THE STATE OF THE ETHIOPIA'S MIDWIFERY 2012

BASED ON ETHIOPIAN MIDWIVES ASSOCIATION DATABASE

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Ministry of Health

UNFPA

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ETHIOPIAN MIDWIVES ASSOCIATION

Sida

MIDWIFERY: A PROFESSION WITH DIGNITY

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ACRONYMS

AMP	Accelerated Midwifery Programme
COC	Centre of Competency
EDHS	Ethiopia Demographic and Health Survey
EMA	Ethiopian Midwives Association
EFMHACA	Ethiopian Food, Medicine, Health Care and Control Authority (EFMHACA)
EmONC	Emergency Obstetric and Neonatal Care
FMOH	Federal Ministry of Health
HEW	Health Extension Workers
HIV	Human Immuno- Deficiency virus
HRH	Human Resource for Health
HSDP	Health Sector Development Plan
ICM	International Confederation of Midwives
IDM	International Day of Midwives
JP	Joint Programme
MDG	Millennium Development Goal
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health
MOE	Ministry of Education
MTR	Mid-Term Review
SIDA	Swedish International Development Agency
SNNPR	Southern Nations, Nationality and Peoples Regions
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children' Fund
WHO	World Health Organization

FORWARD

The federal Ministry of Health of Ethiopia (FMOH) has placed the issue of maternal and newborn health care a priority in order to reduce maternal and neonatal morbidity and mortality and achieve MDG 4 and 5. Period of highest maternal and new born mortality is during labor, delivery and 24 hours after delivery. Hence, training midwives to monitor and provide basic emergency obstetric care to women in labor is taken and implemented as a means to assist reduce maternal and neonatal morbidity and mortality.

Midwives are the frontline workers of maternal and neonatal health service provision, interacting with colleagues across primary, secondary and tertiary care services. Moreover, midwives are at hand to give routine care during normal deliveries and are able to identify and manage complications of child birth before they become life threatening.

The human resource for health strategy of Ethiopia has indicated that government will train 8,635 midwives by 2015 and deploy 2 midwives at each health center FMOH has, thus, already started implementing strategy by initiating Accelerated Midwifery Training program (AMWTP) and 1,558 midwives have been trained, deployed and assessed; and the finding is encouraging and 1585 more are on training.

The Ministry is not only convinced but also working to avail access to health services, including skilled birth attendance and a functioning health facility will make pregnancy and delivery safe. Besides the effort of increasing the number of midwives, the Ministry is also working on:

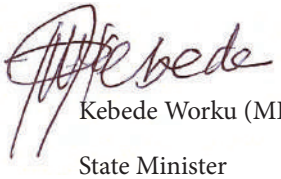
- Fair and equitable distribution of midwifery professionals across the country,

- Synergizing and integrating Collaborative Work of HEWs and health Development Army with midwifery professionals to optimize effectiveness and efficiency on MCH care ; and

- Equipping health Facilities with basic maternal and child health care materials.

The Ethiopian midwifery association database report focuses on the availability of midwives in Ethiopia; midwifery education including the Accelerated Midwifery program, Midwifery Regulation and the Midwifery professional Association. I believe it will be a benchmark for measuring progress in midwifery services. In addition, Midwifery Associations should work to encourage and make their members to develop professionalism of Midwifery.

Finally, I would like to acknowledge UNFPA for its financial and technical supports to on the assessment carried out; and also extend my appreciation to EMA for its dedication in conducting the data base.



Kebede Worku (MD)

State Minister

AKNOWLEDGEMENT

The Ethiopia Midwifery Report was written using information from the Ethiopian Midwives Association data base which consists of midwifery and student profiles. UNFPA and Ethiopian Midwives Association (EMA) would like to thank Dr. Wassie Kebede (PhD) who conducted a census of the midwives and student midwives. Appreciation goes to midwives and student midwives for dedicating their precious time to provide valuable information, to Regional Health Bureaus, Zonal and Woreda Health Offices for providing information.

The document was reviewed by a number of individuals from UNFPA, Federal Ministry of Health and Ethiopian Midwives Association including Dr. Amire Amane, (Director of Human Resources for Health Directorate), Sr. Azeb Admassu, (Midwifery Coordinator FMOH), Asamenew Assefa, (Programme Officer in FMOH), Dr. Luc De-Bernis, (Senior Maternal Health Adviser, UNFPA Headquarters), Hiwot Wubshet, (Executive Director, EMA), Dr. Beyeberu Assefa, (UNFPA Programme Officer) and Sister Aster Berhe, (Country Midwifery Advisor).

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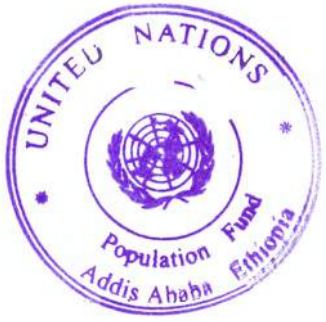
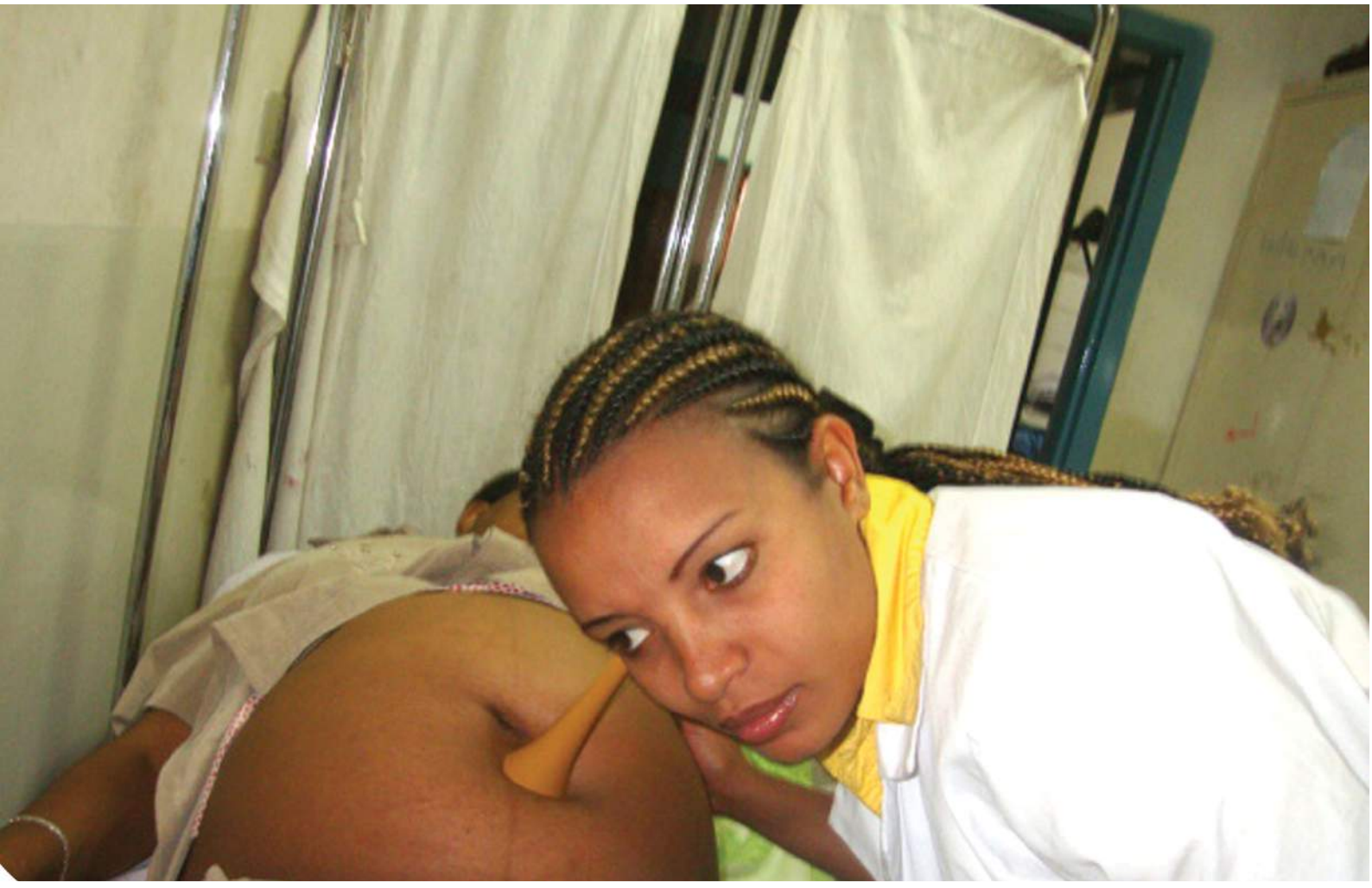
Benoit Kalasa (PhD)

(UNFPA Representative: Ethiopia)





EXCUTIVE SUMMARY

Quality midwifery services that are coordinated and integrated within communities and within the health system ensure that a continuum of essential care can be provided through out pregnancy, child birth and beyond. Midwifery services should ensure timely and appropriate referrals of mothers and newborns from home or health centre to the hospitals whenever they occur.

Federal Ministry of Health made strengthening the health system and training of health workers a priority. A Human Resource for Health Strategy 2009-2020 developed in 2009 has a target of training 8,635 midwives, by the year 2015. The figure of the midwives to be trained and deployed is expected to increase to 9,866 by 2020. To implement this new strategy, the Government has established more training institutions. For example, the number of midwifery training institutions has increased from five in 2000 to 46 in 2012. Currently 18 universities are offering midwifery training at Bachelor level.

The data from the Ethiopian Midwives Association data base shows a substantial increase in the number of midwives from 1,275 in 2008 to 4,725 in 2012. A majority of them; 95.6 percent, are providing midwifery services in various hospitals and health centres while the rest are working as managers, coordinators and lecturers. The "Accelerated midwifery training programme" has contributed to the increase in the number of midwives in Ethiopia as 33 percent were trained through it. The government is the main employer of the midwives since most of the hospitals, health centres and training institutions are owned by the government.

There are more female midwives (3,662) than male midwives (1,063). However, male midwives are more qualified than their female counterparts as most of them have bachelor's degree.

