



## HEALTH AND DEVELOPMENT

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*Overcoming emergencies*



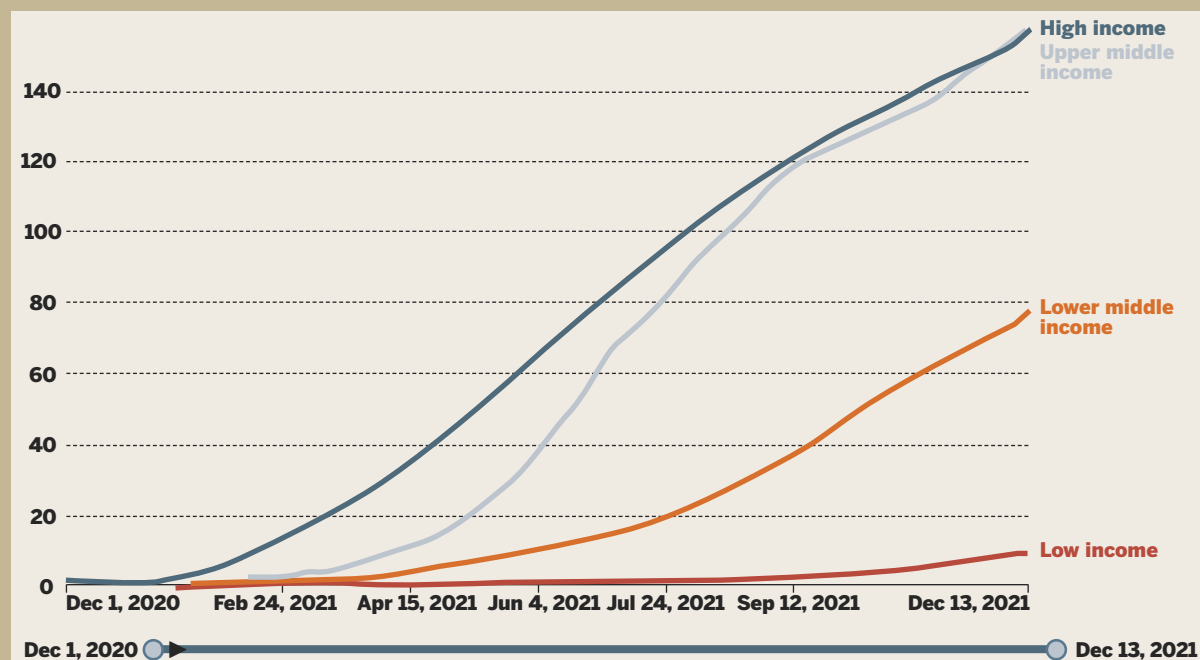
## NEWS

### The pandemic and the market

COVID-19 global vaccine allocation is deeply inequitable (**Figure 1**). And it is in the countries where the virus is circulating most widely that its most dangerous variants are being detected, in part due to the lack of availability of vaccines: last spring the Delta variant emerged in India, and more recently the Omicron variant was identified in South Africa. When news broke about the latter last 25 November, there was likely much toasting by the shareholders of Pfizer, the pharmaceutical company manufacturing the Comirnaty vaccine (**Figure 12**).

**FIGURE 1 / COVID-19 VACCINE DOSES ADMINISTERED PER 100 PEOPLE, BY INCOME GROUP**

All doses, including boosters, are counted individually. As the same person may receive more than one dose, the number of doses can be higher than the number of people in the population.



Source: Official Data collated by Our World in Data, World Bank. [OurWorldInData.org/covid-vaccinations](https://ourworldindata.org/covid-vaccinations) - CCBY

Note: Country income groups are based on the World Bank classification.

**FIGURE 2 / PFIZER STOCK PRICE IN US\$**



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## Overcoming emergencies

Whether triggered by climatic, environmental, economic, political or social factors, emergencies seem to be increasingly structural and protracted in Africa. Together, we will get through and past them by integrating our response to emergencies into our development initiatives.



