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Quarterly Newsletter of the Ethiopian Public Health Association,. Vol. 16, No. 2, June 2006

UNAIDS 2006 Report on the Global AIDS epidemic issues grim picture on sub-Saharan Africa

The 2006 Report on the global AIDS epidemic issued recently disclosed that sub-Saharan Africa still remains the worst affected region in the world accounting for a staggering 64 per cent of all people living with the virus globally.

The report notes that in 2005, there were 24.5 million people living with HIV in sub-Saharan Africa, adding that 59 per cent of all adults living in the region are women. The estimated number of women living with the virus globally stands at 17.3 million, three quarters of which (0r 13.2 million) live in sub-Saharan Africa.

Concerning new infections, the report outlines that an estimated 2.7 million people became newly infected with HIV in the year 2005 alone while another 2 million adults and children also died of AIDS during the same year. In fact, the report notes that one third of the global AIDS deaths occurred in southern Africa, where an estimated 930,000 adults and children died of AIDS related diseases. HIV prevalence rates are known to be exceptionally high in Southern Africa.

The report, however, notes that compared with previous years, "HIV prevalence appears to be leveling off" because "the number of new infections is roughly matching the number of people who are dying of AIDS".

The plight of children is also particularly highlighted in the fact

Cont'd on page two

Inside this issue::

* **UNAIDS 2006 Global HIV/ AIDS report**
* **EPHA to Amend its Constitution**
* **The Unfinished Debate on the Role of TBAs**
* **Humour**

Global summary of the HIV and AIDS epidemic, December 2005

Number of people living with HIV in 2005	Total	40.3 million (36.7 – 45.3 million)
	Adults	38.0 million (34.5 – 42.6 million)
	Women	17.5 million (16.2 – 19.3 million)
	Children under 15 years	2.3 million (2.1 – 2.8 million)
People newly infected with HIV in 2005	Total	4.9 million (4.3 – 6.6 million)
	Adults	4.2 million (3.6 – 5.8 million)
	Children under 15 years	700 000 (630 000 – 820 000)
AIDS deaths in 2005	Total	3.1 million (2.8 – 3.6 million)
	Adults	2.6 million (2.3 – 2.9 million)
	Children under 15 years	570 000 (510 000 – 670 000)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.

00003-E-1 – December 2005

EPHA to Amend its Constitution

With a growing change in the priorities and efficiency of the scope of its activities, the Ethiopian Public Health Association is these days introducing some amendments to its constitution with a view to increasing its contribution to the betterment of public health in the country.

According to information obtained from senior officials of the association, the amendment was necessitated by 'the growing number of projects initiated by EPHA and the need to bolster the Association's capacity for influencing favorable and productive public Health –related policies

Cont'd on page 3...

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

UNADIS 2006 Global HIV/AIDS report

that an estimated 12 million children under the age of 17 living *in the region have lost one or both of their parents to AIDS.*

This reality is compounded that the fact that 2 million children under the age of 15 were already living with HIV in 2005 and almost 90 per cent of the total number of children living with HIV live in sub-Saharan Africa and that fewer than one in ten of those children are being reached basic support services.

The report further notes that around 72 per cent (4.7 million) of all people in need of anti retroviral therapy live in sub-Saharan Africa with *only around one in six people in need of treatment in the region were receiving it in 2005.*

Below are some other highlights of the report:

Country developments

* In 2005, one-third of AIDS deaths globally occurred in southern Africa where an estimated 930,000 adults and children died of AIDS-related illnesses. Almost one-third of people living with HIV globally live in southern Africa, as do about 43% of all children under 15 years living with HIV and 52% of all women over 15 years living with the virus.
* In southern Africa, HIV prevalence levels are exceptionally high (except for Angola – 3.7%). However, in Zimbabwe, where 1.7 million people are living with HIV, data have shown a decline in HIV prevalence which is currently estimated at 20.1%, down from 22.1% in 2003. This decline is twofold; studies have shown both a substantial increase in condom use since the early 1990's and that more young people have been delaying their sexual début and reducing the number of casual sexual partners; however, a significant factor in the decline is attributed to high-mortality rates.
* There are no signs of a decline in other parts of southern Africa, at the end of 2005. Botswana's national HIV prevalence stood at 24.1%, Namibia's was at 19.6% and Swaziland's at 33.4%. In Swaziland, HIV prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004.
* **South Africa's** epidemic is one of the worst in the world with an estimated 5.5 million people (18.8% of adults) living with HIV in 2005. Almost one in three pregnant women attending public antenatal clinics were living with HIV in 2004 and trends show a gradual increase in HIV prevalence. There has been significant scale-up on the treatment front –around 190,000 people were receiving therapy by the end of 2005 – however this still only represents less than 20% of those in need.
* In Mozambique, national adult HIV prevalence is estimated at 16.1% and 1.8 million people were living with HIV in 2005. The virus is spreading fastest in provinces linked by major transport routes to Malawi, South Africa and Zimbabwe.
* In **East Africa** HIV prevalence has either decreased or remained stable in past years. In **Kenya**, 1.3 million people were living with HIV in 2005. However, surveys have shown that condom use has been rising, women have been delaying their sexual debut and people have been reducing the number of sexual partners. As a result, national HIV prevalence fell from 10% in the late 1990's to around 6% in 2005 (increased mortality and saturation of infection

