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SIGN UP TODAY AT PSI.ORG TO RECEIVE IMPACT.
A quarter of HIV+ South African children participating in one study developed TB in 1 year.

On March 24, 1882, Dr. Robert Koch, a German scientist, announced the discovery of TB bacillus, the cause of tuberculosis. The day is observed annually.

Harm Reduction 2010
April 25–29
Liverpool, England.
“Harm Reduction: The Next Generation”
Source: www.IHRA.net

In Latin America & the Caribbean, the proportion of HIV-positive females age 15 years and up rose from 27% in 1990 to 35% in 2007.
Source: Millennium Development Goals.

PSI’s Central American affiliate, PASMO, signed an official agreement with the Guatemalan Ministry of Health in February to solidify an ongoing relationship to improve the health of Guatemalans.

To educate and pay 4 million health workers needed in the 57 countries with shortages, health budgets of these countries will have to increase US $10 per person annually by 2025.

In the Democratic Republic of Congo there is about 1 health worker per 1,000 people, compared to 4 per 1,000 people in the U.S.

A magnitude earthquake struck Haiti on January 12, 2010.
Magnitude earthquake struck off the coast of the Maule Region of Chile on February 27, 2010.

A quarter of HIV+ South African children participating in one study developed TB in 1 year.

In February, PSI/Benin launched Kool condoms, positioned for youth ages 15–24. Local artists and musicians performed in a series of events to promote the new condom.

In April 2010, people everywhere will commemorate World Malaria Day to raise awareness about the global effort to control malaria.

Magnitude earthquake struck off the coast of the Maule Region of Chile on February 27, 2010.

On March 24, 1882, Dr. Robert Koch, a German scientist, announced the discovery of TB bacillus, the cause of tuberculosis. The day is observed annually.

March 24
World Tuberculosis Day

On March 24, 1882, Dr. Robert Koch, a German scientist, announced the discovery of TB bacillus, the cause of tuberculosis. The day is observed annually.

Texting 4 Health
PSI/Laos has launched a new campaign to use text messaging to prompt men who have sex with men (MSM) and transgenders to get regular HIV tests at local drop-in centers. In 2009, more than 700 MSM and transgenders were tested for HIV as part of PSI/Laos’ New Friends MSM/Transgender project.

Resistance
In a recent study, 26% – 44% of ACTs sold in Madagascar, Senegal and Uganda “failed quality testing” because of impurities or insufficient amounts of active ingredient. Source: U.S. Pharmacopeia.

2+
In Latin America & the Caribbean, the proportion of HIV-positive females age 15 years and up rose from 27% in 1990 to 35% in 2007. Source: Millennium Development Goals.

3%
Sub-Saharan Africa only has 3% of the world’s health workers and 24% of the global burden of disease. Source: WHO. 2008.

3%

There is a projected shortage of more than 4 million health workers worldwide. Source: Lancet. 2008.

Resistance
In a recent study, 26% – 44% of ACTs sold in Madagascar, Senegal and Uganda “failed quality testing” because of impurities or insufficient amounts of active ingredient. Source: U.S. Pharmacopeia.

MAJOR Shortage

There is a projected shortage of more than 4 million health workers worldwide. Source: Lancet. 2008.
What's Next for Haiti?
By Carter Dougherty
What’s Next for Haiti?

By Carter Dougherty

People queue for distribution of food aid by the United Nations World Food Programme in front of a building devastated by the 7.0 magnitude earthquake that struck Haiti on January 12, 2010.
When the earth beneath her feet began to shake uncontrollably while preparing dinner in her kitchen, what she now calls “the worst 10 hours of my life” began for Anick Supplice Dupuy.

She and her husband scooped up their two children and raced out of their small home in the hills near Port-au-Prince, onto the relative safety of her front lawn. The spot offered Dupuy, the deputy director of PSI/Haiti, a terrifying view from on high of what had become of her country’s capital city in less than a minute.

“What we saw was not the city,” Dupuy said. “We saw a cloud of smoke rising from the city and realized it was the worst thing that had ever happened in Haiti.”

Dupuy did not, of course, see smoke on the afternoon of January 12, but the dust cloud thrown up by buildings that collapsed during an earthquake whose force matched a 1989 episode in California’s Bay Area in the United States. It set in motion a terrifying stretch in which she knew next to nothing about what had happened to her many relatives now underneath that cloud in Port-au-Prince, Haiti’s commercial and political hub.

But an earthquake that merely shook up Californians has proved utterly devastating for Haitians, many of whom face a daily existential struggle. Their distress demanded a flexible and innovative response from all health organizations active in Haiti, many of whom have torn up the rulebook for how nongovernmental organizations must operate.

The earthquake has thrust PSI into the unconventional, but not unknown role of providing disaster relief – by itself and with partners – while keeping a focus on the longer-term health strategy that is PSI’s mission.

“We’ve been in Haiti for 20 years, and I expect there will be need for us and organizations like us for many more years,” said Karl Hofmann, PSI’s CEO and president. “Our time horizon is much longer than the first-responder, disaster relief organization.”

Hofmann, a California native with an intuitive feel for earthquakes, pointed out that PSI has organized similar responses in recent years to the cyclone in Myanmar and a quake in Pakistan.

The apparent loss of an estimated 230,000 lives in Haiti demanded above all that PSI account for its own staff; in truth, the organization got lucky, since the late-afternoon timing caught its 100 employees on the road or at home. The sole death was Immacula Wagnac, a program assistant who worked on blood donation campaigns for PSI and was attending a university class when the quake struck.

Camped out on her front lawn and handling two upset children, Dupuy, 32, could do little but wait after the earthquake.

News trickled in. Most phones would be down for more than a week. Roads had become impassable, fuel all-but-impossible to obtain. None dared enter the buildings they left, Dupuy recalled, not the least because an aftershock an hour later reminded everyone how precarious their situation was. She would eventually spend days in a tent outside.

Information did get through. Dupuy’s father-in-law, who lives next door, struggled home through the rubble by midnight and brought news that her grandmother had died in a building collapse. An aunt and a sister survived, but only after they were dug out of the rubble. A sister-in-law spent half a day in the wreckage of a Citibank office but made it out alive.

A graduate of Tulane University who returned to Haiti to help her struggling homeland, Dupuy said the worst part was the sheer power of despair.

“I knew that there was nothing I could do, and I also knew that the government was not in a position to do anything either,” she said.

Even before Dupuy knew her family
members’ fates, PSI/Haiti Country Director Alison Malmqvist and her family made their way to Dupuy’s home – a haven because of the outdoor space – to plot PSI’s response to the disaster.

From the initial, urgent task of accounting for its own, PSI/Haiti quickly settled on a strategy that married the organization’s traditional strengths to the urgency of the moment.

Avoiding a focus on the PSI-branded products like condoms, water purification treatments and oral rehydration salts that normally flow through existing commercial channels, Malmqvist is pushing communications to the top of the priority list.

“Our strategy right now is less ‘move the product’ than ‘use the product,’ whatever the brand,” Malmqvist said. “If the demand continues via the private sector, we will meet and see that subsidized pricing is protected. But the emphasis right now is about getting people to adopt healthy behavior.”

Donors have responded positively to PSI/Haiti’s approach as well. KfW, the German development agency, has put about €1 million into epidemic prevention, while the $4 million that PSI/Haiti was granted by the U.S. Agency for International Development (USAID) can potentially be redirected to emergency uses, Malmqvist said.

The squalid makeshift camps that the newly homeless have thrown up in Port-au-Prince have already created breeding grounds for the diarrheal diseases that PSI takes aim at all over the world, she pointed out.

The grueling circumstances in Haiti have bred partnerships between PSI and other organizations with similar goals.

PSI/Haiti’s office survived the quake and, after its reopening on Jan. 25, housed part of the American Red Cross, whose offices were destroyed. USAID is using part of PSI’s warehouse
Massive natural disasters necessarily elicit big responses from the international community. But sometimes, the small efforts are just as impressive.

Certainly, the commitment of American money and soldiers helped set the tone for what is expected to be a long period of healing as Haiti transitions away from disaster relief toward recovery and development. At its peak, the U.S. military had 20,000 soldiers working in and off the coast of Port-au-Prince, according to Gen. Ken Keen, the officer in charge of the operation. By mid-February, the U.S. government had spent $250 million on aid to Haiti, with more in the pipeline.

