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Quarterly Newsletter of the Ethiopian Public Health Association., Vol. 17, No. 3, September, 2007

EPHA Updates and Upcoming Events

E PHA Updates

EPHA Establishment and its Legal Entity

The Ethiopian Public Health Association (EPHA) is a volunteer, legally registered, independent, not-for-profit, and national public health association established in 1989 as a successor. EPHA benefits its members in particular and the public health professionals at large in the exchange of scientific information, and best practices among health professionals. It is one of the foremost and prominent health professional associations in Ethiopia.

Vision

EPHA envisions the attainment of the highest possible standard of health for all Ethiopians.

Mission

To promote better health services for the public and maintain professional standards through advocacy, active involvement, and networking.

Goal

The goal of the Association is the attainment of optimum health to the people of Ethiopia through the advancement of public health measures for the promotion of health, prevention of diseases, timely treatment of the sick, and rehabilitation of the disabled.



Current and past Executive Board of EPHA Meeting

Values

EPHA is committed to improve health and well-being of all Ethiopians through dedicated and active involvement of its members and in collaboration with all stakeholders. EPHA also stands for the professional development of its members without prejudice to gender, political, religious, or ethnic affiliations.

Current EPHA members

Membership is open to all individuals above 18 years of age and organizations that fulfill the requirements of the Association as stated in the Constitution. In 2007, the total members of EPHA reached **2,202**. Out of which **1,115** are currently active and paid their regular membership fee, according to the data obtained from membership affairs unit of EPHA.

Executive Board of EPHA

1. Dr. Mengistu Asnake.....President
2. Dr. Solomon Worku.....V/ president
3. Dr. Mesganaw FentahunMember
4. Dr. Yilma Melkamu.....Member
5. Dr. Abeba Bekele.....Treasure
6. Dr. Yared Mekonnen..... Member
7. Ato Mirgisa Kaba.....Member

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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!

EPHA Updates..... Cont'd from page 1

EPHA Programs/Projects

A. Capacity Building

The organizational structure and staffing pattern of EPHA has been gradually changing through time to adjust to the changing circumstances that are created as a result of its internal and external environmental dynamics. Currently, EPHA is well-staffed and well equipped to meet its national and international requirements.

B. Information Dissemination Mechanisms

EPHA communicate with local and international organizations and particularly with its members through the following venues:

- ◆ Ethiopian Journal of Health Development (EJHD)
- ◆ Public Health Digest
- ◆ Felege-Tena Newsletter
- ◆ EPHA funded MPH theses Extracts
- ◆ Annual Public Health Conference
- ◆ Annual Conference Proceedings
- ◆ Monographs
- ◆ Books
- ◆ Health Extension Workers Newsletter
- ◆ [http:// www.ephpa.org.et](http://www.ephpa.org.et) website
- ◆ EPHA-Public Health Library (e-learning center)

C. Current Projects:

EPHA is closely working with CDC since 2002/03 and has the following components underway in 2007:

- ⇒ Research and Dissemination
- ⇒ Training
- ⇒ Infection Prevention Advocacy
- ⇒ Expanding prevention of mother to child transmission Services in Private Health Sectors in Ethiopia
- ⇒ Strengthening HIV/ AIDS, STI Services for most at risk population (MARP)
- ⇒ Social mobilization intervention on EPI, Afar region
- ⇒ Established Ethiopian Public Health Laboratory Association and in the process of linking with Ethiopian Health and Nutrition Research Institute
- ⇒ Supporting the MPH theses of university students - Addis Ababa University, University of Gonder, Jimma University

⇒ AIDS related mortality surveillance survey in collaboration with universities: more than 5 sites in the country. Regarding this;

- ◇ Addis Ababa—already started in collaboration with Addis Ababa University
- ◇ Gilgel-Gibe—planned to start in 2007 in collaboration with Jimma University
- ◇ Dabat—planned to start in 2007 in collaboration with University of Gonder
- ◇ Butajira—planned to start in 2007 in collaboration with Addis Ababa University
- ◇ Kersa—planned to start in 2007 in collaboration with Haremaya University
- ◇ In 2008 Mekelle University and Arba Minch University will be part of the same project;

⇒ FP/RH repositioning through strengthening Health Extension Workers (HEW) in collaboration with Ministry of Health, Amhara Regional Health Bureau (RHB), Wello zonal health offices, and Addis Ababa University—supported by David & Lucile Packard Foundation—started in 2006.

