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Pic. by JIPHIEGO

Reducing HIV-Related Maternal Mortality

By Ann Noon

HIV accounts for more than 60,000 maternal deaths every year. Because Kenya, South Sudan, Uganda and Zambia all have a particularly high burden of HIV and maternal mortality, the International HIV/AIDS Alliance-together with its linking organizations in these countries, including implemented a 12-month programme during 2011 funded by the UK Department for International Development (DFID) to reduce HIV-related maternal mortality and improve health outcomes, in particular for mothers living with the Virus and their children.

Aiming to address both the demand and supply side of health systems, the initiative sought to increase demand for health care services by pregnant women, including those living with HIV and their male partners, as well as strengthen referral systems and follow up through community mobilisation and awareness raising activities.

In a generalised epidemic, HIV-positive mothers are four to eight times more likely to die during childbirth. But the heightened awareness generated by this programme has seen an uptake in prevention of mother-to-child transmission services and ante-natal care, and more women opting to deliver at health care facilities. This has substantially increased their chances of delivering their baby safely and without the virus. When

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EDITORIAL COMMENTARY

By Florence Machio

In the 90's a succession of International conferences documented the centrality of women's human rights to the health of families and communities. Sexual and reproductive ill health accounts for a full third of the global 'burdedn of disease' among women of reproductive age, and one-fifth among the overall population.

To add to this, reproductive health care contributes to economic development as well as global health. The huge disparities in mother and child mortality rates separate the rich from the poor-both among the countries and within them.

This is not a women's health conference, it is a reproductive health and HIV services one but its difficult to seperate the two.

Looking at this conference there is a lot of research that will be shared as well as best practices to ensure that in the end this conference does indeed make sense to service delivery for the women who carry the burden of disease in sub Saharan Africa.

Healthy mothers who can plan their families, and get the services they require, mean healthy families and greater global health. Yet women in some societies may often be left out of health policy decision making and even homes. Can integration be the answer?

Poorly equipped health care systems, lack of trained medical personnel, and cultural factors such as child marriages conspire against women's health and survival and that of their children. Could integration of services be the solution to saving children under five; avoiding discrimination of HIV positive patients and finally reducing maternal deaths?

Well this conference will have best practice sharing so that we do not reinvent the wheel. Most governments are keen to reduce costs and provide health care services, because a healthy nation is a wealthy nation!

We at INTEGRATIONnews will update you as well as scrutinize some of the results being shared here. This edition gives you a sneak preview of the situation in some of the countries represented at this conference.

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Malawi's Situation

By Owen Nyaka

Malawi continues to experience a severe HIV epidemic. Since 1985 when the first case was reported at Kamuzu Central Hospital in the capital Lilongwe, HIV prevalence increased significantly particularly among the reproductive age of 15 to 49 years.

Although the national HIV prevalence is declining, on average there are nearly 90, 000new HIV infections each year with at least half occurring among young people.

These rates translate into about 1 million Malawians living with the virus.

About 88 percent of all new HIV infections in Malawi are acquired through unprotected heterosexual intercourse and about 10 percent through mother-to-child transmission. About 2 percent of infections are transmitted through blood transfusion, contaminated medical and skin piercing instruments.

HIV infection rates show gender, age, social status and geographical variations, with infections more prevalent in women than men, urban than rural populations, and in the Southern part of Malawi as compared to the rest of the regions.

In response to the challenge, the Government of Malawi in collaboration with its stakeholders has developed and is implementing several prevention strategies and plans aimed at reducing the further transmission of HIV through unprotected sexual intercourse, mother to child, invasive procedures, and blood and blood products.

Malawi's health system is grossly under-resourced. Per capital expenditure is about US$12, which is inadequate for delivery of basic primary health care. In 2002, an extensive exercise to determine the cost of delivering 'Essential Health Package' (EHP) of well proven and cost effective

President Joyce Banda

health services that would deal with the main burden of disease, calculated a figure of US$17.53 per capita per year; according to 2010 Ministry of Health, Reproductive Health Unit (RHU) national Emergency Obstetric Care needs assessment report.

However, the Malawi Government is committed to providing comprehensive and integrated Sexual and Reproductive Health Rights (SRHR) services in line with the recommendations of the International Conference on Population and Development (ICPD) held in Cairo, Egypt, 1994.

Malawi is a signatory to the African Union Maputo Plan of Action which advocates for integrated SRHR Plan. Government through RHU has since 1997 coordinated the integration, implementation, monitoring, and evaluation of SRHR services at all levels. In the year 2000; the RHU developed Reproductive Health policy to guide implementation.

There is a political will as the country has a Department of Nutrition, HIV and AIDS within the Office of President and Cabinet (OPC) with its Permanent Secretary. In additional the incumbent administration has also created a Department for Safe motherhood within OPC with its Permanent Secretary as well.

Malawi President Her Excellency Joyce Banda, who was dethroned as the country's special ambassador on safe motherhood by late president Bingu wa Mutharika replacing her with his wife Callista Mutharika, made the announcement of the Presidential Initiative for Maternal Health and Safe motherhood within 100 days in office.