That did not stop a group of sixth-graders from Brainerd, Minnesota, in the U.S., from collecting pledges to contribute to Haiti’s rebuilding based on the number of points they scored at a basketball tournament. The $2,137 that they raised is enough to purchase safe drinking water solutions to supply 4,274 families of four for a month.

The call for help has been answered far and wide. The European Union pledged €309 million, of which France kicked in €270 million for its former colony. The United Nations has also mobilized resources and hosted a donors’ conference March 31 in New York. The Mexican foundation, Un Kilo de Ayuda (A Kilo of Aid), which works to alleviate the suffering of children worldwide, enlisted the assistance of hundreds of supermarkets across Mexico to raise money for earthquake survivors. In just three weeks, Un Kilo de Ayuda raised about 1,096,513 pesos for PSI/Haiti’s safe water program.

Still, the smaller efforts highlight how the Haitian earthquake in particular has reached into the popular consciousness and conscience. Wall-to-wall coverage of the quake’s aftermath on CNN and other channels may seem excessive, but without television’s potent effects, it is hard to imagine how a godson of PSI Ambassador Molly Sims would have managed to sell so many pies, cookies and cakes.

“The Hope for Haiti Kids Bake Sale” raised $1,741.61.

What’s Next for Haiti?

for ready-to-eat meals, plastic sheeting and a generator. PSI is also training a team of existing Red Cross volunteers to demonstrate and pass out 25,000 bottles of Dlo Lavi, PSI’s water purification product, in Port-au-Prince camps.

“They take what they learned from PSI and explain to people how they use it,” said Matthew Marek, the Red Cross country representative in Haiti. “But the distribution happens via the channels that the American Red Cross has.”

PSI also teamed up with Procter & Gamble to ship 1.1 million packets of PUR Purifier of Water, a water treatment powder, to Haiti. The Red Cross will hand out the PUR as well.

But the mammoth task of doing PSI/Haiti’s work will fall, ultimately, to the very Haitians whose lives have been upended by the tragedy. Dupuy spent several nights on her lawn, then with her two children in the same bed with her and her husband, even as PSI’s work moved ahead.

“I’ve been through the emotional test of going back into this building, but that’s not the case for a lot of people,” Dupuy said from her office. “And every building you walk into is a new kind of test.”

Carter Dougherty is a freelance writer based in Washington, DC.


Haiti Relief Donations to U.S.-based Organizations

Total $980 Million, as of March 16.

The Help for Haiti telethon raised about $66 million on January 22. Organizers awarded $35 million in grants on February 5.

PTIC

© ISTOCKPHOTO
Immediately following the catastrophic earthquake in Haiti, media outlets, relief organizations and concerned individuals launched an unheard-of communications campaign using social media like Twitter, Facebook and SMS messaging.

The picture emerges
With staff in Port-au-Prince, organizations like Médecins Sans Frontières immediately began sharing updates on their websites. Twitter feeds began to describe the scope of the earthquake: “power lines down, one of many things no longer working in Port-au-Prince, after the earthquake”; (January 16, from MSF’s Isabelle Jeanson’s Twitter feed twitter.com/ijeanson). Longer blog accounts by Jeanson and others added detail: “The situation remains critical, few aid agencies in place, still hundreds of bodies stuck in buildings. I’ve only seen about four or five trucks and cranes trying to remove buildings to get people out, in the entire city.... At night, we must be careful not to run over people who are sleeping on the roads. I saw one person sleep in the middle of an intersection, just to avoid any buildings that may fall if there is another earthquake.” (msf.ca/blogs/haiti/2010/01/17/sunday-morning-january-17-port-au-prince-haiti/)

The cry for help goes out
As the enormity of the disaster became apparent, relief groups like the Red Cross turned to social media to mobilize givers. The Red Cross began a text fundraising campaign that allowed donors to give directly to Haiti relief and recovery through their mobile phones by texting “Haiti” to 90999. “Text messaging provided people across the country with a convenient channel to quickly and easily turn their compassion into action,” said Susan Watson, director of marketing and visibility for the American Red Cross. “This has been an unprecedented success, as more than $32 million was raised in the first month at $10 per donation.” Even the White House was tweeting about that success:

“Amazing! Americans raise $8M+ for @RedCross by texting HAITI to 90999 ($10 charged to your cellphone bill) http://bit.ly/7xDSqn
5:53 AM Jan 15th from HootSuite”

The search for missing persons
As chaos mounted in the days following the earthquake, information on missing persons proved elusive. Phone networks were down, and people had to flee their homes. Word of mouth still worked though, and PSI leveraged its website and Facebook connections to ask anyone coming across PSI staff to contact PSI. An online message board was set up to allow staff with access to the internet to share information about their condition and whereabouts. PSI Ambassadors Molly Sims, Mandy Moore and Anna Kournikova all contributed to the effort by tweeting and recording online video spots. Eventually, information on all PSI/Haiti staff was obtained. Meanwhile, organizations like the United Nations Stabilization Mission in Haiti were doing the same. With their main headquarters in Port-au-Prince completely destroyed, UN staff took to Facebook to locate missing staff members and report news from the ground. Another development has been the creation of 24-hour text message hotlines with which survivors can share information about their location, injuries and needs. Dispatchers read incoming messages and coordinate rescue efforts.

Beginning to rebuild
As Haiti works to recover in the weeks and months to come, first-person accounts will bring to life the breadth of one of the worst natural disasters to ever strike the island nation. And media outlets, fundraisers and others will rely, at least in part, on user-generated content to connect people outside of Haiti with the awful, yet hopeful story on the ground.

The experience following the earthquake has shown just how essential social media has become to disaster response and humanitarian media. It is not only the governments and humanitarian relief organizations who have the power to mobilize support, raise money and share experiences; it is also concerned individuals, members of the global neighborhood, who started fan sites, searched for missing persons and took snapshots in an effort to contribute to the relief of Haiti.

—Jim Crow, Founder of Wikipedia

“One of the most powerful ways that technology and social media contributed to relief efforts in Haiti was actually a fairly old and common technology: the use of short message service to allow fast and easy donations. Millions of dollars poured in from ordinary people using their phones to make donations.”

—Jimmy Wales, Founder of Wikipedia

www.psi.org | impact
A Paradigm Shift

By Steven Chapman, Ph.D.
Chief Technical Officer, PSI

Social marketing can no longer be simply defined as the subsidized sale of a health product.

Instead, social marketing programs increasingly are substantial components of mixed health systems, influencing health-seeking behavior across disease areas, increasing access to broad packages of products and services through the public and private sectors, and using their consumer focused techniques to improve the performance of the health system as a whole.

Better data about changing epidemiology is one reason for the shift from diseases and towards systems. These shifts have led to changes in the way PSI operates and in the role of social marketing programs more generally in the developing world.

Social marketing programs increasingly are substantial components of mixed health systems, influencing health-seeking behavior across disease areas, increasing access to broad packages of products and services delivered in households and community clinics, and operational research to evaluate cost-effectiveness.

Sensible.

And in one of the most challenging environments in which PSI works, Myanmar, this is already being done. PSI/Myanmar receives support from the Bill & Melinda Gates Foundation as well as other donors to offer an integrated package of tuberculosis, malaria, HIV, and reproductive and child health products and services through private sector outlets and through doctors and community-based workers operating under social franchising arrangements with links to the public sector. Key learnings will be derived through a research program aimed at gauging impacts on behavior, equity and cost-effectiveness.

An unprecedented expansion in the resources available to address health in the developing world is another reason for the shift from diseases to systems. From the Group of Eight (G8) to The Global Fund to Fight AIDS, Tuberculosis and Malaria, World Health Organization (WHO) and private foundations, there is a new desire to strengthen health systems, including blurring the once distinct line between the public and private sectors. Even the general public seems swayed. A recent Kaiser Family Foundation survey found most Americans support funding health systems, rather than the targeted initiatives that address compelling yet narrow issues in the headline news.

Calls for broadening interventions and the way they are delivered are not new, but responding to them has been a challenge. There are concerns about cost-effectiveness and service delivery constraints, and, for some organizations, losing focus. These concerns have long resulted in very narrow interventions, addressing a specific behavior with a single product or service.