D. Short and long term Trainings:

- The Millennium Development Goals, Managing Reproductive Health Programs, Grant Writing, Research & Ethics
- Supported monitoring and evaluation training in collaboration with Ministry of Health, Jimma & Tulane Universities
- Supporting a one year Leadership in Strategic Information Training Program (LSITP) in collaboration with Ministry of Health, Addis Ababa University and CDC
- Starting Maternal and Child Health Leadership (MCHL) training in collaboration with American Public Health Association (APHA) for 1 year course, a team of 6 health professionals

EPHA Organized 4-Trainings Within a Month

1. EPHA Organized a Nation-wide Training of Trainers

EPHA organized a training on Syndromic Management of STIs for health service providers from August 13-17, 2007 in Adama Town in collaboration with National HIV/AIDS Prevention and Control office (HAPCO) and U.S. Centers for Disease Control and Prevention (CDC)-Ethiopia. About 29 participants were actually involved, among which, 5 were females.

The participants of the TOT were from regional health bureaus, universities, hospitals and health centers. The training aims to upgrade the level of health professionals to be able to provide trainings on syndromic management of STIs to mid-level health providers in their respective regions. The main components of the TOT were; how to formulate learning objectives in relation to syndromic management of STI, design participatory adult learning activities, use and apply different learning methods, art of facilitating, main principle of facilitation, competence and quality of good facilitation, how to develop a lesson plan and managing of trainings.

2. Clinical Training Skill (CTS) Course was Undertaken

The Infection Prevention training of trainers was organized by EPHA in collaboration with John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)-Ethiopia, Making Medical Injections Safe/John Snow Incorporation (MMIS/JSI) and U.S. Centers for Disease Control and Prevention (CDC)-Ethiopia. About 17 participants (6 females) were actually involved in the two week training of trainers course held from August 20-Sept 1, 2007 in Adama Town for IP partners of health professionals. All participants were from health professional associations and teaching hospitals with health backgrounds. The purpose of the training was to prepare competent clinical trainers to conduct competency-based clinical skill courses for health service providers. The training on clinical training skill had two parts. The first part focused on Clinical Training Skill Reference Manual. The second part of the training was practical session. Each participant presented and practiced on how to transfer knowledge for other health professionals by applying the IP training manual. The participants practices well on how to internalize and apply presentation of the guide/manual and reference materials provided during the course.

3. Reproductive Health Management Course was Conducted

EPHA is implementing a pilot project in North and South Wollo zones of Amhara Regional State. The David and Lucile Packard Foundation has granted EPHA an organizational effectiveness fund for three years. The fund is to be used for capacity building purposes. As part of the project, EPHA organized a training for health professionals on "Managing Reproductive Health Programs" from August 20-31, 2007 at Debre Birhan. The main goal of the training was to allow better implementation of Repositioning of Family Planning and Reproductive Health in Amhara region through improved planning, implementation, and supervision and monitoring of Reproductive Health programs. Specifically, the training focused on imparting skills in strategic planning, implementing, logistic management, conflict management, negotiation, resource allocation, alliances building with different stockholders, and monitoring & evaluation.

4. EPHA organized a Training on Leadership in Strategic Information

4th modular training was conducted on August 20-31, 2007 at Adama Town. The training aims at providing skills necessary to make evidence-based decisions regarding HIV/AIDS epidemic. The module in particular focuses on HIV/AIDS and STI surveillance. Seventeen participants from five regions were involved in the training, namely Amhara, Dire Dewa, Harrari, Oromia, Tigray and Addis Ababa including participants from EPHA mortality survey project. Resource persons from CDC Atlanta, CDC Uganda, and Addis Ababa University, Department of Community Health were also involved. As the methodology of the training, participants did a group work on HIV/AIDS and STI surveillance evaluation protocol. After discussions comments were forwarded for each group by their mentors. Finally, each group worked with their respective mentor to enhance their study protocol in the future based on the comments delivered during the presentations and then each group took the assignment for the field work.

Deliberation of the 2007 Africa Malaria Day (AMD)

http://www.moh.gov.et/index.php?option=com_content&task=view&id=62&Itemid=43

It is exactly seven years to the day that, in an unprecedented and historic setting, a gathering of the highest political leadership of Africa was convened to deliberate upon a single issue considered inimical to development and progress of the peoples of the continent. On that 25th day of April 2000, African Heads of State and Government, with Senior Representatives from 44 malaria-endemic countries participated in the first-ever Summit on a health problem - Malaria - in Abuja, Nigeria. At the Summit, the leaders recognized the intolerable and unacceptable burden of malaria on the people of Africa, and signed the Abuja Declaration and Plan of Action. They committed their governments to work with partners in a multi-pronged and multi-sectoral approach, to halve the burden of malaria in Africa by 2010. Since that historic meeting, the 25th day of April of each year has been commemorated as the Africa Malaria Day (AMD).

