Public Health Digest

Quarterly P.H. Digest of the Ethiopian Public Health Association (EPHA)

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Public Health Digest

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Objectives of the Digest

- *Improve the knowledge, and practices of public health professionals*
- *Introduce latest research findings, best practices and success stories to the general public through public health practitioners, trainers, planners and researchers*
- *Motivate health workers to engage themselves in operational studies through dissemination of abstracts from studies made by health professionals working in health units and training institutions*

Target Audiences

The target groups for the Digest are health professionals in general; and trainers in training institutions, public health practitioners at woreda health offices, in health centers and hospitals, in particular. The Digest is also intended for non-health professionals who are interested in public health matters on a demand-basis for free charge.

Strategy

Four thousand copies of the Digest are published quarterly. Distribution follows the modalities of other EPHA publications. In addition, regional, zonal and woreda offices, institutions of the FMoH and HAPCO branch offices serve as channels for distribution. The Digest is bilingual (Amharic and English) .

Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
AMS	AIDS Mortality Surveillance
BP	Blood Pressure
CDC	Center for Disease Control and Prevention
CVD	Cardiovascular Diseases
DBP	Diastolic Blood Pressure
EFETP	Ethiopia Field Epidemiology Training Program
EHNRI	Ethiopian Health and Nutrition Research Institute
EPHA	Ethiopian Public Health Association
FMoH	Federal Ministry of Health
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma-Virus
MARPs	Most at Risk Populations
MPH	Master of Public Health
MSC	Most Significant Change
NCD	Non Communicable Diseases
PEPFAR	President's Emergency Plan for AIDS Relief
PH	Public Health
PHC	Primary Health Care
PHEM	Pre-Hospital Emergency Medicine
RHB	Regional Health Bureau
SBP	Systolic Blood Pressure
SI	Strategic Information
SNNPR	Southern Nations, Nationalities, and People's Region
SPM	Strategic Planning Management
US	United States
WHO	World Health Organization

Editorial Note

A New Initiative towards Strengthened Research Undertakings

EPHA is committed to creating a policy-research nexus through original research on emerging public health challenges, successes and prospects of the national health issues. During the last 23 years of its experience, EPHA has registered remarkable achievements towards realizing the overall goals of the health sector development program in the country. Recently, guided by its 3rd Strategic Planning Management (SPM), it has realigned its internal structure in line with its core functions whereby research has emerged as one newly instituted strong unit within the Research, Publication and Training Department.

Of course, EPHA has been widely engaged in advancing and conducting applied research works in public health and related fields since its formation. In the recent past years alone, it has produced the strategic information (SI) for policy making and established networks with the MoH, universities, international and national professional associations and other societies. Among others, It has been involved in contributing to a variety of research undertakings ranging from support of masters' thesis programs (from Jima, Gondar and Addis Ababa universities) to producing numerous studies in the areas of HIV/AIDS to receiving and reviewing more than 80 abstracts every year. On top, it has also shown its internal capacity and role by conducting surveys on MARP, Pain Management Practices, MSM, and supporting AIDS Mortality Surveillance (AMS) projects to make use of it for decision making at the various administrative echelons across the country.

Despite the aforementioned achievements qualifying the Association as the strongest health professional associations in the country, concerns have been raised repeatedly on different occasions with regard to certain limitations that manifest in the areas of research and policy advocacy.

Some EPHA members have frequently expressed their desire for participation and involvement in research work .

Given its comparative advantages of having numerous track records, well established networks and the pool of its expert members whom it can mobilize and engage in research and consultancy activities, EPHA has initiated to pay due attention to forming a strong research unit within its executive structure.

We are thus congratulating every EPHA member as we are advancing one step farther to ensuring our long envisaged aim in the areas of research and policy advocacy with particular emphasis towards working on a systematic inquiry and scientific undertaking primarily to solve practical problems, with the ultimate goal of improving the quality of health of the people in Ethiopia.

Ethiopia Field Epidemiology Training Program

Updates

The Ethiopia Field Epidemiology Training Program (EFETP) is a comprehensive two-year competency-based post-graduate training and service program designed to build sustainable public health expertise and capacity.

Inaugurated in February 2009, the EFETP has been tailored to the needs and priorities of Ethiopia, and is a partnership among the Federal Ministry of Health, Addis Ababa University School of Public Health, the Ethiopian Public Health Association and the U.S. Centers for Disease Control and Prevention (CDC). The program is modeled after the Epidemic Intelligence Service program (aka the "Disease Detectives") of the U.S. government. Other FETP programs are currently active throughout the world, and these programs work to build local capacity to respond to significant public health challenges.

Field Epidemiology is often referred to as “shoe-leather” epidemiology because the work is done in the field in communities. Residents in the EFETP receive 25% of their training from short modular classroom courses designed to teach principles of epidemiology and public health. The remaining 75% of the training consists of a field residency program, which includes hands-on learning and service. Residents gain competency and experience at field bases within the Federal Ministry of Health and Regional Health Bureaus. The training is closely supervised, is competency-based, and conducted on the job.

Residents in the EFETP investigate disease outbreaks, develop effective prevention and control measures, and work with disease surveillance systems to establish data-derived information about the health burden of reportable diseases.

Graduates of the program receive a Master of Public Health degree in Field Epidemiology and are assigned to positions that provide epidemiologic service to the Ministry of Health. An intake of promising residents each year ensures that a steady stream of qualified field epidemiologists graduates and increases the capacity of the public health workforce.

It is the long-term vision of the EFETP to create smaller training modules for other public health field workers. The trainings will include both outbreak investigations and public health surveillance techniques, which are designed to increase the competencies of a broader range of public health field workers throughout Ethiopia.

The mission of EFETP is to train a cadre of skilled public health professionals who provide in-service assistance to advance and protect public health and contribute to evidence-based decision-making.

The goal is to strengthen the Ethiopian Public Health Emergency Management by:

1. Improving public health event detection and response;
2. Creating a robust disease surveillance system;
3. Building capacity in field epidemiology and public health laboratory systems;
4. Enhancing evidence-based decision making for public health practice; and reducing morbidity and mortality associated with priority diseases.

The objectives of the program include:

1. Building public health capacity by developing a cadre of health professionals with advanced skills in applied epidemiology and laboratory management;
2. Increasing national and regional capacity to respond to public health emergencies such as outbreaks, natural disasters, and other unusual public health events including those that could be a result of chemical or biological terrorism;
3. Strengthening national surveillance systems;

Preparing field epidemiology residents to take part in the leadership of Public Health Emergency Management units at national, regional, and sub-regional levels as well as other health related institutions;

5. Contributing to research activities on priority public health problems;
6. Strengthening laboratory participation in surveillance and field investigations;
7. Improving communications and networking of public health practitioners and researchers in the country and throughout the region;
8. Promoting the sustainability of the EFETP; and
9. Assuring active use and dissemination of public health data, which has been developed by the EFETP staff and residents.

Roles of the Partners in the Program

The EFETP is owned by the FMoH. Addis Ababa University School of Public Health, CDC and EPHA as the major partners that support the program. Each of the partners has specific roles in the program. The FMoH and Regional Health Bureaus provide training field sites, field supervisors and deploy residents. Addis Ababa University School of Public Health is responsible for the academic content of the program, including designing a curriculum, providing classrooms, preparing and evaluating all courses, and granting the program's degree. The EPHA channels funding, provides administrative support, and manages materials, supplies, logistics, and travel. The US CDC provides technical assistance and funding through the President's Emergency Plan for AIDS Relief (PEPFAR).

Admission Requirements to the Program

The program is designed to strengthen PHEM systems throughout Ethiopia. The candidates for the program are often selected from the PHEM systems at the national, regional, zonal and woreda levels. It also includes recruits from national and regional laboratories and professionals from other directorates, which have direct contribution to public

health emergency management. Trainees from other sectors such as agriculture and national defense are also given a chance to participate in the training courses.

Candidates are also required to fulfill admission requirements by the university including:

- holding a first degree in a health related discipline (e.g. health officer, nurse, medical doctor, environmental health professional, laboratory or biological science);
- being available for full-time formal training, field work and related FMoH activities;
- having a support letter from FMoH, RHB, or organizations they are working for ;
- passing an entrance exam and interview by the selection committee.

The admission examination and interview aim at evaluating each candidate's academic and attitudinal preparation to pursue a graduate program and undertake future assignments.

Field Bases

The FETP is designed for the residents to conduct 75% of their residency activities in the field. Accordingly, the program has established five field bases located at PHEM offices at national and regional levels. EFETP field bases have been established within the PHEM center at EHNRI and at four regional health bureaus: Amhara, Oromia, SNNPR, and Tigray. These bases provide opportunities for field experiences in epidemiology and were chosen based on population size, disease burden, and the availability of infrastructure and supervisory staff. Additional field bases will be added in the future depending on program needs.

