FOLLOW UP ASSESSMENT ON MIDWIVE PERFORMANCES AND TRAINING QUALITY

Accelerated Training Programme

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ACKNOWLEDGEMENT

The Follow up Assessment Report on the Accelerated Midwifery Programme and the performance of midwives after training is very essential as it highlights achievements, challenges and lessons learnt. It clearly shows areas where improvements are needed in order to provide quality maternal and neonatal health services. Federal Ministry of Health and UNFPA would like to thank Sr. Azeb Admassu, (Midwifery Coordinator, FMOH), Sister Aster Berhe, (Country Midwifery Advisor, UNFPA), Sr. Feven Alazar, (FMOH), Asamenew Assefa, (Programme Officer in FMOH) and Dorothy Lazaro (Midwifery Specialist-UNFPA) for planning, conducting and writing the report of the assessment.

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FOREWORD

The Federal Ministry of Health of Ethiopia (FMOH) has placed maternal and newborn health as a priority in order to reduce maternal and neonatal morbidity and mortality and achieve MDG 4 and 5. The period of highest maternal and new born mortality is during labour, delivery and 24 hours after delivery hence training midwives to monitor and provide basic emergency obstetric care to women in labour will assist to reduce maternal and neonatal morbidity and mortality.

Federal Ministry of Health initiated the Accelerated Midwifery Training Programme in 2011 to increase the number of midwives and access to skilled birth attendance. Midwives are also providing other sexual and reproductive health services such as family planning and comprehensive abortion care which are essential in preventing maternal deaths.

The Ministry is not only convinced that training midwives is essential but also ensuring that there are functional health facilities, fair and equal distribution of midwives across the country, availability of essential equipment and supplies and collaboration between the midwives, Health Extension Workers and the Health Development Army. This report is therefore important as it highlights achievements, challenges and lessons learnt in the implementation of the Accelerated Midwifery Training Programme.

I would like to acknowledge UNFPA and Sida for financial and technical support during the implementation of the programme and also in conducting this assessment.

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ACRONYMS AND ABBREVIATIONS

A.A	*Addis Ababa*
AMP	*Accelerated Midwifery Programme*
ANC	*Ante-Natal Care*
APH	*Ante Partum Hemorrhage*
BEmONC	*Basic Emergency Obstetric and Newborn Care*
CAC	*Comprehensive Abortion Care*
COC	*Center of Competency*
EDHS	*Ethiopian Demographic and Health Survey*
ETB	*Ethiopian Birr (currency)*
FMOH	*Federal Ministry of Health*
FP	*Family Planning*
HC	*Health Center*
HEW	*Health Extension Worker*
HIV	*Human Immunodeficiency Virus*
HSC	*Health Science College*
IUCD	*Intrauterine Contraceptives Device*
IV	*Intravenous*
MCH	*Maternal and Child Health*
MDG	*Millennium Development Goal*
MVA	*Manual Vacuum Aspirator*
NGO	*Non-Governmental Organization*
PAC	*Post Abortion Care*
PMTCT	*Prevention of Mother to Child Transmission*
PNC	*Post Natal Care*
PPH	*Post-Partum Hemorrhage*
RHB	*Regional Health Bureau*
TVET	*Technical and Vocational Education and Training*
UNFPA	*United Nations Population Fund*
WHO	*World Health Organization*

TABLE AND FIGURES

EXECUTIVE SUMMARY

The Accelerated Midwifery Training initiative was established by the Federal Ministry of Health in 2011. The programme is designed to boost skilled attendants within a period of three years by ensuring access to a core package of maternal and neonatal health services and reduce maternal and neonatal mortality and morbidity. It is designed to meet the needs of rural communities as graduates are assigned to health centres. The target of the initiative is deploying a minimum of two fully-fledged midwives per health centre who are required to show competency in clinical knowledge and skills and provide quality midwifery care.

The goal of Accelerated Midwifery Training Initiative is to contribute to the attainment of MDG 4 & 5 through rapid training and deployment of minimum number of skilled attendants at all Health Centers within shorter time.

The implementation strategy of the initiative is reducing the duration of training from three years to a year using a special curriculum and train unemployed nurses on competency based approach. The initiative started in January 2011 and will end in June 2014.

The first batch of the midwives trained under the Accelerated Midwifery Programme graduated in April and May 2012. 84 midwives, predominantly females (83.3%) from six regions of (Oromiya 49, Amhara 17, Addis Ababa 5, Gambella 5, Somale 4, and Ben Shangul 3) were followed up in order to assess the performance of the programme and their own performance in the health facilities. The 84 midwives are providing services in 66 health centres.

The purpose of the follow up assessment was to appraise the programme through identification of its strengths and weaknesses on service delivery vis-à-vis meeting the predetermined goals of the initiative. Eventually, the assessment result will contribute to improved quality, effectiveness, and efficiency of the program. Specific objectives of the assessment were to:

1. Assess the performance of the Accelerated Midwifery Training Programme

2. Assess the performance of graduates after training in terms of their contribution to maternal and neonatal health services including family planning
3. Identify challenges and successes of graduates
4. Document lessons learnt that will be used for policy decisions.

MAIN FINDINGS

Data collected from both the midwives, instructors and Heads of Health Centres indicate that AMP is a very good programme. 69% of the midwives talked highly of the programme and reported that it is competency based and they were well prepared for the job that they are currently doing. All graduates mentioned that the time for the training was very short hence they had to work extra hard to accomplish all assigned tasks.

The graduates, 30 % mentioned that they did not have any training in basic emergency obstetric and Neonatal care (BEmONC). From interviews and available data, it appears that tutors teach different basic emergency obstetric care functions without actually informing the students that they are learning BEmONC.

Almost all midwives are engaged in maternal and child health services. They are providing antenatal, delivery services, post-natal, prevention of mother to child transmission (PMTCT) of HIV, family planning and neonatal care. Only 5 % of the midwives are providing immunization, abortion care, running under 5 clinics and working in outpatient department.

Data show that 4,995 deliveries were conducted in the 66 health centres from May 2011 to April 2012 before the midwives were deployed compared to 8,042 conducted from May 2012 to April 2013 after deployment. This represents a 61% proportional increase in the use of institutional delivery.

Midwives trained through the Accelerated midwifery programme are using partograph to monitor labour. 76% of Midwives were using the partograph. However, only 43.5 percent of the partographs were correctly and fully completed.

Lack of equipment such as delivery beds vacuum extractors, resuscitators, infection prevention materials was common in many health centres. This is affecting the quality of

care being provided. The assessment revealed that only 27(32%) said that they had adequate resources to enable them provide all required services.

Exit interviews conducted on 89 antenatal women, 39 women who came to deliver and 37 clients who sought family planning services indicate that the clients are satisfied with the services being provided. They were satisfied with the waiting time, the attitude of the midwives and the quality of services that they received.

Clients in Somali and Oromiya regions prefer to be attended and cared for by a female midwife. There was no preference in the other regions. It is however important to note that clients indicated that the attitude of female midwives was much better than that of their male counterparts.

CONCLUSIONS

The report shows that the Accelerated Midwifery Training Programme is a very good programme that is appreciated by both the graduates and the Head of Health centres. The midwives reported that the training was hands on and competency based. However all graduates indicated that they needed more time during the training to enable them to cover all courses adequately. Both the graduates and Heads of health centres reported that more training is needed in Post abortion care and comprehensive abortion care, long term family planning and PMTCT. More clinical practice is also needed during training as 24% of the graduates conducted less than 10 deliveries during their training period.

There has been an increase in the utilization of maternal and neonatal services in all health centres. There has been a remarkable increase in the numbers of deliveries after the deployment of midwives.

The Quality of care provided by the midwives varies from region to region. Although over 76% of midwives are using partographs to monitor labour, only 43% of the partographs were correctly completed. This is an area which require refresher course to ensure that midwives are practicing according to global standards.

RECOMMENDATIONS:

1. All midwives reported that the training was very good but not adequate and the time for practical training was limited. It is being recommended that FMOH

should increse the duration of training to 18 months that is if they decide to continue to train more midwives.

2. For the Midwives to be very effective, the Regional Health Bureaus should provide refresher training in the following areas: Post abortion care and comprehensive abortion care, basic emergency obstetric care, long term family planning and PMTCT.
3. Establish a performance based incentive system to reward best practices, both for faculty and practicing midwives for motivation and to improve quality of care.
4. Training institutions should hire tutors who have been working in the health facilities for two years (minimum) to ensure that they have practical experience.
5. Assign midwives to work in the labour ward. The labour ward should have 24/7 coverage with a skilled midwife who will be able to monitor labour and identify complications before they become life threatening.
6. All midwives should be involved in maternal and neonatal community mobilization and work closely with Health Extension Workers.
7. Most women have been mentioning the user fee as the barrier to the use of health facility for delivery. It is being recommended that FMOH and RHB should enforce the fee exemption policy.
8. Graduates being sent to health centres should be paired with a senior midwife for mentorship and enable them gain confidence.

I INTRODUCTION

The Ethiopia Federal Ministry of Health has developed a Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and mortality in Ethiopia (2012-2015) as a response to the high maternal and neonatal mortality rates and to the Global and Regional calls for each country to develop a country-specific Road Map. The general objective of the Road Map is to reduce maternal mortality ratio from the current 676 per 100,000 to 267/100,000 live births and newborn mortality rate to from 37 to 15/1000 live births by 2015. Its specific objectives are to: (i) strengthen the capacity of Individuals, Families and Communities to improve Maternal and Neonatal Health (ii) increase skilled attendance during pregnancy, childbirth and postnatal period; (iii) scale up the provision and utilization of quality Basic and Comprehensive Emergency Obstetric and Neonatal care; (iv) increase use of key newborn care services and practices by households; (v) increase access to Family Planning information and services at all levels; (vi) Strengthen the Health System Management and Partnership to Deliver Effective and Efficient MNH Services. The major causes of maternal deaths in Ethiopia include: obstetric haemorrhage, sepsis, pregnancy-related hypertensive disorders, abortion and obstructed labour. The contributing factors are lack of access to skilled birth attendance.

Ethiopia as a country is making progress in a number of areas. Notable achievements have been realized in the area of utilization of family planning services which has seen an increase in contraceptive prevalence rate from 15 percent in 2005 to 29 percent in 2011. The impact is shown by the reduction in total fertility rates from 5.4 in 2005 to 4.8 children per woman in 2011. However the unmet need for family planning remains high at 25 percent. The 2011 EDHS also shows a rapid decrease in infant and under-five mortality during the past five years. For example infant mortality has decreased from 77 in 2005 to 59 deaths per 1,000 births in 2011 while under-five mortality had decreased from 123 in 2005 to 88 deaths in 2011. Although there has been progress in reduction of child mortality, current data shows that some 120,000 newborns die of preventable causes annually, making Ethiopia one of the ten countries with the highest number of neonatal deaths per year globally. Currently newborn deaths contribute to more than half of infant deaths and over 40% of under-5 deaths. The 2011 DHS indicates a neonatal mortality rate of 37 per 1,000 live births, virtually unchanged in the past five to ten years. Information

presented above indicates that Ethiopia is having some challenges in the achievement of MDG5 pertaining to the reduction of maternal mortality by three fourth in 2015 from the unacceptably high levels in 1990.

For the maternal mortality ratio to be reduced by 75 %, as the MDGs require, all women must have access to high-quality delivery care. Such care has three essential elements: a skilled attendant at delivery; access to emergency obstetric care (EmOC) in case of a complication; and a referral system to ensure that those women who do experience complications can reach life-saving EmOC in time (UN, 2005). Skilled midwives are required if countries are to provide that level of care. Despite more than half a century of midwifery training in Ethiopia, the number of midwives currently present is estimated at six thousand for a population of nearly 81 million.

A recent government Human Resources for Health assessment report indicates that achieving health related MDG targets; especially reduction of maternal mortality seems to be a daunting task, considering the huge gap in the supply and demand for human resource to meet the minimum staffing pattern for scaling up basic and emergency obstetrics care services in health centers and hospitals. This situation is being improved by training more midwives. Therefore, the Accelerated Midwifery Programme (AMP) is instrumental in strengthening the government efforts to save the lives of mothers and their babies.

The National Reproductive Health Strategy of Ethiopia released in March 2006 has specific targets of increasing skilled birth attendance rate to 60%; to guarantee one health center with basic emergency obstetric care per 25,000 populations; have one rural/district hospital per 100,000 with comprehensive emergency obstetric care and to reduce maternal mortality to 267 per hundred thousand. In order to achieve these huge targets, an increase in the number of midwives trained per year was deemed critical hence federal Ministry of Health established the Accelerated Midwifery Training Programme.

The AMP was initiated by Federal Ministry of Health in January 2011 to increase the number of skilled attendants within three years' time. The implementation strategy of the initiative is reducing the duration of training from three years to a year using a special competency based curriculum. The programme enrolls qualified certificate nurses (Level III to IV)who undertook a nursing training for two years. Students are enrolled after

passing entrance exams to ascertain that they will be able to go through this rigorous training. Since the training is of only one year duration joint supervisions consisting of FMOH and UNFPA were conducted every quarter to ensure that competency based training is being conducted as planned and also students are using logbooks. FMOH also conducted annual performance review workshops where all training institutions and Regional Health Bureaus participated. Upon completion of the training; two midwives are deployed per health centre to provide a core package of maternal and neonatal health services to the community and identify complications of pregnancy and labour early before they become life threatening.

