A look at the statistics worldwide shows that each year more than 60 million women give birth at home without skilled care. About 530,000 women die from pregnancy related complications, with some 68,000 of those deaths resulting from unsafe abortion. Moreover 99% maternal, newborn, and child deaths occur in low and middle income countries including Ethiopia.

Ethiopia has a maternal mortality rate of 673 per 100,000 live births (EDHS 2005), which translates into 25,000 deaths per year. Immediate causes of death are hemorrhage (25 percent), sepsis (15 percent), unsafe abortion (13 percent), hypertensive disorders of pregnancy (12 percent), and obstructed labor (8 percent). Indirect causes of death are malaria, AIDS, and anemia. Because of high mortality and morbidity rates, the Government of Ethiopia is determined to improve maternal, newborn and child health. This is evidenced by on-going efforts to accelerate implementation of the government’s Health Sector Development Plan (HSDP) which is a 20-year health plan implemented in five-year increments. The government has closed its HSDP III and launched HSDP IV, October 2010 which is directly aligned with the health related Millennium Development Goals specifically MDG5 “Improve Maternal Health”. In fact, maternal and child health are two of the four priority areas on which the current HSDP IV will focus.

But the bottom line is this: For Ethiopia to achieve MDG5, the current Maternal Mortality Rate (MMR) of 673 must be reduced to 267 per 100,000 live births over the next five years. Can this be done? It is clearly an enormous challenge. But the government believes it can be achieved, though it will most certainly require a radical shift in the health services and systems of the country.

With the support from donors and non-government organizations (NGOs), the country is currently making considerable investments to accelerate efforts towards achieving MDG5. These measures include increasing the number of health centres (HCs) to 3,200 around the country—up to a third of which will be appropriately staffed and equipped to provide comprehensive emergency obstetric care.

The massive deployment of Health Extension Workers (HEWs)—two for each village—is already having a positive impact on health services for women. HEWs are being trained and now have the skills to provide help in clean and safe delivery with appropriate supervision and there is an on-going investment by government in midwifery training.

Intensive planning is underway for scaling up safe motherhood interventions during HSDP IV.

The Integrated Family Health Program (IFHP) is implemented in partnership by Pathfinder International and John Snow, Inc.. The health program has a five year project period (2008-2013).

It focuses on family planning and reproductive health, maternal, newborn and child health.

The IFHP provides support to the Ethiopian government’s Health Sector Development Program (HSDP) in general and the Health Extension program in particular in 286 woredas of Ethiopia.

Health services and information has become more accessible for rural mothers.
EDITORIAL

COST EFFECTIVELY SAVING LIVES

In Ethiopia, more women die giving birth than they do from malaria, AIDS and tuberculosis combined. Pregnancy and related complications account for a shocking number of Ethiopian women dying, that is, 25,000 deaths per year making it the highest maternal mortality figure in the world. Yet improving maternal health remains furthest from meeting the target set in the Millennium Development Goal.

Managing unwanted pregnancy is one way to help save a significant number of women who die as a result of unsafe abortion and unplanned births. Responding to this problem would be as simple as responding to half of the currently existing 34 percent of unmet need for contraception. Reaching these women with family planning services could drop current maternal mortality by almost one third and save an estimated USD 34 million in what would otherwise be used to treat complications from unwanted pregnancies. Most importantly it would mean 754,000 fewer unintended pregnancies and 178,000 less unsafe abortions consequently leading to 3,300 fewer maternal deaths (http://phe-ethiopia.org/quickfacts/index.html).

Overall, knowledge of family planning method in Ethiopia is high and has progressively improved over the years. This is especially true with the implementation of the government’s Health Extension Program which reaches every household through Health Extension Workers, who are trained to provide health information and services. As a result, knowledge of any family planning methods among married women has currently reached 87 percent. This however, does not mean that family planning programs have fulfilled their objective of helping families to either limit or space their pregnancies because contraceptives are not always in full supply to meet demands. Furthermore, trained service providers are not available at all health facilities to provide family planning services.

