

Sustaining gains in child health and HIV-related MDGs in Ethiopia: Lessons from field research

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Ethiopia seems to demonstrate comparatively promising progress towards child survival MDGs, even though the prospect for achieving maternal health MDGs seem to be a daunting challenge as these are dependent on access and utilization of well staffed and properly functioning health system. With regard to prevention and control of poverty related diseases (HIV/AIDs, TB and Malaria), there are also well designed interventions set within the health care system. Recent achievements are particularly encouraging in terms of reversing the trends in the incidence and prevalence of HIV/AIDS. Findings of field research published in the current issue of the Ethiopian Journal of Health Development offer some insights and directions on what should be done to sustain the gains in child health and HIV-related MDGs in Ethiopia.

Despite the recorded success in child health, malnutrition is still among the major sources of ill health affecting a large proportion of children and adults in Ethiopia. Protein energy malnutrition, particularly coupled with infection (mainly ARI and diarrhea), is a major cause of morbidity and premature death among children and infants. According to the recent round of the Ethiopian Demographic and Health Survey (DHS), chronic malnutrition among Ethiopian children is very high, with 47% of children under five years stunted and 24% severely stunted.

The chronic situations of drought and food shortage that affect the country are obviously the underlying causes for most of the problems of protein-energy malnutrition. However, the response we have address this situation does not seem encouraging. As the study by Deribew and Alemseged (2) shows, responses to the health and nutrition needs of people affected by drought emergency does not seem very strong. Absence of information, lack of human resources, absence of functional surveillance system, and weakness of DPPC offices were the serious bottlenecks which

affected the health and nutrition related response of the drought emergency.

Yet it is not only food shortage that causes nutritional problems in Ethiopia. Inappropriate nutritional practices and food taboos also have significant contributions, particularly to some of the deficiency disorders. As Teshome and et al demonstrate, food surplus areas of the country are not spared from malnutrition since inappropriate feeding practices are also the principal risk factors that bring about nutritional deprivation among under-five children (3). Maru and Haidar also show that pressures from family members and neighbors as negatively affecting mothers' safer feeding practices for their infants in some instances (4).

With regard to maternal health, the study by Hailu and et al also give some indication to the fact that a strong health system with effective deployment of highly trained manpower that is required for executing the scaled up activities related to maternal MDGS (5). Their findings show that maternal deaths are not even properly documented in the health facilities they surveyed, in addition to other avoidable factors that include lack of blood transfusion and delay in transfusion. These health services factors are also compounded with problems related to lack of transportation and delayed health seeking behavior, making significant reduction in maternal mortality to be unlikely within the few years to come.

On the other hand, we should not also despair on our efforts towards maternal health MDGs as the recently introduced Health Extension Program (HEP) offers optimism in accelerating progress towards achieving most of the MDGs (including those related to maternal health). The program focuses on preventive, promotive and minimum curative and rehabilitative services targeting households particularly women and children at the Kebele level. Therefore, it can be considered as the most important institutional framework for achieving the MDGs. However, amidst criticisms that

HEWs seem burdened with a lot of tasks, there are also arguments that they should be equipped with knowledge and skills to manage common health problems at their levels. As they are enabled to handle malaria cases at community level, Degefie et al and Hailu et al in this issue argue that they should also be trained to treat childhood pneumonia and commonly prevailing eye problems respectively (6, 7).

The well designed health systems interventions against poverty related diseases such as HIV/AIDS also require acceleration of efforts for maintaining gains as well as for achieving even better. The study by Demissie and et al among antenatal care attendees shows that there are still gaps to be filled in terms of mothers; knowledge and perception about HIV, mother-to-child-transmission and VCT (8).

Efforts are also need to be strengthened at community and grass-root levels. Abebe and Getnet's study show that there is still a lot to do to institutionalize HIV preventive programs in terms of advocating the benefits of VCT to reduce fear of stigma and discrimination and for minimizing unsafe sex among adolescents (9). Reporting the median age at first sexual intercourse among the youth as being too early especially in rural areas, Mazengia and Worku also call for a well designed sexual education program for delaying sexual debut (10). Such programs also incorporate ways of accessing condoms and other contraceptives for those who already initiate sexual intercourse early in life.

Finally, as components of well designed health information system, the role of Demographic Surveillance Sites (DSS) is highlighted by the comparative analysis by Forrtell and et al. Using survival analysis technique, Forrtell and et al demonstrate the relevance of DSS in complementing data for monitoring progress in child health (11). According to them, child mortality risk profile is fairly similar between DSS and DHS-based estimates within certain limits. This finding is relevant in that DSS based data can be generated more frequently (at least annually) than DHS based data that are usually generated every five years. DSS based data are also relatively more flexible in that they can allow the inclusion of variables as

required and can also be linked to health system performance at local levels. Moreover, according to the investigators, the differing methodological characteristics of the DHS and DSS mean that when combined, these two data sources have the potential to provide a comprehensive picture of national population comparison and health status. This highlights the need to strengthen the recent initiative to establish network for demographic surveillance sites in the country (12).

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