The goal of Accelerated Midwifery Training Programme is to contribute to the attainment of MDG 4 & 5 through rapid training and deployment of minimum number of skilled attendants at all Health Centers within shorter time. Accordingly, specific objectives are:

- To train 4,676 competent midlevel midwifery professionals within three years
- To minimize the prevailing shortage and gap of skilled attendants at primary health care level by deploying a minimum of two midwifery professionals
- To increase the current low skilled delivery rate
- To improve the training quality and capacity of Health Science colleges
- To synergize the collaboration of Health Science Colleges and health facilities in the production of health care providers

The successful implementation of the programme will result in increased skilled attendance at birth which is currently at 10% (EDHS 2011), reduce maternal mortality ratio towards the achievement of MDG 5 and improve and sustain training capacity of Health Science Colleges in producing and supplying competent health care providers.

The supports required for this initiative are multifaceted such as financial, material and human resources. There have been collaborative supports from FMOH, Regional Governments, Regional Health Bureaus, Health Care Facilities, Training Institutions and Development Partners. The three year training requires Birr 56,112,000.00 (Fifty six million ETB) i.e. Birr 12,000.00 per trainee per year.

During the first year of training, 1,600 students were enrolled in 15 Health Science Colleges allocated in the six regions of Addis Ababa, Amhara, Benshangul, Gambella, Oromia and Somali. All students in Oromia were females. 1,558 students graduated and were deployed as planned.

The first intake of students was as follows:

Table 1: Presentations of HSCs Performances

Colleges	Intake			Completed		
	M	*F*	*T*	*M*	*F*	*T*
Fichie HSC	-	*240*	*240*	-	*237*	*237*
Shashamane HSC	-	*247*	*247*	-	*245*	*245*
Negele HSC	-	*93*	*93*	-	*89*	*89*
Goba HSC	-	*67*	*67*	-	*67*	*67*
Nekemte HSC	-	*210*	*210*	-	*205*	*205*
Metu HSC	-	*146*	*146*	-	*140*	*140*
Bahrdar HSC	*47*	*53*	*100*	*45*	*53*	*98*
Teda HSC	*21*	*23*	*44*	*21*	*23*	*44*
Dedratabor HSC	*29*	*15*	*44*	*29*	*15*	*44*
Dessie HSC	*62*	*35*	*97*	*55*	*31*	*86*
Debrabrhan HSC	*24*	*26*	*50*	*24*	*26*	*50*
Menelik II HSC	*30*	*84*	*114*	*20*	*72*	*92*
Arbaminch HSC	*31*	*39*	*70*	*31*	*34*	*65*
Jijiga HSC	*40*	*20*	*60*	*38*	*20*	*58*
Pawe HSC	*12*	*27*	*39*	*12*	*26*	*38*
Grand Total	***296***	***1325***	***1621***	***275***	***1283***	***1558***

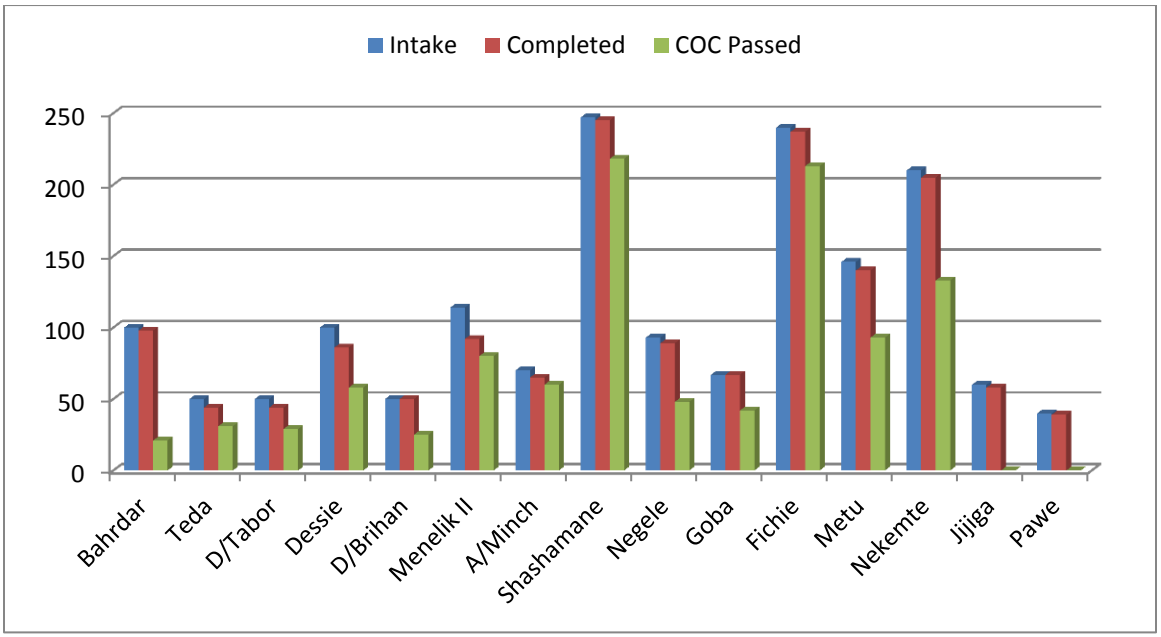

Figure 1: Graphic Representations of HSCs performances

A second cohort of 1742 trainees was enrolled into 13 Health Science Colleges in five Regional States since February 2012. 1,625 students have since graduated.

The midwives who were deployed in the health centre have been providing services for over one year. It was decided to do a follow up and assess their performance and identify successes as well as challenges in the provision of maternal and neonatal health services.

II THE ASSESSMENT DESIGN

1. Assessment Goal and Objectives

The purpose of this follow up assessment was to appraise the AMP through identification of its strengths and weaknesses on service delivery vis-à-vis meeting the predetermined goals of the initiative. Eventually, the assessment result will contribute to improve the quality, effectiveness and efficiency of the program. Specific objectives of the assessment were to:

- Assess the performance of the Accelerated Midwifery Training Programme
- Assess the performance of graduates after training in terms of their contribution to maternal and neonatal health services including family planning
- Identify challenges and successes of graduates
- Document lessons learnt that will be used for policy decision.

2. Assessment Design and Methodology

To develop a complete picture of the strengths and weaknesses of the AMP and the successes and challenges of the graduated midwives, the following data collection methods were utilized:

1. Primary Data Collection (Qualitative and quantitative)
   - 1.1. Interviews of Graduate Midwives
   - 1.2. Exit interview of service seekers
   - 1.3. Interview of Health Center Heads.
2. Secondary data collection : Assessment of Maternal Health service registry books
3. Review of reports of supervisory visits.

3. Study Population

1. The primary population of interest for this follow up assessment is the first round midwifery graduates from 15 Health Science Colleges who were trained through the programme.

2. The secondary population of interest is the women who received care from the midwives in the facility and
3. The third population is Heads of the Health Centres where the midwives are proving the services.

4. Sampling Plan

Using a program evaluation framework, a 5% representative sample of the first graduates were followed up in order to describe to what extent they are delivering quality maternal health care services. The first level of sampling was done using the random sampling method from the first graduates who were deployed in health centres. The second level sampling was a systematic selection of health centres in each region for feasibility reasons. And the third level sampling was by random selection of service seekers who were attending ante natal, family planning and those who came to deliver in the health centres.

III FINDINGS AND DISCUSSIONS

1. Performance of the Accelerated Midwifery Training Programme

Quarterly supervisory visits were utilized to assess the performance of the whole programme. Since the commencement of the training programme, FMOH has been conducting regular joint supportive supervisions in collaboration with UNFPA and Regional Health Bureaus. The supervision focused on the following:

- Implementation of AMP curriculum in the Health Science Colleges
- The Quality of training
- Availability of teaching and learning materials
- Relationship between the Health Science Colleges, Regional Health Bureaus and affiliated health facilities and
- Challenges faced during the implementation of the programme.

At the inception of the programme, a new competency based curriculum was developed by FMOH in collaboration with Jhpiego, UNFPA and WHO. All Heads of the Health Science Colleges and the Regional Health Bureaus had a meeting to review the curriculum and provide input before its implementation.

Implementation of the Curriculum:

At the beginning of the programme, there were challenges in implementing the curriculum due to the modular nature of the curriculum. It requires that students spend more time in the affiliated health facilities to acquire the necessary skills. However, the institutions did not have adequate resources such as vehicles and funds to transport the students to the clinical area and for tutors who are supposed to accompany trainees during practical attachment. The problem was solved by providing additional resources, conducting training during the weekend and during the night and also by assigning trainees for night duty. After sorting out the challenges; all colleges implemented the curriculum.

The Quality of training:

The quality of training varied from college to college with some colleges performing better than others. The quality is influenced by many factors including availability of teaching and learning materials, accessibility of the skill lab, number of midwifery tutors, high staff turnover, the number of deliveries in the affiliated health facilities, the effectiveness of the preceptors and the relationship between the colleges and Bureaus. For example below is a comparison of the performance of two rural Health Science Colleges

Table 2: Example of Training in Dessie and Shashemene H.S.C.

Name of College	Intake 2011	Graduates	Passing Competency Test	Drop outs
Dessie	100	86	58	14
Shashemene	247	245	218	2

The table above shows that although the two training institutions used the same curriculum, their performance was quite different. There were only 2 students dropping out of Shashemane H.S.C while Dessie had 14. During the competency test 67% of students from Dessie passed the competency test while 89% passed for Shashemene H.S.C.

During supervision, it was also found that some tutors always accompanied their students for practical attachment. This was always observed in Pawe H.S.C. The commitment of the instructors also contributed to the quality of training.

UNFPA organized various trainings on Effective Teaching Skills, basic emergency obstetric care and family planning for tutors and engaged international voluntary midwifery tutors to fill tutors gap in the HSCs and improve quality of training.

Availability of teaching and learning materials

The programme enrolled many students ranging from 40 students in Pawe to 247 in Shashemene. Availability of teaching and learning materials also varied from college to college with some colleges such as Nekempte having very few materials while Harari and Arbamirch had plenty of materials. Due to high numbers of students, there was always a challenge to accommodate all students in the demonstration room. The available materials (books, models, simulators, equipment) were not adequate for the large number of students. In this regard, UNFPA Country Office allocated financial resources and procured materials for the demonstration rooms including recent edition of midwifery books and distributed to all HSCs. Direct financial support was also given to the HSCs. FMOH also supported the HSCs with medical equipment and mobilized other materials from other partners such as WHO and Jhpiego.

Figure 2: Demonstration in Arbamirch H.S.C

Relationship between the Health Science Colleges, Regional Health Bureaus and affiliated health facilities

Meetings were conducted between the Health Science Colleges and Regional Health Bureaus for the smooth implementation of the programme. At the beginning of the

Programme, there were delays in transferring funds from Regional Health Bureau to the colleges. In some regions where the HSCs under TVET Commission, these colleges had challenges to run the trainings in harmony with education sector officials due to poor understanding of health context. Joint supervision and the presence of the Regional Health Bureaus assisted to sort out some of the challenges.

There was poor communication between health facilities and HSCs due to lack of prior notifications on the part of HSCs regarding upcoming students' attachment schedules and sometimes students went to facilities without specific objectives. In addition there was persistent demand from the health facilities for payment after assisting and mentoring students during practical training. In some colleges this issue has been sorted out and the staff are assisting free of charge while in others this issue is still a challenge.

Joint supervision also revealed that there were some challenges in the deployment of midwives in Oromia region. Some of the midwives who graduated in April/May 2012 in Oromia have not yet deployed up to now. Discusssions between FMOH and Oromiya Regional Health Bureau might help to sort out this anomally. The HSCs' are now well advanced almost in all aspects and it is vivid that technical and physical capacities have enhanced the quality of training.

2. Performance of the Accelerated Midwifery Training First Batch Graduates:

Midwives who graduated from the first batch of the accelerated Midwifery program were followed in order to assess the performance of the programme and their own performance in the health facilities. 84 midwives, predominantly females (83.3%) from six regions of (Oromiya 50, Amhara 17, Addis Ababa 7, Gambella 3, Somale 3, and Ben Shangul 4) were interviewed. The 84 midwives are providing services in 66 health centres. Majority of the midwives graduated from Fitche (34.5%), Shashemene (15.5%), Bahardar (9.5%), Metu and Menilik HSCs (8.3%) each and Pawi and Arbaminch (4.8%) each. Data collected was analyzed using SPSS version 16.0. The distribution of midwives by region is presented in Figure 3.

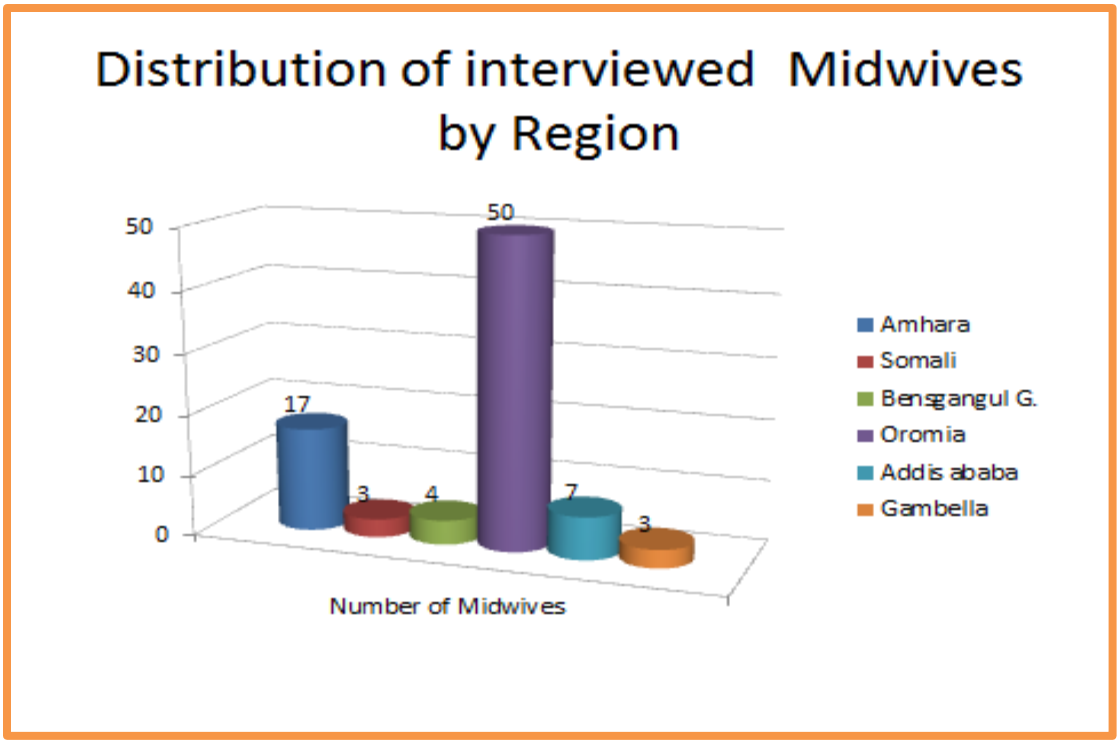

Figure 3: Distribution of Interviewees by Region (Midwives)

Data from the midwives indicate that 87% are providing maternal and neonatal services including family planning. They are working as staff midwife while13% of the midwives are working as coordinators and heads of the MCH Units.

