ETHIOPIA

MDG ACCELERATION FRAMEWORK

ACCELERATED ACTION PLAN FOR REDUCING MATERNAL MORTALITY

MDG ACCELERATION COMPACT
Accelerated Action Plan for Reducing Maternal Mortality

February 2014

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Cover photo: United Nations Ethiopia

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ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti retro Viral Treatment
AWD	Acute Watery Diarrhea
BEmONC	Basic Emergency Obstetrics and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHWs	Community Health Workers
CSA	Central Statistics Agency
DHS	Demographic Health Survey
DRS	Developing Regional States
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EHSP	Essential Health Service Packages
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
FGDs	Focus Group Discussions
FMOH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HCs	Health Centres
HEP	Health Extension Programme
HEW	Health Extension Workers
HHs	Households
HIV	Human Immunodeficiency Virus
HPs	Health Posts
HSDP	Health Sector Development Programme
IMNCI	Integrated Management of Neonatal and Childhood illnesses
IMR	Infant Mortality Rate
ITN	Insecticide-Treated Nets
LBW	Low Birth Weight
MDG	Millennium Development Goals
MOFED	Ministry of Finance and Economic Development

NGOs	Non-Governmental Organizations
PASC	Pastoral Affairs Standing Committee
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PFE	Pastoralist Forum Ethiopia
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
PTB	Pulmonary Tuberculosis
RHB	Regional Health Bureau
SNNPR	Southern Nations Nationalities and Peoples Region
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBAs	Traditional Birth Attendants
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

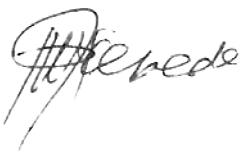
The Millennium Development Goals (MDGs) articulate the global vision for human and social development. The MDGs are time bound minimum benchmarks and constitute eight broad developmental goals with over eighteen specific targets and sixty indicators for monitoring progress on these targets. The goals were adopted by 189 Heads of State and Government at the Millennium Summit in New York and are expected to be accomplished by 2015.

Ethiopia has made significant progress towards meeting most of the MDGs. Whereas the county has already achieved the goal on reduction of child mortality rate (MDG 4) well before the deadline, it is also on track for MDGs on poverty eradication, achievement of universal primary education, and in the fight against HIV and AIDS, Tuberculosis and Malaria. While there is an encouraging trend for the promotion of gender equality and women empowerment, progress on reducing maternal mortality over the last decade has been slow and now merits considerable attention from both government and development partners. Diagnostic analyses has shown that the problems and causes of maternal mortality are multi-faceted and requires a comprehensive and multi-sectoral framework for developing and implementing interventions to reduce these deaths.

For these reasons, the government of Ethiopia and its development partners agreed to utilize the MDG Accelerated Framework (MAF) approach to develop a comprehensive action plan to reduce maternal mortality rates. The MDGs Acceleration Framework (MAF), which was endorsed by the United Nations Development Group (UNDG), is a methodological framework for identifying bottlenecks, solutions, and interventions for accelerating progress on MDGs. The MAF provides a systemic framework for identifying bottlenecks and identifying and prioritizing "acceleration solutions" to speed up progress on those MDGs where progress has been slow and therefore unlikely to reach the MDG targets by 2015. Using this methodology, the proposed action plan will concentrate resources and interventions in communities where maternal death are high and sustaining progress in the rest of the communities where the rates are comparatively low and rapidly declining. Therefore, instead of developing a national-wide MAF action plan for advancing progress on maternal health goals, an action plan on four emerging region states and two pastoral

communities in Oromia and SNNP has been developed. The interventions identified in this action plan on maternal health reflects the different contexts of the selected regional states and communities and has been developed with active participation of staff drawn from relevant federal and regional government departments and the United Nations country team among others. We are confident that addressing identified bottlenecks and implementing prioritized solutions and acceleration solution will significantly reduce maternal deaths and bring the country back on track towards achieving maternal health goals and targets by 2015.

The Action Plan contains detailed analysis of the main causes of maternal health and key bottlenecks that needs to be addressed and prioritized interventions for addressing bottlenecks. We are confident that if these interventions are effectively implemented and supported we shall witness a substantial reduction in maternal mortality and bring the country back on track to achieve the maternal health targets by 2015. Given that this Action Plan contains an elaborate implementation and monitoring framework and costing, it is important that government and development partners work together to strongly support resource mobilization efforts towards the implementation of the Plan.



Dr. Kebede Worku
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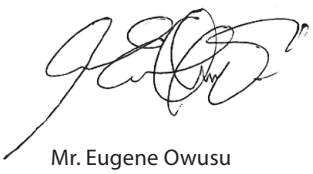

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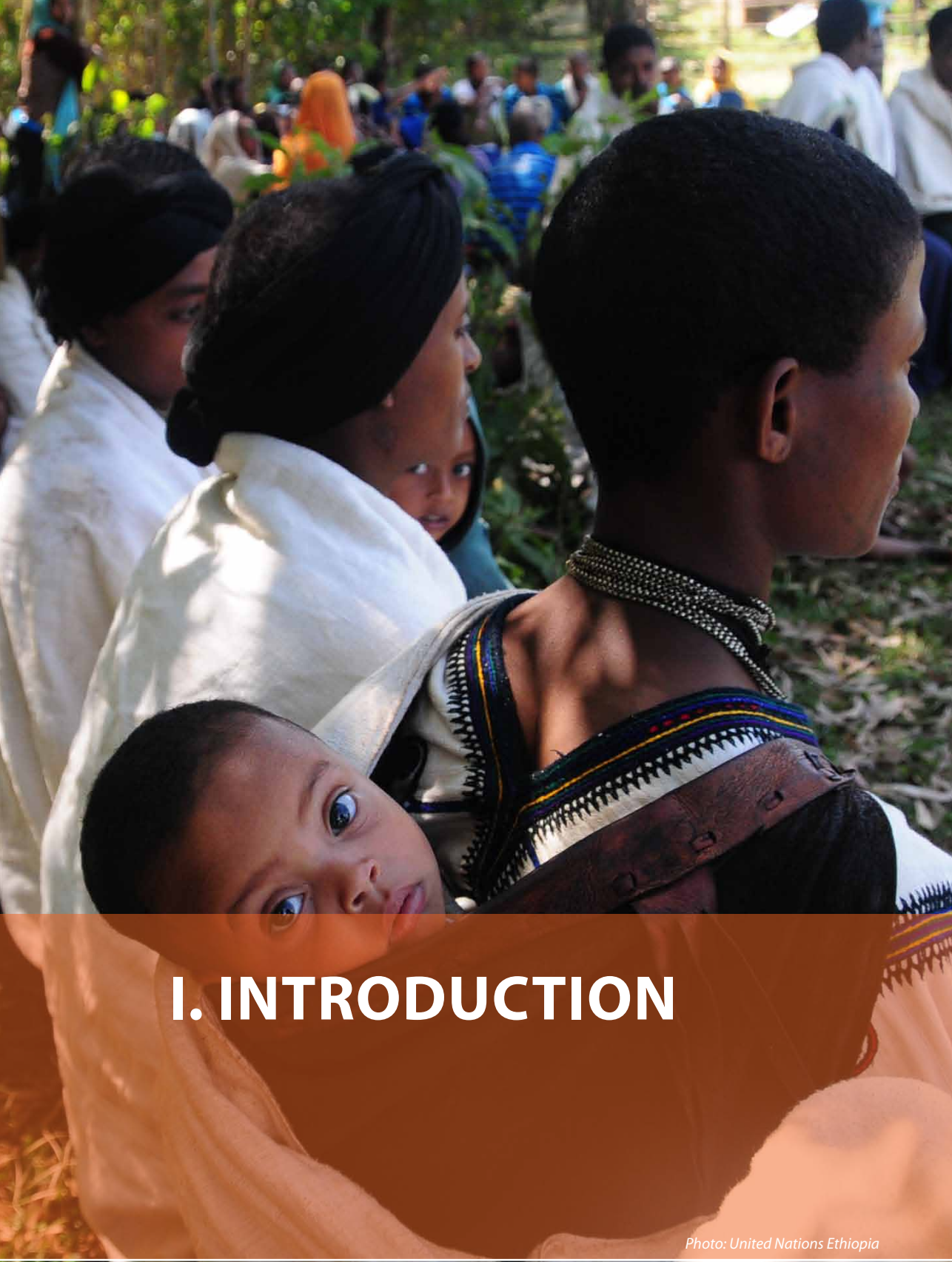


I. INTRODUCTION

Photo: United Nations Ethiopia

With approximately 86 million people, Ethiopia has one of the highest populations in Africa. It is, however, least urbanized, with 83.6 percent of the population living in rural areas and only 16.4 percent in urban areas. About 49.5 percent of the total population is female, of whom 24 percent are in their reproductive age (15-49 years). The population is predominantly youthful, with 44.9 percent of the population under the age of 15 and the entire population estimated to grow at 2.6 percent every year. While fertility trends have declined from 6.4 in 1990 to 4.8 births per woman in 2010, the country's population will continue to increase on account of the large youthful population of childbearing age.

Ethiopia has a federal system of government with nine national regional states and two city administrations (Addis Ababa and Dire Dawa). These are subdivided into 817 administrative districts, or 'woredas', which are further divided into around 16,253 kebeles, the smallest administrative unit in the governance structure. The provision of basic socials services, including health care, has been devolved to subnational regional governments, with the federal government coordinating policy formulation and implementation.

The Government of Ethiopia follows a market–based and agricultural-led industrialization policy for the development and growth of the economy. The country's economy is predominantly agriculture-based, with agriculture accounting for 80 percent of the labour force, 43 percent of the GDP, and 70 percent of value of merchandise exports. Despite serious economic and development challenges, Ethiopia has shown an impressive economic growth over the last eight years, as measured by macroeconomic parameters and strong growth averaging 10.9 percent per annum.

Based on the lessons learned from PASDEP implementation, the Ethiopian Government embarked on a successor five-year (2010/11-2014/15) Growth and Transformation Plan (GTP) that reaffirms the country's vision to become a middle-income economy by 2025. The plan emphasizes agriculture and rural development, industry, infrastructure, social and human development, good governance, and democratization.

Total government expenditure grew from 72.6 billion Birr in 2009/10 to 93.9 billion Birr in 2010/11 and 124.4 billion in 2011/12 – an increase of 71.3 percent. Government expenditure on pro-poor sectors such as education, health, agriculture, water, and roads increased from 47.25 billion Birr in 2009/10 to 62.4 billion Birr in 2010/11 and 87.57 billion Birr in 2011/12 – an increase of nearly 40 billion Birr, or 85 percent (GTP APR, 2011/12). This increased government expenditure on pro-poor sectors accounted for about two thirds, or 70 percent, of total government expenditure in 2011/12. Expenditure on the health sector has also increased significantly: from 4.55 billion birr in 2009/10 to 7.63 billion birr in 2011/12, or about 68 percent. The expenditure on the health sector is planned to increase to 13.89 billion (6.9 percent of planned total government expenditure) in 2014/15 from its 2011/12 level of 6.1 percent of total government expenditure.

According to 2010 estimates by the UN agencies, the maternal mortality ratio declined to 380 deaths per 100,000 births from 700 in 2000, registering an average annual reduction of 6.9 percent over the 10-year period. The rate of reduction is relatively slow and this insufficient progress calls for renewed attention to diagnose the bottlenecks and design interventions that address the bottlenecks and significantly contribute to a reduction in maternal deaths in the country.

Diagnostic studies have shown that most maternal deaths occur during delivery and the postpartum period, suggesting that increasing availability and access to Emergency Obstetric Care (EmONC), antenatal and postpartum care and ensuring that skilled health personnel attend deliveries can immediate reduce maternal mortality. Access to maternal health services are hampered by a poor road network and a lack of transport, making it difficult for expecting mothers to travel to medical facilities in time when complications arise or are anticipated. With virtually less than two years remaining to the MDG target date, Ethiopia needs to devise a comprehensive mechanism for accelerating a reduction in maternal mortality to meet its maternal health targets and other nationally inspired social development goals. However, in order to meet its MDGs on ensuring maternal health, the country should reduce maternal mortality by 16.6 per 100,000 live births annually over the five-year period starting from 2010.

Cognizant of the current realities and the challenges ahead, reaching the target is largely dependent on effective implementation of the strategic and operational blueprints of the acceleration plan, ensuring that resources needed to implement strategic interventions for reducing maternal mortality are mobilized and deployed quickly. The first response has been to mobilize efforts to develop the MAF Action Plan for reducing maternal mortality and placing higher priority on addressing maternal health by the government and development partners.

In view of the sluggish performance on reducing maternal death, the Government of Ethiopia and the UN Country Team agreed to apply the Millennium Development Goals Acceleration Framework (MAF) by developing a robust Action Plan and road map for accelerating the reduction in maternal mortality. In order to achieve maximum impact on the MDG target, it was decided that the development of the Accelerated Action Plan on Reducing Maternal Mortality in Ethiopia should focus on pastoralist regions and communities where the MMR is currently higher and progress seem to be much slower than in other areas. Emerging regions of Afar, Gambella, Benshangul-Gumuz and selected pastoralist communities in Oromia and SNNP were selected and are covered in the MAF Action Plan on maternal health in Ethiopia.

This framework is expected to help the country to fully understand the reasons behind sluggish performance on reducing maternal death, prioritize them, and identify collaborative and multi-sectoral solutions and interventions to speed up progress and to bring performance back on track.

1.1 OBJECTIVES

The main objective of the MAF is to provide a holistic planning framework for identifying bottlenecks and multi-faceted solutions and interventions that can help countries to speed up progress toward meeting those MDGs that have shown slow progress. In the context of Ethiopia, reducing maternal mortality has proven challenging over the last decade and requires identifying targeted interventions to accelerate progress and enable the country to meet this MDG by 2015. Therefore, the objective of this Accelerated Action Plan is to:

a) Identify systemic bottlenecks and constraints to progress on reducing maternal mortality in the country over the last decade;

b) Use the MAF to identify multi-sectoral and innovative interventions that can generate accelerated and sustainable impact on reducing maternal mortality and assist the

country to meet its maternal health targets by 2015; and

c) Produce a consolidated and implementable Action Plan on maternal health that can also mobilize resources to finance the implementation of accelerating solutions to reduce maternal mortality rates in emerging regional states and pastoralist communities across the country.

1.2 METHODOLOGY FOR DEVELOPING THE MAF ACTION PLAN

The MDG Acceleration Framework (MAF) is a methodological framework developed and advocated by the UN Development Group (UNDG) and offers governments and development partners a systematic way of identifying and prioritizing bottlenecks as well as 'acceleration' solutions to enable them achieve MDG targets. The framework also helps to address new challenges that arise in the course of implementing strategies to meet MDGs within a particular country context. The MAF is flexible and enables the integration of new evidence and solutions to maximize multiple benefits for the MDGs, thereby helping countries that use this framework to accelerate the pace of development transformation. Where rates of progress on MDGs vary sharply across geographic regions and/or socio-economic groups, the MAF helps to understand the reasons behind such disparities and therefore helps to provide a coherent framework for addressing them by facilitating the design and implementation of tailored solutions.