The Executive Board of EPHA

1.	Dr. Mengistu Asnake	President	5.	Dr. Abeba Bekele	Treasurer
2.	Dr. Getnet Mitike	Vice President	6.	Dr. Yared Mekonnen	Member
3.	Dr. Misganaw Fantahun	Member	7.	Ato Mirgisa Kaba	Memeber
4.	Ato kebede Faris	Member			

EPHA to Amend its Constitution...Cont'd from page 1.

in the country.

One good illustration of the growing strength of EPHA is a recent one million dollar grant it won after a letter of intent prepared by the Association was selected from among a diverse group of contestants who also presented different project proposals.

The latest move to amend EPHA's constitution was initiated by the General Assembly of members of the Association which gave the mandate to the Executive Board of EPHA to work out all the necessary details for the successful amendment of the constitution.

The Executive Board of EPHA is in turn taking a variety of measures to that end by, among others convening a meeting of noted public health professionals to critically examine the previous constitution and suggest useful amendments in light of current developments.

The amended constitution is expected to be completed and presented at the forthcoming EPHA Annual conference in October 2005.

UNAIDS 2006 Global HIV/AIDS report ..cont'd from page 2.

among people most at risk are also factors in the decline).

* **Uganda** saw a steep decline in HIV prevalence during the mid- and late-1990's. The epidemic appears now to have stabilised, with some groups continuing to see declines, notably among pregnant women in the capital Kampala. In 2005, national HIV prevalence was at 6.7% and around 1 million people were living with the virus.
* In the **United Republic of Tanzania**, 1.4 million people were living with HIV in 2005 (6.5% of adults). The epidemic appears to be relatively stable, however, prevalence has increased markedly in older age groups reaching 13% among women aged 30-34 years.
* In **Somalia**, although national HIV prevalence is low (0.9% of adults), knowledge of HIV transmission is poor and condom use uncommon – one study showed that 17 out of 20 men and 19 out of 20 women aged 15-24 years had never used a condom.
* At 7.1% **Côte d'Ivoire** has the highest national HIV prevalence in **West Africa**. Available data show that the epidemic appears to have stayed relatively stable for almost a decade and significant declines in HIV prevalence are being seen in pregnant women, notably in Abidjan (note: civil conflict in the country has been preventing the gathering of new data).
* In **Burkina Faso** HIV prevalence among pregnant women (15-24 years) attending antenatal clinics in urban areas dropped from almost 4% in 2001 to just under 2% in 2003. This could reflect the effects of increasing HIV prevention efforts over the past decade; sex with non-regular partners has decreased and condom use has increased, especially among young people. National adult HIV prevalence was at 2% in 2005.
* **Nigeria** has the third-largest number of people living with HIV in the world – 2.9 million. Infection levels vary radically across this large country – from 1.3% in the south west to 4.9% in northern and central areas.
* **Senegal**'s epidemic pivots mainly on the sex trade and there is a danger of HIV spreading more widely to the general population. HIV prevalence among female sex workers has remained high at around 20% in Dakar and 30% in Ziguinchor.
* Sex work is also a driving factor in **Ghana**'s epidemic, where adult HIV prevalence is estimated at 2.3%. Infection levels have been rising among antenatal attendees and reached just under 4% in 2005.
* In the **Democratic Republic of the Congo** an estimated 1 million people were living with HIV in 2005. Adult HIV prevalence was estimated at 3.2%, but, HIV prevalence as high as 7% was found in pregnant women in Lubumbashi.