Graduation Requirements

Residents are evaluated using examinations, exercises, presentations, projects and practical assignments. Successful completion requires satisfactory performance in class work as well as in the field residency and progress is monitored by the Field Supervisors and Mentors. Residents are required to produce

outputs in the following areas:

1. Report of at least 2 outbreak or epidemic investigations
2. Report from evaluation of a surveillance system
3. Surveillance data analysis report
4. Accepted protocol for epidemiologic project
5. Health profile description report
6. Final draft of a scientific manuscript for peer review journal publication
7. Abstract for a scientific presentation
8. Narrative summary of disaster situation visited
9. Narrative summary of laboratory activities
10. Record of teaching/mentoring in the EFETP
11. Article appropriate for an epidemiology bulletin submitted to EFETP/ FMoH and
12. Submission of monthly activity reports

Highlights of the Program Achievements

Enrolment and Graduation

The program has enrolled four resident cohorts as of November 2012. Thirteen residents were enrolled in the first cohort in 2009, 22 in the second,18 in the third cohort and 16 in the fourth cohort as of November 2012. The first cohort graduates received their degrees in July 2011 and the second cohort in July 2012. They returned to their sponsoring regions where they were re-assigned to new positions where they will use their newly acquired skills to support important public health response and surveillance activities. Such positions include being ahead of regional head of Public Health Emergency Management units and regional heads of Integrated Disease Surveillance and Response (IDSR) responsible for disease investigation and surveillance and also one graduate has been assigned as an adviser of Public Health Emergency Management issues to the Minister.

Outbreak investigations conducted

EFETP residents have been involved in a number of outbreak investigations during their training. Residents have

conducted outbreak investigations on multiple diseases including diarrheal disease, measles, meningitis, whooping cough, rabies, anthrax, vaccine-derived poliovirus, severe malnutrition, drinking water quality, motor vehicle accident surveillance, nutritional surveillance, Respiratory tract infections, relapsing fever outbreak investigation, Rubella outbreak investigation, febrile illnesses and also participated in the investigational processes of the Hepatic Venous occlusive disease with other team members from various sectors. During these outbreaks, residents characterized the outbreaks, investigated the sources of the epidemics, and offered public health interventions including community sensitization and immunization campaigns.

Surveillance activities conducted

Residents have also been involved in revising disease case definitions, disease reporting guidelines and forms. They have participated in Influenza A quarantine efforts at the international airport, and have routinely furnished the Ministry of Health with disease surveillance updates during outbreaks. Many of their recommendations from their investigations have been implemented including the adoption of mandatory safety belt laws, and provision of water and sanitary facilities during large gatherings at religious and cultural events.

Conferences attended and publications

Most of the first cohorts have participated in the annual scientific conferences of EPHA (Ethiopian Public Health Association), the Ethiopian Medical Association annual conference, the AFENET Regional Conference in Mombasa, Kenya in 2009, Tanzania Dare salaam 2011 and TEPHINET conference in Cape Town, South Africa in 2010 and Jordan Aman, 2012 and also presented their papers at international conference of infectious diseases Thailand, Bangkok 2012 where residents made oral and poster presentations at all the conferences mentioned previously. The academic coordinator and one resident

have also participated at the (Epidemic Intelligence Service) EIS annual scientific conference in April 2012. The program has also started publishing research papers. A summary of the key achievements of the program is shown in table below.

Among the new developments at the program is the introduction of a training course on Global Information Systems (GIS) and stata software training. Currently EFETP is a member of AFENET and TEPHINET.

Table: Summary of Program outputs up until November 2012

	Achievements	No.
1.	Outbreaks investigations and response	95
2.	Surveillance data analysis	55
3.	Surveillance systems evaluated	52
4.	Collaborative and other public health projects	23
5.	Accepted abstracts at conferences	37
6.	Program submissions for publication	8
7.	Manuscripts already published	7

Course completion

So far 34 residents graduated from the first and second cohorts and the remaining 34 (third and fourth cohorts) are on training.

Challenges faced by program

The program has faced a number of challenges. Such constraints include providing adequate mentoring and supervision to residents at regional field bases, challenges with communication and access to information, and lack of transportation to support residents in field work and investigations.

By Alemayehu Bekele Project Coordinator

የጥናት ውጤቶች

እጅግ የላቀ ለውጥ (Most Significant Change)

መግቢያ

እጅግ የላቀ ለውጥ (Most Significant Change)፡ አሳታፊ፡ የክትትል እና ግምገማ ቴክኒክ ሲሆን በተለይ በሰዎች ሕይወት ውስጥ በጊዜ ሂደት የሚከሰቱ ጠቀሚ ለውጦችን በታሪክ መልክ ለመዘገብ የሚያስችል ሳይንሳዊ አካሄድ ነው ። ይህ ቴክኒክ በተለይ የማህበረሰብ አቀፍ ፕሮጀክቶችን አፈፃፀም ለመከታተል እና ተመክሮዎችን በመውሰድ ማሻሻያ ለማድረግ ዓይነተኛ መሆኑ ይነገራል። እጅግ የላቀ ለውጥ ቴክኒክ አንድ ፕሮጀክት ከተጀመረ ቢያንስ ከአንድ ዓመት በኋላ የሚካሄድ የክትትል ዘዴ ነው። አንድ ፕሮጀክት ከተጀመረ በኋላ እና በፊት በተጠቃሚዎች ፤ በአገልግሎት ሰጪዎችና በሌሎችም የፕሮጀክቱ ማዕቀፍ ውስጥ ባሉ ግለሰቦች ህይወት ውስጥ የተከሰቱ አወንታዊ ወይም አሉታዊ ለውጦችን ከነምክንያታቸው በመዘርዘር የሚያስረዳ ስልት ነው።

በአሁኑ ወቅት ይህን ዘዴ በመጠቀም በርካታ ሀገሮች የፕሮጀክቶቻቸውን አፈጻጸም በመለካት ተገቢ ምላሽ መስጠት ብሎም የተሻሉ የተባሉ አሰራሮችን በመለየት ለሌሎች ልምዱን በማካፈል ውጤት እያስመዘገቡ ይገኛሉ። በቅርቡም የኢትዮጵያ ጤና አጠባበቅ ማህበር ፓዝ ኢትዮጵያ ከተባለ ዓለም አቀፍ መንግስታዊ ያልሆነ ድርጅት ጋር በመተባበር በስድስት የሀገሪቱ ክልሎች ተዘዋውሮ በሳሪይንሳዊ መንገድ የተቃኙ የለውጥ ታሪኮችን ቴክኒኩን በመጠቀም ለማጠናቀር ሞክሯል። እነዚህ የላቁ የለውጥ ታሪኮች የተሰበሰቡት ከSCRHA ፕሮጀክት የህክምና እና የኢኮኖሚ ማጠናከሪያ ድጋፍ ተጠቃሚዎች፤ ከበጎ ፍቃድ አገልግሎት ሰጪዎች እና ከሲቪል ማህበረሰብ መሪዎች ሲሆን፤ በጥናቱም በርካታ መልካም ተሞክሮዎች እና አንኳር

የፕሮጀክት ማሻሻያ ነጥቦች ተገኝተዋል።።

በመሆኑም የኢትዮጵያ ጤና አጠባበቅ ማህበር ከታች የተጠቀሱትን ሳይንሳዊ አካሄዶች ተጠቅሞ 160 ታሪኮችን ከተጠቃሚዎች እና ከባለድርሻ አካላት ሰብስቦ፣ መዝኖ ፤ መርጦ እና ተአማኒነታቸውን አረጋግጦ መረጃውን ለሚመለከታቸው አካላት ሁሉ ለዚሁ ዓላማ በተዘጋጀ አንድ አውደ ጥናት ላይ አሰራጭቷል።።

በ1997 ዓ.ም ዴቪስ እና ዳርት በተሰኙ ጠበብቶች የተዘጋጀውን እጅግ የላቀ ለውጥ (Most Significant Change) ቴክኒክ መመሪያ በጥልቀት ለመመርመር ተሞክሯል።።

ክሊር ሆራየዘን ከተሰኘ የአውስትራሊያ ኩባንያ ጋር በተደረገ ስምምነት ባለሙያ ወደ ኢትዮጵያ በማስመጣት ሰፊ ስልጠና ተሰጥቷል፤ በስልጠናውም ከፕሮጀክቱ ባለድርሻ አካላት የተውጣጡ ባለሙያዎች ተሳትፈዋል።።

በመቀጠልም የጥናቱ የትኩረት መዋቅሮች (Domain of Changes) ተለይተው ነጥረው ወጥተዋል።።

መረጃ መሰብሰቢያ ቅፅ ተዘጋጅቶ ለውይይት ቀርቦ ዳብሯል።።

የመረጃ ቅፁ በቅድመ ሙከራ የመስክ ጉብኝት ተፈትሾ በተገኘው መረጃ ላይ በመመርኮዝ መጠነኛ መሻሻያ ተደርጎበታል።።

160 ታሪኮች በአራት ዙር የመስክ ፕሮግራም ከተለያዩ ስድስት ክልሎች ተሰብስበዋል።።

ከእነዚህ 160 የለውጥ ታሪኮች ውስጥ 18ቱ በፕሮጀክቱ አማካኝነት የተመዘገቡ የላቁ የለውጥ ታሪኮች በመሆን ሁሉም ባለድርሻ አካላት በተገኙበት በተዘጋጀ አውደጥናት ተመርጠዋል።። የምርጫ ሂደቱም ራሱን የቻለ ሳንይንሳዊ አካሄድ የነበረው ሲሆን ከዚህም ውስጥ ታሪኩን በቡድን ተከፋፍሎ መተረክ፤ በታሪኩ ላይ ጥልቅ ውይይትና ክርክር ማድረግ፤ ታሪኩ የተመረጠበትን ምክንያት በዝርዝር ተወያይቶ መመዝገብ እና የተሻለውን ታሪክ በድምጽ ብልጫ መለየት ዋና ዋናዎቹ ናቸው።።

