Village Health Partnership

Safer Motherhood in Rural Ethiopia

VILLAGE HEALTH PARTNERSHIP

TRIP REPORT 2025

www.villagehealthpartnership.org

INTRODUCTION

Dear Friends:

The Village Health Partnership (VHP) is a 501(c)(3) non-profit organization that works for safer motherhood in rural Ethiopia. Our mission is to prevent mothers and babies from dying in childbirth and to treat and prevent the development of gynecologic complications of childbirth, including obstetric fistula.

In the rural areas of Ethiopia, the identification of women with obstetric fistula is a marker for a deeper crisis in maternal health. Where there is fistula we know that mothers labor alone at home. Without medical assistance, many die in childbirth, and many more babies die. In western Ethiopia, where there is ongoing active military conflict, we seek out and treat women with obstetric fistula and other serious gynecologic complications of childbirth. In southwestern Ethiopia, we are working to prevent maternal and neonatal morbidity and mortality in childbirth by ensuring that pregnant women have access to clean, safe, and effective medical care at the time of delivery.

Every year, as we have for the last 15 years, we return to Ethiopia, where we work with our partners on the ground to assess programs, ensure progress toward our mission, and define future directions. This year, we began our trip in southwestern Ethiopia, and then we returned to Addis Ababa, the capital of Ethiopia, where we toured St. Paul's Hospital and met with our partners from western Ethiopia, the Hamlin Fistula Hospital, and the Rotary Club of Addis Ababa. We looked critically at all that we are doing, had hard discussions with everyone we are working with, celebrated success with the community, and came away even more committed than ever to continuing our work for safer motherhood in some of the most challenging parts of the world.

SOUTHWESTERN ETHIOPIA

In southwestern Ethiopia, the government is working to address the crises in maternal and neonatal health by encouraging pregnant women to come into health facilities, where it is hoped that they will deliver there more safely than at home. Unfortunately, our early assessments more than a decade ago revealed that without water, measures for sanitation and hygiene, and infection prevention controls, health facilities in this remote part of the country were actually deadly places to deliver.

In an effort to give women access to the medical care that they so desperately need, we have been working to create a health system of care involving a referral network of 10 medical facilities — a regional hospital, three district hospitals, and six health centers — spread out over the West Omo and part of the Bench Sheko Zones (WOZ and BSZ). To this end, we have been attempting to implement year-round access to clean water, measures for sanitation with biohazard areas and concrete pit latrines, infection prevention controls, and infrastructure, equipment, and supplies for maternal health in each of the 10 facilities (see map). We have also been skill-checking and training nurse-midwives. Working with Water Engineers for the Americas and Africa (WEFTA), we have developed a Safe Clinic Tool Kit (SCTK) application that is being used on an iPad to track results and record progress. Now we have data to confirm our efforts and guide decisions about future directions. **See Appendix.**

Last year, medical providers in nine of the rural health facilities facilitated 3,104 deliveries, and health officers in the Maji and Bachuma District Hospitals performed 172 cesarean sections. The regional hospital facilitated an additional 4,259 deliveries and 1,219 cesarean sections.

Mother with new infant at the Jomu HC

Two years ago, we found emaciated pregnant women coming into maternity waiting areas at several health facilities in the WOZ. We researched the issue. Food insecurity in the area involves a deficit of calories, protein, and critical minerals and vitamins. Diets are mostly corn-based. Pregnant women and children up to two years of age are particularly vulnerable to malnutrition, anemia, and vitamin deficiency. This year, we added a food security component to our program.

Our full team gathers for a group photo

ASSESSMENT TEAMS

Water, Sanitation, and Hygiene (WASH) and Solar Team: Traveling with us this year were Marty Howell and Nathan "Nate" Stormzand, volunteer engineers from WEFTA based in Santa Fe, New Mexico, along with Shimeta Ezezew, CEO, Tamirat Fikre, and Girma Genet from the Ethiopian NGO Afro Ethiopia Integrated Development (AEID), and Yonas Worke and Tariku Lemi, engineers from the Addis Ababa-based Sun Transfer Technology (STT). We were joined in Maji, Tum, and Chebera by Markos Gebresilassie, community leader from Maji, who is becoming our WASH "Circuit Rider."

Clean and Safe Healthcare (CASH) Team: Traveling with us were "Migs" Muldrow, MD, a volunteer with the Village Health Partnership (VHP) in Denver, Colorado, and Abraham Tadesse, MD, from the Mizan Tepi University Teaching Hospital (MTUTH) in Mizan-Aman, Ethiopia.

Nurse Midwife Education and Training Teams: Traveling with us to the rural areas were Yared Deyas and Lydia Gutima, both nurse-midwives (NMWs) and educators from the Mizan Tepi University (MTU) and the MTUTH in Mizan-Aman.

MTUTH Medical Team: Patty Kelly, RN and International Master Trainer, and Courtney Nicholas, MD, Neonatologist, both volunteers with VHP, stayed in Mizan to train and work in the MTUTH.

Food Security Team: Traveling with us were Roger Flahive, a volunteer with VHP, along with Teklemariam Ergat, former CEO of the MTUTH, and Mengesha Dobini and Tesfaye Demisle from the WOZ Department of Agriculture.

Asaminew Debele has been our driver for the last 15 years. He organizes our on-the-ground transportation, food, lodging, and security, and serves as a critical "behind the scenes" link with stakeholders. Asaminew is now "family."

Map of southwestern Ethiopia with health facility locations

TRAVEL/SITE OVERVIEW

After three days of international travel, we arrived in Mizan late at night. Early the next day, on Monday, November 3, we drove out of Mizan in a caravan of Land Cruisers and headed for the WOZ. Patty Kelly and Dr. Nicholas stayed in Mizan to work in the MTUTH. We stopped to meet with Zonal government officials in Jomu and then went on to do assessments in Tum and Maji, Kuju, and then Chiruharoot and Jomu over the week. On Thursday, November 6, we celebrated the completion of the Kuju Health Center and Community Water Project. 3,000 people showed up to feast and dance. On Saturday, November 8, the Food Security Team left for Rwanda to train with Gardens For Health and Bridge 2 Rwanda. The rest of the group drove to Chebera and then to Bachuma for more assessments

Kuju dancers

and then back to Mizan for hot showers and some rest. We regrouped and held discussions on Sunday, November 9 at the Salayish Hotel. That night, we hosted a dinner for the CEO of the MTUTH and medical providers. The next day, on Monday, November 10, we drove to Siz, where we did more assessments and celebrated the installation of a new solar power system at the District Hospital. On Tuesday, November 11, we traveled back to Addis Ababa.

