EARHN

Newsletter

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Cover Photo: clinic - Northern Uganda

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EARHN

Eastern Africa Reproductive Health Network
EARHN

From the chairperson...

I have the pleasure to present to you the EARHN News letter. It has been indeed a pleasure to be part of the revival of this very important network. Given the imperatives of change, such inter governmental alliances are relevant as we look for new avenues and innovative ways to move the reproductive health agenda with in the region.

The Eastern Africa Reproductive health Network was founded in 1996 to support population issues through enhanced south -south cooperation. The network has already started galvanizing regional efforts to create and strengthen networks with in member countries sharing of experiences and expertise, transfer of skills and technologies and holding each other accountable in the areas of Reproductive Health, Population and Development. We have succeeded together in revamping this network and putting it back on track.

A four year strategic plan has been re developed and it was indeed important in providing the general framework and refocus on the merging and complex issues that need to be given priority in order to achieve the ICPD goals and the MDGs .The main focus during the coming four years will be on repositioning Reproductive Health as a central component in ensuring sustainable development through the South – South Cooperation as a modality of change.
We welcome Burundi, Rwanda and Ethiopia on board and we wish that other countries in the continent join hands together to address burning Reproductive Health issues specific to the continent.
We are confident that with the blessing of all our stakeholders, we will remain the forerunner in the pursuance of our mission.

Mr. Charles Zirarema
The Chairperson, EARHN

CHILDREN LIVING WITH HIV...

Access to information crucial in HIV fight..

One-year-old Maria sits listlessly on her mother's lap, her frail right hand tugging at one of her mother's breasts, while she hungrily sucks at the other.

Realising that there is nothing coming from the breast, she gives up and, laying her head on her mother's chest, gazes into the distance.

Around her, deep inside Nalweyo sub-county, Kibaale district, children play with the neighbour's four-month old twins. Maria's mother, 40-year-old Federesi Kaahwa watches them. Sighing heavily, as if wondering whether her own little one will one day engage in such antics, she turns her attention back to us.

Thin, pale and sickly, Maria has no idea what is going on in her life, or why. Her appearance strikes a chord in my heart, and my eyes quickly well with tears. Fighting them back, I think of my own one-year-old daughter back at home, and imagine that it could have been her.

Young and innocent as she is, Maria is HIV-positive. Hers is a situation many other children have known. Some have succumbed to the disease very early on in life, while others are still fighting, given hope by the increasing access to anti-retroviral treatment.

Maria's fate is entwined in that of her mother, who is HIV-positive. A widow, Kaahwa's husband died eight years ago, leaving her with four children – aged ten, eight, seven and five. Unknown to her, her businessman husband had another wife with whom he also had four children.

Kaahwa did not consider herself to be at risk for infection until she heard messages on voluntary counseling and testing disseminated by a project run by the Orthodox Church, supported by the Population Secretariat. She then decided to take the HIV test.

The first test came out negative, as did the second, but the third time she was not so lucky. The test showed that she was HIV-positive.
"I was advised to go to the hospital for help after this. I am now on anti-retroviral treatment," she says.

After her husband's death, Kaahwa began a relationship with a casual labourer, which resulted into Maria. The man, a target worker who had just come to the area to make some little money, later returned to his home, leaving Kaahwa pregnant.

Asked why she decided to engage in unprotected sex after finding out that she was HIV-positive, Kaahwa says "it was due to lack of information about the probable consequences." She neither knew the partner's HIV status nor did she think she could just been pregnant.

Even at the hospital where Kaahwa delivered from, was unaware of her HIV status, which could have contributed to baby Maria contracting the disease as available drugs to prevent mother-to-child transmission were not given to Maria upon birth. The same reason explains why Kaahwa has been breastfeeding Maria, and is just in the process of weaning her after being advised to do so by medical personell.

Today, many people in urban areas know how children contract HIV from their mothers, and are able to seek the right avenues to prevent it. However, in the rural areas, information on HIV transmission is not widely disseminated.

In Nalweyo sub-county, where Kaahwa stays, it is not easy to access health information and services. Many women resort to Traditional Birth Attendants (TBAs) to help them give birth, because the hospital is over 20 kilometres away and they would rather spend the Ug. Sh3,500 bicycle fare on buying food for their children. What guarantee do they have, therefore, that the TBA will take into consideration the fact that the mother is on when delivering the baby to ensure it is not infected with

the virus if it was not infected before? Lack of information is therefore a foe in the struggle to stem HIV infections in rural areas. Many of the public information programmes on HIV are targeted at and concentrated in the urban areas, yet according to the Food and Agriculture Organisation (FAO), AIDS is becoming a greater threat in rural areas than in cities. In absolute numbers, more people living with HIV reside in rural areas. The epidemic is spreading with alarming speed into the remotest villages, cutting food production and threatening the very life of rural communities. Every day in the world, about 1,200 children under the age of 15 become infected with HIV, and in 2007, UNAIDS estimated there were 2.1 million children living with HIV, approximately 90 per cent of whom live in Africa. The majority of these children either acquire HIV before they are born, during pregnancy or during delivery or when they are being breastfed (if their mother is HIV-positive).

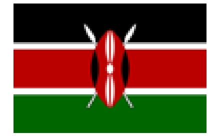
Kaahwa has been breastfeeding Maria, one avenue through which the baby could have gotten the disease. Maria is not on medication because, as her mother says, treatment is only available at the main hospital, which is difficult to reach, yet it is known that without HIV treatment and care, HIV multiplies and destroys children's defense to infection, leaving them less able to resist pneumonia and other common childhood infections.

It is generally understood that about 50 per cent of children who acquire HIV from their mothers die before their second birthday.

Like any other mother, losing a child, or knowing that something is wrong with them, is very heartbreaking. This is why Kaahwa has not taken any of her older children for HIV testing.

She says that at the moment they are healthy, and she is contented with that. If only things could stay that way.

