



**DOCTORS
WITH AFRICA**
CUAMM



HEALTH AND DEVELOPMENT

quarterly magazine
of international cooperation
and health politic
September 2011/ No. **61**





NEWS

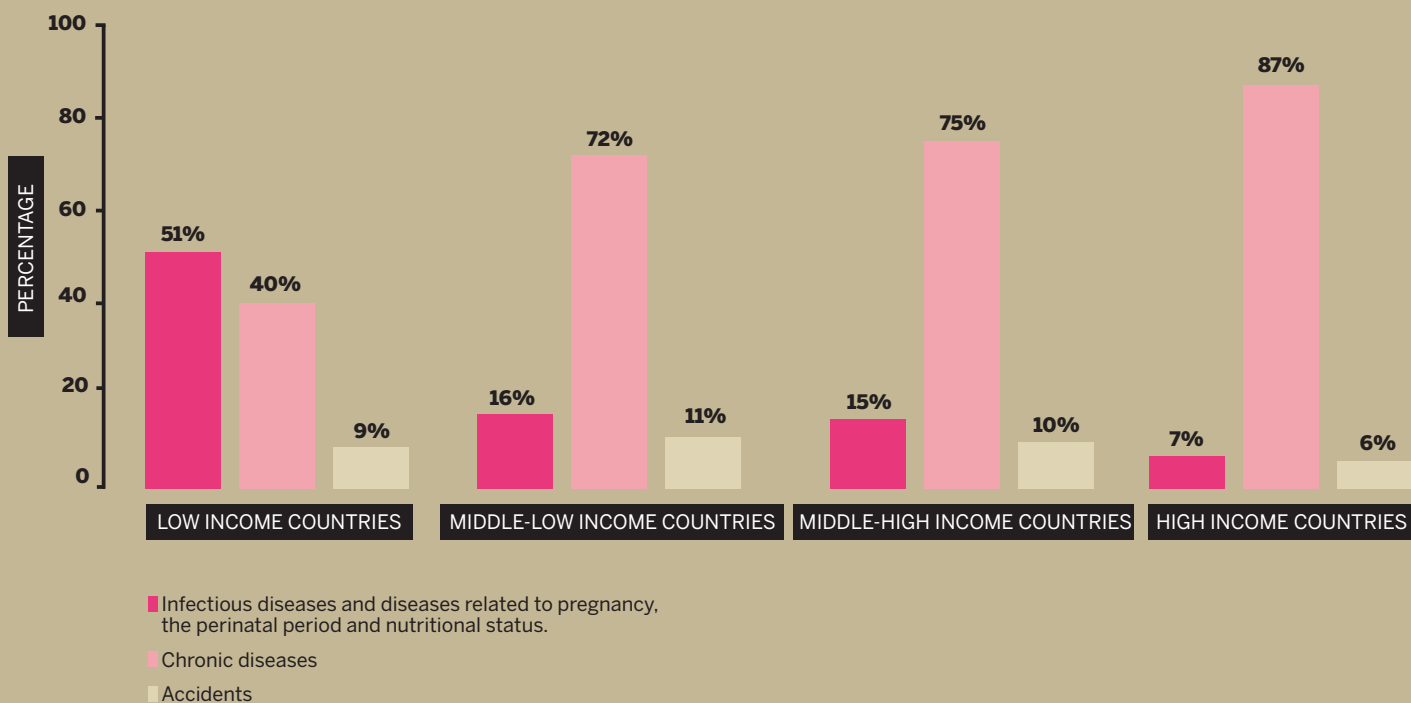
Chronic diseases and Global Health

Last 19-20 September, the Assembly of the United Nations met to discuss the theme of chronic diseases (this marks the second time in its history that the Assembly has dealt with a health issue, the first time being in 2001 on the question of AIDS). Chronic diseases are spreading at epidemic speed, particularly in countries with middle and low levels of development. Two epidemics are simultaneously present in the poorest countries: the rapid growth of chronic pathologies and the persistence of infectious diseases and high rates of child and maternal mortality (**figure**).

Each year 9 million people throughout the world die early (before age 60 years) from a chronic illness (cardiovascular diseases, cancer, diabetes, respiratory diseases). **90% of these premature deaths occur in countries with middle and low levels of development.**

Follow the “Chronic diseases and global health” module in the online course, “Global health and health inequalities” at <http://www.mediciconlafrica.org/accedi-al-corso>

FIGURE / PERCENTAGE DISTRIBUTION OF THE MAIN CAUSES OF DEATH BY COUNTRY DEVELOPMENT LEVEL



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REGISTRATION AND AUTHORIZATION

c.o. the Law Courts of Padova n. 1129
on 5.6.1989 and on 11.9.1999

DISPATCH

in abb. post. D.L. 353/2003 (conv. in L. 27/02/2004 n° 46) art. 1
comma 2 - DCB Padova

TRANSLATION

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DIALOGUE

HEALTHCARE SYSTEM REFORMS

The three different stages of healthcare reforms: the season of rights, the market-oriented season and the season of “second thoughts”. Or the law of the pendulum. Following 11th September, 2001, a series of reforms came into effect, moving differently and sometimes in the opposite direction from liberalist trends.

BY / GAVINO MACIOCCO / PUBLIC HEALTH DEPARTMENT, UNIVERSITY OF FLORENCE

In the last 60 years we have witnessed three different seasons of healthcare system reforms.

The season of rights. The first season began with the establishment of the British National Health Service (NHS) in 1948. It marked a turning point in the concept of health (a “*universal right*”) and healthcare: accessible to all, funded by general taxation, and free-of-charge at the point of service delivery.

The principle of health as a right, in the wake of the United Kingdom experience, spread rapidly and became a fundamental component of many constitutions, including the Constitution of the Italian Republic.

In September 1978, the International Conference on Primary Health Care (PHC), promoted by WHO and UNICEF, was held in Alma Ata, capital of the Soviet Republic of Kazakhstan, and its final document committed governments to achieve “Health for All by the Year 2000”.

The market-oriented season. The spotlights of the Alma Ata Conference had not yet faded when the whole scenario radically changed. The nineteen eighties took a U-turn in international policy, as a result of three fundamental events:

- a period of world recession caused by the oil crisis in the 1970s, which not only brought the economies of the poorest countries in the planet to their knees, but also created serious financial difficulties for the welfare systems of richer countries;
- the assertion of neoliberalism in many countries (particularly the United States and Great Britain) and in the leading international finance institutions (the World Bank and International Monetary Fund), which promoted deregulation of the global movement of capital, goods, services, people, in a process commonly referred to as “globalization”.
- while the “Health for All” objective was becoming a mirage, a “global” healthcare system model (strongly supported by the World Bank) began to assert itself, based on the privatization and private funding of services, mainly through their direct payment (user fees). Consequently, according to a WHO report, every year over 44 million families throughout the world have to deal with financial catastrophes caused by medical expenses and – as a result – 24 million families have been plunged into poverty¹.

Act Three. The law of the pendulum.

Act Three of our story marks the dawn of the third millennium, following the fateful 11th September, 2001, when a series of reforms came into effect, which move differently and sometimes in the opposite direction from liberalist trends. The principles of Alma Ata (the Brazilian² reform) and universality of access (Mexico³, Thailand⁴, Turkey, Taiwan, Malaysia) are returning to popularity. China⁵ and India⁶ have also decided – albeit cautiously – to set up reforms typical of the first period.

The law of the pendulum also applies to the USA where the response to the exasperation of privatism by the Bush government has been a reform – by Obama – bringing the state back into play and aiming to drastically reduce the number of uninsured people⁷.

The law of the pendulum does not, instead, apply to the nation where our story began, i.e. the United Kingdom or more precisely England (since Scotland and Wales are moving in a different direction). From the Thatcher reform in 1991 to the ones by Blair, to the current draft bill proposed by the Cameron government, there has been a growing move in England towards the dismantling of the healthcare model founded in 1948⁸.

NOTES

¹ G. Carrin, C. James, D. Evans, *Achieving universal coverage: developing the health financing system. Technical brief for policy-makers no. 1*. Geneva, WHO, 2005

² <http://saluteinternazionale.info/2011/05/brasil-e-programma-salute-della-famiglia-successi-limiti-e-nuove-sfide/>

³ <http://saluteinternazionale.info/2009/11/la-riforma-del-sistema-sanitario-in-messico/>

⁴ <http://saluteinternazionale.info/2009/08/tailandia-il-coraggio-delle-riforme/>

⁵ <http://saluteinternazionale.info/tag/dossier-cina/>

⁶ V. Patel et al, *Universal health care in India: the time is right*, Lancet 2011; 377:448-9.

