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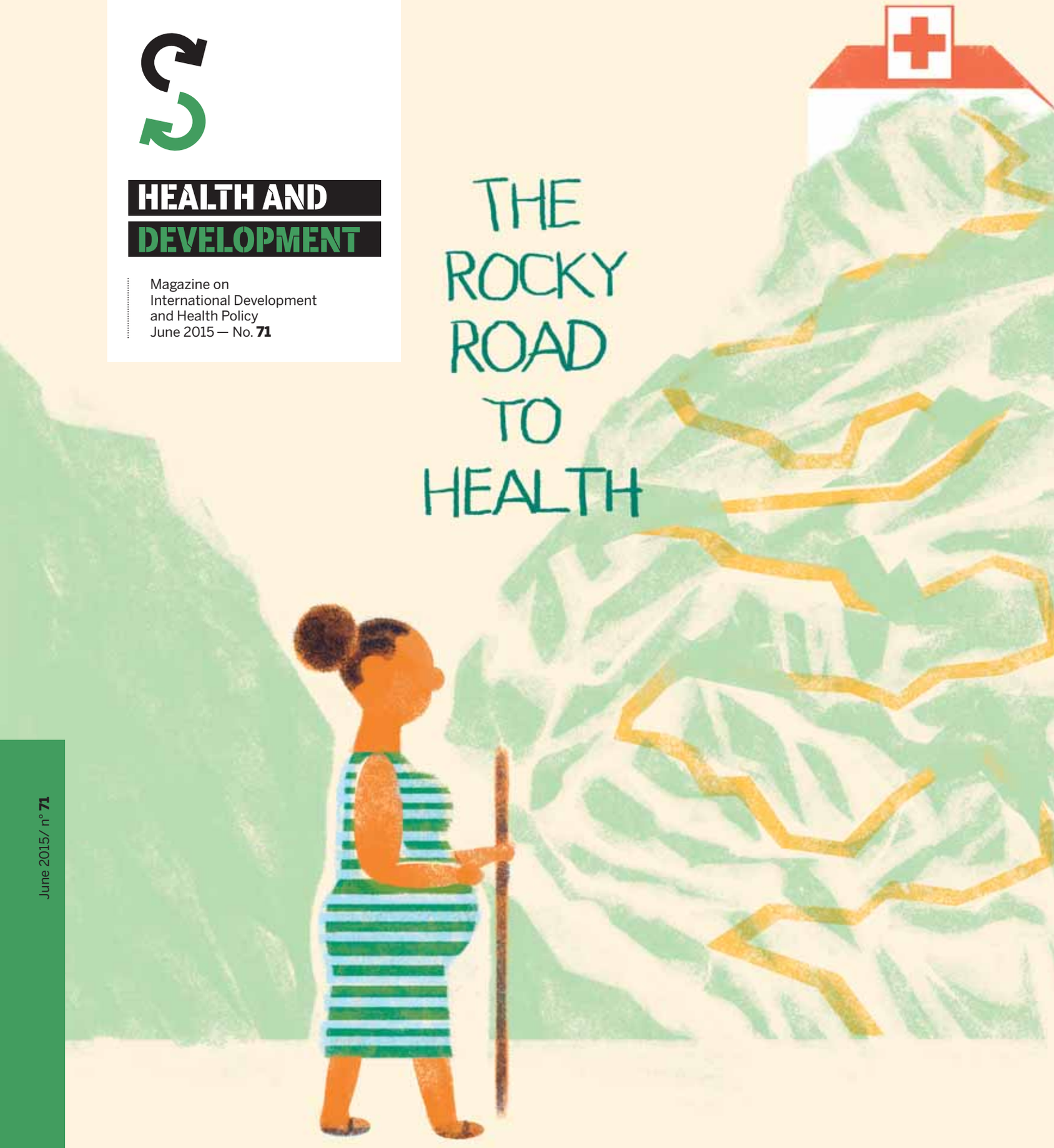
THE ROCKY ROAD TO HEALTH