Regulation is very important in any profession including the midwifery profession. The primary reason for legislation and regulation is to protect the public from those who attempt to provide midwifery services inappropriately. To be licensed is a measure of competence and a sign of independent practice for professionals. However, only 68 percent of midwives in Ethiopia are licensed while the others are practicing without a license.

Seventy percent of the midwives are satisfied with the type of work they do. Client relationship is the second most satisfying factor. Opportunities for education and for transfers are the driving forces for change of employment. Lack of access to further education leads to lack of opportunities for better employment, promotion and salary increment. These multiple indicators are markers for dissatisfaction among the midwives.

Although the number of midwives in Ethiopia is increasing steadily, motivation and retention remains as the two most challenging factors. Evidence show that poor working conditions, low salaries, lack of supervision and lack of opportunities for career development are the main demotivating factors.

There has been a substantial increase in the number of midwifery training institutions from 25 in 2008 to 46 in 2012. More universities (18) are now providing midwifery education at the degree level and one is providing at the master level. 32 percent of the students are being trained at the degree level while the rest are being trained at the diploma level. All regions, except Gambella have midwifery training institutions. There are more female midwife students compared to the male students. The private sector is contributing substantially to the training of midwives as 8 private institutions (17 percent) are providing midwifery training. Seven institutions are providing training at the diploma level while one is providing both diploma and degree courses.

Ethiopian Midwives Association (EMA) has been playing a strategic role in the capacity building of midwives and other health professionals in Ethiopia. EMA has trained health workers and tutors in various skills including family planning, basic emergency obstetric care, prevention of female genital mutilation, safe abortions, management and prevention of postpartum hemorrhage and in effective and clinical teaching skills. Most of these in-service courses were not integrated in previous curriculum hence the curriculum was revised in 2011 to integrate new information and modules.

BACKGROUND

Globally, each year, nearly 350,000 women die while another 50 million suffer illness and disability due to complications associated with pregnancy and child birth. In recognition of the huge magnitude of the problems and their direct link to development, two of the eight MDGs (MDG 4 and MDG 5) deal with maternal and child health. It has been reported that Ethiopia is one of the six countries that contribute to about fifty percent of the maternal deaths; the others being India, Nigeria, Pakistan, Afghanistan and the Democratic Republic of Congo.

About fifteen percent of pregnant women in Ethiopia are estimated to develop obstetric complications which are potentially life-threatening. An estimated 2.6 million births occur each year. Direct obstetric complications account for 85% of the deaths as well as many acute and chronic illnesses. The most common causes of death include: obstructed labor (13%), ruptured uterus (12%) severe pre-eclampsia/ eclampsia (11%), severe complications of abortion (6%), post- partum hemorrhage /retained placenta (7%), postpartum sepsis (5%), ante-partum hemorrhage (5%) and direct complications from other causes (9%). Indirect causes such as HIV/AIDS (4%), anemia (4%), malaria (9%), and complications from other causes (9%) contribute to about 21% of the maternal deaths (HSDPIV 2010-2015). A host of long-term conditions disable women who survive delivery-related complications, such as anaemia, fistula, uterine prolapse, chronic pelvic pain, depression and exhaustion. Fistula is especially common in Ethiopia, primarily due to adolescent pregnancy combined with neglected prolonged labor.

Midwives contribute tremendously in preventing these deaths and in ensuring the health and continuation of the human race all across the world. Quality midwifery services that are coordinated and integrated within communities and within the health system ensure that a continuum of essential care can be provided through out pregnancy, child birth and beyond. Midwifery services should ensure timely and appropriate referrals of mothers and newborns from home or health centre to the hospitals whenever they occur. The 2005 World Health Report: Making Every Mother and Child Count identified midwives and others with midwifery skills as the essential human resource in health systems to reach the Millennium Development Goal number 4 and 5. Midwives are frontline workers that give care and support during pregnancy, labour and post -partum period benefiting not only the client and her immediate family but all members of the society and contributing to the country's human and economic development.

Globally, midwives form an important part of the health workforce. They work with women in their homes, communities, and in the ante natal clinics, health centres, hospitals and maternity units. They provide woman-centered care that includes a listening ear and reassurance. Midwives are the front line workers of maternal and neonatal health service provision, interacting with colleagues across primary, secondary and tertiary care services. They are at hand to give routine care during normal deliveries, and they are able to identify and manage complications of child birth before they become life threatening.

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (ICM/WHO/FIGO). Midwives are experts in women's health care and are autonomous practitioners who are specialists in normal pregnancy, child birth and postpartum care. Midwives understand that every child-bearing woman deserves to give birth within a safe and supported environment for herself and her baby. Most midwives work in health centres and live among the women they serve which in turn builds the trust between the women and the midwives. Their competencies also include delivery of essential sexual and reproductive health services allowing women to make informed choices regarding family planning, testing and treatment of sexually transmitted infections and choosing safe delivery practices. Their midwifery competencies emphasize the importance of cultural sensitivity and require that they have knowledge of cultural norms about the child bearing practices. Midwifery is the only health care profession with a fundamental focus on the care of the mother and her baby. The presence of a midwife at birth can mean the difference between life and death (UNFPA Executive Director 2009)

The occupational role of the midwife is timeless in history. It emerged from the experience of being "with women" for childbirth, as a simple act of caring and compassion, that characterized the way of women regardless of culture or time. Midwifery as a profession has its origins in the 17th Century when European countries such as Sweden, France, Belgium and the Netherlands began to acknowledge that traditional attendants at birth required specialist education, assistance in skills development and appropriate supervision. Other European countries such as the United Kingdom, eventually followed suit later in the 19th and early 20th Century, educational opportunities opened for women. Midwifery institutes opened throughout Europe and, by extension, to developing nations (Summers, 2000).

In Ethiopia there are not enough qualified midwives to manage the estimated number of pregnancies, the subsequent number of births and the fifteen percent of births that generally result in obstetric complications. Information from the Ethiopia Midwifery Data Base and records from the Accelerated Midwifery Training Programme shows that Ethiopia has an estimated 4,725 midwives for a population of 85 million giving a ratio of 1: 17,989. WHO recommends a ratio of 1 midwife for a population of 5,000. The current numbers show that there is a critical shortage of midwives to provide maternal and neonatal services to the growing population of women of childbirth age. This human resource for health crisis is hampering efforts to achieve the Millennium Development Goals 4 and 5. Shortage of providers able to provide skilled attendance at birth and emergency obstetric care particularly in rural settings; is a major human resource challenge that cannot be addressed by government alone. Scaling up training of mid-level health providers including midwives and ensuring that they are working in a conducive environment is a priority for both the government and development partners (Ethiopia Health Service Development Programme (HSDP 1V 2010-2015).

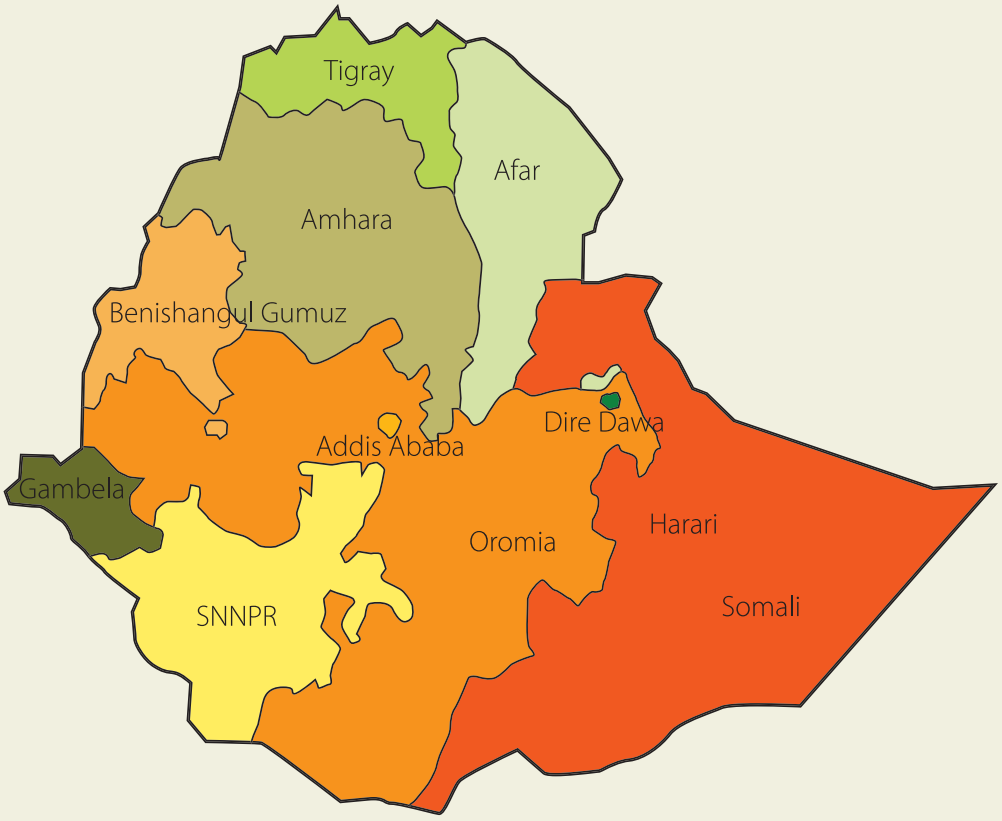
Federal Ministry of Health has recognized the fact that strengthening the health system and training of health workers is a priority. A Human Resource for Health Strategy 2009-2020 (sometimes referred to as the "flooding" strategy) was developed in 2009 and has a target of training 8,635 midwives, by the year 2015. The figure of the midwives is expected to increase to 9,866 by 2020. To implement this new strategy, the Government has established more training institutions. For example, the number of midwifery training institutions has increased from five in 2000 to 46 in 2012. Currently, there are 18 universities that are offering midwifery training at BSc level while the rest are providing diploma level training. Although there has been an increase in the number of the training institutions, the instructors, teaching materials and infrastructure have not grown proportionately to the rapid expansion and the increased number of students. This, together with overburdened clinical training sites and insufficient numbers of clients for delivery, has compromised the quality of the education.