The Unfinished Debate on the Role of TBAs to Reduce Maternal Mortality and Morbidity: The Ethiopian context

by;Dr. Ermias Getaneh (MD, MSc)

Background

Due to recognition of the global tragedy related to complications of pregnancy and childbirth in the developing countries, commitment was made at various international fora to improve access to safe maternity care. A number of strategies were identified and implemented at different countries. One intervention, of which there is now many years of experience in different countries, including Africa, is that of training of Traditional Birth Attendants (TBAs) where skilled attendants are scarce.

Tens of thousands of TBAs were trained to deliver range of maternity services to mothers, particularly at the rural set up: conduct safe delivery, screen high risk mothers by antenatal checkup and enhancing the referral linkage with the health care delivery system. It is estimated that about 50 million women in developing countries give birth assisted by a family member , traditional birth attendant, or no one at all.(**1)**

Having seen the contribution made and performance of TBAs for the last two decades or so, increasingly the strategy is being challenged at regional or international arena. Accordingly, donor community and governments shifted resources from TBAs to increase training of skilled attendants and equipping facilities. In light of this, this paper attempt to synthesize the different views and crystallize critical issues needed to be addressed in the years to come. Finally the author attempted to make feasible recommendations to be considered in the context of Ethiopia.

Definition of TBAs

TBAs are found in most communities of the world although their nature and function vary considerably. The WHO (2) has defined TBAs as " a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs" (Ledham 1985). Likewise, TBAs was referred (3) as "traditional, independent (of the health system), non formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period" .

Historical tracking of TBA training

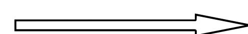
The role of the TBAs started to be taken seriously in the early 1950s when high Maternal Mortality Ratio became an international agenda (4). Mangay-Maglacas (5) even mention the training of TBAs a way back in 1921 in Sudan, in the early 1950s in India and Thailand. In the late 70s, however, the training of TBAs seemed entirely fit in the context of primary health care agenda to foster community empowerment (6).

Rational to support training of TBAs as a Strategy

The basic observation which long served to justify the decision to training Traditional Birth Attendants was that there were not enough health care providers to offer range of maternity care. In line with this, Walraven G. and Weeks A (7) underscored this fact further by saying that inadequate facilities and required resources to provide care would be unaffordable if, all women had access to maternity care in health facilities.

The other popular belief for the rational to TBAs training was, they are easily accessible and culturally acceptable. Furthermore, because they hold a special position of respect and influence within their communities, they are uniquely equipped to influence to promote the health seeking behavior of families and women. (8)

Other view to support the training of TBAs was the unprecedented increase in the number of births, which incur exorbitant cost in terms of human re-



sources and infrastructure related expenditures. It is against this background that training of TBA has been promoted on the basis that they are available, are already engaged in maternity care and appear to present affordable cost alternative (9). Supporters of training of TBAs have defend their position from various criticism by emphasizing the lack of required support and supervision provided from the health care delivery system, which has reduced TBAs effectiveness (10).

Views against the TBA training strategy

Maine et al (11) by referring the low predictive value of the *at – risk approach*, undermines the role of TBAs and Antenatal Care (ANC) to identify life threatening complications and highlighted the need to focus on effort to ensure the availability of skilled attendant. Stating his skepticism regarding TBAs training, Namboze (12) commented that "TBAs are unlikely to change their ways even if they are trained; by training them you are creating a substandard cadre which will never pass an examination; and you are likely to increase the time of delay in the village before antenatal care is sought, particularly in the case of the high-risk mother".

Okafor B and Rizzuto R. (13) observed that since TBAs fear of being viewed by the community as failed practitioner, they delay referral of sever complications and even deliberately discourage women from going to hospital. Reinforcing this observation, Akpala (14) reported that TBAs ability to adopt improved practices is not universal and the extra confidence gained from the training experience may lead to a higher incidence of dangerous procedure. As a follow up of Akpala's skepticism, Goodburn et al (15) indicated that training does not substantially alter the belief systems of TBAs and will therefore have little impact on practices that are rooted in these beliefs. She further highlighted that TBA training divert the scant resource and attention, which would perhaps have been better used to train professionals.

Contrary to TBA proponents view , Vincent De Brouwere et al (16) underscored the supervision of TBAs is a challenging and unaffordable task, neither the weak health delivery system in the developing countries sustain the required cost, nor health care providers have time to supervision. They concluded that a strategy that calls for so much supervision input is not sustainable.

Impact of TBA training

Since several TBA programmes are haphazardly organized in terms of training content, selection of candidates, definition of roles in different countries, it is difficult to generalize evaluation results to a wider context. Koblinsy et al. (17) mentioned China as the only country succeed to reduce the maternal mortality using minimally trained village birth attendants backed up by a strong referral network.