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## DIALOGUE

### OUR MOST IMPORTANT RESOURCE: PEOPLE

How does Doctors with Africa CUAMM respond to a scenario of increasingly protracted and structural emergency crises? By integrating our approach to the latter into our very *modus operandi*: deep knowledge of local contexts, trust in people, and investment in communities. By thinking and acting beyond the immediate crisis, we help build a capacity for resilience.

TEXT BY / DON DANTE CARRARO / DOCTORS WITH AFRICA CUAMM

As 2021 draws to a close, it is striking to review the numerous challenges CUAMM was called on to tackle this year. An onslaught of emergencies – drought in Angola, flooding in South Sudan that only intensified the plight of the malnourished, armed conflicts in Ethiopia, Mozambique and the Central African Republic that left in their wake streams of displaced persons and refugees in desperate need of safe haven – battered areas in already highly precarious conditions, particularly the remote ones where we operate, all alongside a relentless pandemic that continues to underscore the full weight of inequality on a continent where only 6% of the population has been vaccinated despite accounting for 17% of the world's population. As I reflect on what we experienced both this year and in prior ones, aware of the fatigue felt by many, I am also confident that our organization's ability to respond is stronger than ever, guided by our vision of providing healthcare to those most in need. Even as emergencies continue to strike, our objectives remain unaltered: to strengthen primary health systems and care, "grafting" a capacity for extraordinary interventions into our ordinary programs.

Emergency crises seem, in fact, to be increasingly of a structural and protracted nature, triggered by multiple factors – at times climate- or environment-related, at others economic, political and/or social, often a mixture of all the above – and heavily impacting areas everywhere.

Despite, or perhaps precisely because, CUAMM has been called on to respond to all of this, we were fortunate this year as always to be able to count on our greatest strength, what is often described as "human capital" but what we prefer to call people. People whose skills, first and foremost, but also fervent commitment enable us to tackle such challenges day after day, steadfastly "building" development cooperation for seventy years and counting.

This was where CUAMM's visionary yet concrete founding fathers – Francesco Canova, Anacleto Dal Lago and don Luigi Mazzucato – began when they set out to create an organization skilled in doing cooperation "on the ground" while keeping a constant focus on training, especially that guided by universities, to ensure that healthcare for the poor would not be poor healthcare.

And that's who we still are today, a group that views relationships as a key strength: bonds of understanding, respect and engagement with African communities as well as investment in those who choose to put their expertise at the service of the neediest in the farthest corners of the world. CUAMM fosters such bonds with territories and their institutions too, whether they be Italian, African or international, to develop solid networks and opportunities.

This is the job of synthesis we do, the very heart of our *modus operandi*: finding ways to "stitch" and integrate all these components and skills together into increasingly resilient systems.

It's what we've continued to do in recent years as we tackled emergencies of every sort, starting with Ebola in 2014 and moving onto cyclones and COVID-19. *People* make the difference. It's they who support and care for individuals and communities, study the causes of problems and assess possible solutions and communicate with communities and agencies. They're the key element when it comes to ensuring continuity between emergency, rehabilitation and development, which is why building up relationships and skills is the core of our upcoming five-year strategy.

The current issue of *Health and Development* derives from our cognizance of the growing intensification of crises in the areas where we operate in Africa and our desire to share how we intend to tackle such events: by "doing" cooperation as we have from day one, trusting in the people and know-how that have brought us to where we are today and integrating our response to emergencies into our ongoing dialogue around development with local institutions.

Here we share both our experiences from the field – from drought in Angola to the conflicts in Mozambique – and our reflections on the worldwide emergency scenario and the role that organizations like ours can play; for example, by developing preparedness processes, i.e. helping communities ready themselves to the greatest degree possible to deal with crises (one example is Fabio Manenti's piece on how African hospitals are equipping themselves to be strong and resilient in the face of emergency situations).

We start 2022 in a spirit of trust – trust in the people who work with CUAMM and with Africa, heads held high as they move towards the future to meet its challenges.