By: Sylvia Nabanoba
Uganda



Safe motherhood vouchers piloted in Kenya

A PILOT VOUCHER SCHEME IN KENYA IS GIVING POOR PEOPLE AN OPPORTUNITY TO ACCESS QUALITY REPRODUCTIVE HEALTH SERVICES from health facilities they would otherwise not access due to cost. This scheme is known as the Reproductive Health – Output Based Approach (RH-OBA) Project and is being piloted in Kisumu, Kiambu, and Kitui districts as well as Korogocho and Viwandani slums in Nairobi.

Through the use of a poverty tool, voucher distributors recruited by the project screen clients for eligibility before they purchase a safe motherhood (SMH) or a family planning (FP) voucher at a subsidized price of Kshs 200 and Kshs 100 respectively. With the safe motherhood voucher, a client is entitled to access the following services from an accredited service provider: four antenatal care visits, birth by either normal delivery or caesarean section, and a postnatal care visit within 6 weeks after delivery.

The FP voucher entitles a client to access any of the following contraceptives from an accredited health facility; Implants, IUCDs, vasectomy, and tubal ligation. In addition to the services provided under the two vouchers, the project also caters for clients who require gender based violence (GBV) recovery services. Under this arrangement, survivors of GBV are provided clinical examination, treatment, and counseling.

A client with a voucher is required to present the voucher to an accredited service provider in exchange for services. At the end of each month, the accredited service providers submit claims for the services rendered. These claims are submitted to the Voucher Management Agency (PricewaterhouseCoopers) and the population council for processing and payment. The maximum reimbursement levels for SMH and FP services are Kshs 21,000 and Kshs 3,000 respectively. Government, private, NGO, and FBO service providers are eligible to participate in this project if they can meet the required standards for providing the targeted services.
The basic principle of the RH-OBA project is that financing inputs does not always result in the desired health outcomes. As a change of paradigm, the project's approach is to finance pre-defined outputs which are closely tied.
Since the inception of the RH-OBA Project in June 2006, a total of 38,945 poor SMH clients and 4,288 poor FP clients from five sites had benefited from the project as at the end of December 2007. The results of the safe motherhood are an increase of about 20% over the number of similar clients in the accredited facilities before the commencement of the project. The distribution of these SMH and FP voucher clients is shown in the charts ,
Kiambu and Kisumu had the highest uptake of long-term FP methods among the poor people, though the figures are generally low. Kitui district had the lowest uptake of FP methods. In all the sites, implants were the most preferred method.

The mid term evaluation of the project was undertaken in December 2007. Findings of this evaluation show that the project's approach has been successful in targeting the neediest clients. It also points out that this kind of approach works well in urban and peri-urban areas.

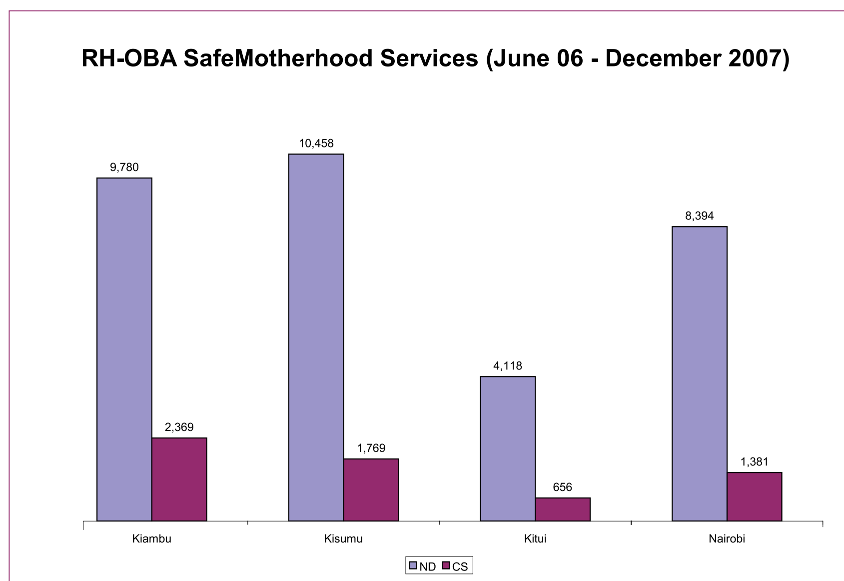
In the rural areas challenges related to communication hamper the uptake of services and this largely explains the low figures for Kitui district which is expansive and has comperatively poor communication infrastructure.

Other challenges experienced by the project include the low uptake of Gender Based Violence (GBV) recovery services. By the end of December 2007, 250 clients had been served in all the sites. The sensitive nature of GBV has been ascribed as the cause and efforts to create awareness on the matter at the community level and encourage reporting and seeking of GBV services have been implemented. However, that this kind of service may not be suitable for a voucher scheme.

In addition cases of fraud by some distributors and service providers have been detected especially during the initial months of the project.The Voucher Management Agency responded by cancelling some vouchers and disqualifying errant distributors and service providers.

"Cases of fraud by some distributors and service providers have been detected..."

by Charles N. Oisebe
Kenya



Background:

The Reproductive Health – Output Based Approach Project (RH-OBA) is a joint venture between the Government of Kenya (GoK) and the Federal Republic of Germany. An agreement to undertake the project at a total cost of Euros 6.579 million was signed between the two parties on 7th March 2005. Funds to finance the project are largely provided by the Federal Republic of Germany through KfW Bankengruppe. GoK is also providing some funds to the Project. The objective of this venture is to improve access to quality reproductive health and family planning services through a voucher system for the economically disadvantaged people living in the 5 project sites. The project is being piloted for a period of 3 years.

The lessons that will be learnt from this project are expected to contribute further to the formulation and implementation of the National Social Health Insurance Fund that is being considered by the Government. In addition, the project is expected to help in reducing the maternal and infant mortality rates in the five sites of operation. It is also envisaged that health facilities in the project sites will improve on the quality of their services as a result of the incentives that are being offered by this project.