PSI, for most of its 40-year history, walked in step with this approach, and still today, a single product—a mosquito net—sometimes delivered in a single campaign, represents the largest contributor to our health impact. Yet, increasingly, PSI programs are overcoming these concerns and challenges and are able to link offerings, such as HIV and family planning products and services, in ways that were historically difficult to do.

In 2010, PSI is placing new priority on integrating offerings and channels in maternal and child health. In the

Democratic Republic of Congo and Malawi, the Canadian International Development Agency is funding PSI and two other nongovernmental organizations to establish an evidence base for the impact on child mortality rates attributable to a community case management approach to prevent and treat malaria, pneumonia and diarrhea. PSI is partnering with the WHO, Special Program on Tropical Disease Research to evaluate the impact.

Using its own funding, PSI and its affiliate PACE are conducting an operations research project in Uganda that offers a package of malaria, pneumonia and diarrhea products and services targeted Basic Care kits and links them to a social franchise program that offers family planning. Mixed health systems have poor performance in part due to their reliance on out of pocket payments and low quality private providers. To address this, PSI has launched a series of pilot projects using performance-based arrangements to increase equity and improve service quality. Efforts are now underway to expand a new global quality assurance program for PSI programs that provide services.

Globally, PSI is responding to these changes by merging historically separate departments and through the use of cross-departmental innovation teams organized in working groups. In 2009, PSI merged its malaria and child survival departments under the direction of Dr. Desmond Chavasse, based in Nairobi. The HIV, tuberculosis and reproductive health departments were consolidated under the direction of Dr. Krishna Jafa, based in Washington, D.C. Lastly, PSI formed working groups in services, led by Nikki Charman in Myanmar, and performance-based financing, led by Nils Gade in Amsterdam.

Nishtar calls on global health initiatives to undertake a series of actions to improve mixed health systems. These include broadening their mandates to include health financing. Doing so would make it easier for social marketing programs to improve health systems’ performance across the developing world.

### Targeted Basic Care Kits

#### HYGIENE KIT
- A plastic 20 liter water storage container with a lid and a tap
- A bottle of WaterGuard and 3 refills, two sachets of Thanzi Oral Rehydration Salts, a bar of soap
- A brochure with instructions on how to use the kit

#### HIV BASIC CARE PACKAGE
- Two insecticide treated mosquito nets
- A water vessel, sodium hypochlorite solution, a filter cloth for water
- Condoms and information on how family members can access HIV counseling and testing
- Use of opportunistic infection prophylaxis
- Point-of-use water treatment products

#### MALARIA KIT
- Artemisinin-based combination therapies
- An insecticide treated mosquito net
- Pneumonia prevention and treatment products
- Diarrhea prevention and treatment products
- Clean delivery kit
- Oral Rehydration Salts, soap

#### CLEAN DELIVERY KIT
- Razor blades, string ligatures
- Plastic sheeting, soap, surgical gloves
- Cord clamp, cotton wool, gauze
- Pictorial, written instructions
- Example: Pakistan

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### Who Is a PSI Community Health Worker

PSI community health workers (CHWs) are volunteers and entrepreneurs. Depending on the country where they work, CHWs clinically diagnose and treat diseases, refer clients to health facilities, conduct outreach and behavior change communication, increase demand for products and services, and distribute health products. They are trained and supported by PSI and partner organizations, local health facilities and the private sector.

### What Does a PSI Community Health Worker Do?

| 1. | In Guatemala, CHWs conduct door-to-door visits, group educational activities and interpersonal communication (IPC) at clinics to increase informed demand for intrauterine devices and implants as part of a program implemented by PSI affiliate PASMO. |
| 2. | In Madagascar, a network of more than 5,000 CHWs distributes products, such as insecticide treated nets, and educates communities to lead healthier lives. |
| 3. | In Sudan, CHWs distribute ACTs and diarrhea treatment kits and make referrals to health facilities as part of a community case management program to ensure holistic treatment of childhood illnesses. |
| 4. | In Mozambique, more than 100 community agents conduct IPC activities with target groups to increase condom use and use of HIV counseling and testing (CT) and to reduce sexual partners. And 60 community counselors work in schools, churches, in markets and workplaces with community leaders to provide CT and referrals for care and support. |

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Social marketing can no longer be simply defined as the subsidized sale of a health product.
Clean Water for a Healthy World

Soak Up the Facts on Disease Burden

Child Survival
In 2008, 8.8 million children born alive worldwide died before age five.

HIV
There were 2.7 million new HIV infections and 2 million AIDS-related deaths in 2009.

A woman in rural Sudan gathers water from the river in her jerry can.
The world’s leading killers of children are pneumonia, diarrhea and malnutrition. On March 22, 2010, World Water Day (WWD), people around the world gathered to raise awareness of the 4,100 children that die every day from diarrhea due to unsafe water, lack of hygiene and sanitation. From the U.S., to Sudan, Myanmar to Madagascar, PSI and its partners, including National Geographic, participated in roundtable conversations, village discussions, street theater, and advocacy activities to raise awareness of the water crisis and highlight that while working towards long-term change, there are simple, effective and inexpensive solutions available that can save lives now. In Washington, D.C., PSI collaborated with partners to support a high-level symposium that highlighted U.S. commitment to water, sanitation and hygiene programs around the world. Building on this momentum, the collaborative organized a briefing on Capitol Hill to encourage the U.S. government to save the lives of more children by increasing its investment in child health, safe water, hygiene and sanitation in low-income countries.

To add to the WWD activities, UNICEF premiered a short film in Nairobi that highlighted PSI programs in Angola and the Democratic Republic of Congo and showed the importance of safe water and the benefits of empowering people to treat their own water.

To learn more about these efforts, please visit waterday.org.

Diarrheal disease is a major killer all over the world. But 15 countries in Africa and Asia rank the highest among countries with poor water supply, sanitation and hygiene.

1. India - 390,000
2. Nigeria - 150,000
3. DR Congo - 90,000
4. Afghanistan - 85,000
5. Ethiopia - 80,000
6. Pakistan - 40,000
7. Bangladesh - 40,000
8. China - 30,000
9. Uganda - 25,000
10. Kenya - 20,000
11. Niger - 20,000
12. Burkina Faso - 20,000
13. Tanzania - 15,000
14. Mali - 15,000
15. Angola - under 15,000

Source: WHO, Global Burden of Disease estimates, 2004 update, 2008. Note: The totals were calculated by applying the WHO cause of death estimates to the most recent estimates for the total number of under-5 deaths (2007).

The report described the impact of simple, inexpensive interventions, such as exclusive breastfeeding, vaccination, insecticide treated mosquito nets and vitamin A supplementation, all of which have helped reduce child deaths.

Speaking at the launch of the report, UNICEF Executive Director Ann Veneman, said, “Community-level integration of essential services for mothers, newborns and young children, and sustainable improvements in national health systems can save the lives of many of the more than 26,000 children under 5 who die each day.”

While the reduction in child mortality is something to celebrate, there is much more to be done. And those in the global health community are looking at ways to further reduce child mortality.

One area that the global health community is embracing is the integration of health interventions that have rapid and effective impact on prevention and treatment of childhood diseases.

Funding for global health, particularly from the U.S. government, increased significantly in the last 10 years, but a large majority of this funding was allocated in silos for projects on malaria or tuberculosis or HIV/AIDS – not for projects that tackle those diseases together. Yet, innovative programs in many countries show that an integrated approach that reaches a child with a package of interventions simultaneously can bring immediate and positive results.

“The world’s biggest child killer is not pneumonia, malaria or diarrhea; it is in fact these and other diseases in combination with underlying chronic conditions, in the same child. This is called co-morbidity,” said Dr. Warren Stevens, a senior health economist specializing in developing countries and technical advisor to PSI.

“A child with a weakened immune system from a previous disease episode or from micronutrient deficiency is up to 12 times more likely to die from a new infection. It is estimated that the average child in Africa or South Asia will suffer four to six episodes of illness each year, and that between a third and a half of children are underweight. Acknowledging the role of co-morbidity by treating each child, rather than each disease, has the potential to significantly impact child mortality, while simultaneously addressing the indefensible level of health inequalities in these regions,” added Stevens.

