Annual report 2013

Maternity Worldwide

Integrated Maternal Health project (2011 – 2014)

West-Ethiopia

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Abbreviations

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHP	Community Health Promoters
EMA	Ethiopian Midwife Association
EmONC	Emergency Obstetric & Newborn Care
GAH	Gimbie Adventist hospital
GPH	Gimbie Public Hospital
HEP	The Health Extension Program
HEW	Health Extension Workers
IGA	Income Generating Activity
MNH	Maternal and Newborn Health
MoU	Memorandum of Understandings
OB/GYN	Obstetrician and Gynaecologist
OCSCO	Oromia Credit and Saving Share Company
PPH	Post-Partum Haemorrhage
SBF	Safe Birth Fund
ToT	Training of Trainer
UNFPA	United Nations Population Fund
WHO	World Health Organization
VSLA	Village Savings and Loan Association

Foreword

Every day, more than eight hundred women die in pregnancy or childbirth. That is one maternal death every second minute. The vast majority of these deaths are preventable.

At the Millennium Summit in 2000, the world society decided to eradicate extreme poverty in the world by 2015 through 8 Millennium Development Goals (MDG). The MDGs have come to play a defining role in framing international development efforts.

Improved health is pivotal to eradicate poverty, and MDG 5 is a specific commitment to reduce maternal mortality and improve reproductive health, including newborn health. Thus, the reduction of maternal and newborn death and disability is at the core of human development efforts. The MDGs has resulted in elevating these health issues to unprecedented prominence on the international development agenda. Unfortunately, progress on MDG 5 has been disappointing, especially in Africa, and maternal mortality still represents the largest health inequity in the world: 99% of maternal deaths occur in developing countries - half of them in Africa.

Ethiopia is one of ten countries that together account for 60% of the world's maternal deaths. In Ethiopia, a woman faces a 1 in 67 lifetime risk of dying of pregnancy related causes. In Sweden the figure is 1 in 14.100. This means that 9.000 women in Ethiopia lose their life yearly due to pregnancy and childbirth related complications. Maternal and newborn health is inextricably linked, and in Ethiopia 85.000 newborns die annually, most from birth related complications. For every woman that dies an estimated additional 25 suffers injury, often with life-long complications. So in Ethiopia alone, 225.000 women suffer disability from childbirth complications every year.

The drivers of maternal and newborn death and disability are complex and multifaceted, and include poor access to health services, insufficient skilled birth attendants, poor quality of care, weak referral systems, long distances, cost and traditional belief and practices.

In West Ethiopia, Maternity Worldwide's response to maternal and newborn mortality and morbidity is based on an integrated approach that works across the health system – community continuum, focusing on:

- Building up clinical capacity for quality of care
- Strengthening the referral link
- Community empowerment

With this approach Maternity Worldwide aims to support national efforts to achieve MDG 5 and supports targeted districts' efforts in scaling up evidence based high impact maternal and newborn health interventions.

Anna Cecilia Frellsen
Chief Executive Officer (CEO)
Maternity Worldwide Denmark

Executive summary

This annual report documents the main activities and achievements of Maternity Worldwide's Integrated Maternal Health Project in West Wollega, Ethiopia in 2013. A brief summary of key achievements is given below.

A major achievement in 2013 was Maternity Worldwide's obtainment of a national accreditation as a BEmONC (Basic Emergency Obstetric and Newborn Care) training partner to Oromiya Health Bureau under the Federal Ministry of Health, and the ensuing establishment of a nationally accredited and fully furnished BEmONC training centre in Gimbie, with an affiliated pool of trained BEmONC trainers.

Other key achievements of the project in 2013 can be summarized as follows:

Building up clinical capacity for quality of care:

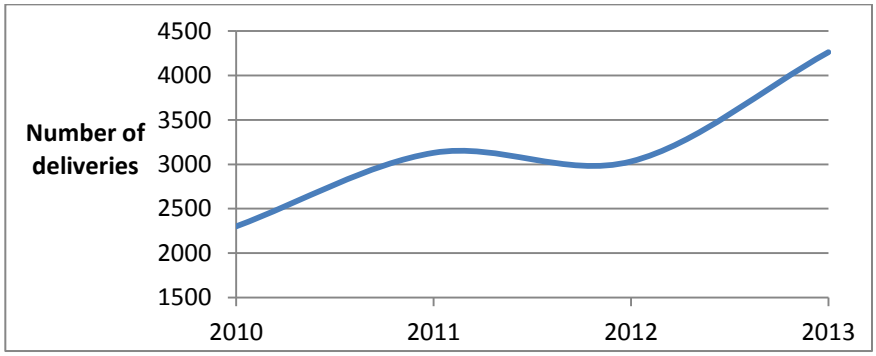
- 2 hospitals had 100% obstetric coverage
- 30 birth attendants were trained in BEmONC
- 14 Health Extension Workers were trained in Clean and Safe Delivery
- 36 Health Extension Workers were trained in Birth Preparedness and Complications Readiness
- 1 Maternity Birth Waiting Home to the Government Hospital was successfully piloted

