



# ECSCA Bulletin

Promoting Best Practices in Health Care

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## Region's Health Radar Screen in Sharp Focus

The 50<sup>th</sup> ECSCA Health Ministers' Conference - Kampala, Uganda

The 50<sup>th</sup> ECSCA Health Ministers' Conference (HMC) ushered in yet another opportunity for the region's leaders in health to focus attention on priority actions and interventions at a critical point in the Millennium Development Goals (MDGs) target period. The theme of the conference was "Improving Access to Quality Health Care to Achieve the Millennium Development Goals (MDGs)".

The conference which took place from 15-19 February 2010 at the Serena Hotel, Kampala, Uganda was inaugurated by The Right Honorable Eriya Kategaya, First Deputy Prime Minister, of the Republic of Uganda.

Once again the regions health radar screen came into sharp focus as participants all agreed that countries needed to direct more effort at the rapid expansion of proven high-impact interventions especially in Maternal, Newborn and Child Health which are both core MDG target areas as well as indicators of overall development of nations.

Ministers of Health from the region emphasised the urgency of moving from evidence to policy and action on critical health interventions if countries in the region are to report tangible progress on the MDGs in this last five year stretch. Based on extensive deliberations presentations by various experts from Ministries of Health, International Health Agencies and partners, Ministers passed a set of resolutions that will inform country efforts in the coming year in the following areas:

- Health Insurance and Financing
- Leadership, Stewardship and Governance
- Leadership and Management
- Improving the Capacity of HRH Departments
- Improving Maternal and Child Health/Family Planning
- Funding and Implementing HIV/AIDS, TB and Malaria Programmes
- Maternal and Child Nutrition
- Prevention of Non- Communicable Diseases
- Tracking Progress towards the MDGs
- Management of HIV/AIDS and Tuberculosis (TB) in ECSCA Region

The full text of the 50<sup>th</sup> ECSCA HMC resolutions is available on the ECSCA website at [www.ecsa.or.tz](http://www.ecsa.or.tz)

### Editors Note

From Evidence to Implementation: How do Countries Tilt the Balance?



Perhaps it was the riveting discussions at the pre-conference experts workshop on unsafe abortion that later generated more passionate discussions during the health ministers conference, highlighting the country positions on prevention and management of unsafe abortion along with the policy implications.

Alternatively, it may have been the equally riveting and passionate discussions at the pre-conference experts meeting on Task Shifting, as a strategy for addressing Human resources for Health in Reproductive Health and the ensuing rich discussion on available evidence on one hand, and the policy and implementation challenges on the other.

Or maybe the discussions on avenues and opportunities for effective health care financing in countries, with the accompanying challenge for suitable models for risk pooling to remove financial barriers and increase access to health care.

Whichever issue the conference took on this year, the urgency was clear. The dynamics and implications of translating evidence to actual implementation and impact was a constant theme.

Increasingly, the consensus was that if the region has to make progress on the MDGs during this critical last five-year stretch, then countries have to shorten the learning curve drastically.

The highlights of these rich deliberations are captured in the conference report that will soon be available on the ECSCA website at [www.ecsa.or.tz](http://www.ecsa.or.tz)

## Media Forum

*In this edition of the Bulletin, we include articles written by members of the ECSA Health Journalists Network, who participated in the 50<sup>th</sup> ECSA Health Ministers Conference. The writers have attempted to capture some of the deliberations, discussions and challenges identified during the meeting from a media perspective. The journalists had an opportunity to interact with technocrats and other senior officials during the conference and put pen to paper on issues of interest in **Family Planning and Reproductive Health**. The views expressed by writers are their own and do not represent the position of the ECSA Health Community.*

### Where Did We Go Wrong?

By Isaiah Esipisu

***We have thousands of unemployed Nurses, yet there is a huge deficit of the Nurses. And now, we want to employ someone else to perform their duties***

As much as evidence-based studies indicate that Community Health Workers can safely and effectively administer injectable contraceptives, paying them for the services is slowly becoming a concern especially in countries where thousands of trained nurses and other health workers do not have jobs.