A number of countries are already developing life-saving interventions for children. Pilot programs in the Democratic Republic of Congo and Malawi are underway to prevent and treat malaria, pneumonia and diarrhea. The projects are being developed in partnership with national ministries of health and will reach areas with 1.5 to 2 million people, with the broader

Making Good News Better

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goal of taking the intervention to a national level.

These projects involve an innovative approach called community case management (CCM). The CCM approach trains community health workers to clinically diagnose cases of malaria, pneumonia and diarrhea in children and determine what type of treatment is appropriate or whether a child needs to be referred to a health facility. This is a particularly effective approach to reaching children in rural areas, where health disparities are significantly higher due to limited access to clinics.

Leading this effort is the Canadian International Development Agency (CIDA) with a multi-country initiative that focuses on providing free diagnosis and treatment in communities with limited access to health facilities. With CIDA funding, the Malaria Consortium, PSI and Save the Children will establish CCM programs that are estimated to reduce child mortality rates between 30 and 40 percent among children under age five. This CIDA-funded program hopes to establish a solid evidence base for the impact of CCM approaches on child mortality rates from all causes.

“The CIDA-funded CCM program is groundbreaking because it focuses on integrating treatment of pneumonia, malaria and diarrhea, which account for almost half of all the child mortality in the world. Through this program we will learn how best to deliver antimalarials, antibiotics, ORS and Zinc within the community to ensure maximum impact on overall child mortality,” said Dr. Desmond Chavasse, vice president of malaria control and child survival at PSI.

Community case management is just one example of the type of intervention that can bring the global health community closer to reducing child mortality worldwide. As the race to halve child mortality by 2015 as part of the Millennium Development Goals heats up, PSI is changing its immediate focus to implement holistic child survival programs at national scale in at least 10 priority countries. The goals are attainable, and PSI will join its partners in turning future funding into lives saved.

PSI Author: Ando Raobelison, Community Case Management Technical Advisor, Nairobi
7Questions
with Raymond G. Chambers

1. You have quickly become a champion for scaling up malaria control to universal coverage through your involvement with Malaria No More and now as the United Nations Secretary-General’s Special Envoy. What drew you to choose malaria in the first place?

I will never forget the first time I saw a photo of two children from Malawi who I thought were peacefully sleeping, but I later learned were in malaria comas and subsequently died. Realizing that this was the fate of 1 million children each year, I had never felt more compelled that something needed to be done. A disease that is so preventable and yet so devastating seemed like an opportunity to improve lives on such a large scale. The more I learned about malaria, the further convinced I was.

2. What do you see as the main challenges and bottlenecks in reaching the 2010 Roll Back Malaria (RBM) targets, such as reducing the malaria burden by 50 percent compared to the year 2000, protecting 80 percent of people at risk from malaria, and ensuring that 80 percent of malaria patients are diagnosed and treated?

Two years ago, the Secretary-General established the dual goals of providing all those at risk of malaria with lifesaving interventions by December 31, 2010, with the ultimate goal of ending malaria deaths by 2015. At this moment, we have never been closer to protecting all people at risk of the disease with long-lasting insecticidal mosquito nets (LNs), with more than 50 percent of the endemic population already covered. Though the majority of these nets are funded, financing gaps for some pose a challenge. In order to realize our goals, donors need to fulfill their commitments, donor and recipient governments need to remain engaged, and malaria-control interventions need to be produced and delivered without interruption.

3. What is your role in addressing these challenges and how does it complement the RBM partnership?

The RBM partnership is at the core of the effort to reverse the course of malaria, and I am so grateful that there are so many committed partners. In terms of addressing challenges and bottlenecks, working with the network that comprises RBM has been the most effective and reliable strategy.

4. What would you consider to be your key achievements to date in helping countries reach the 2010 RBM targets?

The World Health Organization’s 2009 World Malaria Report encapsulates the threshold moment at which the malaria community has arrived. One-third of the planet’s malarious countries have reduced incidence and death by 50 percent or more, and in a two-year period, LN availability has doubled in sub-Saharan Africa.

Some remarkable ventures have reshaped the landscape to allow these developments to occur. During the past two years, global funding for malaria has totaled more than $3 billion. More than 25 African heads of state have formed the African Leaders Malaria Alliance to establish a unified response to malaria control. Currently, more than half of the population has access to LNs.

The ultimate result – that the course of malaria is being reversed, and that lives are being saved – is the most important accomplishment.

5. How can organizations like PSI help achieve further success in reaching the 2010 targets?

Reaching the 2010 targets has been a collaborative effort from the onset, and partnership contributions have been essential. From financing, to research and development, to the procurement and distribution of interventions, to advocacy, and work in the field, every step of the effort has continued on page 21
Trusted Interventions Take Hold

Hygiene Kits Protect Children in Malawi
In places like Malawi, where mothers and caregivers rank diarrheal disease as the second highest threat to their children, inexpensive hygiene kits are a realistic way to prevent and treat childhood diseases.

In 2006, under a joint effort to combine key safe water, hygiene and diarrhea treatment practices into antenatal service delivery, the Malawi Ministry of Health, the United Nations Children’s Fund and PSI, with support from the U.S. Agency for International Development and the Centers for Disease Control and Prevention, implemented a pilot Hygiene Kit Promotion Project in 15 health facilities in Salima and Blantyre districts.

Under the integrated project, 60 nurses in 15 clinics were trained to oversee the provision of 15,000 kits to pregnant mothers. These kits included a plastic 20 liter water storage container with a lid and a tap, a bottle of WaterGuard, two sachets of Thanzi Oral Rehydration Salts, a bar of soap, and a brochure with instructions and information for mothers.

Surveys following the project showed that mothers in Salima and Blantyre used their hygiene kits. After six months of the program, of 330 randomly selected mothers, all were correctly storing their water and 91 percent were correctly using WaterGuard to clean their water. Program participants also proved to be effective communicators, influencing a significant number of friends and relatives to treat their water and practice better hygiene.

Reaching Rural Communities in Southern Sudan
In Southern Sudan, the region’s 8 million people mostly live in small, extremely rural communities, where health disparities are higher than in urban areas. However, through a community case management (CCM) program, the ability to prevent childhood deaths from malaria, diarrheal disease and pneumonia is improving. The program combines the distribution of artemisinin-based combination therapies (ACTs) and diarrhea treatment kits, which include oral rehydration salts and zinc, alongside referrals to health facilities (in the case of pneumonia) to ensure holistic treatment of childhood illnesses. These life-saving treatments are provided by local health volunteers and associated health clinics. By working with health volunteers in villages, PSI is able to bring treatment to families when they need it.

In 2007, PSI received a grant from The Global Fund to Fight AIDS, Tuberculosis and Malaria in an effort to scale up malaria prevention and treatment activities through distribution of long-lasting insecticide treated nets and increased home-based management of malaria. With this grant, PSI hopes to reach 60 percent of children who have a fever with ACTs in 10 states of Southern Sudan.

The Ministry of Health of Southern Sudan is using this opportunity to also reach community members with safe water messages and education. Health workers have taught community members to prevent diarrhea-related diseases by treating water in the home, safely storing water and practicing safe sanitation and hygiene. If children do get diarrhea, health volunteers offer oral rehydration salts to prevent death from dehydration, and pediatric zinc to decrease the severity and duration of diarrhea episodes.

More than 340,000 people have been reached with disease prevention messages and appropriate treatment options in Southern Sudan.

Despite numerous challenges, including weather and transportation logistics, Southern Sudan has made impressive progress. Health workers have been trained, messages disseminated and products are becoming common-place, even in rural communities. The private sector is beginning to thrive as local vendors procure and sell water purification products like WaterGuard chlorine tablets and PUR Purifier of Water sachets. In 2009 alone, more than 5 million tabs of WaterGuard were sold or distributed, along with 350,000 sachets of PUR.

PSI Author: Ashley Latimer, Senior Program Assistant for Malaria and Child Survival, Washington.

1 MDHS 2004
Aminata, a 41-year-old from Bamako, Mali, has had 11 pregnancies. She has miscarried twice and of the nine children she has given birth to, several have not lived past infancy. Unable to properly space her births, she has lived in fear of losing another child.

