Dear friends,

I am sitting in my office in Antwerp, overlooking the nicely renovated gardens of ITM, recovering from a trip to Amsterdam, 16th ISSTDR (International Society for Sexually Transmitted Diseases Research) conference. Interesting meeting covering different aspects of STI research and programs in industrialised and developing countries. And great to run into ITM alumni there such as Dr. Kizito (Kenya, MDC 03-04) and Jocelyne (Madagascar, MCM 98-99)! One of the main themes of the conference was "re-emerging STI" and it was discouraging to note how, after 15 years of declining trends in STI in industrialised countries the rates are going up again since late nineties, coinciding with the introduction of ARV and reduction in AIDS mortality. The changing face of AIDS, from a killer disease to a chronic manageable disease, has led to an increase in unsafe sex especially among the young. The question of course remains whether those trends will also occur in developing countries, where ARVs are now becoming increasingly available. As illustrated in this Newsletter, several alumni are dealing with aspects of rolling out AIDS care, and the challenges of how to offer quality care to a maximum number of people are huge! But the lessons I learned from Amsterdam and other experiences, is that unless Prevention is simultaneously strengthened, the trends of the West will be repeated in the developing world, with even more serious consequences on increased incidence of HIV, and sustainability of treatment initiatives. Rolling out ARV is such a demanding and overwhelming task, that program managers tend to give less attention to Prevention. It would be a historical mistake however to neglect or ignore HIV prevention now. And as was pointed out in Amsterdam by Dr Alex Coutinho from TASO Uganda, access to ARV offers also many new opportunities to reinforce Prevention: more uptake of testing, safe sex packages as part of the adherence support and HIV + people on treatment acting as strong Prevention advocates!

But the prevailing feeling I had when I came back from from Amsterdam was: why is the gap between all the knowledge we collect as researchers and what is ultimately translated into interventions and programs so wide? I hope you are all working hard to bridge that gap! From our side we will make sure that we keep offering the best possible training program that prepares all future students to this task of making programs work! That is why keeping in touch with all of you and learning from your experiences is essential. And that will certainly be the focus of our second alumni meeting in Seam Reap early September.

Best wishes from a sunny and tropical (!) Antwerp, and hope to meet many of you in the coming years, and keep in touch with all of you,

Marie Laga
mlaga@itg.be
Political Advocacy and HIV/AIDS Control: a Strategy or a gimmick?

By Misra Samarendra

(MDC 01-02), India
misranaco@yahoo.com

Introduction
Advocacy is all about winning the support of key stakeholders in order to influence policies and spending, and bring about social change. Successful advocates usually start by identifying the people they need to influence and planning the best ways to communicate with them. Political Advocacy attempts to change the thinking of political leaders and other leaders of governance. Public health programmes have been utilizing political advocacy to mobile resources, generate community interest and facilitate access to services. As an example, let’s take the case of tuberculosis. Effective TB control is not a medical mystery any longer. A highly effective, low-tech treatment exists, using medicines that cost as little as US $11 per patient in some countries. The WHO-recommended TB treatment strategy, DOTS (Directly Observed Treatment, Short-course) has proven successful in every part of the world and is considered to be a cost-effective intervention. And yet each year, TB still kills nearly two to three million people worldwide. There is a reason for this paradox. TB control is a low political priority in many countries.

The HIV/AIDS epidemic has been no different. With the initial infections being reported since the early eighties, the developing world is still fighting for wide-spread recognition of this epidemic which has been the cause of death for 3.1 million people in 2004 alone. Though there has been increasing focus on prevention strategies, access to counseling and testing facilities, affordable antiretroviral treatment and stigma and discrimination are still the stumbling blocks to a successful intervention programs in various countries. Is it lack of technical know-how? Or is it lack of political will?

Objective
This report discusses the role of political advocacy in HIV/AIDS prevention and control.

It is based on personal experiences while working for UNAIDS in India

Discussion
The Joint United Nations Programme on HIV/AIDS, UNAIDS, is the main advocate for global action on the epidemic. UNAIDS supports a more effective global response to AIDS by promoting:

• Leadership and advocacy for effective action on the epidemic;
• Strategic information to guide efforts against AIDS worldwide;
• Tracking, monitoring and evaluation of the epidemic and of responses to it;
• Civil society engagement and partnership development;
• Mobilization of resources to support an effective response.

India has utilised political advocates for programmes such as Family Planning and other welfare schemes. The response has been mixed. On one hand we are seeing a declining growth rate in certain parts of the country, but a low utilisation of birth control methods in other regions. The country being under democratic governance, the involvement of political leaders was a slow process. However, it had a major impact for the first time for the Polio eradication programme. With the Prime Minister of the country and other elected leaders endorsing the National Polio immunisation days, this increased the coverage of immunisation and brought down the incidence of polio cases from a few thousands to less than a hundred within a couple of years.

Political leadership and HIV/AIDS in India
India established a National HIV/AIDS Programme following the first case of HIV/AIDS in 1986. A high powered National AIDS Committee was constituted in 1986 itself and a National AIDS Control Programme was
launched in year 1987. Presently, India is implementing a comprehensive HIV/AIDS Control Programme throughout the country with the objective to reduce the spread of HIV infection, and to strengthen the capacity of Central/State Governments and the private sector to respond to HIV/AIDS on a long-term basis. However, the programme was lacking in an effective leadership. It was very centrally driven without much of a ownership at the state and district level. Considering the fact that countries such as Thailand and Brazil were showing signs of slowing down the epidemic and one of the contributing factors to these countries were a strong commitment from the political leaders. A priority mandate for UN and other donor agencies is political advocacy. It includes engaging the political leadership in an effective manner to mobilise resources, formulate policies which are enabling and sensitive to the needs of the community. Political advocacy has never been more acutely focussed as it is in the field of HIV/AIDS. India realized the importance of involving the politicians and thus was formed the Parliamentary Forum on HIV/AIDS in New Delhi in the year 2000. India has 543 elected parliamentarians at the Federal Government level. This forum initiated and supported by UNAIDS consisted of 14 core members and all other parliamentarians as members. The initial years were mostly on sensitizing the forum and getting the facts right about the epidemic. This included exposure visits to other nations affected by the epidemic and defining the role of the leaders in scaling up the programme. However, the programme got a tremendous boost only in 2003 with the involvement of political leaders at all levels of governance. UNAIDS India facilitated the first ever National Convention of the Elected representatives on HIV/AIDS. This was the largest ever gathering of 2000 leaders from all political parties at the national state and district levels. This 2-day event organized in July 2003 was attended by a large number of political leaders including the Prime Minister. For the first time a ‘Declaration of Commitment’ was endorsed by all the participants. Now, is political advocacy scientific or does it have a public health rationale? It is considered by many as a gimmick to keep the political leaders included as a token gesture. On the contrary, political advocacy for HIV/AIDS prevention in India has produced results. It was due to effective political involvement, that the following successes were achieved:

1. The government moving from a policy to a legislation on HIV/AIDS
2. Formation of a Parliamentary Forum on HIV/AIDS and the involvement of elected representatives at all levels of governance
3. Inclusion of HIV/AIDS prevention as part of regular schemes and programmes for the different ministries
4. Political will in including antiretroviral treatment through government funding.
5. The development by Indian scientists in collaboration with IAVI of a vaccine for the dominant Indian strain HIV 1 subtype C that will be tested in further trials.

It has also been a learning experience for UNAIDS and other stake-holders. Political advocacy has been more of an art than science. The basis of good political advocacy is a comfortable, non-intimidating working relationship with the government and other representatives, frequent interactions through seminars, workshops and individual meetings. Political advocacy requires sustained efforts and resources, both financial and human resources. Though, we do not have an evaluation of the cost-effectiveness of such a strategy, programme managers in the different agencies working on HIV/AIDS in India have come to realise the importance of political advocacy. This has been evident more so after the last International Conference on HIV/AIDS in Bangkok in 2004, where a separate plenary session was organised on political advocacy and leadership.

Do public health and the academic scientific learning have a role in the art of political advocacy? They most certainly do. The strength of political advocacy lies in the scientific understanding of the epidemic and its health implications. With increasing involvement of political leaders, the demand increases on programme managers for correct interpretation of epidemiological data, knowledge and use of advanced technologies in treatment and prevention, promoting research through innovative methodologies and evidence based programme management.
Finally, one also needs to be cautious while on political advocacy. Over-enthusiasm often leads to misplaced activism and wrong media coverage. Incorrect information can produce negative results and sometimes stall successful and well-functioning interventions, particularly among marginalised communities.

Conclusion
A good political advocacy programme for HIV/AIDS is based on sound scientific and public health knowledge. Political advocacy has been an effective strategy in the prevention and control of HIV/AIDS in India. Stigma and discrimination can be overcome to a large extent through political leaders. A better understanding of the epidemic by the political representatives has been fruitful in the scale up of treatment and care options.

Update on Continuum of Care including ART for PLWHA in Cambodia
By Kaoeun Chetra
(MDC 03-04), Cambodia
chetrak@everyday.com.kh or kaoeunchetra@yahoo.com

Cambodia has an estimated number of 123,100 adults living with HIV/AIDS and the highest HIV prevalence (1.9%) in the East Asia and Western Pacific region. Approximately 20,000 individuals are expected to develop serious AIDS related illness in 2003. At the end of 2002 access to comprehensive HIV care and support services was limited, concentrated in urban areas, and almost entirely supported by international NGOs. Availability of treatment for opportunistic infections and ART was limited to three hospitals in the capital, Phnom Penh, and the major provincial city of Siem Reap.

However, significant progress has been achieved over the past two years. The National Center for HIV/AIDS, Dermatology and STI (NCHADS) of the Ministry of Health has successfully established a broad partnership around a National Framework for Prevention and Care that includes increasing access to ART and that directs attention to decentralization of services to districts beyond the main cities. According to the report of NCHADS, by the end of April of 2005, 91 accredited sites are offering testing and counseling, including 77 supported directly by Government, 13 by NGOs, and 1 private centre established in Phnom Penh. There are 228 home-based care teams (HBC) and 310 PLHA self-help support groups (PLHA-SG) in the whole country, most of HBC and PLHA-SG activities are implemented by local Non-Governmental Organizations (NGOs).