The Ministry of Planning and National Development through the National Coordinating Agency for Population and Development (NCAPD) is overseeing the overall implementation of this project. An Advisory Board and a Steering Committee have been put in place to assist NCAPD in overseeing the implementation. PricewaterhouseCoopers and Population Council have been jointly contracted as the Voucher Management Agency (VMA) for the project.
For additional information contact NCAPD through;
Email: info@ncapd-ke.org,
Phone: 020-2711711

Caesarean Deliveries:

Are they becoming common place and prone to abuse in developing countries?

Caesarean delivery rates are rising among mothers in many developing countries, and likely exceed the 15 percent limit recommended by the World Health Organization in 2005.

Caesarean deliveries are especially common in some Asian and Latin American countries, accounting for many as 40 percent of babies delivered—but not in Africa, where they account for just 2 percent of deliveries in some countries.

Within countries, caesarean deliveries tend to increase sharply with wealth. Less than 1 percent of women in the poorest households had caesareans in many countries—below the minimum rate required to cover fatal complications. Rates are much higher among wealthy women—nearing 80 percent in some countries. Indications have shown that caesareans can provide maternal health solutions in case of complications and can also reduce high maternal mortality rates. However, caesareans are prone to abuse (more so in developed countries) and are sometime utilized in non-emergency situations.

Below, health experts answer some critical questions on the importance of caesareans, linkages to MTCTs (Mother to Child Transmissions), availability of these services as life saving options and policy options as well.

Question:
Women who undergo a Caesarean Section (CS) are regarded as failures in Nigeria. This makes even the wealthy ones who can afford this very expensive procedure not to willingly accept it, except as a last resort to save the mother's life. This procedure is very expensive and it seems many doctors do not want to prescribe it to their patients because of these beliefs. How can CS be made more attractive to both experts and women in Nigeria where the mortality rate is as high as 1000 deaths (per 100,000 life births?)

Answer:
Community education is needed so that women and families recognize that cesarean can truly be a life-saving procedure.

Qualitative research from West Africa has shown that women needing cesareans sometimes face severe reactions when they return home from the hospital for having "failed" at childbirth, for subjecting their families to the expense required for the procedure, and for not returning with an infant on their backs (when the child does not survive).

Question:
Do you see a role for HIV programs in developing countries to support local health systems in providing safe caesarean-sections? There is good evidence that elective caesarean-sections can lower MTCT around two-fold and funding in many countries for HIV related programs are often far greater than for maternal health programs. How can the two be linked?

Answer:
I do not know of anyone in the maternal health community who is a proponent of routine caesarean for HIV positive women. It is important to try and achieve safe and appropriate caesarean via the traditional routes of pre and in-service training, clinical audit, insurance schemes to address financial barriers and an increased role for NGOs to address transport for emergency referral.

Question:
Although more than 80 % of women from high income group go for caesarean, less than 1% of women of low income group have caesarean. Does this mean the services are not available or unaffordable by the latter group? Can you suggest some ways to cope this problem?

Answer:
When one sees rates above about 20%, I think most would agree that this must include some non-medically indicated caesareans.
The issue of caesarean on maternal request is controversial; some consider it a woman's right, some argue caesarean delivery can be safer than vaginal delivery, some argue it is less safe and some argue it is not a good use of health care resources. A fair amount of experimentation is on-going regarding provision of caesarean for all women and for for poor women. Governments have found it difficult to assure on-going, timely and adequate reimbursement of funds to hospitals to cover these costs.

Question:
Caesarian deliveries are a quick but efficient solution to a complex maternal health issue. How do nations, especially developing nations, implement national and local level policies to ensure that caesarean deliveries are available to all those who need it?

Answer:
Extensive efforts have been made to document why caesareans are being done across many developing countries. Although information is recorded whenever a caesarean is being done, it was rarely that this information included indication for caesarean among the indicators that they collect in their routine health information systems.

Question:
What have caeserean deliveries got to do with health systems status? How can these deliveries be addressed in regards to the practitioners and the public, especially the wealthy part of the population?

Answer:
The caesarean rate will be affected by the distribution of comprehensive versus basic emergency obstetric care facilities. And, some countries require families to purchase a caesarean kit before the caesarean can be performed.

Question:
Do you think that the Caesarean deliveries cases are on the increase as doctors have discovered a new way of making more money?

Answer:
I'm sure that in some places there are financial incentives for providers to perform caesarean, but it would be unfair to pin all the blame on that. In some countries, the cost of a caesarean is

the same as the cost of a vaginal birth to discourage performing caesarean for financial benefit. Caesarian for life-saving purpose should be widely welcomed.

Question:
In Zambia, caesarean births are only considered as a last option to save the mother and child. People beilive that for a woman to have a caesarean-section that the husband was having extra marital affairs and this caused the to woman fail to have a normal vaginal delivery.

Answer:
Your question makes me realize that we really do have a serious problem in how we talk about this issue.