⁷ <http://saluteinternazionale.info/tag/dossier-usa/>

⁸ <http://saluteinternazionale.info/tag/dossier-nhs/>



DIALOGUE

REFLECTIONS ON “OBSTINATE GOOD”

Often journalists avoid ideas and events that are not part of an information circuit, too strange or difficult to digest. Paolo Rumiz has turned his attention to “black” Africa, health cooperation, and the history of an almost unknown organization that has recently celebrated its 60th anniversary.

BY / ANNA TALAMI / DOCTORS WITH AFRICA CUAMM

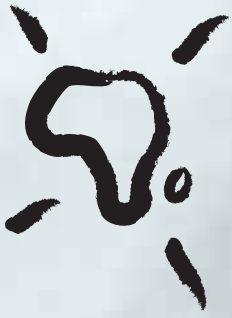
Some topics don't appeal to readers, journalists and less still to editors. If you are forced to write about them, you do so distractedly. It is well known that many journalists don't go in search of the truth, but look for news items; many ideas and events – and there are lot of them! – are not interesting turning points, nor part of an information circuit, nor too strange or difficult to digest, and concern others, rather than our present and our future. Then an opportunity comes up and someone begins to believe in it, reversing the general trend. One exception we can mention is Paolo Rumiz who has turned his attention to “black” Africa, health cooperation, the history of an almost unknown organization that has recently celebrated its 60th anniversary.

«Italians. Great people. The silent heroes who take care of the world», ran the headline in the *La Repubblica* newspaper, on 23 March, of the splendid review by Leonetta Bentivoglio, marking the first in a series. We also receive the following kind of message: «I had had your book for a few weeks and kept putting off reading it. Then my wife urged me to do so because she had found it enjoyable and well written. So, yesterday afternoon I read it from cover to cover and came out happy. That book is my life, its people, places and underlying philosophy: silently and tenaciously. All in all it was very moving indeed».

It is perhaps worth considering why the book was received so well. Why was the critic smitten and the readers moved and captivated? *Il bene ostinato* (“Obstinate good”), published by Feltrinelli in March, gives Paolo Rumiz the chance to practice the very noble art of story telling, which is hard for the writer but satisfying for the reader. Right from the start, he stated that his intention was to: tell a universally relevant story, like an access key to a great adventure, about issues that are often forgotten and not part of the news circuit. If you start reading, you are drawn in from start to finish by an outburst of writing with no falls in tension, no dead times, no respite, which eliminates all superfluousness and keeps a vibrant pace along changing pathways. Many recognize his ability to keep up the tension and his solidity in describing the special, increasingly rare vocation of providing healthcare to the poorest members of the planet. It is instead considered a very humane choice, based on daily actions, on limits and fears, on banal events, a slow pace of life and repetitive routines, well away from the limelight. A choice made by very normal people, who differ greatly from one other in terms of culture, training, sensitivity, social class: people we can all identify with, irrespective of whether or not we share their faith or creed.

So an apparently marginal phenomenon, unveils “another” way of being at the heart of humanity, where vital energy still flows, of building an identity and a future, where the search for peace and solidarity are not ignored, or worse still the object of mockery. «During this time – continued the message – I have reflected at length on how we can cooperate in the future. I consider that book to mark the end of a phase ... Yes, I am very concerned, but not about the lack of funds, we are all well aware that lots of things can still be done in the healthcare sector and there are many very good, very willing colleagues around. What does concern me is the difficulty of creating interest in serious, high quality cooperation. A difficult autumn is about to start. We will be in touch».

Rumiz's gamble and the courage of the editor of Feltrinelli are more than just a search for a place to tell a story. They are looking, in an Italy confused by 150 years of unity, for a space for high quality policy-making decisions. What spring to mind are the words of the President of the Italian Republic, Mr. Giorgio Napolitano, in his visit to Padova during the 60th anniversary celebrations of Doctors with Africa CUAMM. «And isn't the art of politics, awareness raising and taking on responsibility all about making choices, setting priorities, saying 'no, we can't relinquish this, we can't waive that'?». We can not shirk our duty to demonstrate solidarity within society and towards the rest of the world. This is an unrelenting, stubborn search for good, crafting a story that opens up to the future «aware of the price of optimism and hope: a realistic, lucid view, heedless of the trials ahead and the obstacles to overcome». With the aid of a few more supporters. Thank you Rumiz.



GREAT BRITAIN, SEPTEMBER 2011

A demonstrator wearing a mask of United Kingdom Prime Minister, David Cameron, protests in front of Parliament in London against the National Health Service reform proposed by the government. Unlike the direction being taken in other countries (most notably the United States), Mr. Cameron's reform is decidedly private-sector oriented. Many English citizens now fear that the government could end up eliminating the public healthcare system.



NHS
FOR SALE

cameron & clegg agents





GLOBAL HEALTH AND SELF-TRAINING

Brescia, Florence, Genoa, Perugia, Rome. Each self-training group was formed with the aim and desire to share the experiences gained during the national *Laboratorio di mondialità* and to involve colleagues at local level in the issues of Global health and Cooperation in development. Training and exchange of ideas are extended throughout the whole year.

BY / CLAUDIA AMADASI / MEDICAL STUDENT, UNIVERSITY OF PADUA

SISM (Italian Secretariat of Medical Students) became interested in self-training groups in 2009 after three editions of the *Laboratorio di mondialità* (globality workshop). This interest and attention sprang from the realization that training and the exchange of ideas need not be restricted to a weekend, but could become a more continuous process extending throughout the whole year. It also realized that to be truly complete, the experience could not and should not be restricted to SISM members or medical students in general, but that a multidisciplinary approach was needed, encompassing new areas, aspects and students from other degree courses.

This led, more or less recently and in various parts of Italy, to the establishment of self-training groups composed of young people who meet periodically to study topics in Global health and cooperation in development, accompanied on occasions by physicians, professors or students with a little more experience.

We at SISM therefore decided to interview these young people and to summarize their experience in an article. All self-training groups (Brescia, Florence, Genoa, Perugia and Rome) were asked the same three questions to find out how the group was formed, the issues that had been addressed in detail and current progress.

WHEN WAS THE GROUP FOUNDED AND WITH WHICH MEMBERS?

All groups were formed between the end of 2009 and the start of 2011, after members had taken part in at least one *Laboratorio di Mondialità*. The Perugia group reported that this experience «gives you a taste of Global health and a sense of friendship and cooperation» and has been the start of this activity.

The more senior groups include Brescia, strengthened by the presence of members who have been active since 2008, i.e. the year of the second *Laboratorio* (held in their city), and Genoa. The two groups initially formed a self-training group with other northern Italian sections (Milan and Varese), organizing a role-playing session for cooperation players at the LabMond in Rome 2010. Subsequently, the two sections decided to set up independent, active groups of students and young doctors keen to cultivate a common interest on a more regular basis. Generally speaking, the formation of almost all groups stemmed

from a desire to share, at local level, the experiences gained during the national *Laboratorio* and to involve colleagues in the issues of Global health and cooperation in development.

Most members are medical students, but there are plenty of Physiotherapy students in some groups and residents in Hygiene and Preventive Medicine in others (such as Perugia and Genoa). This goes to show that the peer-to-peer teaching format, regularly adopted by members of SISM, can be very effective when it involves professionals who are more or less the same age as the students, but a little more experienced. Students find this an essential part of their training in the various fields.

WHICH OBJECTIVES NEED TO BE ACHIEVED?

The groups all agree that their enthusiasm and motivation stem from a desire to include in their training pathway and that of their peers, activities and subjects neglected or only partly or superficially covered by the current *curriculum*. In their opinion the activities offered by SISM are a way of getting involved in Global health and cooperation in development issues. The aims and intentions of the Rome group are very clear: «Our group does not wish to be merely a training vehicle but also, and above all, a source of human growth. We believe that the topics proper to Global health cannot be addressed, understood and thought out without seriously working on the ethical positioning of our lives and our profession. Our aim is to free the group of the pre-set roles and generators of inequality present in universities, hospital wards and society as a whole».

Some groups have been set up to address specific topics such as health determinants (Genoa) or migration medicine (Brescia), while others, as Florence, have instead decided to consider issues on an *ad hoc* basis.

HOW IS THE GROUP ORGANIZED? WHAT HAS BEEN ORGANIZED TO DATE?

The groups are organized through means such as mailing lists and meetings (monthly or weekly) in which the key word is



SISM SEATS - Italian Secretariat of Medical Students

Bari, Bologna, Brescia, Caltanissetta, Campobasso, Catania, Chieti, Ferrara, Firenze, Foggia, Genova, Messina, Milano, Modena, Napoli "Federico II", Napoli "S.U.N.", Novara, Padova, Palermo, Parma, Pavia, Perugia, Pisa, Roma "La Sapienza", Roma "Sant'Andrea", Roma "Tor Vergata", Roma "Ucsc Policlinico Gemelli", Sassari, Siena, Torino, Trieste, Verona, Udine



IN TOSAMAGANGA

The days spent in Tosamaganga flew by even though time takes on a completely different dimension to the one we are used to. It dilates and the only time you perceive is the present.