ከዚህ በኋላ በመጨረሻ የተመረጡት 18 ታሪኮች ተለይተው የማረጋገጫ የመስክ ጉብኝት (Verification Visit) ተደርጓል ፤ በዚህም የታሪኮቹን ትክክለኛነት፤ የተሟላ መሆን እና የሰዎቹን ነባራዊ ሁኔታ በተጨባጭ ለማየትና ለማረጋገጥ ተችሏል፡፡ በዚህ ረጅም ሂደት ውስጥ ነጥረው የወጡት እነዚህ እጅግ የላቁ የSCRHA ፕሮጀክት ታሪኮች በጥናታዊ ፊልም መልክ እና በህትመት ውጤቶች ተዘጋጅተው ፤ በዚህም የታሪኮቹን ትክክለኛነት፤ የተሟላ መሆን እና የሰዎቹን ነባራዊ ሁኔታ በተጨባጭ ለማየትና ለማረጋገጥ ተችሏል፡፡ በዚህ ረጅም ሂደት ውስጥ ነጥረው የወጡት እነዚህ እጅግ የላቁ የSCRHA ፕሮጀክት ታሪኮች በጥናታዊ ፊልም መልክ እና በህትመት ውጤቶች ተዘጋጅተው ተሰራጭቷል፡፡

ከዚህ በታች የሚነበቡት ታሪኮችም በዚህ ሳይንሳዊ መንገድ ተገኝተው ከታተሙት ውስጥ ጥቂቶቹ ናቸው፡፡

ወ/ሮ አብረኽት ግርማይ - ከመቀሌ

የቀድሞ ህይወቱ ግራ የተጋባ ነበር። ከሶስት የተለያዩ ወንዶች 3 ልጆች አሉኝ። በጓደኞቼ የአኗኗር ሁኔታ እሳብ ነበር። አንድ ቀን አልማዝ ባለጭራ አመመኝና ወደ ሆስፒታል መሄድ ብፈልግም እናቴ ግን ተቃወመች። በመሆኑም አንዲት ሴት ሁኔታውን አይታ ወደ ሆስፒታል ወስዳ እስከምታስመረም ረኝ ድረስ ቤት ውስጥ ቆየሁ። የደም ምርመራ ውጤቱ በጣም አስደንጋጭ ነበር። ኤች-አይ-ቪ በደሜ ውስጥ እንዳለ ተነገረኝ። በአጭር ጊዜ የምሞት መስሎኝ ነበር። ቫይረሱ በደሜ ውስጥ ይኖራል ብዩ በጭራሽ አስቤ አላውቅም ነበር። ከሁሉም በላይ የከፋው ነገር ግን የሚያስጠጋኝ ማጣቱ ነበር። በከፍተኛ ሁኔታ መገለልና አድሎ ይደረግብኝ ነበር። የምጠጋበት በማጣቱ የነበረኝን ብቸኛ ምርጫ ወሰድኩና ልመና ጀመርኩ። ቤተ ሰቦቼን የምረዳው በዚህ መልኩ ነበር። በየሰው መኖሪያ ለልመና ስዞር ኬለታት አንድ ቀን «ራዕይ በተግባር ማህበር» በር ጋር እግሬ ጣለኝ። አንድ ሰው መግቢያው በር ላይ ቆሟል። ሶፎንያስ ይባላል፣ ለልመና እጄን ስዘረጋ የቆምኩት የግለሰብ መኖሪያ በር ሳይሆን በቅርቡ የተቋቋመ ማህበር እንደሆነ ነገረኝ። ግን ለልመናዬም እንዲሁ አልሸኘኝም፤ ከኪሱ 50.00 ብር አውጥቶ ሰጠኝ።

የሰውነት አቋሜንና ድካሜን ሲያይ ስለኔ ብዙ ማወቅ ፈለገ፣ ነገርኩት። ሶስት የበጎ ፈቃደኝነት አገልግሎት ሰጭዎችን እንዲከታተሉኝ አድርጎ መዘገበኝ። ከእግዚአብሔር በታች እንዲህ አይነት ታዳጊ እንዳለኝ አልገመትኩም ነበር። በቤት ውስጥ ይደርስብኝ በነበረው መገለልና አድሎ ህይወቱ ከፉኛ ተማሮ፤ ስነልቦናዬም በእጅጉ ተጎድቶ ነበር። በአጭር ጊዜ ራዕይ በተግባር አባል ሆንኩኝ። ጥምር ቁስሌን የሚሸር መጠለያ አገኘው። ባዕላት ሲደርሱ ልብስ፣ አንሶላና ሌሎችንም ነገሮች ማሸበሩ ይገዘልኝ ጀመር። ይሁን እንጂ ለብዙ ሰዎች ሸክም መሆኔ ቀን ከሌት ይከነክነኝ ጀመረ። እናም አንድ ቀን ህይወቱን ለማጥፋት ወሰንኩ። በመኪና ለመገጨት ብመኝም ድፍረት ግን አላገኘ ሁም።

ከዚያም ከመቀሌ በስተደቡብ በጥቂት ኪሎ ሜትሮች ርቀት ላይ ወደምትገኘው አይናለም ወደተባለች መንደር ተጓዝኩ። በዚያ አካባቢ የትግራይ ጅቦች ሰዎችን ይበላሉ ሲባል ሰምቼ ነበር። እናም በጅቦች ለመበላት ወስኜ አመራሁ። ነገር ግን አንዲት ገርጊስ የምትባል ሴት በምሽት ወደ አይናለም መጋስጌን አይታ ወደ ቤታ ወስዳ ታደገችኝ ። ያን ዕለት ታሪኬን በሙሉ ዘርዝሬ አጫወትኳት። የሚገርመው በእሷ ቤት እንዳለሁ

ሶፎንያስና የበጎ ፈቃደኛ አገልግሎት ሰጭዎች በድንገት መጡ። በምሄድበት ስፍራ ሁሉ ይከተሉኝ ነበር። በድጋሚ ሕይወቴን ታደጉት። ከዚህ በኋላ እነኄህን ሰዎች እግዚአብሔር ነው የላካቸው ብዬ አመንኩ። መቀሌ ከተመለስኩ በኋላ በድጋሚ የአልጋ ቁራኛ ሆንኩ። ያለመታከት አስታመሙኝ። እናም ተሽሎኝ ራሴን ችየ መራመድ ቻልኩ። በታመምኩ ጊዜ ልብሴን ያጥቡልኝ ነበር፣ ይመግቡኝ ነበር። ከምንም በላይ ተስፋ ይሰጡኝ ነበር። እና እነርሱን ባየሁ ጊዜ የእግዚአብሔር መልዕክተኞች ወደእኔ እንደመጡ አስብ ነበር። በቀን ሁለት ጊዜ ይጎበኙኝ ነበር።

ተሽሎኝ ጥንከሬ እንደተሰማኝ በአነስተኛ ንግድ እንድሰማራ በገንዘብ ረዱኝ። በመጀመሪያ ብርቱካን፣ ሙዝ እና በለስ መሸጥ ጀመርኩ። መነሻ ከፒታሉ 1500.00 ብር ነበር። በተጨማሪ የልብስ ስፌት ሙያ እንድሰለጥን እድሉን ተመቻቸልኝና ልብስ መስፋት ጀመርኩ። ከዚያ በተጨማሪ 10 ኪ.ግ ሙዝ እና 20 ኪ.ግ ብርቱካን ለመግዛት የሚያስችል ገንዘብ አገኘሁ። ከዛ ሁሉ ውጣ ውረድ በኋኋላ አሁን ራሴን ችያለሁ። ራሴን ለማልበስ የሚያስችል አቅም አለኝ። ልብሶቼን በራሴ አጥባለሁ፤ ራሴ እመገባለሁ፤ ራሴን እንድችልና የሌሎችን እጅ እንዳልጠብቅ የሚያስችል ድጋፍ ተደርጎልኛል።