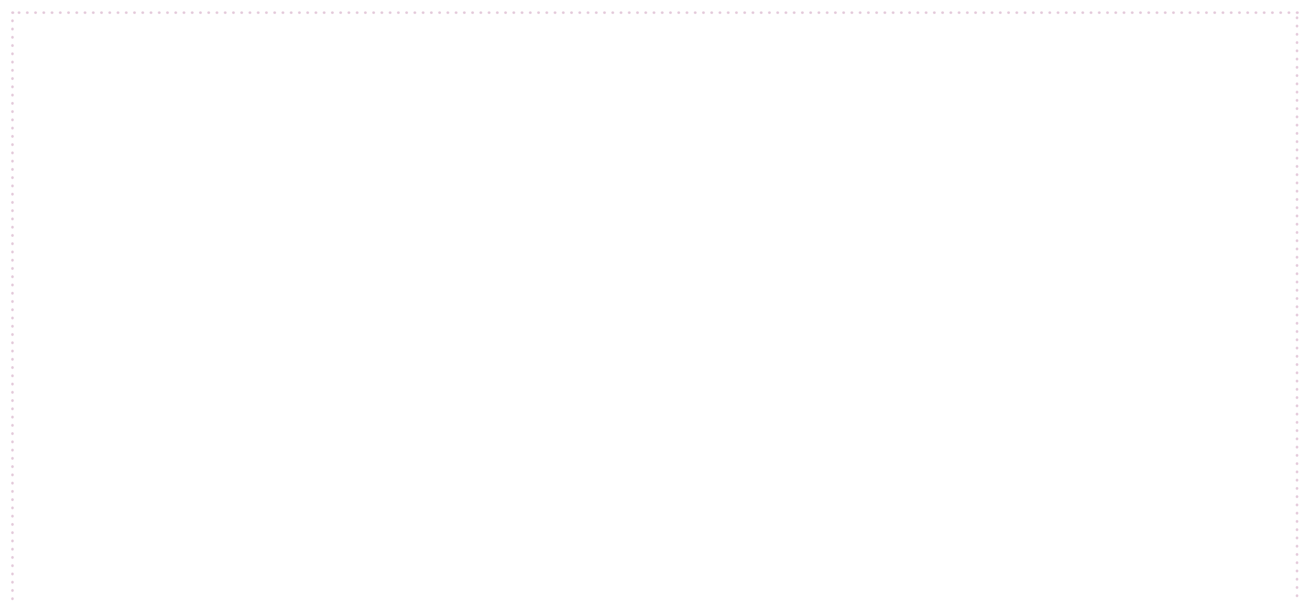
Question:
Some developing countries, I am thinking of Mali, have put in place a policy that provides free caeserean for women to overcome the cost barrier. There has been some discussion that this policy has led to increase demand for c-section since normal assisted delivery is still fee based. Do you know of examples of other policies/ strategies that have been put in place which address the cost barrier to accessing caesarean in developing countries?

Answer:
Several West African countries are trying innovative approaches to improving access to emergency obstetric care, and I really hope these efforts are being documented in a rigorous manner because we have so much to learn from them. However, clearly, more work is to be done as in the case of Ghana. The policy was put into place, but was very difficult to sustain, for example facilities were not reimbursed in a timely manner, putting facility staff in a very difficult position.

Question:
You have mentioned more than once in your responses that people in Asia and Africa do not want to talk about c sections and the issues. What do you think are the reasons why no one wants to discuss the issue?

Answer:
The issue seems to make people very uncomfortable. I had the same experience (talking about free access to caesarean for women in need) with a group of surgeons dedicated to the repair of fistula. You would think that of any group, this group would jump on board. But, actually, there was hesitation. This just tells me there is a great deal we don't understand. I think this whole area is very fertile ground for qualitative research - again, on both the supply and the demand side.

Adopted from Population Reference Bureau An Interview with Dr. Cindy Stanton
www.prb.org



OPINION..

A Comparison between Sexual and Reproductive Health in Uganda and the United States

As an American student of Public Health volunteering at Population Secretariat in Kampala, Uganda, I have encountered reproductive health issues that I have heretofore only read about in text books.

Compared with the United States, Ugandans have higher fertility, higher rates of HIV and other sexually transmitted infections and poorer access to family planning and other reproductive health services. In this light, volunteering with Population Secretariat has given me an opportunity to work where the need is greatest. However, despite the disparities between the United States and Uganda, they share a common limitation in improving and maintaining reproductive health: poor access to safe and legal induced abortion.

Although abortion is legal in the United States, pro-life activists and the religious right interfere with its provision: they stage demonstrations outside abortion clinics in attempt to dissuade women from procuring legal abortions and they lobby for more restrictive abortion laws. Therefore, despite its legality, abortion is becoming increasingly difficult for women to obtain and for health care providers to perform. In 2005, 87% of counties in the United States did not have an abortion provider, further compromising access to this essential service. Despite the United States' prolific biomedical research and relatively high

standard of living, the majority of the developed world has better access to abortion, and consequently better reproductive health indicators.

In Uganda, access to abortion is even worse than in the United States. In order to obtain a legal abortion, the pregnancy must pose a threat to the woman's life or, to obtain an illegal abortion, the woman must have sufficient funds to pay for it. Women can receive abortions only under the most severe circumstances or if they have the resources to pay health care providers who will provide them illegally. Because of this, women seeking to end their pregnancies are forced to resort to illegal and potentially harmful practices: ingesting large quantities of quinine or aspirin, drinking gasoline, or inserting sharp instruments into their uteruses. As a result, women suffer drug overdoses, hemorrhages, infections, permanent damage to their reproductive tracts and even death.

Gynecology wards in Uganda are filled with women experiencing incomplete abortions or the suffering from post-abortion complications: up to one half of beds on these wards are occupied by these women. A large proportion of health care expenditures go to providing post-abortion care, and women who die from post-abortion complications account for some 20% of maternal mortality.

Women are so desperate to end their pregnancies that they will risk their lives. Some estimates state that roughly half of all Ugandan women will require medical care for induced abortions at some point during their lifetime, and 15 out of 1000 women of reproductive age (15-49) are treated for post-abortion complications annually.

During my first few weeks in Uganda, I heard part of an abortion debate on the radio. Several men called in with the opinion that abortion is the result of loose morals and irresponsible sexual behavior, that abortion is only necessary for those who are having extra-marital sex

.."the majority of the developed world has better access to abortion."

or who do not trust in God's divine plan for them and their families. They do not believe that Ugandans need abortion services. However, this attitude does not take into account the numerous and varied situations that can result in unintended pregnancies. First, this assumes that all sex is consensual sex, although we know that women can become pregnant following rape or coerced sex. Second, this implies that women can refuse sex or use contraception if they do not wish to become pregnant. However, this attitude fails to recognize that a woman may receive undue pressure from her husband or family to procreate, or may be the victim of physical or verbal abuse if she refuses sex or suggests the use of family planning. Finally, this implies that family planning methods and the women who use them never fail. Indeed, we know that this is not the case. Therefore, even if a woman only has sex when she wants to, with whomever she desires and uses contraception, she may still become unintentionally pregnant

I believe that in the United States as well as Uganda, abortion services should be expanded to improve reproductive health. There will always be a need for abortion services, as women will always encounter situations in which they do not wish to be pregnant, but become pregnant nonetheless. Currently, large amounts of scarce resources go into providing health care services for women suffering from post-abortion complications. The provision of safe, legal abortions would drive down health care costs and improve maternal and child health. I believe that the work that Population Secretariat is doing is essential to improving reproductive health, and efforts to minimize unintended pregnancies should be continued. However, we cannot continue to deny that abortion is a service that women need: providing it will reduce pregnancy-related morbidity and mortality and promote health among the world's women and girls.