Community Empowerment: Health education and livelihood strengthening

- 79.996 community members were reached with community health education
- 1.225 poor women were empowered through livelihood strengthening activities
-

The key impact indicator for Maternity Worldwide's project is Skilled Birth Attendance (measured by number of facility based deliveries), in which a very positive development is noted. In the supported health facilities located in the targeted districts, the increase in number of deliveries from 2010 (2302 deliveries) to 2013 (4261 deliveries) represents an increase of 85% - even though there was a slight decrease in 2012:

Table 1 Number of health facility based deliveries (2010 - 2013)



2013 was also the year where the project's midterm review was conducted by an external consultant. The report documented positive impact of the project, and that the project is on track to achieve its goals. The full report is available at: www. mww.dk

Where we are - Programme Location

Ethiopia is located in the eastern horn of Africa with a surface area of 1.1 million square kilometres. The country is the second most populous in sub-Saharan Africa with a projected population of more than 90 million in 2013, an estimated annual population growth rate of 2,7%, and fertility rate of 5,4 children per woman. The population structure is typical that of many developing countries, with 44% under the age of 15 years and 64% under the age of 25. The vast majority of the population (85%) lives in rural areas predominantly employed by subsistence farming. The majority religions are Christianity and Islam. The country is home to more than 80 ethnic groups that vary in population size from more than 32 million people (the Oromo ethnic group) to less than 1.000 (various ethnic groups).

Oromia region is one of the nine ethnically-based regions of Ethiopia. It covers 284.538 square kilometres, stretching from the western border in an arc to the south-western corner of the country. Based on the 2013 projection, its population is over 32 million, making it the largest state in terms of both population and area.

West Wollega zone is one of the 18 administrative zones of Oromia Regional State. The zone has 21 districts, of which 19 are rural and 2 are urban. Districts are sub-divided into 533 kebeles/villages (487 peasant and 46 urban). Gimbi is the capital city of the West Wollega zone and located 441 km from Addis Ababa.

According to the projected population size of the zone in 2013 there are about 1.7million people. The Oromo is the major ethnic group with 96%, Amhara, Ma'o and Gurage constitute of the remaining 4%. Afan Oromo is the official language of the zone. A great majority are Christians followed by Muslim and Traditional African Religion.

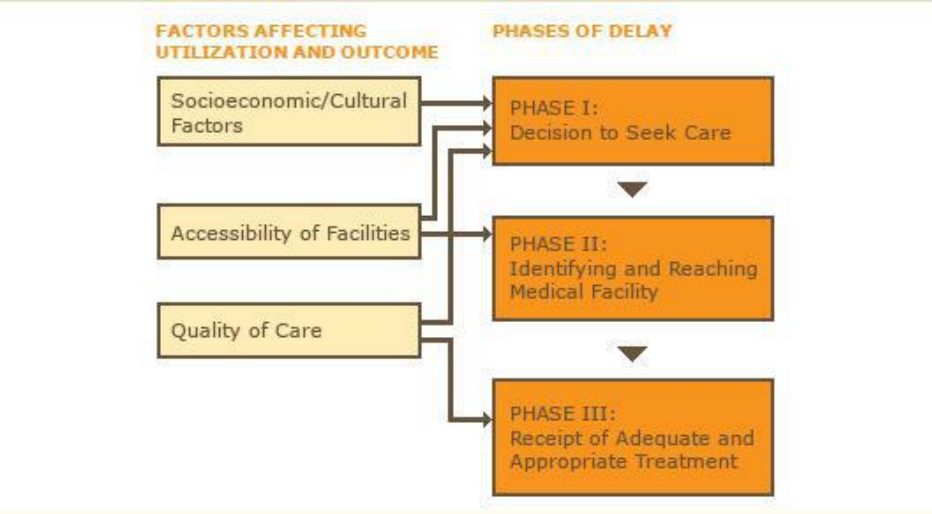
Over 89% lives in rural areas and agriculture is the main economic activity both for food production and income. The agricultural activities include crop production (Maize, sorghum, teff, millet, wheat) and livestock rearing. Coffee is the major cash crop, which grows widely in the area covering 7,91% of the cultivable land.

