

MCHIP Country Brief: Ethiopia



Selected Health and Demographic Data for Ethiopia	
Maternal mortality ratio (deaths/100,000 live births)	676
Neonatal mortality rate (deaths/1,000 live births)	37
Under-5 mortality rate (deaths/1,000 live births)	88
Infant mortality rate (deaths/1,000 live births)	59
Contraceptive prevalence rate	29
Total fertility rate	4.8
Skilled birth attendant coverage	55.9%
Antenatal care, 4+ visits	19.1%
Source: EDHS 2011; World Bank ⁴ .	

Health Areas:

- Maternal Health
- Newborn Health
- HIV/AIDS
- Malaria



Program Dates	October 1, 2010–June 30, 2014					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of regions	100%	No. of districts	72	No. of facilities	287 (54 Hospitals; 233 health centers)
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INTRODUCTION

Although Ethiopia has seen a decline in maternal mortality to the current maternal mortality ratio (MMR) of 676 per 100,000¹ live births in the last 20 years, the country is still a long way from reaching its Millennium Development Goal (MDG) for MMR (MDG 5) of 267 per 100,000 live births by 2015.² The reduction of maternal, newborn and child mortality is the priority of the Government of Ethiopia (GoE). Ethiopia recently met its MDG 4 target for reducing child mortality of 68 deaths per 1,000 live births ahead of schedule. The introduction of the outreach health extension program with service provision led primarily by health extension workers (HEWs) is believed to have contributed to the reduction of mortality in children and toward achieving MDG 4 targets for the country.³ Even so, the utilization of proven high-impact interventions for the most common killers of infants and children under five is still very low. Obstructed labor, ruptured uterus, severe pre-eclampsia/eclampsia and postpartum hemorrhage account for most of the maternal death in the country.⁴

Other indicators for maternal health show a very low facility usage rate, with a skilled birth attendant delivery rate of 10%⁵, one of the lowest rates in Africa. Low facility usage rates undoubtedly also present as a barrier to Ethiopia's prevention of mother-to-child transmission of HIV (PMTCT) program services. Gains have been made in family planning (FP), with contraceptive usage increases from 14% to 27.3% (Ethiopia Demographic and Health Survey, 2005 and 2011); however, the unmet FP need remains high, particularly in the postpartum period. Additional key health indicators are shown in the Country Summary.

MCHIP's first activity in Ethiopia was to document the quality of care in selected hospitals in the Quality of Care for Prevention and Management of Common Maternal and Newborn Complications study. Conducted between 2009 and 2010 with core funding, MCHIP observed that the quality of care in the selected hospitals was often below internationally accepted standards for maternal and newborn health (MNH) care. MCHIP called for a concerted countrywide drive to improve the quality of care particularly focusing on the integration of evidence-based practices and quality assurance processes in health facilities.

Following this, in 2010 the United States Agency for International Development (USAID) asked MCHIP to assist the government's efforts to address MNH priorities. The goal of the MCHIP Ethiopia program was to contribute to reducing maternal and newborn morbidity and mortality in the country. The strategic objective was to increase use and coverage of high-impact maternal and newborn interventions including the reduction of mother-to-child transmission of HIV.⁶ MCHIP used the findings of the quality of care study to inform design of the new project.

- In collaboration with the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs) MCHIP was implemented in the four USAID priority regions: Amhara, Oromia, Southern Nations, Nationalities, and Peoples' Region (SNNPR), and Tigray. Selection of sites was done with extensive consultation with USAID, RHBs, their zonal counterparts and partners, including the Integrated Family Health Project (IFHP) to ensure there was no site overlap or duplication of effort. MCHIP later added the Afar region for Integrated Community

¹ Central Statistical Agency [Ethiopia] and ORC Macro. 2011. *Ethiopia Demographic and Health Survey 2011: Preliminary Report*. Central Statistical Agency and ORC Macro: Addis Ababa, Ethiopia and Calverton, Maryland, USA. Other estimates include 590 per 100,000 (Hogan MC, Foreman KJ et al. Maternal Mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5. *Lancet* Volume 375:1609–1623.)

² Central Statistical Agency [Ethiopia] and ORC Macro. 2005. *Ethiopia Demographic and Health Survey 2005 – Preliminary Report*. Central Statistical Agency and ORC Macro: Addis Ababa, Ethiopia and Calverton, Maryland, USA.

³ Knippenberg R et al. 2005. Systematic scaling up of neonatal care in countries. *Lancet* 365: 1087–1098.

⁴ National Baseline Assessment for Emergency Obstetric and Newborn Care 2008.