ሁነኛው ስሜነህ፡- ከአዲስ ዘመን

ከልክ ያለፈ ጠጪ ነበርኩ። ደረቅ አልኮል የመጠጣት ልማድ ነበረኝ። በተለይም ከ1998 ዓ/ም ጀምሮ አልኮል መጠጣት፣ ከተለያዩ ሴቶች ጋር ወሲብ መፈፀምና ከሴተኛ አዳሪዎች ጋር በጭፈራ ሌሊቱን ማበድ ነበር የዕለት ተዕለት ተግባሬ። በርግጥም እንዲህ አይነት ኑሮ ለመምራት የሚያስችል ጥሩ ገቢ ነበረኝ። በሁመራ በረሀ በአናጢነት ስራ ተሰማርቼ ከፍተኛ ገንዘብ አገኝ ነበር፤ አካባቢውም የግብርና ምርት ስፍራ ከመሆኑ አንፃር ለዓለም አቀፍ ገበያ የሚቀርብ ሰሊጥ የሚመረትበት ገንዘብ የሚታፈስበት ነው። እኔ ግን በየቀኑ የማገኘውን ገንዘብ በዚያው ዕለት አጠፋ ነበር። የገንዘብን ዋጋ አልተገነዘብኩም ነበር። በየቀኑ ከተለያዩ ሴቶች ጋ ወሲብ እፈፅም ነበር። ብታምኑም ባታምኑም አንዳንድ ቀን አንዲትን ሴት ሁለት ወይም ከዚያ በላይ ሆነን እንገናኛት ነበር። ከተወሰነ ጊዜ በኋላ ግን መታመም ጀመርኩ። ያመኛል መልሶ ይሻለኛል። በዚህ ሁኔታ ከቆየሁ በኋላ በ1999 ዓ/ም ሙሉ ለሙሉ የአልጋ ቁራኛ ሆንኩ። የህመሜን መጥናት ያዩ ጓደኞቼ የቀረችውን ዕድሜየን ከወዳጅ ዘመዶቼ ጋር እንዳሳልፍ በማሰብ ወደ

አዲስ ዘመን ላኩኝ። ነገር ግን ቤተሰቦቼ ለህክምና ወደ ባህርዳር በወሰዱኝ ጊዜ የህይወቴን አቅጣጫ የሚቀይር ክስተት ተፈጠረ።

የህመሜ ምክንያት ኤች-አይ-ቪ መሆኑ ተነገረኝ እናም «በህይወት ተስፋ» ወደሚባል ማህበር ተመራሁ። ከዚያን ጊዜ ጀምሮ ህይወቴ በተለያየ መልኩ መሻሻል አሳየ። አራት በጎች ገዙልኝ አንዱን በግ ሸጨ በ500.00 ብር የቤት ቁሳቁሶችን ገዛሁ። ከሸጥኩት በግ ውጭ ሌሎቹ ተራብተው ስድስት ደረሱ።

ከእነዚህ መካከል ሶስቱን በጥሩ ዋጋ ሸጨ ቴሌቪዥን ገዛሁ። አሁን በምኖርበት ቤት አነስተኛ ግሮሰሪ አለችኝ፣ ቢራና ለስላሳ እሸጣለሁ። ቴሌቪዥን መግዛቴም ደንበኞችን ለመሳብ ረድቶኛል። ንግዱን የጀመርኩት ከማህበሩ ባገኘሁት ብድር ነበር። በዚህ ስራ ከተሰማራሁ በኋላ ቀስ በቀስ እድገት እያሳየሁ መጥቻለሁ። ከንግዱ ጎን ለጎን የፀረ ኤች-አይ-ቪ ኤድስ መድሀኒቱን በአግባቡ እየወሰድኩ ነው። ዛሬ መጠጥ ሙሉ ለሙሉ አቁሜያለሁ። እንዲሁም የራሴንና የአከባቢዬን ንፅህና በአግባቡ አጠብቃለሁ ። በአሁኑ ወቅት በማህበሩ አባል ሴት ጋር ትዳር መስርቼ ሰላማዊ ኑሮ እየመራሁ አገኝለሁ።

የሁሉም ለውጦቼ መሰረት በመጀመሪያ ያገኘኋቸው በጎች ቢሆኑም የኢኮኖሚ አቅሜን እንዴት ማጎልበት እንዳለብኝ ማወቄ ትልቁን ድርሻ ይይዛል። አራቱ በጎች የተሰጡኝ በቂ የኢኮኖሚ ማጠናከሪያ ስልጠና ከገኘው በኋላ በመሆኑ ገንዘቤ አየር ላይ አልቀረም።

አያል ሰዋገኝ - ደብረማርቆስ

ም1996 ዓ/ም በወዶ ዘማች ወታደር ቤት ገባሁ። በ1998 ዓ/ም መጨረሻ በጦር ሜዳ ቆሰልኩ። በ1999 ዓ/ም በቦርድ ተሰናብቼ ወደ ትውልድ መንደሬ ለመመለስ ተገደድኩ። ከዛን ጊዜ ጀምሮ በተደጋጋሚ እታመም ጀመር። ከበሽታዬ ለመዳን የቻልኩትን ሁሉ አደረኩ። ሆስፓፒል ሄድኩ፣ ወደ ጠበል ስፍራም ሞከርኩ፣ ጠንቋይ ጋ ሁሉ ደረስኩ ግን አንዳቸውም መፍትሄ አልሰጡኝም። ከዚያ በጣም ተረበሽኩ። በቃ መሞቴ ነው ብዬ አሰብኩ። በመጨረሻ ክሊኒክ ሄጄ የኤች-አይ-ቪ ኤድስ ምርመራ አደረግኩ። ከደም ምርመራ ውጤት በኋላ የችግሩ ሁሉ ምንጭ እሱ እንደሆነ ተረዳሁ። ምርመራውን ያደረግኩት በ2000 ዓ.ም ሲሆን በቀጥታ የፀረ ኤች-አይ-ቪ ኤድስ መድሀኒት መውሰድ ጀመርኩ። ነገር ግን ከሚያገሉኝ ሰዎች ጋር ህይወቴን መምራት በጣም ተቸገርኩ። ቤተሰቦቼና ጎረቤቶቼ ተገዳደሩኝ።

በተለያዩ መንገዶች ፍራቻቸውን ያሳዩኝ ጀመር። እናቴ ሳትቀር ተፀየፈችኝ። ራሴን መጠየቅ ጀመርኩ። ለምን እኖራለሁ አልኩ? እናም ኑሮ ለማቆም እርምጃ ጀመርኩ። የፀረ ኤች-አይ-ቪ ኤድስ መድሃኒቱን አቁረጥኩት። እንደገና የአልጋ ቁራኛ ሆንኩ። ተስፋዬ ተሟጠጠ። አንዳንድ ጓደኞቼ የኔን ሁኔታ ተረድተው እንደገና ወደ ፀበል ወሰዱኝ። ፀበል እየተጠመኩኝ ሳለ ከዕለታት በአንድ ቀን ሂሩት የምትባል ሴት ወደ ቤተክርስቲያን መጣች። ከዚያን ቀን በፊት አይቻት አላውቅም፤ ብሩህ ከኤች-አይ-ቪ ጋር የሚኖሩ ወገኖች ማህበር እና የፈቃደኝነት በጎ አድራጎት ሰጭ ማህበር አባል ነች። ከዚያ በየቀኑ እየመጣች ትጎበኘኝ ጀመር። በዚህ ጊዜ እንደማንኛውም ሰው መኖር እንደምችል አመንኩ። ማንኛውም ሰው የሚሰራውን ስራ መስራት እንደምችል ተረዳሁ። በእርግጥ እዚህ ደረጃ ለመድረስ ብዙ ጊዜ ወስዶብኛል። ከብዙ የምክር አገልግሎት በኋላ ነው የተለወጥኩት። ከዚያ በፊት በርካታ የህክምና ባለሙያዎች ሊያበረታቱኝ ሞክረው ነገር ግን ሀሳባቸውን መቀበል አልቻልኩም ነበር። ይሁንና ሒሩት እሷም እንደኔ ቫይረሱ በደሟ ውስጥ እንዳለና መኖር እንደቻለች ባሳወቀችኝ ጊዜ ነቃሁ። አስተሳሰቤን ቀየርኩ። ቀስ በቀስ አገገምኩ፤ በመንፈስና በስነልቦናም በረታሁ። ከሁሉም በላይ አመለካከቴን መቀየሬ ጠቀመኝ። በቤተሰቦቼና በጎ ረቤቶቼ ላይ የነበረው አስተሳሰብ ከበሽታው በላይ ጎድቶኝ ነበር። ዛሬ በአነሱ ላይ ባየሁት ለውጥ ረክቻለሁ። ቀደም ሲል ኤች-አይ-ቪ ስላለበት ሰው ያላቸው አመለካከት የተዛባ ነበር።

አሁን በሚደንቅ ሁኔታ በተረጋጋ የስነልቦና ሁኔተ በሰላምና በስምምነት እንዲሁም በፍቅር ከጎረቤቶቼ ጋር እኖራለሁ።

በዚህ አጋጣሚ ሂሩትን ላመሰግናት እወዳለሁ። ከራሷ ተሞክሮ ተነስታ በምትሰጠው ትምህርትና የምክር አገልግሎት ለመለወጥ አዳጋች የሚመስሉአስተሳሰቦችን ለመለወጥ አቅም ያላት ጀግና ሴት ነች። ሂሩት የህይወቴ መድሐኒት ነች። አሁን ከሂሩት ጋር ተጋብተን በአንድ ጣራ ስር በደስታ እንኖራለን።