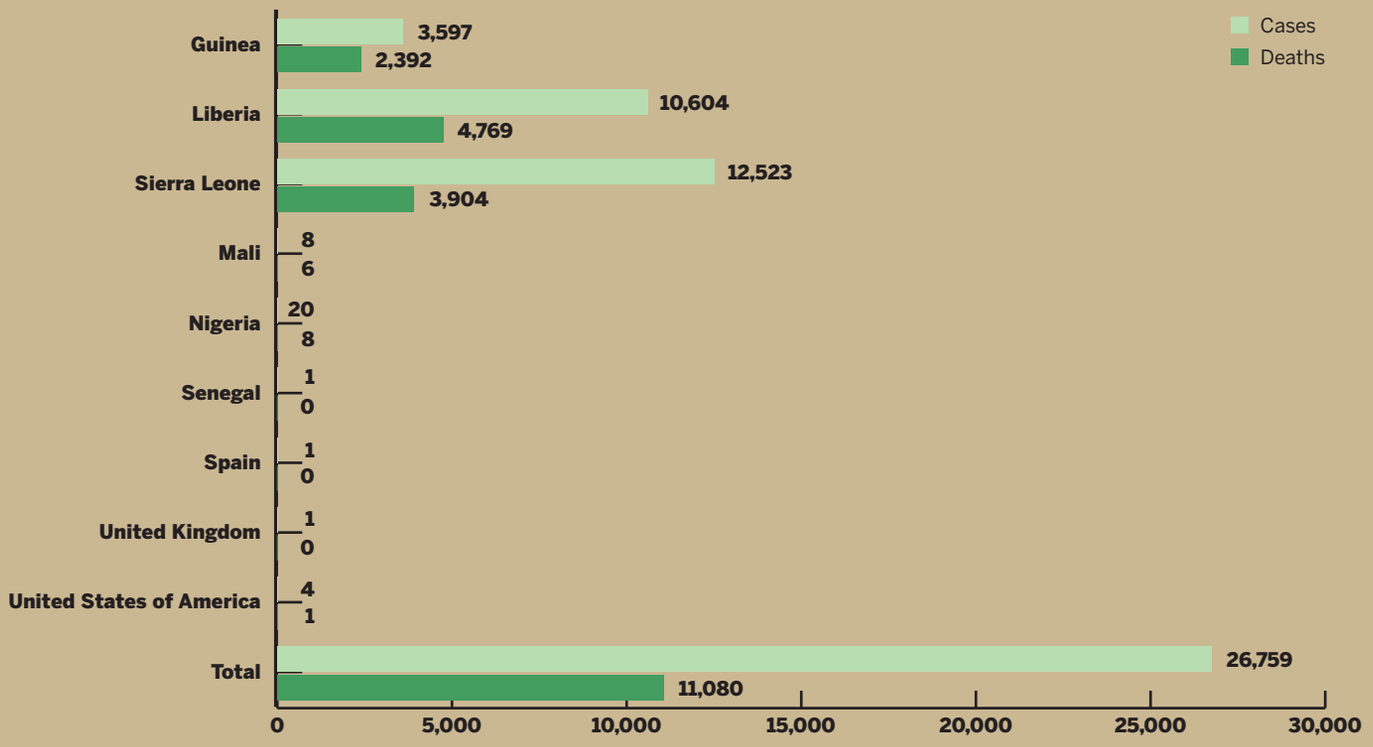


NEWS

Ebola news

The Ebola epidemic is petering out. Over the past several weeks no more cases have been recorded in Liberia. However, according to recent WHO updates 10 cases were reported in Guinea and 14 in Sierra Leone in the week to 14 june 2015. See the Figure for the overall situation in terms of confirmed cases of and deaths from the virus.

FIGURE / CASES AND DEATHS - DATA UP TO 10 MAY



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TRANSLATION

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Cover illustration by Lorenzo Gritti.
The road to health is often a rocky one, especially in Sub-Saharan countries, where the obstacles are not only of a physical, but also an economic, social and cultural, nature. Doctors with Africa CUAMM continues to fight to ensure that it will become less arduous over time.