BY / MARIA CATERINA VESCOVI / MEDICAL STUDENT, UNIVERSITY OF UDINE

This is an account of my experience as a medical student in Tosamaganga (Tanzania), where I took part in a Doctors with Africa CUAMM project.

From Dar es Salam ("house of peace"), the journey takes 9 hours, 600 km, across savannah and baobabs, heading for Iringa and then to Tosamaganga. This is where the Doctors with Africa CUAMM headquarters and guest house are located, close to St. John of the Cross hospital. On the evening of our arrival, the Doctors with Africa CUAMM staff outlined the Iringa Rural Project to us, the healthcare system that Tanzania has recently implemented, working at three levels: hospital, local health centres and communities.

Tosamaganga hospital is very different from any other hospital we visit during our training. It is a simple hospital: the male ward is divided into two rooms, for medical and surgical patients, whereas the forty or so women are all in one big room; then an operating theatre, paediatric and obstetric wards and an outpatient consulting room. What surprised me most of all was a big pan outside the hospital where patients' relatives cooked things for members of their family to eat.

Our training was monitored by two doctors, a local one and a Doctors with Africa CUAMM one, who supported us at the difficult times: it has been hard to see a child suffering from tetanus, a pathology that can be prevented with a simple dosage of vaccine. Or that young girl: high temperature, dyspnoeic, hypersplenism and leukocytosis. Was it leukaemia? I didn't see her again.

In the short period spent in Tosamaganga I experienced many cases, all equally and incredibly unfair. But besides these I also met doctors, nurses, persons who fight without getting overwhelmed by the difficulties: I saw lots of plaster casts coming off, children walking again, women giving birth in a safe environment. This is a concrete sign of hope.

The days spent in Tosamaganga flew by, even though time takes on a completely different dimension to the one we are used to. It dilates, going beyond time itself and the only time you perceive is the present. The same bus journey, the usual adventure, taking with me thoughts, places, people, scents that I will never forget.

sharing: ideas, material, experiences, readings, knowledge. And that is not all: some groups have gone one step further and taken this wealth of knowledge outside.

Some groups are an active part of the academic world and have implemented from scratch various optional courses (ADE) that were not already on offer (Perugia and Genoa), or have helped organize pre-existing courses, or gone beyond the university confines, seeking spaces offered by civil society.

The courses have dealt with a broad range of subjects, covering issues dear to students, as health determinants, health inequalities, migration medicine, public health and the organization of National Health Systems, the impact of globalization on the world of health, and international cooperation and development. The Genoa-based group has very decidedly sought to incorporate the entire *Laboratorio di Mondialità* experience into their university curriculum by creating a university-sized "Urban Lab Mond".

The Roman group is an integral part of RIISG (the Italian Network for Global Health Teaching) and helps develop the teaching of subjects at university level.

Groups' members are also well integrated into city life and organize awareness-building days in Rome addressed to the community as a whole. The participants' enthusiasm and the success of these events kindle the hope that, deep down, change is possible.

The satisfaction of the members, however, is not just a matter of professional results, training, and the offer of a wide range of activities: each of them stresses the social side to the group, showing that harmony and effective team building are not only a way of getting things done but also a great opportunity for human growth.



THE EQUAL OPPORTUNITIES FOR HEALTH PROJECT

The “*Equal opportunities for health: action for development*” project wants to develop courses to train doctors and professionals able to promote truly global, fair health, both locally and internationally. Only with an awareness of clinical and social relations and interactions can doctors and health providers work to build healthcare that does not stop at individuals but involves society as a whole.

BY / CHIARA DI BENEDETTO / DOCTORS WITH AFRICA CUAMM

THE PROJECT

7 countries, 18 universities, non government organizations and student associations, 3 years' activity, from March 2011 to February 2014: the European project, “*Equal opportunities for health: action for development*”, is now underway and intends to give room and voice to awareness building and education in Global health, with a view to arousing interest in this often invisible approach to health. Addressing Global health means taking a “panoramic view of health”, like the piece of a composite puzzle with many interlinked, interdependent factors. To achieve this goal, the aim of the project is to train and build awareness among healthcare professionals. Medical students, on the one hand, and doctors, nurses and health providers, on the other, will be involved in numerous professional exchange pathways along which to reflect on a new health paradigm that takes account of themes such as globalization, international health cooperation, and health determinants¹.

The project is once again led by Doctors with Africa CUAMM, as was the European project of the same name implemented over the two-year period 2007-2009. This time, the NGO is mainly supported by new partners, prevalently from new members of the European Community: Romania, Poland, Bulgaria, Latvia, Hungary and Malta.

ITALY

1. Doctors with Africa CUAMM, Italy
2. University of Bologna, Department of Medicine and Public Health, Italy
3. Italian Global Health Watch – OISG, Italy
4. Italian Secretariat of Medicine Students – SISM, Italy
5. Region of Veneto, Italy
6. National Federation for the Orders of Doctors and Dentists, Italy

ROMANIA

7. Transilvania University of Brasov, Romania
8. Medicine Students Scientific Association of Brasov MSSAB, Romania

POLAND

9. Humanitarian Aid Foundation “Redemptoris Missio” Medicus Mundi, Poland
10. Poznan University of Medical Sciences, Poland
11. International Federation of Medical Students' Association – IFMSA, Poland

LATVIA

12. Association for Family Planning and Sexual Health “Papardes Ziedis”, Latvia
13. Latvian Medical Students' Association – LaMSA, Latvia
14. University of Latvia, Latvia

BULGARIA

15. Medical University - Pleven, Bulgaria
16. Association of Medical Students in Pleven, Bulgaria
17. Association “Development of Personality and Human Communities” Pleven, Bulgaria

MALTA

18. Medical Students' Association - MMSA, Malta

HUNGARY

19. Central European University, Hungary

A SHARED MODEL

The training activities in each country are coordinated with a view to establishing a shared model of reflection, oriented towards the same objectives. This prompts the question of the impact of working in a network of this kind. We asked Angelo Stefanini, scientific director of the CSI (International Health Centre) of Bologna University. «Networking is extremely important, particularly because it facilitates the exchange of knowledge, practices and perceptions - which can differ greatly - of some key concepts, such as “health”, “globalization”, “training”. Secondly, a diverse group of people can draw out distinct metaphors that conceal contrasting strategies and policies which can be grouped under the heading “Global health”. Promoting Global health can be viewed as a foreign policy tool, a means of protecting own population, a key element in providing aid to poor countries, a true form of eco-





EQUAL OPPORTUNITIES

The activities of “Equal opportunities for health: action for development” are chiefly addressed to the medical-healthcare community but some also envisage general public involvement.

The activities of the project, “Equal opportunities for health: action for development” are chiefly addressed to the medical-healthcare community – doctors, health providers, lecturers and trainers, medical students – but some also envisage general public involvement and awareness raising. Project work started on 1st March, 2011 and will continue until 28 February, 2014, in various Italian cities and in all countries that are partners to the project. To find out more, click on the following link: www.cuamm.org/educationglobalhealth

EDUCATION/TRAINING

- Academic courses for students of Medicine and from other faculties
- Seminars for doctors and health professionals in cooperation with medical associations, hospital directorates and healthcare units
- Update courses on content and teaching methods for university lecturers and trainers

AWARENESS RAISING AND INFORMATION

- A web area dedicated to the project, with project material and references
- Publication of the journal *Health and Development*, which will also be available online
- Production of video documentaries
- Meetings and thematic events at local level
- Organization of an international conference

NETWORKING

- National and international meetings among project partners, experts, lecturers, and students
- Development of new synergies among Global health players at national and European level

STUDY AND RESEARCH

- Mapping of university courses in Global health
- Updating of the standard curriculum in Global health
- Participation in conferences and congresses on the subject
- Research work on the conditions of the African healthcare system
- Publication of scientific articles and joint international studies

conomic investment, or a public health intervention to reduce the disease load of the world population».

OBJECTIVES

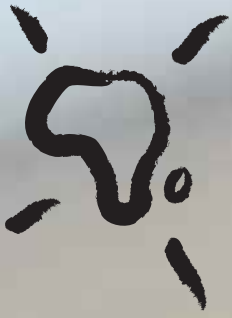
The project training programme focuses not only on common contents but also gives priority to efficacious training methods able to more closely involve course participants, particularly young medical students. «Teaching Global health, particularly at university – maintains Stefanini – equates to an attempt to un-hinge a training system that loses sight of the underlying ends and values of the medical profession. It means training socially responsible professionals who are aware of their duties towards human society and are therefore ready to actively promote the health and well being of the community as a whole, enhance diversity and combat prejudice and inequality».