## VACCINE APARTHEID

With only 6.6% of Africa's population fully vaccinated against COVID-19, we could describe the current scenario as a kind of "vaccine apartheid". Low vaccination rates and scarce bilateral agreements in the global South have worldwide consequences, with new variants of the virus threatening even countries that stockpiled vaccines.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF THE SCIENCE OF HEALTH, UNIVERSITY OF FLORENCE

Until populations across the world are protected from the threat of the COVID-19 virus, new variants will continue to emerge and spread around the globe.

"Inequity is the common denominator in many of the challenges faced by public health professionals, and this rings true for our attempts to tackle the Covid-19 pandemic," writes Maggie Rae, President of the Faculty of Public Health, in the *British Medical Journal* (BMJ). "While 80% of the UK population is fully vaccinated, this figure stands at only 6.6% for the African continent. While we still seek a definitive answer as to where the Omicron variant of Covid-19 originated, what is certain is that unless populations across the world are protected from the threat of the virus, we will continue to see new variants emerge and spread internationally. Our most important call to governments then, is to support global vaccination efforts through lifting import restrictions and intellectual property protections, while also resourcing and supporting vaccine delivery programmes in low-income countries"<sup>1</sup>.

The idea of applying a waiver on some intellectual property rights provisions around COVID-19 patents and tools including vaccines, drugs, diagnostics, personal protective equipment and other medical technologies for the duration of the pandemic has been under discussion since October 2020, when India and South Africa first proposed it to the World Trade Organization (WTO) in an effort to ensure the equitable distribution on a global scale of tools to fight the virus. The proposal gained the support of most WTO member countries, United Nations agencies including the WHO, UNICEF, UNAIDS and UNITAID, the Holy See, economists such as Joseph Stiglitz, and over 400 worldwide civil society organizations working for global access to essential medicines, but was strongly opposed by the industrialized countries, the same ones that financed the vaccine research effort using huge amounts of public money while failing to negotiate even the most basic price conditions, clinical study transparency levels, or technology transfers with the pharmaceutical industry.

This opposition led to a stalemate, with progress on WTO negotiations being repeatedly postponed. In early 2021 cracks began to appear in the wall of opposition by the U.S., the EU, the U.K., Switzerland, Canada and Norway. The European Parliament (EP) then passed a resolution affirming the urgency of a temporary waiver of TRIPS (the agreement regulating patents) "to enhance global access to affordable COVID-19 vaccines and to address global production constraints and consequent supply shortages". Further hope was offered following statements by European Commission (EC) President Ursula von der Leyen, Italian Prime Minister Mario Draghi (*"Vaccines are a global common good. It is a priority to increase their production, ensuring their safety and removing obstacles that limit vaccination campaigns"*) and U.S. President Joe Biden in support of the temporary patent waiver, but thus far it has all proved to be just an illusion.

With the emergence of the Delta variant in Spring 2021, the main priority of the world's rich countries was to stockpile vaccines through bilateral agreements with the pharmaceutical industry, avoiding vexing it with any talk of vaccines as a global public good. Despite the EP's resolution, in fact, in July 2021 the EC slammed the door on any solution that might call into question the validity of patents even on a temporary basis. From that time on, the pharmaceutical industry – especially the mighty Pfizer – has become the absolute arbiter of vaccine distribution, setting both which countries will be prioritized (at the top of the list, high-income nations) and delivery schedules (at the bottom, not just poor countries but also South Africa, which can afford the vaccines). All of this, alongside the failure of COVAX, the voluntary initiative to ensure equitable access to COVID-19 vaccines by poor countries as well as rich ones (only 25% of the 2 billion doses promised by the end of 2021 have been delivered), has led to an unacceptable, reprehensible situation of vaccine apartheid to Africa's detriment – a situation that, as we have seen with the spread of the Omicron variant, is also coming back to haunt countries that hoarded vaccines, who are now facing a brutal and unanticipated crisis involving thousands of deaths and heavy new restrictions.