During the follow up assessment, 69% of the midwives indicated that the AMP is a very good programme, competency based and they were well prepared for the job that they are currently doing. 31% indicated that they were somewhat prepared but were not very confident and could have benefitted with more time during training. All graduates mentioned that the time for the training was very short hence they had to work extra hard to accomplish all assigned tasks. Graduates indicated that they had a good training background on normal delivery (68%), antenatal care (63%), active management of third stage of labour (AMTSL (65.5%), Post natal (51.2 %) and family planning (51.2%).

The graduates, 30 % of them mentioned that they did not have any training in basic emergency obstetric and neonatal care (BEmONC). From interviews and available data, it appears that tutors teach different basic emergency obstetric care functions without actually informing the students that they are learning BEmONC. For example all

students learned about vacuum extraction, neonatal resuscitation, how to give oxytocin but they were not informed that these are signal functions of basic emergency obstetric care. Graduates also indicated that they needed more training in HIV/PMTCT (52.4%), essential newborn care (44%) and in management of abortions and abortions related complications (83%).

The global accepted number of deliveries for a student during midwifery training is 40. Information collected shows that those students trained in Addis Ababa managed to get the required numbers of deliveries some even surpassing the required numbers. This is not surprising considering that skilled birth attendance in Addis Ababa is high at 83.9% (EDHS 2011). Oromia also had high numbers of deliveries. However graduates from Somali, Benshangul and Gambela had very low number of deliveries. This may affect the quality of care that they provide. This finding corresponds with the response from the midwives from Benshangul and Gambella as all of them felt that they were not adequately prepared during the training.

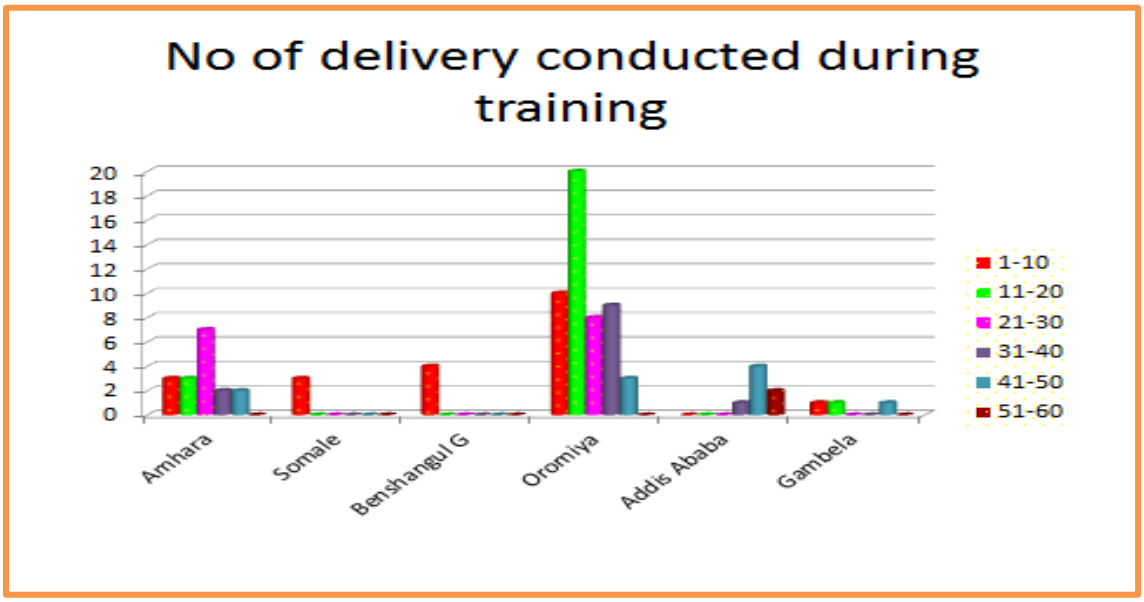

Figure 4: Deliveries conducted during training.

STRENGTHS OF AMP

The Midwives reported that the tutors have very good knowledge and skill in midwifery, the students were given ample time to practice in the skills lab and clinical attachment

was very good. The good relationship between the instructors and students contributed to the increase in knowledge and skills. The previous training which midwives received as nurses gave them an added advantage.

Most midwives expressed that the AMP training is better than the regular one as the programme produces midwives who have both nursing and midwifery. The graduates understood the subject better and easily and the dual profession has increased the level of confidence to work comprehensively in any setting. The curriculum used is also very good, in a modular form and competency based. The midwives reported that the programme will assist to increase the number of midwives in the country and will also contribute to the reduction of maternal mortality ratio.

The Regional Health Bureaus also played a very critical role in ensuring that the graduates are deployed soon after graduation. Data from the graduates indicated that majority of midwives 77(91.7%) were assigned within 3 months after graduation. However, there are still 7 midwives who were deployed between 6-10 months after their graduation. The programme was intended to deploy midwives to remote health centers. Data collected show that all 84 midwives are indeed working in health centres and none is assigned to a hospital hence the objectives of the programme are being met.

WEAKNESS OF AMP

Midwives reported that there were limited opportunities in the education program to practice certain life-saving skills such as MVA and shock management due to time constraints. Long term family planning was not adequately covered and the practice time was very limited. The clinical practice sites were inadequate and also had low case load. Moreover, shortage of midwifery tutors, equipment and supplies in the demonstration room also contributed to the above situation.

Almost all midwives expressed concern on the lack of promotion after the midwifery training. They were trained at level four as nurses and they are still at level four after the one year training and this is causing discontentment. Despite this fact, midwives indicated that this was a very good programme and they would recommend it and encourage other to join.

Finally the graduates suggested the following on the training program:

- Increase duration of training
- Increase the amount of Pocket money during training
- Assign qualified tutors for theory and clinical attachment and preparation for the government administered competency test (COC).
- Increase materials in the demonstration rooms and increase the duration of practical attachment.
- Provide in service training and emphasize on long term family planning, safe abortion and post abortion care and BEmONC.
- Increase hardship/Risk allowances for midwives as majority of them are working in remote and underprivileged rural communities and
- Provide opportunities for further education.

3. Utilization of Maternal and Neonatal Health Services after Deployment of Midwives.

Almost all midwives explained that they are engaged in maternal and neonatal health services. They are providing antenatal care, delivery services, post-natal care, prevention of mother to child transmission (PMTCT) of HIV, family planning and neonatal care. Only 5 % of the midwives are providing immunization, abortion care, running under 5 clinics and working in outpatient department. Data from registers show that midwives are mainly conducting deliveries ante natal, PMTCT and family planning services. The registers show that post natal care is not provided although the midwives reported that it is one of the services that they provide. The table shows the number of services provided by each midwife, the minimum and maximum number conducted during the year under review.

Table 3: Percentage of midwife interventions after deployment at health center: Work with Aster on this table

Variable	Frequency	Percentage
Delivery (n=84 midwives)		
1-10	18	21.4
11-75	59	70.2
76-125	7	8.4
ANC		
0	1	1.2
1-400	65	77.4
>400	18	21.4
PMTCT		
0	7	8.3%
1-400	71	84.5%
>400	6	7.2%
Neonatal Resuscitation		
0	20	23.8
1-10	59	70.2
>10	5	6%
Short term Family Planning		
0	19	22.6
1-500	55	65.5
>500	10	11.9
Long term Family Planning		
0	40	47.5
1-10	25	29.5
11-75	16	19.4
76-156	3	3.6

The above information indicates that midwives are performing various services but mainly deliveries. 23% of midwives visited are not providing family planning services. Those who are providing family planning are mainly providing short term methods.

Data also show that 4,995 deliveries were conducted from May 2011 to April 2012 for the 66 health centres visited compared to 8,042 conducted from May 2012 to April 2013 after deployment. This represents a 61% proportional increase in the number of institutional deliveries.

Table 4: Number of institutional deliveries at Health Center before and after Accelerated Midwives deployment

	Before Acc. midwife deployment(May2011-April2012)	After Acc. midwife deployment(May2012-April2013)	change
Number of delivery conducted	4995	8042	3047(61%)
Maximum	573	988	415

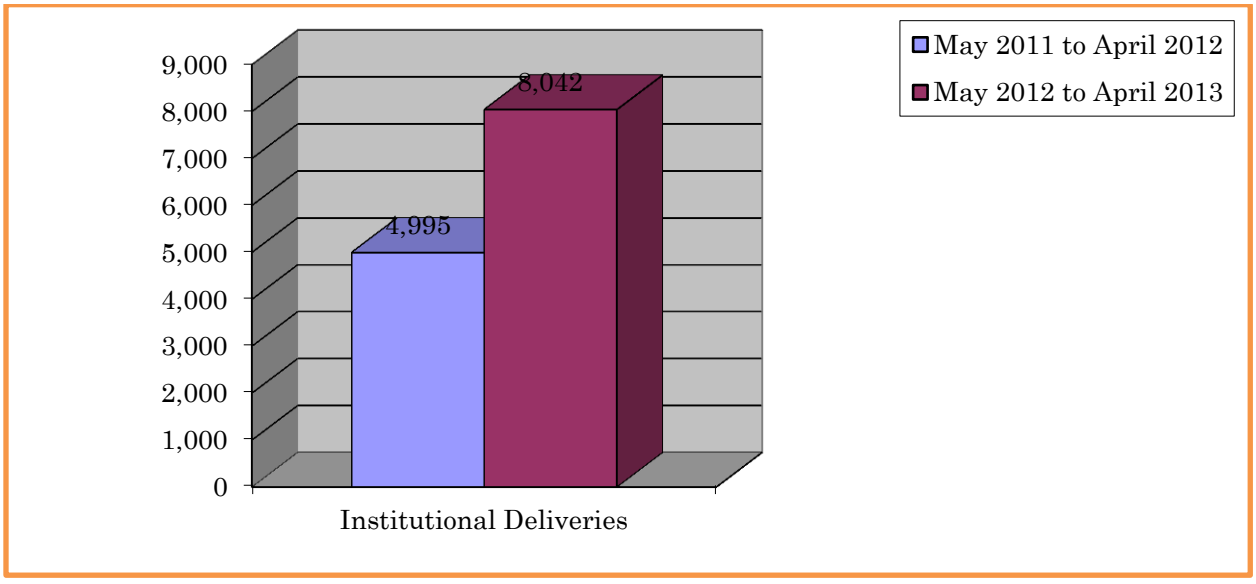

Figure 5: Institutional Deliveries

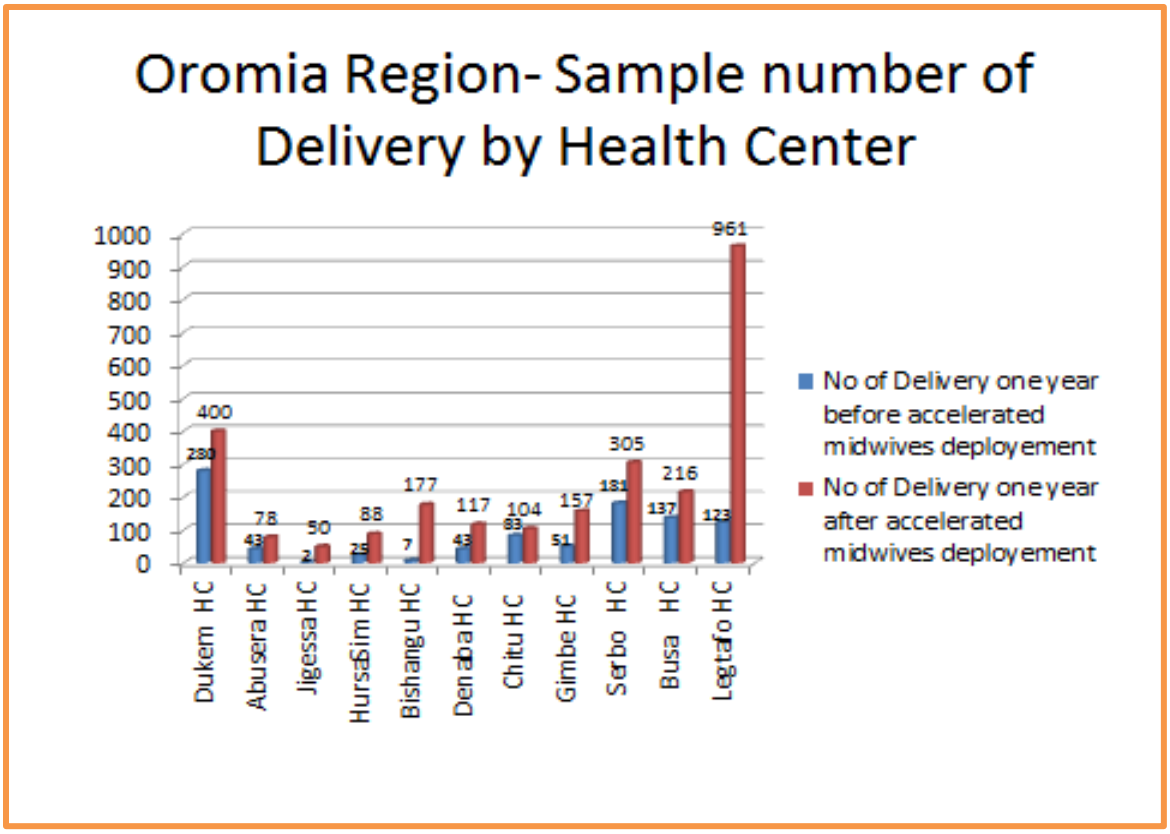

Figure 6: Number of deliveries in Amhara Health Centres

The numbers of deliveries in the above health centres allocated in Amhara region show a remarkable increase after the deployment of midwives. Although this increase cannot be solely attributed to the presence of the midwives as there are also other initiatives in the community such as the presence of the Health Development Army and the strong linkage between the health post and health center including the pregnant women conferences, it is reasonable to assume that the presence of accelerated midwives has to some extent contributed to this success.