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EXPERIENCES FROM THE FIELD

TACKLING MALNUTRITION ON THE GROUND IN TANZANIA

Doctors with Africa CUAMM began implementing a two-year-long community health program aimed at strengthening relations between health centers and communities. The main objective of the project is reducing mortality associated with conditions of severe acute malnutrition in the Iringa and Njombe Regions, in Tanzania.

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As part of the project to combat severe acute malnutrition (SAM) in Tanzania (*Program for ensuring care and support of severely malnourished children in Irigna and Njombe*"), the non-governmental organization Doctors with Africa CUAMM, in cooperation with local authorities and UNICEF, has developed a set of ad hoc tools to enable the community health worker network there to collect data on the nutritional status of children under the age of five and, if necessary*, to refer them to the nearest health centers.

Facilitated by CUAMM's long-time experience in Tanzania's Southern Highlands, a field analysis was carried out revealing that on the whole, health structures in the Iringa and Njombe Regions have no systems in place for managing cases of acute chronic malnutrition. Indeed, in its examination of the unexpected process of health personnel subdivision promoted by the country's Ministry of Health, and the interconnection between health structures and local communities, the analysis brought to light the fact that there is a complete failure of management overall, with repercussions not only in terms of child mortality but also for the physical and mental development of future generations. The analysis of health coverage for cases of SAM, in fact, revealed the inadequacy of services: prior to the project's realization, less than 10% of hospital and health centers had dedicated treatment units.

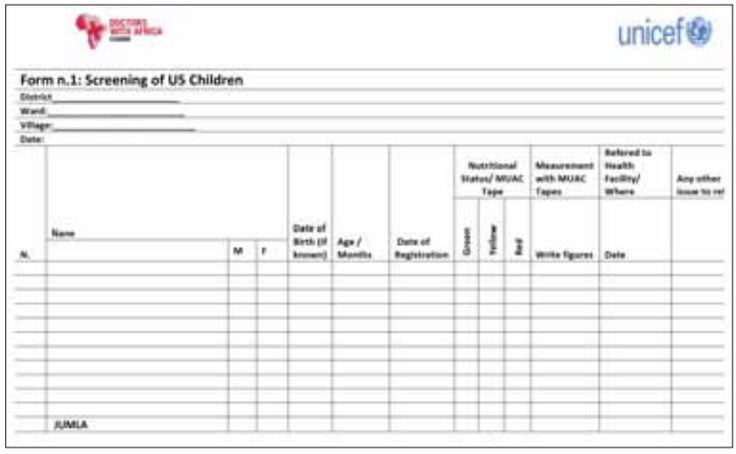
Based on these findings, Doctors with Africa CUAMM began implementing a two-year-long community health program (January 2014 through December 2015) aimed at strengthening relations between health centers and communities. Starting from its main objective – to help reduce mortality associated with conditions of SAM in the Iringa and Njombe Regions – the program identified three priority outcomes: 1) to improve treatment access and coverage in 9 hospitals, 25 health centers and 13 dispensaries located in the two regions; 2) to ensure treatment for at least 3,500 children with SAM in the two-year period of the program; and 3) to guarantee program performance based on the recommended guidelines (80% cure rate and less than 5% child mortality)[1].

In addition, in order to consolidate patient management services, the program has involved the implementation of five separate training, management and reporting policies to help improve the professional skills of 103 health workers and the technical abilities of 350 community health workers (CHW), to help train operational staff in the dispensaries (150 health workers), and to improve the chain management of therapeutic nutritional supplies** as well as performance reporting and monitoring for the Integrated Management of Acute Malnutrition (IMAM) program[2].

Accordingly, in July 2014 Doctors with Africa CUAMM introduced a training course in the Njombe and Ludewa Districts (Njombe Region). Its primary focus was on how to use the MUAC (Mid-Upper Arm Circumference) tape to measure that part of a patient's body in order to determine his or her nutritional status, and to fill out three forms especially designed by CUAMM in cooperation with local authorities, thereby making possible the general screening and, if necessary, follow-up, of all patients examined, particularly those with SAM or moderate acute malnutrition (MAM), and the referral (by way of a letter addressed to health and hospital centers) of those with serious health conditions related to their acute malnutrition[3].

