

# Public Health Digest

Ethiopian Pubic Health Association (EPHA)

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Addis Ababa

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## Public Health Digest

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## Abbreviations and Acronyms

### Objectives of the Digest

- *To improve the knowledge and practices of public health professionals*
- *To introduce latest research findings, best practices and success stories to the general public*
- *To motivate health professionals to engage themselves in operational studies*

### Target Audiences

*The target addresses for the Digest are health professionals in general, public health practitioners at Woreda health offices, health centers and hospitals, in particular. This Digest is also intended for non-health professionals (general public) who are interested on the subject on a demand-basis for free subscription.*

### Strategy

*The Digest is published annually with hundreds of copies and the distribution follows the modalities of other EPHA publications. In addition, to disseminating the Digest to regional, zonal and woreda health offices, mainly through EPHA chapters and subchapters, EPHA website serves as channels for electronic distribution of the publications. The Digest is bilingual (Amharic and English).*

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Treatment
CDC	Center for Disease Control and Prevention
CPT	Co-trimoxazole preventive therapy
FHAPCO	Federal HIV/AIDS Prevention and Control Office
EPHA	Ethiopian Public Health Association
EPHI	Ethiopian Public Health Institute
FMoH	Federal Ministry of Health
HCW	Health Care Workers
HDSS	Health and Demographic Surveillance System
HEP	Health Extension Program
HEW	Health Extension Workers
HIV	Human Immunodeficiency Virus
HRBs	Health Regional Bureaus
ICD	International Statistical Classification of Diseases
IPT	Introduce Isoniazid Prevention Therapy
IRB	Institutional Review Board
IUCD	Intrauterine Contraceptive Device
LARC	Long Acting Reversible Contraception
MARPs	Most-At Risk-Populations
OIs	Opportunistic Infections
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV
TB	Tuberculosis

## Message from the Editor

Welcome to this edition of *Public Health Digest*, our annual issue designed especially for members of EPHA and the general public as part of advancing public health communication. While mainly as members you might be at home with various public health concerns and messages, we want to refresh and help you live better and cause others live better, too. But it's not always easy to know what we should and shouldn't be doing. We are bombarded by physicians and/or health professionals giving us inconsistent advice – eat this, don't do that – so it's difficult to know what to believe and what to drop. In some cases, clients seem to question the dependability of the services and forced to see other options to get remedies or solutions to their health and related problems. There is also concern on the adequacy and strategy of health education to be added to the design of healthy communities. I hope you enjoy the following probing message and do let us know if there are any topics you'd like to see covered in the future.

## A Network of Healthy Homes to Design Healthy Community

The existing environment is the people-made features of our communities: home surroundings, sidewalks, public transportation, swimming and other recreational areas and more. The way we sketch and build our communities affects our physical and mental health which calls for evidence based public health response. The design for healthy environment and community should encompass all members in communities at all levels from newborn to old age, home to school and workplace. When people can walk where they need to go, car traffic decreases, and that can improve air quality and respiratory health. In addition, it fosters the culture of physical exercise as one of the core determinants of health life. Though it may seem a silly question, "what is the point of being healthy?" There are many ways to answer the question. Here, our concern is environmental health among other critical public health issues. Definitely, it is understood that everyone in any community deserves healthy life.

Those are communities where everyone has a safe and healthy home; everyone has access to safe and healthy food, healthy sidewalks, transportation, recreational areas and healthy environment in general. A built environment is the basis for health community.

It can feel sometimes like everyone is talking about the intersection of health and environment. And yet, the actual work is mostly at the very beginning stages and lacks sustainability. For instance, if we take our Capital, Addis Ababa, a cleaning campaign was initiated and everybody seemed to join the endeavor to create clean Addis Ababa and the campaign went on well

across the city in the beginning. However, the continuity seems to be questioned as the operation is likely to be less organized. A new set of case studies unveils a range of strategies that metro area planning agencies can take advantage of in strengthening the local economy, improve public health outcomes, promote social equity and better protect the environment if they tend to work in partnership.

So, what should we do? Who should be responsible to protect the environment in a more coordinated fashion and who to participate? We would recommend the need to create a forum where key stakeholders come together and establish cross-sector

coalitions working with communities to enhance the environment and advance the design for healthy community. This is, therefore, a call to action to bring about the intended outcome.