Addressing traditional chiefs at Mount Soche Hotel in Blantyre, President Banda says she will rally behind traditional leaders to sensitize their subjects in the villages on safe motherhood.

"Chiefs are very instrumental in this aspect. You are able to tell your subjects that please go to deliver at the hospital. A chiefs committee on Maternal Health and Safe Motherhood will be established. There shall be workshops in the villages. I am very passionate about this subject," she stressed adding, "As a mother, I will not allow mothers to die as they deliver. Maternal deaths are preventable, and access to health care is at my heart of my leadership".

Reducing HIV-Related Maternal Mortality

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prevention of mother-to-child transmission services are used, the chance of a baby born to an HIV-positive mother becoming infected is less than 1%. Without these services there is a 20-45% chance.

Through the strengthening of community systems, the effects of HIV on maternal and child mortality, key danger signs during pregnancy, and the importance of giving birth at health facilities to improve the chance of survival for mother and/or baby if complications arise was raised.

The programme also saw an increase in the number of pregnant women referred to available services – some 80,000 altogether - as well as in the number of women attending antenatal care and opting to deliver at health care facilities.

Male involvement

In Kenya and Zambia, key informants cited more male involvement in supporting female partners through the pregnancy journey as a result of the programme. Interestingly, health care workers reported that when a man did accompany his female partner to antenatal care services, they were usually very willing to have an HIV test when this was offered, facilitating sero-status disclosure between couples.

The Integration for Impact conference is an important regional forum to specifically bring together SRH and HIV practitioners to ensure that people living with HIV and hardest to reach populations' needs are addressed through a comprehensive approach. As we move towards a post-MDG era, strengthening linkages between SRH and HIV will provide a valuable example of how integration increases efficiencies, maximises investment and above all makes sense for improving individuals' health and quality of life.

According to Felicia Wong, the International HIV/AIDS Alliance's policy advisor: "We need to join up safe family planning and HIV services in order to make real headway in reaching vulnerable and marginalised populations and respond more fully to their needs. We also need to be mindful of the fact that integration will only work if countries really own their response and harness the power of community mobilisation which we have seen used so effectively in the HIV response."

She went on to say: "Raising awareness with communities on the types of health care services they have a right to receive strengthens national advocacy efforts, and leads to increased demand for services. The reality on the ground is that in many communities these services are of poor quality or may not even exist. It's vital that further advocacy and pressure is placed on governments to address the fundamental lack of primary health care services through increased funding, systems strengthening and increased human resources."

The writer is the media manager of The International HIV/AIDS Alliance(The Alliance) Kenya AIDS NGOs Consortium is the Linking Organization of The Alliance

Uganda: Can we Close the gaps?

By Jame Kityo

With a population of 32million people, Uganda continues to struggle with one of the highest fertility rates in Africa. The country also has a long way to go in attaining a truly responsive approach to sexual and reproductive health(SRH)intervention for all. The fertility rate which is estimated to be at seven children per woman, is risky to the economy and also signals danger for women who are reliant on traditional birth attendants (TBAs) while many of them still prefer delivering outside the designated health facilities.

Apparently,despite the need and interest in improving healthcare across the board, as stated in Uganda's public led sector policies, the allocations to the health sector since 2009 has not increased significantly. In some cases, funding to health has slightly reduced, ensuring that meagre resources that would have been channelled to ensuring safety of mothers during delivery, is not available. This is an unfortunate development, becauseany reduction in the budget allocation adversely affectssome crucial SRH services.

The budget estimates for Uganda in financial year 2010/2011 alone, showed that the portion of health sector allocations within the total budget was 10.2%. This is still indicative of a slight reduction compared with what had been offered in the years earlier (2008/09, which was 10.7%). At this trend, the much acclaimed target of the 15% Abuja Declaration on HIV/AIDS,Tuberculosis and Other Related Infectious Diseases, which the Government of Uganda signed in 2001, remains a hard challenge.

Priorities

Available statistics (Uganda Ministry of Finance, Finance, planning and economic development), show us that Uganda has made progress in broad areas within the health sector. The statistics indicate an increasing availability of basic medicines and achieving immunization rates of children against major killer diseases of 90%. In addition, we are told that infant and maternal mortality rates have been reduced to 54 per thousand persons and 352 per hundred thousand persons, respectively. However, the health care system still requires major improvements in access to quality basic health care, if some of these figures can be believed.

While reading the 2011/2012 national budget, Maria Kiwanuka, the Uganda Minister of Finance, planning and economic development, placed emphasis on strengthening the institutional facilities.

"Government's objective is to address poor child and maternal health, weaknesses in the drug management system, inadequate health infrastructure and personnel constraints" She said.