Moreover, given the problems that can arise in complex settings such as that of rural Tanzania (lack of support from communities and/or village leaders, logistic problems related to the layout of the land, data collection problems), a series of quarterly meet-

TABLE 1 / A PATIENT SCREENING FORM (TRANSLATED FROM THE ORIGINAL DOCUMENT IN SWAHILI)



Form n.1: Screening of U5 Children

District:
Ward:
Village:
Date:

Nr.	Name	M	F	Date of Birth (if known)	Age / Months	Date of Registration	Nutritional Status/ MUAC Tape: Green	Yellow	Red	Measurement with MUAC Tapes: Write figures	Referred to Health Facility/ Where: Date	Any other issue to re
	JUMLA											

TABLE 2 / TOTAL NUMBER OF PATIENTS EXAMINED AND PERCENTAGES OF MAM/SAM***

DISTRICT	CHILDREN EXAMINED	CHILDREN WITH BETWEEN 60% AND 80% MAM	CHILDREN WITH UNDER 60% SAM	PERCENTAGE OF CHILDREN WITH BETWEEN 60% AND 80% MAM	PERCENTAGE OF CHILDREN WITH UNDER 60% SAM
NJOMBE TOWN COUNCIL	927	175	10	19.1	1.1
NJOMBE DISTRICT COUNCIL	1927	103	6	5.34	0.3
LUDEWA DISTRICT COUNCIL	6.270	248	36	4	0.6

TABLE 3 / CASES OF MAM/SAM FOUND IN VILLAGES WHERE FOLLOW-UP WAS CARRIED OUT (SEPTEMBER-DECEMBER 2014)****

WARD	VILLAGE	CHILDREN WITH BETWEEN 60% AND 80% MAM	CHILDREN WITH UNDER 60% SAM	REFERRAL TO A HEALTH FACILITY	DEATHS
KIFANYA	LWANGU	58	6	2	-
KIFANYA	LWANGU	78	4	0	-
KIFANYA	LWANGU	14	2	-	1
KIFANYA	LIWENGI	4	1	-	0
IKONDO	IKONDO	48	2	0	-
IKUNA	IKUNA	4	3	-	-
IKONDO	IKONDO	11	3	0	1
IKUNA	IKUNA	36	0	0	0
MAWENGI	MAWENGI	9	4	0	-
MAWENGI	LUPANDE	10	4	0	-
MAWENGI	MAWENGI	6	2	2	2

ings was fixed between CHWs and a facilitating team made up of CUAMM staff and local health workers such as nutritionists and community development officers in order to facilitate the work of the CHWs. Between 25 September and 10 October 2014, we conducted an initial supervision of the work of these social and community workers in 11 villages in the district of Njombe Town Council, 11 villages in Njombe District Council and 28 villages in Ludewa District Council[4].

The first quarterly meeting enabled us to get a clear picture of the problem of child malnutrition within the regional setting of Njombe, and to identify the most critical areas: the villages of Lwangu, Liwengi, Ikondo, Ikuna, Mawengi, Lupande, Mkomang' ombe, Ligumbilo, Shaurimoyo and Lupanga[5]). One of the main problems had to do with the quality of the data collection. In fact, the quarterly meetings were also useful in helping to understand whether the CHWs, given their low level of education, were using the tools provided at the end of the training course in an appropriate manner. Some of them found it particularly difficult to use the MUAC tape or correctly list the data they'd collected on the appropriate form. This affected the reliability and effectiveness of the fieldwork and delayed the taking of an accurate census of under-5 children living in the areas involved in the program. Supporting CHWs with ongoing training and monitoring is thus essential in order to improve the service.