At every health facility and town we visited, we worked with Regional, Zonal, and Woreda government officials, town mayors, heads of medical facilities and medical directors, doctors, NMWs, and other medical professionals, as well as Orthodox and Christian priests and pastors. We had rigorous discussions about programs, identified constraints, defined who could do what, and we celebrated progress. At times, the outpouring of support was truly overwhelming.

Nate dancing

HEALTH SYSTEM OF CARE (10 MEDICAL FACILITIES)

Water, Sanitation, and Hygiene (WASH) and Solar Assessment

Six years ago, VHP started by finding no water in health care facilities, no mechanism for medical waste disposal, open defecation, minimal light on labor and delivery, and no refrigeration for critical medications. Now all facilities have some water, biohazard areas, concrete pit latrines, and solar power. Because of this, all facilities are offering delivery services, and the Maji and Bachuma District Hospitals, with operating rooms that were found to be up and running, are able to provide emergency obstetric care, i.e., cesarean sections. With water and a newly installed solar power system, the Siz District Hospital was found to be working to open its operating room for emergency obstetric care. Women are coming into facilities by the hundreds over the course of a year to access cleaner and safer medical care at the time of delivery, but problems were identified.

Now that facilities have water, repair of storage tanks and indoor plumbing has become an issue in the Maji District Hospital and the Tum, Chiruharoot, Kuju, Jomu, and Siz Health Centers. For example, with the implementation of the new Kuju Health Center and Community Water Project, the labor and delivery room flooded as water to the facility was turned on. Water quality has also become a

Flooded postpartum room

concern. Jomu Health Center, which gets its water from a capped-off community spring that shares the water source with livestock, and the Chebera Health Center, which gets its water from a rainwater catchment system and an open hand-dug well, were found to have water that tested strongly positive for E. coli. It was clear that in health care facilities where access to water has been interrupted, such as the Chiruharoot and Siz Health Centers, infection prevention controls in the facilities had gone downhill fast, threatening safe delivery.

Most facilities now have improved biohazard areas. The exception was the Kuju Health Center, which still had an open, unfenced pit for disposal of placentas and medical waste. At the Siz Health Center, personnel had failed to dig a new burn pit. Bloody gauze, gloves, needles, and syringes were piled high next to a community garden. All incinerators were crumbling. There was no safe way to burn sharps and then collect the debris into a covered pit. The danger can't be overstated.

For the first time in several years, we saw open defecation. The Chiruharoot Health Center maternity waiting area was full and overflowing with pregnant mothers waiting for delivery, along with their young children. In the crush, nobody was educating those coming in on the need to use the concrete pit latrines. But who could blame them? With an interrupted water supply, the latrines weren't being cleaned.

All facilities now have access to solar power. This has been one of the most important recent accomplishments. This was deemed critical as there is minimal, if any, access to the electric grid and to diesel-powered generators at most locations. Small solar systems, dedicated to labor and delivery that provide light and power to refrigerators for critical medications like Oxytocin, work best. It was easy to overload whole facility systems with laboratory equipment, autoclaves, refrigerators for vaccines, and personal cell phones and laptops. In this type of setting, labor and delivery wasn't usually prioritized.

Siz HC burn pit

Solar

Strategic Realignment

Facing these challenges, it was clear that we weren't ready to scale up our model of intervention — as the VHP board had considered for 2026 — and begin working in health facilities west of Mizan in the Bench Sheko Zone or further south in the Omo River Valley. Instead, we needed to pull back and double down on the implementation of WASH and solar infrastructure in the 10 health facilities that we have been working in. A strategic decision was made to refocus our direction. In on-site discussions, we re-engaged stakeholders to do their part, and we turned our efforts toward the implementation of robust "circuit riding" programs.

Government officials pledged to help and ensure that all facilities had year-round access to water, as well as measures for sanitation and hygiene. In Tum, officials "forgave the facility debt" and promised to connect the health center and maternity waiting area to the town water system. In Chiruharoot, government engineers worked to install a large new solar-powered pump on the community well. They assured us that the health center would have water within a week. In Siz, they promised to renovate the health center, connect the facility to the town water system, fix the water storage tank and plumbing in the facility, and create a new biohazard area. Heads of health facilities said that they would take personal responsibility and make sure that open defecation did not happen.

For the long term, WEFTA engineers found that the four borehole wells that VHP had implemented, as well as the Maji town well, did not need much maintenance. Problems could be identified during our yearly visits, and AEID could be engaged to handle issues as they arose. The engineers talked with Markos. They would work with him to fix leaking storage tanks and repair plumbing (inside and out) at the Maji District Hospital. The hospital would pay for his help. VHP would pay Markos to fix storage tanks and repair plumbing at the Maji hospital maternity waiting area and at the Tum, Kuju, Chiruharoot, and Jomu Health Centers. Markos agreed to also repair and upgrade the rainwater catchment system on the new building at the Chebera Health Center. We would not work to fix the indoor plumbing there. Water was in extremely short supply. Providers would still need to use jerry cans. The plan was to create a maintenance budget and to ultimately train and hire Markos and his team to proactively visit all health facilities, except the MTUTH since it has its own engineers, to proactively maintain and repair all water systems.

Nate investigated the issue of biomedical waste disposal and incineration. The WEFTA engineers would work with Markos to implement a new kind of medical waste incinerator and model biohazard area at the Tum Health Center. The model would be scaled up and implemented in Chiruharoot and Kuju this year and then in all other facilities over time. Biohazard areas would also need to be on a maintenance schedule.

Markos

Yonas with cell phone

Clean L&D

Sustaining solar power systems required a different approach. STT and WEFTA engineers would assess all solar systems every year and make recommendations for maintenance and repair. In addition, hospital systems would be monitored 24/7 using an application on an iPhone. STT installed the required hardware when implementing the solar power systems at the Bachuma and Siz Hospitals. We would price out and implement the same remote monitoring system for the Maji District Hospital and all the solar-powered pumps. Yonas would call and check on the smaller health centers every six months, and stakeholders (who have his phone number) would call if they encountered problems before then. Each facility agreed to hire someone to clean solar panels on a monthly basis. In the long run, VHP would work with STT to implement dedicated solar systems for labor and delivery at Tum and Chebera and to maintain the dedicated solar systems for labor and delivery at all other facilities. The government would need to be responsible for replacing batteries and repairing the larger whole health facility solar power systems.

