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# Felege Tena

Quarterly Newsletter of the Ethiopian Public Health Association,. Vol. 17, No. 1, March 2007


EPHA Updates and Upcoming Events

## EPHA Conducted its 17th Annual Conference with the Main Theme of ''Emerging Public Health Problems in Ethiopia''

The 17th Annual Public Health Conference of the Ethiopian Public Health Association was held on 26th – 28th October 2006 in Harar with the attendance of hundreds of public health professionals from different parts of the country. The President of Haramaya University, Prof. Belay Kassa, and the president of EPHA, Dr. Mengistu Asnake respectively made a welcome address and opening remark of the conference.

Human Resource Crisis in Health, Challenges of RH/HIV/AIDS in meeting the MGDs, Subsistence Abuse and Environmental Degradation: water scarcity and its consequence as the 2006 conference sub-themes were presented.

Special sessions, Injection Safety and Health Informatics as well as scientific sessions were undertaken concurrently. Fifty scientific researches had been selected for the concurrent sessions and 25 of which were oral presentations and the rest were poster presentations. Warm discussions were made on the presented issues under different themes, special sessions and scientific research findings. As a result; it is believed that participants of the conference have got sound information during the 17th Annual Public Health Conference of EPHA.

EPHA award ceremonies, business meeting, book and EPHA Website launching and demonstration were also the main components of the conference. During the business meeting of the General Assembly nearly 20 Life Members of EPHA were recognized and awarded **Life Member ID and Life Member PIN**. The Book entitled "**Epidemiology and Ecology of Health and Disease in Ethiopia**" was launched during this conference.

The book has 861 pages, contains 6 major parts and 52 main health topics written by 14 non-Ethiopian citizens and 73 Ethiopians. It was edited by a number of senior public health professionals and EPHA members, namely, Yemane Berhane (MD, MPH, PhD) Professor of Epidemiology & Public Health/ AAU, Damen Haile Mariam (MD, MPH, PhD) Associate Professor of Health Economics & Management/ AAU, and Helmut Kloos (PhD) Department of Epidemiology & Biostatistics, Medical Center, University of California/ San Francisco. USAID/ Ethiopia supported printing of the book and promised to support the next edition.

The EPHA website ***http://www.epha.org.et*** was launched and demonstrated to the participants of the conference.

### Inside this Issue:





*Becoming a member of the EPHA affords you the chance to contribute your share of expertise to the development of the health sector of the country, thereby also strengthening your belongingness to the important profession of public health!*

## 17 th annual conference .....Cont'd from page 1.

This newly developed website serves as an indispensable tool for the members and other interested people to access pertinent and current information related to EPHA activities, projects, publications and announcements of the Association.

During the conference Dr. Getent Miteke, the vice president of EPHA, presented the annual activity and audit report of the association. The EPHA chapters also presented reports on activities and challenges they faced during the implementation period. Discussion was made on the report and challenges of chapters and consequently important pointes were suggested and forwarded.

The constitution of the association stated that a member who is elected as an executive board could serve only for two years. Based on this rules and regulations, two new Executive Board members of EPHA, Dr. Solomon Worku and Dr. Yilema Melekamu were elected and replaced Dr Getnet Miteke and Dr. Yayehyirad Kitaw. Besides, sister Tekabash Araya was also elected to serve as Internal Auditor of the Association. The conference was finally closed by a guest of Honor, Minister of MoH, and H.E. Dr. Tewodros Adhanom G/yesus with his keynote addresses.

### Information & Upcoming Events of EPHA

* EPHA recently launched a library (Internet, Books & Journals) at EPHA office in front of the National Stadium and it is serving its members free of charge.
* EPHA in collaboration with FMOH and David & Lucile Packard Foundation is in the process to publish a Health Extension Workers newsletter very soon.
* EPHA is organizing international training on MDGs in collaboration with federal and regional government & non-governmental offices, teaching health institutions, David & Lucile Packard Foundation and World Bank.
* EPHA is also organizing modular training on Leadership Strategic Information in close collaboration with federal & regional offices, FMoH, DCH/AAU and CDC offices in Ethiopia & Atlanta.