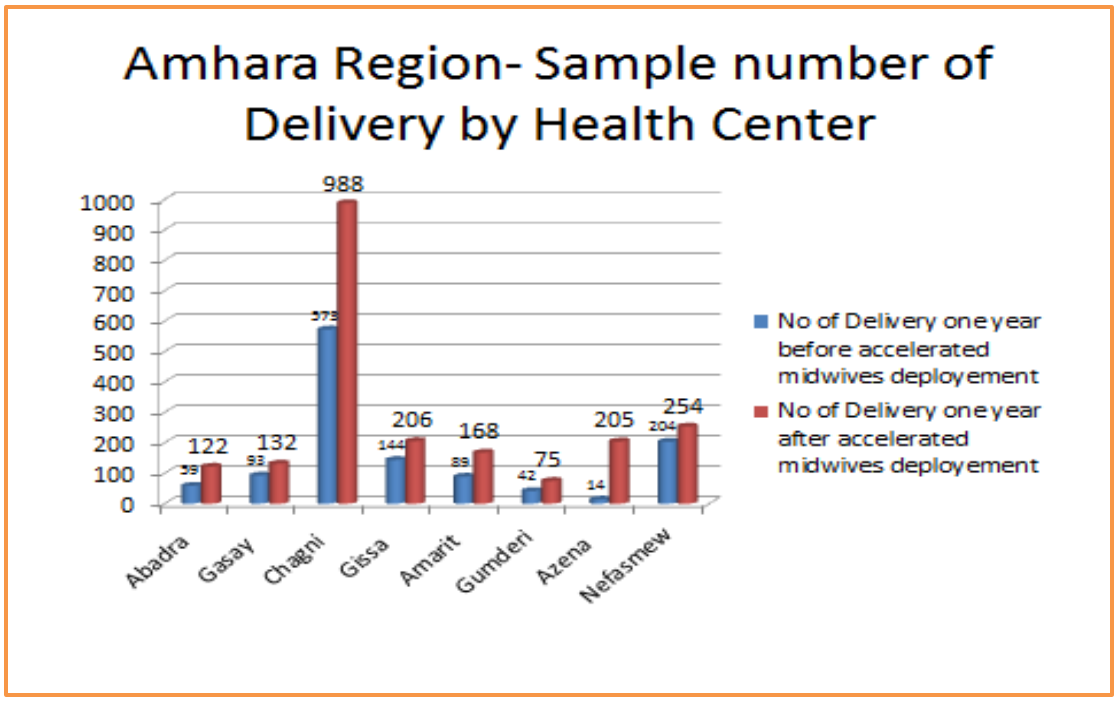

Figure 7: Deliveries in Oromiya Health Centres

In Oromia region, the increase is also similar and has occurred in all health centres. All regions including Gambella experience this increase For example; Gambela health centre had 40 deliveries before deployment and 159 after deployment of midwives.

Habtam Dessie is a male midwife who was trained at Debratabor Health Science College and was assigned to work in Gobgob health centre in February 2013. He is a very active and motivated young man who has been visiting every pregnant woman in the community and encouraging them to come and delivery in the health facility. He is working in the labour ward 24 hours a day as he is always on call. When he arrived at the health centre, the average number of deliveries was 3 per month but he has managed to increase that number to 11 per month. Similarly the average number of antenatal care attendances was 86 per month and has increased to 172 per month. His commitment and community mobilization efforts have been acknowledged by the Health centre Head and staff and they are amazed at his work.

Data shows that midwives trained through the Accelerated midwifery programme are using partograph to monitor labour. 76% of Midwives were using the partograph. However only 43.5 percent of the partographs were correctly and fully completed while 45.2 percent were partially completed and 6.5 percent were wrongly completed. Those midwives who do not use partograph cited shortage of time and lack of copies of partograph as the reason for not using them. All midwives in Somali Region do not use partograph to monitor labour and the main reason is unavailability of the partographs. Midwives in Amhara Region are performing much better than the other regions in terms of monitoring of labour using the partograph.

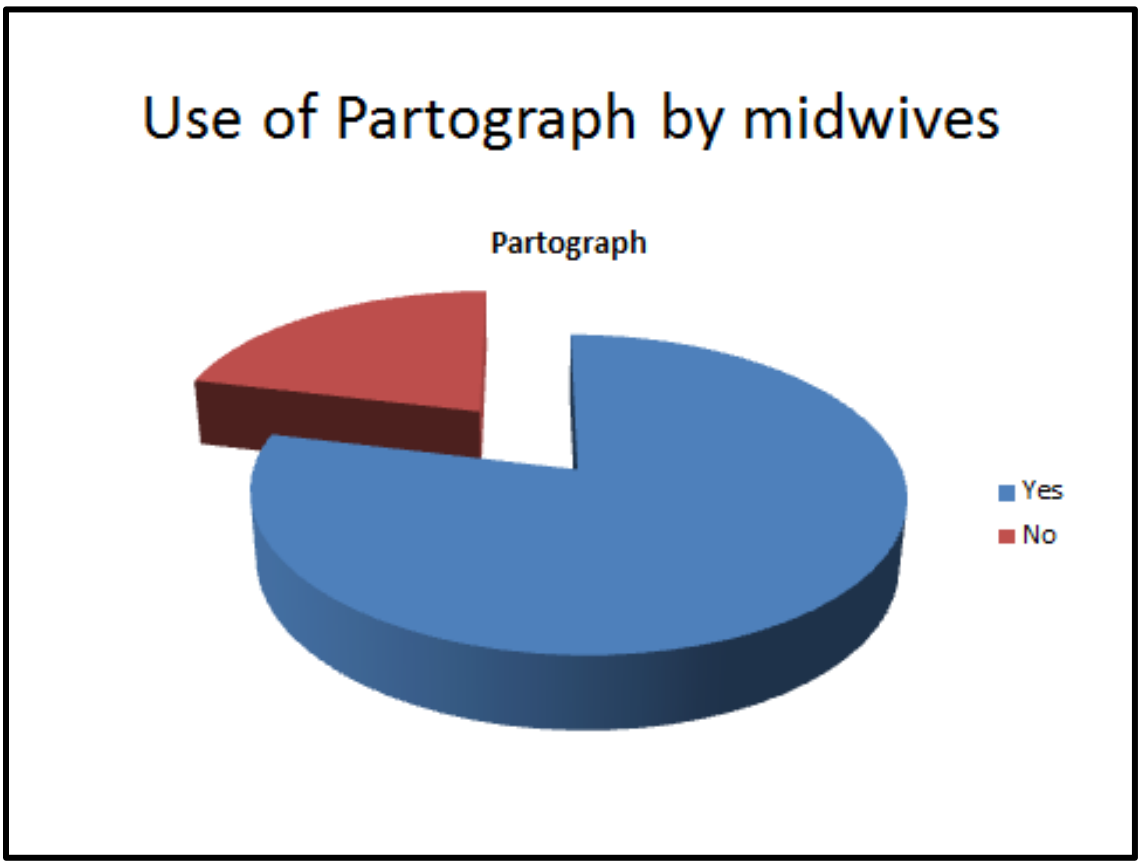

Figure 8: Use of Partograph by Midwives to monitor labour

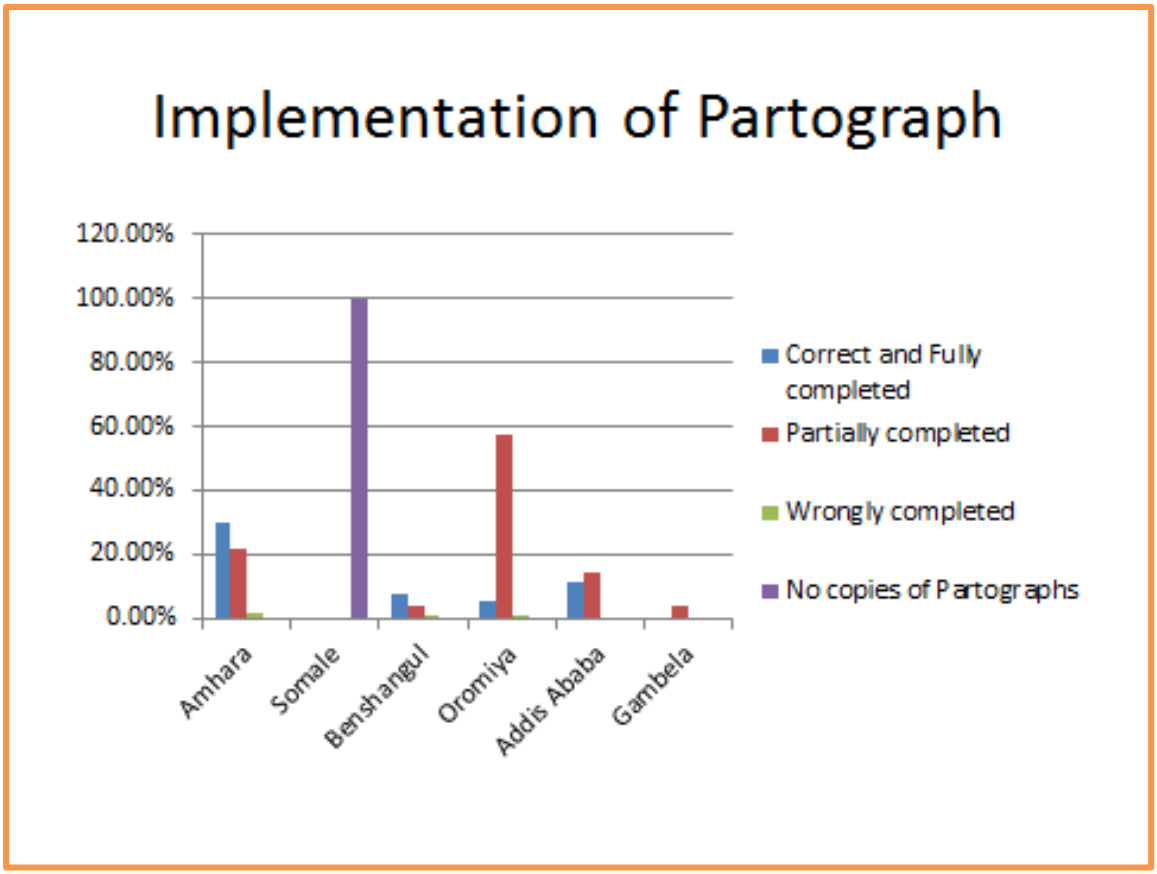

Figure 9: Implantation of Partograph

The Midwives are working in an environment where resources are very scarce. This is affecting the quality of care being provided. The assessment revealed that only 27(32%) said that they had adequate resources to enable them provide all required services. Lack of equipment and supplies was very common in many health facilities. Although midwives were taught on how to do vacuum extraction as one of the functions of basic emergency care; most of the health centres have no vacuum extractors, delivery beds, neonatal resuscitation equipment and infection prevention materials. This has affected their ability to provide quality midwifery care and also to use the skills they have learned.

The midwives also managed complications of labour. The most common complications were PPH, preeclampsia/Eclampsia, prolonged/obstructed labour, retained placenta and APH. Management included identifying the cause of complication, mobilize personnel for help, securing IV line and arrange for referral. The most common drugs prescribed and administered by midwives are oxytocin, antibiotics, iron tablets, pain killers such as

paracetamol and anti-helmentics, therefor management of eclampsia did not include administration of magnesium sulphate as magnesium sulphate is not available in the health centers.

Although midwives request to cover the labour ward for 24 hours some of the woreda health officer do not accept their request as was the case in all visited health centers in Benshangul Gumuz region. During the assessment; the data collectors witnessed a situation where a woman with eclampsia in Gelgel Belese health center was mismanaged by the nurse on call (See story).

This situation shows that the woman was mismanaged and misdiagnosed at the health centre while being attended to by the nurse. Assigning midwives 24 hours in the labour ward can prevent such situations.

Harmful Traditional Birth Practices in Ben Shangul: A challenge to skilled birth attendance.

