VILLAGE HEALTH PARTNERSHIP

Safer Motherhood in Rural Ethiopia

Program Update & Annual Ethiopia Trip Report
April 2015

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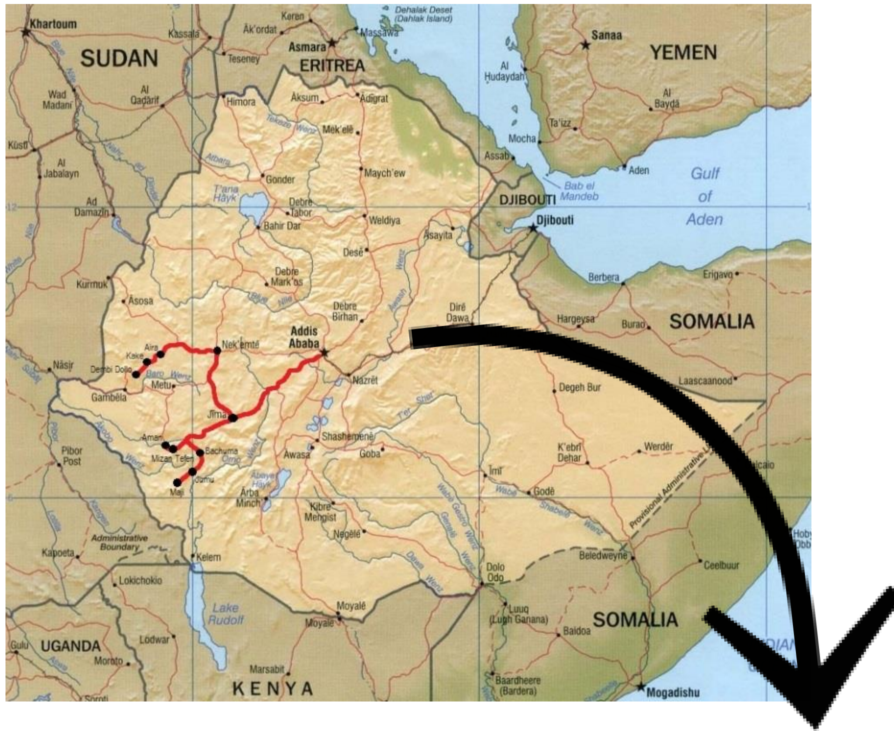
Regions of Ethiopia

Zones of Ethiopia Where We Work

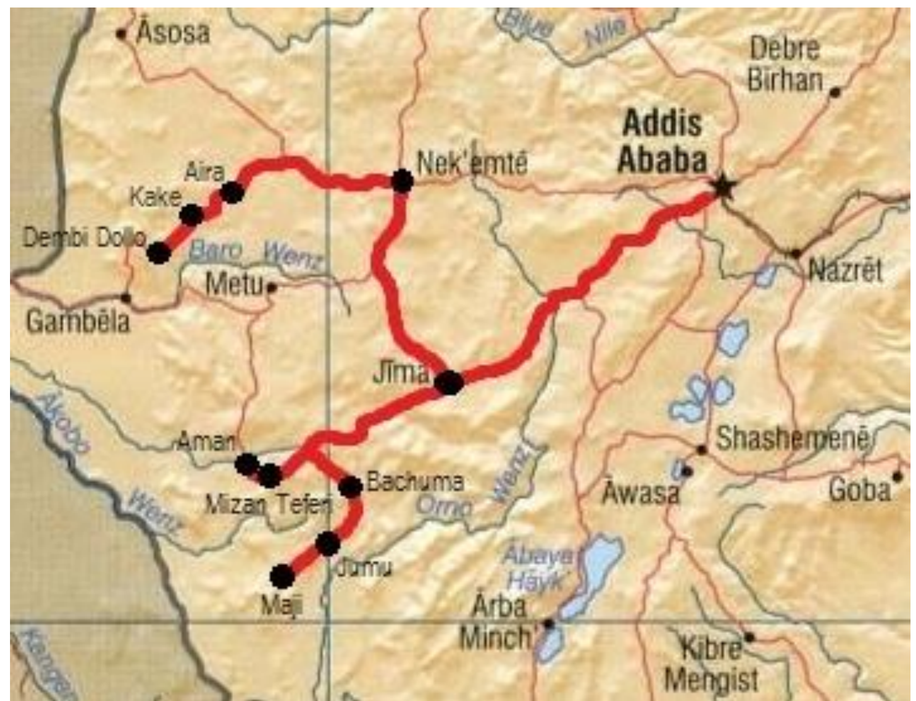
Western Wollega Zone
in the Oromia Region