ያረጋል ባይነግረው - ላሊበላ

ትምህርቴን አቋርጬ ብሔራዊ ውትድርና በፈቃዴ ገባሁ። ለ7 ዓመታ ት ያህል ለእናት አገሬ ሉዓላዊነት ታገልኩ። በመካከሉ 4,000 ብር ካሳ ተ ሰጥቶኝ ከውትድርና ተሰናበትኩ።

ከላሊበላ ውጭ የምሄድበት ምንም አማራጭ አልነበረኝም። የተወለድኩት ያደግኩትና ውትድርና እስከምሄድ ድረስም ያደግኩትና ውትድርና እስከምሄድ ድረስም የኖርኩት ላሊበላ ነው። ድንገት ታላቅ ወንድሜ ወታ ደር ቤት ያሳለፍኩትን ኑሮ ጠርጥሮ ኤች-አይ-ቪ እንድመረመር አነሳሳኝ፣ አነቃኝ። እናም በፍፁም ባላሰብኩት ሁኔታ ቫይረሱ በደሜ ውስጥ እንዳለ ተረዳሁ። ሲ.ዲ.ፎሪ እያሽቆለቆለ እንደሆነ ነገሩኝ። መጠንቀቅ እንዳለብኝም አስረዱኝ። ያለሁበትን ሁኔታ ከተረዳሁ በኋላ የፀረ ኤች-አይ-ቪ ኤድስ መድሐኒት መውሰድ ጀመርኩ። ነገር ግን አልቀጠልኩበትም፤ የመድሀኒቱን ሀይል መቋቋም አቃተኝ።

በሳምንት ውስጥ ክብደቴ ባስደንጋጭ ፍጥነት ቀነሰ። አልጋ ላይ ወደቅኩ። በዚህ ጊዜ ቤተሰቦቼ እናቴን ጨምሮ አወገዙኝ። እንደማልድንና ተመልሼ ሰው እንደማልሆን ነገሩኝ። በመጨረሻ ከቤት አስወጥተው ከዕይታ አርቀው ኩሽና ውስጥ አስቀመጡኝ። ለ3 ዓመታት ያህል ከአልጋ ሳልነሳ ተስፋ አጥቼ ተጥዬ ቆየሁ። እጅግ በጣም ዘግናኝ ጊዜ ነበር። የኩሽናው ጣራ ያፈሳል፤ በቢጋ ጊዜ ደግሞ ፀሀዩ አሳት ነበር። በዚህ ወሳኝ ወቅት ነበር የላሊበላ ቤዛ ማህበር የበጎ ፈቃድ አገልግሎት ሰጭ አባላት ደርሰው ከሞት አፋፍ ያወጡኝ። እንደ ቆሻሻና ጥቅም አልባ ዕቃ ከተወ ረወርኩበት ኩሽና ውስጥ አወጡኝ። ያኔ በመጀመሪያ በአቅራቢያዬ ወዳለ ሆስፒታል ወስደው የህክምና እርዳታ እንዳገኝ አደረጉኝ። ቀስ በቀስ እያገገምኩ መጣሁ። ሰውነቴ ተመለሰ። ቁመናዬም መልካም ሆነ። ነገር ግን በህመሜ ወቅት ያሳለፍኩትን መከራ ቁስል መርሳት አልቻልኩም። ያ ጊዜ ጥሎብኝ ካለፈው ፍርሀት በቀላሉ መላቀቅ ተቸገርኩ። አእምሮዬ ሙሉ ለሙሉ አልተመለሰም።

በዚህ ጊዜ ራሴን ለማጥፋት ወሰንኩ። በቢላዋ ራሴን ለመግደል ሞከርኩ። ነገር ግን አልተሳከም። ወንዝ ውስጥ ሰጥሜ መሞት ባስብም በሚገርም ሁኔታ ውሃው ላይ ተንሳፈፍኩ። በዚህ ጊዜ አንድ ነገር ተረዳሁ። በቃ ገና በህይወት ብዙ ነገር አያለሁ፤ እግዚአብሔር እንድሞት አልፈቀደም ብዬ አሰብኩ። በዚህ ሁሉ ሂደት ላሊበላ ቤዛ ማህበር የበጎ ፈቃደኝነት አገልግሎት ሰጭዎች መንፈሴን ለማበረታታት ብዙ ጥረት ሲያደርጉ ነበር። በማያቋርጥ የምክር አገልግሎታቸው ወደ ድሮ ማንነቴና ወደ ሙሉ አስተሳሰቤ ተመለስኩ። በየቀኑ ስለሚከታተሉኝ በስነልቦናም እየጠነከርኩ መጣሁ። የፀረ-ኤች-አይ-ቪ መድሃኒት በማቋረጤ የከፈልኩትን ዋጋ በማሰብ ከዚህ በኋላ በጭራሽ መድሃኒቱን ላለመቋረጥ ቃል

ገባሁ። አሁን ሲ.ዲ.ፎሬ በጥሩ ሁኔታ ጨምሯል። ጠንካራ ሆኛለሁ። የበጎ ፈቃደኝነት አገልግሎት ሰጭዎች ለቤተ ሰቦቼ በሰጧቸው ግንዛቤ አስተ ሳሰባቸው ተቀያይሯል፡ ከሁሉም በላይ ቤተሰቦቼ ከእኔ ጋር መሆናቸውን ማየቴ ያስደስተኛል። ከሞት ወደ ህይወት ነው የመጣሁት ማለት እችላለሁ። ከአልጋ ቁራኛነት ወደ ራስን መቻል እና ከመገለል ወደ ተሳስቦና ተስማምቶ በአንድነት ወደ መኖር ተሸጋግሬያለሁ።

ወ/ሮ እታለም አዲስ - ፍኖተ ሠላም

ትዳሬን አፍሪሼ በብቸኝነት የምኖር ሴት ነበርኩ። በአንድ ወቅት ታመምኩና ተኛሁ። ህመሙ ቀፋኛ ጎዳኝ። ወደ ህክምና ከመሄድ ውጭ አማራጭ አልነበረኝም። ነገሩ ግን በጣም አስደንጋጭ ነበር። ኤች-አይ-ቪ በደሜ ውስጥ እንዳለ አወቅኩ ። የሆነውን ሁሉ አላስታውስም። ብቻ ምድር ተከፍታ ብትውጠኝ በመረጥኩ ነበር።

ትንሽ ተረጋግቼ በከፊል ወደ አእምሮዬ ስመለስ ወደ ቀበሌዬ ሄጄ ልጄ እናቴ በቅርቡ ትሞታለች ብላ እንዳታስብ እባክችሁ ውሰዱልኝ ብዬ ለመንኳቸው። ምክንያቱም ስለ ኤች-አይ-ቪ የነበረኝ መረጃ በፍፁም የተሳሳተ ነበር።

ተረጋግቼ ወደቤቴ መመለሴን እስኪያ ረጋግጡ ድረስ የጤና ባለሙያዎች እንዴት እንደተንከባከቡኝ አልረሳውም። በድጋሚ ጠሩኝና ስቃዩን የሚያስረሳና የሚያበረታታኝ የህክምና እንክብካቤና የኢኮኖሚ ማጠናከሪያና ድጋፍ ሰጭ ፕሮግራም ተጠቃሚ እንድሆን ወደ አዲስ ህይወት በኤች-አይ-ቪ የተያዙ ወገኖች ማህበር ላኩኝ።

ቀበሌው ስላለሁበት ሁኔታ የሚገልፅ የድጋፍ ደብዳቤ በታሸገ ፖስታ አስይዞ ነበር የላከኝ። የማህበሩ አባላት ደብዳቤውን ካዩ በኋላ በኢኮኖሚ ማጠናከሪያ ድጋፍ ውስጥ መዘገቡኝ።

የማንበሩ አባል ከሆንኩ አንድ ዓመት ሞልቶኛል። በመጀመሪያ 3 በጎች ለመነሻ ያህል ተገዝተው ተሰጡኝ። ከሁሉም ለውጦች 3ቱ በጎች ከተገዙልኝ በኋላ የመጣው ለውጥ ለኔ የህይወት ለውጥ ነው። በጎቼን በዓይነት ድጋፍ መልክ ካገኘሁ በኋላ እንዲሁ አልተቀመጥኩም። በጎቼን ማድለብና ማርባት ጀመርኩ። ዛሬ ቁጥራቸው ሰባት ደርሷል። ሁለቱን ሸጬ ገንዘቡን ተጠቅሜያለሁ። በእኔ አቅም የምንከባከባቸውን ያህል እስከማረባ ድረስ