So far, a 2004 trials conducted in the Nakasongola district in Uganda demonstrated that if Community Reproductive Health Workers (CRHW) are given proper training, they can successfully administer injectable contraceptives just like the professionals as long as they are supervised.

Another ongoing trial in Tharaka district in Kenya has shown early signs of success, where more than 500 individuals have already been injected with the Depo-Provera by community based workers without recording any complication. Malawi, Tanzania, Zambia and other countries within the East Central and Southern African Countries are in the process of planning their trials for the same.

But is it morally viable in countries where fully trained health workers have no work to do? "It is a great idea to involve RHCW in this because they are more acceptable to communities. But when we talk of paying them, or extending incentives to motivate them, what message are we sending out to the fully trained experts who do not earn a cent from the profession?" asked Dr Margaret N Meme, a Senior Assistant Director of Medical Services – Reproductive Health Division, in the Kenyan Ministry of Public Health and Medical Services.

Statistics indicate that Kenya teems with upto 8,000 trained nurses who do not have employment, yet the country has a deficit of 44,000. It is the same situation in Uganda, where media reports indicate that 80,000 nurses are needed to fill health facilities, with an irony of thousands seeking for jobs.

At the same time, the employed nurses are not satisfied with their remunerations. "840 employed Kenyan nurses apply for jobs outside the country every year, with most of them preferring to work either in the US or in the UK," said Elizabeth Oywer, the Registrar, Nursing Council of Kenya.

The arguments came up during a consultative workshop for task shifting in Uganda with a focus on injectable contraceptives, where some participants wanted a clear line to be drawn indicating whether the RHCW should be paid or not.

Researches have shown that injectable contraceptives are the most preferred methods of family planning in all the ECSA countries. At the same time, experts say that it is one of the most effective methods, with very limited chances of contraceptive failure.

"These are the reasons why we want to scale up the uptake of the injectable contraceptive. And involving community based workers is not only affordable, but also acceptable in several countries within the region," said Dr Odongo Odiyo, the Manager – Family Planning and Reproductive Health at the ECSA Health Community secretariat.

Apart from administering injectable contraceptives, a method that required a slight medical skill, studies have identified community health workers to be the most effective group for reaching out to communities within the African setting.

They have been used in management of sometimes very contagious diseases such as tuberculosis, HIV/AIDS, worked as birth attendants among several interventions. However, this is the very first time they are being involved in administering injections.

The consultative meeting on task shifting finally developed recommendations that would see RHCW involved in providing injectable contraceptives in seven ECSA countries including Kenya, Uganda, Malawi, Tanzania, Lesotho, Zambia and Zimbabwe.

All the countries are now working on the evidences to inform policy development in the government.

# ECSA states attempt to deal with restrictive laws on safe abortion

By Caroline Somanje

Senior ministry of health officials and technical experts from ECSA members states believe that universal access to comprehensive sexual and reproductive health may be far from being attained in the region unless the issue of unsafe of abortion is addressed, by among other things, dealing with restrictive laws that drive many women to their deaths through deadly methods of pregnancy termination from quacks.

The officials made their fears known at a two-day, Ipas supported workshop in Kampala Uganda titled “improving maternal health in ECSA region with a focus on unsafe abortion”, ahead of the 50th ECSA health ministers’ conference. The workshop brought the group together to review reproductive health in the region, with a particular focus on safe abortion.

They agreed that it was time governments in the region considered the issue of unsafe abortion as a reality that continues to affect many women, families and that it occurs on daily basis in spite of its illegal status.