Glegel Belese health centre is in Ben ShangulGumuz and has a population of 18,000 with 960 expected deliveries per year. Glegel has three midwives who have a very good working relationship with the health extension workers (HEW). The HEWs have telephone numbers of the midwives and call them when there is a complicated case. One of the midwives goes with an ambulance to the village to bring the labouring mother to the facility. In that locality when the pregnant woman reach term she prepares her food and razor blade and go to the nearest forest to deliver alone and she will return home two month after delivery. During her stay in the forest she is visited by her mother or mother in-law who brings food to her. When she returns from the forest after delivery, she stays in a separate house with her baby. In case of complicated delivery, no one will assist her and she will die alone in the forest and later on her community will come to collect her body. HEWs have been conducting community mobilization activities against this practice and promoting skilled birth assistance. This practice is slowly dying down. However during the midwives follow up assessment; an 18 years old prim gravida went to the forest to deliver. HEWs heard about it, traced her in the forest and informed one of the midwives. The Midwife and HEW went to the area with an ambulance; the catchment area is 6 hours' drive from the health centre. The midwife went into the forest and convinced the prim gravida and later her family to come to the health centre for delivery. She came to the HC accompanied by her sister and grandmother. Although, the prim gravida came to the health facility, it was very difficult to interact with her. She refused to be examined and refused all procedures such as checking of contractions, foetal heart, and vaginal examinations. The whole team had to convince her that all procedures were harmless and was good for her and the baby. By the time the assessment team was leaving the HC, she was still in the health centre and had agreed to be examined.

Midwives (85%) reported that they were supervised by the zonal and woreda officers. Some NGOs also carried out supervisory activities based on the programmes that they are running in health centres. Supervision was constructive and was appreciated by most midwives. Therefore, lack of equipment appears to be a much bigger issue for midwives than supervision.

4. Clients Satisfaction with services provided

In order to assess the AMP trainee's contribution to maternal and neonatal health services including family planning, client satisfaction exit interview were conducted in all six regions. Exit interviews focused on antenatal, delivery and family planning services.

ANTENATAL CARE

Exit interviews were conducted on 89 antenatal care women who were found in the five regions of Oromia, Addis Ababa, Somali, Benishangule and Amhara. ANC exit interview were not conducted in Gambella region as they were no clients in all health centres visited.

A. Waiting time

Almost all clients were happy with the time they waited to receive ante natal services with 77% of the clients waiting between 1 to 20 minutes before being seen by the midwife.

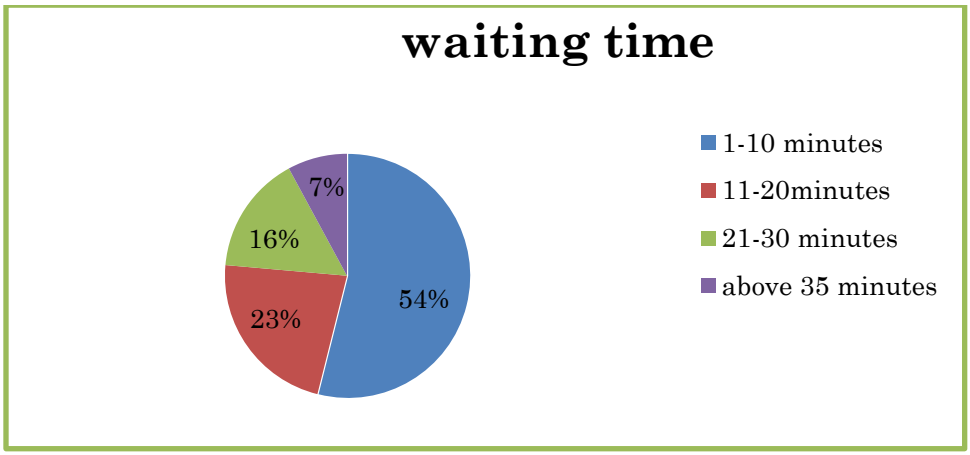

Figure 10: Waiting time for ANC

B. Ante natal service given by the midwife

There are various tasks that the midwife does as she provides care to pregnant women. Some critical tasks such as taking blood pressure, weighting clients, blood and testing urine, PMTCT services and Iron supplementation are considered as a must for any pregnant woman who visit ANC. Women were asked about the service they received from the midwife and their records were also reviewed and the results for each region were as follows:

Table 5: Tasks carried out in ANC

Types of Procedures	*Amhara*	*somali*	*Benshangule*	*oromia*	*A.A*
weighted	*100%*	*90%*	*90%*	*95.8%*	*100%*
BP	*97%*	*100%*	*90%*	*87%*	*100%*
urine	*85%*	*80%*	*90%*	*58.3%*	*100%*
Blood sample	*90%*	*70%*	*90%*	*70.8%*	*100%*
Iron	*90%*	*60%*	*60%*	*87.5%*	*100%*
PMTCT	*100%*	*100%*	*50%*	*91.7%*	*100%*

The midwives in Addis Ababa are providing the services according to the set standards. All women who came to the clinic were weighed, checked blood pressure, their urine and blood were tested, they all got PMTCT counseling and services and received iron supplementation. This is very encouraging. The services are also very good in Amhara region. However, 50 % of the interviewed women in Benshangul were not counseled for PMTCT and 40 % did not get any iron supplementation. There is need to improve the ANC services in Somali, Ben Shangul and Oromiya regions.

C. Client awareness about complication of pregnancy

Midwives are giving information to pregnant women about complications of pregnancy. However, the information is not comprehensive. From the 89 respondents, 87.6% were told about the sign of complications and mentioned the following: Oedema, headache, blurred vision, bleeding and reduced foetal movement. Data collected show that the

common mentioned danger sign is bleeding. However, only 35% of the women were informed about severe headache and only 15 % about blurred vision.

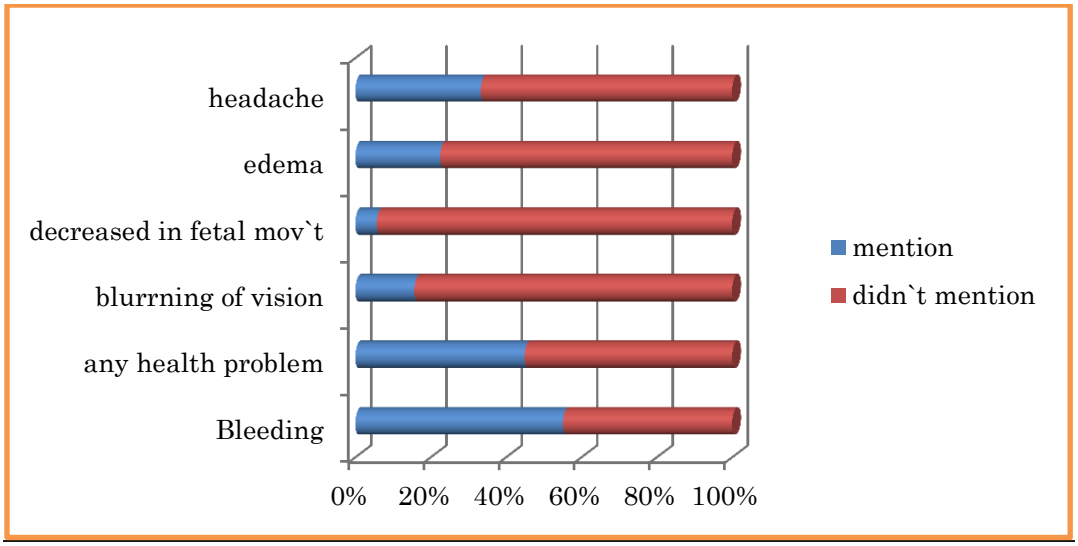

Figure 11: Danger signs mentioned by the Midwife during ANC

D. Client awareness about birth preparedness

Birth preparedness plan is very important for every pregnant woman. The plan is usually prepared together by the woman and the midwife. The plan consists of how the woman should prepare for delivery, how to travel to hospital when labour starts, who will accompany her, resources needed like money and clothes and what will happen in case of emergency which may require surgery or blood transfusion. Data shows that midwives discussed with 64% of the women who came for ante natal care. Although midwives discussed with the women, only few remembered what was discussed. The most mentioned issues that the women remembered are baby clothes and the importance of delivering in health facility and this was mainly mentioned in Benshangul.

Table 6: Birth Preparedness Plan

Region	Baby clothing	Means of transport	Financial readiness	Institutional delivery
Amhara	*40%*	*12.8%*	*17.5%*	*40%*
somali	*40%*	*20%*	*20%*	*30%*
Benishangule	*60%*	*0*	*10%*	*50%*
oromia	*12.5%*	*13%*	*29.2%*	*37.5%*
A,A	*20%*	*20%*	*0*	*0*

E. Satisfaction with care provided by the midwife

Women responded that the care they received was good. 77.5% indicated that the care provided by the midwife was very good while the rest 22.5 % said that the care provision was good. All women were satisfied with the care they received.

F. Sex of the midwife preferred by women across the regions

In most countries, midwifery is a female dominated profession with only very few countries that are training male midwives. There have been concerns that some women may not be comfortable receiving care from a male midwife hence a question was included on the perception of women on receiving care from male midwives. Data shows that preference varies across the region. In Amhara, Addis Ababa and Ben Shangul there is no preference, women are happy to get services from either male or female midwife. The situation is different in Somali and Oromia where women prefer to receive the services from a female midwife. No woman in Somali was willing to be seen by a male midwife. This is mainly due to social cultural factors where Somali is predominantly a Moslem community and the case is similar in some parts of Oromia.

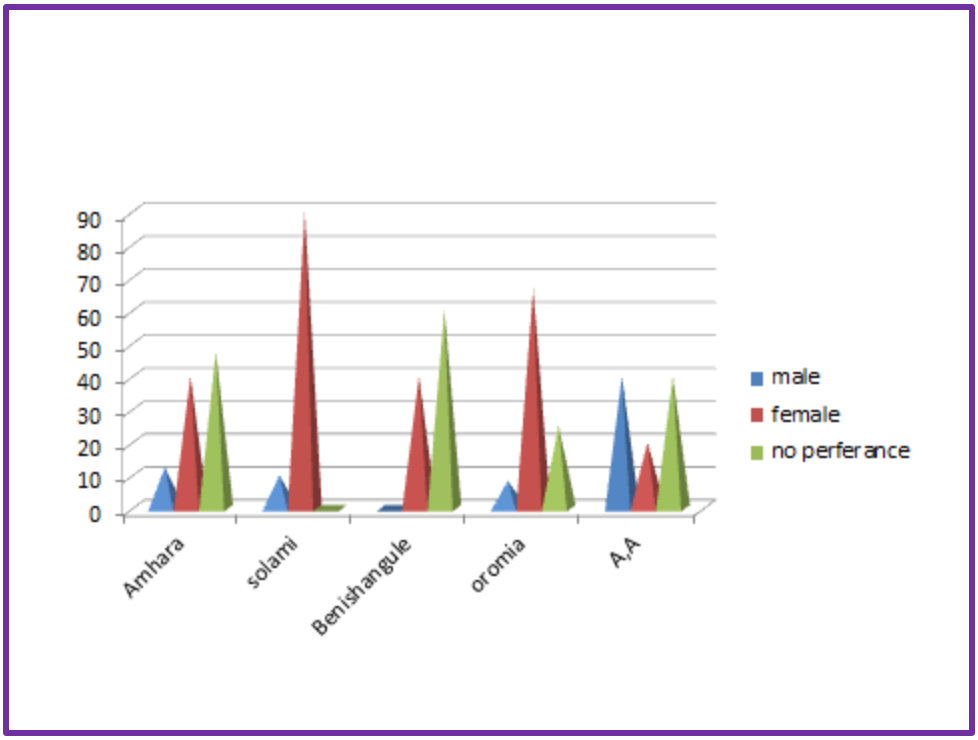

Figure 12: Women Preference on the sex of midwife

DELIVERY SERVICE

Exit interviews were conducted for 37 mothers who were delivered by the AMP midwives within the five regions (oromia, A.A, Somali Benishangule and Amhara). No exit interview was conducted in Gambella region as there were no women who came for delivery in the health centres during the time of the follow up. The data was analyzed and summarized as follow.

A. Basic service given for the mothers during labor.

The clients were asked about the basic care that a midwife is expected to provide for a woman in labour. Women responded that they received the following care. 89% of women were counseled and given PMTCT services, all women got responses when they asked questions to the midwife. However, it is a concern that 41% of women did not have their temperature checked, 8% did not have their blood pressure checked and fetal heart monitored while 19% were not comfortable with the delivery position (Lithotomy) that is utilized in health facilities.

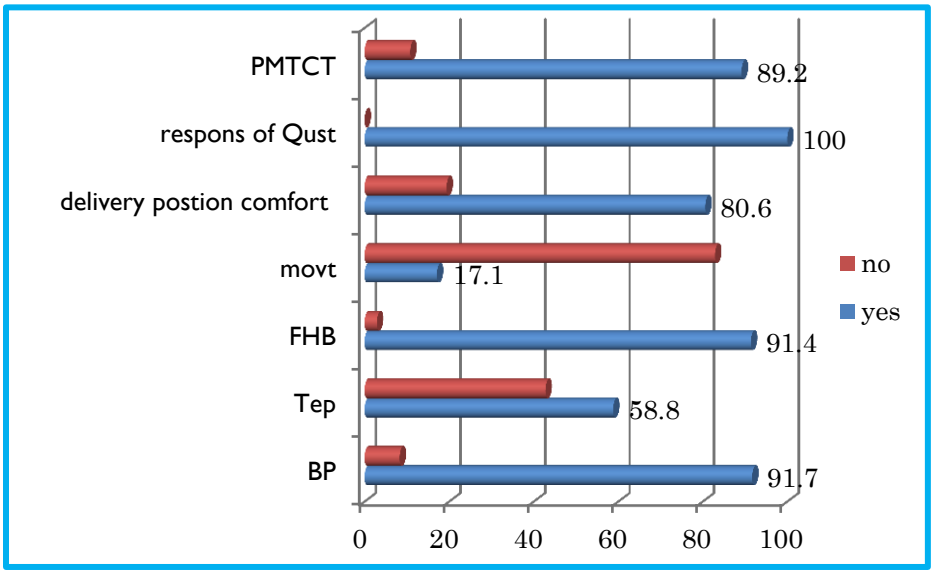

Figure 13: Type of Procedure done

Women were also asked about the post natal counseling before discharge from health centre.