Together, the environment as well as healthy life can move forward faster than either can alone!

Kindalem Damtie /PhD/  
Editor in chief

# Projects Update

## Paediatric Effective Testing and Enrolment: HIV Prevalence in High-Risk settings of Selected Health Facilities in Ethiopia

### Project Description and Justification:

This survey will help to generate data on testing priorities and HIV prevalence of high risk children. The findings of the survey will be utilized for the overall improvement of pediatric HIV care and support program.

### Project Goal

The goal of this project is to inform national and international testing priorities by kind of setting (inpatient, malnutrition, TB, child of adult on ART, or OVC) applicable to low prevalence countries, to assess missed opportunities and initiation barriers, and to understand which policies lead to successful linkage and ART initiation based on findings from high client load facilities in Amhara and Addis Ababa.

### Objectives:

#### Primary Objectives:

1. To determine HIV prevalence among children 2 – 14 years of age in examples of each of the following high-risk settings: inpatient facilities, malnutrition facilities, TB clinics, ART clinics (children and adults on ART), and OVC support programs, in selected high client load facilities in Amhara and Addis Ababa;
2. To measure the rate of enrollment into HIV services of children who are HIV infected;
3. To describe missed opportunities where testing might have occurred among the infected children earlier in life;
4. To describe parent or legal guardian-perceived facilitators and barriers to enrollment.

### Secondary Objective

To assess health care providers experiences with implementation of the WHO recommendation to perform confirmatory testing in individuals who are diagnosed with HIV infection before initiation of treatment.

Partners of the project are FMOH, EPHI, Addis Ababa and Amhara RHBS, CDC and EPHA.

### Achievements:

- Technical working group has been established to conduct the study;
- Protocol has been developed;
- Site visit was made;
- Ethical clearance has been obtained from different IRBs;
- Senior study staffs have been hired;
- Field level staffs have been hired;
- Facility staff in the health facilities of both regions have been trained;
- Classroom and practical training have been provided to the field team;
- Good Clinical Practice training and certification have been given to all

study team;

- First and second phase data collection process has been finalized in the health facilities of Addis Ababa;
- Field supervision and quality assurance monitoring have been carried out; and
- The data collection process is underway in the health facilities of Amhara region.

## Care and Support (National Assessment on Retention Status of PLHIV)

**Project Description:** Poor linkage, engagement and retention leads to poor outcomes for health systems and individuals. Whereas efforts to engage and retain those who are enrolled in care and treatment, and the promotion of optimal adherence to antiretroviral therapies are critical in the achievement of desired clinical outcomes, prevention of new infections, and restoring quality of life for individuals, families, and their community. Reports indicate that at each step along the clinical care cascade, more and more patients are lost to follow-up. The FMOH and PEPFAR recognize the critical role that linkage, engagement, and retention play in improving patient outcomes. PEPFAR aims to provide countries with a framework to gain an improved understanding of their current situation and to develop plans for continued improvement, innovation, and shared learning. However, there is a dearth of data on the changes in status of linkage, engagement and retention in HIV/AIDS chronic care service following the revision of the national guideline by adopting the 2013 WHO recommendations. Within the context of the continuum of HIV related prevention, treatment and care, the National Guideline for Comprehensive HIV Prevention, Care and treatment issued by FMOH in 2014 is a consolidation of existing different guidelines with update of latest recommendations and intended to serve health providers and program managers at different levels of service facilities. The guideline is expected to contribute for the improvement of the quality of

service delivery and patient outcome. It is now high time to assess the status of the system in line with the guideline. This study will primarily focus on assessing the transitioning from HCT test result to chronic HIV care and support services and the status of the flow along the steps of the continuum of care and support services within a facility. It will try to map out the landmarks along the cascade, the type of services provided at each stage, the linkage between the landmarks, accessibility, patient outcome and gaps and challenges.

**Project Goal:** The overall goal of the project is to assess the status of referral linkage, engagement and retention in chronic HIV/AIDS care and treatment services among PLHIV in Ethiopia and identify root causes and program

gaps to develop plans for continued improvement, innovation, and shared learning.

