

## The Review

# Developing primary care in Ethiopia to meet the Millennium Development Goals

### HAS IT BEEN EFFECTIVE?

The Ethiopian government's response to the Millennium Development Goals (MDG) has been to dramatically increase primary care and community-based services, with four- to fivefold increases in workforce and facilities. In rural Ethiopia, where 85% of the population live, over 90% now have access to a healthcare facility within 2-hours walk. However, the 2015 MDG 5 target for maternal mortality in Ethiopia is 218 per 100 000 live births and in 2000 the Ethiopian Demographic Survey reported a maternal mortality rate of 871 per 100 000 live births, falling to 673 in 2005, but static at 671 in 2010.<sup>1</sup> The harsh reality is that one in 31 women in Ethiopia still die from complications of childbirth. Despite the increase in health provision, only 19% of women attend four antenatal appointments, and 57% have no antenatal care. There are at least four major factors that prevent women gaining access to care that will allow them to deliver more safely.

### INADEQUATE TRANSPORTATION

Many women have to walk for 2–3 hours to reach a health centre: a mere 2.7% of rural Ethiopian households have access to any form of transport, and only 0.1% have access to a car. Labouring women are often refused access to buses or are charged greatly increased fares, and have to rely on the village 'foot ambulance', which consists of a team of villagers taking turns to carry the woman on a wooden, leather-meshed stretcher.

### LOW VALUE PLACED ON COMMUNITY-BASED MATERNITY SERVICES

There is still a lack of acceptance of the need for a skilled birth attendant among Ethiopian families. Although 34% of women now attend at least one antenatal appointment, in rural areas 96% deliver at home, with a caesarean section rate of 0.5%. In Jimma University

'Foot ambulance'.



Hospital, which serves a rural community, 179 of 1468 (12%) deliveries were obstructed, with uterine rupture in 55 (45%). Local health centre staff, who referred these women were judged insufficiently skilled or experienced to recognise that labour was becoming obstructed.<sup>2</sup>

### A LACK OF TRUST IN THE QUALITY OF CARE

Because staff in the health posts and health centres often lack the skills or facilities required to identify and deal with the main causes of maternal mortality, infection, and haemorrhage, women may consider that there is little to be gained from delivering there. Concerns have been expressed about poor staff attitudes towards patients, with nurses failing to listen to their concerns, not taking their symptoms seriously, and shouting at them when they arrive for treatment.<sup>3</sup> It is unsurprising that women prefer to give birth at home. Other problems include lack of accountability, absence of complaint procedures, incomplete clinical records, and only rare investigations into maternal mortality. Promotion seems to be based on time served, and disciplinary action is virtually unheard of. Staff appointments are made centrally with no individual choice on location, generating demotivation and family difficulties.

### INABILITY TO MEET THE COSTS OF CARE

Although maternity care is free at the point of access, charges are made for medication and clinical supplies. With additional costs for transportation, many very poor Ethiopian families simply cannot afford to seek primary and secondary care services.

### A WAY FORWARD?

There are no quick fix solutions to Ethiopia's difficulties in reducing maternal mortality. High-risk women must be identified and advised to seek hospital treatment. This will require a change in attitude among healthcentre staff, who should always ask women about their obstetric history and carefully assess them for hypertension and malpresentation when they attend in later pregnancy. Providing sublingual misoprostol to take immediately after the birth will reduce the incidence of postpartum haemorrhage. A tabloid message about obtaining help if labour continues for more than 12 hours can be delivered to all families through various

### ADDRESS FOR CORRESPONDENCE

**Karen Ballard**

School of Health & Social Care, University of Surrey, Guildford, Surrey, GU2 7XH, UK.

**E-mail: k.ballard@surrey.ac.uk**

media sources, and may prevent some of the maternal deaths from obstructed labour.

Ethiopia's expenditure on community-based health care needs to be supported by ensuring that staff are adequately and continually trained and are accountable for the quality of service that they deliver. Most women deliver at home, so it makes sense to improve the quality of community-based care and increase the range of treatments in the health centres. Women who require hospital services should be able to access them in a timely manner. A waiting house attached to the hospital, where women can literally 'wait' for the onset of labour, is ideal. Early recognition and transfer of women with obstructed labour is crucial. As the African proverb says:

*'The sun should never set twice on a woman in labour.'*

Just taking heed of this would go some way to moving Ethiopia closer to MDG 5.

**Karen Ballard,**

Senior Lecturer in Women's Health, School of Health & Social Care, University of Surrey, Guildford, and voluntary worker for Maternity Worldwide, UK.

**Jeremy Wright,**

Visiting Professor, Obstetrics and Gynaecology, University of Surrey, Guildford, and voluntary worker for Maternity Worldwide, UK.

DOI: 10.3399/bjgp12X656883

### REFERENCES

1. Central Statistical Agency [Ethiopia] and ICF International. *Ethiopia demographic and health survey 2011. Demographic and Health Surveys*. Addis Ababa, Ethiopia and Calverton, MD: Central Statistical Agency and ICF International, 2012.
2. Shimelis F, Hailemariam S, Fessahaye A. Incidence, causes and outcome of obstructed labor at Jimma University Specialised Hospital. *Ethiop J Health Sci* 2010; **20**(3): 145–151.
3. Lindelow M, Serrneels P. The performance of health workers in Ethiopia: results from qualitative research. *Soc Sci Med* 2006; **62**(9): 2225–2235.