Continuum of Care services, including access to ART is currently being expanded to 8 sites in
Phnom Penh and a further 13 operational health districts in 10 provinces. At the end of March 2005, 7,217 patients are receiving ART (36% of AIDS cases estimated in 2003) of which around 8% are children.

Because of Cambodia’s increasing experience with HIV/AIDS care, an inter-country field-orientated Workshop on Continuum of Care for Rapid Scale-up of HIV/AIDS Care and Treatment was held early March 2005 in Battambang province, Cambodia, to provide an opportunity for participants from China, Vietnam, Papua New Guinea, Thailand and Cambodia to meet, discuss and review current and planned health sector responses to the HIV epidemic. Cambodia presented detailed information about the implementation of the Continuum of Care in Battambang Province (as I did for my thesis) and provided an opportunity for participants to visit two sites where the Continuum of Care is already operating.

This workshop was organized by NCHADS and the Ministry of Health, Cambodia, in collaboration with WHO and with financial support from Sasakawa Memorial Health Foundation and Family Health International/USAID – Cambodia.

Sharing of experience on data management at the ISAARV ('Initiative Sénégalaise d’Accès aux Antirétroviraux' or Senegalese Access to Antiretrovirals Initiative)

By Ndella Diakhate

(MCM 02-03), Sénégal
ndella90@yahoo.com

Dear readers,

The principle of « learning on the job », as advocated by the WHO in the framework of 3 by 5, requires not only the sharing of experience in different strategies developed for this purpose, but also the follow-up and evaluation of these interventions to reach the strategic objectives.

Having barely left the MCM 2002-2003 brood, I joined a technical group for data management in the public health sector in addition to my clinical activities (lack of human resources!). This limited group was set up to support the division for the fight against AIDS and STI’s of the Ministry of Health and Medical Prevention in Senegal. I would like to share with you my first year with this group.

The HIV situation in Senegal in 2003 can be characterised as a stable epidemic, with a weak seroprevalence of 1.5% in the general population.

The Initiative Sénégalaise d’Accès aux Antirétroviraux (ISAARV), founded already in 1998, is currently part of the national strategic plan for the fight against AIDS 2002-2006; the strategic objective being to treat 7000 patients with ARV’s by the year 2006. They started with a pilot study (from 1998 to 2000) in three hospital sites in Dakar. One of the objectives of this pilot phase was to demonstrate the efficacy of antiretroviral multi-therapies and the feasibility of such programs within the health structures of countries in the South. The ISAARV today finds itself in a transition phase,
its new objective being to accelerate free access to ARV in all regions of Senegal in 2005. Today, ARV therapy is offered in the country’s 11 regions.

Other strategies for the national program for the fight against HIV/AIDS are also in full expansion: the Prevention of Mother To Child Transmission (PMTCT) and the setting up of Centres for Voluntary Counselling and Testing (VCT). The objective of the national strategic plan is to set up VCT and PMTCT services in all regions by the end of 2006.

It has therefore become essential to put in place an operational data management system using the appropriate tools for data collection on performance indicators of the program, data collection on the follow-up of patients in health care/treatment centres and PMTCT sites and collection of data at VCT centres.

**Methodology to attain these objectives**

One must remember that during the pilot phase, for the research needs accompanying this phase, a data management system was put in place. Several tools were developed: a biomedical register with double pages to be filled in by the doctors, a register to follow up the adherence at the level of the pharmacy where the ARV were dispensed, and a register containing socio-medical information on the social services provided by the different hospitals included in the pilot phase. An epidemiologist was recruited for the collection of information in the health care/treatment centres and the data entry and analysis on the first patients of the ISAARV.

Quite early on, the actors at ISAARV realised the need to develop more efficient follow-up tools. The question of the collection and treatment of information was timidly ventured into without follow-through. At that time (late 2000), the existing operational data card had to be filled in by the different service providers, to respond to the pressing needs of the extension to other sites in Dakar. Little by little, as the decentralisation continued in other regions, this tool became less adapted (cumbersome method of filling in, relevance of data to be collected, etc.)

To improve on data management on HIV/AIDS in the health sector, a limited multidisciplinary technical group was set up by the end of 2003 to support the division for the fight against AIDS/STI of the Ministry of Health and Medical Prevention.

This group’s mission was:

- To coordinate activities linked to the development of data management:
  - development and validation of data collection tools (3rd generation of data collection tools of the program);
  - carrying out a baseline survey on the collection of data in the past years;
  - setting up support for data collection at the intervention sites;
  - developing a system for computerisation.

- To publish the results and keep actors informed regarding the indicators of the different components of the strategic objectives: treatment/care, VCT, PMTCT.

**The baseline survey on the collection of data**

The objectives for this survey were:

- To collect data on the facilities for the clinical management of HIV/AIDS patients (including data on post-exposure accidents, VCT and PMTCT services), from 1998 to July 2004.

- To put into place tools for the collection and analysis of data on AIDS from the health sector at health care facility level and at VCT and PMTCT services.

All national and regional hospitals (of the 11 regions of Senegal), and all health care centres involved in the different activities of ISAARV (treatment/care, prevention of transmission from mother to child) and all VCT services were visited.

An exhaustive review of all registers or other tools available at the facilities visited was carried out to itemise the targeted data and to transfer them to an appropriate questionnaire. A complementary discussion was held with the person in charge of the visited structure whenever this was necessary.

We took advantage of this survey to put into place new collection tool at the intervention sites. We asked the service providers to use them and, at the debriefing in Dakar, asked them for their feedback on the new data collection systems and for their suggestions regarding the format of the tools and the ways to send the information to a higher level.
While putting together this 3rd generation data collection system we had in mind:

- To simplify it taking into account the necessary data for the individual follow-up of a chronic pathology and the follow-up of performance indicators for the strategic plan,
- To ease the completion of the data

Part of the adjustments was secondary to the review of strategies in view of a decentralisation of ISAARV (suppression of viral load, use of WHO classification instead of that of the CDC).

Limitations
The following limitations were identified in the collection of data from the health sector:

- Absence of a uniform standardised data collection system at a facility level (several types of tools sprung up spontaneously in the field but are sometimes filled out incompletely)
- Absence of a sustained communication in the data collection between the pharmacy and the health care-facilities.
- Insufficient notification of deaths and patients lost to follow-up. Deaths at home are not systematically reported.
- Problems with the recording of data: during the survey we noted that the PLWHIV who are not under the ARV are rarely listed in the registers, even when they come to consultations frequently.
- Archiving of files was also noted as a problem encountered at certain sites.
- Harmonisation of the tools: several types of tools were used for the same data. For instance, data on treatment and patient care are noted in several notification tools (consultation register, death register, data cards for the follow-up of TB patients, records on laboratory tests and radiological exams)

Lessons learned
The problems and limits encountered are classically described in information systems, particularly because there was no preliminary work done before the system was set up and no follow-up was organised on the use of these data collection tools. The urgent need, from a public health point of view, to increase access to antiretrovirals, made that the decentralisation of ISAARV (especially when it comes to the treatment component) went faster than the development and implementation of the data collection tools.

Based on the survey the technical group for data management formulated the following recommendations:

- Reflect about the implementation of a system to improve data management of the different target components: treatment/care, VCT, PMCT. This system necessarily implies:
  - implementing data collection tools with instructions on how to fill in documents (registers, data cards,…);
  - implementing a system for the filing of the tools (registers, files for the data cards, folders, etc.);
  - archiving of data collection tools;
  - computerisation of the data collection system;
  - defining of the information flow with the different actors involved and assuring the coordination of this system;
  - guaranteeing an integrated and formative supervision. These supervisions should follow each other closely (every semester or trimester) during the first year.
- Evaluating the system in place every two years.

This survey, which was more a review of the operational data cards and registers, allowed us to demonstrate the urgent need to put up a functional data management system throughout the facilities involved in the interventions of the programme. The importance of disposing over reliable data is no longer under discussion as to their effective use. Actually, only analysed and synthesised data will allow us:
- to use them as advocacy,
- to measure performance,
- to evaluate the relevance of strategies,
- and to improve the quality of interventions.
Managing TB/HIV coinfection in NEPAL: Obstacles and opportunities

By Bhatta Narendra

(SC/TD 2004), Nepal
narendrabhatta@yahoo.com

TB and HIV are both driven by poverty, homeless, poor nutritional status and crowded living conditions; meeting the twin challenges of TB and HIV involves issues fundamental to both health and human rights. Surveillance data in Nepal suggest that about 50% of HIV infected people have tuberculosis. Infection with HIV greatly increases the risk that an infected individual will develop active TB, thus inextricably links the two epidemics. Most of the increase in HIV sero-prevalence occurs among tuberculosis patients in the age group of 25 to 40, which is supposed to be the economically productive age group. The majority of co-infected persons live in semi urban and rural areas. Within the background of rapid socio-demographic transition in Nepal, tuberculosis will be difficult if not impossible to control in HIV-infected individuals, their families and communities, unless the barrier of silence and fear is broken.

In Nepal, at present, most of HIV infected patients are unaware that they have tuberculosis. If they know, they may fear a dual stigma if their TB-HIV status becomes known. However, prompt treatment would increase the length and quality of their lives, to the benefit of themselves, their families and communities. There is also a need for a technology that allows a quicker diagnostic procedure and improves its accuracy especially among the co infected patients. This would greatly cut down the interval between case detection and starting the treatment.

The government is committed to the DOTs strategy, but it is important to acknowledge that it is not yet fully adapted to the realities of HIV-associated TB. Many times, the public health authorities running the DOTs program do not approve of anti-tuberculosis chemotherapy being given empirically to patients if they are from semi-urban and rural areas. The opportunistic infections that characterize AIDS and the symptoms of advanced pulmonary TB frequently result in prolonged hospitalizations for infected, acutely ill individuals. The presence of infection with HIV/AIDS heightens the risk of nosocomial transmission of TB. Prolonged stays, crowded wards, atypical clinical presentations of TB in the presence of co-infection with HIV, and delays in diagnostics place every one (staff, patients and their family members) who has repeated contact with individuals with active pulmonary tuberculosis at risk of infection, but individuals infected with HIV are particularly vulnerable.