Seven years after the Summit, malaria remains a major contributor to the disease burden in Africa. Out of the 300-400 million annual cases of malaria worldwide, more than 90% are reported from Africa south of the Sahara. In Ethiopia, malaria is the leading cause of morbidity and mortality. Almost 75% of the land is malarious and an estimated 51 million people (68% of the population) live in areas at risk of malaria. Annually, 5-6 million clinical malaria cases and close to one million confirmed malaria cases are reported from health facilities. In addition to the health problems, the impact of the disease on social and economic well-being of the affected communities, particularly during epidemics is immense. However, these epidemiological figures are on the edge of spectacular change. Ethiopia's long and hard battle with the scourge of malaria has reached a turning point. In the last three years malaria in Ethiopia has shown a remarkable decline according to the above statistics. This is happening due to governments and partners consorted efforts. Ethiopia has been engaged in one of Africa's largest and most ambitious roll-out of Long Lasting Insecticide Treated Nets (LLINs),

Rapid Diagnostic Testing (RDT) kits and the new and highly effective drug Coartem.

To date Ethiopia has distributed 15.8 of the 20 million LLINs to reach 10 million households estimated to be residing in malarious areas. Each household will receive on an average 2 LLINs free of charge that will mainly be used by women and children. Ethiopia has secured funding to distribute 20 million of those nets to meet the target set by August 2007. Significant steps are also in progress to scale up access to prompt diagnosis & effective treatment malaria cases and scaling up of Indoor Residual Spraying (IRS) of houses in epidemic prone areas of the country. When Ethiopia reach that target, it will have struck a decisive blow against the spread of malaria. The theme of the 2007 AMD is "**FREE AFRICA FROM MALARIA NOW**", and the slogan is: "**LEADERSHIP AND PARTNERSHIP FOR RESULTS**". The focus of this year's AMD will, therefore, be on the need to work in partnership to reverse the progression of malaria and make a significant impact. It is a call to all stakeholders in the fight against malaria in the Region-communities, governments at all levels, NGOs, research institutions, private sector, development partners, and others - that the fight against malaria can only be won if we all work together.

Notes: This part will continue in the next issue.

Humor

Doctor: I regret to tell you that you have a brain tumor.

Mr. Bean: Yesss!!! (Jumps in joy)

Doctor: Did you understand what I just told you?

Mr. Bean: Yes of course, do you think I'm dumb?

Doctor: Then why are you so happy?

Mr. Bean: Because that proves that I have a brain!

New strategy adopted on diseases of poverty

<http://www.who.int/mediacentre/news/releases/2007/pr33/en/index.html>

The World Health Organization (WHO) based Special Programme for Research and Training in Tropical Diseases (TDR) has adopted a new strategy for strengthening and expanding research to prevent and control 'infectious diseases of poverty.' The strategy builds on the programme's 30-year record of developing new drugs, delivery strategies and enhancing research capacity in countries where parasitic tropical diseases are endemic. The new plan addresses some of the emerging disease challenges facing developing countries, such as TB-HIV co-infection.

Over the coming decade, TDR will focus on addressing key bottlenecks in getting health care treatments to poor and remote populations, and fostering research and policy leadership in countries where these diseases create significant health problems. "If we want better health to work as a poverty reduction strategy, we must reach the poor. This is the acid test, and this is where we are failing," said WHO Director General Dr Margaret Chan, speaking at the opening session of the TDR Joint Coordinating Board.

The Board approved the new ten-year strategy and vision. The Board includes the four TDR cosponsors - UNDP, UNICEF, the World Bank and WHO- as well as 30 representatives of governments of developed and developing countries. The vision calls on TDR, one of the major UN-based programmes dedicated to health research in the developing world, to "foster an effective global research effort on infectious disease of poverty in which disease endemic countries play a pivotal role."

Over the past three decades, TDR has sponsored research that paved the way for the control of leprosy, onchocerciasis (river blindness), Chagas disease, lymphatic filariasis and visceral leishmaniasis. These five neglected tropical diseases, which previously killed or disabled millions of people every year, are now targeted for global or regional

elimination, "largely as a result of tools and strategies developed through TDR-coordinated activities," noted Dr Chan. Research and Training in Tropical Diseases (TDR) also initiated and sponsored the first large-scale field trials of insecticide-impregnated bed nets in the mid 1990s, demonstrating their life-saving value in malaria control.