SECTION ONE 1

1.1 AVAILABILITY OF MIDWIVES

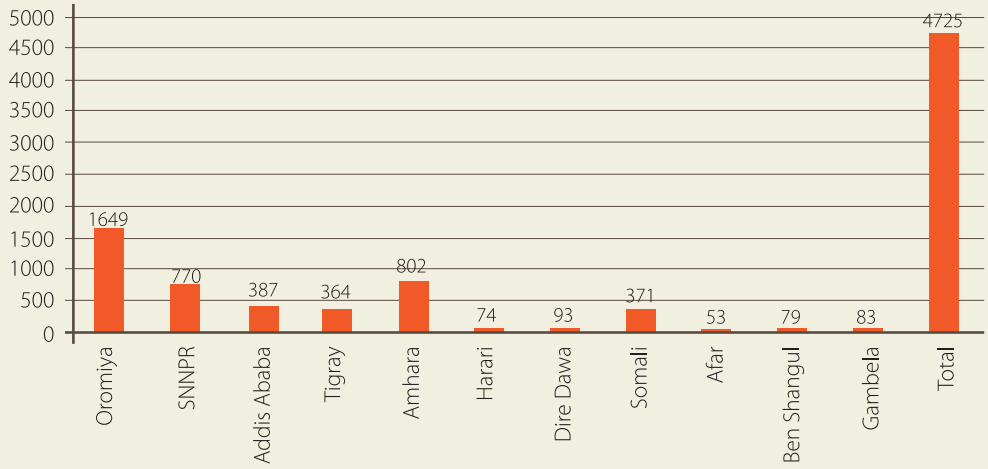
Ethiopia is divided into nine regional states and two administrative councils. The states are sub-divided into 75 zones and 817 woredas/Districts. The three most populous regions—Oromia, Amhara, and SNNPR—constitute about 80 percent of the total population. Employment and deployment of midwives is the responsibility of individual states for diploma level and FMOH for degree level.

Figure 1 Map of Ethiopia showing regions



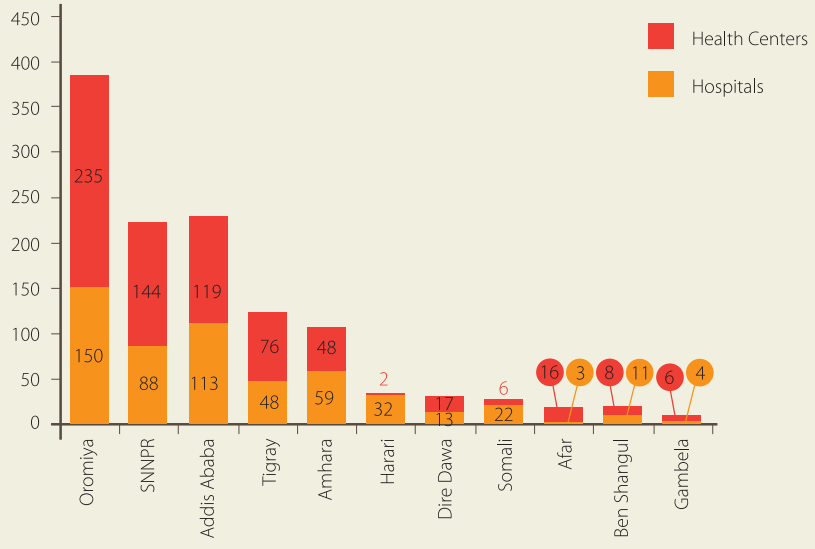
The Ethiopian Midwives Association data base and the records from the Accelerated Midwifery Training Programme show that Ethiopia has 4,725 midwives of which 1,558 were trained through the accelerated midwifery training programme. This figure show a substantial increase from 1,275 recorded in 2008 by the emergency obstetric and neonatal care assessment (EmONC 2008). Data also show that availability of midwives in each region has increased substantially. The graph below shows the number of midwives in each region.

Figure 2 **Graph showing distribution of midwives in each region**



This data is collected and tabulated at 2012.

Figure 3 **Distribution of Midwives by Region (UN MTR, May 2009)**



From the information presented, it shows that Oromiya region has the highest numbers of midwives which accounts for almost 34.9 percent of the total registered midwives. This is mainly due to the accelerated midwifery programme which trained 983 midwives during the year 2011 to May 2012. This data shows that 95.6 percent of the midwives are actually providing midwifery services while only 4.4% are in coordination, teaching or managerial services.

Data also shows that number of midwives in Gambella has increased from 10 in 2009 to 83 in 2012. The least number of midwives is in affar region which has only 1 percent of all midwives. However the graph below shows that Affar is a region with a met need for emergency obstetric care of only 1 percent and a high case fatality rate of 4 percent. Ethiopia Demographic and Health Survey (EDHS 2011) indicate that 6.8 percent of deliveries in Affar take place in health facilities.

Figure 4 **Met Need for EmONC by region: EmONC Baseline Assessment, FMOH, 2009**

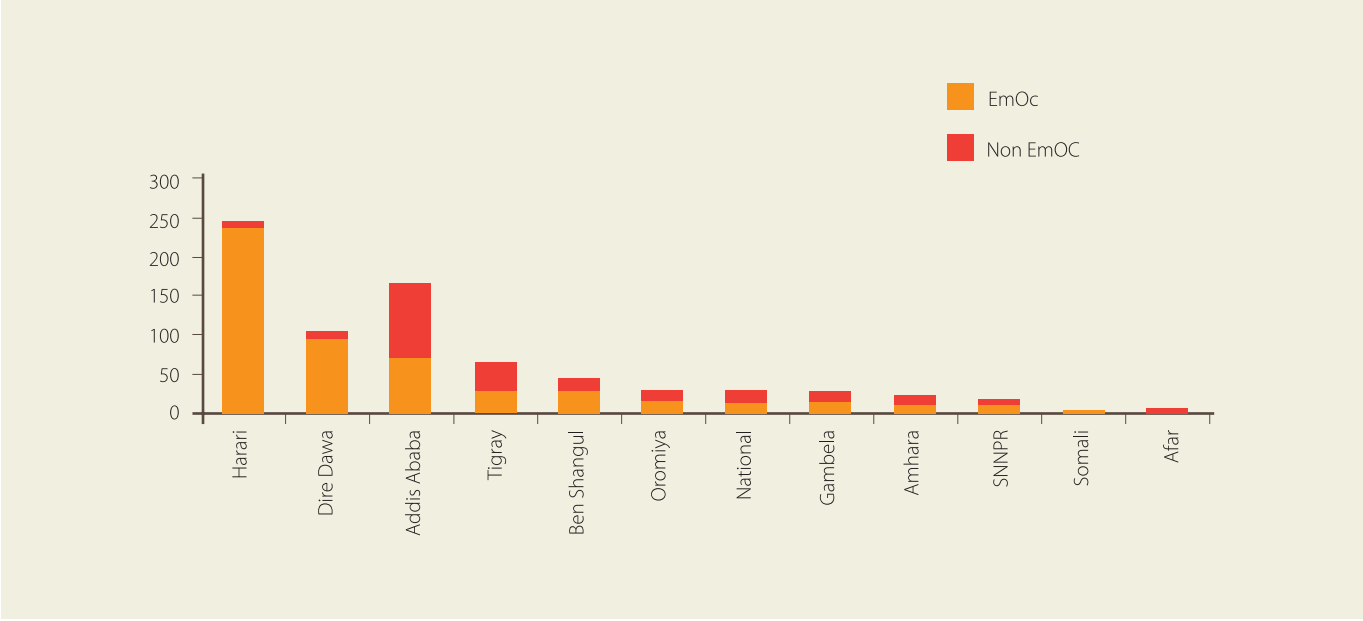
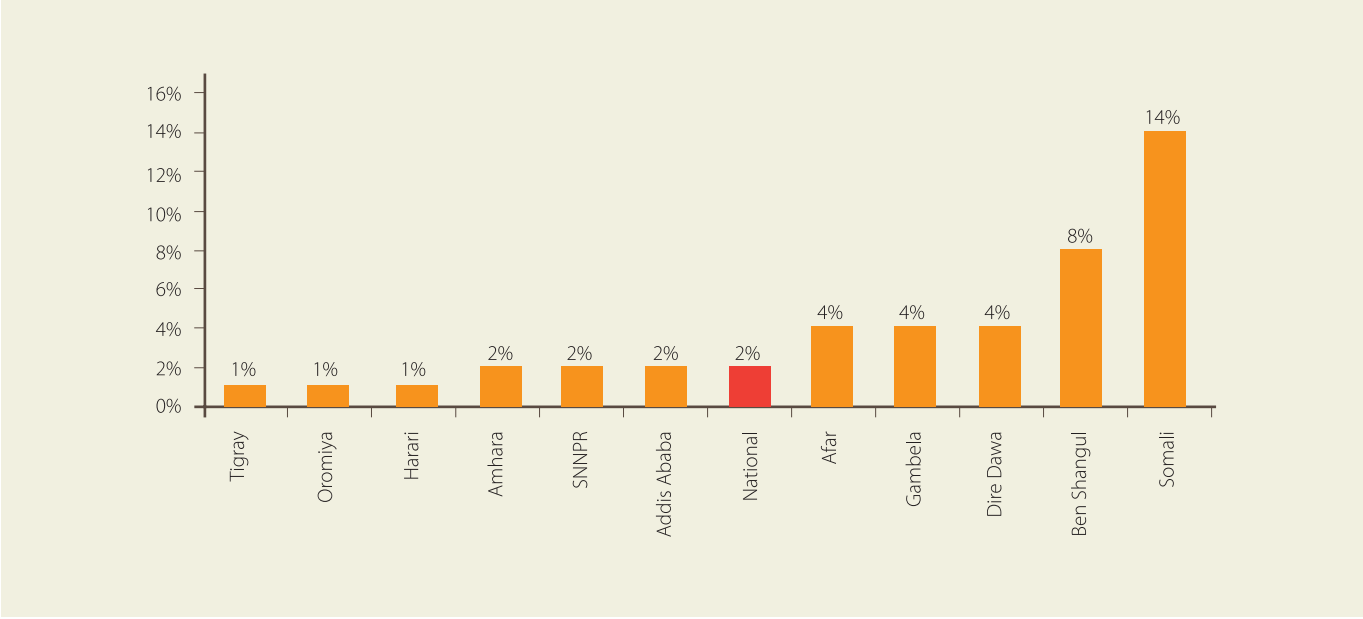