Another threat to the effectiveness of treatment is the emergence of MDR-TB.

The provision of anti retroviral drugs for TB/HIV co-infected patients is one of the most essential but difficult aspects of managing this dual epidemic in low income countries like Nepal. It becomes apparent that the achievement of a more advantageous, sustainable outcome for impoverished individuals with TB/HIV co infection in low income countries like Nepal will require an effective collaboration and coordination between the National Tuberculosis and National AIDS programme. There is also a need for more open collaborative activities to be conducted between various NGO/INGO and patients organizations like PLWHA to counter this twin epidemic in Nepal.
The improvement in quality of post abortion care thanks to formative supervision

By Fatim Tall

(MCM 02-03), Sénégal
fshiam@msh.org

In Senegal, as in many other developing countries, information on the number of abortions is rare, not only due to legal reasons, but also due to political, religious and cultural constraints. The available data come essentially from hospitals and only shows us part of the situation.

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, it was recommended to the countries to «pay closer attention to the management of complications following abortion as a strategy to reduce maternal mortality».

To move on its commitment to the fight against maternal mortality, the Ministry of Health (MOH) initiated the «Soins Après Avortement» - Post-Abortion Care (PAC) in Senegal in 1997. A series of operational research studies were carried out to test the feasibility, the acceptability, and the efficiency of the PAC in the university hospitals, then in regional hospitals and health districts. The conclusions of these experiences motivated the decision to expand the PAC to all levels of the health pyramid to have a significant impact on the reduction of maternal mortality and morbidity by complications after abortion.

Thus, the «Projet de Réduction de la Mortalité et de la Morbidité Maternelle» PREMOMA de MSH (Management Sciences for Health), financed by USAID, received the mission to support the Division Reproductive Health (DRH) in the 22 sanitary districts in the regions of Thiès, Kaolack, Louga, Ziguinchor, and Fatick. I was recruited to manage this part of maternal health within the project. This gave me the opportunity to be confronted with the same problems most other programme managers encounter, such as:

1. Managing relations between partners in development and political authorities on one side, and local health authorities and care providers on the other.
2. Planning of activities
3. Elaboration and implementation of a programme for clinical training
4. Managing information
5. Supervision…

I would like to share my experiences concerning this last responsibility

The formative supervision

Three observations caused the Project to support the Division of Reproductive Health (DRH) and the sanitary districts in the revitalisation of the supervision of reproductive health care:

1. The insufficiencies noted in the offer and continuity of care motivated the decision of the MOH to reduce the formative sessions from 45 days (in 2002) to 6 days.
2. To render the services more accessible to the population, certain capacities were delegated. Thus, midwives and nurses were trained to practice manual intra uterine aspiration and the nurses in charge of health posts were involved in the delivery of RH services in general (follow-up of pregnancies and deliveries, family planning, PAC,...)
3. Supervision, even though it is essential to the improvement of quality of care, is often ‘neglected’ in practice, and is most often limited to the collection of statistics on the services.

The objectives of the supervision as planned by the Project are:

1. to evaluate with the staff the adequacy between services offered and the standards and protocols prescribed by the PAC
2. to build the capacities of the care providers in the clinical field, in health education and in the logistics of essential drugs, including contraceptives
3. to help resolve problems encountered by care providers in the application of skills acquired during the training

The teams of supervisors are made up from a pool of clinical instructors (DRH, PREMOMA, gynaecologists from reference hospitals) and...
regional reproductive health coordinators. The supervisors are given an orientation training of two days.

**Three tools** were used:
1. A supervision grid that differs from other grids in that it is both qualitative and quantitative. It allows us to calculate the performance (in %) in relation to standards and protocols and to compare services with one another.
2. A synthesis data card for the performance of PAC services in three copies to be filled in during the visit and left with the health managers of the region and the district at the end of the visit.
3. A questionnaire for the exit interview with the client.

The dates of the visits were fixed by the doctors in charge of the districts themselves. A technical note containing all necessary information (the objectives, methodology, and expected results,...) was sent to them by fax. Twenty four maternities (20 public health centres, 1 private and 3 regional hospitals) in the four health regions of Thiès, Kaolack, Ziguinchor and Louga were visited first.

The supervision visit lasts two days per site and is made up of the following stages:
1. Discussions on the objectives with the assembled staff.
2. Observation of the building, equipment and materials, and of the status and use of management tools.
3. Capacity building of the care providers in their usual work environment by observation of an encounter with a client, or by simulation on a dummy in the absence of a client on the day of the supervision. Every observation is followed by a feedback session and possibly a demonstration of the skill by the supervisor.
4. Discussions on the organisation of services and the management of essential drugs including contraceptives.
5. Interview of clients after treatment.
6. A meeting to discuss on the problems identified and the possible solutions with the managers of the health facility, the staff (care providers, matrons, guards, sweepers,...) and the representatives of the community (health committee, women’s an youth clubs, religious and political leaders,...). The performance indicators of the service are presented and validated by the assembly. The different problems concerning respect for the rights of clients and the needs of post abortion care providers are identified. A plan of action is developed in a participative manner, favouring local, feasible, efficient,... solutions.

**A few important results that came out of the supervision:**
1. The collection of information on abortions that are a sensitive topic.
2. The capacity building of care givers on the site.
3. The observation of care givers in their usual environment, which helps to better appreciate the limitations (time, material,...) in the application of acquired skills and to help propose solutions.
4. The clinical performance of care providers.
5. The satisfaction and motivation of health managers and care providers due to the skills and attitude of supervisors who were able to establish a relationship of confidence with their supervisees and to help them. The supervisors participated fully in the activities of the service during two days (consultations, cleaning, ...) This satisfaction resulted in a positive atmosphere during the visits with the availability and collaboration of the entire staff.
6. The reinforcement of communication between the community and the care givers.
7. The mobilisation and commitment of the community to resolving the problems in their health facility. For instance, a health committee engaged itself to recruit community staff and to buy enough chlorine for the regular upkeep of the building according to the standards for the prevention of infections; another committee took the decision to close the maternity ward that did not attain the security norms; the manager of a health service decided that the pharmacy should be open 24 hours a day to ensure the continuity of care; ...

Based on these results we can conclude that supervision is a fundamental element in the improvement of the quality of health care. An interactive “human” approach, oriented towards resolving problems and offering help to care providers is essential for the supervision to be fully effective. The skills of the supervisors are an important factor to take into account. There remains however one major problem: what strategies to apply to assure sustainability?
Background
About 95% of Uganda is endemic for malaria. The other 5% of the country experiences epidemics after rain seasons. Malaria is responsible for about 100,000 deaths annually and accounts for 40% of all outpatient visits. The current malaria control strategies in use include: case management, intermittent preventive treatment and vector control. Under the vector control strategy we have got insecticide treated nets (ITNs) and indoor residue spraying (IDSR). IDSR has in the past been successfully applied in the highlands in the south west of the country where transmission is low to avert malaria epidemics but not in the rest of the country where malaria transmission is high.

Challenges
The malaria control programme has recently embarked on a programme to increase usage of IDSR in areas of low transmission and institutions like schools and military camps where people live closely together. The NMCP has chosen DDT as one of the pesticides to be used in IDSR because of its efficacy and low price. This has drawn a lot of criticisms from the environmentalists and the European Union. We have got the political support from the government and WHO to go ahead and use DDT but the EU has threatened sanctions against Ugandan agricultural and fish products. The environmentalists and exporters of fish have threatened court action against the NMCP if it goes ahead and sprays DDT. They have also threatened not to support the current government in the upcoming presidential elections for the same reasons. We have carried out several sensitisation workshops for the communities and other stakeholders. The rain season is three months away but we can not begin the spraying before this issue is resolved.

Lessons learnt
In MDC we were taught stakeholder analysis during the project management cycle. The importance of advocacy and diplomacy was stressed on several occasions. Unfortunately these are usually very slow and painful but necessary processes if a programme is to be successful. We can only talk to the EU through other government departments like foreign affairs who may not understand the urgency of the problem. My greatest fear is the end to this saga is not in a foreseeable future so can’t go ahead and implement this IDSR strategy using DDT this coming malaria transmission season. We have now to take the decision to change to the other alternatives although they are more expensive. My message to other programme managers is that: “It’s not only good science that matters but the political implications have to be taken into consideration before policies in public health are made.”
Dear Friends,


I have not been writing to you since a long time. How long is it ago that we said farewell to each other? I remember that some of us even discussed how difficult it was going to be, to part and maybe never see each other again, after we had developed such a strong relationship. But it is not so, because even if I have not exchanged lots of mail over the last months, I have been constantly in touch with the recent past, that means MDC and all of you, as if there hadn’t been any interruption. I am amazed about the continuity of the MDC, about the flow of information and knowledge gained there and then, into the here and now.

Yes, I have prolonged MDC by conducting a household survey in Chad from October 2004 to January 2005, on access to malaria treatment (artesunate combination therapy) in a rural district. It has been a great experience: organising and implementing the survey quite confidently while “eying” into the handouts of Marjan’s presentation, conducting focus groups as explained by Peter in order to culturally adapt the questionnaire, meeting local leaders and heads of households. I loved the proximity with the local population and with our team of supervisors and surveyors. It was so much fun to explain the principles of chance, of lottery, to identify the centre of the villages and the first house that we were going to start with. I still could see Marleen in front of the class throwing her coin again and again, deliberately bluffing us about chance.

Yes until then it was great.

But what I really wanted to share with you is how small I felt when analysing the data and how much I missed our MDC class during that time.