Only 15 percent of women have a met need for family planning. This means that if all currently married women who say that they want to space or limit their children were to use a family planning method, the contraceptive prevalence rate would increase three-fold to 49 percent.

This again would mean stopping a significant number of unwanted pregnancies and consequently preventing unsafe abortions and reducing the number of women dying.

Thus, investing in improved availability and accessibility of contraceptive is not only a sure way of gaining in health benefits but a certain way of slashing maternal mortality numbers down significantly. Family planning method use is the cost effective way of saving lives.

源: Maternal and Neonatal Program Effort Index

Tackling …. (Cont. from page 1)

These measures are expected to expedite the overall progress towards achieving maternal health targets.

IFHP’s Response

As one of the major partners of Ethiopia’s Federal Ministry of Health, IFHP designed a novel support strategy which complements other partners’ interventions on maternal and newborn health.

As its contribution towards improving health parameters, one area of support is creating awareness of pregnant women, families, voluntary community health workers, and communities on the risks of every pregnancy and promoting birth preparedness and complication readiness. Increasing knowledge on the danger signs associated with pregnancy and delivery is of paramount importance. Accordingly, HEWs will be encouraged to counsel pregnant women to deliver at health centers with the assistance of skilled attendants. Nonetheless, HEWs will continue to help mothers who deliver at home with clean and safe delivery techniques. Most importantly, HEWs’ skill and knowledge will be built to identify complications early and facilitate prompt referral.

IFHP’s interventions also include equipping nurses and midwives in health centers with skills in comprehensive care package: focused antenatal care (FANC), intrapartum care, postnatal care (PNC), essential newborn care (ENC) and resuscitation, and basic emergency obstetric and newborn care (BEmONC).

Understanding Causes of Maternal Mortality and Morbidity

Maternal mortality refers to those deaths which are caused by complications due to pregnancy or childbirth. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth. For each woman who succumbs to maternal death, many more will suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications, such as obstetric fistula. Since most maternal deaths occur during delivery and during the postpartum period, emergency obstetric care, skilled birth attendance, postpartum care, and transportation to medical facilities if complications arise are all necessary components of strategies to reduce maternal mortality. These services are often particularly (minimal or are unavailable in most) rural areas, so special steps must be taken to increase the availability of services in those areas.

源: Maternal and Neonatal Program Effort Index
With its significant development challenges, Ethiopia is a high visibility country among international donors, particularly since the United States has selected Ethiopia as one of the first eight countries—of 80—that will receive additional technical and management resources from the new U.S. Global Health Initiative (GHI).

These developments have captured the attention of some U.S. media who have been interested to understand the impact and implications of U.S. programs abroad. In August 2010, a three-person media delegation visited Ethiopia. Visiting project sites supported by IFHP in Oromia (Arsi Negelle Woreda) and Southern Nations, Nationalities and Peoples’ Regions (Halaba Woreda), the journalists observed how the Health Extension Program works especially by following Health Extension Workers (HEWs) as they provide services in health posts and in the communities of the mentioned rural parts of the country.

Aziza Ismael and Yitayesh Tsige are two of the HEWs from Galeto Health Post in Halaba Woreda visited by the journalists. These HEWs have reversed the health situation in Galeto Kebele from an insignificant level to a striking 100% coverage of households (356 households in the kebele) in building and using latrines and improving health practices.

To understand the nature of health services provided at different levels, the journalists also visited Shishito Health Center in Kacha Bira Woreda of the South. They met with the service providers and an administrator who gave them an overview of services provided by the Health Center. They discussed with families who were at the Health Center in search of health services.

On their return to Addis Ababa, the journalists briefly stopped at Abyiata lake to observe how climate change has negatively impacted the environment. The lake, which has shrunk by 8 kms, has been further affected by fast growing human population in the area.

The visit gave the three journalists the opportunity to explore health issues in Ethiopia, by meeting with rural health service providers, beneficiary communities, officials from the regional and federal Ministry of Health, Mission Director of USAID Ethiopia and Director of Center for Disease Control.
Twenty one years later, World Population Day was instituted in 1989 and marked on July 11 to raise awareness on population issues and the impact they have on development. It encourages planning for a family and thus, underscores the need for availing contraceptives and access to services.