Bench Maji Zone in the
Southern Nations,
Nationalities, and
Peoples' Region

Route Traveled During the Ethiopia Trip, January 2015



1. Addis Ababa
2. Jimma
3. Mizan Teferi
4. Aman
5. Bachuma
6. Jumu
7. Maji
8. Nek'emte
9. Aira
10. Kake
11. Dembi Dollo



Introduction

The Village Health Partnership (VHP) is an all-volunteer organization that works for safer motherhood in rural Ethiopia. 501(c)(3) non-profit status was granted by the United States government in November of 2013. The mission of VHP is to prevent maternal and fetal death in childbirth, and to treat and prevent gynecologic complications of childbirth. We fund programs that involve capacity building, treatment, prevention efforts, and, in the future, the development of income-generating schemes that will allow for the ongoing provision of healthcare services. All programs are based on and driven by working partnerships with local communities.

Over the last several years, VHP has begun to implement programs for safer motherhood in Western Wollega and, more recently, in the Bench Maji Zone, rural areas in the southwestern part of Ethiopia along the Kenya and South Sudan borders. A team of volunteers from the United States returns annually to build relationships and work with communities to understand their needs. They then define programs that will address those needs, assure alignment on priorities, and monitor program progress. Ultimately, the annual trip forges and renews grassroots partnerships, and determines what projects and programs will be implemented the following year. This developmental approach has been successful. VHP efforts for safer motherhood are beginning to have an impact.

Ethiopia Trips, December 2013/January 2014 and January 2015

On the trip to Ethiopia in December 2013/January 2014, VHP volunteers worked closely with government officials, hospital administrators, and healthcare providers in the Bench Maji Zone to define needs and future projects at the Mizan Aman General Hospital (MAG Hospital) and in the rural health centers that refer patients into the MAG Hospital. In the process, it became clear that the hospital lacked equipment and required funding for capital construction, and that providers in the health centers lacked adequate education and training in emergency obstetric care. In Western Wollega, volunteers worked with medical providers and hospital administrators at the Dembi Dollo Regional Hospital (DDR Hospital) to identify leadership and lay out a framework for project proposal and funding. Volunteers also worked with members of the Western Wollega Bethel Synod Development and Social Services Commission Branch Office (WWBS DASSC BO) to solidify and more clearly define a model for screening, transporting, and treating women with gynecologic complications of childbirth (the Screen, Transport, and Treat (STT) Program).

Upon returning to the United States in February of 2014, the VHP Board of Directors (VHP BOD) voted to fund the purchase of a generator (pictured left) and the construction of a maternity waiting area at the MAG Hospital. Development and implementation of an education and training

program at the health centers in the Bench Maji Zone was to be considered in the future. The VHP BOD chose a slower pace for programs in Western Wollega. The BOD did not elect to fund construction of a maternity waiting area next to the DDR Hospital. Instead, the BOD agreed that if the DDR Hospital Administration could prove their leadership with the submission of a proposal for an industrial washing machine, the BOD would vote to fund the purchase. The BOD chose to continue to support the screening, transport, and treatment of women under the STT Program, but put on hold plans for a women's village to house women before and after surgical treatment. Finally, the BOD voted to engage an in-country director who would be charged with facilitating program development and implementation, as well as ensuring accountability year-round.

VHP volunteers returned to Ethiopia in January of this year to evaluate progress made in 2014 and work with local communities to define future directions. Traveling on this trip were Laury Bowman, Assistant Secretary of the VHP BOD and General Counsel for the Kaiser Permanente Medical Group in Colorado, myself, a physician, Founder and Chair of the VHP BOD, and Tefera Endalew Yayeh, VHP In-Country Director (ICD), who facilitated our trip and worked side by side with us. A small group was important for an immersion experience. As we traveled 3,500 kilometers over two and a half weeks to the Bench Maji Zone and Western Wollega, we needed to listen and work in the minority to ensure that our partnerships with local communities were healthy and strong.