“African Countries have some of the most restrictive abortion laws in the world with serious consequences for women’s reproductive health and rights. This has caused an increase in numbers of unsafe abortions, maternal death and disability. Presently there is an attempt of growing trends towards liberalization of the restrictive laws guided by the Maputo protocol and other international treaties,” said Winnie Lichuma com-  
*(turn to page 4)*



*A team from Zambia in a discussion session during the experts workshop on Maternal Health ahead of the 50th ECSA HMC*

## ECSA receives Grant for FP and Reproductive Health

By Caroline Somanje

The official opening of the 50th Health Ministers Conference (HMC) on Wednesday, 17th February, 2010 was characterised by among events, the launch of the Money Well Project of TIDES foundation which has given ECSA a US\$ 1, 060, 000 grant to improve the effectiveness and efficiency of funding for family planning and reproductive health in the region.

Acting director general Dr. Helen Lugina told a roundtable meeting for ESCA’s stakeholders and partners three days before the HMC conference that ESCA was selected among six organisations worldwide to receive funding totalling over US\$2.7 million after what she described as a rigorous review process involving more than 150 applications.

She said the three year grant will be used to increase commitment from policy makers, service providers, strengthen donors and partners’ collaboration as well as integrate family planning with other health services.

Dr. Lugina’s announcement came after participants to a pre-conference on improving maternal health in ESCA, focussing on unsafe abortion expressed worry at inadequate allocation of funds towards the health sector by their governments, in particular FP services.

She said the main objective of the roundtable was to provide an opportunity for stakeholders in ECSA members states and partners to be briefed and become familiar with the project as well as agree on modalities for its implementation in order to ensure maximum results.

Said Dr. Lugina: “The secretariat will over the next three years undertake a series of activities aimed at integrating fostering change approaches into programmatic activities focussing on among other things prioritising FP and reproductive health, and identifying documentation, sharing and scaling up of best practices”.

## Unmet Need for Family Planning: Need for Fresh Impetus

Zipporah Karani

Many of the Sub Saharan Africa’s most successful family planning programmes are “fragile” that is they have experienced marked reduction in the rate of progress, if not a complete halt as reflected by the countries levels of modern method contraceptive prevalence, total fertility, and unmet need for modern contraception.

With the United Nations Millenium Development Report 2009, estimating that 99% of annual deaths due to complications related to pregnancy and child birth occur in the developing countries, recent efforts have focused on highlighting the link between reduction of maternal mortality and effective family planning initiatives in the region

## Laws on unsafe abortion *(continued from page 3)*

missioner with the Kenya human Rights Commission.

The World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy which is carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Lichuma said, while attempts have been made to reform abortion laws legislatively in the region, very few countries have succeeded in their flexibility, with South Africa being the only country that allows abortion without restriction as to reason.

Research has shown that women procure abortions through the ingestion of herbs, bleach, gasoline, gunpowder, vaginal insertion of sharp tools, twigs, pouches filled with arsenic, voluntary blows to the stomach and intentional falls

From an overview of unsafe abortion status in the ECSA region, University of Nairobi's professor of obstetric and gynaecology Joseph Karanga said Africa, especially the sub-Saharan has the greatest toll of unsafe abortion in terms of its contribution to maternal mortality

He said out of 70,000 unsafe abortion deaths related worldwide, 40,000 occur in Africa which is also characterised by low contraceptive and high unmet need for family planning.

"Abortion laws are generally restrictive and stigmatised. Even in the few countries where the law is less restrictive, access to services is low. Apart from South Africa, Zambia and Zimbabwe's laws are less restrictive unlike Kenya, Uganda, Tanzania and Malawi," he said.

The restrictive laws demand among other things permit an abortion only for saving the mother's life, seek the opinion of two other doctors, parental or spousal consent and pass out stiff sentences to those who give or seek abortion.

Ipas, one of ECSA's partners that is committed to implementing safe abortion services in Africa says safe abortion is one of several essential reproductive health services that must be considered by countries.

Legally restricting abortion does not necessarily reduce the number of abortions that occur in a country. Where abortion is legal and safe services are available, deaths and disabilities from abortion are greatly reduced," said Ipas's Dr. Brookman Amissah

She said that in some countries, as much as 50% of hospital Ob/gyn budgets are spent treating complications of unsafe abortion.