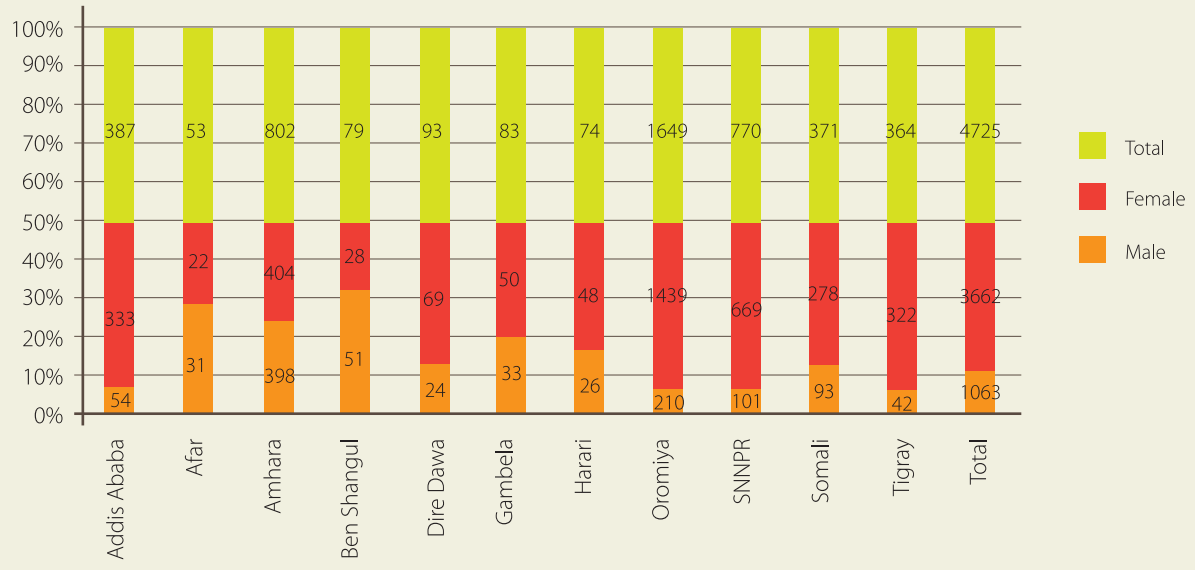
Figure 5 **Direct obstetric case fatality rate by region: EmONC Baseline Assessment, FMOH, 2009**



1.2 MIDWIVES GENDER

Ethiopia has been training both male and female midwives. The proportion of male to female midwives is approximately 1 to five. However, there is a variation across regions with Affar, Benishangul and Gambella having more male midwives than female midwives as can be seen from the graph below. Students do not choose to be midwives but are assigned by Ministry of Education and Health to study the profession. Data also show that a high percentage of female midwives (96%) are providing direct professional services than the male professionals (93%).

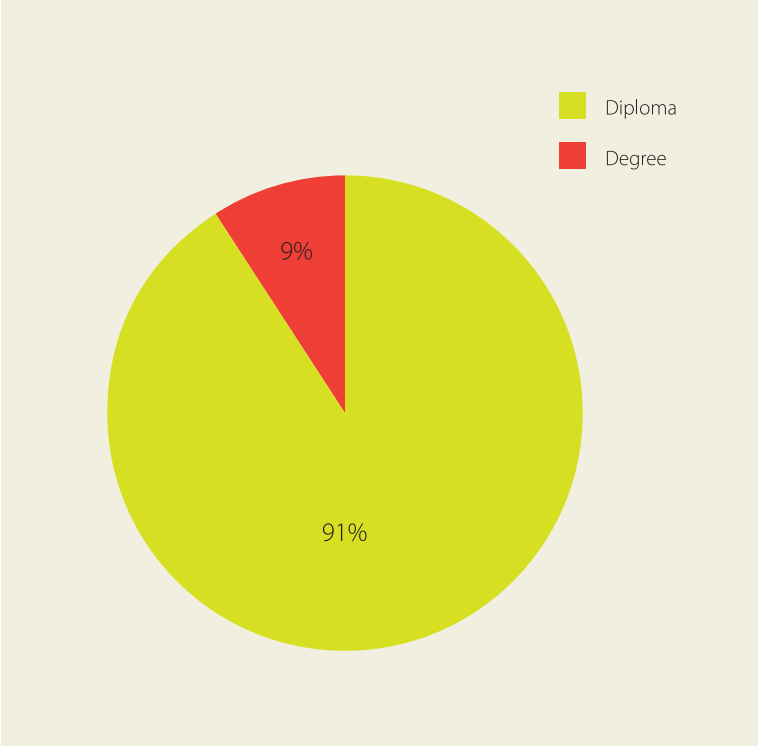
Figure 6 Midwives by Gender and by Region



1.3: MIDWIVES BY LEVEL OF EDUCATION

Majority of the midwives across all regions received training at diploma level.This is a three year direct entry programme and accounts for 91percent of all midwife professionals registered during the census. 8.8 percent are trained at degree level while only 0.2 percent of midwives have masters degree. There are more male midwives than female midwives at the degree level. Amhara, Benishangul-Gumuz, Affar and Gambella are the regions where no single female midwives have been trained at the degree level.

Figure 7 Midwives by level of Education



1.4: JOB SATISFACTION

According to the information collected from the survey, 70 percent of the midwives are satisfied with the type of work they do. Relatively speaking liking the job/training outweighs all other incentives that midwives receive. Client relationship is the second most satisfying factor. Those working in NGOs cited better salaries as a driving force for midwife professionals to change their working organizations. Opportunities for education and for transfers are the second and third driving forces for change of employment and for job satisfaction.

1.5 CHALLENGES

Although the number of midwives in Ethiopia is increasing steadily, motivation and retention remains as the two most important factors. Motivation improves the midwife performance and prevents exits from the workforce. Evidence shows that poor working conditions, low salaries (82.8 percent mentioned low salaries as a demotivating factor), lack of supervision and lack of opportunities for career development are

the main demotivating factors for midwives. Data also shows that 35 percent of the midwives have a salary of 1,000 to 1,500 birr ($56-84).Only 7 percent of midwives have a salary of about $200. Midwives believe that motivation can be achieved through expanding continued education opportunities, career development, practice in the private wing within public facilities after working hours and introduction of hazard allowance among others. Most midwives and health cadres engaged in MNH services have fears of high risk of blood contamination and HIV/ HBV infection although there is no proven data that those who work in maternity units have high risk of HIV infection. Lack of equipment and supplies in the health facilities and lack of access or limited access to information have always been cited as challenges. Although midwives are very much happy to work with others as team of experts, they feel that they are not respected by fellow health workers.

SECTION TWO 2

2.1 MIDWIFERY EDUCATION

There are three pillars of a quality workforce: the midwifery education program, regulatory frameworks and association development. In 2010 ICM published global standards for the initial education of midwives. The standards include: (1) entry level of education should be completion of secondary education; (2) minimum length of a direct-entry midwifery education program is three years, (3) minimum number of post-nursing/health care provider program is eighteen months, and (4) midwifery curriculum include both theory and practice elements. The guidelines also demands that the training should be competency based covering theoretical knowledge as well as regular, tailored, supervision and hands-on practice in a variety of clinical settings.

In Ethiopia, the first group consisting of 3 midwives graduated in 1953 at the certificate level. The diploma midwife training started in 2003. Eligible candidates to this program are tenth graders. They receive three years midwifery training leading to a diploma certificate. In 2006 and 2007 BSc training programs in midwifery were opened in Gondar, Addis Ababa and Harumaya Universities and from 2008 midwifery training programmes were initiated in various universities. The Government of Ethiopia has rapidly expanded the training institutions. For example, the government has increased the number of public universities offering midwifery training from two in 2006 to 16 in 2012. Currently there are 18 universities that are offering midwifery training at BSc level of which 2 are private institutions. 27 regional colleges are training at the diploma level. The instructors, teaching materials and infrastructure have not grown proportionately to the rapid expansion of training institutions. For example in 2011, Menllik Health Science College had four tutors for 214 students. The increased number of students and overburdened clinical training sites and insufficient numbers of clients for delivery, has compromised the quality of the education provided. Most students will graduate without the required numbers of delivery (40 deliveries per student)

2.2 NUMBER OF TRAINING INSTITUTIONS

Ethiopia has 46 midwifery training institutions located in all the regions except in Gambella. The distribution of Midwifery training institutions are as follows:

Table 1 Distribution of Training Institutions by Region

Region	Name of Inistitution	Level of Training	Type of Inistitution
Addis Ababa	1. Addis Ababa University	Degree	Government
	2. St Paulos University	Degree	Government
	3. Menlik Health Science College	Diploma	Government
	4. Hamlin College	Degree	Private
Afar	1. Semera Health Science College	Diploma	Government

Region	Name of Inistitution	Level of Training	Type of Inistitution
Amhara	1. Barhir dar University	Degree	Government
	2. Gondar University	Degree/ Masters	Government
	3. Debra Markos	Degree	Government
	4. Barhir dar Health Science College	Diploma	Government
	5. Debra Berhane HSC	Diploma	Government
	6. Dessie HSC	Diploma	Government
	7. Tseda HSC	Diploma	Government
Ben Shangul	1. Victory HSC	Diploma	Private
	2. Pawi H.S.C.	Diploma	Government
Dire Dawa	1. Alkan College	Diploma	Private
Harari	1. Harari H.S.C	Degree	Government
Oromia	1. Harumaya University	Diploma	Government
	2. Wollega University	Degree	Government
	3. Jimma University	Degree	Government
	4. Mada Wallabu University	Degree	Government
	5. Adama University	Degree	Government
	6. Ambo University	Degree	Government
	7. Rift Valley College	Diploma	Private
	8. East African H.S.C.	Diploma	Private
	9. Horn College	Diploma	Private
	10. St Luke HSC	Diploma	Private
	11. Negele H.S.C.	Diploma	Government
	12. Nekempte H.S.C	Diploma	Government
	13. Metu H.S.C.	Diploma	Government
	14. Shashemene H.S.C.	Diploma	Government
	15. Goba H.S.C.	Diploma	Government
	16. Filche H.S.C.	Diploma	Government
Somali	1. Jijiga University	Degree	Government
	2. Jijiga H.S.C.	Diploma	Government
	3. Gode H.S.C.	Diploma	Government
SNNP	1. Hawassa University	Degree	Government
	2. Dilla University	Degree	Government
	3. Mizan Mtepi University	Degree	Government
	4. Arbamich University	Degree	Government
	5. Hawassa H.S.C.	Diploma	Government
	6. Hossana H.S.C	Diploma	Government
	7. Amani H.S.C	Diploma	Government
Tigray	1. Mekelle University	Degree	Government
	2. Sheba University	Degree/ Diploma	Private
	3. Axum H.S.C.	Diploma	Government
	4. Mekelle H.S.C	Diploma	Government
Total	46		