### Objectives:

- Identify the proportion of newly diagnosed PLHIV linked into HIV/AIDS care and treatment services following HIV positive testing;
- Determine factors for not initiating rapid ART and underlying reasons for those factors including refusal;
- Assess the proportion of newly diagnosed PLHIV engaged into HIV/AIDS care and initiated ART treatment following linkage;
- Examine factors associated with linkage and engagement into HIV/AIDS care and treatment services;
- Determine the time lag between HIV positive testing and linkage (enrollment into care) and linkage and initiation of

treatment services and factors associated with time lag (initiation of ART and other clinical services like evaluation for OIs, CPT\IPT, Cryptococcal Ag testing etc.);

- Describe level of adherence to ART among the clients and;
- Determine the proportion of ART patients virally suppressed at six and twelve months following ART initiation and factors associated with it;

#### Secondary Objective

- Assess the magnitude and reasons for lost follow up among

new clients enrolled to ART at the baseline;

**Study Setting:** Nationwide  
**Partners:** FMOH, Regional Health Bureaus, CDC and EPHA

#### Achievements:

- Technical working group has been established to conduct the study;
- Terms of Reference has been produced;
- Protocol development has been finalized; and
- Submission for ethical clearance is in progress;

## National MARPs Survey

**Project description:** In Ethiopia, the HIV prevalence estimates in the general population remains low despite the increasing number of people living with HIV/AIDS and those on ART. The nature of the epidemics is heterogeneous and is assumed to be fueled by some groups which have higher level of infection and risk behavior. These segments of the population (Most At Risk-Populations, MARPs) such as female sex workers, long distance drivers, daily laborers etc showed higher level of risk behavior in the two rounds of behavioral surveillance surveys (2002 & 2005). This potentially leads to the assumption that this group of the population may play a pivotal role in the HIV epidemic in Ethiopia.

Generally, there is limited information about the magnitude of

HIV among certain segments of the population (hidden population) that are at a relatively higher risk of acquiring HIV due to their risky sexual behaviors. Because of the limited information on MARPs in Ethiopia, the Ethiopian Public Health Association in collaboration with EPHI, FHAPCO and CDC Ethiopia is undertaking a national MARPs survey in selected regional capitals and major transport corridors. The first round survey on female sex workers and distance drivers was recently completed and a subsequent MARPs survey in other high risk groups planned. Due to the expansion of development sites including hydroelectric dams, road construction and agricultural development sites in Ethiopia, thousands of professionals, daily laborers and construction workers are moving

towards these sites from different corners of the country with different HIV related risk behavior. However, there is lack of evidence on HIV related risk behaviors and magnitude of HIV in these segments of the population.

**Project Goal:** To establish a surveillance system to monitor HIV prevalence and related risk behaviors among key populations to increase the availability of information to better inform national HIV prevention and control efforts in Ethiopia.

**Objective:** To measure the level of HIV infection among MARPs group and identify the risk factors for HIV infection

Partners of the project are

FMoH, EPHI, CDC and EPHA

#### **Achievements:**

□ The report of the first round MARPs survey has been approved and is ready for dissemination.

□ A technical working group has been established to conduct the round MARPs survey.

□ A concept note to develop a full-fledged protocol for the round two MARPs survey has been developed;

□ Discussions are underway to develop a protocol to conduct the second round MARPs survey.

□ Manuscript development on the findings of the first round MARPs survey has been carried out

## **Health and Demographic Surveillance System (HDSS)**

### **Background:**

Health and Demographic Surveillance System (HDSS) in six Ethiopian universities research centers is a longitudinal, population-based health and vital event registration system that monitors demographic and health outcomes in a geographically defined population with timely production of data. This continuous surveillance makes it possible to easily and clearly define risks of demographic and health outcomes for individuals' overtime. HDSS in Ethiopian universities research centers have been established in Ethiopia as platforms to monitor epidemiologic and population dynamics. There are seven sites in six universities. Sites function in Addis Ababa (AAMSP), Oromiya, Amhara, SNNP and Tigray regions. These sites collaborate by forming a

network established in 2007 to work together and coordinate activities, standardize activities including field procedures, data collection tools and databases. Currently most sites are moving their data collection system from paper to electronic based and this will enhance data quality and reduce costs.