ቀንና ሌሊት አልተኛሁም። ልጄ ዛሬ ቀኝ እጄ ናት፣ ከትምህርት ቤት ሰዓቷ ውጭ ትረዳኛለች። ዛሬ ራሴን እንደቻልኩ ይሰማኛል። ሞራሌም ተገንብቷል። ይህ ለውጥ የመጣው አዲስ ህይወት ከኤች-አይ-ቪ ጋር የሚኖሩ ወገኖች ማህበር ድጋፍ ከደረገልኝ በኋላ ነው። ብሩህ ተስፋ ያለው ህይወት ለመምራት የራዕይ ጉዞ ጀምሬያለሁ።

ወ/ሮ በላይነሽ አለም ዘውድ - ወረታ

የስጋ ቤተሰቦቼን አቁሮውቃቸውም። ያደኩት በማደጎ ነው። በኋላም ፓዊ በረሀ (ቤንሻንጉል ክልል) ሄጄ አንድ ያፈቀርኩትን ሰው አገባሁ። ውሎ አድሮ ውብ ትዳራችን ተበተበጠ። ምክንያቱ ደግሞ ልጅ መውለድ አለመቻላችን ነበር። በዚያ ማህበረሰብ ባህል ልጅ መውለድ የማትችል ሴት ምንም አይነት ክብር አይሰጣትም። እናም በባለቤቴ ቤተሰቦቼች በኩል የሚደርስብኝን ጥላቻ መሸከም ሲያቅተኝ ባለቤቴን ፈትቼ ወደ ወረታ መጣሁ።

ወረታ ከመጣሁ በኋላ ሙስሊም ሰው ጋር ተገናኘን። ምንም መጠጊያ ስላልነበረኝ ሰልሜ አገባሁት። እሱም ቢሆን ባላወቅኩት ምክንያድ ደንገት ትቶኝ ወደ ሩቅ ስፍራ ሄደ። የእደል ነገር ሆኖ ሶስተኛውን ባሌን ከገባሁ በኋላ አረገዝኩ። በጣም አስቸጋሪ የእርግዝና ጊዜ ነበር። በሕይወት ዘመኔ ሁሉ አጋጥሞኝ የማያውቅ የስቃይ ጊዜ አሳለፍኩ ልጅን ያህል ትልቅ ስጦታ አገኘሁ ስል በተደጋጋሚ በተለያዩ በሽታዎች እታመም ጀመር። በ1999 ዓ/ም የ8 ወር ነፍሰጡር እያለሁ ባደርኩት የህክምና ምርመራ ኤች-አይ-ቪ በደሜ ውስጥ እንዳለ አወቅኩ። ልጄን ከቫይረሱ ለመታደግ አልቻልኩም። አሁን ባቢ የሚባል ቫይረሱ ያለበት የ6 ዓመት ሕፃን ልጅ እናት ነኝ።

ከተወሰነ ጊዜ በኋላ የኦርቶዶክስ ቤተ ክርስቲያን የበጎ ፈቃደኝነት አገልግሎት ሰጭዎች የስነልቦና እንክብካቤ ድጋፍ ያደርጉልኝ ጀመር። የእነሱን ድጋፍ ካገኘሁ በኋላ በፍጥነት ያለሁበትን ሁኔታ አምኜ በመቀበል ራሴን አወጣሁ።

ኤች-አይ-ቪ ለኑሮዬ እንቅፋት መሆን የለበትም ብዬ አመንኩ። እናም ወጥቼ ልዩ ልዩ ዝግጅቶች ባሉበትና ሰዎች በተሰበሰቡበት ስፍራ ሁሉ ማስተማር ጀመርኩ። ራሴን አውጥቼ ለህብረተሰቡ ትምህርት በመስጠት የማህበረሰቡን አመለካከት በመለወጥ ረገድ ትልቅ ድርሻ ስለነበረኝ ከኦርቶዶክስ ቤተክርስቲያን ተጠቃሚዎች አንዷ እንድሆን እድሉን ተፈጠረልኝ። በ2002 ዓ/ም የኢትዬጵያ ተዋህዶ ቤተክርስቲያን የፈቃደኝነት አገልግሎት ሰጭዎችን እንድቀላቀል ተጋበዝኩ። በመሆኑም የኢኮኖሚ ማጠናከሪያ ድጋፍ

ና የችግሩን ስቃይ የሚያስረሳ እንዲሁም ያለሁበትን ሁኔታ በፀጋ ለመቀበል የሚያስችል እንክብካቤና ድጋፍ ማግኘት ጀመርኩ። አሁን የመሀበሩ አባል ነኝ። እናም ከፕሮጀክት ብርና ጥቅማ ጥቅሞችን አገኛለሁ። የበጎ ፈቃደኝነት እንክብካቤ፣ ድጋፍና የምክር አገልግሎት ተቀብያለሁ። ከሁሉም በላይ ግን በመንፈሳዊ ድጋፍና የምክር አገልግሎት ያገኘሁት የመንፈስ ብርታት ከሁሉ የላቀ መልከም ለውጥ ነው። ከዚያ ሁሉ ውጣ ውረድ በኋላ ዛሬ ከልጄ ጋር ሰላማዊ ህይወት እየመራሁ እገኛ ለሁ። በአከባቢዬ ሰዎች መሃበራዊ ተ ቀባይነት አለኝ። በተለያዩ ማህበራዊ ጉዳዮች ተወካይ ሆኜ እያገለገልኩ ነው። በአሁኑ ሰዓት ለስላሳ መጠጦችን በመሸጥ፤ ምግብ በማብሰልና ዳቦ በመጋገር እንዲሁም ልብስ በማጠብ እተ ዳደራለሁ።

ከሁሉም ከተደረገልኝ ድጋፍ የሚበልጠው መንፈሳዊ ምክሩ ነበር። ህይወቴ እንዲ ረጋጋና ሠላማዊ እንዲሆን አግዞኛል። መንፈሳዊ ምክር ባለገኝ ኖሮ የወደፊት እጣዬ ለዘላለም ጭንቀትና መከራ በሆነ ነበር። ከመንፈሳዊ አገልግሎት በኋላ ሁሉንም ነገር ለእግዚአብሄር ተውኩ። ከሁሉ በላይ የሚንከባከበኝና የሚከታተለኝ አምላኬ እሱ ያውቃል ብዬ አርፌያለሁ።

አለም አከሉ- ደቡብ ወሎ (መካነ ሠላም)

ልጅ እያለሁ ከፈቃዴ ውጭ ለማልፈልገው ሰው ተዳርኩ። ትምህርቴን መከታተል አፈልግ ስለነበር እንድንፋታ ባለቤቴን ጠየቅኩት። ግን ፈቃደኛ አልሆነም። ከዚያ በ1998 ዓ/ም ትቼው ወደ መካከለኛው ምስራቅ ስራ ፍለጋ ሄድኩኝ። ከዚያም ቢሆን መልካም ህይወት አልገጠመኝም። ደጋግሞ ያመኝ ነበር።

ለአስር ዓመታት ያህል ከኢትዮጵያ ውጭ ቆይቼ እንደተመለስኩ ህመሙ ጠናብኝና አዲስ አበባ ባልቻ ሆስፒታል ተኛሁ። የኤች አይ-ቪ ምርመራ አደረኩ ውጤቱ አስደንጋጭ ነበር። ቫይረሱ በደሜ ውስጥ እንዳለ ተረዳሁ። በቃ ተስፋዬን ቆረጥኩ። እድሌን ረገምኩ። እቅዴ ከሸፈ ከረጅምና አስቸጋሪ የመካከለኛው ምስራቅ ኑሮ በኃ ላ ያላሰብኩት ዱብዳ መጣብኝ።

የነበርኩበት ሁኔታ አስጊ ስለነበር ወደ ጥቁር አንበሳ ሆስፒታል ሪፈር ፃፉልኝ። በዚህ ጊዜ ከመሞት በስተቀር ተስፋ እንደሌለኝ አሰብኩ። እህቴ ከሆስፒታል

አውጥታ ወደ ትውልድ ስፍራዬ ወደ መከነ ሠላም ወሰደችኝ። ያዩኝ ሰዎች ሁሉ የምሞትበትን ቀን ይቆጥሩ ጀመር። በእርግጥም ሰውነቴ በሙሉ በቁስል ተሸፍኖ ነበር። ውሎና አዳሬ አልጋ ላይ ነበር። በጣም ተረብሼ ነበር። በዚህ ወሳኝ ሰዓት የባሌ ወንድም ከ(SCRHA) ፕሮጀክት የበጎ ፈቃድ አገልግሎት ሰጭዎች ጋር አገናኘኝ።

ሰለሞን የሚባል ሰው ሁኔታዬን አይቶ በአስቸኳይ በከተማው በሚገኘው ጤና ተቋም ወሰደኝ። የሰውነቴ ክብደት 37 ኪሎ ግራም ብቻ ሲሆን እጅግ በሚያስደነግጥ ሁኔታ ሲ.ዲ.ፎሬ ወርዶ 4 ደርሶ ነበር። በዚህ ሁኔታ በህይወት መቆየቴ ሁሉንም ያስደነቀ ጉዳይ ነበር። ከዚያ ወዲያውኑ የፀረ ኤች አይ ቪ ኤድስ መድሀኒት ጀመርኩ።