When she brought her newborn to a local clinic for immunizations, Aminata found a PSI/Mali midwife was also counseling women about contraceptive methods including long-acting and reversible contraception (LARC). Aminata knew little about modern contraceptive methods when she met the PSI/Mali midwife. But that afternoon, after learning about her family planning options, Aminata decided to have an intrauterine device (IUD) inserted.
Over the past five years, family planning has received limited donor support and government attention in Mali. Like Aminata, many women of reproductive age are unaware of their family planning options and the related health benefits. As a result, Mali’s modern contraceptive prevalence rate (CPR) of six percent is among the lowest in the world, and has stagnated since 2001.

In early 2009, with support from the Dutch government through the Strategic Alliances with International Nongovernmental Organizations (SALIN) program, PSI/Mali expanded its existing family planning program to include the promotion and service delivery of LARC methods, specifically the IUD and contraceptive implant.

As part of this effort, PSI implemented a pilot program in coordination with local clinics to provide family planning services when mothers bring their newborns in for immunization services. Given that Mali’s unmet need for family planning is highest (79 percent) among women just after childbirth, this is an important population to target, and clinics offering immunization services, a logical place and occasion to reach women.

PSI/Mali initiated the integration of family planning and immunization services in five of the 53 private clinics that comprise the franchised ProFam network in Bamako, piloting “clinic event days” – a strategy in which PSI staff work with the host clinic to create demand for family planning and support LARC service delivery. During the event days, a PSI midwife conducts an interactive presentation detailing the benefits of family planning to the women waiting with their children to be immunized. Women who opt for a LARC method receive it immediately, on-site and at a subsidized cost.

Through a partnership with the Mali Ministry of Health to expand LARC services to the public sector, PSI trained 50 public sector midwives in LARC service delivery. From May to November 2009, PSI/Mali reached 12,204 women with family planning messages through event days held in private and public facilities when immunization services were offered; 18 percent of women reached opted for a long-acting contraceptive method. In total, PSI/Mali provided 3,434 implant and 563 IUD insertions in 2009.

These results demonstrate a demand for LARC methods among new mothers in Mali and the potential impact for integrating family planning into maternal and child health services. Yet, challenges remain. One major obstacle is that overburdened and understaffed clinics lack the capacity to offer immunizations and family planning services on the same day.

PSI/Mali plans to continue exploring innovative family planning models to address this and other issues to ensure women like Aminata have access to the services they need in order to space and time their births.

“Women who opt for a LARC method receive it immediately, on-site and at a subsidized cost.”

**LARC methods have many benefits** – in particular, they require one trip to a clinic for insertion with a follow-up visit in six weeks and then again once a year. They are 99 percent effective and prevent unintended pregnancy for 5–12 years.

**99% effective**

*PSI Authors: Stephanie Gallagher, Technical Advisor, and Christine Bixiones, Associate Program Manager, Reproductive Health, Washington; Boureima Maiga, Family Planning Technical Advisor and Steve Lutterbeck, Country Representative, Mali.*
Going the Last Mile

Many global health organizations recognize community-based distribution (CBD) programs as one of the most beneficial ways to increase access to essential health interventions in countries that lack ample resources and infrastructure. Properly managed CBD programs, which employ networks of community-based distribution agents to refer individuals to clinics and provide subsidized health products, have been effective in increasing access to a wide range of services from oral contraceptives to insecticide treated nets.

A PSI/Myanmar Sun Primary Health Agent conducts talks with women about their family planning options.

With 67 percent of the population in Myanmar living in rural areas, the need to connect resource-poor communities with appropriate health services is vital. Created in 2008, PSI’s Sun Primary Health program offers a network of community-based distribution agents (CBDAs) that provide a range of health services and connect communities with clinics located within a three-hour radius of their home.

Sun’s CBDAs are trained in a range of interventions including family planning, malaria diagnosis and treatment, tuberculosis screening, diarrhea management, and pneumonia diagnosis and treatment. In the event they are unable to provide services on location, CBDAs are taught to refer patients to nearby private sector Sun Clinics for assistance. In addition, CBDAs sell oral contraceptives, condoms, diarrhea treatment kits, malaria treatment and safe water products directly to clients at a highly subsidized cost. Today, just 18 months after its inception, Sun Pri-
Mary’s network has grown to include 775 agents and covers nearly 1 million people in 31 townships.

In Madagascar, 70 percent of the 20 million residents live below the poverty line, and 76 percent are situated in rural areas, making implementation of widespread health interventions a significant challenge. Malaria and acute respiratory and diarrheal diseases are the leading causes of mortality and morbidity in pregnant women and children under 5, respectively. Although Madagascar has a robust public sector which provides the majority of the country’s health products and services, more than 60 percent of the population lives more than 10 kilometers (6.2 miles) from the nearest health facility. By segmenting the market and offering health products and services at a subsidized cost to those who can afford it, PSI/Madagascar is broadening overall accessibility and allowing the public sector to reach the lowest socioeconomic segment with their cost-free services.

With support from The Roll Back Malaria Partnership, The Global Fund to Fight AIDS, Tuberculosis and Malaria, the U.S. Agency for International Aid (USAID), the United Nations Children’s Fund and other donors, PSI/Madagascar introduced its CBD program in 2005. In 2009, PSI/Madagascar worked in 66 districts out of 115 across Madagascar with a community-based approach. This was achieved through its partnership with 13 local nongovernmental organizations (NGOs) under the Santénet2 USAID-funded project Kaominina Mendrika (“Model Communities”), and 267 other local NGOs.

Through the efforts of 2,843 CBDAs managed by PSI’s partner NGOs, and 2,296 managed by Santénet2’s partner NGOs, in 2009, more than 1.7 million long-lasting insecticidal nets (LLNs), 67,000 oral contraceptives, 1,380 injectable contraceptives doses, 18,000 cyclebeads, 651,000 condoms, 218,000 water treatment solutions, and 12,000 diarrheal treatment kits were distributed at the community level. In addition, CHWs are now being trained and equipped for community-based service delivery of injectable contraceptives. Finally, a network of 133 community agents in urban areas educated and referred youth and women of reproductive age to franchised clinics for various reproductive health services by providing emotional and personalized support. This led to 15,206 long-term contraceptive method adoptions in 2009, and 140,000 youth having been counseled on reproductive health topics.

While CBD programs hold great promise for reaching a broader audience and increasing access, critics say overworked community-based distribution agents result in low morale and high turnover. Even so, global health organizations continue to explore ways to best develop sensible CBD programs which bolster existing health infrastructures. PSI and its partners stand by the intervention’s ability to reach more people with essential health messages, products and services in challenging and diverse environments.

PSI Author: Jeffrey Matthews, Reproductive Health Intern, Washington

Questions with Raymond G. Chambers

Over the long term, how can we ensure that gains in malaria control will be sustained beyond 2010? When we take into account that we are on the brink of eliminating such a massive burden that inflicts so much suffering on so many people, we cannot afford to allow progress against the disease to erode. Historic levels of resources have been infused into malaria control, which has already begun to yield results in the form of lives saved. While we can end malaria deaths by 2015, these gains will require sustained efforts to ensure permanence. Eventually, and with the onset of breakthroughs such as the malaria vaccine, this permanence can be realized.

What will get you out of bed on January 1st 2011? Achieving universal mosquito net coverage by the end of 2010 is a significant step toward ending deaths from this disease, but it is by no means the end of my commitment to reversing the course of malaria. As long as children are still dying of malaria, I intend to remain completely involved.
Nicaraguan Women, Focus of Graduate Program for Health Providers

SI’s affiliate in Nicaragua, PASMO, is partnering with the Universidad Nacional Autónoma de Nicaragua (UNAN) to train a future crop of providers in family planning services.

PASMO/Nicaragua’s Regional Coordinator for Reproductive Health programs, Dr. Alicia Rivas, talks with Yadira Medrano, the coordinator of a unique certification program in intrauterine device (IUD) and implant insertion at UNAN. Dr. Rivas also speaks with Dr. Vilma Martínez, a private provider who is part of PASMO/Nicaragua’s franchise network, Segura, and a graduate of the program.

Providers are often a barrier to women accessing reproductive health care services. They may lack training in family planning counseling and service delivery; have misperceptions about medical eligibility for contraceptive method use; or lack the time necessary to offer counseling and the full range of family planning (FP) methods, especially long-acting and reversible methods of contraception (LARC). One way to increase access to FP and bring sustainable change to a country’s reproductive health care system is by increasing medical students’ capacity in family planning counseling and LARC service delivery.