In the health sector, there are 5 hospitals (3 governmental and 2 non-governmental), 11 type A health centres and 42 type B health centres, 40 clinics (25 governmental and 15 non-governmental), 440 health posts (governmental), 54 rural drug vendors, 10 drug shops, 2 pharmaceuticals in the zone. In Education sector, there are 45 kindergartens, 306 primary schools (1-8 grade), 28 secondary schools (9-10), 10 preparatory schools (11-12) and 6 technical/vocational schools in the zone based on 2011 data. Taking into account the population size of the zone, the existing infrastructure in the social sectors is not enough and not well equipped.

Transport and communication is an integral part of social and economic development. There is a total length of 2.250 km road network in the zone (708 km is all weather road, 1.550 km dry weather road). There are telecom services in all districts, with wireless telephone centres and mobile network coverage in most areas.

Who we are - Our programme interventions

Maternity Worldwide's programmatic approach in Ethiopia, and its contribution to the global effort to reduce maternal and newborn death and disability, builds on an integrated approach that focus on strengthening clinical as well as community capacity on reproductive, maternal and newborn health, including the promotion of women's rights. This approach is designed to address the commonly acknowledged 3 delays model that describes phases and factors affecting health care seeking behaviour and outcomes. The delays place at 3 different levels: 1) at household level - delay in decision to seek care; 2) at referral level - delay in reaching care; and 3) at health facility level - delay in receiving care. The factors affecting these delays are depicted in the model below:



The 3 delay model

Maternity Worldwide's objective is to address those delays, through a strategy of:

- Enhancing availability and improving the quality and of clinics and hospitals that offer basic/comprehensive emergency obstetric and neonatal care
- Improving the quality and availability of professionally trained skilled birth attendants
- Empowering women through improving their social status and financial security and promoting women's rights through a network of income generating groups
- Empowering and mobilizing the local community through reproductive health education and information

Currently, Maternity Worldwide is implementing 2 major projects in West Wollega:

- The Integrated Maternal Health Project (2011 – 2014)
- The mHealth for Maternal and perinatal health project (2013 – 2014)

Whereas this annual report concerns primarily the Integrated Maternal Health Project, a short summary of both projects is given below.

Integrated Maternal Health Project

Maternity Worldwide has outlined its Integrated Maternal Health Project Goal, Objectives, and key outputs as follows:

Project Goal: Contribute to the reduction of maternal and neonatal deaths and morbidity among women and their babies in West Wollega and beyond.

Project Objectives: To increase percentage of births occurring in the health facility attended by skilled birth attendants from 12% to 60% in the targeted districts through developing local emergency obstetric care, health promotion, strengthening health facilities capacity and improving economic status of women by the end of 2014.

Project Outputs: 75% of the health institutions offer basic and comprehensive emergency obstetric and newborn care (EmONC); 85% of all Birth are attended by skilled Birth Attendants; Government Facilities' Maternal Health capacity built; Referral System in the four districts improved; Community Capacity on Maternal Health Issues enhanced; and, Livelihood Status of 50% of the targeted districts poor women will improve.

mHealth for Maternal and perinatal health

In collaboration with the University of Copenhagen (department of international health, immunology and microbiology), Maternity Worldwide implements the research project: "mHealth for Maternal and perinatal Health" (2013 – 2014) using the infrastructure of the Integrated Maternal Health Project. mHealth entails using mobile phones for health promotion, and with the IT and Tele-revolution sweeping over Africa, the potential for mHealth is undeniable. Maternity Worldwide sees mHealth as a promising innovative approach to improving maternal health. The project has 2 modules:

- **The Safe Delivery app:**

Screenshot from the Safe Delivery App

I collaboration with University of Copenhagen, Maternity Worldwide has developed, and is testing, The Safe Delivery app; an innovative mHealth tool for smart-phones that via animated videos gives clinical instructions for birth attendants to enhance intra-partum and post-partum management of delivery and Basic Emergency Obstetric Care. The app increases the capability of the birth attendant for early recognition, correct diagnosis and/or management of active management of third stage of labour, bleeding after birth (PPH) and neonatal resuscitation.