Table 7: Post Natal Counseling before discharge

	Amhara	Somali	Ben Shangul	Oromiya	Addis Ababa
Family Planning	95.9%	50%	90%	100%	100%
Breast feeding	91.3%	100%	100%	100%	100%
Immunization	91.3%	100%	100%	100%	100%
Post-Partum Infection	69.6%	50%	80%	15%	0%
Neonatal Problems	65.2%	50%	25%	65%	0%

The data shows that although graduates from Addis Ababa provided the best antenatal care they do not provide essential post natal information. They do not give information about post-partum complications such as fever, bleeding or post-partum pre/eclampsia.

The above information suggests that there is need to emphasize more on post natal counseling as midwives in all regions focus on breast feeding and immunization. Supervisory visits and refresher courses can sort out this problem.

B. Preference of the sex of the midwife

Most delivering mothers Amhara, Somali and Oromia would like to be cared for by female midwives as shown on Figure 14 below. However in Addis Ababa women did not mind. All women in Addis Ababa did not mind the sex of the midwife.

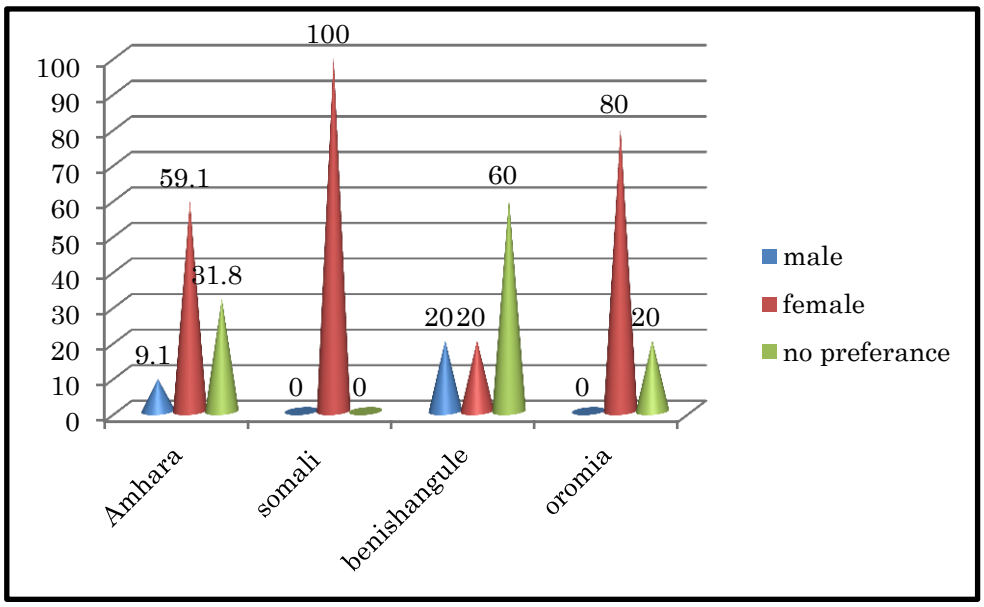

Figure 14: Preference between male and female midwives for Delivery

C. The attitude of the midwife while providing care to women in labour

No woman mentioned that she was treated badly at the health facility. 75.7% of the women mentioned that the attitude of the midwife was very good while the rest said that it was good.

FAMILY PLANNING

Exit interviews were conducted on 39 family planning service seekers in the four regions of (oromia, Amhara, A.A and Benishangule). No family planning clients were found in Gambella and Somali regions.

A. Counseling about family planning methods

It is a requirement that all clients who come for the first time to get family planning serviced should be counseled on all available methods in order to enable the client make informed decisions. Data indicates that only midwives in Addis Ababa region provided counseling on all available methods. In the other regions clients chose a method and information was provided for the chosen method.

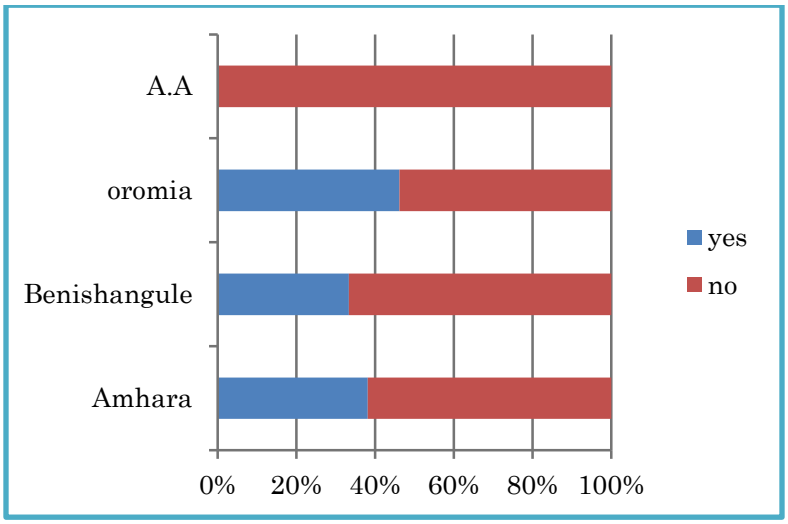

Figure 15: Counseling on all family planning method

B. Waiting time for family planning associated with client satisfaction

Information shows that clients are attended within the acceptable waiting time. Only two clients thought that the waiting time was two long.

Table 8: Client Satisfaction with Waiting Time

Waiting time	Client Satisfaction with waiting Time		Total
	Yes	*No*	
1-10 minutes	*22*	*1*	*23*
11-20minutes	*9*	*0*	*9*
21-30 minutes	*4*	*1*	*5*
Above 35	*2*	*0*	*2*
Total	*37*	*2*	*39*

C. Chance given to choose family planning method

The choice of family planning method is very important as it may ensure continued use of the chosen method. 35 out of the 39 were given chance to choose family planning method of their choice and they got the method that they wanted. However 4 clients were not given any chance to choose and did not get a method of their choice. 92.2% of the clients thought the service was very good and would encourage their friends to access the services provided by the midwife while 5.3% thought the service was not good and can not encourage friends to access it while the rest 2.5 did not give their opinion. From the above information it shows that the performance of the midwives is quite good.

D. Time spent with the midwife to get family planning method

Information was also collected on time spent with the midwife in each region. Data shows that there are variation on the duration of time that the client spends with the midwife. Clients in Addis Ababa are spending more time with the midwives than in the other regions.In Amhara 79% of clients spends less than 10 minutes which is very short for the client to be given all information.

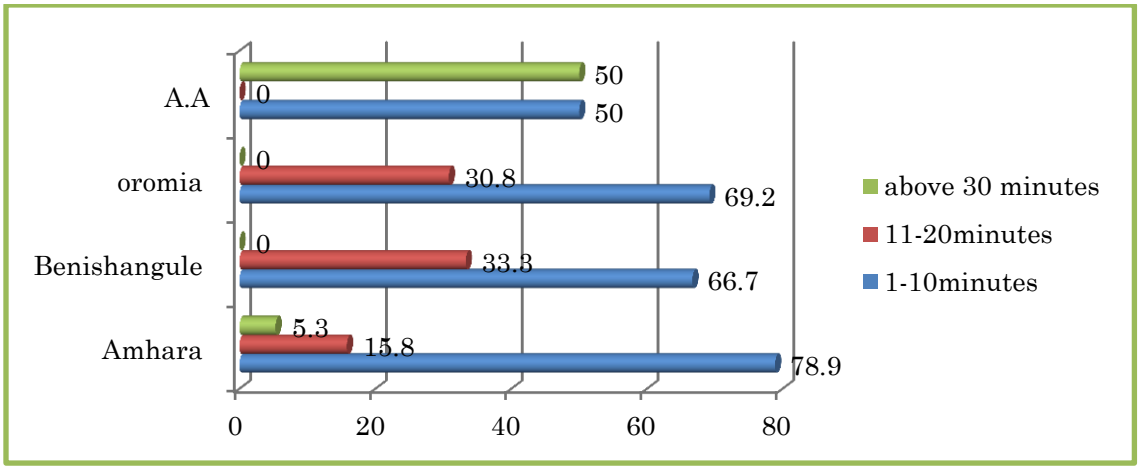

Figure 16: Time spent with midwife in family planning clinic

E. Attitude towards the clients associated with the sex of service provider

Clients were asked to give information on the attitude of the midwife and to give their opinion on the quality of care provided by both male and female midwives. Data shows that the attitude of female midwives is better than that of male midwives. Almost 56% of

the female midwives were rated as very good compared to 46% of male midwives. 18% of male midwives were rated fair as compared to 4 % of female midwives.

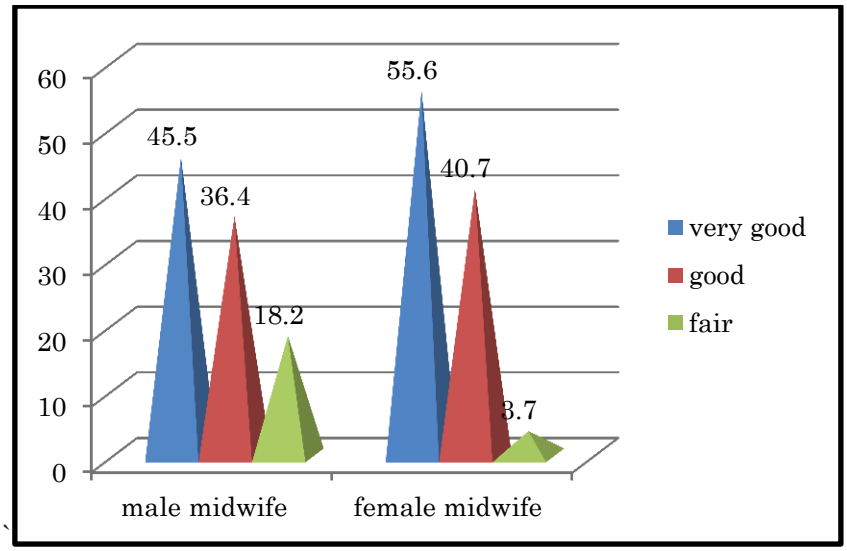

Figure 17: Cients perception towards the Attitude of Male and Female Midwives

Accelerated midwives contribute to provision of family planning

Buya health centre is in Amhara Region, Awi Zone, AnkasheWoreda. The health centre was established in 2011 and has neither water nor electricity. The facility has one accelerated midwife Alemu, assigned in February 2012 right after graduation.

Photo: Midwife inserting implanon

Alemitu Sheferaw is 15 years old, married at the age of 14 years. She came to Buya health centre for family planning and chose injectable methods. Later on Alemitu decided to change the method to implanon. In Buya health center the accelerated midwife is the only health professional able to provide long term family planning including insertion of IUCD. He got the knowledge and the skill in Bahardar HSC where he was trained as a midwife. The head of the health center explained that " Before the accelerated midwife was assigned to the health center, we referred all women who wanted long term family planning to the nearest health center) which is 12KM away. We are lucky in getting him. Now the clients have a chance to get the method of their choice and as a result the uptake for family planning has increased. In fact the uptake of all services: Antenatal and Delivery have increased".

IV MANAGEMENT RESPONSE

This section of the report is an account provided by selected Heads of Health Center who gave information regarding the performance of the midwives who have been providing services for one year. Information also includes quality of the pre-service training. 64 HC heads were interviewed using structured questionnaire designed to supplement information gathered from midwives and balance the reliability of data collected from the primary targets. Data was analyzed using both qualitative and quantitative approaches.

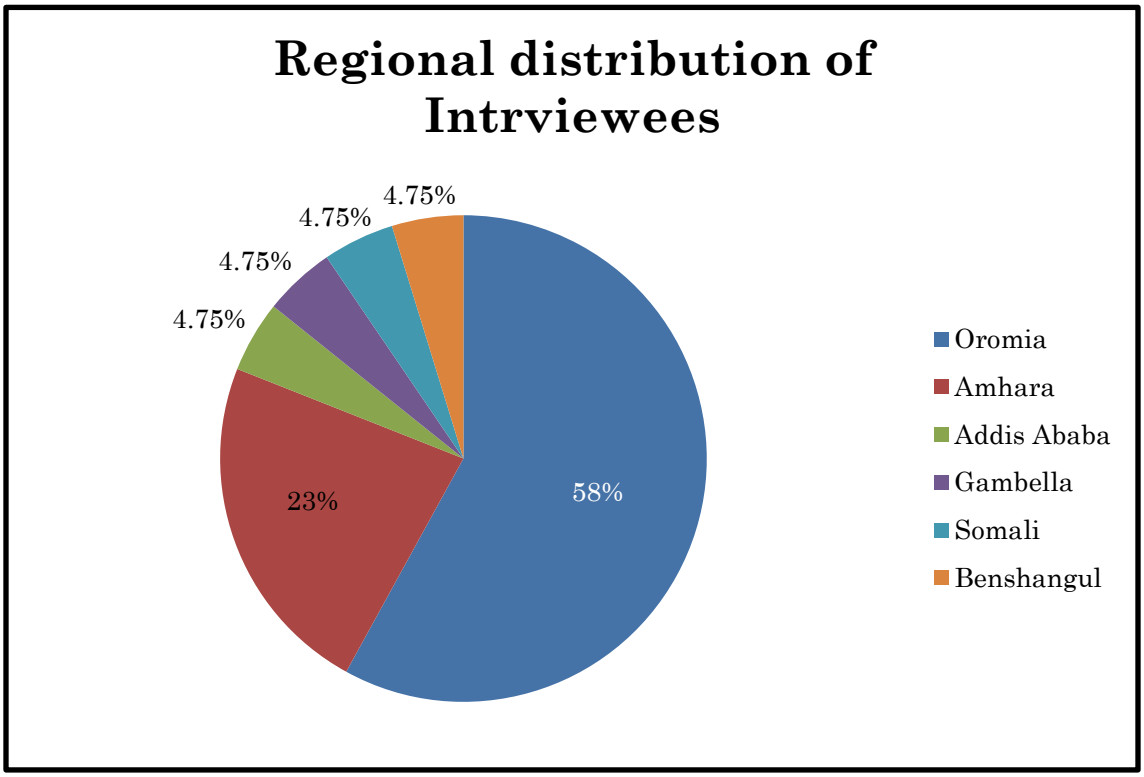

Figure 18: Regional Distribution of Interviewees

The findings and discussions are presented below.