We would continue to collect data and monitor results.

Clean and Safe Healthcare (CASH) Assessment

Six years ago, we started with labor and delivery rooms covered with layers of dried blood, no hand washing, no protective gear, and no sterilization of surgical instruments. There was little understanding of how to dispose of medical waste or how to practice medicine safely. Delivery tables were rusted and dilapidated. Pregnant women labored outside in the rain, sleeping under trees with no food, as they waited to deliver.

The full-scale transition to clean facilities and procedures is a major accomplishment. Now all delivery rooms are clean. They no longer smell of blood. Dr. Abraham had been coming to visit

each health facility every three months for the last two years. He worked hard to train housekeeping staff and the NMWs on how to clean labor and delivery twice per day and after each delivery. Last year, we purchased and distributed chlorine to the smaller health centers. The district hospitals were already sourcing and using chlorine being purchased in the local markets. Dr. Abraham also trained the NMWs on hand washing, the use of protective gear, the appropriate disposal of medical waste, and the need to clean and sterilize surgical instruments. He ensured that all medical providers were practicing medicine so as to limit infection at labor and delivery, in the neonatal areas, and in the operating rooms.

Remarkably, even the labor and delivery room at the Chiruharoot Health Center with a limited supply of water was clean. The Chebera and Siz health centers were disappointments. Chebera, in spite of repeated intervention, was clean but disorganized, and its infection prevention controls did not measure up. Leadership was poor. Siz Health Center had minimal water. Although labor and delivery was clean, medical providers weren't washing their hands before or after procedures. The autoclave was broken. Surgical instruments weren't being sterilized. The community needed to decide either to intervene or close the facility as the new Siz District Hospital, nearby, was now ramping up to provide care. The Bachuma District Hospital, for all its progress, did not have a hand-washing station in labor and delivery.

VHP had been purchasing critical equipment and supplies for labor and delivery. Only two facilities needed new exam tables and surgical delivery sets. All facilities had pharmacies that were fully stocked with critical medications for maternal health and laboratories that had the reagents necessary to test for pregnancy, HIV, hepatitis, syphilis, and malaria. The bigger hospitals were also able to measure hematocrits and test for anemia before surgery. This was critical as blood products are in short supply.

Cleaning L&D

Chiruharoot maternity waiting area

All facilities except the Siz Health Center and District Hospital had maternity waiting areas. These buildings were being heavily used. Mattresses needed replacing. VHP would make that a priority if the government ensured that each bed had a mosquito net and pregnant mothers had nets to take home after delivery. The community was suffering through a major outbreak of malaria. Approximately 80% of the population was estimated to be infected. Many people were dying, including pregnant women. Without support from

Maternity waiting area beds with nets

USAID, Médecins Sans Frontières (Doctors Without Borders) had been called in to help.

We would continue our CASH "circuit riding" program in partnership with the MTUTH. It is highly effective.

Nurse Midwife Education and Training

During our early assessments, medical providers asked for education and training. Alone on the front lines of healthcare, a large number of them did not feel qualified to handle deliveries. In 2021, we skill checked NMWs in a number of facilities. Unfortunately, many failed their assessments. With the help of Yared Deyas, we designed a Skill Check, Training, and Mentorship Program to intervene. Over the last four years, Yared and Lydia have been traveling regularly to all 10 facilities to assess the obstetric and neonatal resuscitation skills of two NMWs in each facility and to train on the spot. Those found to need extra support are referred for a three-week intensive BEmONC course at the MTUTH.

Lydia Training

The program has its challenges. Medical directors love the medical training, but the data shows slow improvement in NMW skills. Turnover of NMWs is high. The government is prioritizing centrally located large development projects over salaries for healthcare workers. Some NMWs aren't getting paid. Morale is low. Those who need the most support aren't being referred to the BEmONC training course.

We held extensive discussions with Zonal administrators, hospital leadership, and NMWs. We agreed to expand the education program and begin training all NMWs in each facility every three months. The training would now become a required part of their job duties. In the District Hospitals and the MTUTH, NMWs would now perform daily rounds with physicians. Once a month, they would present difficult cases, discuss poor outcomes (morbidity and mortality), and watch a BEmONC training video on a key topic. We voted to close the BEmONC training program at the MTUTH for now. Government officials agreed to the changes and promised to prioritize paying the NMWs their monthly stipend.

We would continue our Education and Training "circuit riding" program in partnership with the MTUTH. We would collect data and monitor results.

MTUTH

The MTUTH is the regional hospital that serves as an anchor to the network of healthcare facilities that we have been working with. The hospital has a catchment area of 2.6 million people and is the referral hospital for all medical facilities in southwestern Ethiopia.

The hospital should be a center of excellence for the care of pregnant mothers and neonates, but the facility has its challenges. It is dependent on river water that is trucked in daily. The facility is connected to the electric grid, but power is only intermittent, and the generators that are used to power lights and equipment in the operating rooms are old and failing. Maintenance and diesel fuel are expensive. NMWs assisting with labor and delivery aren't resuscitating neonates "born not breathing." Some equipment is locked in a closet. The neonatal intensive care unit (NICU) is overwhelmed with babies with asphyxia and hypothermia, and with septic babies being referred in from outlying facilities. Premature babies "disappear" after several days of care. Parents perceive that care is futile and take the infants home to die. They may not be wrong. Hospital statistics only reflect that the infants have been discharged. Last year, Dr. Abraham lost his newborn son. The child aspirated meconium. Without ventilator support, the infant died. We all felt the loss.

Everyone we interviewed, including Dr. Erkyihun, CEO of the hospital, is motivated to "lift up" labor and delivery, the maternal operating rooms, and the NICU. For the last year, VHP, Patty Kelly, RN, Dr. Courtney Nicholas, and medical providers at the MTUTH have been working to craft a plan to intervene. VHP purchased critical equipment and supplies for the NICU. On this trip, Patty trained six trainers and then 48 medical providers on Essential Newborn Care (neonatal resuscitation), and Dr. Nicholas worked in the NICU helping establish protocols for infection prevention, temperature regulation, and feeding, and for treating septic babies and neonates in respiratory distress with CPAP up to, but not including, ventilation. Ventilator support will require adequate power, trained biomedical engineers, detailed protocols including the ethics of intubation, and the ongoing education, training, and mentorship of medical staff.