Nessa, (18) particularly cited the Sir Lanka and Thailand success in lowering MMR below 100 after adopted a strategy of progressive increase on coverage by skilled attendants . Similarly, Gloid (19) in Mozambique reported that TBA training was not improved TBAs effectiveness in managing delivery complications. In contrast, TBA training evaluation (20) in 1992, Quetzalteango, Guatemala has indicated a 200 percent increase in referral rate of mothers with obstetric problem to a hospital, although minimal reduction of perinanatal mortality reduction observed. Recently, Sibley L. et al (21) study in the southern Ethiopia showed that training of TBAs on "home based life saving skills" improved management of postpartum hemorrhage.

Although Goodburn (23) agreed that TBAs provide cultural and social support and linkage with referral centers, she argued that their skills are limited and can not prevent maternal death in isolation. In the same study it was emphasized that there was no significant difference observed in the level of post-partum infection between trained and untrained TBAs based on study carriers out in Bangladesh . Commented on the entire TBA approach, Staffan B. and Elizabeth G. (22) remarked that the strategy is a counterproductive endeavor, which holds back the training of the required number of health care providers, particularly midwives.

The Ethiopian context

Before embarking on the vicious debate and argument regarding the impact of TBA training in the Ethiopian context, one has to see the capacity of the health delivery system in addressing reproductive health problems

The Unfinished Debate on the Role of TBAs ….*Cont'd from page 5*

in general, and obstetric care in particular. A thorough analysis of the human resource situation within the health sector has great relevance to contextualize the TBAs strategy in order to make appropriate and lasting policy recommendation to the cause of improved maternal and newborn health.

In light of this, undoubtedly, the author belies that ensuring skilled attendance at birth is a worthy objective that any nation, including Ethiopia, has to aspire to achieve. However, in the Ethiopian context, where serious shortage of skilled attendants, is the rule, particularly to the rural population or the urban poor, this target remains a distance goal. The majority births, more than 90 % are attended by TBAs, a relative or in some settings by mothers them selves (24).

Compared to global recommendation (25), which is at least one skilled attendant for every 200 births per year, the situation in Ethiopia far way behind, 1 Mid wife is for more than 4,000 births and one obstetrician or surgeon for more than 40,000. Shortages are especially severe in rural areas, since health professionals are often concentrated in cities. (**26)**

Ensuring the required number of low level and mid - level health care providers who are supposedly 'skilled' in managing common obstetrics emergencies is a tremendous challenge that will be difficult over some time in the futures. The number of new health providers graduated in each year is far lower than the required number to narrow the existing disproportion of skilled attendants to pregnant mothers.

Furthermore, not only the prevailing serious shortage but the majority of low level and midlevel health care providers including general practitioners are highly demotivated, reluctant to serve the rural communities and lack the life saving skills they need to save the lives of women who suffer life threatening complications. Besides, they are often insensitive to cultural and social norms.

To make matter worse, current government statistics (27) revealed that even accessible obstetrics services in health centers and rural hospitals are utilized to the lowest level by pregnant women, because of unfair treatment by providers and unacceptable poor quality of care. The contribution of the health delivery system further significantly diminished because of health facilities face chronic shortage of equipment, drugs, and basic supplies. Anecdotal information disclosed also the midwifery area is being deliberately avoided by many health care providers because of the perceived high risk exposure for HIV/AIDS infections.

Therefore, the government has to reinforce two pronged strategy: strive to ensure the required skilled attendants and establish a robust interim community strategy, where TBAs play a key role. Involving them to link health provider's effort to the community has a vital role to bridge the existing maternal health service gap. In addition to basic obstetric life saving skills, effort must be made to equip them with best practices in universal precaution, and provided them with necessary supplies to avoid transmission of HIVAIDS. Particularly, the high prevalence of HIV/AIDS among pregnant mothers both at rural and urban areas, calls for an urgent action to involve and equip them with requires support. So an affordable and effective mechanism has to be in place to establish functional link between TBAs and the health delivery system, to enhance the team spirit with professionals and facilitate referral.

Conclusion

The extremely low physical access compounded by poor quality of care , and poor utilization of available obstetrics services justify the need to focus on community strategies, apart from the quest to ensure skilled attendance rate in Ethiopia. TBAs are continue to play significant role in maternity care in the foreseeable future, so policy makers need to make the best use of TBAs. As the numbers of client-friendly skilled attendants increase, traditional birth attendants would evolve to disappear. The community resort to the community because there is no other alternative at hand. ***Thus , experience has shown us that the fate of TBAs depends on the extent how the formal health care delivery system organized itself to deliver effective client friendly service, rather than by enacting a provision to eliminate TBAs.*** The current reality dictates us, if the high level of maternal mortality is to be reduced in Ethiopia, then TBA centered community-oriented strategies should be reconsidered and expanded.