STEPS FOR DEVELOPING MAF

The methodology for developing the Action Plan broadly followed the following four systematic steps:

Step 1: Identification and prioritization of country- and/or area-specific interventions
Step2: Identification and prioritization of bottlenecks
Step3: Selection of feasible, multi-partner acceleration solutions to overcome the prioritized bottlenecks
Step 4: Preparation of consolidated Action Plan

- The MAF is therefore a tool for preparing a focused, agreed upon Action Plan to address specific MDGs that rallies the efforts of governments and development partners, including civil society and the private sector, to provide critical investments and services needed to advance key policy, institutional, and organizational reforms to overcome constraints and use existing enablers for accelerating progress on MDGs. Being robust, the MAF has been widely applied to development Action Plans for addressing off-track MDGs in a number of countries, including Ghana and Uganda, which developed comprehensive national Action Plans to address high maternal mortality rates, and in Tanzania to address off-track MDG 1. Like Uganda and Ghana, Ethiopia seeks to use this planning framework to identify critical interventions that will enable the country to identify and address constraints behind the slow progress in reducing maternal mortality over the last decade. While the nationwide road map for accelerating the reduction of maternal and newborn morbidity and mortality in Ethiopia have been under development and implementation since 2012, this particular Action Plan focuses on pastoralist communities where maternal mortality is particularly high and requires unique acceleration solutions. This Action Plan, developed specifically for pastoralist communities, complements the national roadmap on maternal health and seeks to operationalize implementation of interventions tailored to specific contexts of pastoralist communities in Ethiopia.

The criteria for the selection and prioritization of interventions, bottlenecks, and acceleration solutions took into account the fact that identified interventions will be dynamic and effective and will generate significant impact rather quickly. Sector-specific and cross-sectoral bottlenecks to successful implementation of the interventions are identified and prioritized so that those with potential near-term impact and positive spillover effects can be selected for accelerated implementation. In addition, the MAF approach helped to determine and isolate short-term solutions to priority bottlenecks in order to accelerate progress on maternal health MDGs. This is done with full consideration of the effort and time required to bring about the required impacts, the cost-effectiveness and sustainability of selected interventions, the overall governance challenges, and the country's constraints on implementation and resources.

This Action Plan builds upon existing programmes such as HSDP IV, the UN joint programme on DRS, the UN joint programme on maternal and newborn health and survival (H4+), and other ongoing efforts to achieve the target of reducing maternal mortality by three quarters. The Action Plan ensures that relevant multi-sector and cross-cutting issues important for improving maternal health are integrated. Accordingly, interventions already on the ground and/or planned for consequent implementation have been reviewed and priority interventions were selected during the interagency and interregional workshops held in Adama, Ethiopia, between 30 May and 1 June and 8-9 August 2012.

The Action Plan was developed using the MAF process described above and is organized as follows: the Section 1 presents the context for the MAF and outlines the objectives and methodology for developing the MAF Action Plan. This is followed by presentation of the overview progress toward the MDGs in Ethiopia (Section 2). Sections 3 and 4 deal with the situation of the health sector in general (including policies and strategies) and in developing regional states. Section 5 presents priority challenges and gaps concerning maternal health; a bottleneck

analysis (Section 6) and presentation of priority solutions to mitigate the identified bottlenecks (Section 7) follow. Sections 8 describes the consolidated MAF Action Plan for the target regions. The MAF Action Plan concludes with a section on implementation and a monitoring plan (Section 9).

II. OVERVIEW OF PROGRESS ON THE MILLENNIUM DEVELOPMENT GOALS IN ETHIOPIA

Photo: United Nations Ethiopia

The Millennium Development Goals (MDGs) articulate the global vision for human and social development and rallies government efforts and resources to advance global human development. MDGs are time-bound minimum benchmarks, rather than the ultimate development goals, that comprise eight broad developmental goals with 18 specific targets and 60 indicators for monitoring progress toward meeting development goals. Below, the country's performance with respect to each of the eight development goals is reviewed. This sets the context for prioritizing maternal mortality as a goal requiring deeper commitment and efforts from government and other stakeholders.

MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

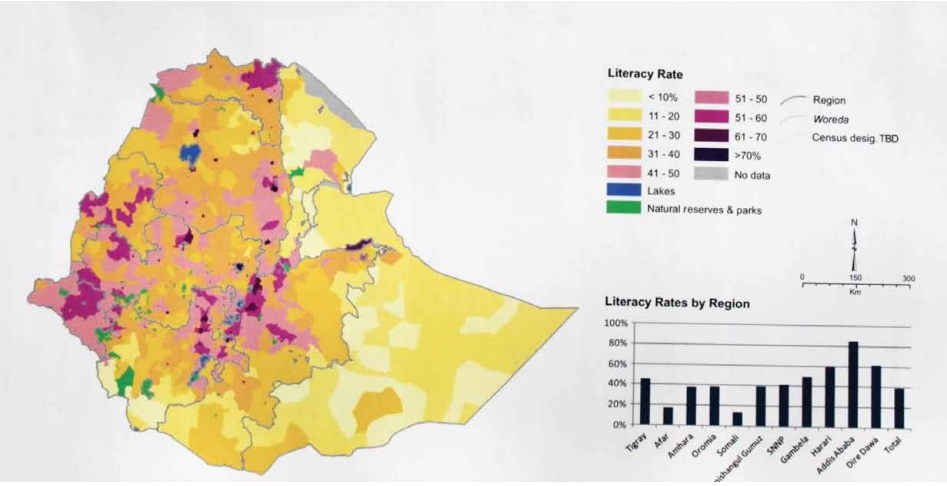
The Government of Ethiopia is committed to achieving the Millennium Development Goal of reducing poverty and hunger and halving the number of people living below poverty line by 2015. Achieving this goal requires accelerating economic growth, creating wealth and employment, and, most critically, boosting national and household food security. The strategies for reducing income and food poverty are anchored in, among other factors, boosting agricultural growth, with a specific focus on raising production and the productivity of smallholders, coupled with strategies to enhance agricultural commercialization. For the urban population, poverty reduction strategies are anchored in increasing employment through agriculture-led industrial development and the promotion of micro and small enterprises.

Evidence shows that these development strategies are working. The economy has registered an annual average growth rate of over 10 percent during the last decade. The recent poverty analysis report indicates that the national poverty head count index declined from 42 percent in 2000 to 38.7 percent in 2004/05 and 29.6 percent in 2010/11, while the food poverty head count index had also declined from 38 percent in 2004/05 to 33.6 percent in 2010/11. Poverty has declined in rural and urban areas, but poverty in rural areas is greater than in urban areas. Rural poverty declined from 39.3 percent in 2004/05 to 30.4 percent in 2010/11 and urban poverty declined from 35.1 percent to 25.7 percent during the same period. Income inequality declined from 44 percent to 37 percent in urban areas, while, in rural areas, inequality increased marginally from 26 percent to 27 percent during the same period. These declines in poverty is attributed to favourable developments in the economic and social sectors and the implementation of social protection programmes, the major one being the productive safety net programme that benefits over eight million food-insecure people. Building resilience and sustaining these rates of growth and poverty reduction in the remaining five years will enable the country to achieve the MDG on poverty reduction.

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Ethiopia has made significant progress in raising primary school enrolment rates and the country is on track to meet the MDG 2 on universal primary education. According to the GTP Annual Progress Report for 2010/11, the gross primary school enrolment ratio rose from 32 percent in 1990/91 to 91.3 percent in 2010/11: 94.2 percent for boys and 88.3 percent for girls. When enrolment rates in alternative basic education are taken into account, total primary school enrolment rate increases to 96.4 percent: 99.5 percent for boys and 93.2 percent for girls. However, in spite of the impressive enrolment levels, there are significant disparities across regional states. For example, net primary school enrolment in 2010 in the underserved regions of Afar and Somali was 30.4 percent and 45 percent, respectively, compared to, for example, 95 percent in the Amhara region.

GRAPH 1: **LITERACY RATE BY *WOREDA* (2007 CENSUS)**



However, enrolments rates are much lower in junior and senior secondary classes, averaging 38.4 percent and 7 percent, respectively, suggesting high drop-out rates in higher grades. Similarly, gender parity is over 90 percent in primary schools, but only around 79 percent in secondary schools, suggesting that drop-out rates are far higher among girls than boys. This is partly attributable to early marriages and intra-household division of labour, which disadvantage girls. Greater attention is therefore needed to increase and to secure secondary enrolment rates for girls. This would also improve adult literacy and reduce disparities across regions (Figure 1).

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The Government of Ethiopia is committed to promoting gender equality, equity, and the empowerment of women. To this end, it has clearly enshrined the rights of women in its constitution, promulgated its women's policy, and revised family and criminal law in order to protect women's rights. The government has also incorporated gender is¬sues into different national policies such as health, education and training, HIV/AIDS, population, and other sector poli¬cies. The formulation of the National Action Plan (NAP) on gender equality and women's empowerment aims to ensure that gender is mainstreamed into all development programmes and projects. The establishment of gender focal persons in all re¬gional bureaux is evidence of the government's commitment to gender mainstreaming.

In terms of progress on MDG 3, Ethiopia is on track toward achieving gender parity in education, but off-track with respect to achieving women's participation in decision-making, especially in terms of seats occupied by women in parliament and the executive branches. Gender parity in educational institutions has significantly improved over the years, exceeding 90 percent and 79 percent in primary and secondary schools, respectively. Women's representation and participation in government decision-making positions has also improved. About 27.9 percent of the seats in the House of Peoples' Representatives, 30 percent of the judiciary and 16.5 percent of the executive are occupied by women (GTP APR, 2010/11). Addressing gender equality and em¬powering women remain challenging because of the deep-rooted cultural attitudes against women.

MDG 4: REDUCE CHILD MORTALITY

The Government of Ethiopia has prioritized child health and promulgated a child survival policy, which is believed to have significantly helped to reduce child mortality. Recent evidence shows that Ethiopia has already achieved the under-five mortality goal well before the 2015 deadline. However, there are significant disparities across socio-economic groups and national regional states. These disparities need to be bridged over the coming years in order to reduce health inequalities and to promote inclusive social development (Bwalya and Alebachew, 2012).

MDG 5: IMPROVE MATERNAL HEALTH

In 1990/91, the country had one of the highest rates of maternal mortality in Africa, with an MMR of 810 deaths per 100,000 live births. Reducing MMR by two thirds by the end of 2015 requires targeted interventions in high-impact areas, including raising the proportion of deliveries attended by skilled health personnel, increasing antenatal attendance, and widening family planning service coverage, which are currently very low. For example, a recent demographic and health survey shows that only 10 percent of all deliveries were attended by skilled health professionals and 34 percent of mothers attended antenatal health services – against targets of 60 percent and 86 percent, respectively.

In addition, only 27 percent of women aged 15-49 years used modern methods of contraception, compared to the projected target of universal access to reproductive health (DHS, 2010; MDG report, 2012). More important, skilled birth attendance is particularly low in rural areas, standing at 4 percent compared to 50 percent in urban areas. The incidence of births attended by traditional birth attendants and family or neighbours is still high, accounting for 28 percent and 57 percent of all births attended, respectively (DHS, 2010). These unfavourable indicators, coupled with low access to emergency obstetric care services, show that maternal mortality is unlikely to significantly decline. It is therefore important to exert maximum efforts to improve maternal health precursors, namely, skilled birth attendance, antenatal attendance, emergency obstetric care, and access to reproductive services, among others.

As per the 2010 estimate by UN agencies, the maternal mortality ratio declined to 350 deaths per 100,000 births from 700 in 2000; this is an average annual reduction of 6.9 percent over the 10-year period. Nevertheless, the country has not made sufficient progress toward reducing maternal deaths over the last decade. Thus, immediate and innovative interventions should be designed and implemented in order to accelerate progress and bring performance on maternal health back on track and possibly progress toward meeting the MDG target by 2015. The lack of progress and, indeed, the

possibility of regress on maternal health make MDG 5 a priority for targeted intervention. It is therefore pertinent that the government and its development partners agreed to develop a comprehensive MDG Acceleration Action Plan for maternal health, with a special focus on areas where maternal deaths are relatively higher and unlikely to drop in response to the set of measures currently being implemented across the country.

MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

The Government of Ethiopia has demonstrated over the last decade great commitment to reducing HIV/AIDS prevalence and infectious diseases. It launched the HIV/AIDS Preven¬tion and Control Office (HAPCO) at the federal level in April 2000, updated the planning framework, and set targets for achieving universal access to anti-retroviral therapy. In addition, the government launched the Millennium AIDS Campaign, which has been the major initiative for scaling up HIV/AIDS prevention and treatment programmes across the country. These programmes have resulted in significant reductions in the incidence and prevalence of HIV/AIDS, with prevalence rates declining to 1.5 percent in 2010 (DHS, 2010), down from 8.6 percent in 2005. This means that the country has achieved the HIV prevalence target of 2.5 percent well ahead of the 2015 deadline. This rapid reduction in HIV/AIDS prevalence has also been attributed to the steady increase in the number of facilities for HIV counselling and testing (HCT), the prevention of mother-to-child transmission (PMTCT), and the provision of anti-retroviral treatment (ART), the number of which stood respectively at 1469, 877, and 420 facilities in 2009, compared to 525, 877, and 32 facilities in 2005. Awareness about the epidemic, behavioural change, and the rise in psychoso¬cial, educational and nutritional services for people living with HIV and AIDS have also played a major role in reducing incidence and prevalence rates of HIV and AIDS. These significant achievements need to be sustained in order to eradicate the scourge of HIV completely.

Ethiopia has one of the world's highest rates of tuberculosis, ranking seventh among the top 10 countries (WHO, 2008). The incidence of all forms of TB is estimated at 247 and smears positive PTB is 108 per 100,000 populations (national TB prevalence survey, 2011), while total prevalence and mortality due to tuberculosis was estimated at 224 and 18 per 100,000, respectively (WHO, 2013). The performance targets refer to increased TB detection that is a precursor to achieving the treatment rate target of 90 percent by 2015. While the country has made progress toward this target, having recorded 90.6 percent treatment rate by 2013, TB detection rates are still low at 58 percent and far below the international standard of 70 percent and should therefore be increased (FDRE HMIS, 2013). Notwithstanding low TB detection rates, the country has already achieved the TB detection and treatment targets ahead of 2015.

One of the leading causes of morbidity and mortality in Africa is malaria. Malaria control and prevention is one of the core activities of Ethiopia's primary health care system. Although comprehensive information on the incidence and mortality due to malaria is currently unavailable, the country has made marked improvements in the distribution of insecticide-treated nets (ITNs) in malaria-prone regions, covering 65.6 percent of all pregnant women and 42.5 percent of under-five children. Nationally, the distribution and use of ITNs have risen sharply from less than 3 percent in 2000 to 42 percent in 2010 (MDG Report, 2012). Estimates by the World Health Organization Child Health Epidemiology Reference Group (WHO/CHERG) in 2010 indicated that malaria accounted for 2 percent of child mortality in Ethiopia, and 4 percent of children under five

who had fever also received antimalarial drugs, while 7 percent received antibiotics (DHS, 2011). Already in 2010, the country met the 2015 target of distributing treated bed nets to 100 percent of the population.

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Ethiopia has taken bold steps to ratify international environmental conventions, established the Environment Protection Authority (EPA), and promulgated various proclamations, including the Environment Impact As¬sessment Proclamation, the Pollution Control Proclama¬tion, and Industrial Waste Handling, among others. Furthermore, Ethiopia has formulated the Climate Resilient Green Economy strategy (CRGE) in an effort to promote carbon-neutral and climate-resilient economic growth and development. Massive watershed and reforestation activities, water supply and sanitation services, and improvement of urban slum areas are under way. Access to clean water supply has increased to 73.3 percent (71.3 percent rural and 92.5 percent urban); urban slum areas have been reduced to 50 percent; 2.1 million kilometres of stone embankments have been constructed; 1 billion trees have been planted; 7,000 kilometres of small-scale irrigation canals have been developed; and 191,600 ponds have been constructed for agricultural use.

MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Ethiopia is receiving significant development assistance from its development partners. During 2010/11, Ethiopia expected to receive debt relief worth US$9.97 million under the HIPC initiatives, but actually received US$9.11 million. In 2010/11, the country also received US$2.57 billion (a US$1.92 billion loan and a US$650 million grant) in Official Development Assistance (ODA) from bilateral and multilateral development partners. The funds were used to finance development programmes and projects in agricultural and rural development, road construction, drinking water development, rural electrification, education, health, industrial development, tourism, capacity-building, and integrated (cross-cutting sectors) development projects. Per capita ODA to Ethiopia is still lower than that provided to other, yet similar countries, and the need for substantial increase for external financing remains important in achieving the country's growth and MDGs. The country is also benefiting from increasing revenue from the international market. Total merchandise export revenue in 2010/11 recorded a robust growth of 37.1 percent vis-à-vis the preceding fiscal year, totalling US$2.75 billion.

In conclusion, Ethiopia requires further efforts to address challenges, particularly with respect to MDG 5. Furthermore, coordinated and systematic efforts must respond to challenges related to disparities across geographical areas.

III. SITUATION OF THE HEALTH SECTOR IN BRIEF

Photo: United Nations Ethiopia

3.1 OVERVIEW

Prior to 1991, Ethiopia's health indicators were very low, with only 38 percent of the country's population having some access to basic health services. After taking power in 1991, the transitional government of the EPRDF realized that economic development could not be achieved without an educated, healthy, and productive labour force, which required massive investment in human development. Investing in health care service provision was therefore prioritized in the country's subsequent medium-term development plans. Policy coordination across sectors and ministries was significantly improved and public investment in health infrastructure and service provision increased. Access to health facilities, which averaged 38 percent in 1991, expanded to 89.6 percent by 2010. Hospitals, the number of which was as low as 72 in 1990 (even smaller than the 82 hospitals that existed in 1982), increased to 183 by the end of 2010. The number of primary health care facilities also increased. Health centres quadrupled from 635 in 2004/05 to over 2660 in 2010/11. Similarly, the number of health posts doubled from 6,151 in 2005/06 to 15,095 in 2010. This impressive investment in expanding health infrastructure, though, was not matched by improvements in the availability of health personnel, materials, and essential drugs that are critical for improving service delivery and the uptake of health services.

To address shortfalls in human resource and other essential health inputs, the government launched a comprehensive health extension programme (HEP) in 2003. The number of health extension workers who were trained and recruited through the HEP rose from 9,900 in 2004/5 to 34,382 in 2010/11. Health extension workers require basic medical equipment, materials, and steady supply and availability of essential drugs in order to provide quality health care services. To provide this, the government set up the Pharmaceutical Fund and Supply Agency, which is tasked with the responsibility of overseeing the procurement and distribution of medicines to health facilities. With distribution points within a 160-kilometre radius of health facilities and an efficient procurement and distribution system in place, essential drugs are now more readily available than before. The close monitoring and efficient procurement and distribution system has reduced wastages due to expiry of procured drugs or due to mismanagement and misuse of medicines by health facilities. Incentives were introduced to encourage recruitment and retention of health professionals in order to ensure that underserved areas (such as rural households) have access to health care comparable in quality to that in, for example, urban areas. Working closely with development partners such as PEPFAR and the Global Fund, the country ensured an adequate supply of medicines and items for the prevention and treatment of AIDS, tuberculosis, malaria, and other diseases. These strategies have greatly helped to increase the availability of health inputs at health facilities and have enabled the country to achieve MDG 4 (reducing infant and under-five mortality) and to be on track toward achieving MDG 6 (combatting malaria, TB and HIV/AIDs).

The distribution of insecticide-treated bed nets and improvements in the diagnosis and treatment of malaria reduced mortality due to the disease by 51 percent between 2005 and 2010, with the distribution of insecticide-treated bed nets reducing death by 33 percent, compared to an average of 3 percent between 2000 and 2004 (Banteyerga et al., 2011).

There has been significant progress toward reducing HIV/AIDS infections. New infections declined from 4.6 percent in 2005 to 1.5 percent in 2010 – an impressive achievement, given the large population of the country, currently estimated at 85 million. Access to ART, which was largely non-existent and inaccessible in 2000, is currently available in over 517 ART centres, and approximately 843 facilities provide PMTCT services across the country. Ethiopia has one of the world's highest TB burdens, ranking seventh globally and third in Africa, according to the World Health Organization (WHO, 2008). The incidence of all forms of TB was estimated at 350 per 100,000, but smear TB-positive is estimated to be 135/1000, while the prevalence of TB is 533/100000. Evidence shows that 21 percent of TB patients are also HIV-positive. Through the national TB and leprosy control programme, the country has made important strides in treating TB, with a TB success rate of 86 percent in 2009, which marginally surpasses the WHO benchmark of 85 percent. However, TB detection rates, at less than 33 percent, are significantly low. This should be increased to ensure that people have access to TB treatment and to reduce mortality and morbidity due to TB infections.

3.2 HIGHLIGHTS OF SELECTED HEALTH SECTOR POLICIES, STRATEGIES AND PROGRAMMES AND INSTITUTIONAL FRAMEWORK

The Federal Ministry of Health (FMoH) has formulated and implemented a number of policies and strategies that afforded an effective framework for improving health service delivery in general and maternal health in particular. Some of these include: the implementation of far-reaching and focused strategies such as Making Pregnancy Safer (2000), Reproductive Health Strategy (2006), Adolescent and Youth Reproductive Health Strategy (2006), and the Revised Abortion Law (2005). Others include: strategies for free provision of key maternal and child health care services; the training and deployment of health extension workers (all of them female) for the institutionalization of community health care services (including clean and safe delivery at the community level); and the training of health officers at the BSc and MSc degree level in Integrated Emergency Obstetrics and Surgery (IEOS) and Anaesthetists. The national five-year strategic plan for malaria control in Ethiopia also gives top priority to the protection of infants and pregnant women, as they are high-risk groups for malaria-related morbidity and mortality. Among the national programme instruments, the implementation manual of the national nutrition programme is also relevant to maternal health. In addition, the establishment of the MDG fund and the priority given to maternal health therein is expected to mobilize much-required additional funding opportunities.

3.2.1 National Health Policy

The health policy, which was endorsed in 1993, has been guiding the country's engagement in the health sector for the last 19 years. The main focus of the policy is the decentralization of services, with a special focus on less-privileged rural communities. The policy aims to improve and ensure access to and equity of service distribution and strong community representation at all levels has been emphasized.

Maternal health is one of the priority areas of the national policy, which stipulates that special attention would be given to the health needs of the family, particularly women and children. Moreover, the document promotes family health services through core strategies such as ensuring adequate maternal health care and referral facilities for high-risk pregnancies, intensifying family planning for the optimal health of the mother, child and family, and inculcating principles of appropriate maternal nutrition to guide maternal health initiatives in the country. Other strategic issues highlighted in the policy document are the expanding of services and facilities, the ensuring of the availability of necessary equipment and medicine, and the strengthening of management capability and human resource development. These are also believed to play a role in improving maternal health services.

3.2.2 Health Sector Strategy

Being part of the implementation frameworks of the policy document, the 1995 health sector strategy also aimed at the provision of comprehensive primary health care services at the community and facility levels. A particular feature of this strategic document is its elaboration of the hierarchical structure of health care service delivery from the top to the grass roots and community level. The document clearly states that special attention would be given to maternal and child health and stipulates the provision of antenatal, prenatal, and postnatal care, family planning advice and service, growth monitoring and nutrition, and education and immunization services. The health policy and strategy emphasize the commitment to comprehensive and integrated primary health care, including maternal health, in health institutions. Particular emphasis has also been given to improving access to quality community-level health services. A strategic document for an essential health service package for Ethiopia is the guiding document for the design and implementation of various development initiatives pertaining to the health sector. The document defines maternal and newborn health interventions are the responsibilities of all levels of the tier system, with necessary referral linkages.

3.2.3 Health Sector Development Programmes (HSDPs)

A comprehensive Health Sector Development Programme (HSDP) was formulated in 1998 as a medium-term framework for the implementation of the health policy. Three successive HSDPs were formulated and implemented and HSDP IV is currently under implementation. The formulation of these comprehensive HSDPs has significantly contributed to the implementation of the nationally identified areas of health interventions. While HSDP III and HSDP IV gave particular attention to maternal and newborn health, HSDP IV (2010/11-2014/15) specially emphasized training more midwife nurses and enhancing the capacity of HEWs on clean and safe delivery services; it also identified strategies for raising demand for and improving access to and quality of health care services.

The HSDP IV has also emphasized addressing issues related to the health of mothers and infants, such as PMTCT, attendance of delivery by skilled health workers, and the environmental management of malaria and other diseases. The family planning programme focuses on ensuring contraceptive security and the provision of long-acting and permanent contraception. Focused antenatal care with four visits per pregnancy has also been mainstreamed at all service delivery levels.

A quite innovative approach of HSDP is the Health Extension Programme (HEP). The Programme has 16 key components and aims to ensure the universal and equitable delivery of a comprehensive package of health interventions at the household and community levels. The package, among others, consists of health promotion, disease prevention, and basic curative and rehabilitative services. The health extension workers (HEWs) play a pivotal role in the delivery of the various components of the HEP. About 34,382 HEWs have been trained and deployed so far, with two female HEWs assigned to each health post. Similarly, an urban HEP has been developed based on identified core health problems and about 5,080 urban HEWs have been deployed to date. The Health Extension Programme is considered to be an appropriate response to the challenges of meeting the health MDGs, including MDG 5.

The HSDP Harmonization Manual has also been established in order to improve the management and implementation of the health sector plan and enhance its efficiency and effectiveness. The Manual emphasizes the use of 'one plan, one budget, and one report', whereby every stakeholder who is involved in the process sees himself or herself as part of a bigger team working for the same goal.

3.2.4 The National Reproductive Health Strategy (NRHS)

The NRHS is a 10-year strategy to be implemented from 2006 to 2015. A comprehensive document, it deals with all aspects of reproductive health, one of which is maternal and newborn health. In addition to providing an overview of the broader social and institutional contexts and how they are influencing maternal health, the Strategy identifies priority issues and a list of actions to be taken at different levels in order to reduce maternal and neonatal morbidity and mortality. Additional strategies incorporated into the document include mass-mobilization and sensitization on pregnancy-related risks, creating a supportive environment for safe motherhood, and taking responsibility for developing and implementing appropriate responses, especially in rural areas where health facilities are limited.

Cognizant of the extent of the problem of unsafe abortion and with due recognition of the need for an integrated approach to reduce maternal morbidity and mortality, the FMOH has issued its Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia. This operational guideline was developed to assist health personnel at different levels to implement the relevant legislative and operational requirements pertaining to abortion and to mitigate the risk of maternal death associated with abortion.

According to the nationwide road map for accelerating the reduction of maternal and newborn morbidity and mortality, the main strategies for the reduction of maternal mortality in Ethiopia are: (i) empowering women, men, families, and communities to recognize pregnancy-related risks; (ii) ensuring access to a core package of maternal health services, including access to transportation facilities; (iii) creating an environment supportive of safe motherhood; and (iv) increasing community awareness of complication readiness, birth preparedness, and the availability of basic, comprehensive emergency obstetric care (EmOC).

The H4+ (i.e., UNFPA, UNICEF, WHO, WB. under the umbrella of the UNCT) and FMOH Flagship Joint Programme on Improving Maternal and Newborn Health (MNH) and Survival (2010

– 2011) was signed as a special agreement to focus on implementation of selected high-impact interventions to curb maternal mortality. Among the much wider range of health programme support to Ethiopia, the Joint Programme focuses on the weakest links of current MNCH programmes: pregnancy, child birth, and the immediate postpartum period.

3.2.5 Institutional Framework for Health Service Delivery

Ethiopia has a three-tier health care delivery system. The first level, the Primary Health Care Unit (PHCU), consists of a woreda/district health system comprising a primary hospital (with population coverage of 60,000 to 100,000 people), health centres (with a threshold value of 15,000 to 25,000 people per health centre), and their satellite health posts (with a threshold value of 3,000 to 5,000 people per health post).5 Primary health service coverage reached 96 percent in 2010/11, up from 89.6 percent in 2009/10. The second level is a general hospital with a threshold value of 1 million to 1.5 million people, while the third tiers refers to a specialized hospital covering a population of 3.5 million to 5 million. In the major urban centres, each kebele has a health unit headed by specially trained nurses, with a HC for each sub-city, forming the urban PHC unit. The health care system is augmented by the rapid growth of the private-for-profit and NGO sectors, which are playing a significant role in expanding health service coverage and use. The health sector is one of the pro-poor sectors receiving significant government expenditure. In 2010/11, health sector expenditure accounted for 6.7 percent of total government expenditure and 10.1 percent of expenditures on pro-poor sectors. Expenditure on the health sector in 2010/11 increased 34 percent from its level in 2009/10.

The devolution of power has shifted the decision-making for public service deliveries to the regions and woredas/districts. Regions and districts have regional health bureaux (RHBs) and district health offices, respectively, for the management of health services at each level. The FMOH and RHBs focus more on policy matters and technical support, while woreda health offices have basic roles of managing and coordinating the operation of the district health system under their jurisdiction.

3.3 MATERNAL HEALTH SITUATION IN ETHIOPIA

The following are some basic indicators on the situation of maternal health in Ethiopia:

TABLE 1: SELECTED MATERNAL HEALTH INDICATORS (EDHS, 2011)

Description	Status in 2004/05	Status in 2010/11
CPR (%)	15	29
CPR among urban women (%)	47	53
CPR among rural women (%)	11	23
ANC coverage (at least one visit) (%)	28	34
ANC coverage (recommended four visits) (%)	n/a	19 (46 % for urban and 14 % for rural women)
Protection against neonatal tetanus (%)	32	46
Delivery in health facilities (%)	5	10

If MDG 5 is to be achieved in Ethiopia, MMR should decline from 350 per 100,000 live births in 2010 to 237 per 100,000 live births in 2015. An estimated 2.6 million births occur each year in Ethiopia and about 15 percent of pregnant women are estimated to develop life-threatening obstetric complications. Direct obstetric complications account for 85 percent of the deaths as well as many acute and chronic illnesses.

The HSDP – III set a goal of achieving comprehensive EmONC in 87 percent of hospitals and in 20 percent of health centres by 2010. The objectives also include the upgrading of health centres so that all can provide basic EmONC. The EmONC assessment data show that only 51 percent of hospitals qualify as comprehensive and only 1 percent (or 25) of health centres offer the full package of basic EmONC, which is key to the reduction of maternal and neonatal morbidity and mortality. Several signal functions were often missing: blood transfusion, parenteral anticonvulsants, assisted vaginal delivery with vacuum extraction or forceps, and neonatal resuscitation, and many facilities were missing equipment, skills or operational guidance.

Though there have been some improvements in all aspects of the service, actual achievements are much below planned targets. For example, the 2011 FMOH/WHO/UNICEF assessment indicates that health facilities providing EmONC services in developing regional states were very few: in Afar, only two of the 28 HCs (7 percent) provide EmONC; in Somali, none of the 35 HCs provide it; and, in Gambela, f eight of its 23 HCs (35 percent) provide EmONC.