The aim of the ongoing project is therefore to train these new specialists in Global health to position health within a dynamic, multifaceted setting. It is natural to wonder what the purpose of this training will be. Where will this discipline be put into practice? According to Stefanini, «The meaning of Global health surpasses the “international” perspective, encompassing “them”, i.e. the poor countries of the southern hemisphere and “us”, the rich countries with long life expectancies. This oversimplification is essentially wrong because it limits the comparison to average values of wealth and health. As Fr. Milani points out, “the media are cowards because they mix the richest of the rich with the poorest of the poor, as though this levelled things out!” The term “Global health” does instead emphasize how geopolitical factors and national boundaries are irrelevant when it comes to the spread of disease and the distribution of health determinants among neighbouring population groups. Inequalities are found not only among the various countries, but also within the same countries, since the various communities are exposed to very different health determinants, as income, work opportunities and social support. What is certain is that intervention is needed to effectively address these problems at each level (local, intermediate and global)».

Over the next three years the aim of the “Equal opportunities for health: action for development” project will be to develop courses to train doctors and professionals able to promote truly global, fair health, both locally and internationally. Only with an awareness of clinical and social relations and interactions can doctors and health providers work to build health that goes beyond individuals and involves society as a whole.

NOTES

1 After collective research and discussion, the disciplines embraced by the topic of Global health were defined during the project, “*Equal opportunities for health: action for development*” 2007-2009 and are contained and described in a document adopted by the project partners, referred to as the standard curriculum, <http://www.cuamm.org/en/university-education>.



KENYA, AUGUST 2011

A newborn child yawns for the first time in Hagadera hospital, in the refugee camp in Dadaab in Kenya. Maternal, fetal and neonatal deaths are among the key health problems in Sub-Saharan Africa. The crisis in the Horn of Africa will put the populations of the Somali Republic and other affected countries even more severely to the test. During the international meeting, *"Prima le mamme e i bambini"* ("Mothers and children first"), organized by Doctors with Africa CUAMM for next 5th November, space will be given to this particular emergency.







EXPERIENCES FROM THE FIELD

TUBERCULOSIS CONTROL IN ANGOLA

The aim of the programme, which started in August 2005, was to reorganize the network of anti-tuberculosis services and ensure application of the treatment strategy promoted by WHO (Directly Observed Treatment – DOT) in 11 provinces of Angola, which account for approximately 85% of the population. Intervention has led to the rapid development of guidelines on staff training, work supervision and expansion of DOT services.

BY / ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

The Republic of Angola is situated on the west coast of Sub-Saharan Africa. It is one of the largest countries in the continent, with a surface area of 1.2 million km². Its constantly increasing population is estimated to stand at about 14-17 million inhabitants, approximately 60% of whom are younger than 18 years. Politically and administratively, Angola is organized into 18 provinces, 164 municipalities and 557 communes. Angola's health indicators are among the worst in Sub-Saharan Africa. The infant mortality rate is 154 deaths per 1000 live births, while the death rate in the first 5 years of life is 260 per 1,000. The total fertility rate has been calculated at 7.2 children per woman, while average life expectancy is only 40 years. The maternal mortality rate has been estimated at between 900 and 1,300 maternal deaths per 100,000 births. These health indicators reflect a series of competing factors, such as lack of access to healthcare services, water, a sewage system, personal hygiene, food, food safety, housing, family income, health care knowledge and practices at community and family level. Between 2005 and 2010, in its capacity as sub-recipient of the UNPD in 11 of the 18 Angolan provinces, Doctors with Africa CUAMM implemented the project, "Support to the National Tuberculosis Control Program", financed as part of the 4th round of the Global Fund (GF). The aim of the project, designed to provide "support to the national tuberculosis control programme," was to reorganize the network of anti-tuberculosis services and ensure that the treatment strategy promoted by WHO (*Directly Observed Treatment - DOT*) was applied in 11 of the 18 provinces of Angola (Luanda, Huambo, Benguela, Moxico, Biè, Cabinda, Huila, Lunda, Norte, Uige and Malanje), since they account for approximately 85% of the population and because over 80% of all reported cases of tuberculosis in Angola occurred there. The total budget for the project was 11,163,763 dollars, over a period of five years. During the five-year period, the GF paid out a total of approximately 6,500,000 dollars. The GF project funded all aspects relating to extension of the DOT programme and improvement of quality, excluding the purchase of anti-tuberculosis medicines. The main implemented activities were:

- extension of the network of diagnosis and treatment centres;
 - renovation and restoration of diagnosis and treatment centres and procurement of equipment and consumables (laboratory reagents, registers, stationery);
 - provision of means of transport: a car for each provincial supervisor and a motorcycle for each municipal supervisor, plus running and maintenance costs;
 - human resources training (supervisors, nurses, laboratory technicians);
 - activation of monitoring programmes consisting of periodic meetings between provincial and municipal supervisors;
 - use of community theatres to promote knowledge and awareness of tuberculosis, treatments and care within the community.
- During the five years, almost 1,800 healthcare providers have been trained according to new standard guidelines, with manuals created by the staff employed in the project:
- 286 laboratory technicians specialized in tuberculosis laboratory management;
 - 447 nurses trained in the management of cases of tuberculosis according to the DOT strategy;
 - 213 supervisors trained in the programming and management of tuberculosis and in supervision techniques;
 - 22 provincial supervisors trained in the supervision of tuberculosis diagnosis and treatment centres;
 - 805 nurses trained in the diagnosis and treatment of tuberculosis;
 - 26 provincial logisticians trained in activities to support tuberculosis control.
- The number of laboratories with an adequate diagnosis and reporting system has risen from 18 in 2004 to 112 in 2010, and the number of treatment centres (DOT centres) from 44 in 2004 to 158 in 2010. The expansion of tuberculosis services and improvement of their quality through training and supervision can be associated with the positive results recorded in terms of success rates and treatment drop out rates. Since the start of the project, in the 11 supported provinces, the treatment success rate for category 1^a rose from 69% to 73%, while the drop out rate for categories 1 and 2 decreased from 23% to 19%. The health information system for tuberculosis has been improved and today over 90% of the 11 provinces observes the deadlines for sending reports, providing quantitatively more and qualitatively better information. Quarterly activity reports are sent to the directors of the National Tuberculosis Control

Programme (PNCT) in the first 60 days of the following quarter, thereby enabling national statistics to be updated reasonably quickly.

Before the start of this project, there had never been any structured, consolidated system in Angola for supervising the activities of tuberculosis diagnosis and treatment centres. After three years, the number of municipal tuberculosis centres receiving a supervision visit increased from 19% in 2005 to 77% in 2008. Collaboration has also been strengthened with the National Institute for Public Health (INSP), which is responsible for the quality of laboratory services in Angola. Today, all laboratories involved in controlling tuberculosis are supervised by PNCT and INSP. A retro-information system, associated with specific recommendations, has also been introduced, which starts through direct discussion straight after the visit.

For many years the procurement of anti-tuberculosis medicines in Angola was both irregular and insufficient. When the GF project started, the PNCT had not yet developed a valid, regulated method of managing drugs to treat tuberculosis. The project has provided technical assistance and supported the distribution of medicines on a regular, quarterly basis. Observations made during the first two years suggest that the corrective interventions started by the GF project, relating to procedures used to order and distribute medicines at national and provincial level, have drastically reduced the number of errors in the system. One example is the case of "RHZE" (the fixed combination of doses used in the initial stages of treatment): the number of episodes in which excessive or apparently unjustified quantities were requested has drastically decreased from 64% in 2005 to 32% in 2006: i.e. a reduction of 50%.

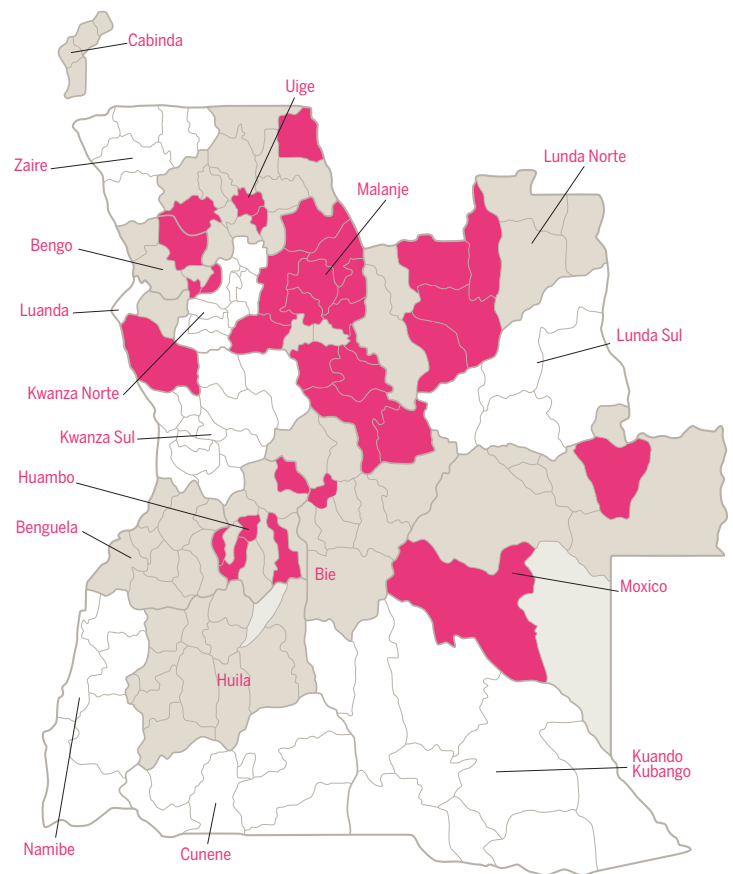
The social and community-related aspects of tuberculosis were analysed via the TB-KAP (*Knowledge-Attitude-Perspective*) study in 2005, when 2,975 complete interviews were collected in the five Angolan provinces taking part in the survey (Luanda, Huambo, Huila, Uige and Malanje).