Figure 8 Type of Training

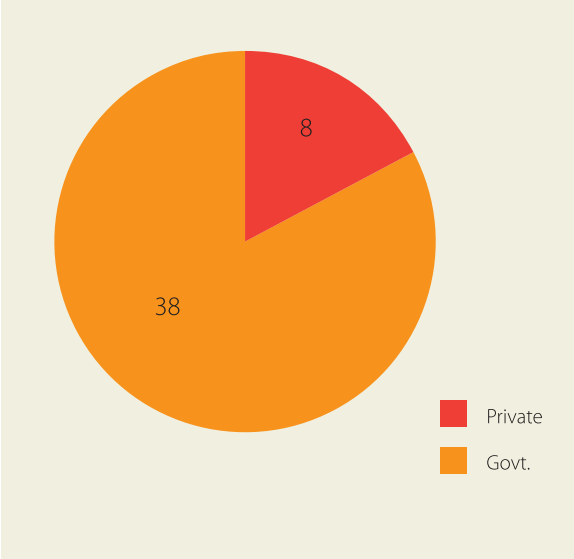


Figure 9 Level of Training

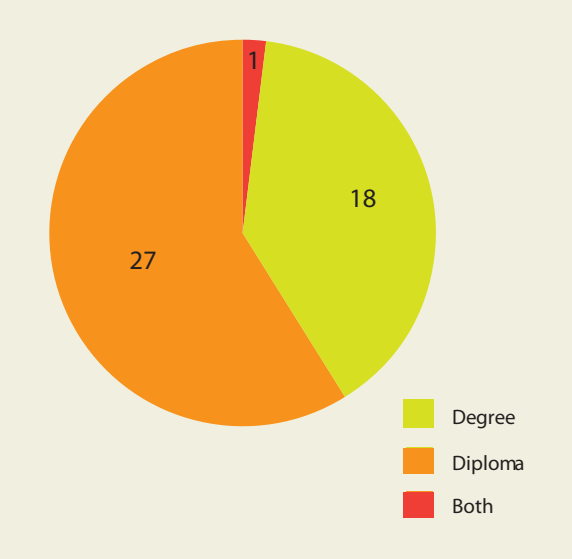
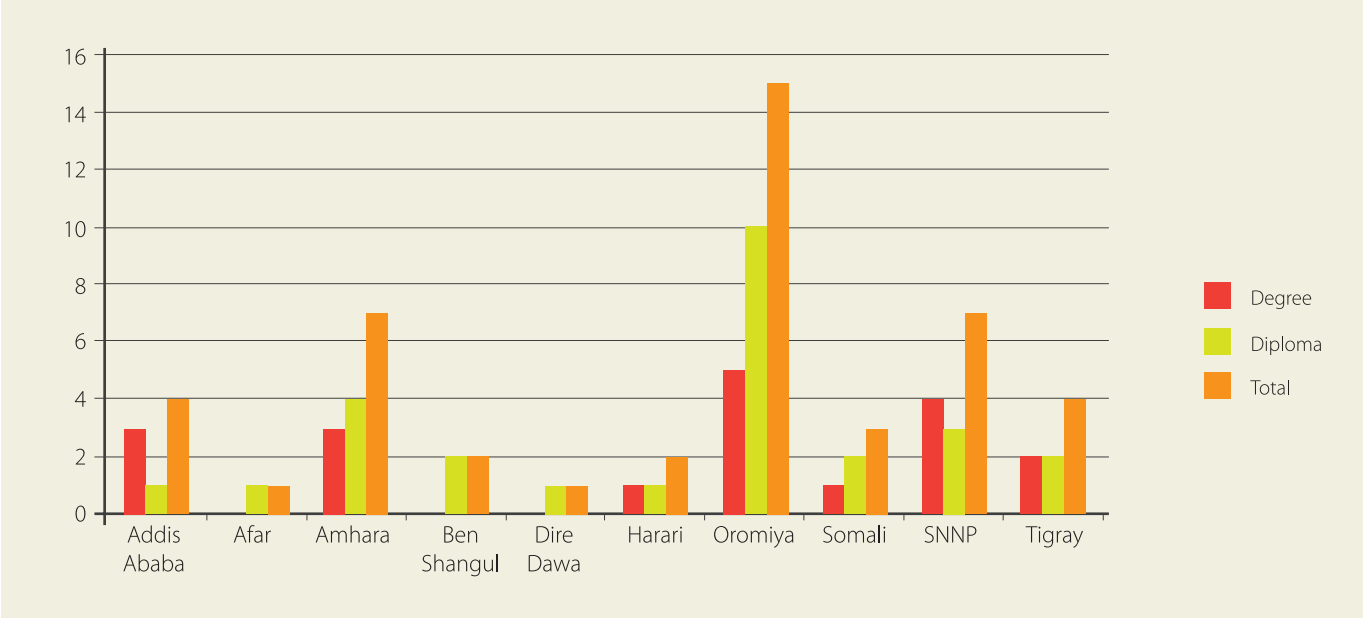


Figure 10 Training institutions by region and by type of training

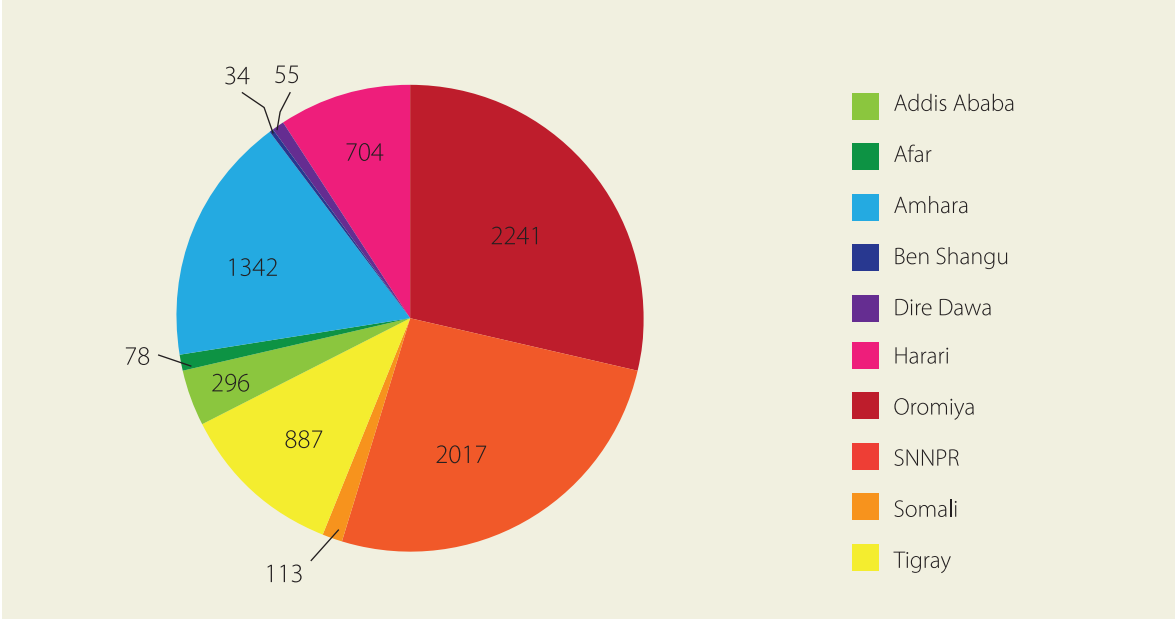


2.3 NUMBER OF STUDENTS:

There are 7,767 midwifery students registered in both universities and colleges. The regional distribution indicates that Oromiya has the highest number with 2,241 midwifery students, followed by Southern Nations, Nationalities, Peoples and Regional State with a total number of 2,017 midwife students. There are no students registered from Gambela region.

For those who are been trained at university level, the assignment by higher education commission to study midwifery was not always by choice rather by chance hence some of them have no passion for the profession as they were assigned. However, there are some students who didn't choose to join the profession but later developed the passion for providing care to mothers and newborns.

Figure 11 Number of students by Region



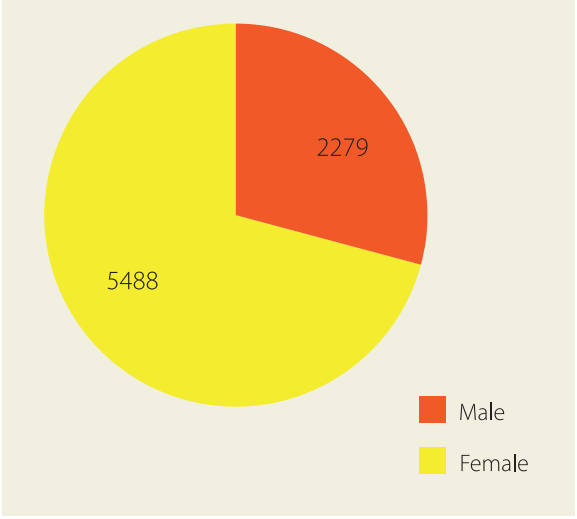
2.4 NUMBER OF STUDENTS BY GENDER

Although data show that there are more female midwifery students, most of them are trained at the diploma level while their male counterparts are trained at the degree level. This is mainly due to the lower levels of education of the girl child. The picture shows a class of Second year students in Hawassa University where there is only one female student in the whole class.

The opposite is true in the Health Science Colleges where there are only female students as can be seen from the picture below.