News and Views

## Millennium AIDS Campaign in Ethiopia (MAC-E)

From the Review Meeting held at Adama town, February 26- March 1, 2007)

It was remembered that the government of Ethiopia launched the free ART rollout program on 24 January 2005. In line with it, the first road map was finalized in May 2005. During the implementation of the first road map, three specific moments in time have prompted for the need to accelerate the uptake of ART and lately also of HIV Counseling and Testing (HCT).

The first two acceleration efforts concluded successfully, in contrast to those, the third acceleration currently underway to be prolonged over a longer period of time. On such a process, the Millennium AIDS Campaign in Ethiopia was launched on 25 November 2006, which is projected to be run till 2008. NHAPCO in collaboration with MOH and CDC initiated the Millennium AIDS Campaign for Ethiopia with the rationale behinds of 'even though services are available, ART and HCT uptake was very low before the campaign in the country'.

MAC is a set of interventions aiming to scale up the speed, volume and quality of HIV/AIDS related services within a short period of time and maintain achievements after the campaign. The campaign has three distinct phases:

***Phase 1:***

25 November 2006-31 January 2007

***Phase 2:***

1 February 2007- 10 September 2007; and

***Phase 3:***

10 September 2007-10 September 2008

## *Millennium AIDS Campaign…….* cont'd from page 2

To review the achievements of the first phases of Millennium AIDS campaign for Ethiopia, NHAPCO, MOH, CDC and ICAP organized a review meeting held at Adama town from February 26 up to March 1, 2007. The meeting gave due attentions on three focus areas: (1) overview of the first phase, (2) preparation of the 2nd and 3rd phases, and (3) updating and strengthening drafts of the revised existing guidelines including National HIV/AIDS policy.

Phase one was focused to ensure an immediate outcome on three main areas including targeted social mobilization, expanded capacity at entry points and create adequate capacity at HIV/AIDS care and treatment. This phase was concluded at the end of January 2007 and has showed an HCT uptake in two months that has nearly equaled to the annual uptake of the proceeding year. Nearly 320,000 people was planned to undertake HCT in the initial phase. However, during the campaign unfortunately 605, 203 people were tested and the achievement became far above the target. This is because effective strategies like extensive social mobilization, assignment of full time counselors, postponing of annual leave, provision of standardized trainings, overtime working hours, outreach and mobile VCT in some areas have been employed and as well as there has been also an already existing demand from the community side. Out of the total population who had taken HIV test 29,312 people became positive with a prevalence rate of 5% and only 20,139 were linked to with chronic care. At the time of the campaign 25,192 pregnant women were counseled and tested and of which 838 mothers became positive with a prevalence rate of 3.3%.

About 22,000 patients were also targeted to provide ART services however only 11,831 patients were achieved, which are below the target. This might be due to the inadequate post test counseling, lack of home based care services, poor referral linkages, low involvement of the community and PLWHA, low social mobilization and advocacy on ART, and very ambitious target which did not synchronize with HCT target. In general, during the initial phase, challenges and lessons have been recognized.

### *Some of the key challenges were:*

* Social mobilization was not adequate and not targeting higher-risk people
* Home based services were poor
* weak linkage between TB and HIV
* Less focus on pre-ART patients
* Poor linkages and referral systems
* Poor family based services
* Incomplete and not timely reporting
* Test kit shortage in some regions (like Dre Dawa, SNNPR)
* Some lab machines were not functional
* High turn over of human resource in some areas like Benshangul Gumuz
* Limited numbers of ART sites in some regions like Afar; and
* Competing priorities like in Afar and Addis Ababa

### *Lessons Learnt from the 1st phases of MAC*

* Have the potentials to perform even better
* Existing high demand at the community
* Strong ownership & leadership by local people
* Setting a target for the Pre-ART is essential
* The impact of social mobilization
* Outreach, mobile services & group counselling were vital strategies; and
* Motivation of staff through incentive has also played a role in testing of many people

*Millennium AIDS Campaign ….cont'd from page 3*

In the review meeting, representatives of the federals and regions have shared their own real experiences from the first phase of MAC. Such evidence-based results and real experience sharing could be undoubtedly an import reference to target the second and third phases of Millennium AIDS Campaign and even for other related health programs. So now we are in the second phase of the campaign and about 50,765 new ART patients and 1,831,538 people for HCT are targeted. Furthermore, based on the lessons learnt from the 1st MAC 8,474 people for PMTCT, 73,093 people for Pre-ART, and 293,210 people for STI were targeted to the second round. Regions will make contextual the matrices of ART, HCT, PMTCT, Pre-ART and STI targets set by the federal.