Back in Addis Ababa, we toured St. Paul's Hospital along with Dr. Abraham and Dr. Kidus from the MTUTH. The hospital's labor and delivery unit with an Advanced Life Support (ALS) Team and their NICU are models for what can be done at the MTUTH. VHP, the MTUTH, and St. Paul's Hospital will partner to establish a comprehensive action plan, train medical providers, and ensure ongoing in-country mentorship. Together, we will work to "lift up" the MTUTH and make it a center of excellence for maternal/neonatal care in

Team at St Paul's Hospital

southwestern Ethiopia.

Of note is the fact that the maternity waiting area at the MTUTH (built by VHP), is now in use by pregnant mothers. All doctors have been moved and housed elsewhere. Dr. Erkyihun directed that the women staying there are to be fed three meals a day from the hospital kitchen. In addition, Dr. Erkyihun says that he plans to take a team of medical providers to visit the Maji, Bachuma, and Siz District Hospitals as part of the MTUTH Mentorship Program. They will work to get neonatal areas to "Level 1 NICU Status."

NEW PROGRAM: FOOD SECURITY

Last year, Roger Flahive traveled with us to Ethiopia. He was so moved by the stories of starving pregnant women coming into maternal waiting areas (MWAs) that he decided, in his own words, "to change his career from engineer to farmer." He researched food and nutrition issues and model programs to support pregnant mothers and their children. He connected with Gardens for Health and Bridge 2 Rwanda in Rwanda. With the support of the WOZ Department of Agriculture, he put together a team and set up training in Rwanda. After training, the plan was to implement similar programs in the WOZ.

Stakeholders were extremely supportive of the idea. In Maji and Tum, officials offered land near the MWAs for demonstration gardens. Markos would oversee the implementation and ongoing management. Women in the community, who were working to establish a women's business cooperative, were already coming together to help feed pregnant women waiting for delivery in the MWAs. These women could be recruited to tend the gardens, learn to cook more nutritious food for pregnant mothers, and even develop income-generating projects with the produce. The hope was to also raise chickens. The eggs could provide a source of protein, and the droppings could be used in compost for the gardens. In Kuju, the government donated to VHP two hectares of land for "conservation" agriculture near the MWA at the health center. This land would be used to grow more nutritious food on a larger scale.

ADDIS ABABA AND WESTERN ETHIOPIA

On Tuesday, November 11, we drove to Jimma and then flew back to Addis Ababa. Marty left for Europe, and Nate stayed in Addis to work on other WEFTA projects. Migs, Patty, and Courtney met up with Laury Bowman, Chair of the VHP Board of Directors, who had flow in that day to join meetings with everyone from the Ethiopia Evangelical Church Mekane Yesus Development and Social Service Committee (EEMY DASSC), our partner in western Ethiopia, to tour St. Paul's Hospital and meet with leadership from the Hamlin Fistula Hospital and members of the Rotary Club of Addis Ababa.

Western Ethiopia with the four Zones that we are working in

SCREEN, TRANSPORT, AND TREAT (STT) PROGRAM

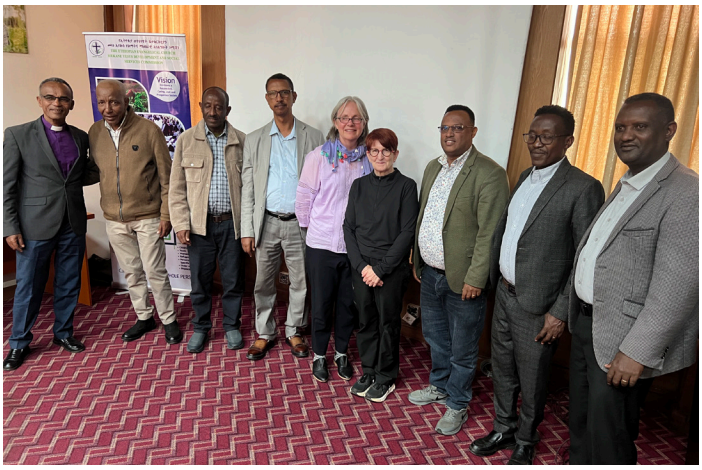
For more than eight years, active military conflict has raged across western Ethiopia. In this remote and rugged area along the Sudan border, women have traditionally had minimal access to healthcare. They often labor alone. Many die in childbirth and many more babies die. Rates of obstetric fistula and severe pelvic organ prolapse are high. Leaking urine and stool, with no water to bathe, these women hide in shame, waiting to die. The suffering is immense.

Fighting between various opposition groups and the federal government makes development work nearly impossible. Nonetheless, the Western Wollega Bethel Synod Development and Social Service Committee Branch Office (WWBS DASSC BO) has a long history of grassroots outreach to even the most remote parts of western Ethiopia. Together, we have been working to identify, transport, and then treat women suffering from obstetric fistula and severe pelvic organ prolapse in four zones, with potential outreach to four million people. The program has had a ripple effect. Women now know that treatment is possible. They are demanding care and encouraging others to seek assistance with delivery. Through the program, Aira Hospital has become a center of excellence for women's health in western Ethiopia. The Dembi Dollo Hospital is also coming online to help. In 2025, we added the renowned Hamlin Fistula Hospital, based in Addis Ababa, to our network of care. Now the hospital in Nekempt is asking to be included in the program. By the end of this year, we hope to treat 35 women with obstetric fistula and 350 women with 3rd- to 4th-degree pelvic organ prolapse.

The work is dangerous. In May, the program manager and his driver were kidnapped at gunpoint, beaten, tortured, and held for ransom. They survived the ordeal, but the event highlighted the dangers of remote outreach, opened up fractures in the leadership of the WWBS DASSC BO, and revealed other problems with the program. Aira Hospital has been the main treating hospital. Dr. Tariku is a skilled fistula surgeon. Redo fistula cases and women with severe injuries, such as rectovaginal fistula, need more specialized care. These patients are screened and treated for comorbid conditions and then transported to the Hamlin Fistula Hospital in Addis Ababa. Most women with pelvic organ prolapse don't want to travel all the way to Addis Ababa for care. In the Horo Gudura Zone, there is no way to treat them for comorbid conditions before transport. Screening in the field is performed by NMWs with little experience. The Hamlin Fistula Hospital offered training, but is now hesitant to

educate medical providers outside of what they perceive as their referring network. Aira Hospital regularly sends data and reports back on patients who have been treated there. The other treating facilities haven't been getting us the information that we need so we can report results to funders.