I did the data analysis in Brussels, in the MSF headquarters. I did “survive my first data analysis”, but let me be honest with you, it was terrible. **Time, place, person**, that’s what it all was about. The time given to me was too short and I felt under constant pressure, working on week ends and evenings; the place was noisy with phone calls and lively conversations about tsunami and crazy expatriates, and I could barely concentrate. And the person, me, felt lonely like never before. Yah, I wonder whether it was kind of a cultural, but also “scientific” shock I was suffering from. After having lived and laughed for about 3 months closely with a 12 people team, sleeping together in remote villages, eating from the same pot, penetrating with our questionnaire into the privacy of miserable people, who did not see themselves as poor, sitting with them talking about socio economic problems and defining poverty (“a rich man who does not share his wealth is in fact a poor man”). So after this qualitative component, I felt terribly lonely in front of the computer that has no sense of humour nor feelings, with its technical problems (one day it started to write in Arabic, from right to left, which means that the back space function worked from left to right). My plan of analysis turned out to be extremely poor and I lost track about the final objectives. I was analysing before describing, looking for confounders before having established associations. It was the world upside down, exposure became outcome and outcome became exposure. I broke my head on prices, on monthly and daily incomes and expenditures, on dollars and Francs CFA. It was quantity without quality (what I call the scientific shock)!! Let’s admit, these were the moments where I missed my MDC friends most, and even more Dr. Jo with his 4x4 tables!! At one moment I broke down: it was on a Friday evening, at about 20:00, in a huge and empty MSF office, when I still had a week to go but thought I was nowhere. I cried crocodile tears in front of that cold bloody computer, like a 15 year old with a broken heart.
(would have liked Win Oo to be there with his smiling face or Kizito, the African man).

Can you remember my small article on “Words can save lives?” Well, I had my live saved by words: the next week, as I was complaining about calculations, numbers, figures, statistics, and threatening to write some kind of thriller (like the Mysterious Cough, or the Bloody Sputum) rather than working with EPI Info, a colleague in the noisy room told me: “just imagine each number is a letter”, and those words made me feel very good.

Fortunately, things went better after the MSF statistician joined the race and I managed to drag myself till the end of the marathon. You know, I even don’t want a medal for that achievement, because I prefer coins, just to throw them up in the air.

Before ending this letter, let me quickly tell you where I am now: a comprehensive HIV/AIDS project with a TB component, in a rural area in Mozambique, close to Malawi and Zimbabwe. I love it, and I feel like being the right person in the right place at the right time.

Lots of love, and “Boa noite”.

---

**A trip to Fina and Mershing**

I am still working for the organisation NCA ACT CARITAS (Norwegian NGO). We are currently revising the funding of our programmes. One of our three local partners called Sudan Social and Development Organisation (SUDO) is planning to rehabilitate a clinic in Fina (South Sudan) and the budget put forward by SUDO needed to be put in perspective. We equally received a letter from the Medical Assistant of Mershing clinic (run by SUDO with the support of the NCA ACT CARITAS Health Programme) requesting among others an increase in the number of the staff, more furniture and more drugs but the claims of the workload did not really tally with the past drug consumption.

Within this background a trip to Fina and Mershing was justified:

- To conduct a rapid health needs assessment for the Fina population and to assess the need to rehabilitate the clinic.
- To initiate discussions with the community leaders and form a health committee in Fina.
- To visit the clinic in Mershing and hold meetings to look for solutions to the staff problems.

The members of the team were a physician and a representative of SUDO and 3 representatives of NCA ACT CARITAS: a nurse, a physician and myself (Health Programme Manager).

**Fina**

Fina is located in the mountains. Most of the population lives in huts in the hills. It was market day. On one side of the market heaps of food, guarded by soldiers, were waiting to be distributed. We visited the compound of the NGO-Safe Harbour International Relief who is actually delivering health services in Fina in a small hut-the clinic. This dusty hut was ¾ full of drugs and we found a health worker attending some patients in the remaining space. The health worker claimed to be a volunteer and did not
keep record of his consultations. His colleagues of Safe Harbour International Relief left two days before for Nyala, to return after two weeks. He told us UNICEF also donated drugs to Fina. One corner of the yard was packed with sacks of food. The NGO Samaritan Purse was planning a food distribution in the coming days.

Meeting with the community leaders
In the discussions with about 50 community leaders we were explained that the most crucial problems of the population (16000 people) were water, schools and shelter material, in that order. The Omda (traditional head) said that with the coming of Safe Harbour International Relief, their acute health problems were resolved. The physician from SUDO went ahead to promise that all their problems could be addressed. I cautioned nevertheless, that the main aim of our visit was to look into the health services. The Omda pointed out to their people in Leba where a health facility had existed before the conflict, but it was non functional now. We enquired how to get there and they delegated a person to show us the way.

Incident in Kidini
At about 4, 15 pm we arrived at a checkpoint in Kidini. The soldiers who had been quite friendly and allowed us to go into Fina were now completely the reverse. They ordered us to come down from the cars and showed us at gun point to enter their office. I smelled danger when the soldiers asked the drivers to turn off the cars and hand over the keys to them. While in the office, we were all thoroughly searched. Every bit of paper was scrutinised to ensure there was no written information gathered from this area. The soldiers took turns in interrogating and intimidating us. I was the only non Arabic speaker in the group and none of the soldiers spoke English. Our female staff member was pulled to another room where she was equally searched and interrogated with a knife pointing at her neck. The doctor from SUDO was taken out for about one hour. By 8 pm, we were released and were cautioned to drive back to Nyala. On our way back, we discovered that the soldiers had taken away all our soft drinks and that more than 100,000 Sudanese dinars (equivalent to about 400 US dollars) were missing. The codan radio had been disconnected and was thrown on the floor of the car and my mobile phone had disappeared.

It was clear that the security situation is very fragile towards Fina. I questioned the rationale of putting up a permanent health facility in this area. Alternative sites could be sought for the permanent clinic of SUDO and I was convinced there are many of such sites in more stable areas of our operations.

Mershing
Next morning we headed to Mershing. Soldiers who were sympathetic with us formed an escort to lead us across the “danger zone”. We arrived at the place at 1 pm without any more incidents. The first thing was to head for the market to have some food, for we had gone for 24 hours without any! The clinic in Mershing, made of temporary material, is actually very spacious as it was constructed to serve as clinic and nutrition centre. The nutrition programme is now organised in another compound by the NGO World Vision. Our team was welcomed by the medical assistant and we congratulated the staff after we were shown round the very clean and attractive clinic. During the staff meeting we discussed about a reorganisation for better patient flow and we addressed the staff issue. Together with the physician from SUDO, we decided to recruit a registration clerk to complete the staff effective of 8. We analysed the drug shortage and ways to correct this situation. As requested we looked into the furniture and how to render the clinic able to withstand the rains. Finally the sensitive problem of salaries was discussed. Before returning to Nyala we took pictures and had refreshments with the staff who were very happy with the visit.

Follow-up
After the sad incident that characterised the mission to Fina in South Darfur and considering that another NGO is active in the health sector in Fina which equally benefits from medical assistance from UNICEF, the planned assistance from my organisation and her partner SUDO was transferred to another community in the West of Darfur.

The health facility in Mershing had its staff effective raised to 8. All the staff members that formerly had been paid incentives as MoH staff were given contracts and were then paid as NGO (SUDO) staff. The clinic was reinforced with semi permanent material, more furniture and essential equipment. A bicycle was provided to the vaccinator of the clinic for out reach immunisation activities.
Satellite Health Posts: a response to post-Tsunami Disaster in Aceh Province, Indonesia.

By Joanes Prastowo

(Sc/RH 2004), Indonesia
prasnug2002@yahoo.com

On 26th December 2004, a huge earthquake followed by tsunami wave hit Aceh, one of Indonesia’s provinces. It has caused a tremendous loss, including 106,523 deaths, 12,147 missing, and ruined 29,579 houses. It has also reflected in loss of resources in the health sector, 1 province health office, 2 district health offices, 26 health centers and 37 sub-health-centers have been severely damaged or completely destroyed, while 15 health centers and 22 sub-health-centers are partially damaged.

Aceh Province with a population of approximately 4,265,000 now has 690,748 Internally Displaced Persons (IDPs). The local government has started to build many semi-permanent barracks for families. The latest information from the authorities stated that there will be 55 relocation sites all over the affected areas in the province, to covers all IDPs. In each site there will be a satellite health post (SHP) providing basic health services and its operation will be coordinated by the health center in the area, or directly by the health district if the health centre is destroyed. It is planned that in mid-March the IDPs start to move in the barracks.

The goal of the SHP establishment is to strengthen the primary health care system in the affected districts of Aceh Province to enable health centers to provide basic health services, especially those related to women and children in a post-disaster situation for a temporary period (3-6 months). Each SHP will have 16 health staff members: two medical doctors, six nurses, three midwives, a sanitarian, a nutritionist, a pharmacist assistant, a surveillance officer and an administrative staff. The health programs they carry out are health promotion, maternal and child health, including family planning, prevention and control of communicable diseases, nutrition, mental health, basic treatment and water and sanitation. The services will be provided 24 hours a day and 7 days a week, with the availability of health staff on call during non-working hours. There will also be outreach services during working hours to deliver public health services for remote communities.

During March 2005, the MOH had trained approximately 864 personnel to be distributed over the 54 SHPs. The 4-days training was to prepare the team before they were deployed to 9 districts (East Aceh, Lhokseumawe, North Aceh, Bireuen, Pidie, Aceh Besar, Aceh Jaya, West Aceh and Nagan Raya). They started to work at April 1st, 2005.
News from MCM 04/05

In the second term we try to equip the MDC participants with a number of skills and tools. Some of them are useful to assess the context in which programme managers work, others are needed to find and interpret the available evidence on health problems and possible interventions.

A bit later than usual, students went through demography with Michel Garenne, a new teacher from the Pasteur Institute in Paris. For research no changes: Umberto D’Alessandro gave away the rules to appraise a research protocol and Anne Buvé drew the attention to ethical issues. We had some reshuffles for advanced methods in statistics: Marleen Boelaert explained the principles of linear regression assisted by Katja Polman, Annette Erhart and Jo Robays took over from Ward Schrooten (who left ITM to work as data manager in a Regional Hospital) to introduce the participants in survival analysis and Matthias Borchert still flew in from London to complete the picture with logistic regression. The idea of all this isn’t to give an in depth training on these methods but to make the material and methods section of an article a bit less “acadabraba”.