## The Easiest Way to Arrest After-Birth Bleeding in Africa

By Isaiah Esipisu

A drug commonly used for treatment of gastric ulcers has another life saving trait, for its ability prevent, and cure postpartum haemorrhage (excessive bleeding after child delivery) which is the main cause of maternal mortality especially in the developing world.

Several studies, including one by the World Health Organisation have found that a single misoprostol tablet is able to arrest bleeding after either a vaginal delivery or delivery by caesarean in just five minutes after the uptake.

And now, experts from the East Central and Southern African (ECSA) region are advocating for Home Based Birth Attendants to be equipped with the drug, which at the moment is sold by prescription only in many countries.

"We have enough evidence demonstrating that misoprostol, whether used by skilled health experts or by unskilled midwives can have a huge impact on reduction of maternal mortality," said Dr. Alice Mutungi, a senior lecturer at the department of obstetrics and gynaecology, faculty of medicine at the Kenyan based University of Nairobi.

According to a WHO statement on use of the drug for postpartum haemorrhage prevention and treatment, severe bleedings after birth are the major causes of maternal mortality, especially in Sub-Saharan African region.

WHO however recommends the use of misoprostol in settings where it is not possible to access oxytocin or other injectable drugs. But the statement advised that Traditional Birth Attendants must be given proper training on its use, and should avoid administration before birth at incorrect doses.

Researches indicate that about 60 to 80 per cent of deliveries within the ECSA region occur at home without skilled care. "It is not possible to predict postpartum haemorrhage on the basis of risk factors even at the hospital setting. This means that every pregnant woman is potentially at risk. Yet it becomes even worse when she has to deliver at home without a skilled midwife," said Dr Mutungi, who also works at the Kenyatta National Hospital.

She says that misoprostol is ideal because it causes strong uterine contractions, acts within three to four minutes when given orally, is cheap, has no contraindications, does not require skilled providers, and it is easy to store since it does not need refrigeration. *(turn to page 5)*

# Media Forum

## Arrest After-Birth Bleeding

However, she is quick to point out the limitations of the drug; “It is less effective than oxytocin (an injectable drug), causes shivering as side effect, and can easily be subjected to abuse,” she warns.

A spot check in three different pharmacies in Nairobi Kenya (where it is strictly sold as a drug for ulcer treatment) revealed that a packet containing 36 misoprostol tablets retails at US\$ 3. Yet according to gynaecologists, a woman needs to take just one tablet to prevent or stop postpartum haemorrhage.

During a forum on best practices in healthcare, held in Arusha Tanzania, Dr Isaac Malonza of Jhpiego/ Kenya pointed out that misoprostol was a suitable intervention drug for countries or regions where a large proportion of births are not attended by skilled providers.

“However, it is important for countries to invest sufficiently in training midwives at community levels and supervision on how the drug is administered.

So far training and counseling materials, program implementation guides, evaluation tools, and posters are already available for adaptation.

Researches have shown that four in 10 women die of pregnancy related causes each year in Sub-Saharan Africa region, mostly due to bleeding after birth. Another report from the Population Action International indicates that an average of 980 women in 45 African countries die of maternal causes for every 100,000 births.

In Kenya for example, the government statistics indicate that 700 women die every year due to pregnancy related complications. Yet most of the deaths are either due to unsafe abortion, or severe bleeding after birth.

“All these are preventable deaths. What we need is to have correct policies in place, dissemination of knowledge, and access to healthcare facilities without delay,” said Dr Odongo Odiyo, a gynecologist and Manager for the family and reproductive Health Programme at the ECSA Health Community.

## Notable quotes from experts’ workshops

By Caroline Somanje

The debate on task shifting and other issues generated a lot of comments, individual country perceptions and reactions during the 50<sup>th</sup> ECSA HMC:

### Notable quotes in reaction to various presentations and debates during the 50<sup>th</sup> HMC

“The capacity to train is there but the few we train are taken though brain drain”.