We held rigorous discussions with DASSC leadership in the central, regional, and branch offices and met with leadership at the Hamlin Fistula Hospital. Problems with communication and reporting would be corrected. We would have to pull out of reaching women in need in the most remote areas where rebel groups are actively fighting. It was just too dangerous. The safety of those working in the field had to be prioritized. In 2026, we would work to screen, transport, and treat 20 obstetric fistula patients at Aira Hospital. There were still lots of fistula patients in need of redo surgeries. 20 of these women, along with others with severe injuries, could be screened at Aira Hospital and then transported to the Hamlin Fistula Hospital this coming year. We would pay to treat 250 women with pelvic organ prolapse at Aira Hospital, but we would not send other prolapse patients to the Hamlin Fistula Hospital this year. We would work



DASSC

to get equipment and medications to Aira Hospital through the Global Health Ministries and Direct Relief organizations. We would also work with Dr. Andrew Browning, the Fistula Foundation, and FIGO to provide more training to Dr. Tariku on complex fistula surgeries. We would continue to support the rehabilitation of 20 obstetric fistula patients in Dembi Dollo with three weeks of improved nutrition, occupational and physical therapy, and a community reintegration program.

CONCLUSION

We returned from the trip, more committed than ever to see our mission of safer motherhood fully implemented in the remote rural areas of western and southwestern Ethiopia. We are indeed grateful for the outpouring of community support and for our partners on the ground in Ethiopia and in the United States that make the work possible.

Our effort to end the crises in maternal health is hard and challenging. Nevertheless, we are clearly making incremental progress with treatment and prevention programs. In the face of deep poverty, where so much is broken, we don't have the luxury of siloing development. With our partners, we must do it all. Our integrated model lays this out, covering access to maternal healthcare, prevention, treatment and rehabilitation, medical expertise, community-driven programs, and sustainability.

In western Ethiopia, we will continue to seek out and treat women in need with serious gynecologic complications of childbirth. Until the conflicts end, we will depend on a ripple effect from the program to empower women and to create channels for accessing the medical care that exists. We will use the program to push local medical facilities to better

provide care. We will continue to work where we can in the hope of someday reaching all women in need, in even the most remote parts of western Ethiopia, with the goal of ultimately preventing their suffering.

In southwestern Ethiopia, we will continue to work to prevent injury and death in childbirth by giving women access to clean, safe, and effective care at the time of delivery. This requires building an integrated health system of care that includes ensuring that medical facilities have access to water, measures for sanitation and hygiene, improved power, and infection prevention controls. It also means educating and training healthcare providers. As the capacity of the health system improves, the complexity of medical services offered increases from basic delivery services to emergency obstetric care and now neonatal intensive care. We need to maintain and sustain what is being implemented but we also need to work with hospital leadership and medical providers to guide and support the implementation of more complex medical care.

To continue these efforts, we need to raise money through individual donations and foundation grants. We can't do what we do without your help and support.

Thank you for hearing our voice, for partnering with us on our mission, and for your generosity.

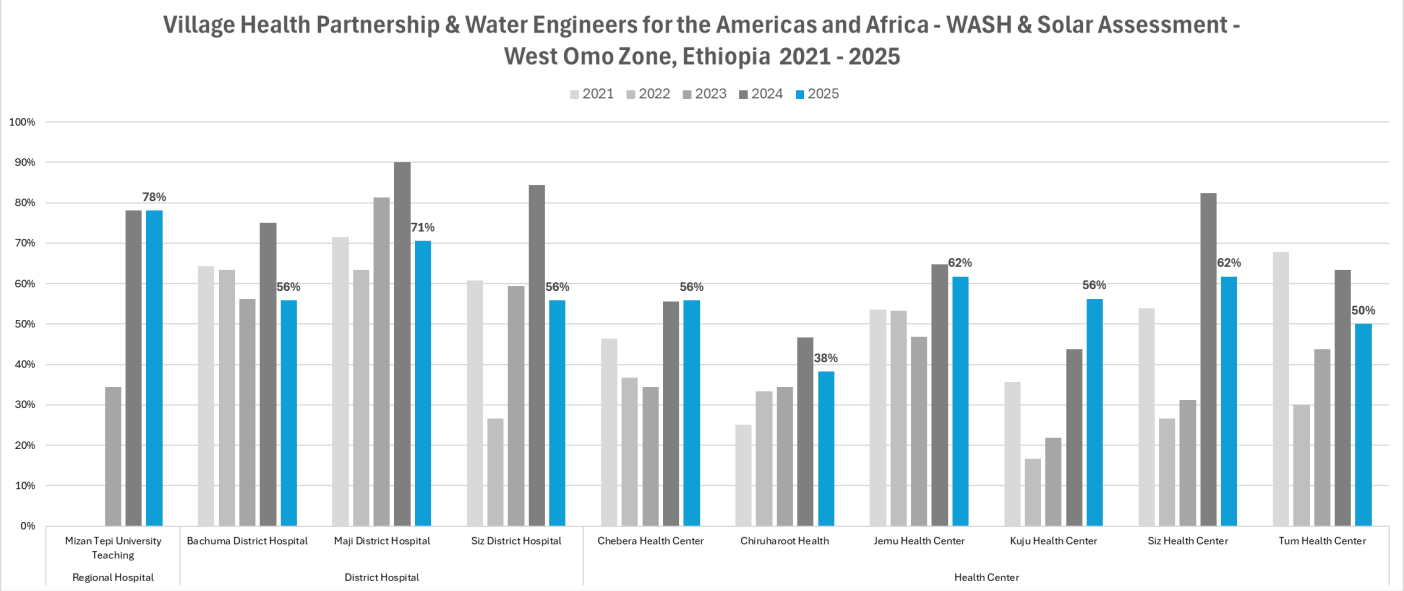
Pregnant woman in Maji Maternity Waiting Area