UNAN has validated, endorsed and adopted PASMO/Nicaragua’s LARC training methodology which now serves as course material for UNAN’s certifications in IUD and implant insertion. This year, the methodology will also be incorporated into the UNAN’s master’s degree in Reproductive and Sexual Health. The university has also established a teaching clinic in collaboration with PASMO where future family planning providers receive practical training in IUD and implant method insertion. This integration has brought family planning counseling and LARC method training into an academic program that previously did not offer either of these components.

DR. RIVAS: How has the relationship between PASMO and the university helped you and your students?

MS. MEDRANO: It has been a privilege to have this relationship with PASMO because we now have the opportunity to serve the university community in promoting healthy sexuality among university students. We are now equipped to provide university students with personal counseling services on healthy sexuality; a range of family planning methods; and information on correct contraceptive use.

DR. RIVAS: What benefits did you receive from participating in the training, and what value does the UNAN certification add?

DR. MARTÍNEZ: The trainings provided me with information on new advancements in hormonal methods, such as the two-rod implant, and new guidelines for IUD client eligibility. It is important that UNAN provides a certification in LARC training as it is the governing body of health professionals and validates university courses at the international level. The course ensures that providers are competent in LARC method delivery, which will result in high-quality care for the client.

Authors: Dr. Alicia Rivas, PASMO Regional Coordinator for the Women’s Health Project in the Northern Pacific Region, Nicaragua; Christine Bixiones, PSI Associate Program Manager for Reproductive Health, Washington.
Breaking the Silos
HIV Experts Focus on Impact of Integration

Since 2001, new HIV infections worldwide have declined by 17 percent. According to the 2009 AIDS Epidemic Update released by the Joint United Nations Programme on HIV/AIDS and the World Health Organization, this decline is due, in part, to HIV prevention efforts. According to the report, impact on HIV was highest where prevention and treatment programs were integrated with other health and social welfare services.

HIV services have been diverted from related health care services for many years, operating in silos with separate and often competing programs and resources. To address this, PSI has increasingly focused on the importance of integrating HIV prevention into related health services, such as reproductive health, treatment for sexually transmitted infections, and tuberculosis diagnosis and care. Accomplishing this requires close collaboration with governments, non-governmental organizations and other health systems stakeholders to ensure coordinated approaches that lessen the burden on health care systems. PSI is committed to restoring the powerful synergies between HIV and related health services to maximize the effectiveness and value of programs and to open new opportunities to reach those at risk for or living with HIV.

Krishna Jafa, Director of HIV and Reproductive Health, PSI

The photos provide a glimpse of the services PSI provides around the world.
The landscape of commercial sex has changed in Cambodia in recent years. Sex work has shifted out of brothels and into entertainment establishments, such as beer gardens, karaoke bars and massage parlors.

Now entertainment sex workers (ESWs) are an emerging high-risk group in Cambodia. Little was known about their sexual health behaviors until the 2007 Cambodia Behavioral Surveillance Survey data showed high rates of abortion among ESWs, suggesting a possible link between high-risk sex and unmet need for contraception.

To learn more, PSI/Cambodia conducted research to explore behaviors and behavioral determinants driving condom use and reproductive health practices among ESWs. The findings provide a clear indication for the integration of HIV and reproductive health messaging targeted to ESWs.

ESWs often have concurrent partners – commercial partners and ‘sweethearts’. Sweetheart relationships are characterized by strong emotional attachments involving a degree of trust between partners. Consistent condom use is high with commercial partners but much lower in sweetheart relationships. For many ESWs there is a crossover between commercial and sweetheart relationships; paying clients often become ‘sweethearts’ over time. As trust and affection develop, condom use becomes rare, putting both partners at serious risk for HIV.
Low condom use puts Cambodia’s entertainment sex workers at high risk for HIV and unwanted pregnancy. PSI is working to integrate HIV and reproductive health programming to meet the unique needs of these women.

The main reason ESWs use condoms with sweethearts is to avoid pregnancy. Women fear losing their jobs but equally important, ESWs fear an unwanted pregnancy could end their sweetheart relationship.

Despite this, there remains a serious need for consistent use of modern family planning methods; while ESWs prefer condoms, the withdrawal method is cited as the second most practiced method, nearly equal to that of oral contraceptives. Myths and misconceptions about hormonal methods are common, and there is low awareness of intrauterine devices. The need for family planning is underscored by survey findings that more than 30 percent of ESWs reported having had at least one abortion in the previous 12 months, and nearly 50 percent reported having had one in the past.

Armed with these research results, PSI/Cambodia is integrating HIV and reproductive health programming to meet the unique needs of entertainment sex workers. A first step is adapting existing communication materials under its birth spacing “Myths and Misconceptions” campaign to target ESWs in sweetheart relationships. This includes the broad dissemination and promotion of the PSI-supported reproductive health hotline, which receives more than 800 calls per month. Peer educators and outreach workers link ESWs to HIV-testing and reproductive health services through PSI/Cambodia’s private sector provider network, Sun Quality Health, and through partner and public sector health services. PSI/Cambodia is also exploring training local partners to distribute and socially market oral contraceptives directly to ESWs and surrounding establishments. Finally, PSI/Cambodia is investigating the use of Unique Identifier Codes, modeled on programs in Vietnam and Central Asia, to track reach, message delivery and referral services among ESWs.

"The need for family planning is underscored by survey findings that more than 30 percent of entertainment sex workers reported having had at least one abortion in the previous year, and nearly 50 percent reported having had one in the past."

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PSI Authors: Mary Warsh, Senior Technical Advisor and Dianna Long, Director of Strategic Information, Cambodia.
Confronting Co-infection
HIV and Tuberculosis

Tuberculosis is a major cause of morbidity and mortality worldwide, particularly in Africa and Asia. People living with HIV and AIDS (PLWHA) are especially vulnerable to developing active tuberculosis (TB). While TB is both curable and preventable, it remains the most common cause of death and one of the most common opportunistic infections among PLWHA.

Expanding Access to Counseling and Testing for TB Patients

South Africa has the fourth highest TB incidence rate in the world and an adult HIV prevalence of 10.9 percent. The South African National Department of Health policy requires that all TB patients be tested for HIV, since offering HIV testing to TB patients is vital to avoid missing effective treatment opportunities. Yet, in 2006, only a third of all TB patients were tested.

With that in mind, local PSI affiliate Society for Family Health (SFH) partnered with two health facilities in the KwaZulu Natal province of South Africa to increase HIV testing among TB patients. SFH began providing mobile HIV counseling and testing (CT) for individuals from the out-patient departments and TB wards of the Prince Mshiyeni Memorial Hospital and the V Clinic. Individuals testing HIV-positive are referred back to the health facilities for treatment.

From July 2006 through September 2009, more than 7,000 patients were tested for HIV through this program, and 37 percent tested HIV-positive. Among the TB patients who were tested during that period, 90 percent were HIV-positive. All patients who tested positive received referral letters to the hospital and records show that 80 percent accessed follow-up care.

SFH introduced telephone tracking to ensure patients were using the referral services, gather information about patients’ referral experiences and to investigate why 20 percent of individuals did not use referrals. The tracking showed that some patients had accessed care but had not used their referral letters while others had gone to a traditional healer for care instead.

The impact of SFH’s TB/HIV integration has been significant. Prince Mshiyeni Memorial Hospital has increased its capacity to offer HIV counseling and testing. The V Clinic, where SFH still implements services, is working closely with counselors to improve the continuum of care by addressing challenges in the referral system.

Socially Franchised Networks Support National TB Strategy

In Myanmar, a high TB-burden country, a large percentage of health services for those living in low-income communities are accessed through the private sector, which encompasses about 6,000 private doctors. Historically, this was not the case. The private sector was often too expensive for low-income users and lacked medical professionals trained in TB diagnosis and care.

In 2004, PSI/Myanmar expanded the scope of its Sun Quality Health (SQH) franchise to include high-quality TB diagnosis and treatment services for low-income communities. Private general practitioners in the SQH network are trained in TB symptomatic screening, diagnosis and treatment. SQH clinics are supplied with free, PSI-branded complete drug treatment packages and diagnostic costs are reimbursed by PSI/Myanmar. This enables SQH clinics to provide free TB services and treatment using a directly observed treatment short course (DOTS). The SQH network now has 600 clinics treating more than 12,000 TB patients annually.