Future programme managers are not only supposed to know how to assess the evidence in an article, they should be able as well to find and select relevant articles. This ability was identified as relatively weak by last year’s members of the jury. We decided to reinforce training in literature search strategies with the help of library staff and people from the Belgian Centre of Evidence-Based Medicine. ITM data bases, Pubmed and the Cochrane Library were presented in an interactive way in the computer room. To further explore the databases students were asked to perform a search on a research question related to their vertical analysis topic. They have to document their strategy, write a summary of the “state of the art” and produce a bibliography list. We hope this effort will result in an improved quality of the literature reviews in the theses as a start.

After all these technical issues it was high time to return to real life: Wim Van Damme put health policy on the agenda. Lively discussions were held on the human resources crisis, on financing mechanisms, on the role of the private sector, on health sector reform and last but not least on the donor agencies.

To digest this heavy stuff Wim invited all MDC participants and staff for a party at his place.

Jo Robays was the star of the evening and the cooking by the MDC women deserved 3 stars!
March was marked by the stress of dealing with deadlines for the vertical analysis, the data analysis and the literature review; and some more stress was added by the end of term tests. Participants asked repeatedly to delay the dates. Should we conclude students have to learn to comply or could it also be a sign of an overloaded programme?

Vincent closed the 2nd term with the Part One of the module on Management and Evaluation of Programmes. He took off with the presentation of his reference framework on functions and capacities to manage a programme. To link up with Health Policy we first dealt with advocacy and stakeholder analysis. Thereafter implementation issues were on the agenda. One participant presented the point of view of a district health manager and a second one the view of a Family Planning programme manager working with health providers in the private sector. The last sessions were dedicated to the monitoring function. Participants could put the theory into practice analysing data from TB, Maternal Health and PMCT programmes.

Part Two of the programme management module does focus on the functions of Formulation and Evaluation. As from now this part is integrated in the MDC Options.

News from the Short Courses 05

On April 15 we welcomed 13 newcomers who joined our 18 MDC participants for the Options or Short Courses on Planning and Management of Tropical Disease Control and Reproductive Health Programmes. We did foresee a special day to introduce the programme and get to know each other.

The Tropical Disease group was reinforced with the director of the national malaria programme and a regional EPI coordinator from RDC, with an all round district medical officer from Burkina Faso, a social scientist from a public health school in Niger, a hospital doctor from Benin who wanted to complete his recent training on Health Programme management in Senegal and a Rwandese female doctor working on surveillance who took the course as an advanced module for her TropEd Master’s in International Health programme.

The Reproductive Health group we also welcomed people with different professional profiles working at different levels: the responsible for the PMTCT programme of Burkina Faso, an ex-MScBT participant now in charge of a regional Family and Population Office in Tunisia, a midwife leading a regional Reproductive, Maternal and Child Health programme in Algeria, a Belgian gynaecologist and an anthropologist working for the National Child Health programme, a RH consultant for the MOH in Nicaragua and an ex ICHD participant dealing with several programmes as a District Medical Officer.

Incorporating a new group into an existing one always carries a risk but this year the mix of “fresh blood” with “the-ones-already-together-for-six-months” resulted in vivid group dynamics.

Of course the subject also contributed to the vitality of the discussion. Indeed we started off with the module on HIV, a problem that concerns all participants in one or another way. We look at the problem from different angles, a technical, managerial, political, social and human point of view, but the main focus of the module is the one of programme management. To reinforce this aspect and get a better link between theory and practice we decided to integrate part of Vincent’s lectures on Programme formulation and evaluation in the HIV module. We can say that the cross fertilisation did work!

The common sessions with the ICHD students were another novelty: we had a discussion on the Film “the silent witness” and a well attended special seminar with “our” Peter Piot. More synergies can be explored.

Also new was the session on “Scenarios for the Future”. Marie Laga had been involved in the building process and invited one of the facilitators to try-out the discussion on these scenarios with the MDC students. Following our concern to involve more people from the field we invited R. Epkini who worked at Project RETRO-Ci and now at WHO and J. Essombo (MCM 00/01) from Ivory Coast to share their experience with HIV programmes and projects. Needless to say their lectures were convincing.
The final exercise or what we called now “project” was completely reorganised. Participants started to work on it from the fourth week of the short course, at the frequency of one afternoon per week until the end of the course, with the weekly support of South Research Team.

What’s new in the TD programme?
In the malaria module we did benefit from the experience of Christian Lengeler, who participated in research to document the efficacy of Insecticide Treated Nets in reducing child mortality and is now involved in the scaling up Bednet programmes in Tanzania. Blaise Genton highlighted the current state of malaria vaccine research. For the case study we opted for Rwanda, a country that has to deal with both endemic and epidemic malaria. Moreover 2 participants could share their experience from a clinical and surveillance point of view and both facilitators Umberto D’Alessandro and Marc Coosemans did collaborate with the National Malaria Programme in research and development cooperation projects. The applied exercise still needs some fine tuning but the discussions were interesting.

The TB module was now prepared by Francine Matthys and Greet Dieltiens, who took over from Marie Laurence Lambert since she left ITM. The main novelty was the case study. We decided to invite one of our former participants, Dorothée Ntakirutimana (MCM 02/03), Director of the National TB and Leprosy Programme in Burundi. She introduced the context and brought real data to be analysed by the participants, who were also asked to explore ways to improve the detection and cure rate. With Dorothée as resource person and Francine Matthys and Etienne Declercq (Damian Foundation) as TB experts this exercise had excellent facilitators.

As in former years, for the Filariasis/Dracunculosis/Onchocerciasis module & Schistosomiasis/Helminthiasis module we relied on WHO expertise. But in the Trypanosomiasis module we could again count on an MDC alumnus, Pascal Lutumba from RDC (MCM 00/01). Together with Jo Robays he selected hot issues related to diagnostic tests, surveillance, case finding & treatment strategies to be discussed by the participants. In the Leishmaniasis module we could build on the experience of a former short course participant, Suman Rijal from Nepal (SC/TD 2002), who was in Antwerp to work on his PhD thesis. The language barrier was bridged by Veerle Van Lerberghe (MCM 00/01) and Marleen Boelaert.

What’s new in the RH programme?
The inclusion of public health part 2 and the reorganisation of the final exercise or “project”, (which started from the 4th week of the short course, one afternoon per week), were aimed to better address programme formulation and evaluation within the modules. These changes did also modify the previous schedule of our three RH modules which used to start on a Monday (or Tuesday when holiday) and end on a Friday… For the STI module, as last year, François Crabbé came from the field to share his long-term experience of a STI programme in Cambodia. The novelty this year was to work on writing a proposal for the Global Fund (using as an example a proposal designed for the third round in Cambodia by François and colleagues). The Family Planning module (started on a Thursday!) and included the contribution of Dr Slah Meddeb from Tunisia who shared the interesting experience of Tunisia in implementing FP programme. The morning spent on gender and development with the lively contribution of Pascale Maquestiau from the Belgian NGO “Le monde selon les femmes” was highly appreciated by participants. Douchan Beghin and Isolde Deschampheleire addressed the logical framework approach in their famous evaluation exercise.

The Maternal Health module started on a Wednesday and was, as usual, under the excellent direction of Carine Ronsmans. Our participant from Mauritania, Salif Diagana, shared the experience of Mauritania which tries to increase access to antenatal and obstetric care by expanding the concept of flat flee scheme for pregnancy and delivery. A new guest was Prof Gaspard from University of Liège who came to speak about menopause and its management.

Intermezzo
To put MDC and SC participants in good shape to finalise their Projects we organised a Party in “Zaal Elcker Ick” on Saturday 11 June. They all underwent a therapy package that consisted in exquisite food and drinks, world music and African dance. Also highly recommended for staff!
**Project Formulation Exercise**

The MDC Options / Short Courses culminate in a Poster Exhibition in Room Agora. In the Posters each participant displays the different steps of the project they formulated in response to a problem they identified and explored in a problem tree. The strategies deemed most relevant and feasible were included in their project proposal that had to be fitted in a logical frame work. Even when the exercise is artificial in the absence of other stakeholders to discuss the choices to be made, it is a “nearly real life” exercise that for the first time was spread over six weeks to allow for more reflection. The quality of each poster was assessed by three people: two ITM staff members, chosen according to the topic, focused on technical and public health issues where as people from South Research and our ITM logframe expert Jan Coenen looked more into the methodological side. Students highly appreciated this individually coached exercise but for next year they suggested inviting potential donors, you never know they get convinced to finance a few MDC projects.

**The End …**

On Friday 24 June the International Short Courses on Planning and Management of Programmes on Tropical Disease and Reproductive Health Programmes got to an end. After a speech of Marie Laga recalling on the MDC values – technical excellence, flexibility and solidarity- the 12 external students were awarded a certificate and we had a farewell drink in Room Broden. Since we were in competition with the nurses for the ITM choir we asked volunteers for the piano!

Marjan Pirard, mpirard@itg.be

and

Thérèse Delvaux, tdelvaux@itg.be
YOUR DISCUSSION FORUM IS NOW OPERATIONAL!

Dear Alumni,

In the last MDC Alumni Newsletter we announced that a Discussion Forum was under development on the new Alumni Web site. We are happy to inform you that this Forum is currently operational and we invite you to visit the alumni web site and register yourself for the Forum today!

You can access the Forum from the ITM web site: http://www.itg.be/alumniforum/Forum/policy.asp

The Forum’s objective is to promote and facilitate interaction among former students and between former students and ITM staff.
To encourage a collaboration between the networks of the different courses, (MDC/MCM/MScBT, ICHD/CIPS, RIPROSAT), the Forum has been structured in a way to allow members of each of these networks to contribute.

The discussions will be organized in 5 thematic groups:
• Health systems/health policy
• Tropical disease control
• Reproductive health
• HIV/AIDS
• Animal disease

For each of these topics, moderators were selected among ITM staff members. Their role is to guide the discussion, clarify ideas or give technical advice where needed. In future we might invite you to play the role of moderator.