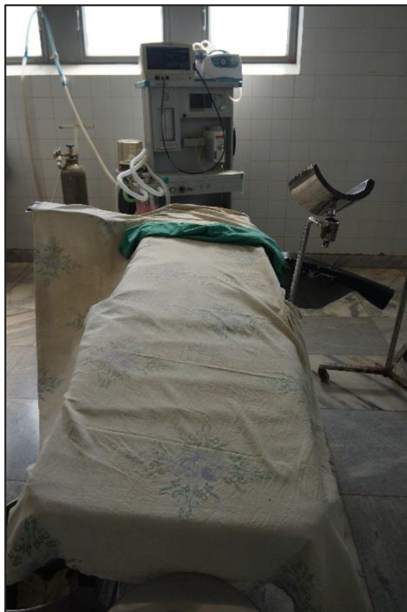
Bench Maji Zone in the Southern Nations, Nationalities, and People's Region

Laury and I flew directly from Washington Dulles to Addis Ababa on Ethiopian Airlines, landing in the early morning hours. We quickly passed through customs, connected with Tefera, loaded our gear into a waiting land cruiser outside of the airport terminal, and drove southwest to Jimma and then on to Mizan Teferi in the Bench Maji Zone.

After being officially welcomed over dinner by government officials, hospital administrators, and physicians from the MAG Hospital, we spent the next two days working in the hospital. We collected statistics and information on the MAG Hospital and the healthcare system that the Ethiopian government is in the process of implementing. Reducing maternal mortality is now a priority. Local officials have been directed to encourage pregnant women to come into the health centers to deliver there rather than at home. The government has established a land cruiser ambulance network that extends from the health centers in rural areas to the MAG Hospital. They are also working to build district hospitals next to the health centers in Bachuma and Maji, and to establish training programs in emergency obstetric care at the MAG Hospital for health officers and physicians who are targeted to serve in those district hospitals. In the future, the MAG Hospital will play a bigger role as both as a teaching hospital and as a regional referral center for women with high risk pregnancies and gynecologic complications of childbirth.

With all of this in mind, we toured the MAG Hospital to ensure that the facility has the capacity to play this larger roll. Hospital Manager At'enafu Girsha Awegechew had recently received recognition from

the federal government of Ethiopia for his leadership and superb administration of the facility. A blood bank with the capacity to hold ten units had been set up to assist with treating post-partum hemorrhage and blood loss during surgery. A generator had been installed and it was indeed providing backup power to the surgical operating rooms, labor and delivery, and the wards. Construction of a maternity waiting area (pictured right) was underway. The building, which consists of eight large rooms, will have 48 beds, a separate bathroom and shower, a laundry stand for washing clothes, and huts for families to gather. The huts will represent each of the six indigenous cultural communities in the Bench Maji Zone. The surrounding acreage will be used for a garden and coffee orchard to support the facility.



In spite of these efforts, it was clear that the MAG Hospital still faces challenges that impact the provision of healthcare. The hospital provides medical services to 2.5 million people in southwestern Ethiopia and South Sudan. Labor and delivery is crowded, the equipment is dilapidated, and there is little room for neonates. With only 100 beds, the wards are clearly full and overflowing. The two operating rooms are being used around the clock for caesarian sections, gynecologic surgery, and general surgery, but the equipment is marginally functional and surgical instruments and supplies are limited. There is no surgical recovery area or intensive care unit, no cardiac monitors or ventilators, no neonatal incubators, and the water supply is limited. Medical providers such as OB/GYN Surgeon Dr. Yesak, a Dizi from Maji and a highly dedicated physician who has worked in the Zone for years, are clearly trying doing a great deal with very little.

We held long discussions with the hospital administration and medical providers regarding these problems and the potential solutions. They already had a plan: continue to partner together to capacitate the hospital and create a regional referral center for maternal health. First, construct a new building that will house the obstetric, neonatal and pediatric wards, labor and delivery with operating rooms for cesarean sections, and outpatient clinics focused on maternal health. Once that project is complete, renovate the current operating rooms and construct a surgical step down area and an intensive care unit. Finally, renovate the current obstetrics and gynecology wards to form the new general surgery and gynecology wards. On reflection, it was felt that it would not be enough to just build and renovate buildings; the plan needed to include equipping and staffing the facility. All agreed.