### **Objectives:**

□ Support research undertaking capacity of graduate-level trainees using data generated from research centers

□ Strengthen research centers capacity to generate and disseminate information on major health and socio-demographic indicators.

□ Provide up-to-date information for local and international researchers to enable collaborative and multi-center studies

□ Identify causes of death using verbal autopsy method

□ Generate accurate, valid and up-to-date information for evidence-based decision making for public health interventions.

### Achievements :

a) **Capacity Development:** Initially HDSS sites and the network had experience sharing visits from Ghana and South Africa HDSS sites and participated in two international conferences. HDSS team members received trainings on project administration and management, HRS database system- 2 times, longitudinal data management and analysis using STATA software- 2 times, GIS/GPS application software training, Open HDS, and VA cause of death assigning for physicians

b) **Standardization of HDSS procedures:** Initially all sites started by their own and have different

approaches and databases. After this network establishment and EPHA support all sites able to use same database system-(HRS), now Open HDS, developed a standardized network protocol for HDSS, vital events capturing tools standardized, VA cause of death determination- physician reviewers, and field operations standardized- through the network meetings and learning forums.

Several publications produced from sites independently with the support of EPHA/CDC technical staffs.

c) **Data quality improvement:** The data is now significantly improved through quarterly meetings, supportive supervisions done with site leaders, research team members, data managers, EPHA and CDC team. The network also applied different mechanism to improve the data

including joint site visits among HDSS sites, joint data quality assurance meetings, joint data analysis and reporting meetings, refresher trainings and learning forums among members and establish scientific working group. Currently, the network in the process to transfer paper based data capturing into an electronic based system.

d) **Data use and sharing policy:** a data sharing policy is developed and endorsed by university officials for use. Each site has also developed their own data use and sharing policy in line with the network policy. A working

document was drafted.

e) **Dissemination of findings:** Several publications produced and published. At national level, dissemination workshops were organized. To mention few research to policy translation workshop organized with series of policy briefs. Jointly produced surveillance reports shared for FMOH, EPHI and others partners focusing on TB, HIV/AIDS and Malaria. Furthermore, each sites disseminated to their own site specific surveillance findings to their communities.

# Research Findings

## በኢትዮጵያ የአፍላ ወጣቶች የፅንሰ ማቋረጥ ሁኔታን አስመልክቶ የተደረገ ጥናት

በ1997 ዓ.ም. የተደረገው የፅንሰ ማቋረጥ ስርዓት መሻሻል ሕጋዊና ደህንነቱ የተጠበቀ የፅንሰ ማቋረጥ አገልግሎት ተደራሽነትን በማምጣቱ አፍላ ወጣት ሴቶች በእጅጉ እንደተጠቀሙ ይህ ጥናት አመለካከቷል። በኢትዮጵያ የአፍላ ወጣቶች የፅንሰ ማቋረጥ ሁኔታ ጥናት በሚል ርዕስ በጉትማቸር ኢንስቲትዩት እና በአይፓስ ትብብር በተደረገው ጥናት ዕድሜያቸው ከ15-19 የሆኑ አፍላ ወጣት ሴቶች የሚያደርጉትን ደህንነቱ የተጠበቀ ሕጋዊ የፅንሰ ማቋረጥ እንዲሁም በድብቅ ደህንነቱ ባልተጠበቀ ሁኔታ የሚከናወነውን የፅንሰ ማቋረጥ መጠን እና በዚህ የእድሜ ክልል ውስጥ ከፅንሰ ማቋረጥ ጋር በተያያዘ የሚደርሱ ውስብስብ ችግሮችን ክብደት አካቷል። ጥናቱ አፍላ