- **Wired Mothers:**

The Wired Mothers is an already tested system that can enhance utilization of ante-natal care and skilled birth attendance through mobile phones. It links the pregnant women to the health system via text messages that sends reminders for appointments and health education messages fitted to gestational age. The project comes with a study setup in order document the impact of the mHealth interventions so that results can feed into the national and international mHealth knowledge base and inform the development of mHealth strategies for reproductive health going forward.

Results: Building up clinical capacity for quality of care

According to the UNFPA, skilled attendance at birth is the single most critical intervention for ensuring safe motherhood. It hastens timely delivery of life-saving emergency obstetric and newborn care, central to reduce mortality because all major life threatening complications (haemorrhage, sepsis, unsafe abortion, hypertensive disorders, obstructed labour and birth aspyxia) can be treated at a well-staffed, well-equipped health facility.

Importantly, "skilled attendance" denotes not only the presence of a 'skilled attendant', but also the enabling environment they need to perform capably. "Skilled attendant" refers exclusively to people with midwifery skills, trained to manage normal deliveries and diagnose, manage, or refer obstetric complications. "Skilled attendance" refers to a professional with midwifery skills working within an enabling environment - linked up with a larger health care system with the facilities, supplies, transport and professionals needed to provide basic and comprehensive emergency obstetric care.

WHO recommends that for every 500.000 people there should be at least 1 health facility offering Comprehensive Emergency Obstetric and Newborn care (hospital level), and 4 facilities offering Basic Emergency Obstetric and Newborn Care (health centre and hospital level).

To strengthen the health system's capacity for delivering quality care and ensure safe motherhood Maternity Worldwide works across 3 levels of care in the health system in West Wollega: Hospital, Health Centre and front-line (Health post) level. The activities primarily address the third delay and to some extent the second delay.

Hospital level

Comprehensive Emergency Obstetric and Newborn Care (CEmONC) support

Maternity Worldwide's targets 2 District hospitals (Gimbie Public and Gimbie Adventist Hospital) with CEmONC support, to enable the hospitals to recruit and retain qualified Obstetrician/Gynaecologists to deliver CEmONC services. The package includes salary subsidy and support to equipment and drugs. A concern is sustainability. Recruitment retention of qualified doctors with CEmONC skills to rural hospitals like those of Gimbie remains a challenge. Therefore, Maternity Worldwide is simultaneously lobbying for Oromiya Health Bureau to prioritize using the deployment of the OB/GYNs to conduct Task Shifting trainings to general physicians to ensure higher sustainability long-term.

Results 2013:

- 2 hospitals (Gimbi Public and Gimbi Adventist Hospital) had 100% obstetric coverage.
- Hospital deliveries have increased with 61% since 2010 and with 25% from 2012 – 2013.

Hospital deliveries	2010	2011	2012	2013
GPH	167	387	1085	1857
GAH	1572	1750	1146	947
TOTAL	1739	2137	2231	2804

Health Centre level

Basic Emergency Obstetric Care (BEmONC)

Basic Emergency Obstetric and Newborn Care is a key intervention to enhance maternal and newborn health and survival. Improving availability, accessibility, quality and use of BEmONC for the treatment of complications that arise during pregnancy and childbirth is one of Maternity Worldwide's key activities. Maternity Worldwide targets 8 health centres in 4 districts.

To align with the government's BEmONC strategy, Maternity Worldwide has in 2013 pursued to establish itself as a nationally accredited BEmONC training partner to government. In collaboration with Gimbie Adventist Hospital Midwifery College and Oromiya Regional Government Health Bureau, has established a BEmONc traning centre. From 2014 the scope of Maternity Worldwide's BEmONC training activities will therefore be significantly scaled up to cover all of Wollega Zone (East and West) with approximately 40 districts, and Maternity Worldwide will train BEmONC providers as part of a joint national effort to reach ambitious targets of heightening the number of BEmONC providers from this area. The Ethiopian Midwife Association (EMA) supervises the training.

Results achieved in 2013:

- 30 birth attendants from 8 health centres and 2 hospitals were trained in BEmONC facilitated by an expert team from Chelsea & Westminister hospital in London and the resident expat midwife trainer and local clinical team.
- 8 health centres in four districts were supplied with necessary medical equipment and drugs for BEmONC
- 1 nationally accredited BEmONC training centre in Gimbie is furnished and launched and 5 BEmoNC trainers are trained and affiliated

BEmONC training to skilled birth attendants

Medical equipment and drugs

When giving BEmONC and other clinical trainings where there is a reliance on certain drugs and equipment, Maternity Worldwide strategically delivers some of this equipment in order for the trained health professionals to be able to implement what they learn. The supply of sufficient drugs and equipment, and the ensuing documentation of improved quality of care and health outcomes can serve as a model for best practice that can be used to lobby towards duty bearers for better and more sustainable supply to health facilities.