⁵ Central Statistical Agency [Ethiopia] and ORC Macro. 2011. *Ethiopia Demographic and Health Survey 2011: Preliminary Report*. Central Statistical Agency and ORC Macro: Addis Ababa, Ethiopia and Calverton, Maryland, USA.

⁶ MCHIP Core funds were provided in 2009-2010 to conduct a national Quality of Care study.

Case Management (iCCM) activities upon request from the Afar RHB and USAID to support the iCCM expansion to the region's pastoralist communities. Overall, in addition to national-level support to the FMOH, national partners, and regional health bureaus (RHBs), MCHIP supported 49 hospitals, 235 health centers, and 843 health posts in 12 zones and 72 woredas/districts, as well as 10 health science colleges (see program timeline in figure below), during which MCHIP received numerous requests from the GoE for expansion, in particular, increasing the number of health centers supported by the project.

MCHIP's implementation strategy emphasized strengthening the enabling environment for MNCH and PMTCT care (Intermediate Result [IR]1), improving access to quality, high-impact interventions in MNH and PMTCT care at the health facility level—hospitals and health centers (IR 2), and improving knowledge and behaviors on MNCH/postpartum FP/PMTCT at the household level (IR 3).

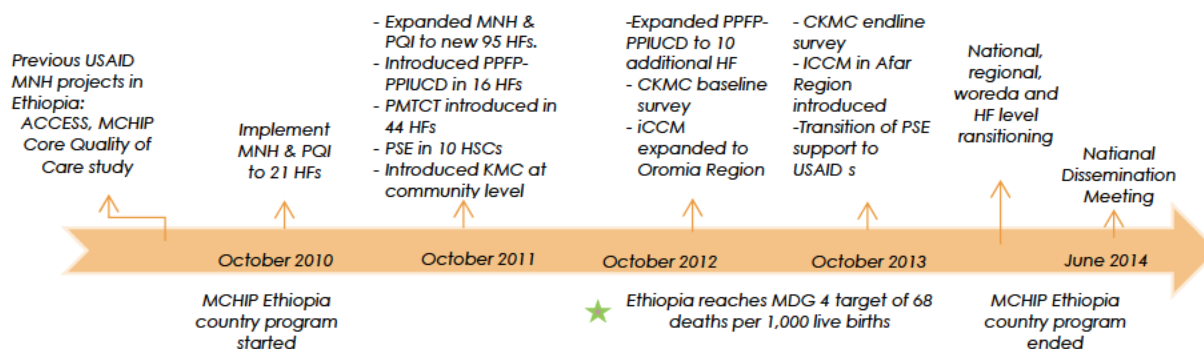
By health systems structure level, MCHIP's interventions included:

- **National and regional level:** strengthening MNH policies and initiatives, providing literature and evidence to improve MNH policies and scale-up, and building local capacity through the Ethiopian Midwives Association.
- **Facility level:** improving the quality of comprehensive MNH programs using a performance and quality improvement (PQI) approach with an integrated package of essential MNH care, including PMTCT and Kangaroo Mother Care (KMC), and introducing postpartum intrauterine contraceptive device (PPIUCD) insertion in selected facilities.
- **Community level:** implementing integrated community case management (iCCM) and implementing and evaluating the feasibility of Community KMC at the household level.
- **Education and training:** improving midwifery pre-service education (PSE) nationally and in selected regional midwifery colleges, and field-testing innovative approaches for in-service training in Basic Emergency Obstetrics and Newborn Care (BEmONC).

With support from MCHIP:

- 96,761 pregnant women were provided with quality ANC services
- 36,712 mothers who delivered in the facility received quality and respectful MNH care
- 42,540 pregnant women and mothers received HIV counseling and testing
- 20,000 pregnant women and mothers received PPFP counseling
- 1,062 were provided with PPIUCD insertion
- 4,627 newborns born asphyxiated were successfully resuscitated
- 24,245 newborns were kept in their mothers KMC at the facility and 5,022 at were kept in KMC at home
- 30,454 children under five years of age were registered and treated in iCCM

MCHIP Ethiopia Events



KEY ACHIEVEMENTS

IR 1: MNCH and PMTCT services improved by enhancing and strengthening the enabling environment for MNH care

MCHIP actively participated in national MNH technical working groups (TWGs) and provided highly visible technical and financial support in the adaptation and standardization of MNH and quality improvement national policies, strategies, and training packages (See text box, right).

MCHIP conducted two reviews of key areas influencing MNH care, access and utilization: a literature review of cultural barriers for women seeking maternal health care and a documentation of nine existing promising MNH, FP and Reproductive Health practices in Ethiopia. Based on the findings, MCHIP actively advocated for the inclusion of respectful maternity care (RMC) in MNH care to be a national standard and introduced RMC to its supported facilities; a recommendation for the scale up of promising practices nationally was made to the FMOH.