The first finding to emerge from the TB-KAP study was that 32% of interviewees had never heard of tuberculosis. On analysing familiarity with the disease by age group, the percentage rose to 40% among young people below 18 years of age.

After publication of the TB-KAP study, a consultant was made available to the Ministry of Health with the aim of defining a national communications and social mobility plan for tuberculosis. The plan, completed in 2007, was entitled PENPS-TB: *Plano Estrategico Nacional de Promoção da Suade para a tuberculoses*. This plan defines Angolan national standards for the production/printing of fliers, gadgets, cartoons, T-shirts and other material for information campaigns on tuberculosis. The PENPS-TB plan also defines the key players and beneficiaries of information, education and communications activities.

In addition, Doctors with Africa CUAMM in collaboration with Angolan civil society organizations has also implemented a series of "community theatres" to spread messages on tubercu-

FIGURE 1 / THE 18 PROVINCES OF ANGOLA



losis. In five years, 423 performances have been put on show, reaching approximately 86,000 spectators.

To conclude, the project can be said to have had a decisive impact on the relaunch of the Angolan National Programme for Tuberculosis Control which, like the rest of the country, was recovering from 30 years' civil war. In a relatively short space of time, the project has enabled the rapid development of guidelines for staff training, work supervision and the expansion of DOT services in the 11 supported provinces. PNCT management capacity has been improved. The project has also created many of the conditions that have paved the way to approval of new funding from the 9th round of the Global Fund, a grant that will enable similar activities to be supported in all the provinces of Angola.

NOTES

1 *Category 1:* newly diagnosed cases; *category 2:* relapses, treatment failure; *category 3:* extrapulmonary tuberculosis / smear-negative pulmonary tuberculosis; *category 4:* chronic cases.



EXPERIENCES FROM THE FIELD

“STRENGTHENING THE HMIS” IN TOSAMAGANGA, TANZANIA

Mortality and morbidity can be reduced through careful analysis of reliable demographic and health data (and the ensuing interventions). Considering the good results achieved through the project at Tosamaganga hospital, it was decided to implement the same programme at Mikumi hospital.

BY / NÚRIA MARZO RODRIGO / DOCTORS WITH AFRICA CUAMM

INTRODUCTION

In 2007 the healthcare authorities of Iringa region (Tanzania) realized that population healthcare data and the efficacy of healthcare interventions lacked reliability. Experience gained elsewhere in Tanzania showed that mortality and morbidity could be reduced through analysis of reliable demographic and health data (and the ensuing interventions)^{1, 2}. Doctors with Africa CUAMM drew on this experience to promote the “*Strengthening the HMIS (Health Management Information System)*” project, focused on Tosamaganga hospital, which serves as the district hospital in Iringa District Council, with its 261,938 inhabitants.

The project, which began in June 2009 and ran for two years, was managed by a CUAMM doctor (the project leader) and funded by the Maria Bonino Foundation³.

The main aim was to consolidate the HMIS of Tosamaganga hospital in order to collect appropriate information on healthcare activities, identify critical points, and support and plan activities based on adequate priority-setting criteria.

In healthcare facilities in Tanzania, data on the various activities are manually collected in twelve different registers. They are then summarized and sent on a quarterly basis to the District Medical Officer, where district reports are drawn up.

METHODS

All objectives and results were achieved at the end of the project⁴ through the creation of a solid data collection strategy, with data flow analysis, computerization, training, participation in the hospital management team and quality improvement.

The main outcome was the making available of a data collection system able to provide accurate information on which to make evidence-based planning decisions, and therefore contribute to improving the efficiency, efficacy and quality of delivered health services.

o data flow analysis

The information system was analysed at national and health

facility level in order to establish and understand the flow of data and identify any strengths and weaknesses.

One of the strengths at Tosamaganga hospital is the practice of drawing up a daily report in the various wards, indicating the number of admissions, discharges, deaths and referred cases. These documents are then taken to the admissions office and computerized.

However, data entry is done on a basic Excel spreadsheet, where a lot of information remains incomplete; the lack of a back-up system also makes it easy for files to be damaged or deleted. Above all, reports were created manually without exploiting the software’s report-creating potential.

o creation of a computerized programme

Starting from these identified strengths – i.e. the existence of a daily patient-data sheet and basic familiarity with software – a new simple, flexible, user-friendly Excel programme was created in the form of a calendar, incorporating the national health information system’s data collection forms for hospitals. This enabled data collection to be extended to all hospital departments, creating a new data collection flow and harmonizing form filling.

o training, supervision

Training sessions were focused on identified areas of weakness, such as data collection, statistical analysis, feedback, computer skills, management quality and analysis, and healthcare planning.

25 seminars were organized with 282 participants and a mean duration of 4 days, including new teaching material and practical exercises to make sure that participants put what they had been taught into practice. Hospital staff were involved as facilitators to improve the performance of the various professionals and increase their motivation. Supervision and continuous training were constants in the project to ensure learning, follow up and use of the new Excel programme.

o Hospital Management Team (HMT)

The aim of the programme was not simply to produce reliable information but also to make sure that this information could help guide managerial decision-making. Hence, active participation in the HMT had a decisive role in increasing the

team's ability to use data for informed decision-making purposes⁵.

o **quality improvement**

The HMIS was also an effective tool for improving the quality of hospital services, being designed to identify good practices and promote staff motivation and accountability. Accordingly, support was given to implementation of the *Quality Improvement Programme* adopted by the Tanzanian Ministry of Health⁶.

RESULTS

Thanks to the newly created system, valid, accurate data can be obtained to show actual hospital activities⁷, as shown in **Figure 1**:

The graph clearly shows that outpatient examinations were not properly recorded before project implementation. This led to underestimation of the work actually being performed. In 2010, recorded outpatient activities were up by 261% compared 2008.

It is therefore evident that before the intervention, the hospital was unable to report its actual work level, while we all know how important it is to demonstrate performance (particularly when it is good), in order both to attract more financial resources to support service costs, and to justify the need for more human resources to deliver a given quality level⁸.

The next step was to develop an integrated approach to data and disease control. After collection, analysis and interpretation, data were used to make conclusions by which to undertake corrective and therefore **healthcare management** actions⁹.

Below are two examples of how data has had an impact on disease management.

In recent years, **urinary tract infections** have been among the most frequent diagnoses for children aged under 5 years. In 2009 they accounted for 26.6% of outpatients and 21.8% of inpatients. The evidence of the data¹⁰ was discussed by HMT: the main cause was found to be failure to comply with quality standards for urine collection, which systematically led to sample contamination. On identifying the problem and adopting the consequent solution, a significant reduction was achieved in the diagnosis of urinary infections in children under 5, as illustrated in the graph:

Another example of how data can be used for planning and organizational improvements relates to requests for laboratory **testing of malaria**, which require a considerable workload with minimal diagnostic benefits. The District is located at an altitude of 1450m asl in the region of Iringa, where there is a low incidence of malaria. Of the very high number of samples sent

FIGURE 1 / TOSAMAGANGA HOSPITAL. NO. OUTPATIENT EXAMINATIONS BEFORE THE START OF THE PROJECT AND AFTER PROJECT IMPLEMENTATION