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በ2006 ዓ.ም. ከነበሩት ፅንሰ ማቋረጥ ተግባራት ውስጥ 64 ከመቶ የሚሆኑት በጤና ተቋማት የተደረጉ ደህንነታቸው የተጠበቀ ሄደቶች ነበሩ። በዕድሜ ትልቅ በሆኑ ሴቶች ከተደረጉ ፅንሰ ማቋረጥ ተግባራት ውስጥ ደህንነቱ በተጠበቀ መንገድ የተፈፀመው ከአፍላ ወጣቶች ጋር ሲነፃፀር ያነሰ ሲሆን ደህንነቱ ባልተጠበቀ መንገድ የተከናወኑት ደግሞ የበለጡ ነበሩ። ዕድሜያቸው ከ25 እስከ 29 በሆኑ ሴቶች ከተደረገው ፅንሰ ማቋረጥ ውስጥ 46 ከመቶ የሚሆኑት እንዲሁም ዕድሜያቸው ከ35 በላይ በሆኑ ሴቶች ከተደረገው

ፅንሰ ማቋረጥ ውስጥ 22 በመቶ የሚሆኑት ብቻ ደህንነቱ በተጠበቀ መንገድ የተከናወኑ ነበሩ። የተቀሩት ደህንነቱ ባልተጠበቀ ሁኔታ የተከናወኑ ነበሩ።

የኢትዮጵያ የፅንሰ ማቋረጥ ሕግ መሻሻል ብዙ ሴቶች ደህንነቱ የተጠበቀ የፅንሰ ማቋረጥ እንክብካቤ እንዲያገኙ አስችሏል ይላሉ ከአጥኝዎቹ አንዱ የሎንደን ዲባባ (ዶ/ር)። አሁንም ግን ቁጥራቸው ቀላል የማይባል ሴቶች ድብቁን እና ጥንቃቄ የጎደለውን ፅንሰ ማቋረጥ ሂደት ለምን እንደሚፈፀሙ ተጨማሪ ጥናት መካሄድ አለበት በማለት ያክላሉ።

በተጨማሪም በድብቅ በሚፈፀም ፅንሰ ማቋረጥ ወይም በፅንሰ ማቋረጥ ምክንያት የሚፈጠረውን ውስብስብ ችግር ለማከም የድህረ ፅንሰ ማቋረጥ ሕክምና ካስፈለጋቸው ከአራት አፍላ ወጣት ሴቶች ውስጥ አንዷ ከባድ ውስብስብ ችግር እንዳጋጠማት ጥናቱ ይፋ አድርጓል። ከፅንሰ ማቋረጥ በኋላ

እንክብካቤ የፈለጉ በዕድሜ ትልቅ የሆኑ ሴቶችም ተመሳሳይ መጠን ያለው ውስብስብ ችግሮች አጋጥሟቸዋል። ደህንነቱ ባልተጠበቀና ድብቅ በሆነ የፅንሰ ማቋረጥ ውስብስብ ችግሮች ውስጥ ያለፉ አፍላ ወጣት ሴቶች በሕጋዊ መንገድ ፅንሰ ካቋረጡ ሴቶች አንፃር ሲታዩ አብዛኛዎቹ ያገቡ፣ በዝቅተኛ የትምህርት ደረጃ ላይ የሚገኙና የእርግዝና ጊዜው የገፋ ፅንሰ ይዘው የመጡ ነበሩ። የጋብቻ እና የትምህርት ሁኔታ የአፍላ ወጣት ሴቶችን ደህንነቱ የተጠበቀ የፅንሰ ማቋረጥ አገልግሎት ተደራሽነት እና ተጠቃሚነት ላይ እንዴት ተፅዕኖ እንደሚያሳር ለማወቅ ተጨማሪ ጥናት ያስፈልጋል።

በኢትዮጵያ አፍላ ወጣት ሴቶች በሌሎች የዕድሜ ክልሎች ካሉ ሴቶች አንፃር የሚፈጽሙት ፅንሰ ማቋረጥ በመጠን ያነሰ ነው። ሲሉ በጉትማቸር ኢንስቲትዩት ከፍተኛ ተመራማሪ እና የአጥኚ ቡድኑ መሪ የሆኑት ኤልዛቤት

ሉሲ ተናግረዋል። ሆኖም በአፍላ ወጣት ሴቶች ዘንድ ከሚከሰቱ እርግዝናዎች ውስጥ ግማሹ ያልተፈለገ ሲሆን ይህም ያልተሟላ የእርግዝና መቆጣጠሪያ ዘዴዎችን የመጠቀም ፍላጎቶቻቸውን ለማሟላት ብዙ ሥራ እንደሚያስፈልግ ግም ያመለክታል ብለዋል።

