train HEWs in essential maternal and newborn care at the community level. Twelve health centers in the Oromia Region were selected as target sites, based on established criteria that included an adequate number of deliveries, as well as availability of ART and PMTCT services. Based on results of a needs assessment, materials and supplies were procured and distributed at each of these sites to fill identified gaps and create an enabling environment for trainees.

Subsequently, working closely with the Federal Ministry of Health Family Health Division, UNICEF, Save the Children US, the ENMA and others, ACCESS formulated a learning resource package consisting of a reference manual, trainer's guide, participant's manual and a monitoring logbook. The reference manual is based on *A Book for Midwives* (Hesperian Foundation) and is targeted to the knowledge and skills that HEWs need to provide safe and clean birth and newborn care.

Standardization courses were then conducted for 47 trainers, including midwives, nurses and health officers, from the selected sites. The trainers were provided with updates on essential maternal and newborn care, oriented to the HEW learning materials for safe and clean birth, and prepared to teach effectively through participation in a clinical training skills course.

Between March–October 2008, these 47 trainers in turn trained 358 HEWs from 265 health posts, and during each round of training, ENMA and ACCESS staff provided supportive supervision in collaboration with the regional health bureau. To date, trained HEWs in 153 of these health posts have since reported attending 3,208 births, providing misoprostol for 2,596 women during delivery, providing 3,112 newborns with immediate essential care (e.g., drying and wrapping, clean cord care and immediate breastfeeding), and conducting 3,347 postpartum visits within three days of birth. Based upon the DHS 2005 rural crude birth rate of 37.3% and the catchment population of a health post being 5,000 individuals, the HEWs attended 11% (or 3,208) of all expected births for these 153 health posts. Linkages between HEWs and referral health centers have also been strengthened through ongoing monthly meetings at the district level.

Improvements in maternal and neonatal health services have been made at all 12 health centers where training was conducted, including the use of skilled birth attendants (SBA), partographs, AMSTL, FANC and IP. (See Table 1 below.)

Figure 2. Map of Oromia with distribution of 358 trained HEWs

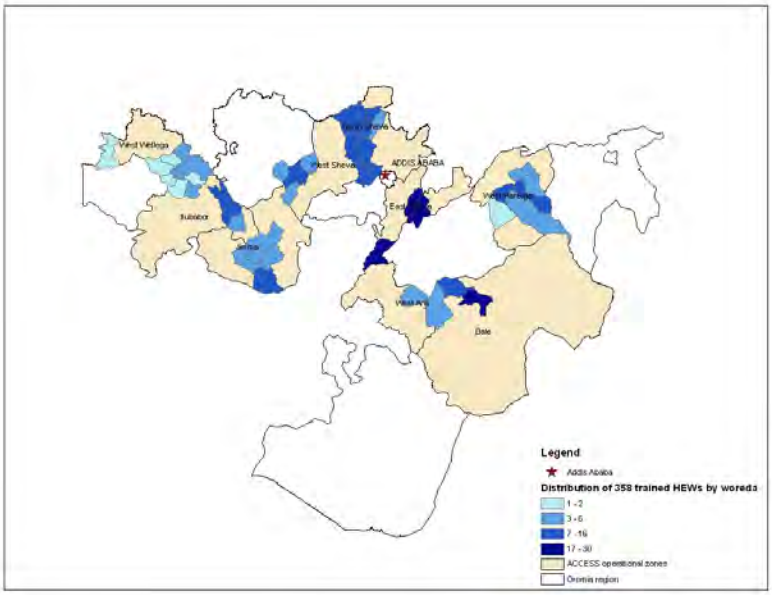


Table 1. Performance of ACCESS-supported health centers and hospitals in SBA deliveries, AMTSL and partograph use

INDICATOR	OROMIYA PROGRAM: JAN. 2008 – OCT 2008	WEST HARARGE PROGRAM: APRIL 2009 – JULY 2009*		TARGET	% ACHIEVED
	Health Center (n=11)	Health Center (n=4)	Hospitals (n=6)		
Number of deliveries with a SBA at USG-assisted programs	2,617	36	2,968	7,500	75%
Number of women receiving AMTSL through USG-supported programs	1,917	36	2,774	1,500	315%
Number of births in ACCESS-targeted facilities that occurred with a skilled attendant using a partograph	1,108	19	504	1,740	94%

*Note: The West Hararge program began in the spring of 2009, with data collection initiated in April 2009.

B. Community Mobilization

Within the ACCESS program, ACCESS partner Save the Children (SC) has assisted the HEWs in the Oromia Region to conduct community mobilization activities to increase demand for their maternal and newborn health services and to extend the reach of these services in their communities. SC has also played a leading role in adapting and distributing information, education, communication (IEC)/behavior change communication (BCC) materials to be used by HEWs and by other community members to educate families about maternal and neonatal health issues. In West Hararghe, 1,090 IEC materials (e.g., flip charts, misoprostol cue cards, and birth preparedness and complication readiness cue cards) were distributed. SC meets quarterly with the HEWs and reviews implementation of activities such as weekly collection of money and/or savings by communities for emergency use, and preparing stretchers using locally available materials to transport women/patients to a health facility.