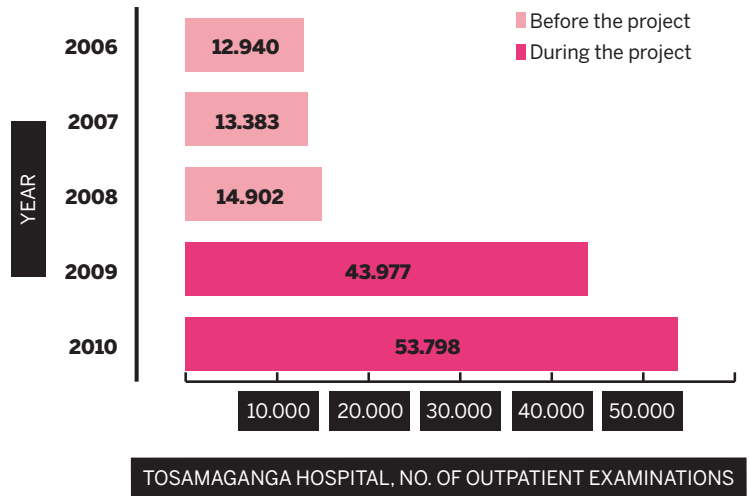
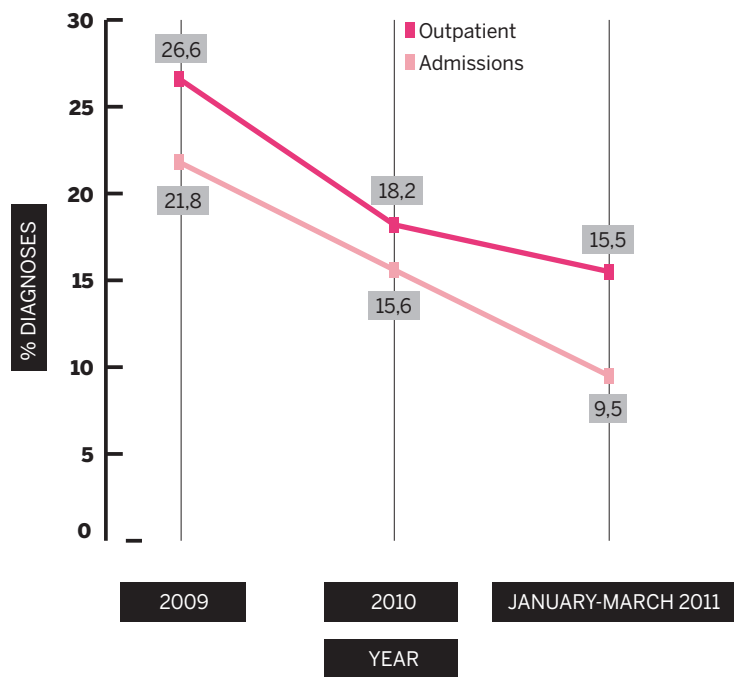


FIGURE 2 / TOSAMAGANGA HOSPITAL. % DIAGNOSES OF URINARY TRACT INFECTIONS IN CHILDREN <5 YEARS OF AGE



for testing, very few proved to be positive, with rates falling, if anything, in recent years from 8% in 2007 to 1% in 2010 and to as low as 0.5% in the first quarter of 2011.

Given this evidence (over 99% of suspected clinical cases testing negative), it was decided to act on the malaria diagnosis and management protocol, in order to drastically reduce requests for unnecessary, inappropriate testing, thereby reducing laboratory work load and decreasing costs for supplies and reagents¹¹.

In addition, the project not only achieved the results described above, but also contributed to develop and implement the national **Quality Improvement Programme** at Tosamaganga hospital, which, after the first evaluation, came second in effi-

ciency out of 33 hospitals taking part at national level (and second only to the programme's pilot hospital).

CONCLUSIONS AND RECOMMENDATIONS

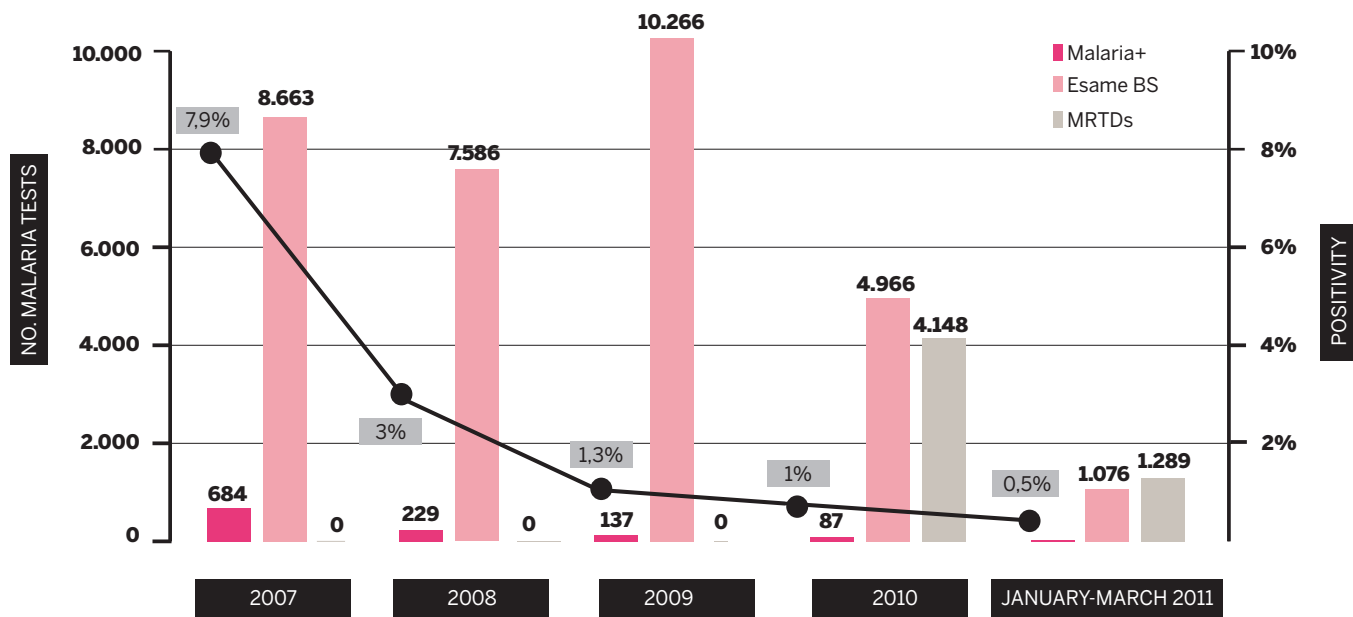
The project demonstrated that creating a simple, new Excel programme based on the strengths identified in the hospital data flow, made it possible to develop an office and a centralized system for collecting and computerizing hospital information and, consequently, for recording actual activities. Analysing and using this information for operating and deci-

sion-making purposes (*decision-making integrating data*) led to improvements in clinical management in terms of hospital efficiency, efficacy and quality.

Considering the positive results of the project at Tosamaganga hospital, it was decided to implement the same programme at Mikumi hospital (where Doctors with Africa CUAMM has been present since 2005), after making minimal adjustments to the setting, to obtain the same benefits for the hospital staff and authorities involved.

This experience shows how a "small" project, with limited resources, proved to be a useful hospital planning and management tool, based on a method which could be transferred to other centres and districts¹².

FIGURE 3 / TREND IN NO. MALARIA TESTS



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A CLOSER LOOK

IT IS BECOMING QUICKER TO DIAGNOSE TUBERCULOSIS

A tool designed for use in any environment, even by relatively unskilled staff. This is one reason why WHO has recommended GeneXpert for use at district and subdistrict level, by mobile teams in remote areas. The diagnosis of tuberculosis and rifampicin resistance takes 100 minutes.

BY / ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

In December 2010, WHO officially endorsed *GeneXpert*, a new diagnostic test for tuberculosis designed to both diagnose tuberculosis and detect the presence of mutations that confer rifampicin resistance in *Mycobacterium tuberculosis* (MT). Clinically and diagnostically, *GeneXpert* marks an historic turning point since it is the first fully automatic molecular test suited to use at district and sub-district level in developing countries.

GeneXpert may help intensify tuberculosis screening, particularly in patients with HIV infection and/or suspected of having MDR tuberculosis. In African settings, this technology may also be a turning point in the integration of tuberculosis/HIV services and mother and child healthcare services, by fostering rapid, certain diagnosis of tuberculosis in children (in some cases HIV-positive) and mothers, as well as promoting tuberculosis screening during antenatal examinations and intensifying it for all HIV-positive mothers.

The technology was originally created to help US postal workers test for anthrax contamination in the post. The American company Cepheid Inc., in collaboration with the diagnostics foundation Find, subsequently adapted the technology to the diagnosis of tuberculosis. In the near future, the company also plans to develop the same tool for other diagnostic tests (*an integrated molecular platform*), including the one for HIV viral load.

The tool has been developed for use in any environment, even by relatively unskilled personnel. This is one of the reasons why *GeneXpert* has been recommended by WHO for use at district and subdistrict level, including remote and rugged areas.

GeneXpert can run 15-20 tests per day, with an average time of 100 minutes to diagnose tuberculosis and rifampicin resistance. The tool requires annual maintenance, which entails sending the diagnostic module to Cepheid Inc. laboratories, at a cost of approximately 1,800 dollars, including module shipment costs. Find has set a preferential rate for developing countries, for both *GeneXpert* (17,500 dollars, including the portable computer for reading the tests) and the cartridges (16.86 dollars each).