“Why load the community when governments are busy buying 4X4s without considering any form of incentives?”

“Essentially, our problems of human resource shortage stem from foreign policy. The issue of migration should be addressed at that level before looking for alternatives”.

“We need to ask ourselves, what is your abortion laws saying? Is government only responsible for those who are morally correct?”

“If most countries legalized abortion, more women will die. We should rather focus on male involvement



**EAST, CENTRAL & SOUTHERN AFRICAN HEALTHY COMMUNITY  
IMPLEMENTING THE HMC RESOLUTION ON TASK SHIFTING, FOCUS ON  
INJECTABLE EVIDENCE REVIEW AND DEVELOPMENT OF COUNTRY WORK PLAN  
12-13 FEB. 2010 IMPERIAL ROYAL E HOTEL KAMPALA UGANDA**

# Free Contraceptives in Kenya still not reaching the Poor

By Isaiah Esipisu

Despite the fact that the government of Kenya distributes contraceptives free of charge to both public and private health facilities, it is clear that poor women who live on less than one US dollar per day cannot afford to pay money charged by health experts for inserting implants.

“Failure for the government to control the cost of services offered by health practitioners has turned the would-be free contraceptives to a lucrative business especially for private practitioners, making it unaffordable to the intended users,” said Rael Atieno, a community health worker in Western Kenya.

A spot check in various clinics and hospitals in the country has revealed that clients pay different amounts of money, ranging from US\$ 3 in government health facilities to US\$46 in private clinics for insertion of an implant or a coil.

“The most ideal cost to be charged by private practitioners would be US\$ 6 for inserting an implant like Jadelle. But sometimes the cost depends on how the client presents herself. But sometimes we subject it to bargain,” said Japheth Akwabi who operates a clinic in Mumias, 500Km west of Nairobi city.

However, the US\$ 6 price-tag remains unaffordable for several people living in rural Kenya. Under normal circumstances, casual laborers earn slightly above one US dollar for working on someone’s farm. This means that she has to work for one week and save 100 per cent in order to undertake a family planning measure.

In Nairobi, charges for inserting an implant were as high as US\$ 46 with a consultation fee of US\$ 13 in the majority of clinics within the city centre. However, other private clinics within low class estates were charging a total cost of US\$ 100 for the same service.

According to Dr Simon Kigundu of the Kenya Medical Association, the government does not have clear guidelines providing a range of service-cost for such contraceptives. “Though we distribute them free of charge, the doctors have the prerogative to decide how much a client should pay in order to benefit from the product,” he said.

He says that the service-charge by health professionals has made it difficult for poor Kenyans who unfortunately have the heaviest burden of huge families to access such highly effective contraceptives despite of them being distributed free of charge.

“I have been forced to rely on the injectable contraceptives because they are absolutely free of charge in government health centers, despite the side effects. I cannot afford the US\$ 3 required for the implant at the same clinic. The little money I make is used for food and other basic needs,” said Judith Njeri, who sells food by the roadside in Dandora sprawling estates in Nairobi.

Jadelle is a reversible contraception used by women. It contains two thin flexible rods made of silicone tubing and filled with levonorgestrel, a synthetic progestin. The rods are inserted just under the skin of a woman’s upper, inner arm in a minor surgical procedure.

Protection from pregnancy is provided within 24 hours, when insertion is performed during the first week of a woman’s menstrual cycle. The woman rapidly returns to her normal fertility when the implants are removed. The most common side effects are changes in menstrual bleeding patterns. Most other common side effects are similar to those experienced by women who use other hormonal contraceptives.

The method replaced the Norplant, which used to function in the same way but required six rods to be inserted. The contraceptive has since been faced out of the market because it was not as convenient as the Jadelle.

In Kenya, there are two implant products thus Jadelle and Implanon. Both products are considered to be highly effective in preventing pregnancy, and are provided for by the government free of charge through both public and private health facilities countrywide.

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*The ECSA Bulletin welcomes articles from health journalists and technical experts on topical issues in health from the region.*

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