APPENDIX

WATER, SANITATION, AND HYGIENE (WASH) & SOLAR ASSESSMENT

Village Health Partnership & Water Engineers for the Americas and Africa - WASH & Solar Assessment - West Omo Zone, Ethiopia - November 2025										
Survey Date	10/14/2024	11/8/2025	11/4/2025	11/10/2025	11/8/2025	11/7/2025	11/7/2025	11/6/2025	11/10/2025	11/4/2025
Facility Name	Mizan Tepi University	Bachuma District	Maji District	Siz District Hospital	Chebera Health	Chiruharoot	Jemu Health	Kuju Health	Siz Health Center	Tum Health
Facility Level	Regional Hospital	District Hospital	District Hospital	District Hospital	Health Center	Health Center	Health Center	Health Center	Health Center	Health Center
Total Catchment Population	2,500,000	350,000	108,484	218,000	24,551	11,298	29,000	19,110	48,500	18,401
ASSESSMENT SCORING										
Compound	1	1	2	1	2	2	2	2	2	2
Drainage/Standing Water	2	2	2	1	2	2	1	2	2	0
Vector Control	2	1	2	0	1	1	0	1	0	0
Facility	2	2	2	1	2	2	2	1	2	1
Biohazard Area	2	0	2	1	2	1	2	0	1	1
Latrines	2	0	2	2	1	1	2	1	2	1
Handwashing Stations	2	1	0	2	1	0	2	1	1	0
Water Source	0	2	2	2	1	1	2	2	2	2
Water Quality	2	0	1	0	0	0	0	1	1	2
Facility Water Storage	2	2	1	2	2	0	2	2	2	2
Chlorine Production and/or Acquisition	0	1	2	1	1	1	1	2	1	2
Facility Water Treatment	0	0	0	0	0	0	0	0	1	0
Facility Wastewater System	2	1	2	1	0	0	0	2	0	1
Facility Power	2	2	2	2	2	1	2	N/A	2	2
Facility Solar	N/A	2	2	2	2	1	2	1	2	1
Facility O&M	2	1	0	1	0	0	1	0	0	0
Facility Tools and Equipment	2	1	0	0	0	0	0	0	0	0
TOTAL Assessment Score	25	19	24	19	19	13	21	18	21	17
Assessment Points Available	34	34	34	34	34	34	34	34	34	34
PERCENTAGE (Total Assessment Score/Assessment Points)	74%	56%	71%	56%	56%	38%	62%	53%	62%	50%
Adjusted Points Available (Assessment Points - N/A)	32	34	34	34	34	34	34	32	34	34
ADJUSTED PERCENTAGE SCORE (Total Assessment Score/Adjusted Points)	78%	56%	71%	56%	56%	38%	62%	56%	62%	50%