A series of multicentric studies have shown that the test has 92% sensitivity and 99% specificity in detecting the presence of *Mycobacterium tuberculosis* in the expectorate. In addition, test performance is not impaired where tuberculosis and HIV are both present, where microscope sensitivity tends to be low (47%)¹.

As concerns rifampicin resistance, which predicts MDR-TB, *GeneXpert* has approximately 90% specificity for mutations that confer rifampicin resistance although the positive predictive value is lower than 80% where MDR prevalence is less than 8% and lower than 50% where it is less than 2%.

Besides studies on the sensitivity and specificity of *GeneXpert*, operating studies are now warranted to assess the cost-efficiency ratio, the necessary human and organizational resources and impact on access, antituberculosis treatment outcomes and tuberculosis-related mortality².

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<http://www.stoptb.org>

NOTES

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² WHO, *Rapid Implementation of the Xpert MTB/RIF diagnostic test: Technical and operational 'How-to' Practical considerations*, March 2011.



REVIEW

IS HAART THERAPY HELPING TO MODIFY THE HIV EPIDEMIC?

Analysing the benefits of “highly active antiretroviral therapy” in terms of prevention. It’s essential to combine the use of drugs with risk-reduction strategies and to identify infected subjects through information and education interventions which promote access to screening programmes.

BY / SILVIO DONÀ / DOCTORS WITH AFRICA CUAMM

In 2008 the number of HIV-positive subjects stood at 33 million (UNAIDS data), 2.7 million of whom were new cases; 68% of them live in Sub-Saharan Africa. Why is the HIV epidemic still out of control 27 years after its discovery? To date pharmacological interventions to interrupt transmission of the virus have been disappointing and risk-reduction strategies based on information, education and behavioural changes have produced unsatisfactory results. The benefits of highly active anti-retroviral therapy (HAART) in terms of prevention in the general population have been extensively analysed¹. Their efficacy depends on the proportion of HIV-positive people treated, the ability to treat the people most at risk of transmitting HIV, the extent of viral-load control, the emergence of drug-resistant viral variants, and the effect of the treatment on risk behaviours.

DATA

The study by Montaner² is a complete epidemiological analysis of the Canadian province of British Columbia where, in the period 1996-2009, the number of subjects in treatment with HAART increased from 837 to 5,413 (+547%, $p = 0.002$). During the same period, new HIV-positive cases decreased from 702 to 338 per year (-52%, $p = 0.001$). There was assumed to be a link between the spread of treatment and new diagnoses of HIV. After the launch of HAART (1996-99) and after implementing more aggressive treatment guidelines (2004-09), new cases of HIV drastically decreased (by 40% and 23%, respectively). A relationship was also identified between viral load and new cases of HIV. These results were obtained chiefly through a significant fall in the number of HIV-positive cases among drug abusers, while incidence remained stable among subjects with other risk factors for HIV.

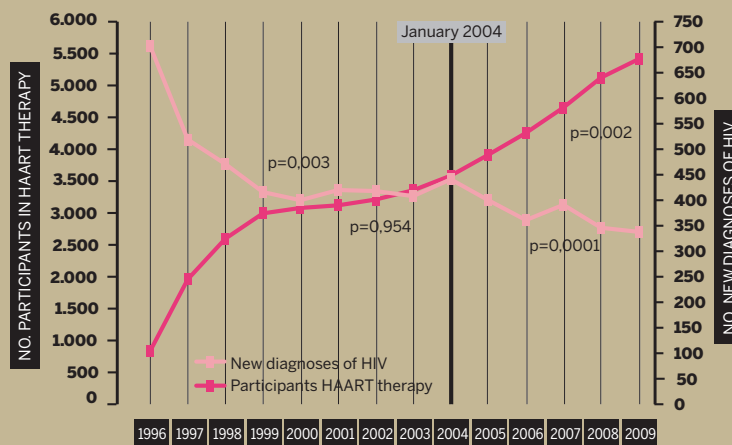
EFFECTS OF THE THERAPY

At the individual level, HAART delivers important results in terms of quality of life and survival. We now have an alternative use for HAART, as a epidemic-control strategy that can improve public health and reduce infectivity and transmissibility due to the reduction in viral load.

Two conditions are required to obtain these results: potent effective drugs to prevent the selection of resistant mutants; programmes designed to identify HIV-positive people who are unaware of their status.

Today’s results have been achieved mainly through the reduction in new infections among drug abusers, who are aware of the

FIGURE / BRITISH COLUMBIA (CANADA). PARTICIPANTS IN HAART THERAPY AND NEW DIAGNOSES OF HIV IN THE PERIOD 1996-2009



Adapted from².

risk of HIV infection, are often in contact with the health system and therefore have a greater probability of undergoing HIV screening.

PROSPECTS

HAART could also prove effective in other risk populations, provided that the subjects in question are fully identifiable and correctly treated. This prompts the need to combine the use of drugs with risk-reduction strategies and to identify infected subjects through information and education interventions which promote access to screening programmes.

NOTES

¹ F. Maggiolo, S. Leone, *Is HAART modifying the HIV epidemic?*, Lancet 2010, 376-492.

² JSG Montaner, VD Lima, R Barrios, B Yip, E Wood, T Kerr, K Shannon, PR Harrigan, RS Hogg, P Daly, P Kendall, *Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population-based study*, Lancet 2010; 376: 532-39

STILLBIRTHS AND HEALTHCARE SYSTEM ENHANCEMENT

Fetal health is intrinsically conditioned by maternal health. 1.4 million intrauterine deaths occur before labour (antepartum stillbirths) due to infectious and chronic pathologies and the mother's poverty.

BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

What is the issue? Stillbirths and their invisibility. The Lancet has sought to bridge the awareness and visibility gap through a special series whose salient points are summarized below¹.

○ Stillbirths are a serious public health problem.

In 2008, according to analysed data, there were an estimated 2.6 million stillbirths. Of them, 55% were concentrated in rural parts of Sub-Saharan Africa and southern Asia (see figure below). The mean annual rate of reduction in stillbirths between 1995 and 2009 was 1.1%, making it lower than that of maternal mortality.

○ The causes of stillbirths are chiefly related to the mother's state of health.

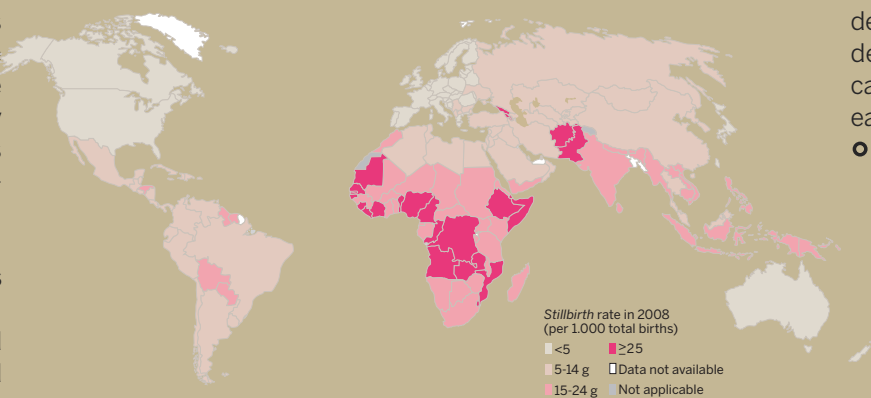
Fetal health is intrinsically conditioned by maternal health. 1.4 million intrauterine deaths occur before labour (antepartum stillbirths) due to infectious and chronic pathologies and to the mother's poverty. Some are related to fetal pathologies. Conversely, 1.2 million intrauterine deaths occur after the start of labour (intrapartum stillbirths) and are prevalently due to avoidable obstetric causes.

○ Integrated mother-child programmes and the continuum of care approach remain key strategies

In low-income countries stillbirths do not require additional or vertical interventions. The problem is addressed by strengthening maternal, neonatal and infant health programmes based on the continuum of care approach. With a 99% coverage rate, over 2.7 million maternal, neonatal and fetal deaths could be prevented each year, through 15 interventions of proven efficacy – 10 relating to basic and advanced antenatal care and 5 to assisted deliveries and obstetric emergencies – and a total investment of 10.9 billion dollars, at a per capita cost of 2.32 dollars.

○ The intrapartum period takes priority and obstetric emergency management is the most cost effective intervention.

About half of intrauterine deaths, three quarters of maternal deaths and a quarter of neonatal deaths occur in this period. Universal access to assisted delivery and emergency obstetric interventions would reduce intrauterine mortality by 27%, maternal



deaths by 46% and neonatal deaths by 18%, at a per capita cost of 0.84 dollars for each dollar spent.