በግብረ ሥጋ ግንኙነት ላይ የሚሳተፉ ሴቶች ውስጥ አፍላ ወጣት ሴቶች ከፍተኛ መጠን ያለው ያልታቀደ እርግዝና (ከ1,000 ሴቶች ውስጥ 176ቱ) እንደሚያጋጥማቸው ጥናቶች ያመለክታሉ። ሆኖም ግን በግብረ ሥጋ ግንኙነት ላይ ከሚሳተፉ ዕድሜያቸው ከ15-49 በሆናቸው 1,000 ሴቶች ውስጥ ያልታቀደ እርግዝና የሚያጋጥማቸው 101 ናቸው። አፍላ ወጣት ሴቶች በዕድሜ ከሚበልጧቸው ሴቶች ጋር ሲነፃፀሩ ብዙውን ጊዜ የግብረ ሥጋ ግንኙነት የማያደርጉ ቢሆንም የእርግዝና መከላከያ ዘዴዎችን ከመጠቀም አንፃር ግን በርካታ መሰናክሎች አሉባቸው።

አፍላ ወጣት ሴቶች በእድሜ ከገፉ ሴቶች አንፃር ሲታዩ ዝቅተኛ የሆነ የግብረ ሥጋ ግንኙነት ተሳትፎ ያላቸው በመሆኑ በአጠቃላይ ባለው የፅንሰ ማቋረጥ ምጣኔ ላይ ተፅዕኖ ያሳድራል። በ2006 ዓ.ም. ዕድሜያቸው ከ15-19 ካሉ አፍላ ወጣት ሴቶች ውስጥ 96,243 ፅንሰ ማቋረጥ ተከናውኗል። ይህም ከእያንዳንዱ 1,000 አፍላ ወጣት ሴቶች ውስጥ 20ዎቹ ፅንሰ ያቋርጣሉ እንደሚለት ነው። ሆኖም ግን በግብረ ሥጋ ግንኙነት ላይ ተሳትፎ ያላቸውን ሴቶች ብቻ ነጥለን ስንመለከት ዕድሜያቸው ከ15-19 ያሉት አፍላ ወጣት ሴቶች ከፍተኛ የፅንሰ ማቋረጥ ምጣኔ ያላቸው ናቸው። የዚህ ጥናት አቅራቢዎች ለአፍላ ሴት ወጣቶች የተሟላና ከፍተኛ ጥራት ያለው የእርግዝና መከላከያ አገልግሎት መኖሩን ማረጋገጥ ያስፈልጋል በማለት ምክረ ሀሳብ ያቀርባሉ።

ተጨማሪ ጥናቶችን ማካሄድ ለአፍላ ወጣት ሴቶች ደህንነቱ ያልተጠበቀ ፅንሰ ማቋረጥ ሊያከናውኑ የሚችሉባቸውን ምክንያቶችን ለመለየት ይረዳሉ። ከነዚህ ምክንያቶችም ውስጥ በተዋልዶ ጤና ጉዳይ ላይ ውሳኔ የመስጠት ነፃነት፣ የጤና ተቋማት ርቀት፣ ፅንሰ ማቋረጥ አስነዋሪ ድርጊት ሆኖ መታየት፣ እንዲሁም ሴቶች በፅንሰ ማቋረጥ ሕግና አሠራር ዙሪያ ያላቸው የግንዛቤ መጠን ተጠቃሽ ናቸው። በሴቶች መካከል ያለውን ልዩነት በማስቀረት ሁሉም አፍላ ወጣት ሴቶች አስተማማኝና ደህንነቱ የተጠበቀ የፅንሰ ማቋረጥ አገልግሎት እንዲያገኙ ለማረጋገጥ እነዚህንና መሰል ጥረቶች ቁልፍ ሚና ይኖራቸዋል።

ምንጭ:- [www.gutmacher.org](http://www.gutmacher.org)

## Is Sharing the task of provision of LARC to community health worker safe and effective?

### *Mixed methods evaluation of a pilot project*

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**Introduction:** Poor access to all options of family planning have kept the unmet need for rural women in Ethiopia very high. The method mix is also skewed towards short acting methods, because those are the only options available at the health post level. One of the strategies employed to address these challenges was, provision of long acting reversible contraception (LARC) by Level 4 Health Extension Workers (L4HEW) at health post level. It was initiated in 66 selected health posts, as a pilot project. The effectiveness and safety required rigorous evaluation.