WASH Scoring November 2025

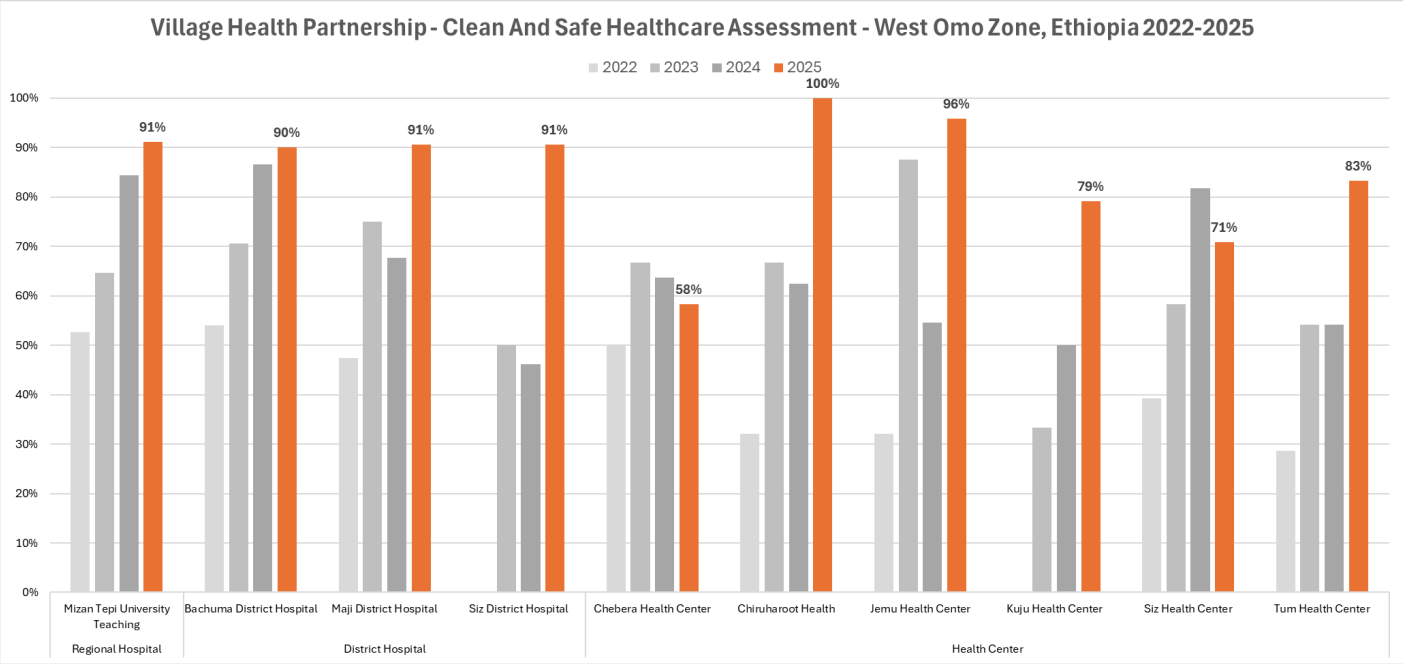


WASH Graph 2021-2025

CLEAN AND SAFE HEALTHCARE (CASH) ASSESSMENT

Village Health Partnership - Clean And Safe Healthcare Assessment - West Omo Zone, Ethiopia - November 2025										
Survey Date	11/21/2025	11/8/2025	11/3/2025	11/10/2025	11/8/2025	11/7/2025	11/7/2025	11/6/2025	11/10/2025	11/3/2025
Facility Name	Mizan Tepi University Teaching	Bachuma District Hospital	Maji District Hospital	Siz District Hospital	Chebera Health Center	Chiruharoot Health	Jemu Health Center	Kuju Health Center	Siz Health Center	Tum Health Center
Facility Level	other	District Hospital	District Hospital	District Hospital	Health Center	Health Center	Health Center	Health Center	Health Center	Health Center
Catchment Population	2,500,000	350,000	108,484	218,000	24,551	11,298	29,000	19,110	48,500	18,401
Women Served by Facility	1,275,000	178,500	24,951	50,000	12,300	6,194	6,670	4,359	11,300	54,000
Maternal Deliveries in Facility/Year	4,259	303	527	408	625	175	250	243	374	199
Cesarian Sections in Facility/Year	1219	27	145	0	N/A	N/A	N/A	N/A	N/A	N/A
ASSESSMENT SCORING										
CLEAN & SAFE HEALTHCARE (CASH)										
CATCH-IT Program	2	2	2	2	1	2	2	2	2	1
IPC Labor and Delivery Section	2	2	2	2	1	2	2	1	1	2
IPC NICU	2	1	0	1	N/A	N/A	N/A	N/A	N/A	N/A
IPC Operating Theatre	2	2	2	2	N/A	N/A	N/A	N/A	N/A	N/A
IPC Facility										
Cleaning Protocols	2	2	2	2	2	2	2	1	2	2
Handwashing and Hand Hygiene	2	2	2	2	1	2	1	1	0	1
Personal Protective Equipment	2	2	2	2	1	2	2	1	2	2
Sterilization of Surgical Instruments	2	2	2	2	1	2	2	2	2	2
Disposal of Medical Waste	2	2	2	2	2	2	2	2	2	2
INFRASTRUCTURE FOR MATERNAL/NEONATAL HEALTH										
Maternity Waiting Area	2	2	2	N/A	2	2	2	2	0	2
Equipment Labor and Delivery Area	1	N/A	2	2	1	2	2	2	1	1
Equipment NICU	1	1	1	1	N/A	N/A	N/A	N/A	N/A	N/A
Equipment Operating Theater	2	N/A	N/A	2	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacy	2	2	2	2	0	2	2	2	2	1
Laboratory	2	2	2	2	1	2	2	1	2	2
Blood Bank	2	1	2	1	N/A	N/A	N/A	N/A	N/A	N/A
Patient Referral	1	2	2	2	1	2	2	2	1	2
TOTAL Assessment Score	**31**	**27**	**29**	**29**	**14**	**24**	**23**	**19**	**17**	**20**
Assessment Points Available	34	34	34	34	34	34	34	34	34	34
PERCENTAGE (Total Assessment Score/Assessment Points)	91%	79%	85%	85%	41%	71%	68%	56%	50%	59%
Adjusted Points Available (Assessment Points - N/A)	34	30	32	32	24	24	24	24	24	24
ADJUSTED PERCENTAGE SCORE (Total Assessment Score/Adjusted P	**91%**	**90%**	**91%**	**91%**	**58%**	**100%**	**96%**	**79%**	**71%**	**83%**