The TB and HIV co-infection rate in Myanmar is high: 11 percent of TB patients also have HIV. National policy restricts HIV testing to public sector labs; however, PSI/Myanmar received permission to run two HIV counseling and testing centers. From January to October 2009, the two centers identified 243 SQH TB patients who were HIV-positive and guided them to appropriate support and treatment services.

Authors: Miriam Mhazo, Sibusiso Sithole, Bongani Dube and Scott Billy, Society for Family Health/South Africa; John Hetherington, Dr. Nyo Nyo Minn, Dr. Aung Kyaw Linn, and Matthew Boxshall, PSI/Myanmar
Cross-sector Programs Enhance Harm Reduction

In Thailand, the HIV prevalence rate among injecting drug users (IDUs) is more than 27 times what it is among the general adult population. Whereas 1.4 percent of the general adult population in Thailand is HIV-positive, 38 percent of IDUs are infected by the disease. This high HIV prevalence is largely attributable to the efficiency of HIV transmission by blood from the sharing of injecting equipment and limited access for IDUs to health services and information.

IDUs suffer significant stigma and discrimination in Thai society, where drug dependence is closely associated with crime and not well understood as a health problem. The concept of harm reduction – reducing the harms associated with the use of drugs in people unwilling or unable to stop – is relatively new. While opioid substitution therapy, HIV counseling and testing, and anti-retroviral therapy are offered under the government’s universal health scheme, their use by IDUs has been low due to fear of a hostile reception or being reported to the police; distrust of the quality of the services, particularly in terms of meeting their health and lifestyle needs; low awareness of available services; or low expectations of benefits from using the services. “The challenge is to scale up IDU-friendly government-run HIV prevention services and to integrate them with current health outreach activities that IDUs already trust,” says Alex Duke, program development manager at PSI/Thailand.

In response, the Royal Thai government and The Global Fund to Fight AIDS, Tuberculosis and Malaria launched a five-year harm reduction program in 15 Thai provinces to scale up comprehensive HIV prevention services for IDUs. Seven community-based organizations and up to 150 pharmacies are a part of the program, with PSI leading the network as Principal Recipient of the Global Fund grant. Key components of the program include street-based peer education, drop-in centers and prison outreach to reduce sharing of injecting equipment and increase condom use; the strengthening of linkages with IDU-friendly health services; and the distribution of clean injecting equipment by peer educators and a voucher scheme through pharmacies.

As part of the program, PSI runs a branded network of drop-in centers and peer educators in four major cities. Called “O-zone,” these centers serve as a trust point through which IDUs access health services and information, clean injecting equipment and condoms. Many O-zone staff and peer educators are current or former IDUs, making it easier to build trust with clients and refer them to health services at other facilities. This integration of community-based and government health services maximizes the health impact for IDUs.

The O-zone center in Chiang Rai has been particularly successful in building commitment to the project’s goals among government and civil society partners. Through a series of roundtable discussions with key stakeholders, the O-zone team helped establish a cross-referral network with public hospitals and Baan Sakul, a government-supported sexual and reproductive health program targeting youth. Most significantly, the roundtables brought about plans to incorporate lessons learned on improving the lives of IDUs into the government’s provincial health plan. By working to integrate nongovernmental organizations and government health services for IDUs, O-zone has ensured that comprehensive HIV prevention services for IDUs are a part of future health plans.

PSI Authors: Carmen Chan, Country Representative, and Alex Duke, Program Development Manager, Thailand.
UNAIDS Ambassador for the Netherlands

Marijke Wijnroks

Dr. Marijke Wijnroks was appointed the Netherlands’ ambassador to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in July 2009.

MR. GADE: You have been the Dutch AIDS Ambassador since July 2009. What do you see as the main challenges for you in this role, and how are you planning to tackle these?

DR. WIJNROKS: Keeping the focus on HIV/AIDS in times of economic downturn and with many competing issues, most notably climate change, is a challenge. We have successes to claim and we have made impressive gains over the past few years which provide a good basis for building the case for a continued effort. We must argue to continue the fight against AIDS as a humanitarian cause but also as a precondition for countries’ social and economic development. At the same time we must put even more effort to increase our effectiveness and efficiency – getting more health and less AIDS for the money.

MR. GADE: This year the Dutch government is chairing the UNAIDS Programme Coordinating Board. The recent evaluation report on UNAIDS says that UNAIDS needs better governance in view of the diversifying epidemic and changing aid architecture. Do you think that UNAIDS can still win the fight against AIDS?

DR. WIJNROKS: I believe that UNAIDS continues to play a vital role in the fight against AIDS and will be able to rise to the challenge. The evaluation not only confirmed this, but also highlighted a number of issues where performance must be improved. During the last Programme Coordinating Board (PCB), we had a frank discussion of the evaluation findings and we agreed on an ambitious plan to take the recommendations forward. We see the follow-up process as a key priority for our chairmanship.

MR. GADE: The evaluation report also concludes that UNAIDS leadership for effective HIV prevention policies has been inadequate. Do you agree with this statement and do you feel you can contribute to improve in this area?

DR. WIJNROKS: It is indeed true that UNAIDS has only recently taken a more active stance on prevention and we welcome the strong call by Executive Director Michel Sidibé for a ‘Prevention Revolution’. As chair we will highlight the importance of prevention, in particular the linkages between HIV/AIDS and sexual and reproductive health and rights (SRHR). The thematic session at the June PCB will actually be dedicated to HIV/AIDS, SRHR and gender – an excellent opportunity to focus on prevention. We will in particular push for evidence-based prevention programs that tackle the modes of transmission that are most prevalent, and that address the needs of key populations such as men having sex with men, sex workers and drug users.

MR. GADE: PSI is one of the members of the Strategic Alliance of International Non-governmental Organizations (SALIN) that is supported by the Dutch government. What is the role of NGOs? Should they make room for local partners?

DR. WIJNROKS: I believe that international NGOs still have an important role to play in areas such as advocacy, networking and building capacity of their counterparts in the South. Over time, as local partners become stronger, the role of international NGOs will, however, need to adapt, and the role of local organizations will become more important.

MR. GADE: You mentioned the Strategic Alliance of International Non-governmental Organizations (SALIN). How can SALIN contribute to increasing the impact of HIV/AIDS prevention? And what is the appreciation of foreign aid in the western countries?

DR. WIJNROKS: The cuts in the Dutch aid budget are directly related to the shrinking Dutch economy. Whilst the target of spending 0.8 percent of Gross National Product (GNP) on aid has been maintained, the decline in GNP has meant less funding for aid in absolute terms. It is true that we are under increasing scrutiny to demonstrate effectiveness, and I believe that this debate is healthy as long as complicated issues are not overly simplified. International NGOs are convincing advocates who have always had a great deal of public support. I believe that the clear focus and results that an NGO like PSI can communicate will certainly help to increase awareness and appreciation of our common aid efforts.

MR. GADE: One of the themes of the PSI program that is funded under SALIN is the integration of HIV and family planning. What will be your role in the process of HIV/AIDS and reproductive health (RH) integration? Is the distinction between RH and HIV justified, given the high rate of HIV transmissions through sexual intercourse?

DR. WIJNROKS: Improving linkages between HIV/AIDS, sexual and reproductive health and rights is actually one of my priority areas. I believe that in the past HIV/AIDS and SRHR have been divided in an unhelpful way, whereas in practical terms both areas are intrinsically linked. HIV transmission worldwide is predominantly through sex, so SRHR is key to HIV prevention. At the same time, people with HIV have SRHR needs, including family planning, which must be met.

MR. GADE: PSI has just turned 40. What contribution do you expect from PSI for its next decade?

DR. WIJNROKS: PSI has always been a frontrunner in finding practical and creative solutions to health problems of the poor. Please continue to be this pathfinder.
United States

Global health community members have been eagerly awaiting details on a new, comprehensive global health strategy, called the “Global Health Initiative” (GHI), since the Obama Administration first announced it in May 2009. The administration finally released more details of its vision on February 1, 2010.

According to the document, the GHI will:

- Implement a woman- and girl-centered approach;
- Increase impact through strategic coordination and integration;
- Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement;
- Encourage country ownership and invest in country-led plans;
- Build sustainability through health systems strengthening;
- Improve metrics, monitoring and evaluation;
- Promote research and innovation.