Results achieved in 2013:

- 8 health centres and 2 hospitals were supplied with drugs and equipment

Item	Unit	No.	Item	Unit	No.
Ringer 5% lactate with IV set	box	268	Paracetamol 500mg tablet	box	96
Dextrose 40% ,20ml	box	160	Diclofenac sodium 75mg/3ml	box	168
IV cannula 18G	box	160	Tetracycline eye ointment,1%	box	80
Disposable syringe 5ml	5ml	164	Mebendazole 100mg tab	pkt	224
Surgical Gloves 7.5	box	496	Methyldopa 250mg tablet	pkt	64
Disposable gloves 7.5	box	72	Oxytocin injection,10u/ml	amp	3200
Dextrose 40% ,20ml	box	160	Misoprostol	pkt	108
Surgical gauze	Roll	168	Pillows	pcs	32
Folly catheter	Pcs	800	Delivery sheets	pcs	48
Water for injection 10ml	box	320	Delivery kits	pcs	16
Cut gut	box	136	Adult Sphygmomanometer	pcs	16
Elbow gloves	box	32	Cervical dilation display	pcs	4
Adhesive plaster	roll	384	Head covers	pcs	16
Savlon	bottle	64	Masks	pcs	16
Alcohol 70% in 1000ml	bottle	64	Barrier goggles	pcs	16
Magnesium sulphate injection	box	64	Guaze 4x4	pcs	64
Hydralazine 10mg tablet	box	64	Baby blankets 1x1	pcs	48
Vitamin K injection	amp	1600	Soft pelvis and placenta models	pcs	16
Amoxacillin 250mg capsule	box	224	Plastic buckets large	pcs	24
Amoxacillin injection,500mg in vial	box	224	Large steamer pot with lid(for steaming/boiling)	pcs	8
Metronidazole ,IV,5mg in 100ml	box	224	Chlorine bottle	pcs	8
Knee High nylons	pcs	32	Heavy cleaning gloves	pcs	8
Rubber bands(Neutral color)	pcs	32	Tooth brush	pcs	8
Office scissors	pcs	16	Hemostat	pcs	4
Stuffing for breasts(cotton wool/ synthetic stuffing)	pairs	88	Oxygen tubing	pcs	4
Sewing needles-need 22	pcs	64	New born suction tubes	pcs	16
Thread-white or tan color-2 large rolls	pcs	8	Instrument tray	pcs	4
Strip of cloth about 4 inches(13cm)	sheets	12	Dish soap	pcs	4

Ante-Natal Care (ANC)

Quality focused ante-natal care is a core part maternal and newborn health. Regular check-ups allows detection, treatment and/or prevention of health problems throughout pregnancy. In 2012, ANC training was given to all health workers at the targeted health facilities, and refreshment planned for 2013. However, as ANC training currently is a key focus area of government, Maternity Worldwide redirected part of this focus to other clinical trainings, to avoid duplication of efforts. In 2014, ANC training will be an integral part of the BEmONC trainings for Skilled Birth Attendants, and the Clean and Safe Delivery training to front-line health extension workers.

Results achieved in 2013:

- Onsite refresher ANC training for health workers at 3 health centres

2013	Number of ANC visits (all visits - 1st to 4th)				
Health centre	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Homa	289	154	127	82	**652**
Genji	1035	421	253	411	**2120**
Nole	828	498	310	306	**1942**
Haru	319	274	196	134	**923**
Ujumo	373	229	210	95	**907**
Chonge	209	236	227	213	**885**
Siba Kochi	249	149	93	73	**564**
Ula Babu	255	130	104	78	**567**
Total	**3557**	**2091**	**1520**	**1392**	**8560**

Sustainable water supply

Water supply at health facilities is a basic necessity for Infection Prevention and Control and to keep up adequate hygiene standard for a safe birthing environment. In 2012, 2 health centres were equipped with roof water harvesting systems. To ensure sustainability, Maternity Worldwide draws up a Memorandum of Understandings (MoU) and formally hands over systems to administrative bodies, involving Zonal and District Health and Water Bureaus and the Health centres. Maternity Worldwide also ensures that basic training on the management and maintenance of the water harvest systems is given. In 2014, Infection Prevention and Control trainings for the health centres are planned, whereby the centrality of water to keep up a clean and safe birthing environment will be emphasized.