የበጎ ፈቃደኝነት አገልግሎት ሰጭዎችና የፕሮጀክቱ የህይወት ውለታ አለብኝ፤ ከሞት ጋር ታግለው ህይወቴን ታድገዋታል። ብዙ ነገር አድርገውልኛል። ሰለሞን ብርድልብስ የተለያዩ የንፅህና መጠበቂያ ዕቃዎች ያቀርብልኛል። በየቀኑ ቤቴ ድረስ እየመጡ ይጎበኙኛል፣ ይንከባከቡኛል። ሰለሞን ሲ.ዲ.ፎሬን በየጊዜው እንድለካ መድሀኒቱን ተከታትዬ እንድወስድ ያበረታታኛል። ለዚህም ነው የስነ ልቦና ብርታት አግኝቼ ያለፍርሀትና ጭንቀት ራሴን አውጥቼ ለማህበረሰቡ ያሳየሁትና ከኔ ተማሩ ያልኩት።

ባለፉት 8 ወራት ቀስ በቀስ ወደ ጤናማነት እየተመለስኩ ነው። ሲ.ዲ.ፎሬ ከ4 ወደ 147 ከፍ ብሏል። ክብደቴም 52 ኪሎግራም ደርሷል። በዚያ ጊዜ ያዩኝ ሰዎች ዛሬ ቆሜ መራመዴን ማመን አቅቷቸዋል። አንዳንዶቹ እንዲያውም መንገድ ላይ ሲያገኙኝ አይለዩኝም። ዛሬ ወደ ቤቴ ተመልሻለሁ የራሴን አነስተኛ የንግድ ስራ ስለጀመርኩ የቤተሰብ ሸክም አይደለሁም። ቡና እና ሻይ እሸጣለሁ። ሁሉም የሆነው በበጎ ፈቃደኝነት አገልግሎት ሰጭዎች ድጋፍ ነው። የእኔ ብቸኛው ምርጫ ሞት ነበር።

This information is taken from NCDs booklet initiated and published by EPHA with financial support from CDC Ethiopia. The booklet is produced based on comprehensive review of literature focusing on chronic non communicable diseases along with interview of key informants at the federal and regional health offices and academic institutions as well as civic societies.

The Issue

Chronic Non-communicable Diseases – the Ethiopian Situation

Overview

A non-communicable disease, or NCD, is a medical condition or disease which is non-infectious. NCDs are diseases of long duration and generally slow progression. These include heart disease, stroke, cancer, asthma, diabetes, chronic kidney disease, arthritis, osteoporosis, cataracts, and more. While often referred to as "chronic diseases", NCDs are distinguished by their non-infectious causes. In contrast, some chronic diseases such as HIV/AIDS, while also lasting medical conditions, are caused by transmissible infections. They are similar in being requiring chronic care management. The U.S. National Center for Health Statistics defines a chronic disease as one lasting three months or more.

Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 63% of all deaths. Out of the 36 million people who died from chronic diseases in 2008, 29% were under 60.

This invisible epidemic of chronic diseases hinders the economic development of many countries and contributes to poverty. Contrary to the common perception, 80% of chronic disease related deaths occur in low and middle income countries.

The growing burden of NCDs is yet another emerging challenge to socioeconomic progress particularly in developing countries.

Total deaths from NCDs are projected to increase by a further 17% over the next 10 years. The rapidly increasing burden of these diseases is affecting poor and disadvantaged populations disproportionately, contributing to widening health gaps between and within countries. As NCDs are largely preventable, the number of premature deaths caused by them can be greatly reduced.

The Burden of Non communicable Diseases in Ethiopia

Ethiopia, like many developing countries, is a country in transition, facing the consequences of epidemiologic, demographic, economic and nutrition transitions which continue to favour the chronic diseases epidemic. Current projections indicate that the proportion of people living in to older ages and in the urban areas will significantly increase over the coming two decades. For example, life expectancy is expected to rise from the current 53 for males and 56 years for females to 65 and 68 years for males and females respectively in the years 2025 - 2030. The proportion of the population living in urban areas is expected to reach 23 percent from the current 15 percent during the same period.

Some of the available data also indicate that chronic diseases and their risk factors in Ethiopia tend to occur at younger age groups and result in higher mortality compared to the developed world. The following section is a summary of the evidence on the growing importance of chronic diseases particularly among urban residents of the country.

Cardiovascular Diseases (CVD) and Stroke

In Ethiopia, there is a lack of reliable CVD mortality and morbidity data which is partly due to the nature of the diseases (for instance silent myocardial infarction or asymptomatic coronary

heart disease) and the less attention given to chronic diseases in general. There is a growing consensus among clinicians and public health officials that the magnitude of CVDs and contributing conditions including obesity and diabetes has increased in the past couple of decades.

Alternative explanations for the apparent increase include increased awareness and service utilization among the general public, improved diagnostic capacity in health facilities, and rapid population growth which should be carefully investigated to establish the extent of the increase with reasonable accuracy.

Since under nutrition rather than dietary excess continues to be a pressing problem in much of rural Ethiopia, low birth weight and sub-optimal development may also be an important determinant of cardiovascular diseases in later age for people moving to towns and cities and adopting western lifestyles.

Available evidence from some of the hospital based analyses of causes of death as early as 1984 indicate that cardiovascular diseases have been among the list of the ten most top causes of mortality in hospitals in Ethiopia.

Studies also show that the hospital burden of stroke has increased over the past three decades, hemorrhagic stroke being the most common type. Major risk factors for stroke include hypertension followed by cardiac diseases. The same study also found that the majority of hypertensive patients were either on no form of treatment (28.9%) or erratic and irregular treatments (38.3%).

In contrast to the disease pattern in the west, Ethiopian patients with cerebrovascular disease tend to be younger. Recent study reports that substantial percentage of stroke patients are young adults (28 %) with hypertension and rheumatic heart disease being the commonest risk factors.

Hypertension

High blood pressure, also known as hypertension, is the most common car

diovascular disease and it is the leading cause of stroke and a major cause of heart attack.

A population based study in Addis in the year 2006 found that the prevalence high blood pressure, defined as systolic blood pressure (SBP) ≥ 140 mmHg (millimetres of mercury) or diastolic blood pressure (DBP) ≥ 90 mmHg or reported use of anti-hypertensive medication, was around 32 percent among males and 29 percent among females. This is in contrast to the relatively low prevalence of hypertension in rural areas (10 percent among males and 5 percent among females in rural Butajira) for example.

Among adults with high BP, less than 6 % of those in Butajira and about 33 % in Addis are aware of their BP. Similarly, less than 5 % in Butajira and 15 % in Addis were receiving anti-hypertensive treatment. Females in Addis had better awareness and access to treatment compared to males, while the difference between males and females in Butajira was not marked.

A more recent study among working adults in Addis Ababa found a slightly lower prevalence of hypertension of 22 percent and 19 percent among men and women respectively.

Type II Diabetes Mellitus

Diabetes represents a considerable health problem and is a growing cause of death in Ethiopia. It is one of the chronic illnesses that require continuing medical care and ongoing patient self-management education and support to prevent acute complications and to reduce the risk of long-term complications.

Classification of diabetes is not always clear. Data from Ethiopia suggest that majority of insulin-requiring diabetes differ from what is typically classified as type 1 diabetes in the western world. According to findings from some of the local studies, the clinical features of many of insulin requiring patients in Ethiopia resemble what has been described as malnutrition related diabetes, a category which is not recognized in the current WHO classification. . In general,

the insulin requiring diabetes in Ethiopian patients occurs at a relatively older age (peak 25-29 years), with male predominance and often in the background of malnutrition and poverty. This is in contrast to type 1 diabetes in the west which usually occurs at a younger age among the privileged with a similar incidence among boys and girls. Available estimates on the prevalence of diabetes vary considerably from 0.3% for Gondar region in northwest Ethiopia to 1.9 for the whole country.

Type 2 diabetes is more common among urban residents, 71 percent among urban residents compared to 23 percent in rural areas. This is in agreement with the global trends in many developing countries which are undergoing economic and nutrition transitions. The fact that more and more people are living in urban areas and are leading a sedentary life coupled with the existing culture of consuming fatty foods and related meat products seems to have contributed to the growing disease burden in recent years. Increasing harmful use of alcohol and tobacco are also risk factors associated overweight and obesity which are the main drivers of type-2 diabetes.

Anecdotal evidence from a private clinic caring for patients with diabetes in Addis Ababa indicates that the majority of patients with type 2 diabetes belong to what may be regarded the middle socioeconomic class who are usually traders or office workers with sedentary work routines.

According to a study from Gondar, the median age for presentation for type-2 diabetes is around 50 years for both sexes. Females tend to have higher body mass index (BMI) than their male counterparts (with a mean BMI of 25.0 and 23.3 respectively).

Existing data show that the common causes of morbidity among diabetics are infections with prevalence as high as 44 percent among hospitalized patients while cardiovascular diseases and end stage renal diseases contribute more to mortality. Common infections among diabetics include diabetic

foot infection, pulmonary tuberculosis, urinary tract infection, pneumonia, and skin and subcutaneous infections.