Up to 20 “GHI Plus” countries will be identified over the next several years for accelerated implementation of these GHI principles. GHI Plus countries will benefit from extra program funding. They will be selected based on criteria, such as partner country interest in participation, impact of existing programming, magnitude and severity of health problems, and the potential to leverage investments from other donors.

The administration has asserted that new resources will be applied to fund the GHI. The GHI funding goal of $63 billion between 2009 and 2014 covers both program implementation and research and development.

In line with the commitment to increase funding, President Obama’s Fiscal Year 2011 (FY11) budget request to Congress, also released on February 1, proposed an overall increase in global health spending.

Global health accounts that received the biggest increases were maternal and child health, with a 27.5 percent increase over the amount appropriated in FY10, and malaria, with a 16.2 percent increase.

Advocates were disappointed to see only a very small increase for HIV/AIDS funding in the request, despite an ongoing need to scale up prevention, treatment and care programs around the world. In 2008 alone, the most recent year for which data is available, there were an estimated 2.7 million new HIV infections. An additional disappointment was a requested decrease in funding for The Global Fund to Fight AIDS, Tuberculosis and Malaria, which has saved the lives of more than 5 million people since 2001.

Congress will spend the upcoming months considering the president’s budget request.

Europe

The Lisbon Treaty, Sexual and Reproductive Health and Rights

The Lisbon Treaty, signed December 1, 2009, aims to increase the effectiveness of the European Union (EU) institutions and their decision-making mechanisms. Expectations exist for the Treaty to deliver an adequate framework for development cooperation and Sexual and Reproductive Health and Rights (SRHR) to prosper. Within the Treaty, development cooperation is clearly identified as an independent policy area with European Commission competence and is centered on the main objective of poverty eradication, in line with the Millennium Development Goals.

Under the Treaty, the EU has attained a single legal personality. Therefore, advocacy work with the EU delegations is now more important than before, as they play a key role in coordinating the EU’s positions and priorities on SRHR issues. From now on, it will be crucial to ensure that the new EU delegations include development and health professionals to strengthen the development and SRHR voice.

Report Calls for More Targeted Development Aid

The Dutch Scientific Council for Government Policy has criticized Dutch development aid for being too broad in scope, in a report offered to the Prime Minister in January 2010.

The report stresses that foreign aid should only make up a small portion of a bigger development process. It concludes that all countries offering development aid should focus on offering concentrated aid to a few countries. This would imply that the Netherlands, instead of being present in 36 countries, would provide well-functioning aid in a few of them. Concentrated aid efforts would furthermore mean country specialization; each donor country should only offer help in what it does best. The council’s report offers non-binding advice.
The United Nations Millennium Development Goals (MDGs) were first agreed upon in 2000. Earlier this year, U.N. Secretary-General Ban Ki-moon said, “We need to focus attention and accelerate the process to achieve, to realize, the goals of the MDGs by the target year 2015.”

The chart below places the impact of PSI’s interventions from 1990–2009 in the context of the Millennium Development Goals.

<table>
<thead>
<tr>
<th>MILLENNIUM DEVELOPMENT GOALS</th>
<th>GLOBAL SITUATION</th>
<th>TARGETS TO REACH BY 2015</th>
<th>PSI’S RESPONSE 1990–2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 4</td>
<td>Deaths in children under 5 have declined steadily worldwide. Around 9 million young children die each year from largely preventable or treatable causes.</td>
<td>Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.</td>
<td>PSI averted 27,755,249 diarrhea cases, 6,088 pneumonia cases (since 2008) and 75,638 deaths (from diarrhea, nutrition and pneumonia).</td>
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<td>Goal 5</td>
<td>Every year, 536,000 women and girls die as a result of complications during pregnancy, childbirth or the six weeks following delivery.</td>
<td>Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.</td>
<td>PSI averted 123,522 maternal deaths.</td>
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<td>Goal 6</td>
<td>One in every four women who is married or in a union has an unmet need for family planning, a figure that has remained almost unchanged since 1995.</td>
<td>Achieve universal access to reproductive health.</td>
<td>PSI averted 24,476,349 unintended pregnancies and provided 105,408,278 couple years of protection.</td>
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PSI Measures Health Impact in 2009

PSI recently released its December Health Impact Report, summarizing the impact of PSI’s interventions in 2009. The report looks at how many infections or deaths PSI averted in each of the main health areas and regions in which it works. This impact was also converted into the international standard measurement of Disability-Adjusted Life Years (DALY), which measures both the years of life spent with a disability and the years lost due to an early death. In 2009, PSI’s interventions averted 16.5 million DALYs, a 17 percent increase over PSI’s 2008 performance.

The family planning products distributed by PSI in 2009 provided 14.4 million couple years of protection (CYP), a standard measure of the performance of family planning programs. PSI has seen a 14 percent annual growth in its CYPs for the past two years.

To view the December Health Impact Report 2009 in its entirety, go to Resources on PSI’s website, www.psi.org.
A Land of Contrasts

In March, I traveled to Haiti to visit our PSI staff. It was an incredibly moving experience to meet in-person the people we have spent weeks supporting from Washington.

Approaching Haiti, we fly over the United States Naval Ship Comfort, Medical Treatment Facility, anchored in the bay and a Navy helicopter follows us in to land.

Arriving in Port-au-Prince, the azure water and green hills are deceptive. But any repeat visitor to Haiti knows that. The airport tarmac has calmed from the chaotic post-earthquake days, but our American Airlines jet still competes with a Brazilian C-130 and a United States Air Force jet. On the ramp are many U.S. servicemen, smiling and waving. They are happy in this mission, I think.

The Arrivals hall is temporary, clean and orderly. Outside on the street it’s less so – soldiers from various nationalities, crazy traffic, Haitian street peddlers who remind me that no matter what disaster strikes, the market breathes, commerce continues.

Even after countless news reports and images, it’s still a shock to see downtown Port-au-Prince in ruins. We drive by the presidential palace, leveled. The cathedral I recall visiting in 1984 is destroyed. Rubble litters the streets, but traffic moves. There are tent cities in all the big public parks. The inhabitants are waiting; what are they to do?

It’s not clear that anyone is telling them.

Meeting with the PSI/Haiti staff, I ask each one to say how long they’ve been with us, and then to talk about their experiences. An hour later, I am stunned. Tales of despair, drama, fear and courage. Frantic hunts for family members, children. Thankfully our staff is mainly intact, save Immacula Wagnac, who perished. Another staff member lost 17 members of her family. Another broke down in pain just before our meeting; she was having stomach trouble, but also she came from Leogane, the quake’s epicenter. Leogane is no more. She is dealing with that disheartening reality.

Across from the PSI/Haiti office, Place Boyer in Petionville is a tent city. We are doing communication work to promote safe drinking water. I’m told there may be an informal brothel in operation; the team plans for how they can organize HIV prevention activities and distribute condoms.

The marketing infrastructure of the country has been badly mauled; our distribution network is in tatters. Traditional social marketing programming is largely on hold. But our funders don’t want us to engage in free distribution – not clear we have the legs right now anyway – yet, the international relief organizations seem absent.

It’s frustrating.

Staff told stories of individual acts of grace and personal heroism of average Haitians who climbed into rubble to help save complete strangers. There were thousands of such acts. I sense a morbid feeling of pride: Haitians helped Haitians deal with death before the international community could even try.

While I am here, an official communiqué from the Education Ministry is released: no Haitian school may open as scheduled on March 1. Ostensibly it’s because buildings haven’t been ruled safe yet. But I see parents’ reactions: will their children lose a whole year, or more? The shutdown of education feels very bleak.

Our staff speaks glowingly of Jim Malster, PSI’s ‘first responder’, who arrived in Haiti within days to account for staff and assess the unimaginable damage. He soon began rallying Haitian staff to think about returning to work. They really needed that nudge, they said. They needed to have a task.

It will be a while before PSI/Haiti is operating at capacity again. But I am pleased to report that PSI/Haiti is very much still standing.
Almost one billion people drink dirty water every day

Does a cockroach in your teacup look more scandalous than the failure to provide safe water to millions of people? Can you imagine drinking water polluted by chemical or human waste? Did you know that one gram of faeces can contain 10 million viruses, 1 million bacteria and a hundred worm eggs? Now you do.

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