Results achieved in 2013:

- 2 health centres supplied with sustainable roof water harvesting tanks of 10.000 litters.

Front-line level (health posts)

Frontline Health Extension Workers

The Health Extension Program (HEP) is a package of 16 basic and essential promotive, preventive and curative health services targeting households. The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. It is expected that almost all of the activities listed in the National Child Survival Strategies are to be implemented through the HEP. Maternity Worldwide supports government policy of deploying frontline health extension workers at village level to take part in enhancing maternal and newborn care. Maternity Worldwide is therefore involved in delivering the Clean and Safe Delivery training to Health Extension Workers (HEW) on maternal and newborn health. However, the safe and clean delivery training curriculum has been reduced from a 30 days full training, to an 8 days theoretical training, after which participants are responsible to attend 20 supervised deliveries at a health centre, before they can be certified. The quality of the training is therefore a concern, why Maternity Worldwide is backing up with the Birth Preparedness and Complications Readiness. For 2014, the 24 remaining HEWs who have not yet taken Clean and Safe delivery training will be trained.

Results achieved in 2013:

- 14 HEWs were trained on the Clean and Safe Delivery
- 24 HEWs were trained in Birth Preparedness and Complication Readiness

Results: Strengthening the Referral System

Access to a referral hospital as soon as possible from the primary health care level is crucial in emergency cases to save lives. A major barrier to access is costs. Costs can both be for the transport needed, as well as for the user fees for the health services.

At baseline, the situation was that the family of the mother had to find resources both for transport and for medical fees for maternal health services. During the course of the project, however, positive developments have taken place reducing both barriers. As for transport, the government has responded to the need for better referral structures, and all health centres have now access to emergency transport (ambulances). This has dramatically minimized the need for finding your own transport, and implicated costs have been reduced, albeit a family can experience being asked to pay fuel costs. Furthermore, the government of Ethiopia is gradually freeing up maternal health care services in public facilities. By now, the cost is significantly reduced, although some costs still apply.

Safe Birth Fund (SBF)

As a consequence of recent developments, and to work more sustainable, Maternity Worldwide has reshaped its Safe Birth Fund (SBF) scheme to only target the most poor and vulnerable women in the remote villages who are unable to meet both direct and indirect costs of accessing emergency obstetric and newborn care. Vulnerable families thus have the opportunity to access Maternity Worldwide's safe birth fund scheme to pay related costs for emergency referrals.

Results achieved in 2013:

- 361 poor women have been referred through the SBF scheme from the districts to a safe birth at a hospital in Gimbie.

District referral infrastructure

The referral process between primary and secondary level of care remains an area of concern. In 2012, Maternity Worldwide in collaboration with West Wollega Zone Health Office developed a referral form that health centres can easily complete and send with the pregnant women. Nevertheless, a feedback form for the health centres from the hospitals to facilitate the communication further was not developed. Besides, government policy of free maternal and newborn health care seems to encourage clients to directly come to hospitals without a referral document. However, enhancing community awareness to refer all pregnant women to health facilities through trained community health facilitators and promoters is the starting point of the support. Based on the reviewed existing standard government health facilities referral form, health centres are putting in place the system and its consistent use. Hospitals are also able to rely on the ANC follow-up of the health centres for their medical decision.

Results achieved in 2013:

- The standard government health facilities referral form was reviewed and a revised Obstetric Referral Form is introduced at Maternity Worldwide supported health centres.

Results: Community empowerment

The role of community empowerment in improving health seeking behaviour and health outcomes in local communities is indisputable. Maternity Worldwide works with two legs of community empowerment – a community health education program and a livelihood strengthening program. This builds on the fundamental pillar provided by a rights based approach, which places human rights at the centre.

Empowerment: Community Health Education

It is said that well designed community health education is vaccination. Empowering local communities with needed information and awareness, builds up people's capacity to be able to better take care of their own health. Community health education thus plays a critical role in facilitating access to health services, promoting participation and advocating for essential interventions as well as in addressing structural barriers for health. Maternity Worldwide is committed to strengthening community capacity through a wide range of activities under the community maternal and newborn health education programme and the community education and mobilization activities have been very successful in increasing the ANC attendance and institutional deliveries in the targeted districts. The community mobilization model is cost effective and produces sustainable results.

Community Health Promoters

One of the methods Maternity Worldwide uses in the Community Education program is the "community care group model" that has a far-reaching impact. The approach trains Community Care Group facilitators as trainers. The Facilitators then go back to their communities and train a herd of Community Health Promoters (CHPs). The CHPs then reach the community at household level with community health education.