Consolidating and Updating the drafts on the existing guidelines of ART, HCT, PMTCT, 2nd Road Map, National HIV/AIDS policy and zero draft of newly developed national HIV/AIDS Pediatric guideline were also the main agendas in the review meeting. In the near future all the revised and newly developed guidelines and the revised national HIV/AIDS policy will be finalized and introduced for implementation in the general population.

*Our Guest , Dr Yigeremu Abebe, Country Director-Clinton Foundation HIV/AIDS Initiative / Ethiopia*

**Felege Tena:** Could you please tell us the essence and objectives of the Millennium AIDS Campaign in Ethiopia (MAC-E)?

**Dr. Yigeremu:** The essence of MAC-E is universal access to HIV care and treatment. The objectives are to scale up testing and ARV therapy using the most popular event in the history of Ethiopia, i.e., the Ethiopian Millennium Celebration.

**Felege Tena:** Some people suggested that MAC-E is too long to be a campaign. What is your suggestion?

**Dr. Yigeremu:** Apparently, HIV/AIDS is a long-standing emergency, therefore naming any activity pertaining to the epidemic, as a campaign seems inappropriate. Since a campaign is not a normal process you cannot have it for a long time. HAPCO and MOH are making use of the celebration of Ethiopian Millennium as opportune time to scale up the testing and HIV care. The celebration has a time frame and that timeframe is going to be used as a campaign time. There is now a consensus of changing campaign without losing the inspirational opportunity created by the Ethiopian Millennium celebration. For instance the Millennium Accelerated Access to Testing and Care is one possibility.

**Dr. Yigeremu …..***Cont'd from page 4*

**Felege Tena:** Do you think that the issue of quality, coverage and speed can be addressed simultaneously during the campaign?

**Dr. Yigeremu:** We have to strike the fine balance between quality versus speed and volume. Quality in all settings needs capacity in all its dimensions. Capacity in the resource-limited settings is very low. On the other hand if there is no care what follows, obviously, is death, since AIDS is 100% killing disease. We must not use quality or standards of quality to deny access to care, but to improve quality itself through building reasonable capacity. This does not preclude "Do No Harm". While trying the best to ensure reasonable quality we have to aim at universal access. We should not stretch the physics of speed, volume and quality to one side. We must strike the right balance. We should make three issues mutually inclusive.

**Felege Tena:** What is your suggestion on the cost-effectiveness of the campaign?

**Dr. Yigeremu:** It is difficult to say anything about cost effectiveness unless there is reasonable economic calculation of the campaign. In fact the impact of the campaign on other programs such as EPI has not been assessed. This is a critical issue since we are using the same resources in terms of human resource and infrastructure. The traditional programs must not slide down while we scale up HIV testing care. On the other hand opportunities harnessed by implementing HIV must strengthen the other programs and the health service delivery system. Of course the cost effectiveness of the campaign needs to be calculated using standard approach.

**Felege Tena:** In our country, especially rural parts, social problems like stigma and discrimination have been deep-rooted and widened. Research findings also revealed that behavioral change regarding to HIV have not been yet observed as expected. The campaign was/ is applying mass counseling strategy, which may lead into such social problems. So what is your opinion on the occurrence of such problems during and after the campaign?

**Dr. Yigeremu:** Stigma and discrimination is fewer manifests in certain urban centers such as Addis Ababa compared to the time of the onset of the epidemic some 20 years back. A well-structured study conducted in 3 African countries has clearly shown that although there are improvements in some urban centers, stigma and discrimination is prevalent in Ethiopia. The widespread of HIV "education" by different sectors together with the availability of care and treatment might have lessening the stigma. However, this is an issue that needs to be intensively and comprehensively addressed for the HIV/AIDS responses to be effective. Since stigma and discrimination is related with a number of social, economic, religious, cultural, etc factors the situation is expected to be more serious in rural centers and villages. In rolling out any HIV-related program in such communities we must always make sure that no individual be affected by stigma and discrimination because of accessing the program we are implementing. Hence, including strategies that address stigma and discrimination is an inevitable component of any program of HIV prevention, mitigation, care and treatment in Ethiopia, in particular rural Ethiopia.