By Bonnie Smith, Masters' Public Health Student at UCLA
While interning Uganda Population Secretariat

Youth need comprehensive information for responsible sexual **decision-making**..

Focusing MAINLY ON ABSTINENCE AND BEING FAITHFUL MAY NOT REALLY BE RELEVANT FOR MANY YOUTH

As an American masters student in public health who has only studied reproductive health in Uganda and sub-Saharan Africa from afar, having the opportunity to live in Kampala and work at the Population Secretariat for the summer has been a truly rewarding experience. I am constantly impressed by the efforts of so many organizations and community members that I have had the chance to meet and observe during various conferences, meetings, and public debates. Witnessing the passion and concern that Ugandan citizens have for the health of their women, children and families is deeply inspiring.

What I have been most impressed by thus far is the community participation at these reproductive health public meetings (such as the Safe Motherhood Conference in Arua and the Sexual and Reproductive Health Meeting for Policy Makers in Kampala). I strongly believe that allowing community members to not only attend these debates but to also give them a venue to express their concerns and personal challenges results in a true sense of empowerment. It is through this active participation in such processes that communities can continue to grow, evolve and become further empowered to create positive changes within their own lives.

One aspect of reproductive health in Uganda that has been particularly disconcerting to me is adolescent sexual health. Although I have studied this topic in graduate school and have worked in this field in the United States, being able to observe programs in action and hear community members and professionals discuss the challenges faced by these adolescents has been illuminating.

I have attended numerous conferences and parliamentary meetings in which the topic of the ABC approach (abstinence, be faithful, use condoms) is emphasized as the primary means to prevent the spread of HIV/AIDS among youth in Uganda. However, it seems as if the C part of this approach is often de-emphasized and sometimes completely neglected.
Focusing on abstinence education can be useful for teenagers who are not yet sexually active as a way to delay their sexual debut; however, studies have demonstrated that emphasizing abstinence without discussing contraception or communication and assertiveness skills is ineffective in deterring risky behavior among sexually active youth.

According to the Guttmacher Institute, focusing on abstinence has shown to be unsuccessful in sustaining any long-term beneficial impact on youths' attitudes or behaviors. Furthermore, this research indicates that in comparison to comprehensive sex education programs, recipients of abstinence-only programs are not any more likely to delay their sexual initiation than recipients of comprehensive sex education programs. Advocates for Youth has also found that abstinence-only education programs in the U.S. have failed to produce any statistically significant changes in the sexual behavior of youth who were exposed to such programs. This is primarily

because abstinence programs do not provide any information about how to protect oneself against pregnancy, sexually transmitted infections or HIV. Furthermore, if these programs do discuss condoms and contraception, they emphasize their failure rates rather than provide information about the positive consequences of their usage. This method of education has resulted in feelings of confusion and ambivalence among youth regarding the usage of condoms and contraception.

Considering that 26% of women age 15-19 in Uganda are mothers and that the adolescent pregnancy rate is currently 43%, it seems that focusing mainly on abstinence and being faithful is irrelevant for the many youth who are already sexually active. Furthermore, not educating teenagers about condoms and access to contraception and reproductive health services can be seen as punitive against youth who are sexually active.

Additional studies have demonstrated that giving youth information about contraception and how they can access reproductive health services does not encourage them to have sex. In fact, providing comprehensive sex education to teenagers often results in a delay of first sexual intercourse, fewer sexual partners and better contraceptive use. Withholding information about condoms or health services from youth has not been proven to discourage youth from having sexual intercourse, especially when youth's sexual curiosity and propensity for experimentation are taken into consideration.

In addition, emphasizing being faithful to one's sexual partner, the B part of the ABC message, generates a false sense of security among those who are faithful to their partner but whose partner may be engaging in other sexual relationships. By providing to youth the A and B messages as the sole way to prevent the transmission of HIV, many youth who comply with these messages will find that their compliance fails them.

Research states that along with correcting myths and misinformation about condom use, programs should aim to teach young women and girls' assertiveness and communication skills that will give them the confidence they need to avoid unsafe sex. Programs such as Girls Power in Nigeria that do such activities to educate females about safe sex have proven effective in empowering young women to make responsible decisions regarding their sexuality. Further, reducing idleness among both boys and girls via opportunities of extra-curricular activities such as skill-development and sports has also been shown to reduce the prevalence of casual sex among youth. These types of youth interventions have proven to serve as protective factors against adolescent risk behaviors. Although the ABC strategy has been effective in helping to curb HIV prevalence rates within Uganda from 15% in 1991 to 6.5% currently, sexually active youth would benefit greatly from the provision of comprehensive information regarding responsible sexual decision-making. In addition to offering information to youth about their risks of contracting

HIV, skill-based information regarding condom and contraception use must be included in these discussions: simply increasing youth's awareness of their risks of HIV does not lead to behavior change unless this education is coupled with skill-building lessons regarding condoms and contraception.

If Uganda can commit itself to improving the health of its adolescents in this manner, not only will HIV prevalence rates among young people decline, but the health of a generation will be improved.

"..However, it seems as if the C part of this approach is often de-emphasized and sometimes completely neglected.."

By Caroline Elson
Masters' Public Health Student at UCLA while interning with Uganda Population secretariat Office (July – September, 2008)

Waiting to Network

Partners in Population and Development (PPD) and the East African Reproductive Health Network (EARHN) finally got the opportunity to meet with Southern Africa Development Community (SADC) government officials dealing with population and development issues.

The meeting took place at the Lord Charles Hotel in Somerset West on June 5, 2008.