The CHP's are change agents from different categories of people:

Men:

Male involvement is crucial to achieve improved reproductive health. Men are the decision makers in the home and control access to resources. Low awareness in men about maternal health, therefore highly contributes toward the first delay. Attitudinal change can happen in the women, but men may not believe or listen to what the women say. Therefore, male change agents are key. In the training, government representatives were involved too as they lead the male activities and need to know and take ownership over the content of the trainings. Their involvement is highly helpful for high number of male participation.

Women group leaders and Health Extension workers:

The Community health promoter combination of Women Groups and HEWs is the combination of three resourceful local women and two health extension workers, who after training combine their effort and work closely together to help disseminating community health education messages in their village.

Religious leaders:

Religious leaders are highly respected and trusted and have a great influence in the community and speak to large congregations. They are part of defining moralities connected to e.g. health behaviour in communities and as such they are potentially very effective change agents.

Religious leaders as community health promoters

Results achieved in 2013:

- 75 care group facilitators were trained or refresher trained
- A total of 1.345 Community Health Promoters were trained (659 men, 263 Women/HEWs formations, 423 religious leaders)
- A total of 29.146 community members were reached by the Community Health Promoters through house visits, meetings etc. (Men: 14.705, Women 6.322, Religious leaders 8.119)

1 to 5 cluster leaders

Another approach for the Community Health Education used by Maternity Worldwide is to tap into the Government organized "health army". This is a mode of organization whereby 5 households form a cluster, and they appoint 1 woman as a cluster leader. The formation is used for many different purposes, and Maternity Worldwide has tapped in to this structure and educates the 1 – 5 cluster leaders on reproductive, maternal and newborn health issues. The cluster leaders disseminate the information to their subordinates.

1 - 5 cluster leaders as community health promoters

Results achieved in 2013:

- 791 - 1 to 5 cluster leaders were trained
- 9.418 women received community health education in 1.734 meeting sessions and 284 household visits

Community Conversation Sessions

The third approach applied for the community health education component is the Community Conversation approach. This is a method whereby conversation among different groups of community is facilitated by trained Community Conversation facilitators. The Community

Conversation sessions can bring radical change in the community, and change harmful attitudes and practices toward maternal and newborn health.

Results achieved in 2013:

- 158 Community Conversation facilitators were trained
- 11.431 people were partaking in the community conversation session

School Reproductive Health Clubs

Youth is a crucial target group for change. The project has organized groups of secondary school youth in Reproductive Health clubs. These students are the change agents and the future of their communities and enhancing their capacity on sexual, reproductive, maternal and newborn health is vital. The school reproductive health clubs have merged with pre-existing HIV/AIDS clubs, and succeeded in engaging health centres into their activities. As a result, health workers from the health centres introduce and provide different contraceptives for high-school youths to prevent unsafe sex, and the students in giving community health education. A key method of the Reproductive Health clubs to do community education is using the "Edutainment" approach, which is a combination of entertainment and education and has proved to be an effective way of imparting knowledge in rural Africa. The clubs use drama plays to create awareness.

Results achieved in 2013:

- 5 reproductive health clubs have had weekly meetings, and given health education to the school community every week or twice a week
- 30.000+ community members were reached by Community Awareness Dramas on Maternal and Newborn Health

Radio programs

Using radio is another documented best practice in rural Africa to effectively disseminate e.g. health messages. In general, mass media has shown it can play an important role in development and impact on attitudes and promote health seeking behaviours.

Results achieved in 2013:

- A Maternity Worldwide Radio Based Community Health Education guideline was developed and adopted.
- 8 radio programs were aired, covering five zones and a population of 5 million people in 70 districts.

Summary of Community Health Education 2013

Community members reached directly	
Community Health Promoters	29.146
1 – 5 cluster leaders	9.419
Community Conversations	11.431
School Community Drama plays	30.000
Total	**79.996**
Community members reached indirectly	
Radio programs	5.000.000

Empowerment: Livelihood and social status

Women's low status and lack of financial capacity is known as one of the key social determinants of maternal and child health. In societies where men traditionally control household finances the health of women is often not considered a priority and women are frequently not in a position to decide if or when to become pregnant and the number, spacing and timing of their children. It is documented that when women are financially empowered and able to control resources, her health seeking behaviour and health outcomes improve. The financial empowerment of women heightens her social status in society as well. Therefore, Maternity Worldwide emphasizes the need to address the underlying socioeconomic status of women, through the empowerment component focusing on livelihood strengthening programs for poor women.