**Felege Tena:** Is there any thing you would like to add?

**Dr. Yigeremu:** The trend of the epidemic as seen in the 6$^{th}$ edition of AIDS in Ethiopia is downhill: be it in prevalence, new infection or death. However, we are not fully sure of the reasons for the decline. It may be a combination of different factors. Whatever, the trend of HIV/AIDS is, the epidemic is still not only a public health emergency but also major determinant of the future of Ethiopia. This indicates that much more work in prevention, care and treatment remains to be done by the society, the government, and partners. Our approach to this epidemic must be balanced in that prevention must not be forgotten in any program of prevention, care and treatment. It is the primary prevention that impacts on the epidemic. Whatever we do on HIV in particular in the health sector, must strengthen the health delivery system and all other programs, not the other way round. This must be addressed in relation with MAC-E.

# Some Successful Actions and Responses to HIV/AIDS

*Taken from* World AIDS Campaign of 2003-2004:Best practices, UNAIDS, 2004 .

(By Peter Aggleton)

In ***Israel*** and ***Jamaica***, more positive attitude towards people living with HIV/AIDS have been promoted through peer education, lectures, pamphlets or workshops, although the effects of such behavioral change remain undocumented.

Combining information-based approaches with counseling has shown to increase disclosure among people living with HIV/AIDS, and has triggered improved community attitudes compared with baseline measures in countries such as ***Uganda*** and ***Zimbabwe***. In ***Uganda***, the work of The AIDS Support Organization (TASO) and other community- based groups has been central to encouraging greater openness about the epidemic and in providing support and care to individuals, families and communities living with HIV/AIDS.

**Zambia** was one of the first countries to implement HIV home-care services, and the 'Ndole Catholic Diocese Home –Based Care Program' has been internationally recognized for the high quality of its work. Thanks to strong community participation and the motivation of the program's volunteers, over 70% of those in need of HIV/AIDS-related care and support being reached. Consequently, perhaps, negative attitudes towards HIV/AIDS reportedly lessened and local people have been empowered with the knowledge, skills and self-confidence they need to cope with the impact of the epidemic.

In Phayao Province in the north east of ***Thailand***, multisectoral work bringing together a range of governmental and non-governmental organizations was a key to reduce new infections in this badly affected area in the late 1990s', and in promoting good quality home and community based care. A people-oriented approach facilitated greater openness about the epidemic, and the promotion of a 'care not scare' approach reportedly stimulated greater social cohesion and support.

In the United Republic of ***Tanzania***, teachers and health workers implemented a two-to-three months program of AIDS related information, small group discussions, and role-play to improve primary school age children's knowledge, attitude and practices. Follow-up 12 months later showed that attitudes towards people living with HIV/AIDS had significantly improved.

In the **United States of America**, an early study used information and coping-skills development to resolve negative feelings among physical therapy students and increase their willingness to treat people living with HIV/AIDS.

Contact with HIV infected or affected groups has been used in several studies and programs. The belief here is that a more personal relationship with people living with HIV/AIDS (either through face-to-face conversation, or by hearing a testimonial from infected or affected individuals) will demystify and dispel misinformation, generating empathy, which in turn, reduces stigma and prejudices. Such work shows mixed results, with some studies reporting reductions in negative attitudes, and others not.

# Nexus between Poverty and HIV/AIDS

UNDP: Issue paper no. 27. (By Desmond Cohen )

http://www.undp.org/hiv/publications/issues/english/issues 27e.htm/

**Poverty and HIV Infection**

The characteristics of the poor are well known, as also are some of the causal factors at work, which contribute to a "culture of poverty" - the fact that the children of the poor often become the poor of succeeding generations. Poverty is associated with weak endowments of human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and low labour productivity as a result. An aspect of the poor health status of the poor is the existence amongst many Africans of undiagnosed and untreated STDs, which is now recognised as a very significant co-factor in the transmission of HIV. Poor households typically have few if any financial or other assets and are often politically and socially marginalised. These conditions of social exclusion increase the problems of reaching these populations through programmes aimed at changing sexual and other behaviours.