### NOTES

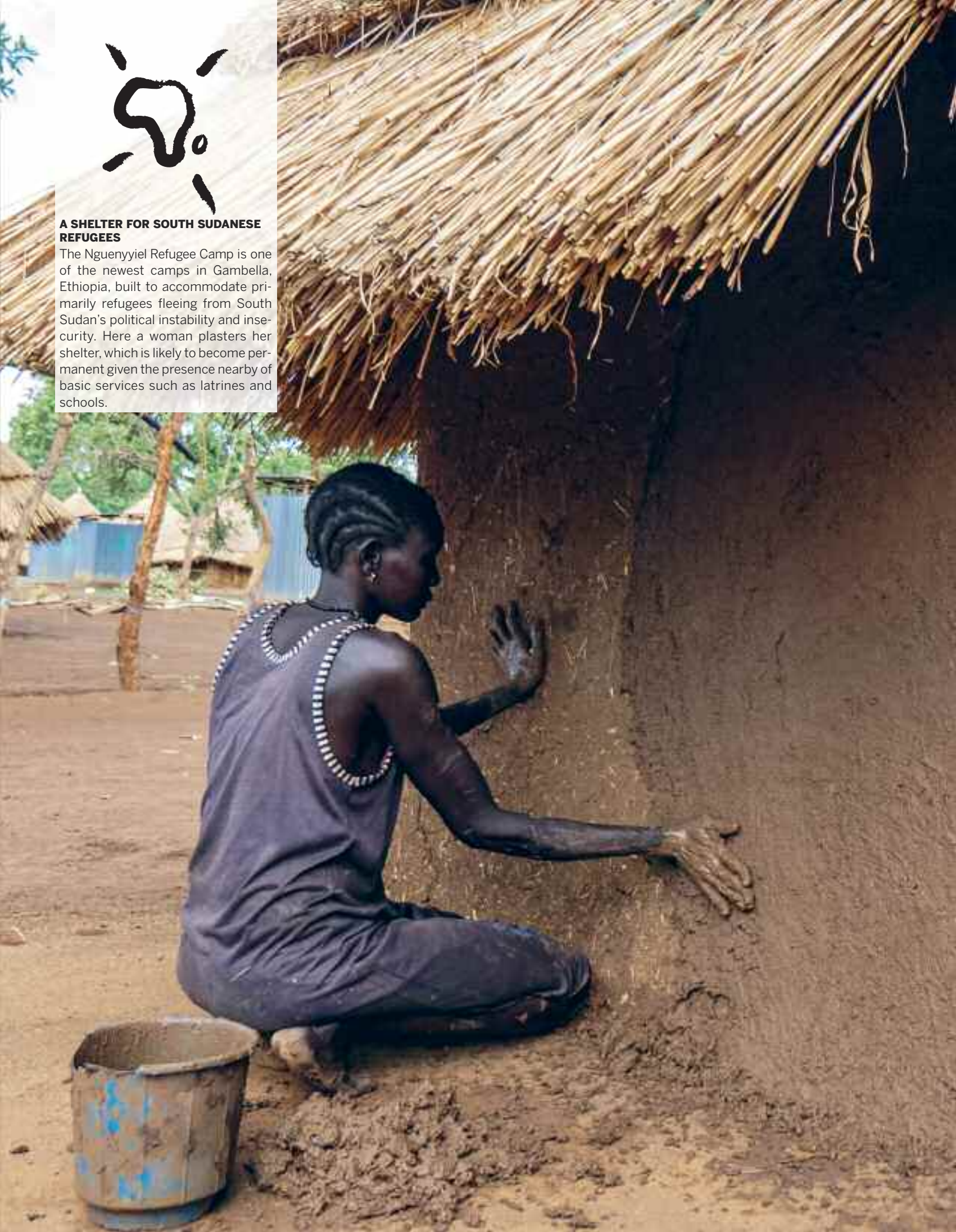
<sup>1</sup> Rae M, Omicron: A failure to act with a global focus will continue the proliferation of new variants of covid-19, BMJ 2021;375:n3095





## **A SHELTER FOR SOUTH SUDANESE REFUGEES**

The Nguenyyiel Refugee Camp is one of the newest camps in Gambella, Ethiopia, built to accommodate primarily refugees fleeing from South Sudan's political instability and insecurity. Here a woman plasters her shelter, which is likely to become permanent given the presence nearby of basic services such as latrines and schools.