Focus is also placed in motivating and retaining health workers through gradual salary increases and construction of staff houses, construction of regional facilities in Karamoja,Kirudu, Kawempe. In addition they talk of rehabilitation of referral facilities. There are also specifics like the solar powered fridges, Emergency Obstetric Care (EmONC) lifesaving medicines and kits, family planning equipment and commodities to health facilities, with improved mechanisms for conducting maternal and pre-natal death audits.

"Protecting children from pneumonia and diarrhea by mitigating the effects of HIV/AIDS through undertaking prevention strategies such as ABC, Safe Male Circumcision, and elimination of mother to child transmission (PMTCT), while enrolling an additional 100,000 people infected with HIV/AIDS on Anti-Retroviral Treatment." The only problem with all these good ideas is that they are sweet to the ears and are sometimes never fully implemented.

Partnerships

The success of SRH rights and provision of an integrated range of servicesin Uganda has also benefitted from partnerships between the public and the private partnerships, like the Infectious Disease Institute (IDI and Mulago hospital, who are providing a range of services exclusively to Persons living with HIV/AIDS. Other organizations like International HIV/AIDS Alliance and MarieStopes International (MSI) are implementing maternal and, Family planning based interventions for specific communities in Uganda and beyond.

Challenges

One of the observable challenges to Sexual and Reproductive Health (and even rights) in Uganda, which an integrated approach for greater impact can address is the fact that there has always been anuneven share of donor funding allocated to somedisease areas, like HIV/AIDS and Malaria. In most cases thefocus is on treatment not prevention. This leaves other areaslike family planning, sexual and reproductive health rights (SRHR), Cervical and breast cancer screening, strengthening institutional networksfor increased and equitable access of services to hard to reach areas un attended to.

There are also retrogressive legislations, based on embedded stereo types and biased approach to the provision of SRH and other services in Uganda other African countries. A case in point is the threats to LGBTI and the lack of an open door policy to engagingtransactional sex workers. With an attitude encouraging people to bury their heads in the sand, it will always become very difficult to provide services to all, without discrimination. Withoutopenness to tackling disease and health hazards, sickness will remain in populations and everybody, including those who chose not to act,will eventually become sufferers.

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Tunza Family Health Network

The private healthcare sector in Kenya represents a significant share of the overall healthcare system in the country. More than one-third of healthcare facilities in Kenya are private. For many of the poorest Kenyans, private facilities are their first—and sometimes their only—choice when they need healthcare. However, regulation and oversight of these facilities is weak. In many cases, especially in rural and low-income areas, the staff at private facilities have inadequate education and training, and they provide services of very low quality. For those private providers who are interested in improving their skills and the quality of their services, opportunities for continuing education and skills development are scarce.

PSI/Kenya established the Tunza Family Health Network to support the development of a strong private healthcare sector in Kenya. Jointly funded by USAID and UKAID, the Tunza network contributes to a private sector that is coordinated, operating with harmonized service delivery quality standards, cost effectiveness, and quality metrics and data collection tools. The private facilities of the Tunza network act as a seamless component of the overall healthcare system, playing a truly complementary role in the delivery of quality healthcare in Kenya.

Tunza is a network of private healthcare providers serving low-income populations in Kenya, operating under the PSI Social Franchising business model. PSI/Kenya has used this model to increase the availability of quality health care by improving existing health facilities, a far more cost-effective approach than building and setting up new facilities. Tunza providers are medical practitioners—typically nurses and clinical officers—who have already set up a private practice, are licensed to operate a clinic, and have signed an agreement to join the network. By agreeing to serve as a Tunza franchisee, a provider commits to adhere to the standards and procedures of the network, but also enjoys access to training and continuing medical education as well as a number of other benefits.

Tunza franchises promise friendly, quick and affordable services offered by a qualified healthcare provider. The network currently has 295 active providers spread throughout all eight provinces of Kenya. The Tunza network accounts for 11 percent of all private facilities and 3 percent of all healthcare facilities in the country.

When the Tunza network was established in 2008, the flagship service was family planning with a focus on cost-effective, long-term and reversible methods such as intrauterine devices (IUDs) and implants. In the last two years, PSI/Kenya has integrated other services into many Tunza facilities, including cervical cancer screenings, sexually transmitted infection (STI) screenings, HIV Testing and Counseling (HTC), Voluntary Male Medical Circumcision (VMMC), and Integrated Management of Childhood Illnesses (IMCI). Most of the new services were started in 2011 and, in that year alone, 104,127 clients received HTC services with 98,772 agreeing to be tested for HIV. 4,904 of those tested were positive for HIV and referred to facilities where they could access care and treatment, usually public sector facilities. Also in 2011, 22,557 women were screened for cervical cancer at Tunza facilities. 295 had positive results and were referred to public sector facilities for further management.

Another recent innovation in the Tunza network was the introduction of a family planning voucher programme in July 2011. By December 2011, 33,949 low-income women had benefited from subsidized family planning services through the voucher program. New services added into the network in 2012 include a VMMC pilot in Nyanza province and the launch of the first phase of IMCI training for all Tunza franchisees, focusing on diarrhea and pneumonia case management.

Bridging the Gap, Delivering on the Promise