Under the new strategy, TDR's field research experience and networks will be harnessed to address one of the biggest challenges faced by the global health community: access to primary health treatments for poor people. Implementation research -that is, research to investigate how best to use health tools and drugs more effectively in communities and health systems - has traditionally been a key element in TDR's work.

In the mid-1990s, for instance, TDR created a model for community-directed treatment with ivermectin for onchocerciasis that causes river blindness. This delivery system has become the backbone for control strategies in remote, rural African communities where there are no doctors or healthcare centers. Community directed treatment systems now cover 60 million Africans, and by 2010 will cover some 100 million people, nearly one-sixth of the sub-Saharan population. The onchocerciasis control effort has been described as "one of the most triumphant public health campaigns ever waged in the developing world" (UNESCO, 2005).

Now, Research and Training in Tropical Diseases (TDR) is supporting African scientists to explore how community-directed systems could be used to deliver other essential primary health care interventions that are still underutilized - such as insecticide-treated bed nets, home-based malaria treatment, TB diagnosis and treatment, and Vitamin A supplements.

R

esearch Findings and Best Practices

The Effect of Health Worker-Patient Relationship on Client Satisfaction and Use of Health Care Services: A Case of TORORO , Eastern Uganda

<http://www.afrihealth2007.co.za/abstractDownload.php?absID=16>

The doctor patient relationship has long been assumed to be a straightforward association and an encounter between an expert in medicine and a person in need of medical care. The interaction between health workers and clients comprises of interpersonal relations which include effective listening and communication skills that have a critical impact on client satisfaction which leads to use of health care services.

The overall objective of the study was to examine the nature of provider-patient interaction and its effect on client satisfaction and use of health care services at specified health facilities. Specifically, the study aimed at describing the nature of interaction between health workers and patients, its effect on client satisfaction and use of health care services. The research was a cross-sectional descriptive study carried out in Tororo district. Both quantitative and qualitative methods of data collection were used. The study population included both providers and users of health care services. Health care users included out-patients who had visited the health facility while health workers included those that had provided the health care service at the time of data collection. Two health sub-districts were selected randomly and health centers were also randomly selected from the different health service levels of hospital, health centre III and health centre II. Fifty percent of the total numbers of health facilities at each level were selected. Two hospitals, four health centre III and eight health centre II were sampled.

A total number of 390 patients were systematically selected from both private and government health facilities. A questionnaire was used to carry out face-to-face interviews with patients and key informant guide with health workers. The study findings showed that the nature of interaction between health workers and patients was a substantial one that deserves attention in relation to patient satisfaction and use of health care services.

Out of 390 patients that had presented their illnesses, 77.7% (303/390) were not explained the type of illness they had while the majority of patients (69.0, 269/390) desired such knowledge.

Seventy nine percent (308/390) of patients wished to have more information about their health conditions and 86.7% (338/390) reported that they were not given enough time to ask about their health. This was because there was basically no enough time for this because of big numbers of patients and less numbers of health workers that attended to the patients. Some patients who knew that they could ask questions had attained some level of education. There was a very strong association between patients getting information about their health conditions and patient satisfaction with the quality of health care received. Patients also waited for a long time, minimum 30 minutes and maximum 5 hours before seeing health workers. Limited space in health facilities affected interaction, as there were always other people present during consultation. These included health workers (52.5%), fellow patients (27.9%), caretakers (18.0%) and visitors to health workers (1.6%). This affected privacy and confidentiality in the whole exercise. Efforts should be made to improve on health workers-patients relationship in the treatment process. Health workers should take the initiative to invite patients into a collaborative relationship to understand patients' wide-range expectations.

Best Practices in Client-Provider Interactions in Reproductive Health Services:

<http://www.prb.org/pdf/NewPerspQOC-LitRev.pdf>

"Client-provider interactions" refers to the interpersonal exchanges between a client who receives health information and services and the clinic-based or outreach health providers who offer these services.

Key Processes in Client-Provider Interactions (CPI)

1. Treat the client well. Clients are more likely to be satisfied with services if all staff, not only the counselor,

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treat them in a respectful and friendly way. In turn, client satisfaction is often associated with effective use and continuation of family planning, while poor CPI can lead to discontinuation and method failure. Sound CPI need not take much extra time. Research in Egypt found that client-centered (vs. physician-centered) consultations were associated with tripled levels of both client satisfaction and method continuation, even though the client-centered sessions lasted only one to three minutes longer on average. In fact, recent research in Peru found that little additional information was conveyed after 15 minutes of counseling. Clients feel more comfortable if visual and auditory privacy is maintained during counseling and family planning procedures, and if they are assured that all information will be kept confidential. This respect for privacy contributes to an atmosphere of trust in which the client and provider can explore emotional, sexual, or gender-related issues relevant to method choice. Providers should encourage clients to ask questions and seek clarification or repetition of instructions; such encouragement is associated with positive outcomes. Both verbal and nonverbal communication skills are important; counselors must listen and observe carefully to understand clients' needs and feelings.