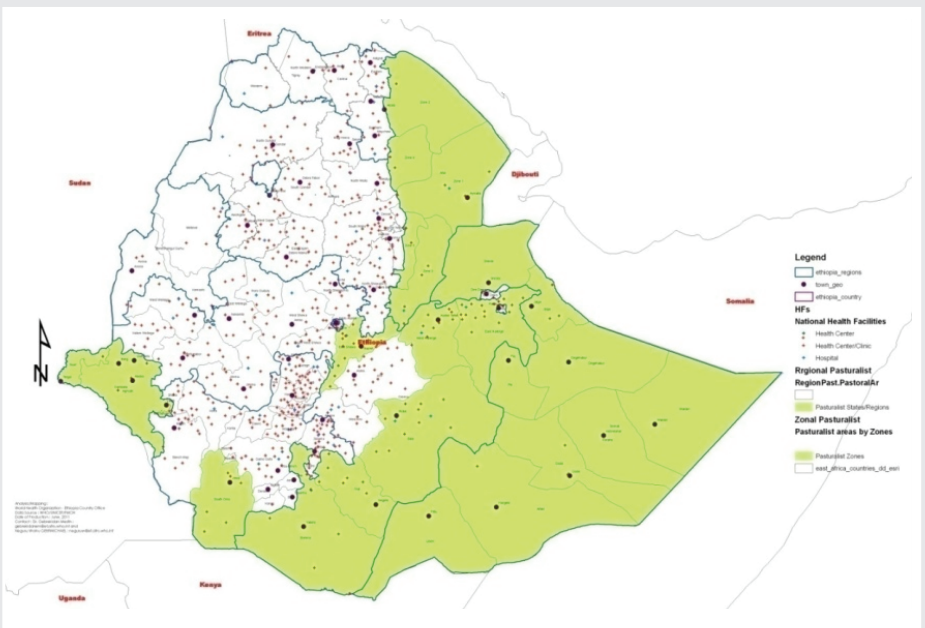
Though a lot has been done to improve maternal health service utilization in Ethiopia, the service and outcome seem to be far from sufficient. The percentage of deliveries attended by skilled health personnel, considered as a proxy indicator for measuring improvements in maternal mortality, is very low (Table 1).

IV. HEALTH CARE SITUATION IN DEVELOPING REGIONAL STATES AND PASTORAL COMMUNITIES

Photo: United Nations Ethiopia

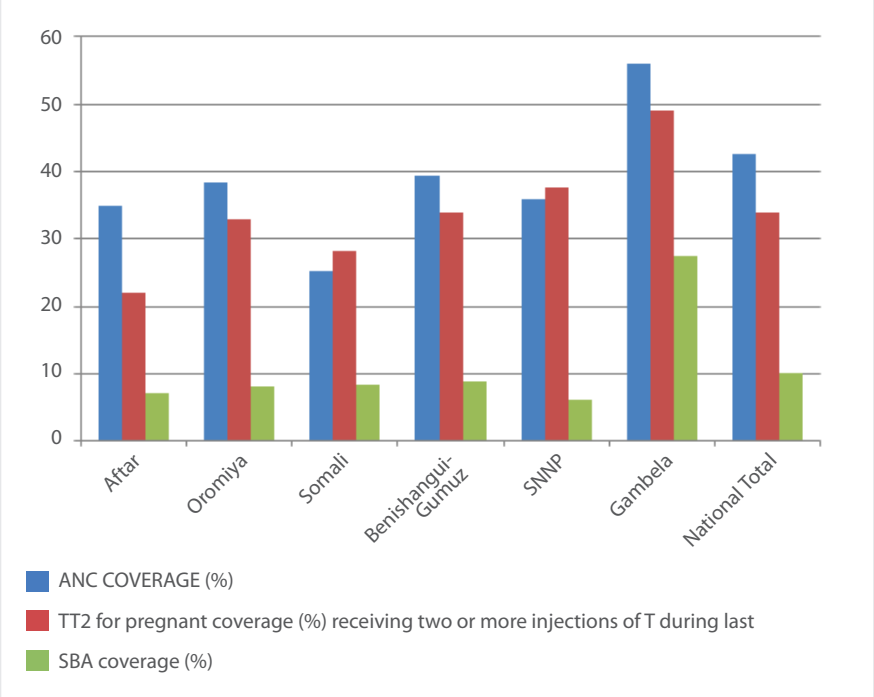
Pastoralists belonging to about 29 different ethnic groups occupy 60 percent of the territory and constitute about 12 percent of the total population, making the country one of the most pastorally populous in Africa. Somali, Afar, Oromo (particularly the Borena and Kereyu), many groups in South Omo Zone of SNNPR, and the Nuer in Gambella constitute the majority of Ethiopian pastoralists. These communities mainly reside in developing regions, namely, Afar, Somali, Gambella, Benishangul-Gumuz, and pastoralist areas of Oromia and SNNPR States (Mussa, 2004) The pastoral areas are home to an estimated 42 percent of all national livestock. Moreover, the pastoral areas are rich in bio-diversity, mineral, water and energy resources, and untapped tourist attractions. The pastoral areas are characterized mainly by unpredictable and unstable climatic conditions and their ecologically fragile environment. Consequently, seasonal movement is the unique lifestyle of pastoralists, which is a significant factor affecting the health care provision. The major problems in pastoral areas include lack of appropriate livestock marketing, education, public health, veterinary services, and water for humans and livestock.

MAP 1: **MAP OF ETHIOPIA SHOWING PASTORALIST AREAS WITH THE ROAD, RIVER AND HEALTH FACILITIES**



The Federal MOH recognizes the lack of an appropriate health service delivery package for pastoralist communities and the need to develop a viable strategy for health service delivery. As part of the government's effort to provide technical assistance to the developing regions (of which the pastoralist regions are part), a federal special support board composed of members from six ministries was established under the Ministry of Federal Affairs and includes a technical committee for the integration of support for these regions. Moreover, the Health System Special Support (HSSS) Directorate was established within the FMoH to address the problem of health care in pastoralist areas. Graph 2 indicates the status and coverage of maternal health care in developing regional states as well as in Oromia and SNNPR.

GRAPH 2: **SELECTED MATERNAL HEALTH COVERAGE, IN PERCENT (EDHS, 2011)**



With regards to access to and availability of skilled birth attendance, the 2011 FMOH/WHO/UNICEF assessment found that less than 8 percent of deliveries were assisted by qualified health personnel in all assessed pastoralist areas. The same is true for ANC use. Less than 32 percent of pregnant women in pastoralist areas use the service, in contrast to the then 71 percent national average, according to the same report. Evidence indicates large differences in levels of contraceptive use by region. Addis Ababa has the highest CPR, at 63 percent, while Afar and Somali rank below 10 percent. Implementation of the HEP in pastoralist areas is also slow and faces complex challenges. Overall, in developing/pastoralist regions, the number of health facilities is limited, unevenly distributed, and often falls short of providing a minimum package of primary health care services. Most facilities operate at a level far below their intended capacity and are poorly organized, staffed, and managed, resulting in a very low use rate (FMOH/WHO/UNICEF, 2011). In addition to the pastoralist lifestyle of seasonal mobility, difficulties associated with transportation and communications prevent people in pastoral areas from using services. This is further exacerbated by less identified and understood cultural, social, and behavioural determinants that may harm health care practices, including health-seeking behaviour.

V. ACCELERATING PROGRESS TOWARD MATERNAL HEALTH: PRIORITY CHALLENGES AND GAPS

Photo: United Nations Ethiopia

Seven key priority interventions have been identified to accelerate achievement of MDG 5. These include: (a) skilled birth attendance (SBA); (b) antenatal care (ANC); (c) emergency obstetric care (EmOC); (d) family planning (FP); (e) maternal health education and awareness (MHEA); (f) human resource (HR) and materials and equipment (ME); and (g) infrastructure (Infra).

5.1 SKILLED BIRTH ATTENDANCE (SBA)

Skilled birth attendance helps to detect and manage complications. It also ensures appropriate referral for further management of these complications. Yet, despite the rapid expansion of the health facilities and the deployment of health personnel at all levels, the SBA rate remains very low: 10 percent at the national level and even much lower than that in the developing regional states.

5.2 EMERGENCY OBSTETRIC CARE (EMOC)

Direct obstetric complications account for 85 percent of the deaths as well as many acute and chronic illnesses. The most common causes of death include: obstructed labour, ruptured uterus, severe pre-eclampsia and eclampsia, severe complications of abortion, post-partum haemorrhage/retained placenta), postpartum sepsis, ante-partum haemorrhage, and direct complications from other causes. Emergency obstetric care significantly curbs these causes of death.

5.3 ANTENATAL CARE (ANC)

Effective antenatal care helps in the early identification of danger and calls for prompt action and care. It helps in preventing, detecting, and treating problems such as malaria, anaemia, HIV/AIDS and other infections, which frequently are indirect causes of maternal deaths. The 2010/11 EDHS report indicates that only 19 percent of pregnant women have made the recommended four visits during pregnancy. The following two graphs show the percentage of women receiving ANC from skilled providers by region and trends in use.

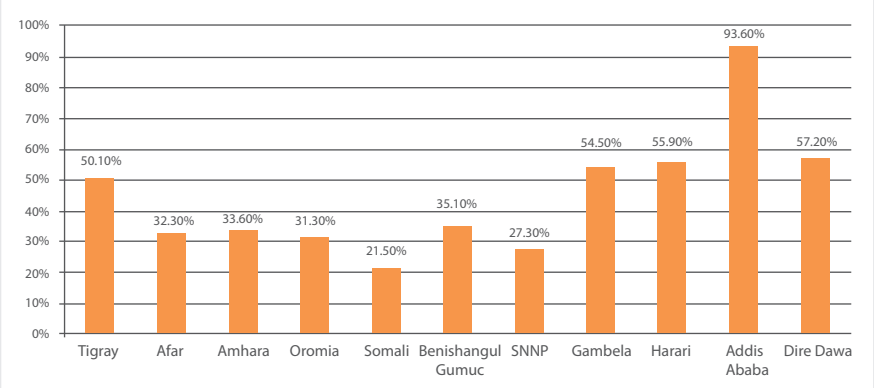
5.4 FAMILY PLANNING (FP)

Though the CPR nearly doubled from 15 percent in 2004/05 to 29 percent in 2010/11, it is still very low. Family planning prevents unintended/unwanted pregnancies and enables women not to have pregnancies too early, too late, or too frequently, thereby avoiding exposure to risks of death from complications of pregnancy. Even though contraception does not directly contribute to a reduction of the MMR, it does prevent many deaths that would otherwise have occurred during the course of pregnancies.

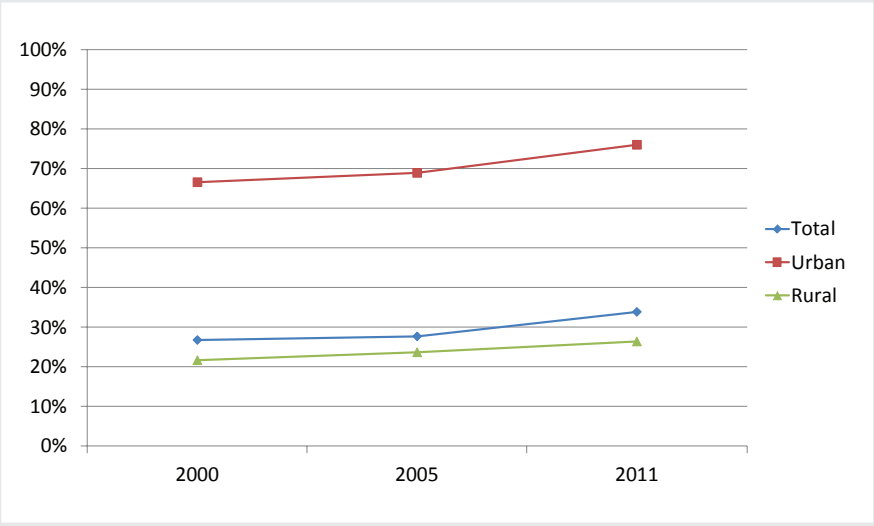
5.5 MATERNAL HEALTH EDUCATION, AWARENESS AND ADVOCACY

People are generally not well aware of the possible complications and treatments pertaining to maternal health and pregnancy. Where services are available and accessible, their use is also very low, indicating low health-service-seeking behaviour and practices. The creation of wide-scale health education programmes targeting various groups would significantly reduce the incidence of complications and thus maternal morbidity and mortality rates.

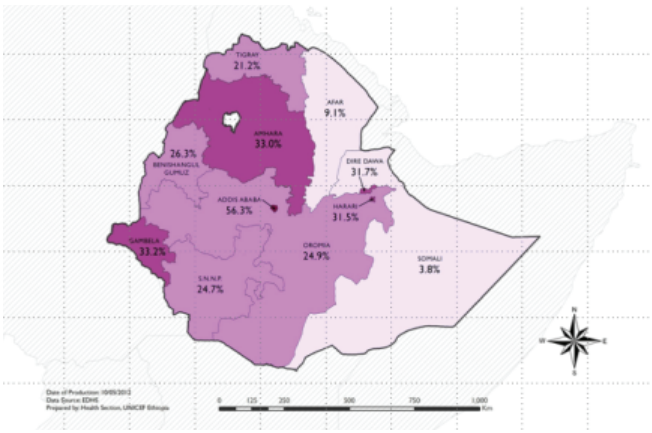
GRAPH 3: **PERCENTAGE RECEIVING ANC FROM A SKILLED PROVIDER, BY REGION IN PERCENT (DHS, 2011)**



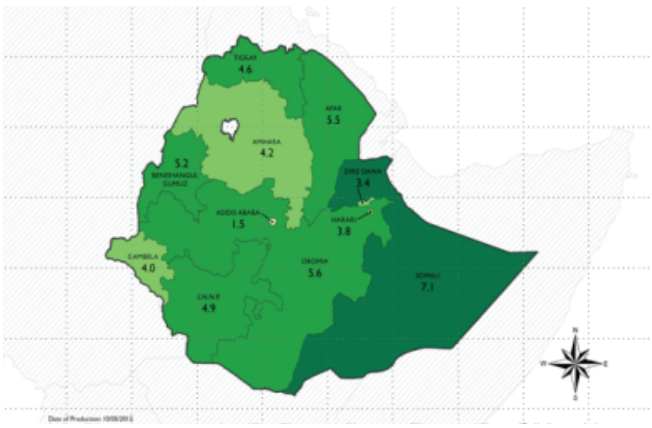
GRAPH 4: **TRENDS IN WOMEN AGED 15-49 WHO ATTENDED AT LEAST ONE ANC GIVEN BY SKILLED HEALTH PROVIDERS**



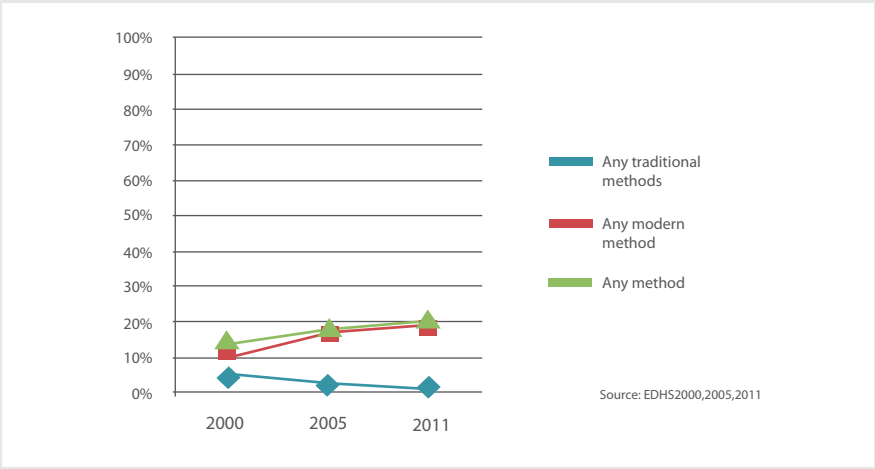
MAP 2: **USE OF MODERN CONTRACEPTIVES AMONG MARRIED WOMEN AGED 15-49 BY REGION**



MAP 3: **TOTAL FERTILITY RATE BY REGION, 2011**



GRAPH 5: **TRENDS IN THE USE OF MODERN CONTRACEPTION AMONG WOMEN AGED 15-49**



5.6 HUMAN RESOURCE CAPACITY AND SUPPLY OF REQUIRED MATERIALS AND EQUIPMENT

The availability of technically and functionally qualified, ethical, and committed health personnel is a prerequisite for well functioning health facilities. Likewise, health facilities need to maintain the minimum stock of health supplies and equipment required to provide maternal health service at all time. Yet assessments indicate that many health facilities have insufficient staffing, materials, and equipment to provide satisfactory maternal health services.