Ultimately, the focus will need to turn to medical education and training, and the implementation of medical systems that will support the provision of high quality maternal healthcare. The administration agreed that they will commit to this larger vision if VHP will partner with them and provide a significant amount of the funding that will be required to implement the project.

Once the hospital assessment was complete, we headed out to evaluate the health centers in Bachuma, Maji, and Jumu with Hospital Manager At'enafu and OB/GYN Surgeon Dr. Yesek from the MAG Hospital. We were tasked with understanding the realities of the healthcare system that was being implemented outside of the hospital in more remote areas, and with identifying gaps in that system that would impact the delivery of care. With encouragement from government officials, pregnant women are slowly beginning to come to the health centers for medical care, and medical personnel are being challenged to provide the needed care. It was clear that it will take the district hospitals several more years to become fully functional. Referring everybody to the MAG Hospital is out of the question. Ambulance land cruisers are in short supply and often break down. Even if other vehicles are available, transport from some health centers such as Maji to the MAG Hospital could take up to 4 to 6 hours in the dry season. The roads are impassable in the rainy season. Nurses, nurse midwives, and health officers in the health centers will be asked to do a great deal. Complicated deliveries will be particularly challenging as healthcare providers have academic knowledge but little practical training.

The deficit of medical skills, especially emergency obstetric care, in the health centers is clearly a gap in the healthcare system that will impact the delivery of care to pregnant women. A solution to meeting this need came together quickly. Tefera, ICD and educator by training, can identify Ethiopian physicians to write the curriculum, define culturally sensitive methodology, and develop an education and training model to be implemented in the health centers in the Bench Maji Zone. It might also be possible to collaborate with other international groups that have developed training curriculum in emergency obstetric care. These education and training programs can be modified to reflect the Ethiopian Minister of Health guidelines of care that are appropriate for the rural areas, which can then be translated into Amharic. Medical providers in the United States can act as consultants. Dr. Yesak can identify individuals in the health centers who have a "deeper commitment to their community." If trained, they can in turn become trainers. In the future, if the MAG Hospital hires another OB/GYN physician, Dr. Yesak will have time to play a lead role. It will take a great deal of work, but Tefera and Dr. Yesak wanted to see Ethiopians put the training program together and be the ones to implement it. The program is theirs to own.

Upon returning to Mizan, we were invited to participate in a community event celebrating the installation of the generator and construction of the maternity waiting area at the MAG Hospital. Local and regional government officials, members of Parliament, hospital administrators, medical providers, Orthodox and Protestant Christian leaders, Muslim religious leaders, and prominent community members all gathered to give speeches, tour the hospital, feast, and celebrate together. It was indeed a great day that demonstrated a successful local partnership for safer motherhood.

Western Wollega in the Oromia Region

We drove north from Mizan to Jimma, spent the night, and then traveled to Nek'emte and Dembi Dollo the next day. We were welcomed in Dembi Dollo by Dugasa Beyene, director of the WWBS DASSC BO, who was charged with running the STT Program in Western Wollega. Over the following three days, we worked with the WWBS DASSC BO members to interview women who had been treated under the program.

At the health center in Kake, we were greeted by government social workers who had recruited women from the surrounding villages for screening. We were told to expect to interview six women who had been treated in July of 2014. Much to everybody's amazement, 35 women showed up to talk with us, the majority of whom had not yet been treated. A pregnant woman also came to talk, worried that her delivery would be problematic. We did our best to interview those who had been treated and some who had not, and to arrange for screening and medical care for all who needed it.

One young woman, emaciated and depressed, stood out in the crowd. We asked to speak with her. Through an interpreter, Zahara (pictured left), age 35, told us her story. With no access to birth control, she became pregnant again and again, never receiving skilled assistance with the delivery of any of her children. Now her rectum and bladder prolapsed down to her thighs, and she could not control the urine that flowed down her legs. Her husband did not "understand" and often beat her. In pain and unable to care for herself or her family, she spent most of the day in bed waiting to die. Her brother heard that we would be at the health center in Kake and convinced her to come and talk with us. She walked four hours to reach us that morning. Dugasa and the government social workers set her up to be screened, and then transported her to Aira Hospital for medical treatment the following week. Next year, we will walk into her village to ensure that she has been treated and is doing well. (Of note is the fact that the international community has focused its attention and funding on the treatment of fistula, but not on the treatment of other gynecologic complications of delivery that have a similar devastating impact on women, families, and communities.)