MCHIP worked to strengthen the core capacity of the Ethiopian Midwives Association (EMA) to lead the professionalization of Ethiopia's midwives. EMA now has a stronger organizational capacity and stronger regional chapters and a wider reach with newly established regional chapters where previously they had little presence. The association is also providing substantial technical support to the FMOH and partners in key issues related to MNH and midwifery including the development of national guidelines on Codes of Conduct and Scope of Practice for midwives.

National policies, strategies and guidelines MCHIP contributed to:

- MNCH Communication and Advocacy Plan
- Guidelines on Implementation of the Pregnant Women Forum
- Guidelines on Maternity Waiting Homes
- PMTCT Guidelines on Option B+ Treatment Protocols and National Roll-out
- Newborn Care Strategy
- Child Survival Strategy
- FP Training Strategy to include PPFP

National training packages that MCHIP contributed to:

- National BEmONC Training Package
- National FP Training Package inclusion of PPFP

IR 2: Availability, accessibility, and quality of key MNH and PMTCT services improved

Examples of MCHIP Scale-up in Ethiopia:

- Contracting out of quality improvement oversight
- Introduced and expanded facility-based KMC
- Introduced iCCM program in an emerging region
- Introduced and expanded PPIUCD services in Ethiopia
- Evaluated the feasibility of CKMC

MCHIP introduced the Standards Based Management and Recognition (SBM-R) approach as a performance and quality improvement (PQI) process to improve the quality of MNCH services in 116 supported facilities. Based on gaps identified during the SBM-R assessment, MCHIP provided need based BEmONC trainings to health providers in these facilities, donated essential equipment and supplies and ensured regular follow-up. As a result these health facilities were able to show marked increases in achieving MNH care standards from a baseline of 29% to 73% across three years. Improved facility services from the introduction of SBM-R matched with simultaneous community demand generation by HEWs and the newly formed Health Development Army (HDA)

volunteers, markedly increased institutional delivery from a baseline of 8.6% to 31% in MCHIP supported facilities. Similarly fourth antenatal care (ANC) visits increased from 5.9% to 21%. MCHIP also used a new “contracting-out of PQI” approach through direct financial assistance to build local ownership of facilities and woredas/districts to independently lead the PQI process even beyond the program.

MCHIP began implementing PMTCT services with PEPFAR funding in FY12, supporting 44 facilities to integrate PMTCT in different MNCH service outlets to make services available in a one stop shop approach for mothers. The integration of PMTCT activities such as community outreach programs contributed to increased facility utilization. In two years' time, ANC coverage in PMTCT supported sites increased from the baseline 4.7 % (ANC) and 29.4% (PMTCT in labor and delivery) to 38.2% and 78% respectively. MCHIP documented the effects of integrated services as well as frequent and enhanced facility-level support on PMTCT as part of its program learning.

In-service Training & mHealth:

- Provided various competency-based courses to a total of 5,207 health workers
- Piloted an innovative “blended learning” approach for in-service training for BEmONC to reduce time spent away from facilities.
- Tested the use of SMS technology for post training follow-up in BEmONC and PMTCT

MCHIP introduced Essential Newborn Care (ENC) services into 116 supported health facilities as part of comprehensive MNH care. MCHIP trained health workers in neonatal resuscitation for management of birth asphyxia, management of hypothermia in pre-term and low birth weight infants, and infection prevention and provided facilities with necessary equipment and materials, such as newborn suction and resuscitation devices. ENC services have visibly improved in all supported facilities.⁷ From the total of 36,954 reported institutional deliveries, records indicated that 4,627 asphyxiated newborns were successfully resuscitated. Moreover, 24,245 mothers (65.5% of the total deliveries) practiced skin-to-skin contact as a component of KMC at supported health centers and hospitals. Nationally, MCHIP supported the FMOH and the Ethiopian Pediatric Society (EPS) to standardize newborn resuscitation (through the Helping Babies Breathe program) and ensure inclusion of KMC in the national ENC and BEmONC training packages.

In 2011–2012 MCHIP introduced and established postpartum family planning (PPFP) and provision of post-partum intrauterine contraceptive devices (PPIUCD) in 26 facilities. MCHIP trained providers counseled over 20,000 mothers on PPFP during ANC and performed 1,069 PPIUCD insertions for mothers who chose the method, representing 3% of mothers delivering in the facilities. MCHIP shared its PPFP/PPIUCD experiences in national and international for a, demonstrating MCHIP's technical leadership in this area and helping to convince the FMOH to incorporate MCHIP's PPIUCD training package (adapted from the Access to Maternal and Newborn Health Program (ACCESS) into the national FP training package. MCHIP has created fertile ground for scale-up of quality PPFP/PPIUCD services in Ethiopia.