Micro-credit loans for small-scale business

Maternity Worldwide collaborates with the micro-finance institution Oromia Credit and Saving Share Company (OCSCO) about training and distributing micro-credit loans to poor women to enable them to start small-scale businesses.

Results achieved in 2013:

- 250 women were trained in entrepreneurship, small scale business management and micro-credit loan and savings
- 165 women took up a micro-credit loan and started income generating activities

Village Savings and Loan Associations (VSLA)

Another way of strengthening women's and community members' financial capacities is through the formation of Village Savings and Loan Associations (VSLAs) - a tested model developed by CARE International. VSLAs are typically used as stepping stones for women to demonstrate their capability to save up and repay loans. Eventually they can become eligible for taking up a micro-credit loan from a micro-finance institution to scale up their businesses.

Results achieved in 2013:

- 120 VSLA management committee leaders were trained from 4 districts
- The committee leaders trained a total of 960 community members in VSLAs
- 32 VSLAs were formed by the trained participants (30 in each)

In-kind loans & women cooperatives

A third livelihood strengthening strategy targets the most vulnerable, who are not eligible for micro-credit loans. The approach focuses on organizing and training women on a specific income generating activity (IGA), and the opportunity to take up an in-kind loan for the start-up of such income generating activity. Maternity Worldwide, district Agriculture office and district Women and Children's affairs office have jointly done the screening and selection of the women, based on a set of criteria to ensure participation of the most vulnerable. Three types of IGAs were trained on in 2013.

IGA cooperatives: Poultry and irrigation scheme

Results achieved in 2013:

- 10 women from 1 district were trained and organised in a modern beekeeping cooperative
- 60 women were trained and organized in a collaborative irrigation scheme (agriculture) in 2 districts (30 in each)
- 30 women were trained in poultry keeping from 3 villages in 1 district

Summary of Livelihood strengthening 2013

Livelihood and social status strengthening	
Women empowered through micro-credit loans	165
Women empowered through VSLAs	960
Women empowered through in-kind loans	100
Total number of women financially and socially empowered	**1225**

Key impact indicators (2013)

Skilled birth attendance (2010 – 2013)

Name of Health facility	YEAR			
	2010	2011	2012	2013
Homa Health Center	179	393	240	424
Genji Health Center	84	172	115	411
Nole Health Centers	180	248	207	424
Haru Health Center	120	179	239	198
Gimbi Public Hospital	167	387	1085	1857
Gimbi Adventist Hospital	1572	1750	1146	947
Total	**2302**	**3129**	**3032**	**4261**
NEW Health Centers 2013				
Ujumo Health Center	-	-	-	116
Chonge Health Center	-	-	-	132
Ula Babu Health Center	-	-	-	134
Siba Kochi Health Center	-	-	-	69
Grand Total (ALL)				**4712**

Maternal and perinatal delivery outcomes 2013

Name of facility	Total births	Alive Baby	Stillbirth/ neonatal death	Maternal Death
Gimbi Adventist Hospital	947	876	71	3
Gimbi Public Hospital	1857	1776	81	1
Homa Health Center	424	418	6	0
Nole Health Centers	424	402	22	0
Genji Health Center	411	407	4	0
Ujumo Health Center	116	110	6	0
Chonge Health Center	132	130	2	0
Ula Babu Health Center	134	129	5	0
Siba Kochi Health Center	69	69	0	1
Haru Health Center	198	193	5	0
Total	**4712**	**4510**	**202**	**5**

Referrals from Health Centre to hospital 2013

Name of health facility	Number
Homa Health Centre	99
Nole Health Centre	95
Genji Health Centre	114
Ujummo Health Centre	36
Chonge Health Centre	24
S/Koche Health Centre	2
U/Babu Health Centre	37
Haru Health Centre	51
Total referrals	**458**

Number of Ante-natal care visits 2013

2013	Number of ANC visits (all visits 1st to 4th)				
Health centre	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Homa	289	154	127	82	**652**
Genji	1035	421	253	411	**2120**
Nole	828	498	310	306	**1942**
Haru	319	274	196	134	**923**
Ujumo	373	229	210	95	**907**
Chonge	209	236	227	213	**885**
Siba Kochi	249	149	93	73	**564**
Ula Babu	255	130	104	78	**567**
Total	**3557**	**2091**	**1520**	**1392**	**8560**