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# EARLY WARNING SYSTEMS FOR RESILIENT COMMUNITIES

Early warning systems are internationally recognized as an integrated tool for monitoring, forecasting and assessing disaster risks and helping to increase preparedness. Using them at the community level, with the active participation of local populations, can be critical for preventing risks and activating timely responses in the event of emergencies in the global South.

TEXT BY / CLAUDIA FERNANDEZ DE CORDOBA FARINI AND DR CARINA FEARLEY / UCL WARNING RESEARCH CENTRE, DEPARTMENT OF SCIENCE AND TECHNOLOGY STUDIES, UCL, UK  
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## A COMMITMENT TO DISASTER RISK REDUCTION

Early Warning Systems are frequently thought of, simply, as fire alarms or mobile phone alerts. They are, in fact, far more complex. The United Nations Office for Disaster Risk Reduction (UNDRR) defines early warning as 'an integrated system of hazard monitoring, forecasting and prediction, disaster risk assessment, communication and preparedness activities, systems and processes that enables individuals, communities, governments, businesses and others to take timely action to reduce disaster risks in advance of hazardous events'. The key to early warning systems, therefore, is more about their integration, as opposed to the warning itself.

On 18th March 2015, representatives from 187 national governments signed the Sendai Framework for Disaster Risk Reduction (2015–2030). In doing so, they formally committed to improving their national assessment of, and risk reduction from, natural and human-initiated hazards. They recognised and accepted that such commitments would require them to acknowledge and address risk accountability and responsibility, whilst also strengthening their national, regional, and local risk governance systems and procedures. It was agreed that early warning should be clearly embedded within national risk reduction strategies and activities.

## COMMON ALERTING PROTOCOL: AN INTEGRATED APPROACH

National early warning systems depend upon trusted communication channels that have been established for risk consultation and information across all levels of society. The Sendai signatories acknowledged that risk reduction in their countries would require an 'all-of-society' approach and partnership. This would require reliable dialogue with, and across, local communities, private sector organisations and critical national infrastructure stakeholders (both national and international). Government ministries and agencies entrusted with accountability and/or responsibility for national risks or hazards were to be required to regularly consult with, and inform (and be informed by), wider stakeholders in order that national, regional, and local risk registers could remain 'alive'; relevant and actioned.

International early warning systems operate via a common alerting protocol (CAP), and include earth observation systems that use sensors and satellites to track changes in the environment, down to more national and local scales. Such systems seek to integrate huge data sets (for example the Famine Early Warning System <https://fews.net>), or are required to activate emergency management systems (ie raising barriers against floods or cutting off power and gas).

## SOME AFRICAN EXAMPLES

Whilst such technology can provide opportunities for remotely monitoring likely meteorological and geological impacts, it is argued that community-based early warning mechanisms, that have been hard-wired into the country's risk reduction governance structures, provide a more cost-effective and efficient early warning mechanism for impending hazards, impacts and loss.

For example, the Africa Multi-Hazard Early Warning and Early Action System for Disaster Risk Reduction validated in October 2021 is a community-based early warning system that empowers local communities in the warning process, in some cases embodying traditional tribal knowledge rather than modern science. A key example of this is the Red Cross (RC) community-based surveillance (CBS) programme for epidemic preparedness which has been implemented in Indonesia, Kenya, Sierra Leone and Uganda. This comprises the systematic detection and reporting of 'events of public health significance within a community, by community members. A wide network of volunteers is selected from local sub-population groups against key diversity criteria. These include ethnicity/tribe, gender, literacy levels and language/dialect.

Volunteers are trained to submit reports using short message service (SMS) applications, and other electronic data forms, on existing mobile phones, deployed with minimal infrastructure, within a wide range of conditions. Reports are designed also to be used by people with minimal literacy and with basic analogue phones.