World Population Day aims to increase people's awareness on various population issues such as gender equality, poverty, and maternal health. The day is celebrated worldwide and this year it has been celebrated yet again in Ethiopia.

With the national theme “Small, Happy, and Prosperous Family,” the 2010 Population Day was celebrated in Ethiopia. In collaboration with the United Nations Population Fund (UNFPA) and Ministry of Finance and Economic Development (MoFED), government and NGOs held various educational and informative activities to celebrate the annual event.

Each year an organizing committee meets to plan and celebrate the day. With UNFPA and MoFED leading the initiative, participants of the committee for 2010 included Central Statistical Agency, IFHP, German Foundation for World Population (DSW), Consortium of Reproductive Health Association (CORHA), Family Guidance Association of Ethiopia (FGAE), and other partners.

The day was celebrated in Addis Ababa with a half day symposium which consisted of different activities. Songs, plays and poem reading were part of the activities which all passed strong messages on planning families and building a healthy nation. The day also marked the 17th anniversary of the promulgation of the National Population Policy of Ethiopia. Highlights on statistical results of the Third Population and Housing Census of Ethiopia, conducted in 2007, were given and the document distributed.

With USAID support, IFHP partners have been working with MoFED for more than ten years to raise awareness on population issues through various forums, including the owner of the Population Core Process, who heads the IFHP Technical Advisory Committee which regularly goes out into the field to observe progress on projects. IFHP in turn annually serves as a committee member on the Population Day Organizing Committee and works to advocate access to family planning services and related issues.

**In 1968 world leaders proclaimed that individuals have basic human rights to determine the number and timing of the birth of their children. Nonetheless, modern contraception still remains out of reach for millions of women, men and young people.**

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It was a rough drive up the hill to Kima’s house. Part of the way to her home, we had to make it on foot. Panting heavily we made our way through a narrow footpath and finally walked out in a field of corn. The serenity and cool breeze caught us off guard and for a minute we stopped in our tracks with awe. A lonely house stood with a huge crowd gathered around it. With warm smiles and hugs we were greeted by the neighbors and friends of Kima. The tough drive and the steep walk up, was worth it all.

Kima Hassen Adem lives in Meta Woreda of East Hareghe Zone, Oromia Region. She was once a fistula victim who suffered the consequences of stigma and discrimination. She tells us her story and we listen captivated by her expressive narration.

“I married at the age of 15 and immediately became pregnant. When I gave birth to my first child I was in labor for three days and I could not get any medical help. I got weak each day and by the time I gave birth the child died and I got fistula.

“When I had fistula, I would refuse to eat so that I wouldn’t leak. But that didn’t stop it. I couldn’t work, so my husband was the bread-winner in our home. He spent all what he earned and sold most of what we had, including our cattle, in search of treatment for me. But the money we earned from the sale of our cattle was stolen and we had to beg. We got broke and had little means to live on. Friends would help us out at times. We’d use the money they gave us to buy injera and we’d eat that for as long as it would last. I lost a lot of weight.”

“Then one day I left my home. Everyone hated me, even my husband. Though he never told me to leave I could see his reaction and could no longer stand it. When I got to the city I could not work as a house maid because of the incontinence. I lived on the streets for six years. One day the Woreda Administrator found me and let me stay in his backyard for a couple of days. Then he sent me back home and told my husband that he should take care of me till death do us part. I feared my husband was not happy with this yet he also feared that I might commit suicide. But we continued to live together for the next 12 years.”

“I visited several places in search of treatment. I went to traditional healers and religious leaders but no one could help me. Everyone discriminated me. People would insult me and call me all kinds of demeaning names because of the smell. I got fed up of seeking help that was unavailable and I planned to commit suicide. But then I met this girl – Masresha. [a Voluntary Community Health Worker]. Masresha came over to my home and told me that I could be sent to Addis Ababa for treatment and she could facilitate my travel. I refused. She tried hard to convince me and she came to my home three times. I refused to go because I had completely lost hope that I could be treated. I did not believe Masresha could help me. But she was persistent and the fourth time she came, I decided to give it a try.”