○ The data and awareness gaps need to be rapidly bridged

The first urgent task is to record stillbirths. Current tools for collecting population data must include more specific measures, using a verbal autopsy

technique where necessary. Intrauterine deaths must be recorded even in health information systems with special sections or registers. Other important aspects include: activities to map and encode stillbirths in the antepartum and intrapartum periods; the collection of data on the direct causes of intrauterine deaths and their correlation with maternal conditions; the spread of perinatal auditing; the selection of a few indicators to measure the coverage and quality of interventions. The following are priority research areas: healthcare and community provider training; perinatal auditing and service accessibility.

CONCLUSIONS

The Lancet series on stillbirths completes the overview of the complex relationship between the health of the mother, fetus and newborn child. The epidemiological picture of intrauterine deaths is defined through estimates and the identification of causes. The pivotal role of labour and delivery is highlighted. Integrated packages of proven efficacy are identified with a view to reducing intrauterine, maternal and neonatal mortality. An agenda has been drawn up to improve data collection and research. Healthcare system enhancement remains the leading healthcare policy strategy to pursue. Lobbying and advocacy to safeguard the health of mothers and their newborn also serve to join forces and share common objectives. Stillbirths have now gained visibility. The goal for 2020 is to halve their number and reduce social inequality. The challenge now becomes implementation in the field by first line healthcare providers.

NOTES

¹ <http://www.lancet.com/series/stillbirth>



DOCTORS WITH AFRICA CUAMM

Established in 1950, Doctors with Africa CUAMM was the first NGO in the healthcare field to receive recognition in Italy (pursuant to the Cooperation law of 1972) and is the largest Italian organization for the promotion and safeguard of the health of the African populations.

It implements long-term development projects, intervening with the same approach in emergency situations, with a view to ensuring quality services that are accessible to all.

HISTORY

In its **60** years' history:

- **1,252** people have departed to work on projects: 367 of these departed on more than one occasion. The total number of departures was therefore 1,908;
- **3,725** years of service have been carried out, with a mean of 3 years per expatriate person;
- **920** students have been accommodated at the college: 640 Italians and 280 from 34 different countries;
- **279** doctors have departed from the Veneto region in almost 60 years;
- **192** hospitals have been served;
- **38** countries have benefited from intervention;
- **150** key programmes have been carried out in cooperation with the Italian Foreign Ministry and various international agencies.

IN AFRICA

Today we are in Angola, Ethiopia, Mozambique, Sierra Leone, Southern Sudan, Tanzania, Uganda with:

- **80 providers:** 47 doctors, 4 paramedics, 29 administrative and logistics staff
- **40 key** cooperation projects and about a hundred minor support interventions, through which the organization assists:
 - 15 hospitals
 - 25 districts (for public healthcare activities, mother-child care, training and in the fight against AIDS, tuberculosis and malaria)
 - 3 motor rehabilitation centres
 - 4 nursing schools
 - 3 universities (in Uganda, Mozambique and Ethiopia).

IN EUROPE

Doctors with Africa CUAMM has for years been actively implementing projects and building networks at European level, with the aim of building public awareness on the subject of equality of access to treatment and healthcare systems. Specifically, from 2011 to 2014 the organization has been coordinator of the European project, "Equal opportunities for health: action for development", on which it has been working with 18 other partner organizations from 7 European countries. Universities, student associations, non governmental associations in Italy, Poland, Latvia, Bulgaria, Romania, Malta and Hungary are working together to give room and voice to training in Global health and to promote greater awareness about the relationships between health and development, both individually and collectively.

NOTICE TO READERS

Support and take part in our commitment to Africa, in one of the following ways:

- **Post office current account** no. 17101353 under the name of Doctors with Africa CUAMM
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Doctors with Africa CUAMM is a not-for-profit NGO. All donations are therefore tax deductible. They can be indicated for this purpose in the annual tax return statement, attaching the receipt for the donation made.

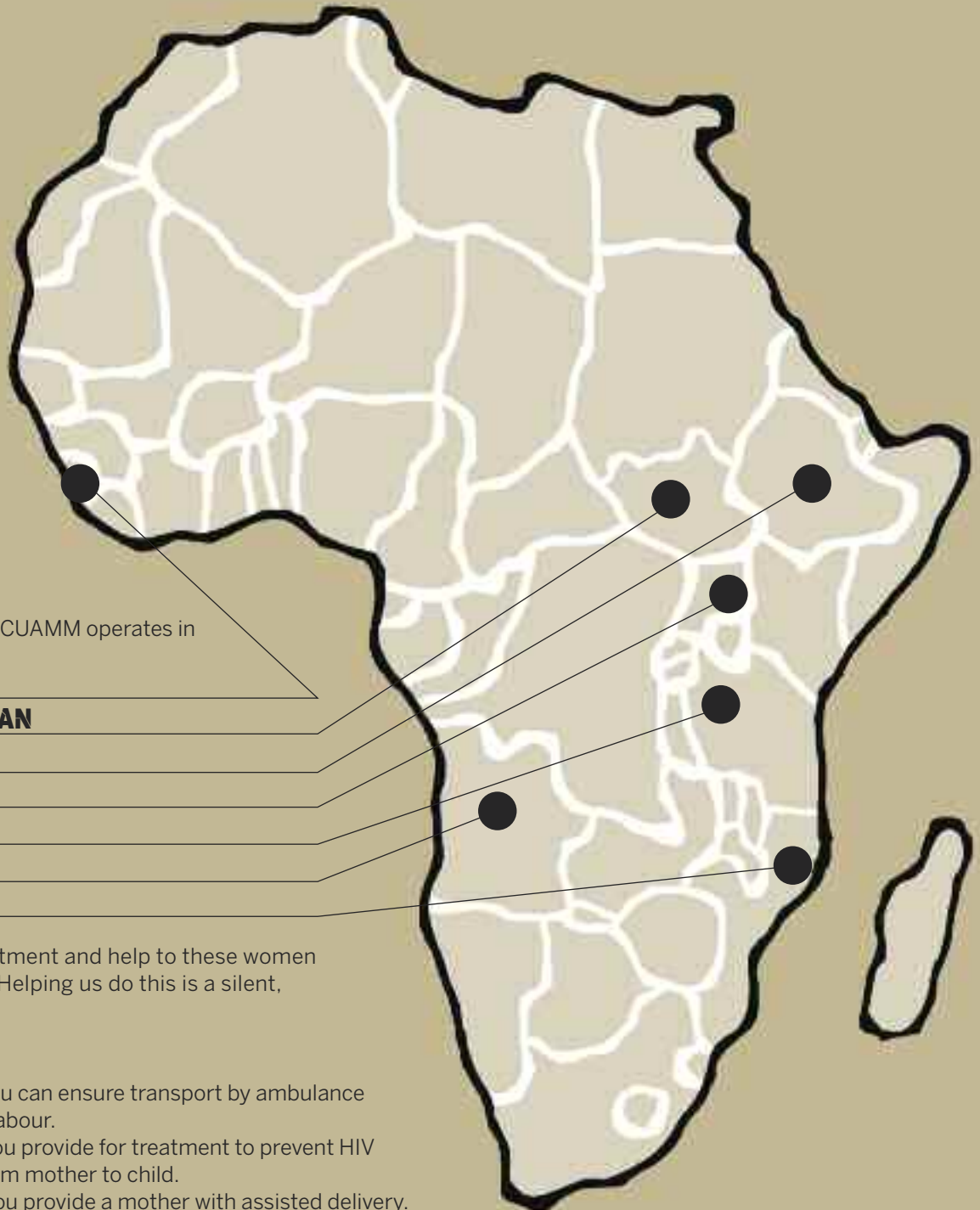
HEALTH AND DEVELOPMENT offers studies, research work and documentation which are unique to the Italian editorial world. Our publication needs the support of all readers and friends of Doctors with Africa CUAMM.



NEEDY AFRICA

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children die before reaching five years of age, for preventable diseases that can be treated at low cost;
- 1.2 million newborn children die in the first month of life through lack of treatment;
- 265 thousand women die from pregnancy- and delivery-related problems.



Doctors with Africa CUAMM operates in

SIERRA LEONE
SOUTHERN SUDAN
ETHIOPIA
UGANDA
TANZANIA
ANGOLA
MOZAMBIQUE

where it offers treatment and help to these women and their children. Helping us do this is a silent, forgotten war.

- With 15 euros you can ensure transport by ambulance for a woman in labour.
- With 25 euros you provide for treatment to prevent HIV transmission from mother to child.
- With 40 euros you provide a mother with assisted delivery.
- With 80 euros you fund a week's training course for a midwife.



Poste Italiane SpA - sped. in A.P. D.L. 352/2003 (conv. in L. 27/05/2004 n° 46)
Art. 1 comma 2 - DGB Padova - "Taxi-Service" "Tassa Tiscosa"



**DOCTORS
WITH AFRICA**
CUAMM



quarterly magazine
of international cooperation
and health politic
September 2011/ No. **61**
www.doctorswithafrica.org



**EQUAL OPPORTUNITIES
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