Consistent with the global literature, Ethiopian patients with diabetes have significant dislipidemia (higher - triglycerides and low density lipoprotein) compared to non-diabetics. In addition to its significant impact on health and wellbeing of individuals, diabetes imposes a considerable economic burden on communities and the health system. A study on the cost of hospitalization indicates that patients with diabetes generally spend significantly higher amount of money on treatment of acute and long-term complications compared to non-diabetic patients.

Furthermore, interviews with key informants in selected referral hospitals indicate that a significant amount budget of public hospitals (for drugs) goes to the procurement of insulin and other drugs for chronic illnesses which have been increasing from time to time.

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Cancers

Burden and pattern

The majority of the global cancer burden is now found in low- and medium-resource countries like Ethiopia. Although, there are indications that cancers are becoming important public health challenges, there is no solid evidence on the incidence and pattern of cancers in Ethiopia as there is no population based cancer registry.

Available data from the only radiotherapy centre in the country at Tikur Anbessa specialized referral hospital show that cervical cancer, followed by breast cancer and other cancers of above the neck are the three commonest forms of cancers among patients visiting the centre. Since cervical cancer is exclusively cancer of women and breast cancer is much more common among women than men, women represent more than 70 percent of cancer patients at Tikur Anbessa hospital. Regarding place of residence close to half of patients (around 45 %) getting treatments for cancers come from Addis Ababa.

The fact that awareness and access to cancer treatment and care is very much limited particularly in the rural areas makes it difficult to generalize if the same disease pattern exists in the general population. Recently, effort is being made to establish a population based cancer registry in Addis Ababa (as a pilot project) with the idea of gradual scale up for the whole country. When implemented, this initiative is hoped to generate reliable data on cancer incidence and prevalence and associated risk factors this is key to plan population based prevention and control measures.

Contributory Factors and Screening

Cervical cancer which is the most common cancer in Ethiopia is often preceded by Human papillomavirus infection (HPV), a sexually transmitted infection found in almost all patients and hence recognized as the necessary cause for cervical cancer. A study from southwest Ethiopia showed that as high as two-third of patients with cervical dysplasia (a pre-cancerous form of the disease) has HPV infection.

There are four basic components of cancer control – prevention, early detection, diagnosis and treatment, and palliative care. With only one dedicated cancer treatment facility and only handful oncologists for the whole population, it is understandable that Ethiopia has been lagging behind in

cancer prevention and control efforts. To date, there is no routine screening program for cancers in Ethiopia. For instance, studies conducted in the year 2001 showed that only 0.6 percent of women in Ethiopia have undergone cervical cancer screening.

Since pathology services are readily available in the capital Addis Ababa, relatively higher number of women get screening for cervical cancer on a demand basis.

Awareness and Treatment Seeking Behaviour

Studies show that patients in Ethiopia have limited or no awareness about cancers which partly contributes to delayed health seeking and higher mortality. In many instances patients are unaware of the signs and symptoms of cancers and, consequently, present too late for effective treatment. And when they are aware of their disease, a sense of hopelessness and fatalism is common which contributes to the delay in health seeking.

Left without clear guidance on where to go for what kind of symptoms and signs, many patients waste significant part of their resources and time before they reach effective treatment centers and get the services they need.

Chronic Kidney Disease and Chronic Respiratory Diseases

Although there is limited information about the pattern of chronic renal and respiratory diseases in the country there is consensus among experts that both conditions are occurring at increasing frequency.

Chronic Kidney Disease

Contributing factors to chronic renal disease include diabetes and hypertension which have become more and more important in recent years. This is in contrast to observations a decade or earlier where infectious causes (mainly malaria and sepsis) and abortion complication were much more common and used to cause acute renal failure. Such indications for dialyses for cases of acute renal failure are now seen very occasionally. Instead, dialyses is now commonly

required for patients with chronic renal failure resulting from hypertension or diabetes.

Chronic Respiratory Disease

The most common chronic respiratory disease in Ethiopia is Bronchial Asthma which appears to increase from year to year. Asthma affects all socioeconomic groups and the major challenge is getting the expensive drugs which are required for a lifetime. Chronic obstructive pulmonary disease is less common as smoking

prevalence is generally low in the population. For instance a study conducted in Tikur Anbessa hospital indicated that chronic persistent asthma is a frequent underlying cause of chronic obstructive pulmonary disease and chronic corpulmonale compared to smoking related chronic bronchitis/emphysema in Ethiopia. There are, however, significant numbers of patients with lung cancer although the prevalence is much lower compared to the western world.

Policy and Strategy for Prevention of NCD

Ethiopia's health system, like many countries in transition, is not yet well equipped to address the challenges of chronic diseases. The majority of chronic disease care is presently being provided by secondary and tertiary institutions, such as regional and teaching hospitals, which are often located in urban areas and major cities. Primary healthcare facilities – the core service providers at community level - often lack trained health workers, medical products and technologies to detect, treat and manage common chronic diseases. More recently, there has been a growing recognition among public health officials and relevant stakeholders about the challenges presented by the worrying trends in the magnitude of chronic diseases and their risk factors. This is evident from the development of a strategy document focusing on NCDs which is hoped to be instrumental to reorient the overall health response in initiatives which

are clear signs of the growing international and national political commitment towards NCD prevention and control. Major landmarks in this include:

Policy and Strategy

The recent publication of a report on situation analyses of NCDs in the country in the year 2008 and the launch of a strategic framework which was informed by the same in the year 2010.

The main policy document guiding health interventions in Ethiopia, the Health Sector Development Program–IV (2010/11 – 2014/15) has for the first time included NCDs as one of the priority health challenges that the health system has to deal with.

The Federal Ministry of Health in collaboration with relevant stakeholders has drafted a Framework Convention to Control Tobacco which is the first treaty ever negotiated under the auspices of WHO. The convention has been ratified or accessed 39 out of the 46 countries in the African region and Ethiopia is expected to follow suit soon.

Human Resources Strengthening

Some progress is being made in this field too. For instance, the School of Medicine at Addis Ababa University (AAU) has recently launched a subspecialty program in cardiology (pediatric and adult) and curriculum is also approved for a fellowship program on hematologic oncology. Effort is also being made to build capacity of health workers in the regions and rural areas so that they can do their share in prevention as well as early detection and referral of patients with chronic diseases.

Development of Clinical Guidelines for Chronic Diseases

Clinical guidelines have been developed for regional and primary health care (PHC) levels for specific NCDs namely Hypertension, Stroke and

Diabetes. Similarly, preparation of a clinical guideline on NCDs to standardize treatment is underway for Tikur Anbessa hospital.

More Committed and Active Civic Societies

The Ethiopian Public Health Association has been working with all relevant stakeholders to advocate for the prioritization of NCDs by the Ministry of Health through organizing informative panel discussions and selecting NCDs as major themes of the annual conferences (Road traffic Injuries in the year 2009 and Tobacco, Alcohol and Substance use in the year 2011). EPHA also uses the media (TV and radio) to get across relevant messages to the larger public.

EPHA has organized a series of awareness raising meetings with parliament members to facilitate the accession of the framework convention for tobacco control which is hoped materialise soon.

The Mathios Wondu YeEthiopia Cancer Society has been active in awareness raising activities as well as mobilization of resources to support patients and families who could not afford to get treatment and care for cancer. The society has also hosted the consortium on non-communicable diseases and convened several meetings which helped to coordinate the fragmented efforts of individual societies.

Major Challenges in NCD Prevention and Control for Ethiopia

Data from interviews with public health officials, clinicians, professional societies, and managers in selected public and private hospitals indicate that there are a multitude of challenges that need to be addressed in order to effectively implement NCD control and prevention activities.

The few population based studies of chronic diseases risk factors in Ethiopia show substantial sex and regional differences (higher risk among males in urban areas), which are important to identify so as to be able to plan suitable

intervention programs.

Although some of the NCDs (particularly hypertension and coronary heart disease) appear in the ten top causes of mortality in hospitals, many health facilities are short of basic equipments and supplies required for chronic disease care and treatment and when they have, regular maintenance is a major challenge. This has resulted in unnecessary delay and referral of patients from facility to facility which also contributes to increasing economic burden on patients and families. Research and training institutes are limited in the country. There are only a handful of specialists/subspecialists even in the biggest tertiary hospital (Tikur Anbessa hospital) that has the dual burden of providing service and training competent health professionals.

Record keeping and reporting is generally poor in many facilities which have made it difficult to make a compelling argument about the burden of NCDs to the health system and the nation at large. Proper examination of risk factors and trend analyses of NCDs is also limited by the unavailability and incompleteness of the health information systems.

Invitation

Dear readers,

Ethiopian Public Health Association once again Respectfully calls upon readers of this PH Digest to send your valuable suggestions and comments which significantly make a difference on the quality of the Digest. Likewise the editors solicit researchers and health professionals to provide your research endeavors. These are vital in providing substantial and up-to-date information to those who are engaged in safeguarding of the public health.

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