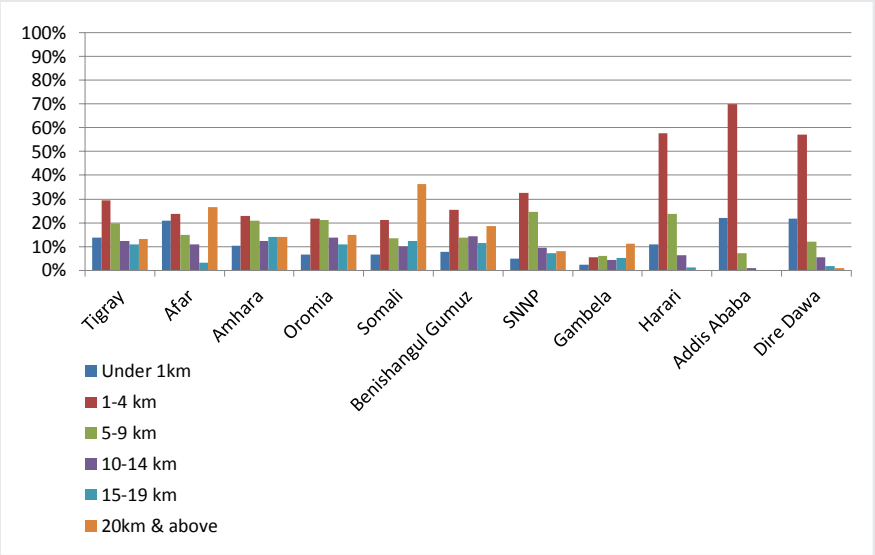
5.7 INFRASTRUCTURE

Health institutions require basic facilities such as water, electricity, and ICT in order to provide effective services. Likewise, access roads to health facilities are essential for the access and use of health services, especially in rural communities. Devising mother-friendly and culturally sensitive waiting, examination, and delivery rooms can encourage mothers to visit and can build mothers' confidence in the health facilities' services.

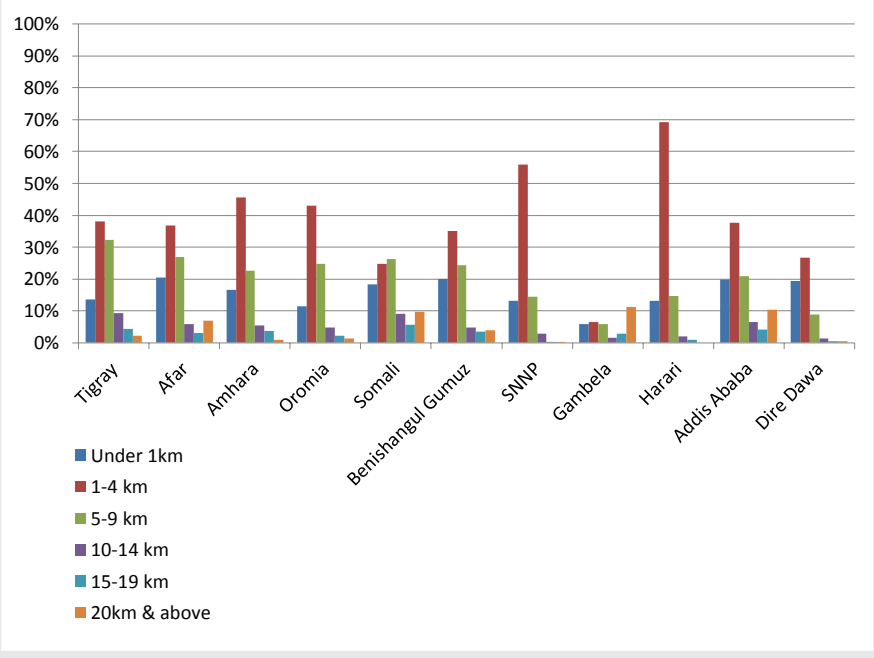
TABLE 2: **HEALTH FACILITIES ACROSS REGIONAL STATES & CITY ADMINISTRATIONS OF ETHIOPIA (FMOH, 2013)**

REGION	POPULATION (2013)	HOSPITALS	HEALTH CENTRES	HEALTH POSTS	HEALTH POSTS
Tigray	5,061,991	14	213	704	1,403
Afar	1,649,999	5	55	238	465
Amhara	19,211,994	19	801	3,242	6,461
Oromia	32,220,001	47	1,123	6,165	12,308
Somali	5,318,000	6	112	846	1,622
Benshangul G.	1,027,994	2	31	321	632
SNNP	17,887,005	19	634	3,869	7,718
Gambela	406,004	3	27	99	191
Harrari	215,000	2	9	85	148
AA	3,103,999	2	15	0	0
Dire Dawa	395,000	7	62	31	57

GRAPH 6: **DISTANCE TO THE NEAREST HC BY REGION, IN KM (WMS, 2011)**



GRAPH 7: **DISTANCE TO THE NEAREST HEALTH POST BY REGION, IN KM (WMS, 2011)**



VI. BOTTLENECK ANALYSIS

Photo: United Nations Ethiopia

According to the 2012 HSDP III Joint Review Mission (JRM) report, progress in the delivery of MNH services was generally far from satisfactory and uneven across regions. The shortage of skilled birth attendants, a weak referral system, inadequate midwifery skills at health centres, the lack of BEmONC and CEmONC equipment, and insufficient financing of the service were identified as supply-side constraints. This assessment also measured the very important gaps in basic and comprehensive EmONC services linked to the lack of three essential components of the health system's performance: qualified human resources at all levels; drugs, supplies, and equipment; and functioning referral systems. On the demand side, cultural norms and societal emotional support bestowed on labouring mothers, distance to functioning health centres, and financial barriers were found to be the major causes for not using available services.

The high maternal and newborn mortality in the country is due to delays in (i) seeking skilled emergency obstetric care; (ii) reaching the health facility; and (iii) receiving timely intervention after reaching the facility. The main targets for monitoring progress involve increasing community awareness about complication readiness and birth preparedness and supplying basic and comprehensive emergency obstetric and neonatal care (EmONC), which would reduce the occurrence of obstetric complications and deaths.

6.1 SUPPLY-SIDE BOTTLENECKS

The developing regional states and pastoral areas are relatively less developed and lack basic infrastructure, manpower, and functioning institutions. The government and other development partners are trying to address those challenges by executing specific policies and development programmes. However, the challenges and bottlenecks for addressing maternal health issues remain unaddressed and are identified below.

6.2 DEMAND-SIDE BOTTLENECKS

The educational level, awareness of health matters (especially maternal health), cultural values, beliefs, and attitudes, as well as the behaviour of individuals and communities all determine the likelihood that someone will seek health services. At the same time, the social and behavioural determinants of maternal ill health and death are the least studied and little understood aspects of barriers to optimal maternal health coverage. The following is a list of prioritized bottlenecks that constrain mothers and communities from seeking maternal health services.

- Serious funding gaps for targeted maternal health programmes and for strengthening health systems, including shortage of drugs, medical supplies, equipment and commodities for obstetric care, which are often attributable to insufficient budgets and weak management and logistics support
- Low quality of care during delivery and emergency obstetric care; poor access to skilled care during delivery and emergency obstetric care, leading to the low coverage of skilled birth attendance
- Unfriendly environment in the health facilities, including in waiting, delivery, and close-monitoring rooms, especially for rural mothers
- Long distance to the health facilities; lack of means of transport and communications whenever medical consultation, advice and service are required
- Weak referral systems, absence of 24/7 services in most health facilities, and too few ambulances and other emergency transport systems without serviceable roads and an adequate budget for fuel and maintenance
- Limited human resources (especially midwives, doctors and, anaesthetists), exacerbated by high turnover and low quality of training (technical, functional, and ethical)
- Inefficiencies in proper deployment of health personnel at health facility levels and frequent transfers
- Poor commitment and unwelcoming attitude of some health workers toward provision of maternal health services
- Absence/shortage of appropriate equipment, medicines and supplies, which discourages demand for care
- Lack of policies and procedures for flexible delivery of key maternal health services at PHCUs
- Lack of understanding among health care providers about how to deal with the pastoralist way of life and lack of consideration and prompt policy and programme response to the specific context of pastoralist regions
- Weak Logistics Management Information System (LMIS) causing delays in requisition and acquisition of critical drugs, supplies, and other health commodities
- Weak follow-up to ensure the availability of adequate skills and of human, financial and material assets
- Absence of maternal and prenatal death registration, identification, and reporting of cause of death. M&E tools (HMIS) are not producing some important data, such as birth and death registration (disaggregated by age and cause of death) for accurate needs determination and planning/decision-making; whenever available, they are not well analysed and used for action and feedback
- Lack of effective coordination and of creation of synergy and value for investment among the various actors

- Lack of women's empowerment: Women are not empowered to make decisions about health issues (such as use of contraceptives without a husband's consent), which hampers their access to maternal health services
- Low financial capacity to cover transport and related logistical costs
- Early marriage and pregnancy: Some traditions promote early marriage as early as 10 to 12 years of age
- High prevalence of FGM/C: Continued traditional belief that female circumcision is necessary to minimize young girls' sexual desire in order to prevent them from having sex before marriage or becoming promiscuous
- Traditional belief about which group is eligible for FP services: Widows, divorced women, newly married couples and sexually active unmarried girls encounter difficulties in obtaining FP methods due to social norms
- Delay in disclosure of pregnancy: Adolescent girls and unmarried women refrain from reporting their pregnancies to health workers and visiting health facilities, which delays effective, timely intervention
- Lack of general awareness about health issues: A lack of awareness about the benefits and risks of maternal health and about danger signs during pregnancy and delivery, the lack of remedial actions, and the general tendency to rely on inappropriate household measures and to seek care from untrained providers
- High rates of illiteracy within the pastoralist community: The percentage of people with no education is 74.5 percent and 74.2 percent in Afar and Somali, respectively, compared to the national average of 50.8 percent (EDHS, 2010/11)
- Unhealthy feeding habits: During pregnancy, women usually fail to take an adequate amount of calories, protein, iodine and Vitamin A
- Harmful traditional practices such as marriage by abduction, wife inheritance, stigmatization of women during birth, abdominal massage, intake of traditional medicines during pregnancy, failure to intervene in pregnancy and childbirth as it is considered 'God's work', body image alteration, tooth extraction, uvulectomy/tonsillectomy, food and water taboos
- Lack of open discussion about sexual behaviour and reproductive health: Discussion about sexual behaviour and reproductive health is not common between parents and young girls, nor are these issues openly and adequately covered in schools
- Unclean delivery: Application of butter or cow dung to freshly cut umbilical cord (which may be untied), discarding of the colostrum, delayed initiation of breast-feeding, and giving prelacteal feeding
- Tendency to go for prolonged labour: Prevalence of cultural and traditional rituals for several hours of prolonged labour before seeking medical help, which is often too late to prevent damage to the baby and the mother
- Low satisfaction and confidence regarding health services within the community: Based on their observations and assumptions, the community is not motivated to seek health services at PHCUs
- Low community participation in alleviating barriers to access to health services: Low community mobilization for addressing the various barriers to seeking and accessing maternal health services at various levels

VII. PRIORITY SOLUTIONS TO MITIGATE IDENTIFIED BOTTLENECKS AND ACCELERATE PROGRESS

Photo: United Nations Ethiopia

Despite remarkable political will and investment in health sector policy and in previous programme and institutional measures, the effects on reducing the maternal mortality rate are far behind the target and require substantial collaboration and innovation to address maternal health challenges. This section discusses solutions to various barriers. The recommended solutions were selected on the basis of their proven rapid effectiveness and their cost-effectiveness and could complement current programmes in the overall effort to accelerate progress toward maternal health targets.

7.1 ENHANCE SKILLED BIRTH ATTENDANCE (SBA)

- Encourage HEWs to ensure that pregnant women in labour go to health centres/ hospitals for delivery and they they seek timely referral when they notice danger signs.
- Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals.
- Support the establishment and operation of an effective mentoring system for newly graduating HWs so that they can gain adequate skills and experience before they take full responsibility.
- Provide training to TBAs and reorient their service to persuade mothers to go to the nearest health facility for delivery, ANC and PNC; train TBAs to assist HEWs.

7.2 IMPROVE EMERGENCY OBSTETRIC CARE (EMOC)

- Make health facilities (HCs and hospitals) fully functional (manpower, equipment, and supplies) and accelerate the placement of BEmONC and CEmONC services; ensure close monitoring and supportive supervision.
- Avail appropriate means of transport/ ambulance service and support its proper use, management, and sustainability.
- Introduce the use of mobile call service for seeking maternal information/advice, request for transport/ambulance at onset of labour, and call for help as soon as the first danger signs are noticed.
- Advocate, promote, and implement EmONC and free maternal health services at all levels of HFs in all developing regional states and pastoralist communities.

7.3 IMPROVE ANTENATAL CARE (ANC)

- Recruit more experienced female HEWs to deliver ANC and other maternal health services, especially in pastoralist communities.
- Prioritize provision of ANC in the HEP, provide essential supplies and make health care provision friendly for users and mothers; deploy adequate numbers of skilled midwives, with priority to strategically located HFs, to make the services accessible to large community groups.
- Provide specific training on implementation of ANC to HEWs.
- Improve the provision of mobile maternal health services in developing regional states and pastoralist communities by using, for example, means of transport such as pack animals and facilities such as solar power, tents, refrigerators, etc.
- Improve the nutritional status of pregnant and lactating mothers through targeted programmes and education.

7.4 ENHANCE FAMILY PLANNING SERVICES (FPS)

- Conduct intensive advocacy targeting religious leaders, elders, and policy makers so that they openly support and promote the use of family planning methods.
- Provide specific skill training for nurses and HEWs on long-acting contraceptive methods, especially LAPMs.
- Make use of comprehensive FP services in health facilities, including adequate counselling, and strengthen the supply chain.

7.5 PROMOTE MATERNAL HEALTH EDUCATION, AWARENESS, AND ADVOCACY

- Develop an evidence-based IEC strategy and plan specific to localities, after proper assessment of social, cultural, and behavioural determinants; accordingly prepare and use appropriate IEC/BCC interventions to enhance timely health-care-seeking behaviour, including teaching aids.
- Raise community awareness about the benefits of delivery in the presence of skilled birth attendants.
- Broaden the awareness of men, women, families, and communities about the pregnancy-related risks, need, and availability of EmONC and FP service.
- Promote intensive advocacy on the use of FP among community and religious leaders and policy makers.
- Promote the demand and use of FP services through IEC/BCC, including by adolescents and youth.
- Reward and recognize, in various forms, role models known for their good practices in the promotion and practice of maternal health provisions.
- Heighten awareness of maternal health issues through regional mass media, including the educational mass media (radio, TV) and facility-based health education through audio-visual facilities.
- Identify, organize, and support the use of 'folk' media to promote maternal health education and behavioural change.
- Ensure home visits by HEWs during pregnancy, labour, delivery, and the postnatal period and ensure mentoring by Health Development Army/Social Mobilization Committee and model HHs/mothers; reward/recognize effective role models.
- Ensure that the identified demand-side bottlenecks are discussed at regular Health Development Team (HDT) and Social Mobilization Committee meetings.
- Promote and scale up community conversation about maternal health (in social events).
- Support the development of culturally sensitive IEC/BCC interventions; use traditional and religious leaders in the community to increase demand for ANC, SBA, PNC, FP, and EmNOC.
- Engage and work closely with traditional and clan/religious leaders for the integration of maternal health education into developmental religious teaching.
- Use ICT for information exchange and maternal health education and awareness campaigns that target diverse groups of community and health care providers.
- Promote and strengthen the sharing of experience among regional actors and service providers.