We returned to Kake the next day, this time to interview women in their homes. One of our initial interviews was with Salia (pictured right), age 20, who gave birth alone in the middle of the night to a baby boy. This was her first child, and her labor had been long and painful. She said that she bled a great deal but "nobody came to help" until morning. After delivery, she developed uterine prolapse and urinary incontinence. Her husband divorced her. Salia was treated at Aira Hospital in 2014. Now, her life has changed. Smiling, she held her son on her lap and told us that she is doing well. She started a small business selling soap and other goods in the local market, and she is able to support herself and her son.

We left Salia and drove to the next village. As we walked down a small path off the main road, the smell of urine filled the air. The men in the community stood back and watched as we approached the home of a woman who had recently been treated under the STT Program. Busee (pictured below) age 25, met us at the front door of her house and shyly welcomed us. We sat outside on wooden benches and talked with her as she whispered answers to our questions. With her second pregnancy, she had prolonged labor complicated by post-partum hemorrhage. The baby died and she was left with urinary incontinence. She underwent surgery to repair her bladder in 2014, but she is still suffering from some urine leakage. (Sadly, not all gynecologic injuries can be completely repaired.) Busee said that her husband loves her, is willing to support her, and does not want her to get pregnant again. However, she is not on birth control and is afraid of what the future holds.

After the interview we walked back to the main road. The men from the village followed us, listening intently as we implored the government social workers to partner with the WWBS DASSC BO in a bigger way. We suggested that they follow up with the women once they have been treated to ensure that they are doing well and, if they can still become pregnant again, are on birth control. In addition, we recommended that they actively encourage all pregnant women to come into the health centers for medical care and skilled assistance with delivery. The risk of death and gynecologic injury will be far less likely in that setting. Prevention and access to birth control are needed for women to lead healthier lives. Moved by Busee's fate, the social workers agreed and welcomed a larger relationship with the WWBS DASSC BO. They noted that the government has made the provision of birth control and access to skilled assistance at the time of delivery a priority, but resources are scarce and Western Wollega has been slow to benefit from government development efforts.

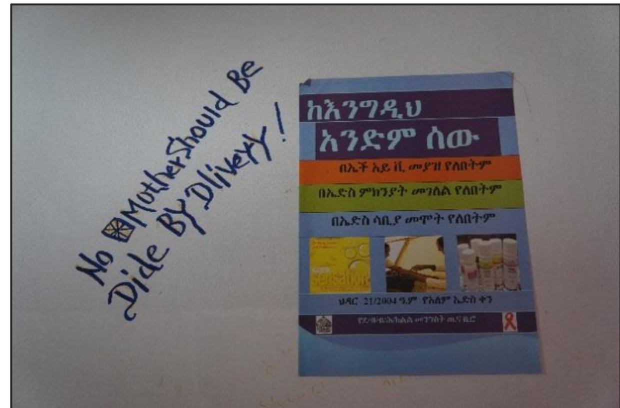
After completing the interviews, we traveled to Aira Hospital where we met with Taffese Bayissa, the new Hospital Manager and Dr. Tariku Wakuma Kena, General Surgeon and Hospital Medical Director. Under the STT Program, Dr. Tariku evaluates all the women who come in for screening at the health centers. He treats their medical problems, selects those who are appropriate for surgery, and then performs all of the surgeries once the women have been transported to Aira Hospital. VHP pays for the surgical treatment of women with gynecologic complications, with the exception of those who are found to have a fistula. These women are treated under a program sponsored by the Fistula Foundation. With only one surgeon, expansion of the STT Program has clearly challenged the capacity of Aira Hospital to provide care, but the hospital administration is working to solve this problem. They hired an OB/GYN surgeon who will begin working at the hospital next year. In the meantime, an outside surgeon will periodically visit Aira Hospital to assist Dr. Tariku with his case load.

Dr. Tariku expressed his commitment and support for the STT Program, noting the depth of the need as well as how successful the program has been. He confirmed that the healthcare effort is having a larger impact on the community. Not only are women coming in for screening and treatment of their gynecologic injuries, but they are beginning to ask for birth control and access the health centers at the time of delivery. The program is paving the way for prevention efforts. The new demand for care is challenging medical facilities and the government to provide needed medical services.

