Independent review of aid effectiveness

> 'Australia helps countries develop better quality, cost effective and community focused health systems that are sustainable and that lead to better health outcomes in the long term' http://www.ausaid.gov.au/keyaid/health.cfm

I have recently been awarded my PhD where I examined Millennium Development Goal 5 and maternal mortality in rural Ethiopia from a development perspective. In December I joined the board of the Birthing Kit Foundation (Australia) (BKFA). I specifically want to comment on:

> ❖ the relative costs and benefits of the different forms of aid, including the role of non-government organisations and the appropriate balance between multilateral and bilateral aid funding arrangements.

by discussing aid that targets the major causes of maternal mortality through the health system. Although the distribution of aid is mostly provided through bilateral channels only a small amount is provided through NGOs who are often in a position to reach women who are unable to access the health system because of distance or cost. This means there are significant cost benefits to expand the role of NGOs as many programs are efficient and effective.

Maternal mortality in Ethiopia

Much of the existing literature about maternal mortality and disability in developing countries focuses on describing the magnitude and causes of the problem; the difficulties in measuring maternal mortality; the obstacles to Safe Motherhood; and the interventions needed to strengthen modern health systems. It is argued that these 'health system factors' largely focus on levels of maternal mortality and morbidity that tell us about the risk attributable to pregnancy and childbirth as well as the performance of health systems in terms of access to health care and the quality of care provided.

To meet the maternal health needs of Ethiopia's rural population, emphasis has been placed on the decentralised health system and delivery of basic community-based maternal and neonatal health services, most notably through Health Extension Workers and mid-level service providers. The aim is to increase to 60 percent the proportion of births attended by skilled health personnel either at home or in a facility (a six-fold increase from the current 9.7 percent). Community-based health workers must be able to refer complications to the appropriate facility; and hospitals must be adequately equipped and staffed to provide Emergency Obstetric Services (EmOC) services. However, so far, the emphasis has been the construction of new health facilities and in many instances, regional and district governments must choose between building facilities or improving the quality of existing facilities because of their limited budgets.

On the way to Deckia in rural southwest Ethiopia (one to two days walk to the hospital)

My research found that people in rural southwest Ethiopia only access the modern health system when a birth is 'abnormal' because things go wrong at home. Most women give birth at home with the assistance of their neighbour, mother, mother-in-law, husband or sister. When there is pain, haemhorrhage, obstructed labour or birth is at night, traditional remedies are generally tried first which means there can be considerable delay if a decision is made to take a woman to a health facility.

Women themselves are not necessarily part of the decision making process to seek biomedical care because decisions are made primarily by a woman's husband, close relatives and neighbours, and sometimes even village elders or witchdoctors. In doing so the decision making process generally involves people who have no training about when to refer women to skilled health personnel. When the decision is made relatives and neighbours will be asked to lend money, to help make a stretcher and to carry a woman to the nearest health facility. In many instances, this process can take between one and three or four days depending on the (walking) distance to the hospital or health centre (see photo).

In my thesis I argue that a picture emerges of 'unsafe' childbirth denoting those births that are transferred to a health facility such as the local hospital or health centre. It is likely women feel it is always 'unsafe' to go to a health facility because of the very real possibility they will die on the way. Because around 75 percent of maternal deaths are caused by direct obstetric causes (haemorrhage, eclampsia, obstructed labour, infection, toxaemia and unsafe abortion), there is no doubt that improved health services will save lives.

The need for two approaches to reduce maternal mortality

Development strategies should start at the top to ensure all the elements of comprehensive EmOC are available at all times. To be an effective referral point, hospitals need medical supplies and equipment, access to blood transfusion and 24 hour electricity, generators that are functional and ambulances to refer patients. This implies that development strategies and the availability of infrastructure—roads, cars, telephones, literacy, skilled manpower and clinics/hospitals—are necessary for implementing this approach.

However, it is equally important to focus on the communities as they are the ones who organise and carry women long distances in rural areas. One way to do this is to work with NGOs who often provide welfare services to those who cannot be reached. In many instances, NGOs have become the preferred channel for providing health services rather than the state. For example, the BKFA works with organisations and communities to provide a clean birthing environment for women in developing countries in order to reduce the incidence of infant and maternal mortality. BKFA provides birthing kits and education in clean birthing practices.

In Ethiopia the BKFA works with the Addis Ababa Fistula Hospital, the Afar Pastoralists Development Association and Abraham's Oasis. To date, BKFA has provided almost 80,000 birthing kits to the Addis Ababa Fistula Hospital where they are used by the outreach centres in Bahir Dar, Mekele, Harer and Yirgalem in their preventative health training programmes in remote regions. BKFA has secured funding from Rotary International to provide funding for possibly another 50,000 kits to be made in country. The BKFA has

provided funding for the Afar Pastoralists Development Association (APDA) to educate women on clean birthing, women's rights and minimizing harmful traditional practices. So far, the APDA has been funded to make 20,000 birthing kits in Ethiopia. Three thousand kits have been sent to Abraham's Oasis.

Ethiopia's Ministry of Health has requested a further 15,000 birthing kits for Gambella in the western part of the country where there are large numbers of displaced people from Sudan due to the referendum, and the recent development of moving some of the Gambella people to new settlement areas. In the new settlement areas there is no existing health facilities and requires setting up temporary services.

The BKFA is an example of how an NGOs can fill a gap that is currently unable to be filled by government or multilateral and bilateral aid funding arrangements.

Dr Ruth Jackson