MCHIP was asked to support pre-service midwifery education nationally and in selected regional health science colleges. Nationally, MCHIP significantly contributed to the development of the curriculum for a new Accelerated Midwifery Education Program, a diploma-level program launched to address the national shortfall of midwives. MCHIP adapted the SBM-R approach to improve the quality of the education in 10 regional health science colleges and updated the existing educational standards for midwifery. MCHIP then built capacity of instructors to improve the quality of instruction with teaching skills and knowledge update courses. Skills labs were strengthened and equipped with anatomic simulation models and improving libraries with up to date national guidelines and resources. The overall support contributed to increasing the success rate of midwifery students in the national competency exam. The combined average exam pass of midwifery students from the supported schools

MCHIP's Gender Approach:

- Integrated culturally appropriate respectful maternity care in routine MNH services
- Improved male involvement in MNH care through PMTCT services; 14,950 (35.1%) of women were tested and received their results with their partners

⁷ Baseline data for ENC were not gathered; this is an observation from supportive supervision.

increased from 40.3% (highest 56%; lowest 25%) in 2011 to an average exam pass of 54.6% (highest 67%; lowest 47.6%) at the end of 2012. In 2012-2013 MCHIP transferred its education efforts to the USAID funded Strengthening Human Resources for Health project that encompasses all midwifery schools in Ethiopia.

IR 3: Caretakers' knowledge and behaviors on key MNH/Postpartum/FP/PMTCT household and care-seeking behavior

Given that most deliveries take place at home in Ethiopia, MCHIP and the FMOH assessed the feasibility of introducing Community Kangaroo Mother Care (CKMC) to mothers to initiate CKMC in their homes using the HEW and HDA volunteers. MCHIP followed this with implementation in 2012 in communities surrounding 89 selected health posts in all four supported regions through 174 trained HEWs and more than 13,000 HDA volunteers. As a result 5,022 newborns were kept in KMC position (79% of the total deliveries reported by HEWs) over the life of MCHIP. A systematic evaluation of the program indicated that CKMC can be practiced by postpartum mothers at home with the support of HEWs and HDA volunteers.

MCHIP supported 29 woredas/districts in Oromia and later five woredas in Afar regions through trained HEWs and other health workers. To sustain the program, HEW supervisors, health workers and woreda health officers were trained as iCCM supervisors. In Oromia, the quality performance of HEWs in assessing, classifying, and treating significantly increased in the second round of the iCCM Performance Review and Clinical Mentoring Meeting (PRCMM), 80% compared to the first 64%. Similarly, in Afar, quality performance improved from 84% in the first round to 96% in the second round. MCHIP's iCCM program was the first iCCM intervention in the pastoralist region of Afar which initially presented a challenge in introducing the program. The service was gradually introduced through awareness creation events organized with the local authorities and community leaders.

WAY FORWARD

- Facilities' efforts to provide RMC are appreciated by women and are felt to contribute to the increases in facility births. At policy level the FMOH should incorporate RMC as standard in the MNH care and educate communities about the importance of and improvements to facility-based care using existing HEW and HDA networks.
- The FMOH should pursue the finalization of the National Comprehensive Health Service Quality Management Manual. A national tool will support the integration of quality in MNH, and will be applicable to both hospitals and health centers and owned in the health system.
- The EMA needs to continue strengthening its management capacity while maintaining appropriate representation in key stakeholder discussions to play a greater advisory role
- The woreda-based blanket coverage of facility support initiated under MCHIP created more opportunities for cross-learning among facilities that were close to each other geographically, leveraged resources, and enhanced synergies. Coordination among partners is crucial to avoid duplication of efforts and where feasible, to work together in a harmonized effort.
- Health offices can improve outcomes of PMTCT services by using the "enhanced and integrated support" approach. Moreover for sustained results in PMTCT, MCHIP strongly recommends better coordination mechanisms among the FMOH, RHB, and the pharmaceutical supplies agency (PFSA).
- From MCHIP's FP program experience, there is a demand for PPIUCD and the FMOH should consider expanding PPF and PPIUCD services using the platform created by MCHIP.

- Future newborn care programs must complement community-based newborn care. A recent government priority includes community-based newborn sepsis management, and use of chlorhexidine gel for cord care. These practices should be integrated with community-based newborn care programs, as well as the inclusion of the rotavirus vaccine and zinc tablets into infant and child survival strategies, and antenatal corticosteroids for preterm birth at facilities.
- Results of the CKMC evaluation of CKMC show that CKMC can be practiced by postpartum mothers at home with the help of HEWs and HDAs. MCHIP recommends scale-up by integrating CKMC in the counseling package of these cadres.