On our last night in Dembi Dollo, we spent time discussing the STT Program with the WWBS DASSC BO team. Under Dugasa's leadership, the STT model is being successfully implemented. Aira Hospital has worked to solve its own capacity limitations by hiring new physicians. In the future, the WWBS DASSC BO will approach the government and ask for their data on women with gynecologic complications of childbirth. They will offer to hold screenings in the areas of greatest need if the social affairs office will continue to raise community awareness and recruit women to come in to be screened. They will also encourage the government to send health extension workers and/or social workers to the villages to follow up with the women once they have been treated. Dugasa promised to keep the cost per woman the same (approximately $233.40 USD) through 2016 if VHP agrees to fund the treatment of 100 women per year.

On another note, in 2014, the DDR Hospital Administration failed to produce a written proposal for an industrial washing machine. We chose not to visit the hospital on this trip and risk raising community hopes and expectations. In the future, when it is clear that the facility has the leadership to move forward with the development and implementation of programs, we will revisit our partnership there.

Future Directions



Future projects and programs are defined by the process of working in partnership with local communities during our annual trips to Ethiopia. Upon our return to the United States, the VHP BOD then votes on what to fund. Fundraising efforts are ongoing.

In February of this year, the VHP BOD voted to partner with the MAG Hospital in the Bench Maji Zone to create a regional referral center for maternal health. This three-year project will include building, equipping and staffing a new obstetric/neonatal and pediatric/outpatient building, and renovating, equipping and staffing the operating rooms, a new surgical recovery area, an intensive care unit, and the surgical wards. To procure the needed funds, VHP is putting together a capital campaign that will launch in June of this year. At the same time, the hospital will hold a fundraising campaign of its own, asking the community to contribute towards the project.

The VHP BOD also voted to move forward with the creation of an education and training program in emergency obstetric care that can be scaled up and implemented in the rural health centers in the Bench Maji Zone. Ethiopian physicians have been recruited to put together the curriculum, drawing on resources from the Ethiopian Minister of Health and other international groups. Physicians and nurse midwives in the United States will act as consultants and return with us next year to assist with training. We hope to find a major donor who will underwrite this education effort.

In Western Wollega, the VHP BOD voted to fund the screening, transport, and treatment of 100 women in 2015 and again in 2016. Data from the interviews performed in 2014 and 2015 will be entered into a database to track outcomes, and then published. The stories of the women will be written up and posted online. We will use social media to spread the word and build support for an online campaign to raise money for the program.

Conclusion

Last year, VHP and the Bench Maji Zone purchased a generator for the MAG Hospital. The hospital administration installed the generator and is charged with maintaining it. VHP contributed funding towards the construction of the maternity waiting area next to the MAG Hospital, and the Zone contributed the land. The hospital will furnish and maintain the facility, which will open in May of this year. In addition, VHP funded the screening, transport, and treatment of 50 women with gynecologic complications of childbirth. Government social workers assisted by raising community awareness and mobilizing women to come in to be screened. In the future, Aira Hospital will hire an OB/GYN surgeon

who will assist with surgical treatment. To date, 180 women with gynecologic complications have been treated under the STT Program.

It is clear that the successful implementation of these programs results from the grassroots partnerships that VHP has developed with local communities in Ethiopia. The foundation for these partnerships involves building relationships that are based on trust and mutual understanding. Partnerships are also about a process of program development. In the Bench Maji Zone, the partnership involves working together to identify gaps in the current healthcare infrastructure and then working to build programs that will fill those gaps in a way that creates medical systems of care. In Western Wollega, the partnership is about working together with communities to define that razor sharp intervention, in the midst of overwhelming need, that might begin to break down barriers to seeking, reaching, and receiving medical care.

These partnerships are also about ensuring that program priorities are aligned with those of the communities that they aim to serve. Partnerships are about leadership and accountability. While we are expected to keep our promises to support programs, local leadership is expected to produce results. Finally, these partnerships are about engaging communities to be stakeholders in projects and programs. Ultimately, Ethiopians must take responsibility for development efforts if the impact is to be sustainable.

Successful implementation of programs is based on a shared vision and process that brings people together in partnership, working as a team for a greater good. Certainly, none of this would be possible without financial support from all of you in the United States who have given so generously. Thank you for being an integral part of this partnership. We hope that we can count on you for continued support as VHP works with local communities to implement programs for safer motherhood in southwestern Ethiopia.

Thank you so very much.