7.6 IMPROVE HUMAN RESOURCE CAPACITY & SUPPLY OF MATERIALS & EQUIPMENT

- Promote and advocate the deployment of skilled manpower for maternal health as per the standard staffing pattern across the PHCUs, with a consideration of the settlement patterns and socio-cultural acceptability/ preferences of communities; recruit more female and mature HEWs to deliver ANC, especially in pastoralist communities.
- Deploy nurses in the HPs where HEWs are absent.
- Provide supplies and materials to ensure maternal health services across PHCUs.
- Enhance skill development opportunities, career advancement, and other incentive/ motivation mechanisms for HEWs to retain health professionals.
- Provide specific training in implementation of the ANC package to all HEWs and capacitate the HEWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities); constitute and support mobile health teams.
- Enhance the capacity of HEWs and nurses to develop client-friendly orientation through ethical, attitudinal, and behavioural training.
- Strengthen the quality of pre-service training by building the capacity of trainers through ToTs, providing packages of essential training materials and teaching aids such as models and dolls.
- Introduce, institutionalize, and scale up mobile health teams in selected areas.
- Arrange linkage of HFs in the surrounding areas of training institutions as practical training sites under qualified supervisors to ensure adequate practical experience in maternal health care, with a focus on skills in child delivery. Consider compensation for their time and incentives for motivating qualified staff in the HFs to take responsibility for supervision and mentoring.
- Implement performance-based recognition and a reward system to motivate staff, especially those working under difficult conditions in developing regional states and pastoralist communities.
- Devise/implement incentive mechanisms such as skill development opportunities, career advancement, and other motivational means to retain health workers.
- Support in-service training for HOs, midwives, and nurses in EmONC and other maternal health care interventions.
- Strengthen the leadership and management capacity of the HF managers.
- Introduce effective mentoring and consultation between HEWs, nurses/midwives, and medical doctors through electronic and mobile communication services.
- Equip health training colleges/centres with adequate models/simulation materials.
- Strengthen the capacity of trainers in midwifery training centres through refresher training.
- Strengthen health institutions with delivery equipment and materials based on identified gaps.
- Make health facilities fully functional for maternal health services (manpower, equipment and supplies).
- Strengthen the Logistics Management Information System and make the supply chain more effective by mending weak links, providing orientation, and training key actors;
- Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis.
- Provide orientation on the proper use and preventive maintenance of medical equipment and machines.
- Providing orientation on the use and maintenance of medical equipment.

7.7 STRENGTHEN INFRASTRUCTURE AND PARTNERSHIP

- Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to the HFs.
- Strengthen the Health Information Management System (HIMS).
- Strengthen the health Logistic Management Information System (LMIS) and make the supply chain more effective by mending weak links, providing orientation, and training key actors.
- Use ICT for the creation of general awareness and the training/refresher training of HEWs.
- Use ICT for information exchange, maternal health education, and awareness-raising campaigns targeting diverse communities and health care providers.
- Introduce the use of mobile call service for seeking maternal information/advice and for requesting transport/ambulance service, and strengthen mentoring and consultation among health workers.
- Strengthen partnership at subnational levels, including among community leaders, CSOs/NGOs, and private sectors, for better outreach and quality service delivery.

These proposed solutions and priority interventions are not all new, quick-impact recommendations. Rather, they are consolidated priority actions for accelerating progress toward maternal health in the developing regional states and pastoralist communities and broadly indicate the roadmap and selected high-impact interventions for focusing investments and mobilizing commitments from various stakeholders. The following table presents the consolidated Action Plan for the developing regional states and pastoralist communities in Oromia and SNNR; more specific tables proposing Action Plans for each region appear in the Annexes.

VIII. CONSOLIDATED MAF ACTION PLAN FOR THE DEVELOPING REGIONAL STATES AND PASTORALIST COMMUNITIES IN OROMIA AND SNNR

Photo: United Nations Ethiopia

TABLE 3: MDG ACCELERATED ACTION PLAN TO REDUCE MATERNAL MORTALITY

*(**Goal:** Reduce MMR by three quarters: **Base:** 948 (1990/91) **Current:** 350 (2010) **Target** by 2015: 237 deaths per 100,000)*

MDG Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs from the current 23% to 60% by 2015	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Communities' low confidence and satisfaction level in health services • Low health-care-seeking behaviour of community, especially pregnant women
Increase proportion of HCs with BEmONC services from the current 5% to 100% by 2015 Increase proportion of hospitals with CEmONC services from the current 51% to 100% by 2015	**Improve Emergency Obstetric Care (EmOC)**	• Shortage of health personnel (especially midwives, doctors and anaesthetists) exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for delivery, transport, and other related logistical costs
Increase focused ANC (1+) coverage from the current 68% to 90% by 2015 Increase focused ANC (1+) coverage from the current 31% to 86% by 2015	**Improve Antenatal Care (ANC)**	• Low quality of care due to lack of skill and experience (technical, functional and ethical) • Mother-Unfriendly environment in health facilities, especially for rural mothers • Low health-seeking-behaviour due to various cultural beliefs • Unsatisfactory services by health facilities
Increase CPR from the current 29% to 66% by 2015 Increase family planning from the current 12% to 75% by 2015	**Enhance Family Planning Services (FPS)**	• Women are not empowered to make decisions about health issues, which hampers their access to maternal health services • Lack of comprehensive FP packages • Lack of general awareness about heath and maternal health matters • Cultural barriers to using FP methods

	Prioritized Acceleration Solutions	Potential Partners	Total Cost (US$) in Millions	Remarks
	1. HEWs encourage pregnant women to go to HC/hospital for delivery and promote timely referral when danger signs are present 2. Support maternity waiting homes/ centres close to HCs/hospitals* 3. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest HF for delivery, ANC and PNC; train TBAs to assist HEWs	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners	0.52	It is assumed that all costs indicated cover only those areas not covered by available funding, which will be considered as resource gap. Running costs like drugs, supplies, fuel, salary, etc. are not included. *items included in cost estimate
	1. Make HFs fully functional and avail BEmONC and CEmONC;*closely monitor 2. Avail sustainable ambulance service* 3. Introduce the use of mobile call service to seek advice, request ambulance,or call for help when danger signs are noticed* 4. Advocate, promote, and implement EmONC and free maternal health services in all HFs	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners	13.4	*items included in cost estimate
	1. Recruit more experienced female HEWs to deliver ANC/MHS 2. Prioritize provision of mother-friendly ANC in the HEP, avail essential supplies 3. Deploy adequate number of midwives, with priority to strategically located HFs 4. Provide specific training in ANC to HEWs 5. Capacitate the provision of mobile MHC in developing regions and pastoralist communities* 6. Improve the nutritional status of pregnant women and lactating mothers	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners	2.2	*items included in cost estimate
	1. Conduct intensive advocacy targeting religious leaders, elders, and policy makers so that they openly support and promote the use of family planning methods 2. Provide specific skill training for nurses and HEWs in long-acting contraceptive methods, especially LAPMs 3. Avail comprehensive FP services in health facilities, including adequate counselling, and strengthen the supply chain	FMOH, RHBs, UNDP, UNFPA, WHO, WB, IFHP, ENGENDER Health, Ipas, MSIE, DKT regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners.		

MDG Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Promote Maternal Health, Education, Awareness, and Advocacy	• Wide practice of early marriage for girls • Wide practice of FGM/C • Difficulties in accessing FP methods for women not currently in wedlock • Delay in disclosure of pregnancy • Lack of awareness about the benefits and risks of maternal health care; presence of a general tendency to resort to traditional measures • High rates of illiteracy • Unhealthy dietary habits • Harmful traditional practices • Lack of open discussion about reproductive health in the family and school system • Lack of flexibility for maternal health services at PHCU-specific context of pastoralist areas • Absence of maternal and perinatal death registration
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted MH programmes and health system strengthening • Weak referral system and lack of 24-hour service • Low quality of care due to poor quality of training (technical, functional, and ethical) • Weak follow-up to ensure the availability of adequate skills, finance, and materials • Gap in proper deployment of health personnel at HF levels and frequent transfers • Poor commitment and unwelcoming attitude of HWs • Lack of knowledge among health care providers about how to deal with the pastoralist way of life

	Prioritized Acceleration Solutions	Potential Partners	Total Cost (US$) in Millions	Remarks
	1. Develop localized IEC strategy/plan, prepare and use appropriate IEC/BCC interventions to enhance timely MHC-seeking behaviour* 2. Create community awareness about the benefits of SBA 3. Enhance awareness about the need and availability of EmONC and FP service 4. Promote advocacy for FP among the community and religious and political leaders 5. Promote use of FP services through IEC/BCC, including youth 6. Reward and recognize good role models in the promotion and practice of maternal health 7. Use regional and educational mass media, CC, facility-based health education and 'folk' media to promote MHC and IEC/BCC training to HWs* 8. Ensure home visits by HEWs during pregnancy, delivery and postnatal period and mentoring by peer mother groups and model HHs/mothers 9. Promote integration of maternal health into religious teachings 10. Promote sharing of experience among regional actors and service providers	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, GAVI, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners	1.1	
	1. Deploy appropriate skilled manpower for maternal health according to plan; consider number, gender and age; deploy nurses/midwives in HPs when HEWs are absent 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in the surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, GAVI, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, GAVI, Ipas, IFHP, ENGENDER Health, MSIE regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners	1. 54	

MDG Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Reduce average time taken to reach HFs from 3.5 in 2010/11 to 1.4 hours by 2015 Increase electricity coverage from 46% in 2010/11 to 75% by 2015 Increase mobile service subscribers (in millions) from 10.7 in 2010/11 to 40 by 2015 Increase rural potable water coverage (within 1.5 km) from 65.8% in 2010/11 to 98% by 2015 Increase primary health services coverage from the current 96% to 100% by 2015	**Strengthen Infrastructure**	• Distance to the health facilities • Lack of means of transport and communications whenever medical consultation, advice, and service are required • Weak Logistics Management Information System (LMIS) • Lack of effective coordination, creation of synergy, and value for investment among the various actors • Too few ambulances and other emergency transport systems, inadequate budget for fuel and maintenance, lack of serviceable roads • Low community participation in alleviating barriers to access to health services
TOTAL		

	Prioritized Acceleration Solutions	Potential Partners	Total Cost (US$) in Millions	Remarks
	7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training in EmONC and other MHC skills for HOs, midwives, and nurses 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector; 11. Strengthen leadership and management capacity of HF managers 12. Introduce effective mentoring and consultation through electronic and mobile communication services 13. Strengthen health institutions with delivery equipment and materials based on identified gaps 14. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs and a continuous basis 15. Provide orientation about the proper use and preventive maintenance of medical equipment and machines			
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to the HFs 2. Strengthen HIMS and make the supply chain more effective by mending weak links and providing orientation and training to key actors 3. Use ICT for information exchange and maternal health education targeting diverse communities and health care providers 4. Strengthen partnership at subnational levels, including among community leaders, CSOs/NGOs, and private sector,, for better outreach and quality service delivery	FMOH, RHBs, UNDP, UNICEF, UNFPA, WHO, WB, GAVI, IFHP, regional and woreda admin, AMREF, USG/USAID, other NGOs and dev. partners		
			18.76	

IX. IMPLEMENTATION AND MONITORING PLAN

Photo: IFAD

Due to its cross-cutting benefits, the Acceleration Action Plan can go a long way toward achieving MDG 5 while contributing to further progress toward other health interventions and programmes. However, this will be possible only if it is backed by the effective implementation strategies and actions, coupled with strong political commitment, adequate funding, and institutional capacities. Central to the success of this Action Plan will be the effective delivery of ANC, skilled birth attendance, EmONC, maternal health education and awareness, and family planning.

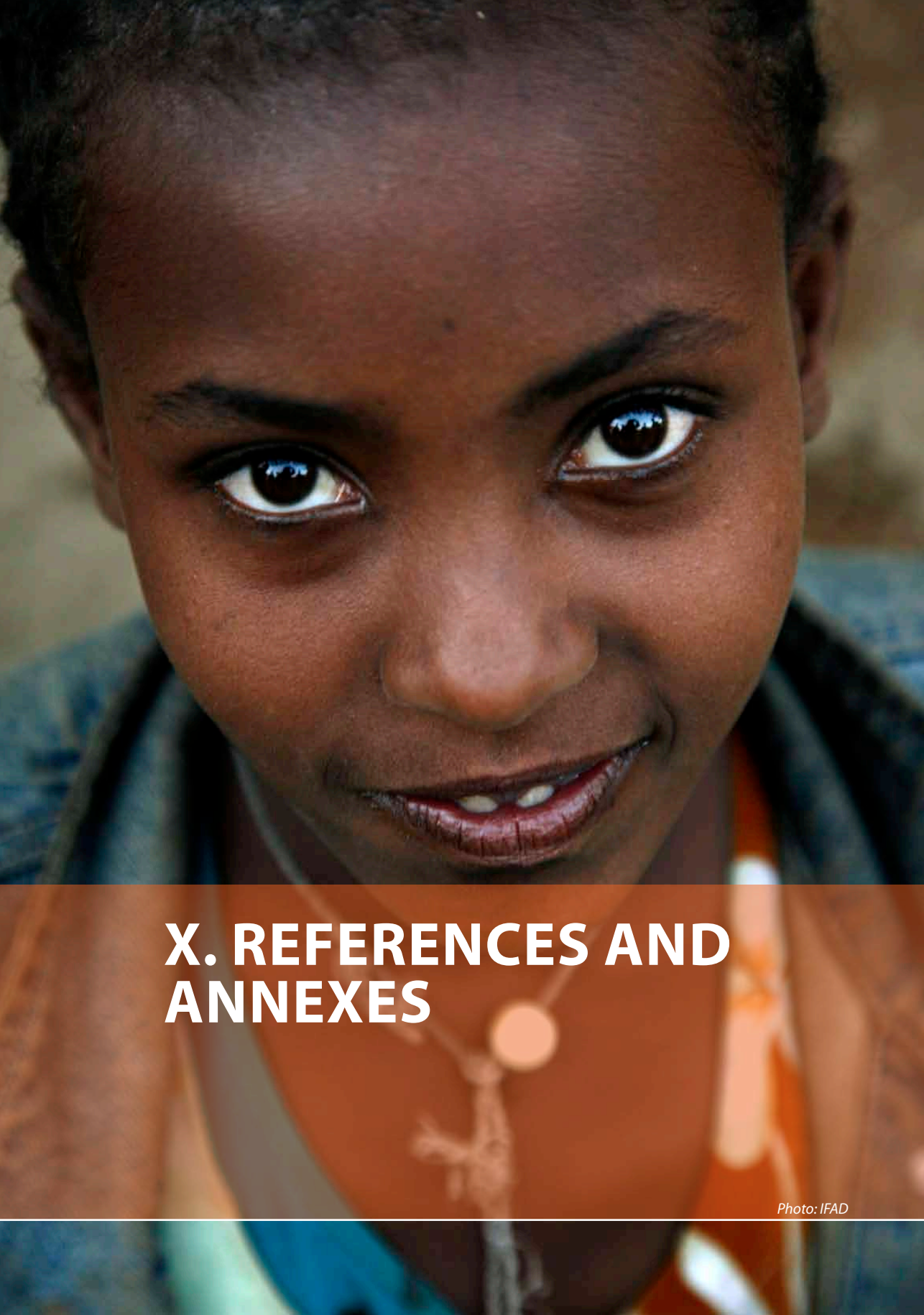
Such efforts can be hampered by a weak monitoring system, particularly with regard to the assessment of the effectiveness of service coverage or outcomes at all levels. The use of existing mechanisms such as HMIS (perhaps with the minor inclusion of a focus on maternal health indicators), LMIS, FIMS, and HF reports on special programmatic indicators of the MOH, an MOFED monitoring framework, and the EDHS conducted every five years will make effective monitoring and sustained accountability possible. The objective of the implementation and monitoring plan – as an integral part of the Country Action Plan – is to follow up on commitments and, above all, to track progress. Resources will be allocated for required human resources, materials, and the equipment for the proper documentation, compilation, analysis, and timely reporting of data as per the standard framework. All stakeholders operating in the health sector are expected to support and use HMIS for programme monitoring.