Registered Forum members have the possibility to subscribe to one or several thematic groups, according to his or her field of interest.

Soon some debates will be launched on the Discussion Forum and we invite you to participate actively.

We eagerly wait for your reactions, suggestions, reflections or anything you want to share with the other Forum Members.

We count on you to make out of this Forum an interesting and attractive tool.

So please don’t wait to register. Do it today!

Coordination Alumni MDC/MCM

Dear friends,

As some of you might have read in the e-mails I send, since March, I have been recruited for a period of six month to collaborate with the coordination of the MDC/MCM/MScBT Alumni activities in the Institute of Tropical Medicine; this in replacement of Thérèse Delvaux who preferred to devote more time on research and teaching activities.

For those amongst you who were in the Institute in 93-94 or 96-97, I am probably not new. During these years, I did a one year training in the epidemiology department and I assisted Professor Aimé De Muynck in EPISTAT teaching.

After having worked with Action Aid UK in Rwanda as HIV/AIDS and Gender project officer, after a short period with MSF-Belgium in Chad and two years of research work in the Observatory of HIV/AIDS and Sexuality of Saint Louis University in Brussels, it’s for me a great pleasure to rediscover this Belgo-Tropical atmosphere and to collaborate with you.

So I would like to invite you to regularly communicate with me regarding the MDC/MCM/MScBT Alumni Network, of course in addition to the persons you used to contact, since we are working as a team.
Please don’t hesitate to contact me or to send me an e-mail if you are in need of information or documents, or if you have a contribution for the Forum discussion or the Newsletter. Your ideas and suggestions about the Alumni Network are more than welcome. I would like to thank those who already did sent me a message and tell you once more I am available to help you as good as I can. I wish you all the best and I am looking forward to read you soon.

Sincerely yours,

Déo Mazina
dmazina@itg.be

Alumni Workshop MDC-MCM, Siem Reap, Cambodia, 6-8 September 2005

In the December issue of the MDC Newsletter we announced the plan to organise our second Alumni Workshop in South East Asia for the Anglophone group. We also asked the ones interested to participate to send in an abstract dealing with the problems and challenges in their current job and with the contributions and limitations of MDC/MCM to deal with them. We received a total of 30 abstracts.

A limited number of grants was available to finance participation in the meeting. To decide on the attribution of these grants we took into account the quality of the abstract, the type of experience, the representation of different MDC/MCM cohorts, the geographical distribution and last but not least the travel cost. We also decided to use the funds available to support local networks to finance the participation all Cambodian alumni. A few former participants managed to find funding from another source. The members of the coordination team blocked the first week of September in their agenda to assure their assistance.

The programme of the meeting is being prepared according to the content of the selected abstracts and issues identified by the MDC coordination team. In the next issue of our Newsletter we will bring you an extensive report on this important event.

NEWS FROM THE FIELD

MDC 03 - 04

✧ Taking over from an MDC colleague

February – I’m in Amsterdam now for my briefing en route to Ethiopia where MSF has sent me to work as an expat in a HIV/AIDS project....the project that Adam Musa worked in. I am going to take over from him...

March - I finally landed in Ethiopia where I work as Medical Team Leader in a MSF project based in a district called Humera. The project is on HIV/AIDS, Kala Azar, Malaria and nutrition. The project area is situated in the northwest of the country, 1000 kilometers away from the capital Addis Ababa. It’s a small town and really nothing much going on apart from work, work, work! MSF has a big compound where all the expatriates stay and eat together. The office is within the compound too. The district hospital that we are supporting is one kilometer away.
All is well apart from the heat. Temperatures now range between 42-44 degrees daily. The evenings are cooler but some days we can’t sleep because the temperature is still too high to do so. The other challenge is communication. There are two ground phone numbers on which you can only receive international calls. We also have a satellite phone which is connected to email. This is very expensive and thus for limited use. Private calls are charged at 4$ per minute! However, the common email is free for everyone. Therefore friends note my new email address below. Keep in touch and get me posted of news from all of you to keep myself abreast with what’s going on in the world otherwise we are isolated.

**Austin Chantulo – Malawi**  
msfh-humera-sat@field.amsterdam.msf.org  
PLEASE WRITE MY NAME ON THE SUBJECT

❖ *Lost sheep in Sudan*

I just got an update of the whereabouts of some lost MDC sheep. All were found in Sudan. Adam Musa is working with International Medical Corps (IMC) as medical coordinator in the famous Darfur region. Michael Woubishet joined MSF and is working in a project in Sudan and Khalid Abdel Rahman returned to his country and is also with MSF yet in another project as assistant Head of Mission. They all seem to do well.

**Austin Chantulo**

❖ *Work with refugees*

May - Some time has passed since we communicated last. I had some difficult to access the internet in Darfur. I have been in Sudan for 6 months after the school.

I have been doing consultancy work for International Medical Corps (IMC), an American NGO, in Darfur. I really enjoyed the work with the Internally Displaced People (IDPs) in Darfur. We used to have a lot of health coordination meetings with all the NGOs.

Now I’m working as Medical Director for IMC in the Eastern part of Chad. IMC has PHC clinics and nutrition programs for the Sudanese refugees who fled Darfur. Definitely I will contribute to the News letter. I do have a lot to tell about my work with the refugees in Chad. It’s a tough mission! Chad is very poor country and has a very poor health infrastructure and very low profile of national staff. The team is very nice and cooperative. There are three MDs from Togo, Cameroon and Southern Sudan, two Kenyan and one Congolese nutritionists and one program manager from Mauritania. It’s very challenging mission. A lot need to be done.

**Adam Musa – Ethiopia**  
adamshara@hotmail.com

❖ *Return to where you belong*

January - I’m now back to Sudan, to be there for a change and to live the good and the bad as part of the Sudan. I was offered another STOP assignment in Nigeria and I’m short listed in some other WHO international jobs BUT I have decided to work in Sudan, so I froze them all. Just last evening MSF-H and myself, we reached to an agreement on a job that was under discussion for some time. I will work as Assistant Head of Mission, it is a post that deals with communication, planning, evaluation, some technical work in the field and reporting. Wish me luck, it is a job with big responsibilities.

May - I’m next door in Holland doing the Basic Management Course for Project coordinators. I did come to Antwerp last weekend and I was very happy to be back. It feels nice and strange not to have all your friends around. I was supposed to visit you in ITM early Monday and then run to Holland, BUT I was surprised by the Holiday in Belgium…

**Khalid Abdel Rahman - Sudan**  
drkharas@hotmail.com
March - Yesterday I was in the bus (a lot of people, 30 degrees, thirsty, etc) and the radio began to play that Turkish song that Charles liked so much and we used to dance in the parties, about a kiss and I remembered all of us dancing at 1 am and having to go back to Antwerp! That was crazy. I began to laugh on my own. These last months were very hard, I am pregnant (now 3 months) and I could hardly eat but still had to work because I was in charge of a big campaign for dengue vector control in 3 districts and couldn’t just leave. I have to confess I didn’t go very much to the field, but now I am much better. The work in dengue is hallucinating, a lot of politics and almost no evidence, but even so it’s interesting.

June - My belly is growing; I’m 6 months pregnant now and luckily everything goes well. It’s again a girl! But my professional future is totally uncertain. Since I returned to Peru I couldn’t really fit in a place. I think it scares people to work with persons who were trained abroad and returned to their country; it’s something nobody does. To Alonso happened the same (Red. Lely’s husband obtained a Master of Science in Biostatistics in Belgium). But I concentrate on my belly now and don’t care too much.

Lely Solari – Peru
lelysol@hotmail.com

From managing a district to managing students and being managed

January - I will start at the Nursing School next week. Imagine me in the class and teaching. Isn’t it a bit weird? The Mrs Gokwe issue is over and I do miss it already! I have worked as a public health nurse for so long and it has just come to an end. (Red. Odrie was District Nursing Officer in Gokwe District, Zimbabwe).

February - I am now at the school of Nursing as a senior tutor. I was on orientation and am going to mother a new group coming in September. So I am starting to plan for the group. I don’t see my self being as good as Marjan but I will try my best. I will try to remember how she did it.

March - I am ok and have settled in my new job. The only problem is I have to read so much and plan for lessons and worse still to deroll into being managed when I was a manager a few months ago. But I am coping.

April - I find myself so busy at times that I feel I don’t like to go on anymore. I suppose teachers in high schools experience it differently as they go on holiday 3 times per year here. I am looking forward to going for field work. I also intend to visit students on community secondment in the districts. This will definitely keep me in touch with what is happening outside the institute. I presented my thesis to all the nurse managers from the whole province last week. They all felt the study was very practical and I am going to be working with the Reproductive health officer to set up a maternal mortality forum at Provincial level. We will also have to travel to the districts to try and revive the maternal mortality meetings since the MMR is alarming in Zimbabwe.

May - Today we had a visit from administrators of our local University. They were doing a feasibility study to see if they cannot offer health related programmes and hence affiliate the Nursing School to the University. We hope something positive will come out of it.

Odrie Ziro – Zimbabwe
odrieziro@hotmail.com

To get the programme implemented

May - I have gotten the approval of our University Chancellor to implement the Adolescent Reproductive Health Programme and now it has been allotted a small budget to get things going...
I have constituted a core group of 4 people and we are starting to unroll the program. We have our own office adjacent to the hospital, conducted several lectures and workshops for the hospital and are mobilizing hospital staff to participate. We have produced a leaflet promoting our Program and its goals and objectives. Things are quite hopeful for the Program but I am not so satisfied yet at the rate we are going. I am also not satisfied with my competence to handle it. I need more training in the hands of people who are really into Program Development.