The proportion of male to female ratio is about 1:2. However there are variations from one region to

Figure 12 Number of students by Gender



2nd Year midwifery students in Hawassa University (Degree)

2nd Year Midwifery students in Gode HSC: (Diploma)

the other. For example, in Benishangul-Gumuze the proportion of males are more than female students with a ratio of 2.25:1. On the other hand, in Amhara region the proportion/ratio of male to female students is more or less equal with a ratio of 0.98:1. The potential impact of higher numbers of male midwives entering the profession, their acceptance by communities and how their behaviour differs to female midwives in the health labour market (i.e. attrition rates, career breaks, willingness to work in rural areas) needs further review.

2.5 STUDENTS BY LEVEL OF TRAINING

5,739 students are attending their training at the diploma level while 1,840 are being trained at the degree level. Only 188 students are being trained at a master's level in various health fields such as

Figure 13 Number of students by Level of Training

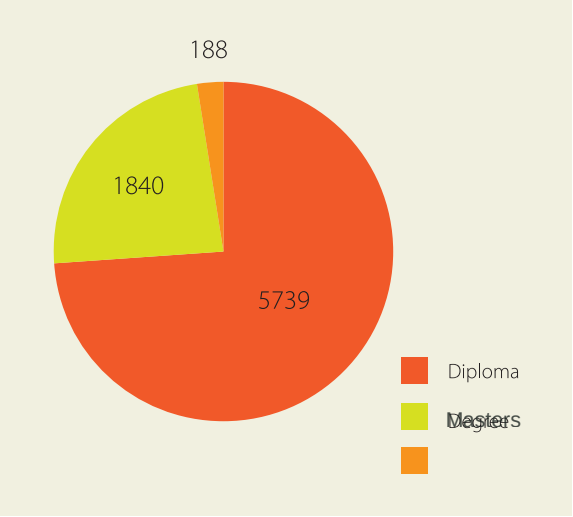


Figure 14 Regional Distribution of training at degree level

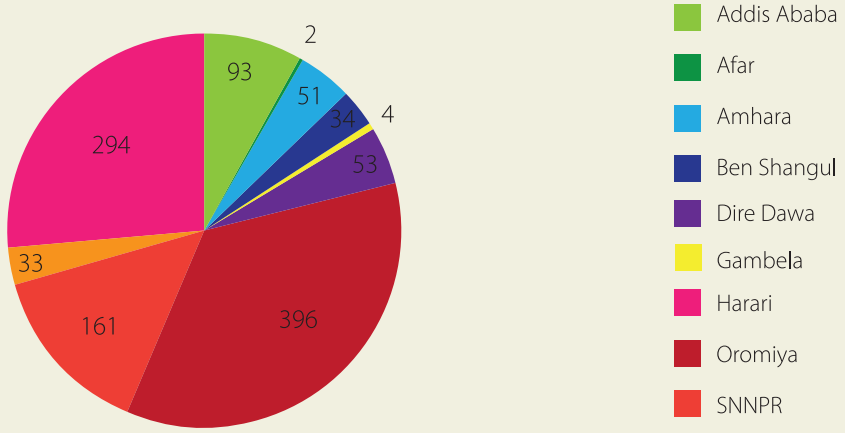
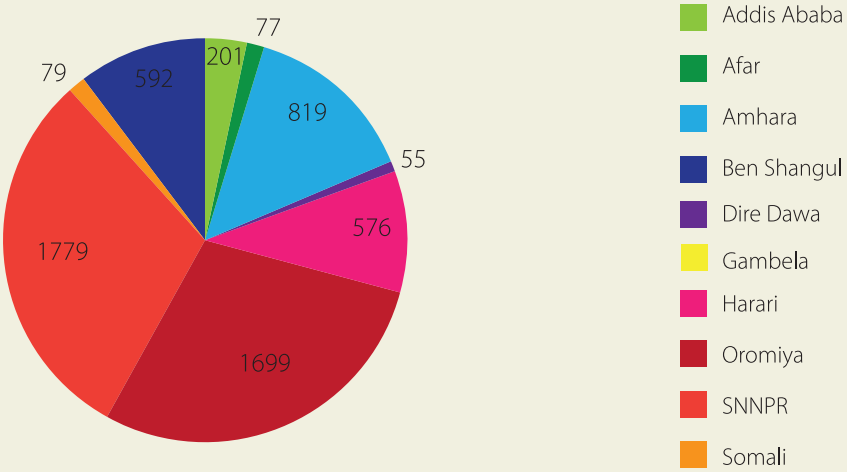


Figure 15 Regional Distribution of trainees at degree level



Midwifery, Reproductive health and Public health). There are more female students (81.67 percent) enrolled to midwifery training at the diploma level.

Note that the pie chart above indicates the number of students from each region. Although there is no university in Benishangul, there are four students who are being trained at Degree level attending training in other universities. There are also only 2 students from Afar studying midwifery at degree level.

Some regions such as Oromiya and SNNPRS have high proportion of midwife students enrolment at both diploma and degree levels compared to the rest of the regions. The age distribution of midwife students is skewed towards the younger age but ranging from 16-25.

2.6 PLACE OF TRAINING

Majority of the students (93.4percent) are enrolled in government training institutions, only 6.6 percent are in private institutions. The table summarizes the type of institutions where midwife students are enrolled in each region stratified by gender.

Table 2 **Students' enrolment by institution type, regional distribution and gender**

Region	Government		Private		Total
	Male	Female	Male	Female	
Addis Ababa	83	213	0	0	296
Afar	31	47	0	0	78
Amhara	646	642	17	37	1342
Benishangul	26	8	0	0	34
Dire Dawa	0	0	3	52	55
Gambella	0	0	0	0	0
Harari	70	267	101	266	704
Oromia	648	1593	0	0	2241
SNNPRS	369	1648	0	0	2017
Somali	18	95	0	0	113
Tigray	266	581	0	40	887
Total	2157	5094	121	395	7767

2.7 MIDWIFERY TUTORS:

Ethiopia has shortage of midwifery tutors. Most of the tutors do not have additional training as midwifery tutors rather they are assigned by FMOH and MOE to training institutions. Some are assigned straight from their university education soon after graduation and have no exposure to clinical and teaching practice. Clinical practice helps the teacher to apply theory to practice and maintain and extend their clinical skills thereby enabling them to educate, supervise and evaluate students. Moreover, teaching practice in both the classroom and the clinical areas is an essential part of teachers. Data from 2009 assessment of Midwifery Training Institutions (UNFPA) showed that 50 percent of the teachers were new graduates with no adequate skills and clinical experience as midwives to teach and evaluate/supervise students. Increasing the number of trainers, and the quality of their training is integral, especially for practical training in maternity units where each student must be given as many hands-on opportunities as possible. The government has been

addressing this problem by providing the following trainings to midwifery tutors: effective teaching and clinical teaching skills, basic emergency obstetric and neonatal care, essential newborn care, comprehensve family planing and prevention of mother to child transmission of HIV.

2.8 QUALITY OF TRAINING:

Many midwife students from all regions have a general impression that the quality of education/training for midwives is improving. The government and partners have been providing teaching and learning materials such as models, books, computers and LCD to facilitate learning. Incentive for tutors is also one factor that has contributed to the improvement. However, it is well known that the clinical sites are very congested with students, the tutors do not accompany the students to the practical area due to pressure of work as there is shortage of tutors, there are no mentors and some students graduate without the required skills. From the students' perspective, one of the students from Amhara region (Dessie Health Science College) stated that "the quality of midwife education is improving. The theoretical concepts are often supplemented by demonstration sessions." The same student, however, expressed some limitations related to teaching and learning materials, especially in the demonstration room and some students felt less time is given to practical teaching and learning. Students from Jujiga University were satisfied with the type of training they are receiving. One of the students explained;

"I am satisfied by the education which I am getting because the school materials we are using are adequate, and the teachers are also exerting their maximum efforts to inculcate the knowledge they have by showing us video and other visual materials. There is also good support from students as peers and the teachers are very supportive to students."

Another student from Jijiga stated that,

"I feel that the professionals have become more [needed] in the market, and even though I am not getting any additional income now, I am stable and I believe in the future, I will get more payment due to the rapid growth of the profession and the demand therein."

2.9 CHALLENGES

The Government has expanded and established new universities and colleges. However; the infrastructure has remained the same in terms of classrooms and teaching and learning materials.

The tutor/student ratio is very high and the classrooms are overcrowded. Some classes have more than 120 students making teaching and learning very difficult due to large number of students.

The health facilities for the practical area are very crowded with large numbers of students while the number of women delivering in the health facilities still remains very low at only 10 percent (EDHS 2011) despite various community mobilization activities. Because of large number of students in the practical area which includes medical students, health officers and nurses, students do not get the required practical skills. There are also no mentors/preceptors and instructors to guide the students in the practical area. Data collected from students indicate the following challenges

Table 3 **Challenges of Midwife students**

Problems	%
Unable to use computers and internet	71.7
Poor financial support	59.8
Poor infrastructure and non-conducive setting of the training centre	57.6
Shortage of training materials	56.5
Poor practicum	43.5
Lesser quality of teaching-learning process	41.3
Small allowances	40

SECTION THREE 3

THE ACCELERATED MIDWIFERY TRAINING PROGRAMME

Federal Ministry of Health embarked in this ambitious programme with the aim of reducing maternal and neonatal mortality and morbidity and achieving Millennium Development Goal number 5. The Accelerated Midwifery Programme is also a response to the Human Resources for Health Strategy which has set a target of training 8,635 midwives by the year 2015. The objectives of AMP are: (1) To achieve a minimum standard of Midwife to population ratio, (2) To increase skill birth attendants by increasing productivity, (3) To narrow the gap of health service delivery and (4) To strengthening the midwifery profession. The AMP is training qualified diploma- level nurses into midwives. This is a one year programme being implemented in 15 midwifery training institutions across the country. Upon completion of the training, two midwives will be deployed to each health centres based on the needs of each region. It is expected that this initiative will increase access to skilled attendance at birth and also provision of reproductive health services especially in the rural areas.

The implementation strategy of the initiative is reducing the duration of training to one year by using a modified curriculum and train unemployed nurses using competency based approach. The curriculum has 27.4 percent theory and 72.6 percent practical sessions covering both skill lab and clinical practice. The curriculum was adapted from the diploma level and special attention was taken to ensure that it is in line with the ICM/WHO Midwifery competencies, WHO Essential Competencies for skilled birth attendants in Africa (2006) and the Ethiopia Occupational Standards (EOS).