Dr Jotham Musinguzi, the Director of PPD ARO (Africa Regional Office)

Dr Jotham Musinguzi, the Director of PPD ARO (Africa Regional Office) gave an overview of the role of PPD Africa Regional Office based in Kampala. He gave some insights into the PPD ARO strategic plan for 2007-2011. PPD is a south-south organization that aims to improve reproductive health and rights in collaborating partners' countries. It also aims at tackling the challenges of family planning, access to reproductive health services, maternal mortality, infant mortality and other population issues that have contributed to the persistence of poverty in Africa.

In addition, PPD strategically aims to use networks to partner with different countries on sharing knowledge and expertise in addressing population challenges. Towards this end, PPD supports EARHN network, which constitutes of Kenya, Uganda, Tanzania, Rwanda, Burundi and Ethiopia, which countries are working closely on issues of reproductive health. The success of this initiative led to the proposal of establishing a similar network in SADC. The technical meeting on June 5, 2008 unanimously welcomed the noble notion, and is currently working to formalize the network. The network will enable SADC member states to work more closely on issues of reproductive health and others. This will also help countries to achieve the Millennium Development Goals related to population and development issues and the ICPD PoA.

South Africa, as the current chair of SADC has to play a fundamental role in ensuring that the proposed network is activated. There is no better opportunity for us to help ourselves in confronting population and development challenges for the benefit of our people. We must seize it!

Intergration IS KEY TO IMPROVING HEALTH INDICES IN Uganda

Reproductive health (RH) is intricately connected with the HIV/ AIDS epidemic that continues to ravage and communities around the world. With over 40 million people infected with HIV, drastic measures must urgently be exploited to compliment the prevention and treatment efforts already underway.

In particular, women and girls continue to acquire HIV at disproportionately high rates, due to socio-economic disempowerment, gender-based violence, and other factors; reproductive health services should target this population, providing an entry for HIV services, and vice versa. Improving reproductive health and tackling the growing challenge of HIV/ AIDS is critical in attaining the Millennium Development Goals (MDGs) and Uganda's Poverty Eradication Action Plan (PEAP) targets. Several concerns continue to impede the progress in Uganda's quest for HIV/AIDS reduction; and universal access to Reproductive Health services (RH).

While there has been significant decline in HIV prevalence, reproductive health indicators remain poor. The HIV/AIDS, has gained graeter attention and funding over FP and RH.

Despite increasing need between 1995 and 2005, global funding for FP, decreased from $723 million to $501 million, while funds for HIV/ AIDS increased from $118 million to $4.9 billion.

A number of RH...?? integration as a way of expanding access to services, improving efficiency and cost effectiveness in service delivery and enhancing opportunities for delivery of more services to all clients who visit the health facilities. Integration also enables service providers to offer more convenient and comprehensive services. Through integration more people are reached with a broader range of services and women, men and young people come into regular contact with the health care system seeking RH services, either within clinical settings or through community based programmes.

This calls for concerted efforts to enhance integration at national level, policy level and service delivery level. (most HIV infections are heterosexually transmitted and half of those infected with HIV/AIDS are women of reproductive age.)

Many of the HIV infected women need RH services and if services are all under one roof, then women seeking HIV prevention, diagnosis and treatment can also access reproductive health services. For example in Uganda the HIV prevalence rate for pregnant women is 6.5% and these women also need the RH services.

Some constraints to integration include low capacity of family planning personnel to offer HIV/AIDS related services, weak logistic systems characterized by frequent stock outs of family planning supplies which may undermines strong HIV/AIDS ??, long waits period of time required for counseling sessions

Therefore, there is a need to strengthen health systems, by supporting reproductive health systems, improving reproductive health commodity security, strengthening human resource management and developing institutional capacities for integrated service delivery.

There is also a need to advocate for better policies supporting integration and ensuring better resource allocation to HIV/AIDS and reproductive health. Advocacy for commitment to health programming that operationalizes the delivery of integrated reproductive health and HIV/AIDS programmes is of paramount importance.

This would go a long way in ensuring a clear understanding of what constitutes integration, its associated costs, benefits and its importance for scaling up efforts to reach more women and men in rural and urban areas. This calls for increased commitment at national level, policy level and service delivery level.

By Diana Nambatya,
Population Secretariat,
Uganda

Family planning now in the **beads?**

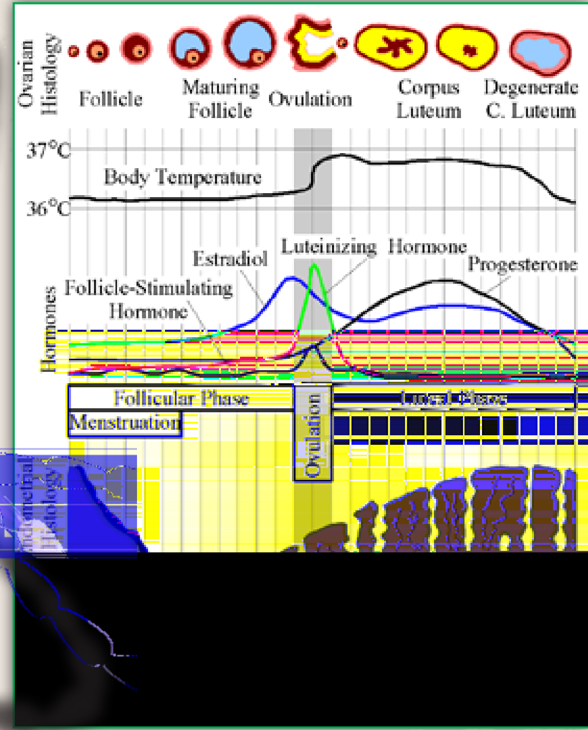
Imagine A FAMILY-PLANNING METHOD YOU DON'T HAVE TO HIDE IN A SECRET PLACE OR KEEP OUT OF REACH OF CHILDREN -- ONE THAT DOESN'T INVOLVE A PRESCRIPTION, LATEX OR SOMETHING IMPLANTED IN YOUR BODY.
IT DOES EXIST. YOU CAN BUY IT IN GROCERY STORES AND IT GLOWS IN THE DARK.