Alert messages are received, and cross-checked, by supervisors. These supervisors include RC Team Leaders, RC District Staff, Vil-



lage Health Team supervisors and local government surveillance officials. Alerts are entered into a real-time database which then triggers appropriate response activities; for example, immediate volunteer and household action for basic health care, or immediate containment (to minimize the spread of infection), or rapid action by local authorities to investigate or conduct laboratory/clinical tests in order to control an outbreak.

The RC program demonstrated high levels of accuracy in Sierra Leone (96%), Indonesia (90%), and Uganda (73%). Some countries revealed lower accuracy levels however (35%) and these highlight the importance of adapting community-based early warning systems to local contexts. Nevertheless, the RC programme demonstrates an overall positive impact of timeliness in ensuring early detection and response to outbreaks.

## INTEGRATED NETWORKS ARE KEY

Common challenges affecting early warning systems include trust in the response decision-making and trust in the communication protocols in place. Governments typically develop their own national concepts of operation for dealing with crises and disasters. Early warning systems should be embedded within these in accordance with the Sendai Framework. Less developed countries, however, often reach out to overseas and private sector organisations for assistance in developing such plans and systems. As a result, conflicting solutions are developed, and

whilst attempts are made to adapt external training solutions to local realities, the result is often a practical hybrid of conflicting doctrines and incompatible assets.

This can frustrate the timeliness and impact of any early warning mechanism, particularly when operating within a challenging multi-agency environment. This in turn affects trust in decision making and communication. For example, the rapid arrival of international agencies and humanitarian actors as part of a bilateral, or multilateral United Nations led offer of assistance can further complicate an already complex field of conflicting decision making and lines of communication. Furthermore, many international humanitarian agencies, such as CUAMM, may already be operating within the affected country with their own well-established local relationships and communication channels within the regions and communities.

A key component of successful early warning systems is therefore improved integration between, and understanding of, national and international governmental and humanitarian networks with local communities. National early warning should be based upon long-term social processes that integrate preparedness, response, recovery, and mitigation across multiple stakeholders from local communities to national governments. International disaster response and early warning should additionally coordinate and integrate within the national early warning systems of the affected country to maximise operational efficiency and minimise disruption to established channels of situational awareness, and long-term relationships of trust and reliability.



## THE LINK BETWEEN ECONOMIC GROWTH AND DEVELOPMENT

A snapshot of the situation in Africa today: regions and even entire states overwhelmed by war, political instability and climate phenomena such as drought and floods, and now the scourge of COVID-19 as well. What is the impact of all this on economic growth? We asked Giovanni Carbone.

CHIARA DI BENEDETTO INTERVIEWS GIOVANNI CARBONE, HEAD OF THE ISPI AFRICA PROGRAM

**o At the start of the COVID-19 pandemic, there was talk of everyone being “on the same boat”, whether in China, Africa or Europe, since the virus would eventually come to all of us. It was the first time in a long while that the global North had experienced such a sense of vulnerability. Nearly two years later, it’s clear that we are not all the same. How has COVID-19 impacted Africa’s equilibrium and vulnerabilities?**

From the economic point of view, last year sub-Saharan Africa experienced its first recession in some time, interrupting a long period of growth. We hadn’t seen such a negative trend for about a quarter of a century. There was some recovery this year, but it wasn’t as strong as could have been hoped for. So the region is lagging behind the progress being made in other economic areas and groups, meaning that the inequality gap with other countries is growing – a reversal of the pattern of the last two decades.

Many factors play a role here, but one of them is unfortunately the pandemic itself. Every day we see how ongoing uncertainty over it continues to shake the markets. And African countries face an aggravating circumstance: uncertainty about what’s going to happen in terms of the virus’s spread and vaccination campaigns, which aren’t going well, with low inoculation rates across the continent. And there’s no reason to believe that things are going to get much better any time soon.

