The Permanent Mission of the Federal Democratic Republic of Ethiopia to the United Nations Office at Geneva and other International Organisations in Switzerland presents its compliments to the Office of the United Nations High Commissioner on Human Rights and has the honour to forward herewith the response from the Ethiopian Government on initiatives that exemplify good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity.

1. Background Information

Globally, at least 585,000 women die each year from complications of pregnancy and childbirth. Almost 90% of these deaths occur in Sub-Saharan Africa and Asia, making maternal mortality the health statistics with largest discrepancy between developed and developing countries. In addition, Africa has the highest newborn mortality rate, estimated at 45 deaths per 1000 live births. More than 70% of all maternal deaths are due to five major complications: hemorrhage, sepsis, unsafe abortion, hypertensive disorder of pregnancy and obstructed labor/uterine rupture. Evidence shows that more than half of these deaths occur during labor/birth and the postpartum periods. In addition to the women who die, many more suffer from serious but not fatal health problems and some suffer long term disabilities including infertility and obstetric fistula.

The Federal Democratic Republic of Ethiopia contains a diverse population of 73.9 million people. Having made rapid gains in both economic development and health improvement, Ethiopia is a leader in development in Africa. Nonetheless, the fourth national Health Sector Development Program (HSDP-IV) has identified a number of strategic areas in which significant health gains are possible.

Ethiopia’s health system is highly decentralized among the country’s nine regions and two city administrations. The essential unit of the Ethiopian health care sector is the primary health care unit (PHCU), which consists of a primary hospital, health centers, each supported by five health posts and the Health Extension Workers (HEWs) based at each Health Post. A primary hospital supported by a general hospital, which is, in turn, supported by a specialized hospital. At the lowest level of care, the Health Extension Program (HEP) is designed to ensure that services reach the community and household level. The HEP strives to enable individuals and families to take responsibility for their own health. HEWs, two of whom are based at each health post, provide basic services and health messages to a population of 3,000 to 5,000 people, and they are present in every kebele in the country. Ethiopia’s rapid expansion of health services is most markedly visible in the increase in HEWs posted around the country—up from fewer than 3,000 in 2004 to nearly 34,000 in 2009.
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Health posts, and the HEWs assigned to them, are designed to closely link with health centers to provide a PHCU network. Planning for the entire PHCU network is done at the PHCU level. There are approximately five PHCUs per woreda (an administrative unit equivalent to a district). Woredas are, themselves, subdivided into kebeles (villages or neighborhoods) with their own administrative structures. Woredas are aggregated into, in turn, zones and regions.

2. Maternal Mortality in Ethiopia

Maternal mortality is difficult and expensive to measure especially in developing countries where vital registration systems are incomplete and inaccurate. Alternative methods such as the sisterhood method give estimates of the maternal mortality ratio (MMR) covering a period of about 10 years prior to data collection, and therefore are not ideal for monitoring the short-term effects of interventions designed to reduce maternal mortality.

Ethiopia, however, is fortunate to have two such measurements in the past decade. The Ethiopian Demographic and Health Surveys (EDHS) of 2000 and 2005 produced the MMR estimates of 871 per 100,000 live births and 673, respectively. These MMRs are critical to monitoring progress towards one of the MDG 5 targets. Generally in Ethiopia, Maternal Mortality ratio has declined from 1068 per 100,000 live births in 1990 to 590 in 2000

3. Interventions to reduce MMR and accomplishments

The Federal Democratic Republic of Ethiopia, under the leadership of the Federal Ministry of Health (FMOH), has made, and continues to make, rapid improvements in the health of its citizens. Following the national Health Sector Development Program (HSDP), now in its fourth iteration (HSDP-IV), coordinated gains have been made across health priorities and at all levels of the health system. In particular, Ethiopia has rapidly enhanced the availability of key structural components: health facilities, major equipment, health work force, and other essential inputs. For example, by end of 2009, a total of 14,416 health posts (HPs) were constructed making the coverage 88.7% and a total of 2,689 HCs were constructed which account for 84% of the target of having 3,200 HCs by the end of HSDP-III. The number of health extension workers (HEWs) providing community-based services has also increased. Similarly, impressive health gains have been made in many other areas through the HSDP.
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Ethiopia is one the first country to have included MDG targets in its poverty reduction strategy. The pace towards achieving goal 5 of the MDG, reducing maternal death by ¾ th, has been promising. A number of programs that have impact on reducing maternal mortality have shown substantial progress. Of these contraceptive prevalence rate, antenatal and skilled birth attendance rate are some of the few. There has been notable progress in contraceptive uptake from 6% in 2000 to 14.7% in 2005. By mid term of HSDP III antenatal coverage has reached 59.7% and proportion of deliveries attended by skilled health personnel was 18% and postnatal care coverage of 19.9%. Studies in four regions of the country in 2009 showed a CPR rate of 32%. The training and placement of HEWs in the country will continue to have immense contribution in increasing contraception uptake and utilization of Antenatal and delivery care.

This has been achieved by improving and strengthening the health system through rapid scale-up of primary health care facilities as well as by training and deploying 34,000 health extension workers, in every village. This has also helped double the Contraceptive Prevalence Rate (CPR) (to 32%) in less than 4 years. The improvement of many of the health indicators in areas implementing rural Health Extension Program sets forth the platform to design and implement the Urban Health Extension Program (UHEP). Currently around 4000 urban health extension professional are trained and deployed. CPR is further expected to increase with full implementation of UHEP.

Building on these achievements, the Government of Ethiopia has committed to provide skilled Emergency Obstetric and Newborn Care at all Hospitals and Health Centers and remove barriers to utilization of these services by women. Different interventions are under implementation to provide basic emergency obstetric and new born care in all health centers and hospitals as well as comprehensive emergency obstetric and new born care in all hospitals. Training of midwives is also one of the interventions and the plan is to increase the number of midwives to 8,635 (from the current 2,050), to reach 60% coverage of Skilled Birth Attendance (from 18%); and to ensure that essential newborn care is made available in all health facilities and at household level.

Although coverage is increasing, utilization of services was low; most of births in Ethiopia occur at home, few details about newborn death are documented. Cognizant of these
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fact, the FMOH has formulated and implemented a number of policies and strategies that provide an effective framework for improving health in the country including the recent addition of maternal and neonatal health in HSDP IV which has set clear and ambitious targets of decreasing maternal mortality ratio from 673 per 100,000 live births to 267, decreasing institutional maternal mortality rate to less than one, increasing family planning service (CPR) from 32% to 65% and increase Delivery Service attended by skilled birth attendants from 18% to 60%.