HSDP IV states, "It is technically impossible to obtain all health and health-related data exclusively through HMIS. Hence, regular demand-side and supply-side surveys will be conducted to capture selected set of data and triangulate various sources in order to improve the accuracy of outcomes and impacts of maternal health interventions. Assessments could also be conducted to measure the performance of a certain intervention or verify if commitments or intended results are realized." Other reports from targeted joint supervision as well as inspection reports on quality and adherence to standards, etc. complement and use triangulation to validate administrative reports.

TABLE 4: MAF ETHIOPIA, MDG 5 IMPLEMENTATION AND MONITORING PLAN

Indicators	Base line	Target		Responsible Source	Interval
		2013/14	2014/15		
MMR	350		237	UN estimate	Every 5 years
Focused ANC (1+) (%)	68	89	90	EDHS /HMIS	Every 5 years/quarterly
Focused ANC (4+) (%)	31	83	86	EDHS /HFS	Every 5 years/2-3 y
Proportion of pregnant women with supplemented iron during pregnancy (%)	10	82	86	EDHS, Survey	Every 5 years/2-3 years
Proportion of pregnant women who slept under LLIN the previous night (%)	41.2	84	86	Survey	2-3 years
Proportion of pregnant women with malaria who are receiving ACT (%)	15		49	Survey	2-3 years
Proportion of mothers protected against tetanus (%)	52		57	EDHS /HMIS	(with birth in last 12 months)
SBA (%)	23	60	62	EDHS /HMIS	Every 5 years/Quart
Proportion of births attended by HEWs (safe and clean) (%)	11	37	38	EDHS /HMIS	Every 5 years/quarterly
Proportion of HCs with B-EmONC services (%)	5	95	100	HMIS	Annually
Obstetric complications treated in BEmONC facilities (%)	12	72	75	HF Survey 2-3 years	Proportion of women with major direct Obstetric complications/HF
Proportion of hospitals with CEmONC services (%)	51	98	100	HMIS	Annually
CPR (%)	32		66	EDHS	Every 5 years
Contraceptive Acceptance Rate (%)	56	81	82	HMIS	Quarterly
Postnatal care (%)	34	76	78	EDHS /HMIS	Every 5 years/quarterly
Unmet need for family planning (%)	25		<10	EDHS/HF Survey	Every 5 years/2-3 years
Percent of HCs & hospitals with PMTCT services (%)	65	96	100	HMIS/HFs	Annually
Proportion of pregnant women receiving ANC at PMTCT sites who receive voluntary counselling and testing (VCT) (%)	54.9	79	83	HMIS/HFs	Quarterly
Percent of deliveries of HIV+ women who receive HAART based on Option B+ * (%)	-	-	90	HMIS	Quarterly

** The nation has just adopted Option B+ for PMTCT and launched the elimination of mother-to-child transmission of HIV (E- MTCT of HIV).*



X. REFERENCES AND ANNEXES

Photo: IFAD

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ANNEXES - REGIONAL PLANS OF ACTION

ANNEX 1: MAF PLAN OF ACTION - AFAR REGIONAL STATE, 2012/13 – 2015/16

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence in and satisfaction with health care providers • Low health-care-seeking behaviour, especially among pregnant women
Increase proportion of HCs with B-EmONC services Increase proportion of hospitals with CEmONC services	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for the delivery, transport and related costs
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill and experience (technical and ethical) • Unfriendly environment in HFs, especially for rural mothers • Low health-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women are not empowered to make decisions about health issues, which hampers their access maternal to health services • Lack of comprehensive FP packages • Lack of general awareness about maternal health • Cultural barriers to using FP

	Prioritized Acceleration Solutions
	. Encourage HEWs to send pregnant women to health centres/hospitals for delivery and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals 3. Support the establishment and operation of an effective mentoring system for new graduate HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC, and PNC; train TBAs to assist HEWs
	1. Make health facilities (HCs and hospitals) fully ready and accelerate the placement of BEmONC and CEmONC services in hospitals 2. Avail appropriate means of transport/ambulance service 3. Introduce the use of mobile call service for seeking help and info 4. Promote EmONC and free maternal health care at all HFs 5. Hire ob-gyn specialist for the region, using incentives
	1. Recruit more experienced female HEWs to deliver ANC and other maternal health services 2. Prioritize provision of ANC in the HEP, provide essential supplies, and make health care provision user-/mother-friendly 3. Support establishment and operation of mobile health teams (avail camel, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct intensive advocacy targeting religious leaders, elders, and political leaders so that they openly support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs. 3. Avail comprehensive FP services in health facilities and strengthen the supply chain

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Enhance Family Planning Services (FPS) **Promote Maternal Health Education, Awareness, and Advocacy**	• Wide practice of early marriage & FGM • Delay in disclosure of pregnancy by adolescent girls and unmarried women • Lack of awareness about the benefits and risks of maternal health during pregnancy and delivery, about the availability of remedial actions; presence of a general tendency to resort to traditional measures • Unhealthy dietary habits • Lack of open discussion about reproductive health in the family and school system • Prolonged labour before seeking medical help • Lack of flexibility for delivery of key maternal health care at PHCU and within the specific context of pastoralist areas
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Poor care due to poor training and poor commitment (technical and ethical) • Weak follow-up to ensure the availability of adequate skills and of human, financial, and material assets • Lack of knowledge among health care providers about how to deal with the pastoralist way of life
Reduce average time taken to HFs by availing all-weather roads Increase electricity coverage targeting HFs Increase potable water coverage in HFs	**Strengthen Infrastructure and Partnership**	• Distance to the health facilities • Lack of means of transport and communications whenever medical consultation, advice, and emergency service are required • Lack of effective coordination and creation of synergy and value for investment among the various actors • Unavailability of safe and adequate water, electricity supply and telecommunication services in several HFs

	Prioritized Acceleration Solutions
	1. Develop localized IEC strategy to create community awareness about the benefits of delivery in the presence of skilled birth attendants and timely health-care-seeking 2. Enhance the knowledge and awareness of men, women, families, and communities about the risk, need, and availability of EmONC and FP services 4. Promote intensive advocacy of the use of family planning among the community and religious leaders political leaders, adolescents, and youth 5. Reward, in various forms, role models known for their good practices in promoting maternal health 6. Enhance maternal health awareness through regional mass media, including the educational mass, CC, facility-based health education, and 'folk' media 7. Ensure home visits by HEWs during pregnancy and postnatal period and mentoring by peer mother groups and model mothers 8. Mobilize community/traditional/religious leaders to increase demand for ANC, SBA, PNC, FP, and EmNOC 9. Engage and work closely with religious leaders for integration of maternal health education into developmental religious teachings 11. Promote and strengthen sharing of experience among regional actors and service providers
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender, and age); deploy nurses/midwives in HPs if there are no HEWs 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen the leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to HFs 2. Strengthen HIMS 3. Make the supply chain more effective by mending weak links and orientating and training key actors 4. Use ICT for the exchange of information and maternal health education targeting diverse communities and health care providers 5. Strengthen partnership at subnational levels, including community leaders, CSOs/NGOs, and the private sector for better outreach and quality service delivery

ANNEX 2: MAF PLAN OF ACTION – BENISHANGUL-GUMUZ REGIONAL STATE

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence and satisfaction with health care providers • Low health-care-seeking behaviour
Increase proportion of HCs with B-EmONC services Increase proportion of hospitals with CEmONC	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for delivery, transport, and related costs
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill and experience (technical and ethical) • Unfriendly environment in health facilities, especially for rural mothers • Low health-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women are not empowered to make decisions about health issues, which hampers their access to maternal health care • Lack of availability of comprehensive FP packages • Lack of general awareness about health and maternal health matters • Cultural barriers to using FP methods
	Promote Maternal Health Education, Awareness, and Advocacy	• Delay in disclosure of pregnancy by adolescent girls and unmarried women due to social norms • Lack of awareness about the benefits and risks of maternal health, about danger signs during pregnancy and delivery, and about the availability of remedial actions; presence of a general tendency to resort to traditional measures • Unhealthy dietary habits • Lack of open discussion about sexual behaviour and reproductive health in the family and school system • Unclean delivery by traditional birth attendants • Pro-longed labour before seeking medical help • Lack of flexibility for delivery of key maternal health services at PHCU and within the specific context of pastoralist areas

	Prioritized Acceleration Solutions
	1. Encourage HEWs to send pregnant women to health centres/hospitals for delivery and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospital 3. Support the establishment and operation of an effective mentoring system for newly graduating HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC and PNC; train TBAs to assist HEWs
	1. Make the health facilities (HCs and hospitals) fully ready and accelerate the placement of BEmONC and CEmONC services in hospitals 2. Avail appropriate means of transport /ambulance service 3. Introduce the use of mobile call service to seek help and info; advocate, promote, and implement EmONC and free maternal health care at all levels of HFs 4. Hire at least one ob-gyn specialist for the region, using incentives (no single ob-gyn specialist in the region)
	1. Recruit more experienced female HEWs to deliver ANC and other maternal health services 2. Prioritize provision of ANC in the HEP, provide essential supplies, and make health care provision user-/mother-friendly 3. Support establishment and operation of mobile health teams (avail means of transport, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct intensive advocacy targeting religious leaders, elders, and political leaders so that they openly support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs. 3. Avail comprehensive FP services in the health facilities and strengthen the supply chain
	1. Develop an evidence-based IEC strategy specific to localities after proper assessment of social and behavioural determinants to enhance timely health-care-seeking behaviour 2. Create community awareness on the benefits of delivery in the presence of skilled birth attendants 3. Enhance the knowledge and awareness of men, women, family and community about the risk, need, and availability of EmONC and FP services 4. Promote intensive advocacy for the use of family planning among community and religious leaders, political leaders, adolescents, and youth 5. Reward, in various forms, role models known for their good practices and promotion of maternal health 6. Broaden awareness about maternal health through regional mass media, including the educational mass media (radio, TV) and facility-based & mobile health education through audio-visual facilities 7. Identify, organize, and support the use of 'folk' media to promote maternal health education and behavioural change 8. Ensure home visits by HEWs during pregnancy and the postnatal period and mentoring by peer mother groups and model mothers 9. Promote and scale up community conversation about maternal health, support the development of IEC/BCC interventions, and use community traditional and religious leaders in social mobilization to enhance demand for ANC, SBA, PNC, FP, and EmNOC 10. Engage and work closely with religious leaders for integration of maternal health education into developmental religious teachings 11. Promote and strengthen sharing of experience among regional actors and service providers

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Low quality of care due to low quality of training and poor commitment (technical and ethical) • Weak follow-up that would ensure the availability of adequate skills and of human, financial, and material assets • Lack of knowledge among health care providers about how to deal with the pastoralist way of life
Reduce average time taken to HFs by availing all-weather roads Increase electricity coverage targeting HFs Increase potable water coverage in HFs	**Strengthen Infrastructure and Partnership**	• Distance to health facilities • Lack of means of transport and communications whenever medical consultation, advice, and emergency service are required • Lack of effective coordination and the creation of synergy and value for investment among the various actors • Unavailability of safe and adequate water, electricity, and telecommunication services in several HFs

ANNEX 3: MAF PLAN OF ACTION - GAMBELA REGIONAL STATE, 2012/13 – 2015/16

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence in and satisfaction with health care providers • Low health-care-seeking behaviour, ,especially among pregnant women

	Prioritized Acceleration Solutions
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender, and age); deploy nurses/midwives in HPs if there are no HEWs 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate the HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in the surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially for those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to HFs 2. Strengthen HIMS 3. Strengthen HLMS and make the supply chain more effective by mending weak links and providing orientation and training for key actors 4. Use ICT for information exchange and maternal health education targeting diverse group of community and health care providers 5. Strengthen partnership at sub-national levels, including community leaders, CSOs/NGOs, and the private sector for better outreach and quality service delivery

	Prioritized Acceleration Solutions
	1. Encourage HEWs to send pregnant women to health centres/hospitals for delivery and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals 3. Support the establishment and operation of an effective mentoring system for newly graduating HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC, and PNC; train TBAs to assist HEWs

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of HCs with B-EmONC Increase proportion of hospitals with CEmONC.	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for the delivery, transport and related costs
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill and experience (technical and ethical) • Unfriendly environment in HFs for rural mothers • Low health-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women not empowered to make decisions about health and accessing MHC • Lack of all-inclusive FP packages • Lack of awareness about maternal health • Cultural barriers to using FP.
	Promote Maternal Health Education, Awareness, and Advocacy	• Wide practice of early marriage and circumcision for girls • Delay in disclosure of pregnancy by adolescent girls and unmarried women due to social norms • Lack of awareness about the benefits and risks of maternal health, danger signs during pregnancy and delivery, availability of remedial actions; presence of a general tendency to resort to traditional measures • Unhealthy dietary habits • Lack of open discussion about sexual behaviour and reproductive health in the family and school system • Unclean delivery by traditional birth attendants • Prolonged labour before seeking medical help • Lack of policies and procedural flexibility for delivery of key maternal health services at PHCUs tailored to the specific context of pastoralist areas

	Prioritized Acceleration Solutions
	1. Make the health facilities (HCs and hospitals) fully ready and accelerate the placement of BEmONC and CEmONC services in hospitals 2. Avail appropriate means of transport /ambulance service; introduce the use of mobile call service for seeking help and info 3. Advocate, promote, and implement EmONC and free maternal health services in all HFs
	1.Recruit more mature female HEWs to deliver ANC and other maternal health services 2. Prioritize provision of ANC in the HEP, provide essential supplies and make health care provision user-/mother-friendly 3. Support establishment and operation of mobile health teams (avail camel, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct advocacy targeting elders and religious and political leaders so that they openly support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs 3. Avail comprehensive FP services in the health facilities and strengthen the supply chain
	1. Develop an evidence-based IEC strategy specific to localities after proper assessment of social and behavioural determinants to enhance timely health-care-seeking behaviour 2. Create community awareness about the benefits of delivery in the presence of skilled birth attendants 3. Enhance the knowledge and awareness of men, women, family and community about the risk, need, and availability of EmONC and FP services 4. Promote intensive advocacy for the use of family planning among the community and religious leaders, political leaders, adolescents and youth 5. Reward, in various forms, role models known for their good practices and promotion of maternal health 6. Enhance maternal health awareness through regional mass media, including the educational mass media, CC, 'folk' media and facility-based health education 7. Ensure home visits by HEWs during pregnancy and postnatal period and mentoring by peer mother groups and model mothers 8. Mobilize community traditional and religious leaders to increase demand for ANC, SBA, PNC, FP, and EmNOC 9. Engage and work closely with religious leaders for integration of maternal health into religious teachings 10. 13. Promote and strengthen sharing of experience among regional actors and service providers