The graph below shows that in 2011, 1,621 students were enrolled and 1,558 students graduated in 2012. Data reveal that 4 percent of the students dropped out from the training. This could be to the fact that the nurses were unemployed and looking for a job. Some of them stopped training once they secured a job. Ethiopia also introduced a Center of Competency (COC) examination which is given to diploma students after graduation to ensure that they have adequate skills and will not endanger patients. The graph in figur 17 shows that 68 percent of the graduates passed the COC test. When students fail the test they are given three more months and then they repeat the test.

Figure 16 Yearly intake if the AMP students

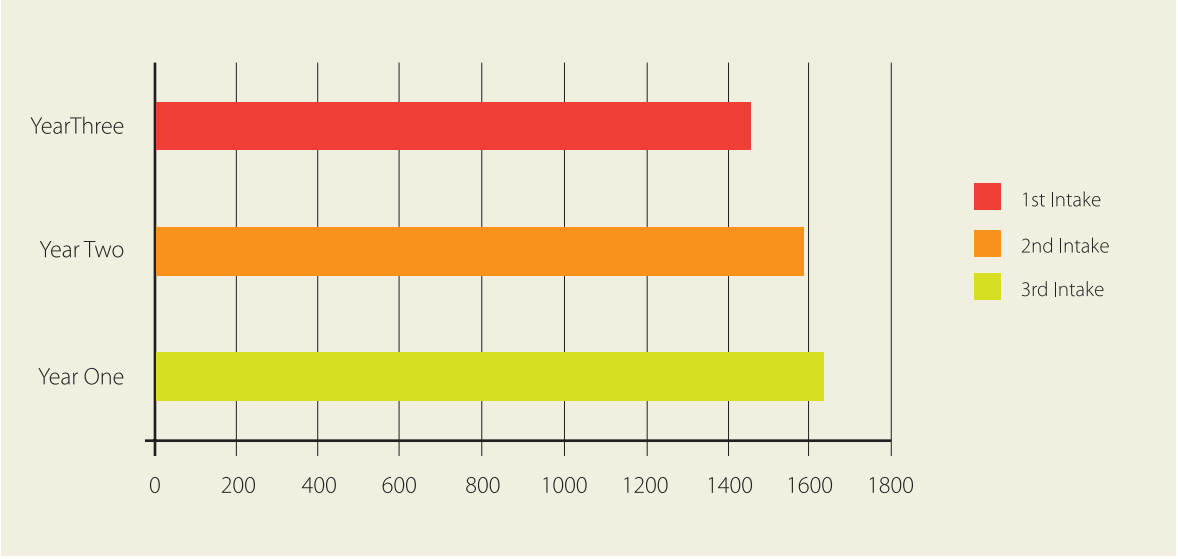
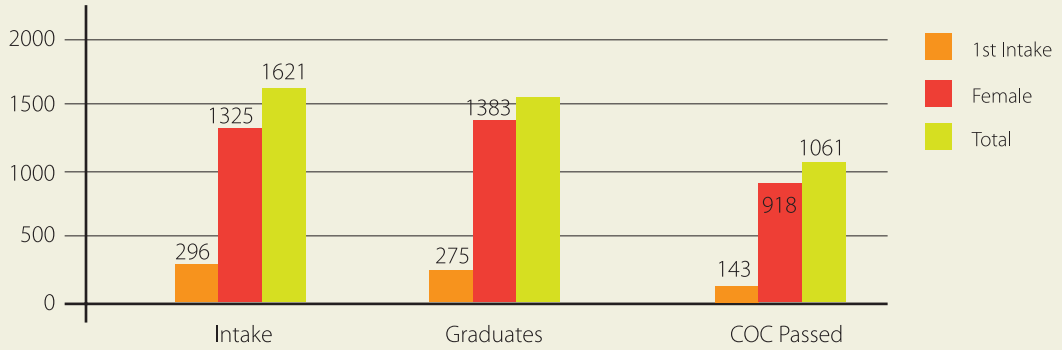


Figure 17 **AMP Students intake and graduates for 2011/2012**

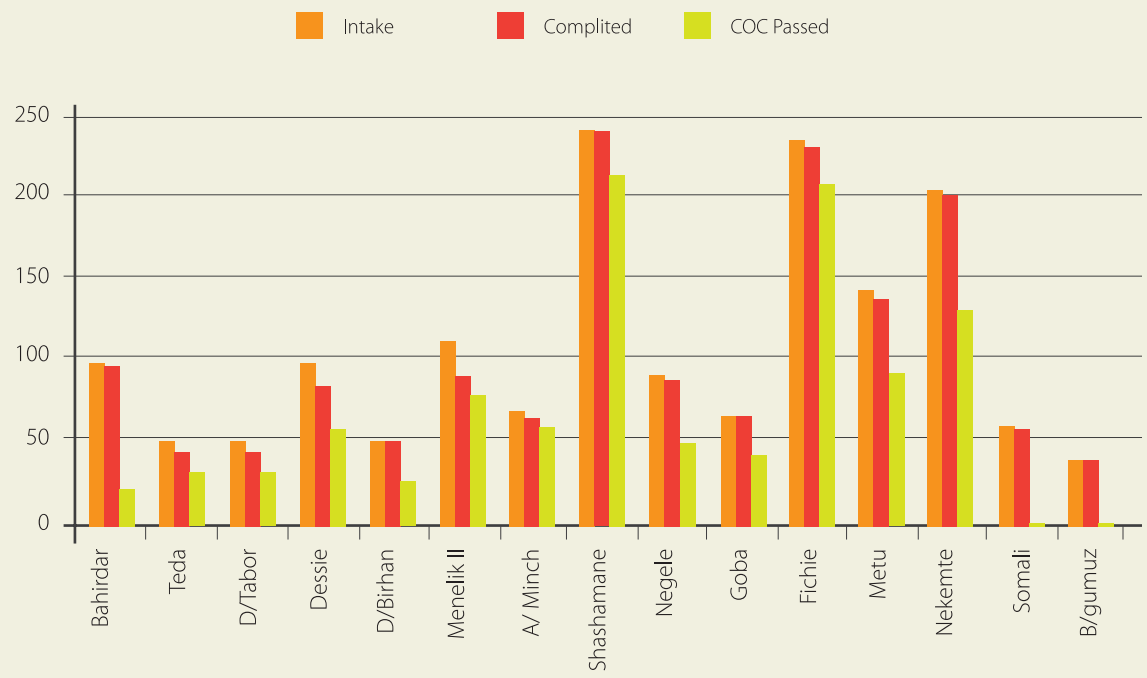


The table below shows the presentation on intake from each college. It shows that 85 percent of the students were female students while 15 percent were males. In Oromiya region all the students were females.

Table 4 **Presentation of HSCS Performance**

Region	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 18 **Graphic representation of HSCS performance**



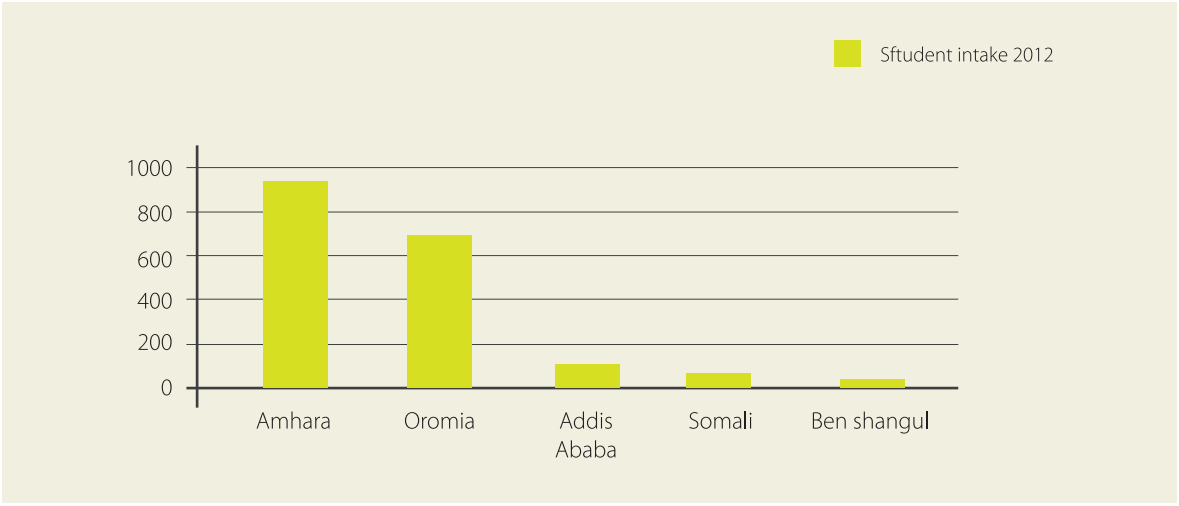
AMP graduate providing PMTCT services in Debreberhan Health center)

The graph shows high numbers of students in Shashemene, Filche and Nekemte colleges. Although Shashemene had the largest number of students making it more difficult for the students to acquire the required midwifery skills, data shows that over 80 percent of the students passed the COC test. The most disappointing college is Barhir dar where only 22 percent of the students passed the COC test.

Graduation Of Midwifery Students –Shashemene H.S.C. (May 2012)

Figure 19 **Sftudent Intake in 2012**

During the year 2012, five regions are training more student midwives and the intake has been increased from 1,621 in 2011 to 1,756; in 2012. Regional intake of students is as follows:



SECTION FOUR 4

MIDWIFERY REGULATION

Midwifery regulation is the set of criteria and processes arising from the legislation that identifies who is a midwife and who is not, and describes the scope of midwifery practice. The scope of practice are those activities which midwives are educated, competent and authorised to perform. Registration, sometimes called licensure, is the legal right to practice and to use the title of midwife. It also acts as a means of entry to the profession. The primary reason for legislation and regulation is to protect the public from those who attempt to provide midwifery services inappropriately (ICM 2011). To be licensed is a measure of competence and a sign of independent practice for professionals. However data collected showed that only 68 percent of midwives were licensed.