**Jessie Foronda-Walde** - The Philippines
jessiewalde@hotmail.com

+v+ Catching mosquitoes with community participation

Almost a year ago we were together talking about how to save the world from terrible diseases… So, I was thinking about how much my life changed after the MDC course. I am working at the same place: Pedro Kouri Institute of Tropical Medicine in Havana. I am still catching Aedes aegypti mosquitoes with community participation. I am still following dreams, utopias… So, what has changed? Definitely I have a bigger amount of work than ever before…

We are doing Popular Education for Dengue Prevention. It sounds nice, doesn’t it? Well, it means, I am having fun with lot of workshops, designing its objectives, techniques, didactic materials, and ways to motivate people to do what anyhow they have to do to be healthy. But, watch out, they are not just a set of workshops to get the community work on dengue prevention. We are also doing research, participatory research, of course!

We finished a two years research project about active participation of the population in disease control. It was also an interesting experience. Usually we define which disease we want to control or prevent. In this case we proposed a participatory approach and the local health institutions and the community decided on their health priorities. At the end we finished working on HIV/AIDS. The results of this project were presented two months ago. The main debate turned about “how to work with communities with several important health problems”. So, we got our opportunity to show our proposal: prepare a platform with our local health staff to work in a participative way, so they will be able to fight whatever disease. It seems like an operative system as Windows. It is like a dream, isn’t it? Let’s run all our disease control programs…

**Dennis Pérez** - Cuba
Dennis1905@yahoo.com ou dennis@ipk.sld.cu

+v+ Collaborating with ITM

January - After my return from Antwerp, I am working in the same Department, same position, same programme but the workload is more. (Red. Parasitology and Entomology Department, NIMPE) However, I am happy to inform you that I was assigned to be involved in a bilateral programme collaboration between ITM and my Institute; that is the Cysticercosis Control Project. By this, I hope I can apply the knowledge learnt into my daily work.

**Dang Quang Tan** – Vietnam
dangquangtan@yahoo.com

+v+ Discovering the world of Research

June - It’s along time since you have heard from me but I’m alive and kicking. I got another job with Infectious Disease Institute (IDI) at Makerere University. IDI is the sole institute in Africa aimed at delivering sustainable, high quality HIV/AIDS Care and Prevention through training and research. I work as a Senior Medical Officer and am involved in clinical care of patients, now totaling up to 12,000, and research work. Currently I’m preparing for a Clinical Trial set up by Tibotec Pharmaceuticals Ltd. I had a nice trip last month for the Tibotec investigators meeting in Madrid Spain on this phase II randomized partially
blinded, dose-finding trial for a new NNRTI. Twenty patients are to be enrolled and followed-up for 2 years and Uganda & South Africa are the only sites in Africa. In Uganda the biggest current challenge with ARVs is not access but treatment failure compounded with limited second line options. Effective monitoring of patients on ARVS is very expensive in our setting "WHO's 3 by 5" is in reality “one at a time”.

Another study I’m going to be involved in is “Validating an algorithm for monitoring the Virological efficacy of antiretroviral therapy in resource limited settings”. This study is coordinated by Bob Colebunders from ITM. He has been the clinical head in this institute and has boosted Research activities here.

It is a whole new experience in the world of research. I hope to be sending some interesting articles as I go along in IDI. My other activities include training of medical officers and nurses in up-country centers and HIV/AIDS and management activities in the institute.

Fred Ssewankambo – Uganda
ssewafi@yahoo.com

✧ Log frames help to find a new job

March - I joined UNFPA as a Programme Officer for their RHIYA (Reproductive Health Initiative for Youth in Asia) project. I’m responsible for monitoring and evaluation. Thanks to Jan for his excellent class on Logframe, this was the main secret behind my success.

Ruh Afza – Bangladesh
ruhafza67@yahoo.com

✧ CDC in Kenya announces

Dorothy Mbori-Ngacha, Chief PMTCT Section of the CDC-Global AIDS Program in Nairobi, Kenya announced us that Dr Kizito Lubano (MDC 03/04) has joined the PMTCT section as a Technical Advisor on secondment from Kenya Medical Research Institute (KEMRI) where he is a research officer. He will be working with all partners on up-scaling of the PMTCT+ programs and will work on the design and implementation of impact evaluation studies for this program.

To Kizito Lubano - Kenya
luby68@hotmail.com

SC/RH 2004

✧ Maternal and Perinatal course in Indonesia

I’m now working for IMMPACT (Initiative Maternal Mortality Programme Assessment) research project. It is a global research initiative co-coordinated by University of Aberdeen in collaboration with University of Indonesia. In that project I’m responsible for Capacity Strengthening and Dissemination Work Programme (CSD WP). My main job is to improve the capacity of health worker at district level, especially in Serang and Pandeglang which represent IMMPACT research project districts.

When I joined IMMPACT in December, 2003, I did not work for CSD WP. Following my participation in the MDC short course on Reproductive Health, I was given the task to develop, for the project, a course program on Maternal and Perinatal health. The course material is part of the MDC reproductive Health module. The objective of that course is to improve knowledge about the concept and theory of maternal and perinatal health. Participants of the course should be the people who are in charge of Safe Motherhood program such as policy maker, MOH staff, lecturer of reproductive health subject, and for district health office staff such as medical doctor, midwives and nurses.

The first Maternal and Perinatal course was conducted for one week from 29 November to 4 December, 2004. There were 20 participants, and their backgrounds vary such as decision maker, lecturer of reproductive health subject, lecturer at midwifery school and midwives. I conducted an
evaluation among participants 2 months after the course. The result showed that they could apply the concept in their daily work.

At this moment, I’m planning the similar course in cooperation with Faculty of Public health University of Indonesia. The course will be submitted within faculty curriculum for students who are interested in reproductive health. People outside the faculty can also join the course (e.g. lecturer at Midwifery school, midwives and district health staff). Project Cycle Management taken from MDC short course will also be given to the participants. The course will be held for two weeks during semester break every year. The students will get credit and others will get a certificate from the faculty. The course will be on 1 – 14 August, 2005. I hope the course will be successful and I will share it with all of you in the next Alumni Newsletter.

Yayuk Hartriyanti - Indonesia
uke_yh@yahoo.com

MCM 02 - 03

Organise training

… We have already organized a training of doctors of the Health Centres and Hospitals of Ambon District and now we are dealing with the nurses (see picture). At the end of this training session, I have to write a report. For your information, each module of the course has been evaluated by the participants…

Alain Disu - Belgium / Indonesia
aliandisu@hotmail.com

The Global Fund discovers MDC

… I did succeed in the recruitment test for the post of Tuberculosis Expert for the Global Fund to fight Aids Tuberculosis and Malaria - GFATM. The file of the Central African Republic was eligible for the fourth round in the fields of HIV/AIDS, TB and Malaria. Also for the component «fight against HIV/AIDS» two doctors have been recruited, one of them is also a former participant of MCM (promotion 2000-2001: Séraphin Ndanga. seraphin_ndanga@yahoo.fr)
Long live MDC and thanks to all MDC teaching staff!

Dominique Sénékian - Central African Republic.
senekian@yahoo.fr

Get to know your country while working

… I support the Division of Reproductive Health of the Ministry of Health in the extension of Post Abortion Care (PAC) at the level of 21 health districts in the frame of a project of MSH - Project to reduce the maternal mortality and morbidity. After the components of Training and Logistic Support, I am currently involved in the second phase of Post Training Follow-up. I have to travel a lot in the country and I’m very happy to have the opportunity to get to know my country while working. We use a very interesting approach during the follow-up visits; and I hope to send you a paper for the MDC Newsletter on this issue (Red. To read on page 8).

Fatim Tall Thiam - Sénégal
fthiam@msh.org
Contracting: from Rwanda to Cameroon

... I did supervise the execution of the baseline household survey and the evaluation of the performance of the health services in the target area of the project I'm coordinating. (Projet de Redynamisation des Soins de Santé à l'Est Cameroun). Thereafter I did participate in a feasibility study for the project on financing methods by contracting/performance. This study was carried out with the support of a consultant from Holland who talked a lot about Bruno 'Messin' (Meessen). Moreover the project on contracting in Rwanda, in which Bruno was involved, was used as a reference!

Joseph Kemmegne - Cameroon
joyekemmegne@hotmail.com

Visits at ITM

In the course of the last 6 months 6 former participants of MCM 02/03 did pay us a visit: The guys of MSF have the good habit to come and say hello when they have to pass by their central office in Brussels. Alain Disu (alaindisu@hotmail.com) did pop in after his Christmas Holidays before leaving again to Indonesia, Dieu-Merci Kivuvu (dmkivuvu@yahoo.fr) did finish his mission in Ivory Coast and works currently in Guinea Conakry, more precisely in the town Guéckédou in the forest region in a project for treatment and care of PLWHA and Popol Lobo (popol_lobo01@hotmail.com) left Liberia and was going to see his family in DRC, he will return to Liberia where he will have a different responsibility, namely of field coordinator in Suedois. Doris Mesia (dmesia@yahoo.com), working in Brussels for MSF-B, did dance with us at Wim Van Damme’s party. Ndella Diakhate (ndella90@hotmail.com), who doesn’t finish studying, comes over regularly from Paris to Antwerp. During her last visit we did remind her of her promise to share her experience in the Alumni Newsletter. You can read the result on page 5. Finally Dorothée Ntakirutimana (dorontakirutimana2002@yahoo.fr ) did pass a week with us as resource person for the case study on Tuberculosis in Burundi. (See news from MCM 04/05)

You are always welcome!

MDC 01 - 02

At the “Crossroads”

March - Last month I was at the crossroad of my career, once again after two long years. I completed my contract with UNAIDS and was on the verge of getting another extension, when I decided to sit back and reflect as to what has happened after my MDC. I felt that UNAIDS was a bit removed from reality and had reached a stagnation point (going round in circles). At that moment I got an offer from the Clinton Foundation HIV/AIDS initiative. I have thus joined the foundation as a Program Director from 1st of March in New Delhi. This foundation is focused on medical and public health issues and would look at scaling up treatment options through ARVs. This is quite a challenge since, unlike the UNAIDS, they are accountable and will be under scrutiny by all stakeholders including the government.

We are a small team at present and were inducted during Hillary Clinton's visit recently. (see Photo). Quite a few are non-resident Indians from the US.