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Low quality of care due to low quality of training and poor commitment (technical and ethical) • Weak follow-up to ensure the availability of adequate skills and of human, financial, and material assets • Lack of knowledge among health care providers about how to deal with the pastoralist way of life
Reduce average time taken to HFs by availing all-weather roads Increase electricity coverage targeting HFs Increase potable water coverage in HFs	**Strengthen Infrastructure and Partnership**	• Distance to the health facilities • Lack of means of transport and communications when medical consultation, advice, and emergency services are required • Lack of effective coordination and the creation of synergy and value for investment among the various actors • Unavailability of safe and adequate water, electricity, and telecommunication services in several HFs

ANNEX 4: MAF PLAN OF ACTION – PASTORALIST COMMUNITY ZONES IN OROMIA REGIONAL STATE, 2012/13 – 2015/16

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence in and satisfaction with health care providers • Low health-care-seeking behaviour

	Prioritized Acceleration Solutions
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender, and age); deploy nurses/midwives in HPs if there are no HEWs 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate the HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to the HFs and furnish existing health facilities 2. Introduce the use of mobile call service for seeking maternal information/advice and requesting transport/ambulance service; strengthen mentoring and consultation among health workers 3. Strengthen partnership at subnational levels, including among community leaders, CSOs/NGOs, and the private sector, for better access to HFs

	Prioritized Acceleration Solutions
	1. Encourage HEWs to send pregnant women to health centres/hospitals for delivery and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals; 3. Support the establishment and operation of an effective mentoring system for newly graduating HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC and PNC; train TBAs to assist HEWs

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of HCs with BEmONC Increase proportion of hospitals with CEmONC	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel, exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for the delivery, transport, and related costs
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill and experience (technical and ethical) • Unfriendly environment in health facilities, especially for rural mothers • Low health-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women are not empowered to make decisions about health and access to health services • Lack of availability of comprehensive FP packages • Lack of awareness about maternal health matters • Cultural barriers to using FP methods
	Promote Maternal Health Education, Awareness, and Advocacy	• Delay in disclosure of pregnancy by adolescent girls and unmarried women due to social norms • Lack of awareness about the benefits and risks of maternal health, danger signs during pregnancy and delivery, availability of remedial actions; presence of a general tendency to resort to traditional measures • Unhealthy dietary habits • Lack of open discussion about sexual behaviour and reproductive health in the family and school system • Unclean delivery by traditional birth attendants • Prolonged labour before seeking medical help • Lack of flexible delivery of key MHC at PHCUs that is specific to context of pastoralist areas

	Prioritized Acceleration Solutions
	1. Make the health facilities (HCs and hospitals) fully ready and accelerate the placement of BEmONC and CEmONC services in hospitals 2. Avail appropriate means of transport/ambulance service 3. Introduce the use of mobile call service for seeking help and info 4. Advocate, promote and implement EmONC and free maternal health services at all levels of HFs
	1. Recruit more mature female HEWs to deliver ANC and other maternal health services 2. Prioritize provision of ANC in the HEP and essential supplies and make health care provision user-/mother-friendly 3. Support establishment and operation of mobile health teams; (avail camel, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct intensive advocacy, targeting religious leaders, elders, and political leaders so that they openly support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs 3. Avail comprehensive FP services in the health facilities and strengthen the supply chain
	1. Develop an evidence-based IEC strategy specific to localities, after proper assessment of social and behavioural determinants to enhance timely health-care-seeking behaviour 2. Create community awareness about the benefits of delivery in the presence of skilled birth attendants 3. Enhance the knowledge and awareness of men, women, family and community about the risk, need, and availability of EmONC and FP services 4. Promote intensive advocacy for the use of family planning among community and religious leaders, political leaders, adolescents, and youth 5. Reward, in various forms, role models known for their good practices and promotion of maternal health 6. Enhance awareness about maternal health creation through regional mass media, including the educational mass media (radio, TV), 'folk' media, CC, and facility-based health education through audio-visual facilities 7. Support development of IEC/BCC interventions and use community traditional, and religious leaders in social mobilization to increase demand for ANC, SBA, PNC, FP, and EmNOC 10. Engage and work closely with the religious leaders for integration of maternal health education into developmental religious teachings 11. Promote and strengthen sharing of experience among regional actors and service providers

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Low quality of care due to low quality of training and poor commitment (technical and ethical) • Weak follow-up to ensure the availability of adequate skills and of human, financial and material assets • Lack of understanding among health care providers about how to deal with the pastoralist way of life
Reduce time to reach HFs (road) Supply electric power and potable water to HFs	**Strengthen Infrastructure and Partnership**	• Distance to the health facilities; • Lack of transport and communication • Lack of effective coordination among the various actors • Unavailability of safe and adequate water, electricity, and telecommunications in several HFs.

ANNEX 5: MAF PLAN OF ACTION – PASTORALIST COMMUNITY ZONES IN SNNPR, 2012/13 – 2015/16

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence in and satisfaction with health care providers • Low health-care-seeking behaviour
Increase proportion of HCs with BEmONC Increase proportion of hospitals with CEmONC	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel, exacerbated by high turnover • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for the delivery, transport, and related costs

	Prioritized Acceleration Solutions
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender and age); deploy nurses/midwives in HPs if there are no HEWs; 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training on implementation of the ANC package to all HEWs and capacitate the HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity and telephone lines to HFs 2. Introduce the use of mobile call service for seeking maternal information/advice and requesting transport/ ambulance service; strengthen mentoring and consultation among health workers 3. Strengthen partnership at subnational levels, including among community leaders, CSOs/NGOs, and the private sector,, for better access to HFs

	Prioritized Acceleration Solutions
	1. Encourage HEWs to send pregnant women to health centres/hospitals for delivery, and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals 3. Support the establishment and operation of an effective mentoring system for new graduate HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC and PNC; train TBAs to assist HEWs
	1. Make the health facilities (HCs and hospitals) fully ready and accelerate the placement of BEmONC and CEmONC services in hospitals 2. Avail appropriate means of transport /ambulance service 3. Introduce the use of mobile call service for seeking help and info 4. Advocate, promote, and implement EmONC and free maternal health services at all levels of HFs

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill (technical, ethics) • Unfriendly environment in health facilities, especially for rural mothers • Low health-care-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women not empowered to make decisions about health and access services • Lack of all-inclusive FP methods • Lack of awareness about maternal health • Cultural barriers to using FP methods
	Promote Maternal Health Education, Awareness, and Advocacy	• Delay in disclosing pregnancy • Lack of awareness about the benefits, risks and opportunities of MHC; presence of a general tendency to resort to traditional measures • Unhealthy dietary habits • Lack of open discussion about reproductive health in the family and school • Prolonged labour before seeking medical help • Lack of flexible delivery of maternal health services at PHCUs that are specific to context of pastoralists
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Low quality of care due to low quality of training and poor commitment (technical and ethical) • Weak follow-up to ensure the availability of adequate skills and of human, financial, and material assets • Lack of understanding among health care providers about how to deal with the pastoralist way of life

	Prioritized Acceleration Solutions
	1.Recruit more mature female HEWs to deliver ANC and other maternal health services 2. Prioritize provision of ANC in the HEP; provide essential supplies and make health care provision user-/mother-friendly 3. Support establishment and operation of mobile health teams (avail camel, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct intensive advocacy targeting religious leaders, elders, and political leaders so that they openly support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs. 3. Avail comprehensive FP services in health facilities and strengthen the supply chain
	1. Develop IEC strategy specific to localities to enhance timely health-care-seeking behaviour 2. Create community awareness about the benefits of skilled attendants at delivery 3. Enhance the awareness of men, women, and community about the risk, need, and availability of EmONC and FP services 4. Promote advocacy for the use of FP among community, religious and political leaders, and youth 5. Reward role models for their good practices and promotion of maternal health 6. Raise awareness about maternal health through regional mass media, including the educational mass media, CC, 'folk' media, and facility-based health education 7. Ensure home visits by HEWs during pregnancy and postnatal period and mentoring by peer mother groups and model mothers 8. Mobilize community, traditional, and religious leaders to increase demand for ANC, SBA, PNC, FP, and EmNOC 9. Work closely with religious leaders for integration of maternal health into religious teachings 11. Promote and strengthen sharing of experience among regional actors and service providers
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender and age); deploy nurses/midwives in HPs if there are no HEWs 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate the HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Reduce time taken to HFs (improve roads) Avail electricity, potable water & telecom targeting HFs	**Strengthen Infrastructure and Partnership**	• Distance to health facilities • Lack of means of transport and telecom when health care is needed • Lack of effective coordination among the various actors; • Unavailability of safe and adequate water and electricity supply in HFs

ANNEX 6: MAF PLAN OF ACTION – SOMALI REGIONAL STATE, 2012/13 – 2015/16

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
Increase proportion of births attended by HWs	**Enhance Skilled Birth Attendance (SBA)**	• Lack of adequate (number & quality) health personnel • Lack of health facilities with required supplies & equipment nearby • Low confidence in and satisfaction with health care providers • Low health-care-seeking behaviour especially pregnant women
Increase proportion of HCs with BEmONC Increase proportion of hospitals with CEmONC	**Improve Emergency Obstetric Care (EmONC)**	• Shortage of health personnel, exacerbated by high turnover; • Shortages of supplies and equipment for obstetric care • Low financial capacity to pay for the delivery, transport, and related costs
Increase focused ANC (1+) coverage Increase focused ANC coverage	**Improve Antenatal Care (ANC)**	• Low quality of care due to inadequate skill and experience (technical and ethical) • Unfriendly environment in health facilities for rural mothers • Low health-care-seeking behaviour
Increase CPR Increase family planning	**Enhance Family Planning Services (FPS)**	• Women not empowered to make decisions about health and access maternal health services • Lack of all-inclusive FP packages • Lack of awareness about maternal health matters • Cultural barriers to using FP methods

	Prioritized Acceleration Solutions
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to HFs 2. Introduce the use of mobile call service for seeking maternal information/advice and for requesting transport/ ambulance service; strengthen mentoring and consultation among health workers 3. Strengthen partnership at subnational levels, including among community leaders, CSOs/NGOs, and the private sector, for better access to HFs.

	Prioritized Acceleration Solutions
	1. Encourage HEWs to send pregnant women to health centres/hospitals for delivery and immediately refer them when danger signs become apparent 2. Support the establishment of cost-effective and culturally sensitive maternity waiting homes/centres close to HCs/hospitals 3. Support the establishment and operation of an effective mentoring system for newly graduating HWs 4. Provide basic and essential training to TBAs and reorient their services to persuade mothers to go to the nearest health facility for delivery, ANC and PNC; train TBAs to assist HEWs
	1. Make HFs fully ready and accelerate placement of BEmONC and CEmONC in hospitals 2. Avail appropriate ambulance services 3. Introduce the use of mobile call service for seeking help and info 4. Advocate, promote, and implement EmONC and free maternal health care in all HFs
	1. Recruit more mature female HEWs to deliver maternal health services 2. Prioritize provision of ANC in the HEP; provide essential supplies and make HFs user-/mother-friendly 3. Support establishment and operation of mobile health teams (avail camel, solar power, refrigerator, tent, etc.) 4. Establish a reward and sanction mechanism for performance of health personnel 5. Strengthen user feedback systems for performance
	1. Conduct intensive advocacy targeting elders and religious and political leaders to support and promote the use of FP methods 2. Provide specific skill training for nurses in contraceptive methods, especially LAPMs 3. Avail comprehensive FP services in health facilities and strengthen the supply chain

MDGs Targets & Indicators	Priority Intervention	Prioritized Bottlenecks
	Promote Maternal Health Education, Awareness, and Advocacy	• Wide practice of early marriage and circumcision for girls • Delay in disclosure of pregnancy by adolescent girls and unmarried women • Lack of awareness about risks, benefits, and opportunities related to maternal health; presence of general tendency toward inappropriate traditional measures • Unhealthy dietary habits • Lack of open discussion about reproductive health in the family and schools; • Prolonged labour before seeking medical help • Lack of flexible maternal health services at PHCUs tailored to the specific context of pastoralist areas
	Improve Human Resource Capacity & Supply of Materials & Equipment	• Serious funding gaps for targeted maternal health programmes and strengthening of health systems • Weak referral systems, absence of 24/7 services • Low quality of care due to low quality of training and poor commitment (technical and ethical) • Weak follow-up to ensure the availability of adequate skills and of human, financial, and material assets • Lack of understanding among health care providers about how to deal with the pastoralist way of life
Reduce time taken to HFs by availing all-weather roads Increase electricity coverage targeting HFs Increase potable water coverage in HFs	**Strengthen Infrastructure and Partnership**	• Distance to the health facilities • Lack of means of transport and communications when medical consultation, advice, and emergency services are required • Lack of effective coordination and the creation of synergy and value for investment among the various actors • Unavailability of safe and adequate water, electricity and telecommunication services in several HFs

	Prioritized Acceleration Solutions
	1. Develop localized IEC strategy to enhance health-care-seeking behaviour 2. Create awareness about the benefits of skilled attendance at delivery 3. Enhance awareness of men, women and community about the need and availability of EmONC and FP services 4. Promote intensive advocacy for the use of FP among the community, religious and political leaders, adolescents, and youth 5. Reward role models for their good promotion of maternal health 6. Enhance awareness of maternal health through regional mass media, including the educational mass media, 'folk' media, CC, and facility-based health education 7. Ensure home visits by HEWs during pregnancy and postnatal period and mentoring by peer mother groups and model mothers 8. Mobilize community, traditional, and religious leaders to increase demand for ANC, SBA, PNC, FP, and EmNOC 9. Work closely with religious leaders for integration of maternal health education into religious teachings 10. Promote and strengthen sharing of experience among regional actors and service providers
	1. Deploy appropriate skilled manpower for maternal health according to plan (consider number, gender and age); deploy nurses/midwives in HPs if there are no HEWs; 2. Provide adequate supplies to ensure sustained MHC in PHCUs 3. Enhance skill development, career advancement, and other incentive/motivation mechanisms for HEWs to retain health personnel 4. Provide specific training in implementation of the ANC package to all HEWs and capacitate the HWs to provide ANC services in pastoralist regions (donkey, camels, solar power, tent, refrigerator facilities) 5. Build the capacity of trainers through ToTs, providing packages of essential training materials and aids such as models and dolls 6. Link training institutions with HFs in surrounding areas for practical training under qualified supervisors, compensating them for their time to motivate them 7. Implement performance-based rewards to motivate staff, especially those working under difficult conditions 8. Support in-service training for HOs, midwives, and nurses in EmONC and other MHC skills 9. Explore the possibility of deploying international and national volunteers, including retirees and those working outside the health sector 10. Strengthen leadership and management capacity of HF managers 11. Introduce effective mentoring and consultation through electronic and mobile communication services 12. Strengthen health institutions with delivery equipment and materials based on identified gaps 13. Ensure timeliness and adequacy of drugs, equipment, and other necessary supplies across all PHCUs on a continuous basis 14. Provide orientation in the proper use and preventive maintenance of medical equipment and machines
	1. Advocate for and work with other sectors to prioritize and improve access roads, water supply, electricity, and telephone lines to the HFs 2. Introduce the use of mobile call service for seeking maternal information/advice and requesting transport/ambulance service and strengthen mentoring and consultation among health workers 3. Strengthen partnership at subnational levels, including community leaders, CSOs/NGOs, and the private sector, for better access to HFs

ANNEX 7: LIST OF EXPERTS

The following individuals made major contributions to the development of this Action Plan throughout different phases of the MAF process.

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