**Methods:** A mixed methods approach was used where the outcomes of the LARC on randomly selected users were assessed using

a follow up questionnaire by going to their homes. A multi-stage sampling method was used to identify the users.

The key outcomes were: success, preparedness, satisfaction, complications, side effects and discontinuation among users. Data was collected from a total of 52 health posts, and 702 randomly selected clients who received LARC from the L4HEW.

**Results:** Most LARC methods were available in almost all (50/52) health posts at the time of visit. Only 2.7% of the users are younger than 19 years old and 96% are from rural settings and 93% are married.

On follow up 90% of the users of the LARC have a good level of knowledge of the pregnancy

prevention duration of the IUCD and Implants. Majority (94%) said their primary source of information for family planning are the health extension workers.

The service met expectation of 92.8% (641/691) and the service was more than their expectation for the remaining 7.2% (5/691). Based on their own experience 94.5% (653/691) would recommend long acting family planning methods to their friends, 3.5% (24/691) would not recommend and 2.1%(14/691) are not sure about it.

Among the study participants, 89.0% (606/681) have reported having no problem following LARC. Only 0.3 %(2/598) reported incidence of pregnancy, and 0.2(1/598) reported expulsion.

Only 3.8% (15/397) of Implant users and 3.5% (8/231) of IUCD users had removals within 8 months of receiving the service. Reasons for discontinuation of LARC are rumors leading to fear

about it, desire to have more children, and other reasons. No facility has reported any safety concerns.

### **Conclusion and recommendations:**

Provision of LARC by L4HEW at health post level is a feasible option, where access to most rural women could be ensured.

Discontinuation, pregnancy and expulsion were much lower than the national rate and expected efficacy of the different methods and no major safety concerns were reported.

Some misconceptions on reasons for discontinuation and side effects of the methods have been observed.

We recommend that expansion to other sites should be considered together with more robust study designs employing comparative prospective approaches. Addressing the main misconceptions is also pivotal.

*A study conducted by the Ethiopian Public Health Association, with funding from Packard Foundation.*

# The Issue

## International Statistical Classification of Diseases (ICD)

### History of the ICD

The history of the ICD traces back to England in the 16th century. Every week, the London Bills of Mortality would announce deaths from distinctly medieval causes: scurvy, leprosy, and the big killer – plague.

It wasn't until the late 19th century though, when Florence Nightingale, just returned from the Crimean War, advocated for the need for gathering statistics on causes of disease and death that data began to be collected more systematically.

Around the same time French statistician Jacques Bertillon introduced the Bertillon Classification of Causes of Death, which

was adopted by several countries.

In the 1940s, the World Health Organization took over Bertillon's system and expanded it to include statistics on causes of injury and disease, producing the first version of the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD). This allowed for the first time the collection of both morbidity and mortality data to map both disease trends and causes of death.

### Disease trends and the biggest killers

The data captured through ICD codes is of huge importance for countries. It allows for the mapping of disease trends and causes of death around the world,

which are key indicators both of the health of a population, but also the social determinants that link closely to health, such as the education, nutrition, and public infrastructure - in short, a snapshot of where a country's vulnerabilities lie.

A country in which people live in crowded, inadequate housing with no clean water are inevitably likely to have a higher incidence of diarrhoeal disease.

The Global Health Observatory is WHO's gateway to health-related statistics for over 1000 indicators. Data coded through the ICD populates the Global Health Observatory allowing WHO to report World Health Statistics annually.

These statistics are critical in tracking progress towards key targets such as the Sustainable Development Goals.

The International Statistical Classification of Diseases and

Related Health Problems (ICD) is the bedrock for health statistics. It maps the human condition from birth to death: any injury or disease we encounter in life – and anything we might die of – is coded.