The Federal Ministry of Health established the Ethiopian Food, Medicine, Health Care and Control Authority (EFMHACA) which is a Regulatory Body responsible for regulating and licensing all health professionals in Ethiopia. The regulatory body is currently developing job descriptions and Scope of Practice for all health professionals. The body is working with individual professional associations to develop the job descriptions and scope of practice. The regulatory framework has not yet been established but there is plan to develop one.

The Higher Education Relevancy and Quality Agency (HERQA) was established as one of the key agencies responsible for guiding and regulating health care education along with the Higher Education Strategy Centre and the National Pedagogic Resource Centre. It ensures that accreditation of private academies and quality audits of education programmes for medicine, nursing and midwifery are aligned with international standards.

A Professional Code of Ethics and Conduct for Midwives was developed by the Ethiopian Midwives Association (EMA) in 2011. The final document was disseminated to midwives during the celebration of IDM and annual conference and also to all teaching institutions.

SECTION FIVE 5

ETHIOPIAN MIDWIVES PROFESSIONAL ASSOCIATION

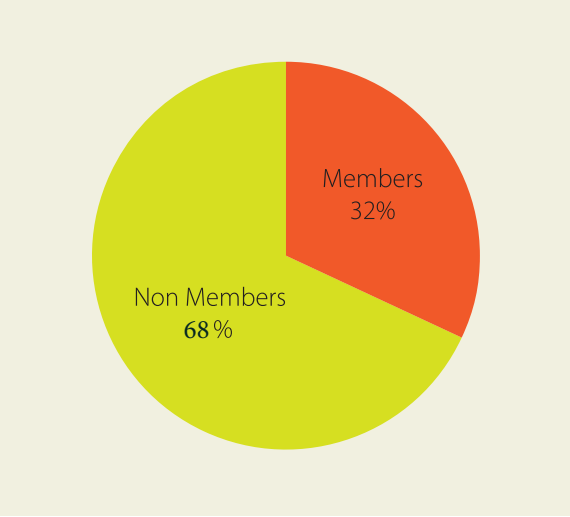
A strong professional association supported by its members and recognized by the government, regulatory authority and education programs is the pillar to promote a high-quality midwifery workforce. Associations that represent midwives have several roles and responsibilities, which include: (1) advancing professional practice, (2) partnering with regulatory authorities, (3) working with other health care professionals, (4) promoting professional networking and (5) partnering with women's groups. There are also additional roles expected of a strong professional association. These roles include; set and maintain standards of practice, adopt and use code of ethics, define scope of practice and set regulations, define educational content and qualifications for midwifery teachers, offer on-going education opportunities and provide leadership for health policies (Thompson, Undated).

The Ethiopian Midwives Association (EMA) was established in the year 1992 and was registered with Ministry of Justice under the new civil society organizations (CSOs) law and renews its membership every four years. EMA has been a member of the International Confederation of Midwives (ICM) since 1993. The vision of the Association is to see that: "Every woman has full access to institutional delivery; there is enhanced reproductive health rights of women free from all forms of reproductive health problems". The mission of the Association is: to promote and enhance the expansion; performance and status of midwifery profession through adopting quality and evidence based practices; adhering to the code of ethics and empowering the professionals with a goal of reducing maternal morbidity and mortality rates through provision of quality services.

The organization continues to make its contribution to the reduction of maternal and child mortality and improving quality of reproductive health service at the grass root level in Ethiopia. The association achieves these goals through partnerships with MOH and Development partners who are supporting programmes that are aimed at reducing maternal mortality.

The association is governed by 7 board members and has 5 regional branches in Tigray, Amhara, Oromiya, Somali and SNNP. The association has 32 staff members. Data shows that although the country has over 4,700 midwives only 1,500 (32%) are members of EMA.

Figure 20 EMA Membership



There are some midwives who are not aware of the existence of the professional association. Although efforts have been done to reach more midwives by establishing regional branches in Tigray, Amhara, Oromiya, SNNP and Somali, more efforts are needed to reach more midwives, especially, those in the rural areas.

EMA communicates to its members during the celebration of the International Day of Midwives and also through the Annual General Assembly Conference. Communication is also done through the regional branches. However, communication is not always easy as most of the midwives have no telephone or e-mail addresses. Data shows that only 673 midwives have e-mails and 1,416 have telephones. SNNPRS is the only region where more midwives have e-mail addresses compared to other regions. In Afar, Ben Shangul, Somali and Gambella, no midwife has an e-mail address. Midwives from these areas indicated that communication is a big challenge.

The Association has developed a five year strategic plan (2010-2015) and is implementing different activities under four main strategic directions. These are: capacity building, Advocacy and representation, Partnership and resource mobilization, and Research and monitoring and evaluation. The Association has been implementing a number of projects to build the capacity of its members as well as other professionals. The following projects/activities have been carried out by the Assocation with in the last 3 years.

Table 5 EMA's Activities

No.	NAME OF PROJECT/ ACTIVITY	NO. TRAINED	CADRE	FUNDING AGENCY
1	Basic Emergency Obstetric and neonatal care	974	Midwives, physicians, nurses and health officers	UNICEF/Jhpiego
2	Infection Prevention	22	Midwives	Ethiopia Public Health Association
3	PPH Management at Community Level	829	334 HEW and 447 TBAs, 30 Midwives and 20 MCH Heads.	Venture Strategies
4	Abandonment of Female Genital Mutilation	59	22 Midwives, 37 HEW	UNICEF
5	Safe Medical Abortion	251	Midwives	DKT, IPAS
6	Comprehensive PMTCT	172	Midwives	ICAP
7	Family planning	264	201 (HEW), 63 midwives	ESOG and Parkard Foundation
8	HMIS	20	Midwives	ESOG and Parkard Foundation
9	Capacity Building (ETS, CTS, leadership and Evidence Based Midwifery	120	80 Tutors 40 Preceptors (midwives), 17 board member	UNFPA

Although there has been an outcry from the midwives indicating that EMA is not doing enough for its members, the table above shows that most of the trainings targeted midwives and health extension workers. The trainings may not have benefited all midwives but a large population of midwives was reached.

Apart from trainings EMA has been conducting advocacy activities during the International Day of Midwives, international events such as ICASA, Congress for Public Health, during graduation of midwifery students and Midwife Anuual General Assembly. These activities include; panel discussions on radio and TV, Big walks, supporting hospitals and healthcentres including provision of infection prevention materials, development and disseminating IEC and advocacy materials.

IDM Celebration in Addis Ababa

IDM celebration in Jijiga, Somali

Evidence Base Midwifery

Training in Management of PPH

Family planning training

IDM Celebtation in Hawassa

CONCLUSIONS

There has been a substantial increase in the number of midwives in Ethiopia from 1,275 in 2008 to 4,725 in 2012. Majority of them 95.6 percent are providing midwifery services in various hospitals and health centres while the rest are working as managers, coordinators and lectures.

The accelerated midwifery training programme has contributed to the increase in the number of midwives in Ethiopia as 33 percent of midwives were trained through this programme.

There are more female midwives (3,662) than male midwives (1,063). However, more male midwives are trained at the degree level enabling them to get a better salary than female midwives.

The gender disparity in the midwifery training institutions is very striking with universities training almost 100 percent males and regional colleges training females.

The tutor/student ratio is very high and the classrooms are overcrowded. Some classes have more than 120 students making teaching and learning very difficult due to large number of students. This is more prominent in the colleges.

The health facilities for the practical area are very crowded with large numbers of students while the number of women delivering in the health facilities is less. This has affected the quality of training as midwives graduate without getting the required skills and number of deliveries.

32 percent of midwives in Ethiopia are practicing without licensure. This is a critical issue as they are not protected and can also endanger the lives of women and children.

There is no clear mechanism for re-licensure. The midwives are required to renew the license after 5 years of practice. However, there is no follow-up to ensure that this is done. The regulatory body has started to work on the mechanism.

70 percent of the midwives are satisfied with the type of work they do. Those working in NGO are more satisfied with their work because of good salaries. Opportunities for education and for transfers are the driving forces for change of employment.

Although the number of midwives in Ethiopia is increasing steadily, motivation and retention remains the two most challenging factors. Lack of access to further education, low salaries, lack of supervision and lack of opportunities for career development are the main demotivating factors.

There has been a substantial increase in the number of midwifery training institutions from 25 in 2008 to 46 in 2012. More universities are now providing midwifery education at the degree level. There are more female midwife students compared to the male students. The private sector is contributing substantially to the training of midwives as eight private institutions (17 percent) are providing midwifery training.

Ethiopia Midwifery Association has been strategic in capacity building of midwives and other health professionals in Ethiopia through training of midwives and other professional in various skills.

RECOMMENDATIONS

Information in this report shows that there has been tremendous amount of work in the midwifery education and services. However, a lot more needs to be done in order to contribute effectively to the reduction of maternal and neonatal morbidity and mortality. The following recommendations are being made:

1. Federal Ministry of Health and Regional Health Bureaus should speed up the implementation of the In Service Training Programme as most midwives cited lack of training and updates as a demotivating factor.

2. The Regional Health Bureaus should post experienced midwife to rural areas as this is where there are more problems and 80 percent of the population lives. The new graduates should be employed in urban setting to gain more experience before being posted to rural areas.

3. Federal Ministry of Health need to develop a supervisory mechanism for all health workers especially midwives and provide regular supportive supervision.

4. Federal Ministry of Health, Regional Health Bureaus and development partners need to develop quality improvement tools and follow up mechanism of practicing midwives in order to improve the quality of care being provided to mothers in maternity units and improve skilled attendance at birth.

5. Federal Ministry of Health and its partners should provide equipment and supplies to enable midwives provide basic emergency obstetric care in the health centres.

6. FMOH, MOE and partners should support the training of midwifery tutors at master's level in order to address the critical shortage of experienced tutors.

7. Ministry of Education and Regional Health Bureaus should ensure that tutors being assigned to teach in midwifery training institutions have at least two years of clinical experience.

8. There is a need to institutionalize the mentorship/ preceptors programme and ensure that each health facility that handles students should have trained mentors to support, mentor and supervise students in the clinical area.

9. EMA should recruit more members and follow up its members to ensure that they are providing good quality of care.

10. There is need to conduct a study on the acceptability of male midwives in Ethiopia in order to inform policy decisions on the training of male midwives.

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