Moreover, they can contribute to the survival of mothers

Humour

How to charge?

An optometrist was instructing a new employee on how to charge a customer: "As you are fitting his glasses, if he asks how much they cost, you say '$75.' If his eyes don't flutter, say... 'For the frames. The lenses will be $50.' If his eyes still don't flutter, you add... 'Each'

Taken from the internet

Depression Recycled

Patient: I have a problem doctor. I feel depressed and worthless.
Doctor: You should cut down on your drinks.
Patient: I don't drink and have never touched a drop in my life.
Doctor: You should cut down on your smoking.
Patient: I don't smoke either doctor.
Doctor: You should cut down on womanizing.
Patient: Good heavens!! Haven't touched a woman in my entire life.
Doctor: Your problem is you have no problems!! Get yourself a drink, learn to smoke, and find a couple of girlfriends and you will be alright.

The Unfinished Debate on the Role of TBAs *….Cont'd from page 6*

and newborns by facilitating access to needed information and required obstetric related support. The successful provision of continuum of care for PMTCT of HIV/AIDS and other important maternity care interventions requires a functioning link between the health care system and TBAs.

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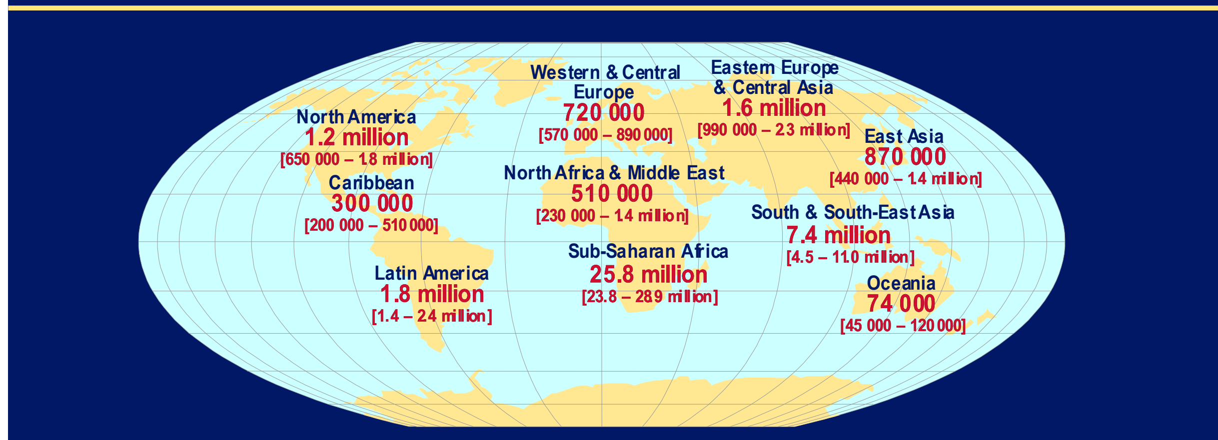
ANNOUNCEMENT

EPHA members are already aware that the Association's annual conferences are always accompanied by a colorful award ceremony for individuals that have demonstrated their competence in the areas of public health research and service delivery. Such a venture is believed to create an atmosphere of competitiveness among health professionals leading to improved health service in the country.

Apart from the various in-house procedures the association employs to select the few people that receive the awards, the Association also maintains a practice of inviting its vast and diverse membership to nominate relevant members and hence help refine the screening process. Hence the Association hereby calls on all EPHA members to send nominees that would be considered for the awards to be held in the EPHA XVIth conference which will be held on coming October 2006.

The Award categories are:

1. *Public health Service Award*
2. *Senior public Health Research Award*
3. *Young public Health researcher Award*
4. *Institutional Award*



Total: 40.3 (36.7 – 45.3) million

00003-E-4 – December 2005

ANNOUNCEMENT- SUBMISSION OF ABSTRACTS, 2ND ANNOUNCEMENT

PLEASE BE INFORMED THAT THE FINAL DATE FOR SUBMISSION OF ABSTRACTS FOR THE FORTHCOMMING EPHA ANNUAL CONFERENCE IS ON JULY 30TH 2006. YOU MAY SEND YOUR ABSTRACTS VIA E-MAIL OR BY CD COPY.

This publication is Sponsored by the US Centers for Disease Control and Prevention (CDC)

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