2. Provide the client's preferred method. Informed choice remains the guiding principle for practitioners: Clients who already have a method preference should be given that method unless it is inappropriate for medical or personal reasons. Clients who receive the method they came for-and many do have a preference-are significantly more likely to continue using contraception than those who do not receive their preferred method. However, even clients who state a preference should be asked whether they would like to hear about other methods, in case they know only the method they asked for or have been pressured to use it. Not surprisingly, continuation is significantly increased if the couple have agreed on the method; in fact, couple counseling has been shown to be more effective in general than dealing with a woman or man alone. However, a woman should always be asked whether she wants her partner present for counseling and services.

3. Individualize. Clearly, the most effective counseling is tailored to the individual. Not only is there great variation in clients' lives and personalities (and needs, skills, intentions, knowledge, beliefs, and values), but there is equally great variation in what clients and their partners find essential, attractive, convenient, or tolerable about contraceptive methods. Some clients place highest emphasis on a method's effectiveness in preventing pregnancy, while others weigh effectiveness against the potential impact of side effects on their sexual relations, personal feelings, and health. Providers need to discover when special help is needed. One U.S. study that examined dropouts and pregnancies among users of oral contraceptives found that one-fourth to one-third of the users would have benefited from more counseling on actual use behaviors, such as developing practical strategies for remembering to take the pill each day. An analysis of Demographic and Health Surveys that had been conducted in Morocco, Tunisia, Egypt, Ecuador, Indonesia, and Thailand found that first-time users of family planning and users under age 24 had the highest dropout rates these clients need extra support. A provider should "locate" a woman and her fertility intentions on her reproductive lifecycle and situation. She may be a young single woman who needs dual protection from pregnancy and sexually transmitted infections, a breastfeeding married mother who wants to space the next birth, or an older woman who wants no more children. Power imbalances are also relevant: If a woman's partner is opposed to family planning, she may prefer an undetectable method. She may also need skills to negotiate family planning use with her partner, and, if a victim of violence, may need to be referred for further help.

4. Aim for dynamic interaction. Only counseling that is interactive and responsive can identify each client's profile, as described above. However, many providers make counseling a one-way process. In one videotaped study of counseling in Ghana, providers talked at length about each available method and then asked the client to choose one. If the client hesitated, the provider recommended a method. There was rarely any discussion of why a client might choose a particular method or any checking to see whether the clients understood the information. The study concluded that providers' skills needed strengthening in the areas of eliciting the needs of a client, prioritizing information to make it more relevant to

Best PracticesCont'd from page 7

the individual, and empowering the client to make the decision about their appropriate method. This and other research has spurred efforts to help counselors engage in dynamic interactions, with much less “telling” and much more asking, listening, responding, encouraging, establishing rapport, and clarifying.

5. Avoid information overload. People can understand and retain only a limited amount of information. One study found that half the information and instructions given during medical visits in the United States could not be recalled by clients almost immediately afterward. However, involvement of the client and tailoring the information to the individual’s learning style engendered not only greater client satisfaction, but also better adherence to instructions and improved outcomes. Instead of giving a detailed recitation about every method offered in a family planning program, providers should focus on the client’s selected method and be brief, non-technical, and clear. This enhances understanding of key information (such as how to use the methods, and what side effects are likely) and leaves time for exploration of clients’ situation, questions and answers, and checking for comprehension. One study, conducted in Guatemala, Hong Kong, Jordan, Kenya, Trinidad and Tobago, and Nepal, found that clients who received the most information were more likely to discontinue the method they received than those who received less information. Information overload may have blurred key instructions, or perhaps left little time to explore considerations that might have led to a more appropriate method choice.

6. Use and provide memory aids. During the counseling session, use of posters, flipcharts and illustrated booklets-pre-tested for comprehension and cultural acceptability, especially with client groups that have low literacy rates-helps clients understand key information and helps the provider remember important points. Letting clients see and handle sample contraceptives can also increase clients’ understanding and comfort. Illustrated take-home materials can be used during counseling to help clients recall instructions later and also to disseminate accurate information, since clients often share the materials with their partners, relatives, and friends.

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