We're talking about CycleBeads -- 32 beads in three colors that come in a tidy little package smaller than a postcard, complete with instructions, a four-year calendar and illustrations to "plan or prevent pregnancy naturally."
Is it basically a version of the rhythm method?

Cat Cabalo, 29, had never heard of CycleBeads. But when they were described to her she said she thought -- "like a rosary for the rhythm method." Cabalo, who comes from a Catholic family and attended parochial schools, said the beads could be workable for traditional Catholics, but she didn't think they were for her. "I don't have the time for this. I barely have time to check my pill pack."

But researchers at Georgetown University in Washington, D.C., who conducted a scientific trial of the beads they call "The Standard Days Method" (SDM) of family planning, a fertility awareness-based method, don't like to hear it compared to the rhythm method.

Victoria Jennings, an anthropologist and director of Georgetown's Institute for Reproductive Health, said, "There was never a scientific study of that method. It was just written into textbooks. People knew they were likely to get pregnant mid cycle. It wasn't well defined. It wasn't studied."
Jennings, Dr. Irit Sinai, a statistician, and Dr. Marcos Arevalo, a gynecologist, conducted clinical trials of SDM on women in Bolivia, Peru and the Philippines -- monitoring them for up to 13 menstrual cycles.



They discovered that fewer than 5 percent of women using the SDM method became pregnant compared to about 8 percent of women who become pregnant while consistently using a diaphragm. If the pill is taken properly, fewer than 1 percent become pregnant, Jennings said.

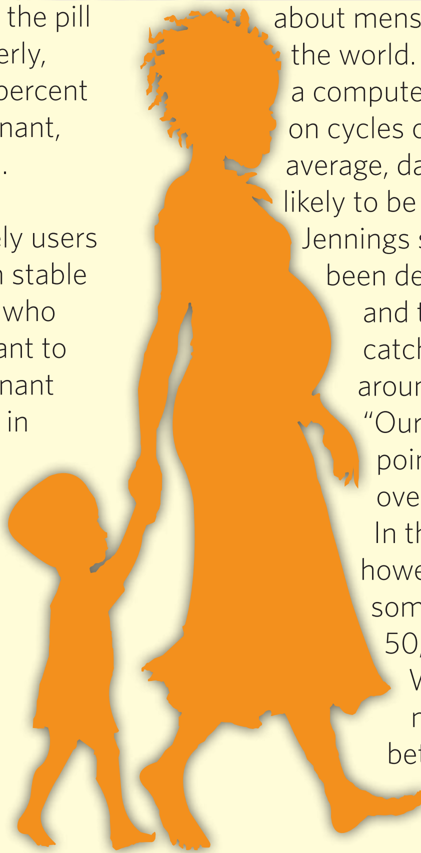
The most likely users are women in stable relationships who know they want to become pregnant at some time in the future, probably 18-39, ages when women tend to have more regular menstrual cycles than younger or older women. The team began their research in 2000, using data from the World Health Association about menstrual cycles around the world. They assembled a computer model based on cycles of 26-32 days. On average, days 8-19 were most likely to be fertile days.

Jennings said the SDM has been defined, studied and tested. It's also catching on in countries around the world. "Our estimate at this point is somewhere over 1 million users. In the United States, however, users number somewhere between 50,000 and 75,000.

Women using beads must have cycles between 26 and 32 days, can't be breast-feeding and must have had three regular cycles after leaving a hormone-based method of birth control. "It's based on good science and if people actually follow the rules, it's 95 percent effective."

How do the beads work? Each Cycle Bead represents a day. The necklace-like circle of beads has one red bead, followed by a series of brown beads, a line of white beads and a group of brown beads with one black bead in the center.

On day one of the menstrual cycle, a black ring is placed on the red bead. The ring is moved daily to the adjoining brown beads. As long as the black ring is on a brown bead, it's safe to have sex. Once the ring arrives at the string of white beads, couples can abstain or use alternative methods to prevent conception. Or they can try to conceive during this period.



Women Empowerment as a critical pathway to development

Women WANT BETTER LIVES FOR THEMSELVES, THEIR CHILDREN, THEIR FAMILIES, AND THEIR COMMUNITIES.

They want to do their best in their roles as mothers, wives, workers, and community members. Many women also want to benefit from new opportunities in life—chances to learn, to make their own decisions, to have more say in the course of their own lives. Women want to have choices. Family planning is one important way that women can take control of their own lives and make more choices possible.

Choices are essential to human dignity. Without choices and without opportunities, a person cannot hope for a better future. Without choices, a person can have little self-respect. A person imprisoned is punished by being denied choices; a person denied choices are punished even without being imprisoned.

Although poverty and lack of education often limit choices and opportunities for both men and women, in general women's choices are especially limited. Social norms, often embodied in a husband, parent, or mother-in-law, prevent many women from having much say in their own lives or much autonomy to choose their own paths. Even if women were allowed to make choices, social and economic options and opportunities are often beyond women's reach.

As a result, compared with men, women have less health care, less education, fewer choices of jobs, poorer pay, and less legal protection.
Family planning can help women meet their needs; both their practical need to perform conventional roles more effectively and their strategic need to find new roles and opportunities. By enabling and facilitating a woman control her own fertility, contraceptive use can help meet a woman's practical needs in several ways. Safe contraception contributes to good health: when couples avoid unplanned pregnancy, they avoid the risks associated with pregnancy and child birth. In Uganda, one woman in 20 dies from causes related to childbearing. Also, birth spacing helps their child survival. Contraceptive use may give a woman more choice in the use of her time by helping her avoid unplanned pregnancy, childbearing, and childcare. With better health and more control over her time, a woman may be able to do more in her customary roles for herself, for the children she chooses to have, for her family and for her community.

Beyond meeting these practical needs, contraceptive use can help to meet women's strategic needs. Women who are healthier and have more control over their time are in a better position to take advantage of education, employment, or other opportunities if they are available. Also, by planning their pregnancies, women may find that they can plan more of other aspects of their lives.