1. Deployment

The Heads of the Health Centres reported that the duration of deployment varied from region to region. Some midwives were deployed immediately after graduation while others waited for a long time before they were assigned. The responses are categorized into three broad ranges. The categories are a period for the midwives those served for one

year and above, those served above six months but less than a year and those served less than six months based on the responses of HC heads.

Table 9: Duration of Services by Midwives

Regions	≥ one year	≥ 6 months but < a year	< 6 months	Total
Oromia	20	13	4	37
Amhara	12	-	3	15
Addis Ababa	2	-	1	3
Gambella	3	-	-	3
Somali	2	-	1	3
Benshangul	3	-	-	3
Grand total	42	13	9	64

2. Increase in Service Seekers

There has been an increase in the number of clients seeking services in the health centres. Almost all the respondents have confirmed a significant increase of service users of maternal and newborn care. From the total of 64 respondents only four said that they had not observed such changes.

3. Types of Services Rendered

In reference to types of maternal and newborn health care being rendered by the midwives, the Heads of the Health Centres mentioned several types of services such as antenatal care normal delivery, short term family planning, PMTCT, abortion care both (PAC, CAC), and Long Term FP.

4. Competency in Providing MNC Services including FP/PMTCT

The Health Center Heads were asked about the competency level of midwives in proving maternal and neonatal health services, FP and PMTCT. From the total of HC heads interviewed 66% confirmed that the midwives are competent whereas the remaining 34% responded no. Those who said no indicated that the midwives need

more training in long term family planning, especially insertion of implanon and IUCD. This was mentioned by 15 Heads of Health centers. 5 indicated that there is need for more training in comprehensive abortion care including use of MVA while another 5 mentioned the need for more training in PMTCT.

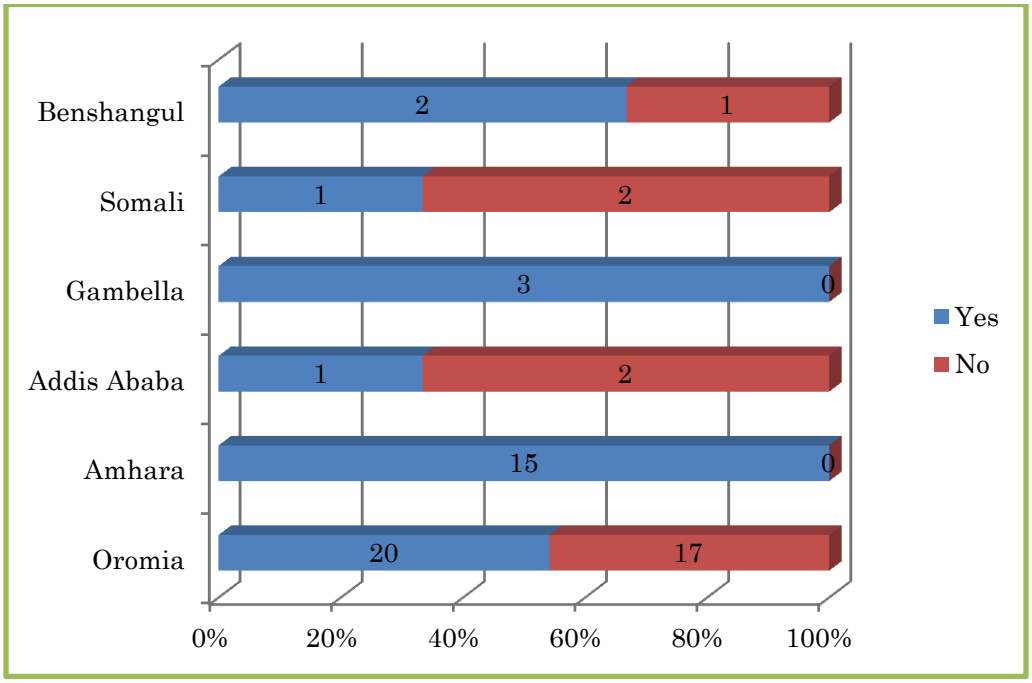

Figure 20: Perception of Health Centre Heads on Competency of Midwives

5. Quality of Pre-service Training

Regarding the quality of pre-service training initiative, nearly all the respondents (61 HC Head, 95%) agreed that the accelerated midwives training curriculum is the best and the most effective way of training midwives. The programme is much better than the generic diploma level. However the following limitations were cited: shortage of training duration, inadequate practical attachment period, lack of coaching by tutor during trainees' placement at health facilities.

6. Challenges in involving Midwives on 24/7 duty.

Twenty four hour coverage of the labour ward by midwifes ensures that women will receive care and complications will be identified early before they become life

threatening. Data show that 65% of HC Heads are assigning midwives on 24/7 duty services however some of these midwives are working without duty payments or partial payments which may also demotivate them. The remaining 35% of the H.C Heads in four regions are not assigning midwives on 24/7 duty coverage. According to the respondents, their major reasons are for fair share of duty payments among other cadres, shortage/lack of budget, shortage of midwives, having only one midwife and security reason for example an incidence of sexual violence to a provider while on duty.

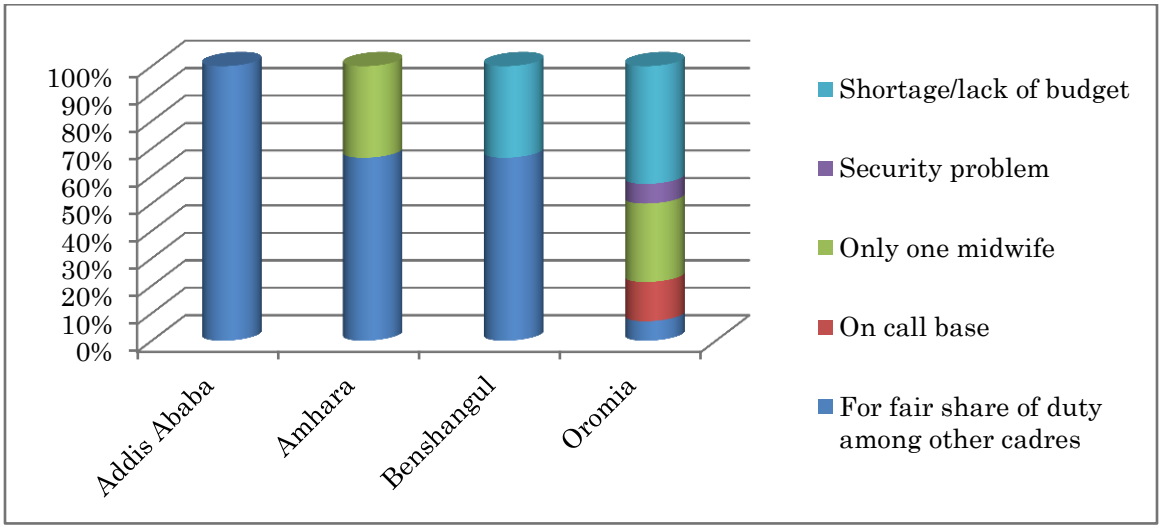

Figure 19: Problems of Assigning Midwives 24 hours in labour ward

7. Level of Collaboration and Integration with the Health Extension Workers and the Community

Since one of the focus areas of the accelerated midwifery training curriculum is community bases approach, the health center heads were interviewed regarding the level of collaboration and integration with the health extension workers. According to the information provided; there are three levels of collaboration:

A. **Strong collaboration** involving those HCs where they are currently conducting community mobilization activities on regular schedule, have

uninterrupted referral linkages and a feedback mechanism and also undertaking supervisions.

B. **Intermediate collaboration** involving those HCs where they conduct monthly meetings for strengthening referral linkage between the health posts in the community and the health centres.

C. **Weak collaboration** where there is no communications between the HEWs and the midwives or the communication is spontaneous and abrupt.

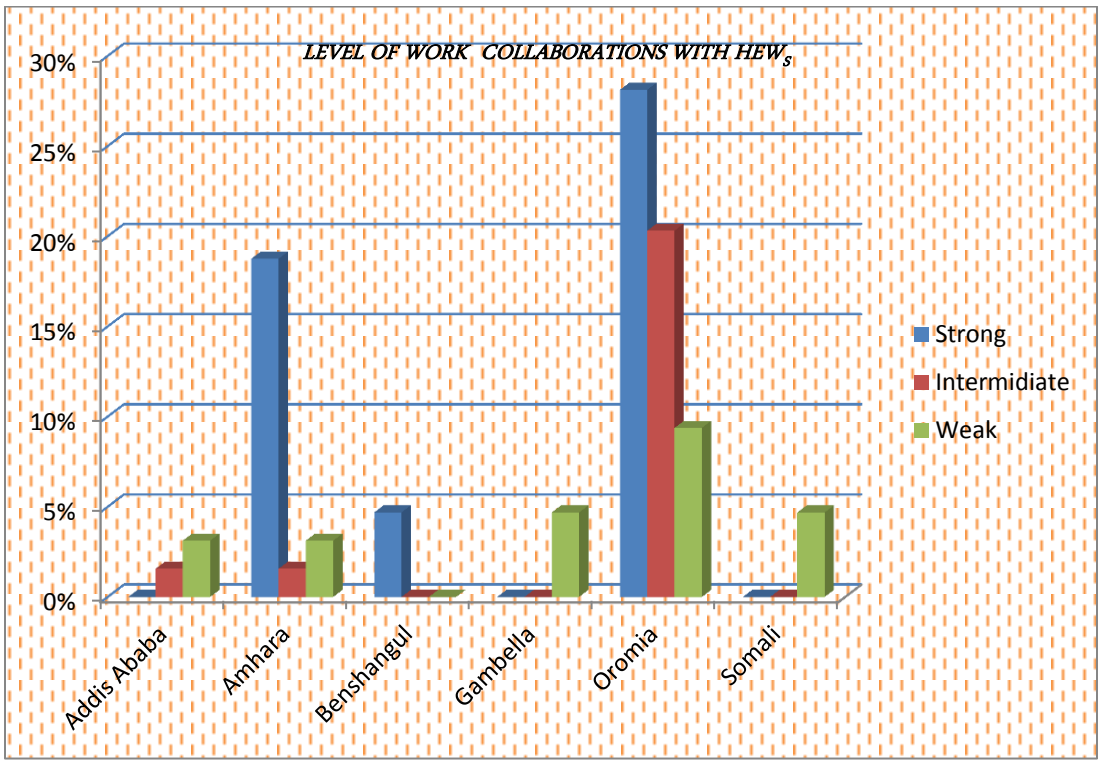

Figure 20: Strength of Work Collaboration with HEWs by Region

V KEY LESSONS LEARNT

A. The mainstay of the health service is an effective referral system from health post to health center and all levels of the health care delivery system. A very positive finding is the strong linkage between the health center and the health posts. In fifty percent of the health centers that were visited there is an active involvement of the accelerated midwives in the community.
B. Failure to assign midwives 24 hours in the delivery room has greatly affected the quality of service given and put the client's safety at risk (as observed in Gelgelbelese HC).
C. For midwives to perform very well in the health centres; comprehensive skills and competencies are required especially for basic emergency obstetric care, post abortion care, long term family planning and PMTCT. Paying duty payment and hardship allowance on time, and provision of equipment and supplies to the health centres will improve the quality of care and motivate the midwives to work harder.
D. There is a strong enthusiasm for the profession and great willingness to provide quality services among the midwives. This was obvious in all assessed midwives. This enthusiasm can easily diminish if midwives are not given incentives to stay and work in the rural areas. All midwives mentioned the need to pay duty and risk allowances on time and provision of refresher courses.
E. The level of engagement of midwives varies from region to region. Some midwives work closely with health extension workers and mobilizing communities for skilled birth attendance while some midwives are not involved at all.

VI CONCLUSIONS

This report shows that the Accelerated Midwifery Training Programme is a very good programme that is appreciated by both the graduates and the Head of Health centres. The midwives reported that the training was hands on and competency based. However all graduates indicated that they needed more time during the training to enable them to cover all courses adequately. Both the graduates and Heads of health centres reported that more training is needed in Post abortion care and comprehensive abortion care, long term family planning and PMTCT. More clinical practice is also needed during training as 24% of the graduates conducted less than 10 deliveries during their training period. All midwives emphasized on the need to increase the clinical practice.

The Programme was designed to deploy 2 midwives in the health centres. The programme is achieving its objectives as 100% of the midwives visited were working in health centres and 87% of them providing maternal and neonatal health services including family planning. The Regional Health Bureaus also played a very critical role in ensuring that the graduates are deployed soon after graduation. Data from the graduates indicated that majority of midwives 77(91.7%) were assigned within 3 months after graduation.

There has been a remarkable increase in the numbers of deliveries in the health centres after the deployment of midwives. Although this increase cannot be solely attributed to the presence of the midwives as there are also other initiatives in the community such as the presence of the Health Development Army and the strong linkage between the health post and health center including the pregnant women conferences, it is reasonable to assume that the presence of accelerated midwives has contributed to this success.