SC is now rolling out utilization of the Community Action Cycle (CAC) to volunteer community health promoters. The CAC is a community mobilization process in which the capacity of the community to address their health needs is enhanced by planning, carrying out and evaluating activities on a participatory and sustained basis. To date, 96 HEWs participated in a two-day training course on the CAC.

C. Prevention of Mother-to-Child Transmission of HIV (PMTCT)

PMTCT is an important strategy to prevent HIV infection in children and to link HIV-positive mothers and their family members with care and treatment programs. Past experience with implementing PMTCT services in Ethiopia shows that the greatest challenges to comprehensive HIV/AIDS services are low ANC coverage and institutional delivery rates, as well as poor uptake of PMTCT services in public facilities. Efforts to increase the uptake of PMTCT and HIV counseling and testing (HCT) services should be directed closer to the community to improve utilization of these services. HEWs, situated at the community level performing ANC and delivery services, represent a viable opportunity to expand the availability of, and thus increase the uptake of, PMTCT services.

Mother and father with new daughter in Robe Health Center

In response to this need, ACCESS is piloting a project

supporting 40 HEWs in 31 selected health posts in Oromia to target women accessing ANC and labor and delivery services in the home and at the health post; and to deliver comprehensive PMTCT services, including HIV rapid testing and referral to health centers for ART. The project also utilizes the HEWs and voluntary community health workers (VCHWs) to improve community awareness and demand for PMTCT services and strengthen community and health center referral linkages to improve access to care and support for women and infants found to be HIV positive. HEWs are encouraged to train the VCHWs in their communities to ensure that they talk with pregnant women about the new PMTCT services and the importance of delivering with the HEW. To date, HEWs in 21 of the 31 pilot PMTCT health posts have provided PMTCT counseling 725 women and provided HIV testing to 625 of these women, seven of whom were HIV-positive. HIV-positive women were referred to health centers and in some cases were accompanied by the HEW for their first visit.

III. ACCESS CORE-FUNDED INITIATIVES

A. Africa Regional Pre-Service Midwifery Education Initiative

In partnership with WHO/AFRO, ACCESS has been working for five years to implement the Africa Regional Pre-service Midwifery Education Initiative. This initiative aims to improve midwifery education in Ghana, Malawi, Tanzania and Ethiopia. ACCESS and WHO/AFRO are working to reduce maternal and newborn morbidity and mortality by ensuring that pre-service curricula for midwives in these countries are revised to include the latest evidence-based standards of MNH care with a focus on BEmONC. ACCESS is also improving the knowledge and skills of midwifery tutors and clinical preceptors in BEmONC so that they in turn can effectively teach their students to care for women and newborns at all levels of the health care system. These tutors and clinical preceptors, now with updated BEmONC knowledge and skills as well as enhanced teaching capacity, will form a core of local experts who can conduct training as well as act as mentors for other trainers.

B. Increasing Use of Targeted Interventions by Skilled Providers

ACCESS and the Ethiopian Society of Obstetricians and Gynecologists (ESOG) worked together on a program to increase the use of targeted interventions (such as AMTSL, essential newborn care and newborn resuscitation) by skilled providers to enhance maternal and newborn survival. Ambo Hospital in the Oromia Region was selected as the clinical training site for this activity and as a result, the hospital was strengthened through capacity-building of hospital staff and provision of essential equipment. The hospital is staffed with an obstetrician and can provide comprehensive emergency obstetric care. In addition, ESOG strengthened the capacity of providers at health centers attached to Ambo to allow basic emergency obstetric care to be performed at peripheral levels so as to decrease the delays in care and promote faster management of obstetric and newborn complications.

C. Kangaroo Mother Care (KMC)

ACCESS Ethiopia, working in collaboration with the Federal Ministry of Health, UNICEF, WHO, ESHE, Ethiopian Pediatric Association and other stakeholders, has adapted the ACCESS Global KMC training manual for use in Ethiopia. ACCESS Ethiopia also provided financial and technical assistance to develop behavior change communication materials including posters, leaflets and videos to support KMC training and implementation in the country. ACCESS has also collaborated in strengthening the KMC component of the national integrated management of childhood illness (IMCI) training by developing a supplementary KMC module to be used in conjunction with the current IMCI training manual. The complementary manual is currently under review. Prior to ACCESS Ethiopia KMC activities, KMC services have been limited to only one health facility, Black Lion Hospital. ACCESS supported the upgrade of the KMC ward in this hospital and used it as the training center for expansion of KMC services to other regions in Ethiopia.

ACCESS Ethiopia supported the expansion of KMC services to five additional hospitals. Assistance provided included the training of service providers, renovation of KMC ward and supply of limited equipment such as beds, nasogastric tubes, cups and weighing scales. The five hospitals were strategically selected (one per region) so that they can serve as learning centers for further expansion through ongoing IMCI training.