CASH Scoring November 2025



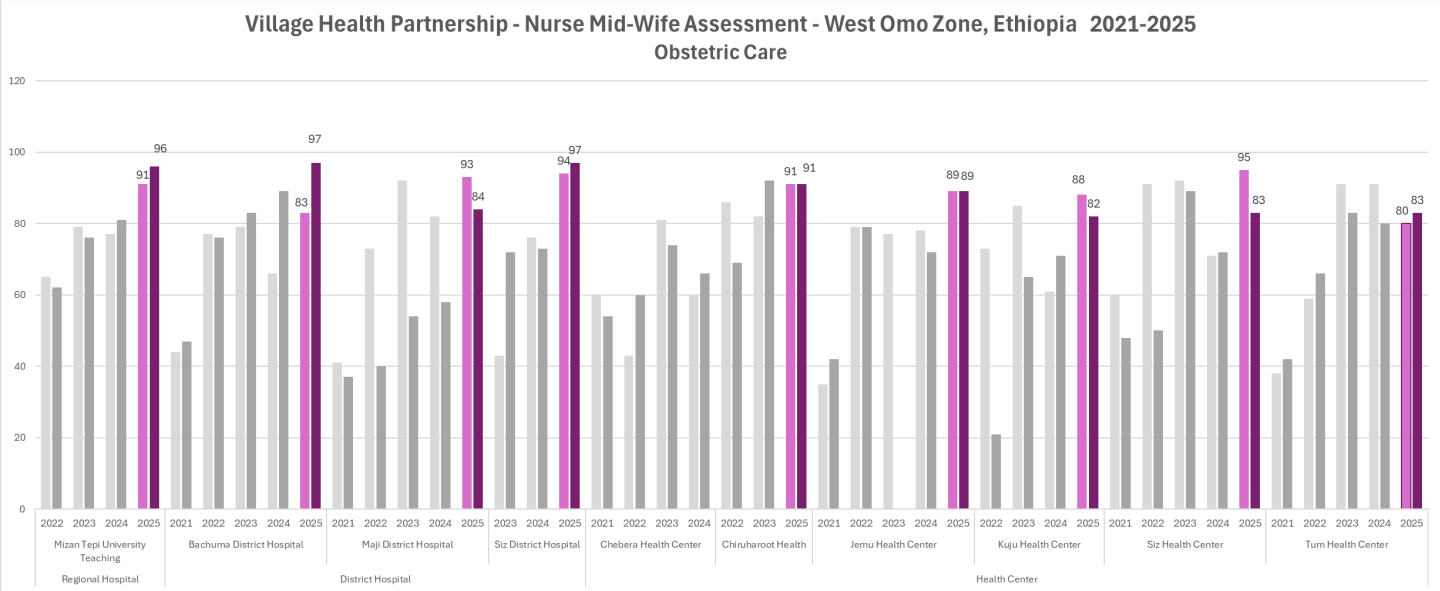
CASH Graph 2022-2025

NMW OBSTETRIC/NEWBORN ASSESSMENT

Village Health Partnership - Nurse Mid-Wife Assessment - West Omo Zone, Ethiopia - November 2025										
Survey Date	**11/12/2025**	**11/7/2025**	**11/4/2025**	**11/10/2025**	**11/7/2025**	**11/6/2025**	**11/7/2025**	**11/6/2025**	**11/10/2025**	**11/3/2025**
Facility Name	Mizan Tepi University Teaching	Bachuma District Hospital	Maji District Hospital	Siz District Hospital	Chebera Health Center	Chiruharoot Health	Jemu Health Center	Kuju Health Center	Siz Health Center	Tum Health Center
Facility Level	other	District Hospital	District Hospital	District Hospital	Health Center	Health Center	Health Center	Health Center	Health Center	Health Center
Catchment Population	2,500,000	350,000	108,484	218,000	24,551	11,298	29,000	19,110	48,500	18,401
Women Served by Facility	1,275,000	178,500	24,951	50,000	12,300	6,194	6,670	4,359	11,300	54,000
Maternal Deliveries in Facility/Year	4259	303	527	408	625	175	250	243	374	199
ASSESSMENT SCORING										
Module 1: NMW #1 - Score	92	75	92	92	75	100	92	92	100	75
Module 1: NMW #2 - Score	92	100	84	92	92	83	92	83	83	83
Module 2: NMW #1 - Score	87	80	93	87	80	80	93	80	87	80
Module 2: NMW #2 - Score	100	93	78	93	87	93	86	93	80	82
Module 3: NMW #1 - Score	94	83	100	94	89	83	89	100	94	83
Module 3: NMW #2 - Score	100	94	78	100	94	83	94	89	83	83
Module 4: NMW #1 - Score	77	77	84	92	62	84	84	72	100	84
Module 4: NMW #2 - Score	100	100	74	92	92	84	77	78	69	84
Module 5: NMW #1 - Score	100	96	96	96	93	96	96	100	96	89
Module 5: NMW #2 - Score	96	96	89	100	96	93	93	93	93	93
Module 6: NMW #1 - Score	89	89	96	96	85	96	93	96	93	74
Module 6: NMW #2 - Score	93	96	89	96	100	93	93	85	89	83
Module 7: NMW #1 - Score	100	91	91	91	73	91	82	91	91	83
Module 7: NMW #2 - Score	100	100	91	100	100	100	91	91	73	82
Module 8: NMW #1 - Score	88	73	88	100	73	98	80	73	100	75
Module 8: NMW #2 - Score	85	100	85	100	100	100	83	43	90	72
Obstetric Care NMW #1 - Total Average Score	91	83	93	94	79	91	89	88	95	80
Obstetric Care NMW #2 - Total Average Score	96	97	84	97	95	91	89	82	83	83
6.1.10. Score the Obstetric Care Section:	2	2	2	2	2	2	2	2	2	2
Module 1: NMW #1 - Score	95	80	100	95	70	95	40	85	100	75
Module 1: NMW #2 - Score	95	90	80	100	100	95	85	85	65	55
Module 2: NMW #1 - Score	100	100	100	100	93	86	86	86	100	86
Module 2: NMW #2 - Score	100	100	100	100	100	76	93	71	86	86
Module 3: NMW #1 - Score	100	70	93	100	45	87	80	66	100	80
Module 3: NMW #2 - Score	100	80	87	100	80	80	100	57	93	73
Module 4: NMW #1 - Score	100	100	96	100	83	87	87	87	100	65
Module 4: NMW #2 - Score	100	100	74	100	96	74	96	43	100	87
Module 5: NMW #1 - Score	100	83	100	100	60	87	87	100	100	60
Module 5: NMW #2 - Score	100	73	73	100	100	60	73	60	100	53
Module 6: NMW #1 - Score	100	95	84	95	68	74	50	66	100	84
Module 6: NMW #2 - Score	100	89	74	95	100	68	89	78	100	84
Newborn Care NMW #1 - Total Average Score	99	88	96	98	70	86	72	82	100	75
Newborn Care NMW #2 - Total Average Score	99	89	81	99	96	76	89	66	91	73
6.2.8. Score the Newborn Care Section:	2	2	2	2	2	2	1	1	2	1

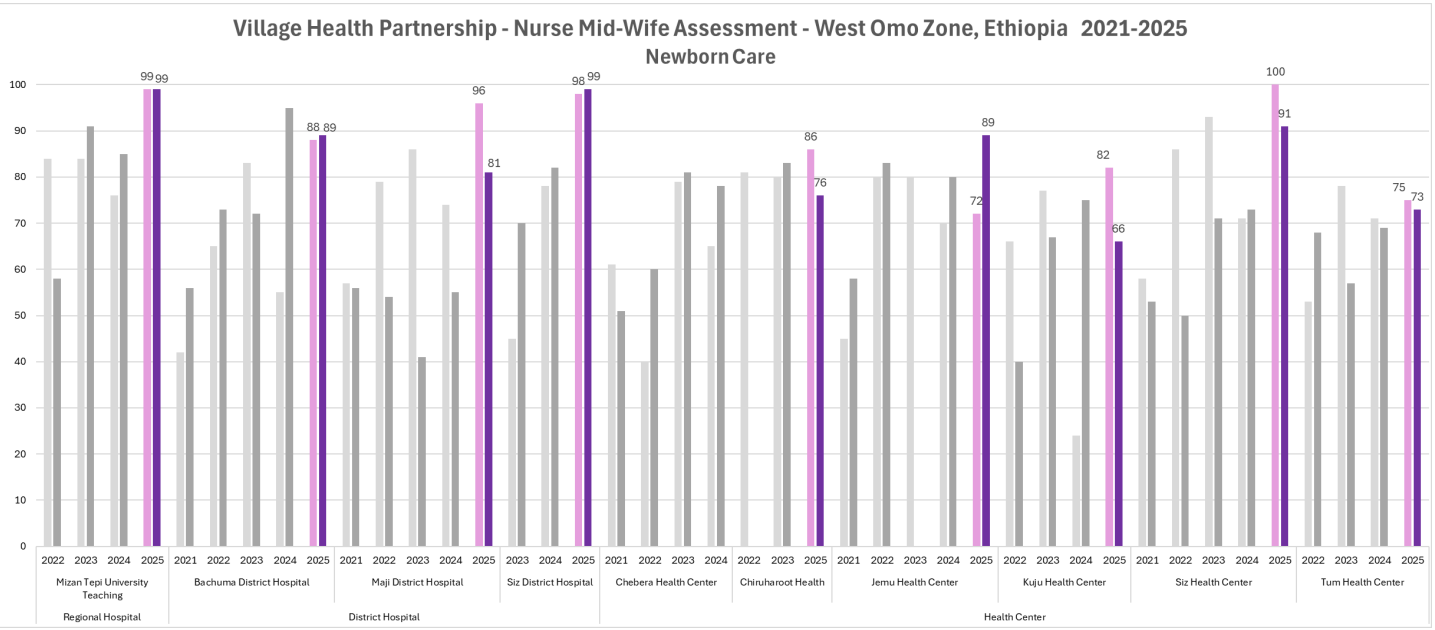
NMW Obstetric/Newborn Scoring November 2025

NMW OBSTETRIC ASSESSMENT



NMW Obstetric Graph 2021-2025

NMW NEWBORN ASSESSMENT



NMW Newborn Graph 2021-2025