The Quality of care provided by the midwives varies from region to region. Although over 76% of midwives are using partographs to monitor labour, only 43% of the partographs were correctly completed. This is an area which may require refresher course to ensure that midwives are practicing according to global standards. Quality of care is also affected by lack of equipment and supplies such as vacuum extractors, delivery beds

and in some cases partographs as was the case in Somali region. The foetal heart beat for 9% of the women was not checked and 41% did not have their temperatures checked. This is an area of concern that needs to be addressed through supervision and follow up. The quality of antenatal care is good especially in Addis Ababa and Amhara region. However most midwives are not discussing dangerous signs in pregnancy with clients and also are not developing the birth preparedness plan with clients as required.

The quality of family planning services provided by the midwives is quite good. Over 90 % of the clients were given chance to choose a method of their choice and got the method that they wanted. All clients were satisfied with the services they received in the health centres. It is worth mentioning that 23% of the midwives are not providing family planning services at all despite being trained as service providers

Clients in Somali and Oromiya regions prefer to be attended and cared for by a female midwife. There was no preference in the other regions. It is however important to note that clients indicated that the attitude of female midwives was much better than that of their male counterparts.

VII RECOMMENDATIONS

1. All midwives reported that the training was very good but not adequate and the time for practical training was limited. It is being recommended that FMOH should increse the duration of training to 18 months that is if they decide to continue to train more midwives using this appraoch.
2. For the Midwives to be very effective, the Regional Health Bureaus should provide refresher training in the following areas: Post abortion care and comprehensive abortion care, basic emergency obstetric care, long term family planning and PMTCT.
3. Some Health Science Colleges did not have adequate equipment in the skills lab. It is therefore being recommended that all training institutions should have all equipment and models needed to train midwives. FMOH and partners to provide equipment and models where there are gaps.
4. Establish a performance based incentive system to reward best practices, both for faculty and practicing midwives to motivate midwives and to improve quality of care.
5. Provide health centers with necessary equipment and supplies such as delivery coach, examination light, vacuum extractors, infection prevention materials, drugs such as magnesium sulphate and partographs.
6. Qualified tutors who have been working in the health facilities for two years should be assigned to teach students. Instructors should also accompany the students during clinical practice.
7. Assign midwives to work in the labour ward. The labour ward should have 24 hour coverage with a skilled midwife who will be able to monitor labour and identify complications before they become life threatening.
8. All midwives should be involved in community mobilization and work closely with the Health Extension Workers to motivate women to deliver in the health facility
9. Most midwives mentioned the user fee as the barrier to the use of health facility for delivery. This came out especially in those health centres where they have monthly meetings with the community. Although FMOH issued a circular for free services for

maternal and new born care, this is not practiced in most facilities. It is being recommended that FMOH and RHB should enforce the fee exemption policy.

10. There is need to revise the amount of pocket money for students and the salary for the Accelerated midwives should be higher than that of the level IV Diploma (Recommendation from Midwives)
11. Graduates being sent to health centres should be paired with a senior midwife for mentorship and enable them gain confidence.
12. Provide computers to health centre to allow electronic data collection.

ANNEX 1: QUESTIONNAIRE FOR MIDWIVES

Date:

Interviewer:

Name:

Health facility:

SECTION I- Professional

1. Position at this health facility_____
2. Which training institution did you attend? .....
3. When did you graduate from your training institution?
   ……
4. When were you posted to this health facility?
   ……..
5. Please give brief description of your job (hours/week, on average number of patients you see in one day)

_____
_____
_____
_____
_____

6. Do you provide the following services? Tick off which is appropriate.

- □ Antenatal care
- □ Conducting Normal Delivery
- □ Postnatal care
- □ Family-planning (FP) services, including emergency contraception
- □ Counseling (infertility, sexuality)
- □ HIV/PMTCT
- □ Essential Newborn Care

- BEmONC (be specific of Seven Signal functions)

  _____

  _____

  _____

  _____

- Abortion, post abortion complications and Management
- Nutrition
- Other_____

7. How many interventions have you done since deployment?

Normal Deliveries	
Antenatal	
Counseling for PMTCT	
Episiotomy/suture (check cards)	
Vacuum Extraction	
Breech Delivery	
Active Management of Third Stage of Labour	
Manual Removal of Placenta	
Manual Vacuum Aspiration	
Setting IV lines	
Managing a Pre/eclampsia with magnesium sulphate	
Neonatal Resuscitation	
Long term Family planning (Please mention them)[1]	
Short term Family planning (Please mention them)	

[1] Type and number of long term family planning method

8. Have you managed any complications of pregnancy (During pregnancy, labour and Delivery? Yes ☐ No ☐

10. If yes which ones?

_____
_____
_____
_____
_____

11. How did you manage the complications? Explain

_____
_____
_____
_____

12. Do you normally use a partograph? Yes ☐ No ☐

(Look at a sample of five partographs and make comments)

- Correct and Fully completed
- Partially completed
- Wrongly completed
- No copies of Partographs

12 b: If no partographs used ask why

_____
_____
_____

12 c: Do you prescribe and administer drugs? Yes ☐ No ☐

If yes, Specify

_____
_____

13. How many deliveries conducted from May 2011 to April 2012?

_____

14. How many deliveries conducted from May 2012 to April 2013?

_____

15. STRENGTHS AND WEAKNESSES OF THE AMP

15.1. Briefly describe the strengths of the AMP: i.e., the advantages it offers.

_____
_____
_____
_____
_____

15.2. What are the weaknesses of the AMP, and the risks it entails?

_____
_____
_____
_____
_____

SECTION II- Educational

16. For each area, please tell me whether the training you received was excellent, good, fair or poor.

(The first area is taking care of pregnant women such as antenatal care, postnatal care…Would you say your training was…..?

	excellent	good	fair	poor	Not offered	Don't know
Antenatal care	5	4	3	2	1	d
Postnatal care	5	4	3	2	1	d
Conducting Normal delivery	5	4	3	2	1	d
Active Management of Third Stage of Labour	5	4	3	2	1	d

Family-planning services, including emergency contraception	5	4	3	2	1	d
Counseling (infertility, sexuality)	5	4	3	2	1	d
HIV/PMTCT	5	4	3	2	1	d
Essential new born Care	5	4	3	2	1	d
BEmONC	5	4	3	2	1	d
Abortion, post abortion complications and Management	5	4	3	2	1	d
Others (Specify)						
	5	4	3	2	1	d
	5	4	3	2	1	d
	5	4	3	2	1	d
	5	4	3	2	1	d
	5	4	3	2	1	d

17- Generally do you feel the AMP prepared you well to manage pregnant women? Did you feel …..

Well prepared……4

Somewhat prepared …… 3

Not at all prepared…….2

Don't know……..1

18- Were there any topics that were not adequately covered during your training?

Yes……1

No……2

Don't know……d

If yes which one (specify)

_____

_____

_____

If no skip question number 19

19- Which topics do you feel should have been more covered?

- ☐ Antenatal care
- ☐ Conducting Normal Delivery
- ☐ Postnatal care
- ☐ Family-planning (FP) services, including emergency contraception
- ☐ Counseling (infertility, sexuality)
- ☐ HIV/PMTCT
- ☐ Essential Newborn Care
- ☐ BEmONC (be specific)
- ☐ Abortion, post abortion complications and Management
- ☐ Complications of Labor
- ☐ Complications of Postpartum period
- ☐ Nutrition
- ☐ Other (specify) _____

20. How many Deliveries did you conduct when you were a student?

_____

21. Would you encourage a friend to join the AMP? Yes ☐ No ☐

If no, why?

_____

_____

_____

22. Do you have adequate resources to enable you function as a midwife?
    Yes ☐ No ☐
    If no what are missing?

    _____

    _____

    _____

23. Since your deployment, have you ever been supervised? Yes ☐ No ☐

24. What changes/recommendations would you like to make?

    _____

    _____

    _____

Thank you for taking your time to respond to these questions

ANNEX 2: QUESTIONNAIRE FOR EXIT INTERVIEWS, ANC

Interview client who received health service from the AMP graduate only

Name of Interviewer……

Date…….

Name of Health Facility ……

1. What service did you come for?

……

2. Was this your first time to receive the service in this health facility?

Yes ☐ No ☐

Women's Satisfaction with ANC Service	
Is the antenatal visit time convenient for you?	yes.....1 no.....2 don't know...3
How long did you wait before being seen by midwife?	_____

Are you happy with the time you waited?	Yes No
Were you weighed? Was your blood pressure measured? Did you give a urine sample? Did you give a blood sample? Were you given iron supplements Did you get PMTCT service?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
During (any of) your antenatal care visit(s), were you told about the signs of pregnancy complications? If yes, mention some _____ _____	Yes ☐ No ☐
Did you get enough time with the midwife during your checkups?	Yes ☐ No ☐ I am not sure ☐
How do you see the care provided by the midwife?	very good.....1 good.....2 fair.....3 bad.....4 very bad.....5

If you had choice, would you prefer to be seen by: (Read out the options)	1.A male provider ☐ 2.A female provider ☐ 3..No preference ☐

ANNEX 3: QUESTIONNAIRE FOR EXIT INTERVIES: DELIVERY

Interview client who received health service from the AMP graduate only

Name of Interviewer ……Date…….

Name of Health Facility……

1. What service did you come for?

……

2. Was this your first time to receive the service in this health facility?

Yes ☐ No ☐

Women's Satisfaction with Delivery service	
For how many hours were you in labour in the health facility?	_____
When you came to the health centre, were you seen by the midwife immediately?	Yes ☐ No ☐
Was your blood pressure checked? And how many times Was the temperature checked? Was the heart beat of the baby checked, How many times? Did the midwife encourage you to walk around during labour? Were you comfortable with delivery position? Did the midwife respond to your questions? Did you get PMTCT service?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Did the midwife counsel you on family planning?	Yes ☐ No ☐
Did the midwife counsel you on breast feeding?	Yes ☐ No ☐
Did the midwife counsel you on child immunization?	Yes ☐ No ☐
Were you given any instructions on signs of post partum infections and PPH	Yes ☐ No ☐
How do you see care provided by the midwife?	very good.....1 good.....2 fair.....3 bad.....4

	very bad.....5
How is the attitude of the health workers towards you?	very good.....1 good.....2 fair.....3 bad.....4 very bad.....5
What is the sex of health professional who attended you?	1. Male ☐ 2. Female ☐
If you had choice, would you prefer to be seen by: (Read out the options)	1.A male provider ☐ 2.A female provider ☐ 3..No preference ☐

ANNEX 4: QUESTIONNAIRE FOR EXIT INTERVIES: FAMILY PLANNING

Interview client who received health service from the AMP graduate only

Name of Interviewer…… Date…….

Name of Health Facility……..……

1. What service did you come for?

……

2. Was this your first time to receive the service in this health facility? Yes ☐ No ☐

Women's Satisfaction with Family planning services.	
How long did you wait before being seen by midwife?	_____
Are you happy with the time you waited?	Yes ☐ No ☐
If first time, were you counseled on all available methods?	Yes ☐ No ☐
Were you given a chance to choose a method of your choice?	Yes ☐ No ☐
Did you get the method that you chose? If no why not? _____ _____	Yes ☐ No ☐
Were you given any instructions on how to use or take the chosen method	Yes ☐ No ☐
Were you told about the side effects of the method that you were given?	Yes ☐ No ☐
Was your blood pressure checked?	Yes ☐ No ☐
Were you checked from head to toe to rule out contraindications	Yes ☐ No ☐
Were you told when to come back to the facility?	Yes ☐ No ☐
How much time did you spend with the midwife?	_____
Did you get enough time with the health professionals during your visit?	1. Yes ☐ 2. No ☐

	3. I am not sure ☐
How do you see the care provided by the midwife?	very good.....1 good.....2 fair.....3 bad.....4 very bad.....5
How was the attitude of the health workers towards you?	very good.....1 good.....2 fair.....3 bad.....4 very bad.....5
What is the sex of health professional who assisted you?	1. Male ☐ 2. Female ☐
If you had choice, are you prefer to be seen by: (Read out the options)	1.A male provider ☐ 2.A female provider ☐ 3..No preference ☐

4. Would you come again to this facility to receive FP service? Yes ☐
   No ☐
   If no, why?

   _____

5. Would you encourage your friend to come and access FP services in this facility?

   Yes ☐ No ☐

   If no, why?

   _____

   _____

Thank you.

ANNEX 5: QUESTIONNAIRE FOR HEAD OF HEALTH CENTRE

Name of Health
Facility…….

Name of Interviewee……
Title…….

Name of Interviewer……..
Date……

1. When was the AMP Midwife/midwives sent to this facility…….....

2. What services has s/he been providing? (probe for more details)

_____

_____

_____

_____

_____

3. Is there an increase in the number of clients accessing maternal and neonatal health services? Yes ☐ No ☐

4. Is the midwife able to provide all maternal and neonatal services including FP and PMTCT?

_____

_____

_____

_____

5. If no what are the areas of challenges?

_____

_____

_____

_____

6. Do you believe that the midwife was adequately prepared to provide services? Yes ☐ No ☐
7. Service provision hours:
    a. Are services in this health centre provided 24 hours a day? Yes ☐ No ☐
    b. Are midwives engage in 24 hours duty for labour and delivery? Yes ☐ No ☐

       If no, why?

       _____

       _____

       _____

       _____
8. How is the midwife working with the Health Extension Workers in the community?

   _____

   _____

   _____

   _____

   _____
9. Any comments for improvement?

   _____

_____

_____

_____

_____

Thank you.

SAMPLING PLAN

Table 10: Distribution of 1st round AMTP graduates and sample size by Region

Region	# of AMTP Graduates	Planned Sample Size (5%)	Actual Number Interviewed	Remark
Oromiya	983	49	50	
Amhara	322	16	17	
Somali	58	3	3	
Addis Ababa	92	5	7	
Benshangul	38	2	4	
Gambella	65	3	3	
Total	1558	78	84	