Contraceptive use is often necessary but seldom sufficient to change a woman's situation in life. When a woman controls her own fertility, she may have more choice about the course of her life. Whether she can make changes in her life, however, depends on her personal circumstances, social norms, economic development, and law, among other factors.

Changes in many households and throughout society will be needed before women can realize their full potential. Therefore, lack of control over one's own life can be a major cause of stress. Thus, the use of contraception can improve

women's emotional health by providing more reproductive control and greater choice about childbearing.

Maternal Health, Mortality and Morbidity
Maternal deaths are estimated at (MMR) 435 per 100,000 live births in Uganda Demographic Health Survey (UDHS, 2006). Due to poor health and poor health care, many women in Uganda face greater risk in each pregnancy than women in developed countries. This is because on the average they have more pregnancies. Thus the lifetime risk of maternal death (a statistic that reflects both the risk per pregnancy and the number of pregnancies) is far greater in most developing countries than in developed countries. In the developing world as a whole, any one pregnancy is, on average, about 16 times more likely to kill a woman than in the developed world. The risk of dying in pregnancy in developing countries is over a hundred times higher than in developed ones.

Couples can also reduce their children's health risks by spacing births. Children who are born within 17 months after the preceding birth are about twice as likely to die before age 5 as those born 24 to 47 months after the preceding child. Even children born after an interval of 18 to 23 months are about one-third more likely to die than children born 24 to 47 months after the preceding child. Research also shows that children are more likely to die if their mothers are younger than age 18. According to available data, delaying the first birth until the mother is at least 18 years old reduces the risk of the first child's death by an average of 20%.

Women and couples who can decide if and when they will become pregnant are better able to plan other aspects of their lives. In the short term, women who use contraception effectively may have more choice about the use of their time because they have fewer children. Women may be better able to make plans to take new educational, economic, and other opportunities. Also, in the long term society in general and women themselves may change their expectations of how women lead their lives. With effective contraception, women are better able to work when they need to without the interruption of unplanned childbearing. Women also may find the burden of household work somewhat lightened. Women in Uganda raise over 80 percent of its agricultural food production and constitute over 75 percent of the agricultural labour force. In most rural areas, women spend long hours carrying water, gathering fuel, and preparing and cooking food.

When a woman cannot be sure of avoiding pregnancy, her occupational choices often are limited. Most such jobs are in the informal sector, e.g(agriculture and petty trade). Even in the formal sector jobs as nursing and teaching have been held mostly by women and have less statutory salary ans less opportunity for advancement In Uganda, most cultural norms call for women to remain at home no matter their own preferences. Also, many employers still discriminate against women, partly because employers assume that women's commitment to their jobs is weaker than men's. Nevertheless, it is recently being recognized that women are an increasingly important part of the labor force. It's important to note that, where contraception is widely available and its use is accepted, employers may be more confident that female workers will not be forced to leave because of unplanned pregnancies. At the same time, however, the possibility that a woman may become pregnant is not legitimate grounds for denying her a job. When women have access to contraception and new economic opportunities, many take advantage of both.

Meeting the Unmet Need for Reproductive Health Care
According to the UDHS 2006, the percentage of women who say they do not want to have more children has grown substantially from 35 percent in 2000 to 41 percent 25 percent of women use contraception for spacing and 16 percent for limiting. The total demand for family planning is estimated at 64 percent and the demand satisfied is only 35 percent, a slight decrease from 40 percent in 2000. Although most women

wanted on average 5 children, men wanted 5.7 children. There is great interest in spacing births among women. In Uganda, 54 percent of births were wanted then, 33 percent were wanted later (mistimed) and 13 percent not wanted at the time of the survey (UDHS 2006).

Such statistics imply large potential demand for family planning services. Even though contraceptive use has risen substantially in recent years, in Uganda 41% of married women of reproductive age report that they are not using contraception but do not want any more children or else want to delay their next birth at least two years. Rates of abortion, even where abortion is illegal and unsafe also testify to women's strong desire to control their own fertility. Demographers describe women who are not using contraception but want to space or limit births as having an unmet need for family planning.

It is important to note that men also have unmet needs for family planning. In the Demographic & Health Surveys in Burundi, Egypt, Ghana, Kenya, and Pakistan, over half of men approve of family planning, but very few are using a contraceptive method.

Below, Women empowerment, Togo

Policy Issues.
To translate this unmet need to control fertility into utilization of reproductive health services, policy makers must let clients know that these services are a safe and effective way to achieve their personal goals. Reproductive health programs can identify the obstacles that prevent women from using services and can design services and communication that will help overcome some of those obstacles. Obstacles may range from lack of supplies and services to dissatisfaction with current services to fears of contraceptive side effects, to social limits on women's mobility or decision-making. Beyond the need to control their own fertility, women also need other reproductive health services, and family planning programs may be able to meet these needs, as well.
Conclusion

Generally, gender inequality constrains women's access to skilled health care. Interventions to improve communication and strengthen women's influence deserve continued support. The strong association of women's education with health care use highlights the need for efforts to increase girls' schooling and alter perceptions of the value of skilled maternal health care.

by: Isabella Birungi
(Additional material from Population Reports, Center for Communication Programs, The Johns Hopkins School of Public Health)

Since the International Conference on Population and Development (ICPD) held in Cairo in 1994 there has been a 30% drop in funding for family planning services.

This is in part due to a major shift in emphasis towards HIV/AIDS activities, resulting in budgetary transfers. But it also follows a general reluctance to discuss demographic issues especially population growth.

The consequences of this decline in budget away from population and family planning have led to a plateau of contraceptive use and fertility decline. Fertility and population growth rates remain very high in most of Sub Saharan Africa, and parts of South Asia and South East Asia. Unmet need for contraception also remains high, approaching 30% of all women in Sub Saharan Africa.

Consequences for MDG Achievement

MDG 1: Poverty Reduction

The proportion of people living in poverty in Africa increased by only 1.8 percentage points between 2001 and 2006 but the actual number of people living in poverty increased by