The complex relationship with local authorities, who do not always ensure the support needed to achieve the main goals of the project, also needs to be taken into consideration. In particular, several problems related to patient referral arose. Even while in most cases the CHWs, having identified those patients in very poor health, expressly required families to refer their children to the nearest health centers, this was not always done. Household decisions were influenced by socioeconomic factors: for example, some families, despite being aware of the gravity of the situation, could not afford the travel and received no support from village authorities. Thus this initial analysis highlights how essential it is that intersectoral relationships (authorities and communities) be bolstered, giving added value to CUAMM's work and fostering the advancement of the region itself. In examining the types of interventions and policies involved in the nutrition program, it becomes clear that the cooperative aspect of the relationship between CUAMM and the local community continues to be a very significant factor, one that plays an essential role in helping to achieve and consolidate program goals. Promoting activities that involve close cooperation with community workers and local authorities is an excellent way to ensure that health cooperation programs are truly effective.

Finally, the problems that arose brought to light a second factor essential to ensuring the effectiveness of community-based work, and therefore also improved living conditions for the inhabitants of the area involved: time. Particularly given the expansion of the scope of the project, which in 2015 began to involve hospitals, health centers and villages in the Kilolo and

Mufindi Districts in the Iringa Region and the Makete District in the Njombe Region, the time factor seems of fundamental importance if we want to achieve the project's stated objectives in these areas as well. In coming months, therefore, Doctors with Africa CUAMM will discuss the possibility of continuing the project beyond 2015, in the hope of consolidating results over a longer time period. Being able to develop projects over the long term is in fact a fundamental condition for guaranteeing well-structured programs that bring significant and positive change to specific areas. Only in this way can community work be consolidated, leading to the real advancement of the communities involved.

NOTES

***** Children identified as being severely acutely malnourished following screening with use of the Mid-Upper Arm Circumference (MUAC) tape are directed to a health facility with the know-how to treat malnutrition and its complications. Community health workers give a letter to the individual accompanying the child to ensure that the facility will have immediate access to key patient information (who she/he is, where she/he comes from and MUAC tape measurements).
****** Chain managing therapeutic nutritional supplies involves an attempt to define a logistics system capable of appraising the need for and procuring and distributing therapeutic tools and supplies (F75 and F100 therapeutic milk products, ready-to-use therapeutic food (RUTF), ReSoMal, boards for measuring patient height, scales, MUAC tapes and monitoring materials) in order to effectively treat patients suffering from acute malnutrition.
******* Table 2 illustrates the absolute number of under-5-year-old children traced door to door by CHWs and screened using MUAC in three different districts of the Njombe Region. Children examined were divided into two categories. Those with between 60 and 80% weight–for-age were recorded as patients with moderate acute malnutrition (MAM), while those weighing less than 60% were recorded as patients with severe acute malnutrition (SAM).
******** Table 3 illustrates the absolute number of under-5-year-old children with moderate to severe malnutrition in the villages involved in the initial follow-up. Following the first quarterly meeting, CUAMM identified those villages with particularly complex situations in order to determine their underlying causes as well as to verify the reliability of data collected by CHWs. This helped confirm how complex these particular areas can be, underscoring how few patients had been appropriately referred to the nearest health centers. Economic difficulties and lack of support from village leaders were found to be among the principal causes of the problem. Moreover, although the project has had positive results in terms of identifying those children who are acutely malnourished, much still needs to be done in order to gain an accurate picture of those subject to the intervention and their possible referral. Some data are still not available. Upcoming quarterly meetings will also make it possible to get a better grasp of the statistics.

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1 Doctors with Africa Cuamm. *Ensuring care and support of severely malnourished children in Iringa and Njombe*. Programme Cooperation Agreement with CUAMM Trustees 2014-2015, p. 8.
2 Doctors with Africa Cuamm. *Ensuring care and support of severely malnourished children in Iringa and Njombe*. cit. p. 8.
3 Doctors with Africa Cuamm. Source: Njombe Fieldwork.
4 Doctors with Africa Cuamm. *Quartely Follow-up and Supervision Report of Village Health Workers for July, August and September 2014*. Community Unit-Cuamm 2014.
5 Doctors with Africa Cuamm. *Ensuring Care and Support of Severe Malnourished Children in Njombe and Ludewa, Follow-up of Moderate and Severe Acute Malnourished Children.* Community Development Unit. Cuamm - Iringa. 2014.