Misra Samarendra - India
misranaco@yahoo.com
One day I had to change

After 13 years of hard labor and multiples interventions (on which I keep very nice memories) with Médecins Sans Frontières Belgium (MSF-B) in the Democratic Republic of Congo, I stopped working for this NGO that was quite important for me.

Here you see a picture that was taken during my last field trip with MSF B in the DRC. It’s me in the MSF vest in Isangi in the Eastern Province (at 150 km from Kisangani).

I work now as an independent consultant. I carry out prospecting missions and other tasks that a public health expert can do.

My first consultancies were:
- For MSF SW: in the field of Trypanosomiasis
- For GTZ, with whom I will work until the end of July:
  - in the field of HIV/AIDS, more specifically the components of Prevention of Mother to Child Transmission (PMTCT), transfusional security and patient management (STI, OI and ARV therapy).
  - in the field of primary health care: the identification of intervention zones for a global support.

That’s where we are now and what we do, it’s to say that our stay at ITM is rewarding and is valued where ever we go to render our services.

For my colleagues from MCM 2000-2001, I just want to inform them that my dear wife and my five angels are fine.

Auguy Kadima Ebeja - RDC
kadimaebaiauguy@yahoo.fr

Hello dear colleagues,

As my eldest daughter is almost 4 years old (Sara is a nice little lady who cares very well for her little sister of 5 months as you see on the picture), it must be also 4 years ago that we were finishing the lessons and starting to write our thesis. So I thought it was about time to share with you what I did since we said goodbye in August 2001.

After some months of maternity leave, we left the rainy Belgium with the whole family to make Chad our new ‘homeland’. I had accepted the job of medical coordinator and head of mission of the Chadian projects of ‘Doctors without Borders-Belgium’ (MSF-B). It was a very busy year with some very interesting activities.
Besides the management of the teams and projects, I had decided to make some time for specific ‘disease control activities’. The MOH and MSF (together with Cathérine Bachy, MDC 1999) elaborated a research protocol and carried out a resistance study for uncomplicated malaria. Last month I heard that the MOH of Chad decided to change the national treatment protocol, which made me happy, because research isn’t always followed by a change of policy. We also wrote two new projects: a malaria project to increase the distribution and use of bed nets, and an HIV/AIDS case management project.

Chad was never boring: some running projects had to be closed down and some emergencies appeared with the arrival of Central African refugees in the South and some outbreaks. However, after one year, we decided to leave Chad and return to Belgium.

Since April 2002, I’m working in the ‘Epidemiology and Disease Control Unit’ at the Institute in Antwerp. My main field of interest is implementation research in vector control of dengue and visceral leishmaniasis. What are the main projects I’m involved in?

(a) There is a ‘community participation’ project in Cuba (together with Dennis Perez, MDC ¾; Alberto Baly, Short course 2004 and Cristina Diaz, Short Course 2003) which aims at the prevention of dengue by reducing the vector. The Cuban team works hard to get the community involved from the identification of needs up to the execution of their own action plan. The main difficulty we experience is the measurement of effectiveness of such a prevention program of a disease that is only present in (small) epidemics. For the moment we are also evaluating the sustainability of such a community based programme and there we are facing a similar problem: how to measure sustainability?

(b) We are one of the partners of a new INCO project on dengue. Our group will work on implementation research of new intervention tools. I think that the importance doesn’t need much comment because we are all confronted with problems related to the accessibility and acceptability by the population of new efficacious intervention tools. The overall objective of this part of the project is to assess the cost-effectiveness, acceptability and sustainability of key strategies which deliver new vector control tools in contrasting environments. The study will take place in Thailand and Venezuela, from December 2005 onward. In summary the study contains:

(1) Formative research with behavioural and feasibility studies
(2) Development of implementation models (control staff and partnership model)
(3) Implementation of models (cluster randomised trial)
(4) Assessment of cost-effectiveness, acceptability and sustainability of the alternative strategies

(c) Another project will soon take place in the Visceral Leishmaniasis endemic areas of Nepal and India. The overall objective is to evaluate the effectiveness, cost and acceptability of long lasting impregnated bed nets in the prevention of Visceral Leishmaniasis. Marleen Boelaert is coordinating this EU project and we will mainly focus our scientific work on the acceptability of the tools by the population, besides being involved in the implementation and overall effectiveness evaluation.

As you see, we will have a lot of work in the coming months and years but it promises to be very interesting. I hope that everything will run smoothly so that I can discuss our results with you in the near future. If anyone of you has experience in these fields or is interested in the projects, don’t hesitate to contact me (vvanlerberghe@itg.be), I will be very happy to share and exchange information.

Veerle Vanlerberghe - Belgium
vvanlerberghe@itg.be

MDC 99 - 00

❖ From MCM to project management and research

Dear disease controllers,

After a long silence, permit me to come on board and give my own contribution to this very important network of MDC alumni. To make things reasonably coherent, in this edition I will talk about myself in terms of what I have been doing after leaving the ITM. In subsequent editions I will address specific issues.
Belonging to the 1999/2000 cohort, and arriving back home in Cameroon at the end of 2000 I picked up a position in early 2001 with the National AIDS Control Program (NACP) in the HIV Epidemiological Surveillance and Research Section, which I later headed as the Section Chief.

My duties from 2001-2004 involved planning, organisation, coordination and monitoring of national HIV/AIDS and STI epidemiological surveillance activities including behavior surveillance and to some extent HIV research with the following major accomplishments:
- Elaboration and adoption of national forms for AIDS and STI case notification.
- Conduct of national HIV sentinel surveillance among pregnant women
- Elaboration and adoption of a national guide for the implementation of second generation HIV/AIDS and STI epidemiological surveillance in Cameroon.
- Expansion of capacity in second generation HIV/AIDS/STI surveillance through training of staff at various levels.
- Coordination, in collaboration with the National Institute of Statistics in Cameroon and ORC-Macro/USAID, U.S.A., the HIV component of the 3rd Cameroon Demographic and Health Survey (CDHS-3).
- Coordination of a national HIV serological and behavioral survey in specific sub-populations such as commercial sex workers, university students, truck drivers, health personnel and population living along the Chad-Cameroon petroleum pipeline.
- Coordination of a national STI & HIV seroprevalence study including behavior and antimicrobial sensitivity testing among STI patients.

The working environment within the NACP was quite challenging with long and intense working days but also fascinating. This enabled me to start developing a strong desire to be part of an HIV Prevention Research. It is in this connection that I applied and was recruited in my present position as the Senior Scientist for a newly established U.S. Centers for Disease Control and Prevention (CDC)/Atlanta HIV research station located in Cameroon in collaboration with the Cameroon Ministry of Public Health. The purpose of this research station is to assess improved methods of HIV prevention, with a special focus on preparing for future clinical trials of HIV vaccines. When operational, the research station will have an advanced HIV research laboratory as well as other infrastructure necessary to conduct large epidemiologic, behavioural, and laboratory studies. The Senior Scientist that I am has as basic functions, to act as principal advisor regarding scientific and policy matters of the project in Cameroon. I collaborate with the Director to develop and oversee scientific studies undertaken by the Project. With this new exposure, future challenges are certainly new and hopefully captivating. I will come back in subsequent editions to address specific issues and contribute in warming up the network.

Jembia Mosoko Joseph - Cameroun
mosokoj@hotmail.com

MCM 98 - 99

I joined USAID/Madagascar as soon as I came back from Antwerp in September 1999. For my current job, I am involved in evaluation and programme management in reproductive health, including HIV/AIDS. I would like to raise two issues that I encountered during my work life for USAID/Madagascar:
- The first issue was when I was assigned to initiate a mid-term assessment/evaluation of the former USAID/Madagascar HIV/AIDS programme in order to design the new strategic framework. The challenging questions at that time included the following:
  - How to conduct a basic research necessary to improve and evaluate on-going interventions?
  - What kind of data to collect and/or how to analyze existing data to orient the decision-making process?
- The second issue is, as part of the Health Population Nutrition (HPN) technical senior staff, I am participating in the development of the monitoring and evaluation plan for the HPN Strategic Framework. The plan is intended to monitor and evaluate performance data throughout the life of the Strategic Plan. This plan includes: the development of performance indicators, the identification of data source and collection method, the collection of baseline data, including quality verification,
the establishment of performance targets and last the planning for other assessment and learning activities.
During the first MCM course, the monitoring and evaluation module was too short. However, I agree that such issues might be of interest for specific professionals in certain positions in specific organizations.

Jocelyne Andriamiadana - Madagascar
jandriamiadana@usaid.gov

Congratulations with the new jobs or new responsibilities!

More news

"I finally got married in church on January 28th 2005. So I am experiencing a completely new life after 38 years of celibacy. Up till now it looks promising."

Albert Lukuka (MCM 98-99) – R.D.Congo
alblukuka@yahoo.fr

Khalid Abdel Rahman (MDC 03-04 – Sudan - drkharas@hotmail.com) and Amina have a new daughter.
Her name is Aya and she looks like Alaa, their first daughter.

On the picture Khalid with Alaa and Adam Musa

Congratulations and lots of luck to Albert and Christine and to Khalid, Amina, Alaa and Aya!
The redaction thanks all those who contributed to this Newsletter, and especially Fiona Robertson, Yvette Jacob and Déo Mazina who were so kind to translate all texts either to English or to French.

The MDC Alumni Newsletter redaction team welcomes contributions in English and French on issues deemed relevant for MDC alumni. There are no stringent requirements regarding format or length. We favour short contributions, even informal ones. Longer contributions can also be accepted, but should then answer to higher standards of scientific writing. We have no objection that materials have been published elsewhere. You can send your contribution by mail, by fax or by e-mail. A computer file in Word facilitates our work. We reserve the right to edit and shorten the text of your contributions, especially when they contain lengthy presentations of the context or general introductions.

The redaction team also welcomes suggestions for copies of articles to be included in the Newsletter – especially when written by MDC alumni.

Address: Yvette Baejen, Institute of Tropical Medicine, Nationalestraat 155, B-2000 Antwerp, Belgium; Fax: 32-3-2476333; E-mail: ybaeten@itg.be