“I was sent to Addis Ababa Fistula Hospital with all my expenses covered by IFHP. I was doubtful and scared of raising my hopes for what could possibly fail. I was then treated and I stayed at the hospital for 15 days. I got my meals and a bed and I was happy. I felt very well during that time but after some time I asked to be returned home. Again all my costs were covered, by the hospital, I was provided with new cloths and shoes and they put me in a car which took me all the way back home.”

“When I got home I told everyone about my treatment. Today I tell women that there is treatment for such conditions. I encourage them to seek assistance if they suffer from fistula.”

“For 19 years I did not know that what I had was called fistula until I went for treatment. I thought it was a condition unique to me. It was only when I got to Addis Ababa Fistula Hospital that I realized that there were so many women suffering in the same way.”

“Ten months now since I’ve been repaired and I’m in good health and my life has completely changed. I am now able to go about my social affairs [weddings and funerals] without fear or shame.”
MATERNAL HEALTH
FACTS AND FIGURES

Maternal health has been one of the major concerns globally and the most challenging to address as one of the targets of the Millennium Development Goals. This is especially true in developing nations. Brief statistical information on maternal health can give an idea of why the issue remains a grave concern.

THE GLOBAL SITUATION

- Maternal mortality shows the greatest disparity among countries: in sub-Saharan Africa, a woman’s risk of dying from treatable or preventable complications of pregnancy and childbirth over the course of her lifetime is 1 in 22, compared to 1 in 7,300 in developed regions. For example, the risk of a woman is about 1 in 7 in Niger as compared to 1 in 17,400 in Sweden. An African woman is more than 200 times more likely than an American woman to die in childbirth, and only half of all women in Africa have access to skilled birth attendant.

- Every year, more than 1 million children are left motherless and vulnerable because of maternal death. Children who have lost their mothers are up to 10 times more likely to die prematurely than those who have not.

- Between 1990 and 2005, maternal mortality decreased by less than 1 percent per year which is far below the 5.5 percent annual improvement needed to reach the MDG target. In sub-Saharan Africa, the region with the highest level of maternal mortality, progress was negligible.

- 200 million women who would like to delay or avoid child bearing are without access to safe and effective contraceptives. Every year, an estimated 19 million unsafe abortions take place in the developing world, resulting in some 68,000 deaths. [http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%205%20FINAL.pdf](http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%205%20FINAL.pdf)

THE ETHIOPIA SITUATION

- Antenatal care coverage rose steadily from 50% in 2005 to 60% in early 2009, and postnatal coverage increased from 16% to 28% over the same period. But this is still not enough.

- Maternal mortality declined from 871 per 100,000 live births in 2000 to 671 per 100,000 live births in 2005 but still remains one of the highest in the world. [http://www.internationalhealthpartnership.net/](http://www.internationalhealthpartnership.net/)

- Just 6 percent of births take place in the presence of a skilled health professional.

> Women may not seek health care for the following reasons: there may not be a health provider especially a female health provider, they may not have money for treatment. In addition, concern about having to take transport and worrying that there may be no one to carry out the household chores are among their major reasons (DHS 2005).

In response to these problems, “the health sector has made a shift from viewing health care services in terms of ‘health care provider’ and ‘receiver’ towards the notion of ‘health as a product. Therefore, the HEP [Health Extension Program] has been developed based on a core principle—transferring skills and knowledge [to households] using social mobilisation and an innovative ‘model family’ approach so that families are able to produce their own health. The Ministry is in the process of finalising a refreshers training package in order to boost knowledge and capacity of the HEWs [Health Extension Workers]. Encouraging results have been registered through HEP that trained and deployed over 34,000 HEWs . . . we must make sure that their potential is fully utilised in the next five years”, says Dr. Tedros Adhanom, Ethiopian Minister of Health. September 2010