It is not at all surprising in these circumstances that the poor adopt behaviours which expose them to HIV infection. It is not simply that IEC activities are unlikely to reach the poor (which is too often the case) but that such messages are often irrelevant and inoperable given the reality of their lives. Even if the poor understood what they are being urged to do it is rarely the case that they have either the incentive or the resources to adopt the recommended behaviours. Indeed to take the long-view in sexual or other behaviours is antithetical to the condition of being poor. For the poor it is the here and now that matters, and policies and programmes that recommend deferral of gratification will, and do, fall on deaf ears.

Even more fundamental to the condition of poverty is social and political exclusion. So HIV-specific programmes are neglectful of the interests of the poor and are rarely if ever related to their needs, and also unfortunately are other non-HIV related programme activities -- such as those relating to agriculture and credit. More generally it is the absence of effective programmes aimed at sustainable livelihoods which limit the possibilities of changing the socio-economic conditions of the poor. But unless the reality of the lives of the poor are changed they will persist with behaviours which expose them to HIV infection (and all the consequences of this for themselves and their families).

Two examples of this state of affairs will perhaps suffice to indicate how poverty leads to outcomes which expose the poor to HIV. Firstly, poverty -- especially rural poverty, and the absence of access to sustainable livelihoods, are factors in labour mobility which itself contributes to the conditions in which HIV transmission occurs. Mobile populations, which often consist of large numbers of young men and women, are isolated from traditional cultural and social networks and in the new conditions they will often engage in risky sexual behaviours, with obvious consequences in terms of HIV infection. Secondly, many of the poorest are women who often head the poorest of households in Africa. Inevitably such women will often engage in commercial sexual transactions, sometimes as CSW but more often on an occasional basis, as survival strategies for themselves and their dependents. The effects of these behaviours on HIV infection in women are only too evident, and in part account for the much higher infection rates in young women who are increasingly unable to sustain themselves by other work in either the formal or informal sectors.

There are increasing numbers of children infected with HIV through perinatal transmission (from mother to child). This reflects the large numbers of pregnant women who are HIV positive. Perinatal transmission is largely preventable through appropriate access to drugs (AZT) but these drugs and the necessary infrastructure for their delivery are more or less unattainable for most African women. Limitation of access to AZT is not confined to the poor although they account absolutely for most of the women who have the greatest need.

A related problem is the transmission of HIV through breast milk where there is now clear evidence that significant numbers of babies are infected by this route. This is avoidable and poverty is a clear factor in access to the methods for prevention of transmission to babies through breast milk. To prevent transmission through breast milk requires the ability to buy baby formula and access to clean water, plus an understanding of why these changes in practise are needed. Neither clean water nor the income for purchasing formula are available to the poor, so they are unable because of their poverty to adopt a form of prevention known to be successful as a means of limiting HIV transmission. This problem is resolvable through relatively inexpensive programme activities backed up by community mobilisation to ensure support to families. There are, therefore, no good reasons why action in this area are not being undertaken by governments, NGOs and donors.

# Ethiopian Health Fact Sheet (1994-1998 E.C)

(Taken from MoH: http:www. moh.gov.et)

| Indicators | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|
| Total population | 65,344,000 | 67,220,000 | 69,127,021 | 73,043,510 | 75,067,000 |
| PHS coverage | 59.1% | 61% | 61.3% | 72.1% | 76.9% |
| PHS* coverage | 68% | 70.7% | 70.2% | 82.9% | 92.0% |
| EPI coverage | 41.9% | 51.5% | 50.4% | 70.1% | 75.6% |
| Health service utilization | 0.27% | NA | 0.29% | 0.3% | 0.33% |
| CPR | 18.7% | 17.2% | 21.5% | 25.2% | 36.4% |
| Antenatal coverage | 34.7% | 34.1% | 27.4% | 40.8% | 51.2% |

**National HIV/AIDS Prevalence in 2005, Ethiopia.**

(Taken from AIDS in Ethiopia 6th report, 2006: MoH)

| | |
|---|---|
| National HIV prevalence | 3.5% |
| Male | 3% |
| Female | 4% |
| Urban | 10.5% |
| Rural | 1.9% |

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**Contact Address;**
EPHA-CDC Project
Tel- 251-15547319/540391
Fax– 251-1514870
P.O.Box-7117
E mail: epha2@telecom.net.et
Website: http://www.epha.org.et

Could you please contact us with comments, information and ideas on how to improve our newsletter.