Not only that, the ICD also captures factors influencing health, or external causes of mortality and morbidity, providing a holistic look at every aspect of life that can affect health.

These health statistics form the basis for almost every decision made in health care today – understanding what people get sick from, and what eventually kills them, is at the core of mapping disease trends and epidemics, deciding how to programme health services, allocate health care spending, and invest in R&D.

ICD codes can have enormous financial importance, since they are used to determine where best to invest increasingly scant resources. In countries such as the USA, meanwhile, ICD codes are the foundation of health insurance billing, and thus critically tied up with health care finances.

Crucially, in a world of 7.4 billion people speaking nearly 7000 languages, the ICD provides a common vocabulary for recording, reporting and monitoring health problems. Fifty years ago, it would be unlikely that a disease such as schizophrenia would be diagnosed similarly in Japan, Kenya and Brazil. Now, however, if a doctor in another country cannot read a person's medical records, they will know what the ICD code means.

Without the ICD's ability to provide standardized, consistent data, each country or region would have its own classifications that would most likely only be relevant where it is used. Standardization is the key that unlocks global health data analysis.

On 18 June 2018, 18 years after the launch of ICD-10, WHO released a version of ICD-11 to allow Member States time to plan implementation. This is anticipating the presentation of ICD-11 to the World Health Assembly in 2019 for adoption by countries. Over a decade in the making, this version is a vast improvement on ICD-10.

First, it has been updated for the 21st century and reflects critical advances in science and medicine. Second, it can now be well integrated with electronic health applications

and information systems. This new version is fully electronic, significantly easier to implement which will lead to fewer mistakes, allows more detail to be recorded, all of which will make the tool much more accessible, particularly for low-resource settings. third, important feature is that ICD-11 has been produced through a transparent, collaborative manner, the scope of which is unprecedented in its history. The complexity of the ICD has sometimes made it seem like an esoteric health tool requiring months of training – of the number of deaths reported in the world, those coded correctly were about one third. An overriding motive in this revision was to make the ICD easier to use.

### Small code, big impact

The consequences that ICD coding has on provision of care, as well as health financing and insurance, means that clinicians, patient groups, and insurers, among others, take the use of the ICD extremely seriously – many groups often have strong positions on whether or not a condition should be included, or how it should be categorized. For instance, some people working on stroke have long been pushing for it to be moved from circulatory diseases, where it has been for 6 decades, into neurological disease, where it now sits in ICD-11. Those advocating for the move cited key implications for treating the disease and reporting deaths as the main driver.

A critical point in engaging with the ICD is that inclusion or exclusion is not a judgment on the

validity of a condition or the efficacy of treatment. Thus, the inclusion for the first time of traditional medicine is a way of recording epidemiological data about disorders described in ancient Chinese medicine, commonly used in China, Japan, Korea, and other parts of the world. Revisions in inclusions of sexual health conditions are sometimes made when medical evidence does not back up cultural assumptions. For instance, ICD-6 published in 1948 classified homosexuality as a mental disorder, under the assumption that this supposed deviation from the norm reflected a personality disorder; homosexuality was later removed from the ICD and other disease classification systems in the 1970s. Gender incongruence, meanwhile, has also been moved out of mental disorders in the ICD,

into sexual health conditions. The rationale being that while evidence is now clear that it is not a mental disorder, and indeed classifying it in this can cause enormous stigma for people who are transgender, there remain significant health care needs that can best be met if the condition is coded under the ICD. For mental health conditions, ICD codes are especially important since the ICD is a diagnostic tool, and thus, these are the conditions that often garner much of the interest in the ICD. These include gaming disorder, which evidence shows is enough of a health problem that it requires tracking through the ICD. Other addictive behaviors such as hoarding disorder are now included in ICD-11, and conditions such as 'excessive sexual

drive' has been reclassified as 'compulsive sexual behavior disorder'.

A significant change in the mental disorders section of ICD-11 is the attempt of statisticians to simplify the codes as much as possible to allow for coding of mental health conditions by primary health care providers ra-

ther than by mental health specialists. This will be a critical move since the world still has a scarcity of mental health specialist – up to 9 out of 10 people needing mental health care don't receive it.

*Source: www.who.int*

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### ***References***

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