All of this is having a clear impact on both the population and social indicators; in fact, we’re seeing a rise in the number of poor people due to the pandemic. So it’s not just a question of positive or negative percentage changes in GDP, but also very tangible negative impacts on individuals.

**o In addition to COVID-19, and in terms of CUAMM’s own experiences, there have been other crises recently including the cyclone in Mozambique, instability in Ethiopia and drought in Angola. If we were to create a sort of map of the emergencies that the continent is facing right now, which would you say are having the greatest impact?**

The first is the challenge of economic growth. There’s a risk when talking about Africa of jumbling all its countries together in the

same pot. While it’s true that the kind of economic slowdown we’re seeing is harder for these countries than for those in the global North, a clarification is needed: *some* African countries are slowing down, like Nigeria, Zambia and Angola, but others, such as Ghana, Tanzania, Ivory Coast and Kenya, continue to do well.

The second threat being faced are armed conflicts. Their numbers continue to grow, and this needs to be underscored, because it hasn’t always been the case. There’s never been a time of peace across Africa, but there have been times – which coincided in part with times of economic improvement – when fewer of its countries were affected by conflicts, and those that did exist were more contained.

The best-known and monitored conflict is the Tigray war, in Ethiopia, a country that stands apart in terms of its growing economy, demographics and geopolitical significance. So the problem is two-fold: the population that’s being forced to live through this atrocity and the economic consequences of the war. Ethiopia was previously doing quite well in terms of well-distributed growth and poverty reduction, but now it’s regressing.

Another vast area where conflict is expanding is the Sahel. After starting in Mali it spread to Burkina Faso and Niger, and now, despite external interventions, it risks spreading further. Then there are newer conflicts, like the one in northern Mozambique, which is in a relatively limited area. This points up something we should keep in mind: the number of conflicts is mounting, but so far we haven’t reached the levels of victims that were seen in the years of the most intense conflicts, the 1990s and early 2000s. We also need to consider how these conflicts and instability are leading to the deterioration of freedoms, of that small bit of democracy that had begun to ripen in parts of the region’s countries, so here too we’re in a phase of regression.

Finally, there’s the climate crisis. We always talk about how Africa’s not to blame for it, that it’s the continent which has contributed the least in terms of the accumulation of greenhouse gas emissions, and is *still* the one that contributes the least. But it’s also the one that’s most exposed to the adverse consequences of climate change, in various ways: through processes of desertification or extreme phenomena risks like floods and heat waves, including for some coastal capitals and island nations. And it’s not just a matter

of exposure. This raises the issue of Africa's role in the fight against climate change, of transition and green growth. These involve costs and financing, which in the global North can also be opportunities, for example by converting companies to green businesses. But it's not as easy to replace what's been built in African countries, because it's less stable and there's less of it.

I'm reminded of the title of an older book on development, *Kicking Away The Ladder*. It's like after using that polluting ladder to reach our own level of development, we Westerners want to snatch it away it from others who'd like to use it to do the same thing. While African countries should be part of strategies for tackling the climate crisis, it's the countries that polluted our planet that should bear the cost of cleaning it up.

o **As we experience an exacerbation of many situations – economic, social, and so forth – do you see any possibility of recovery? Italy's National Recovery and Resilience Plan (NRRP) doesn't mention Africa or relations with Africa as a driver of development.**

I don't think any political entrepreneur or organization raised or pushed the issue hard enough. In recent years, starting around 2013-14, we Italians have paid attention to sub-Saharan Africa. So we haven't remained static; we've changed our approach. Aside from immigration, one of the primary reasons was Africa's economic potential, which I think is still, and should be, a positive incentive. There's a need to go work in and make links with African countries, bringing them into economic processes; it's the only way to help stimulate economic growth as well as the well-being of the population. Development cooperation projects

also have a role to play, but these interventions can't just be done by outsiders, or vertically; they need to be integrated, because they're not enough on their own. Development isn't economic growth alone, but it *can* derive from it. This is why Africa needs to create links with other economies, with trade and investments. It's a fine line, though, since it's clear that such exchanges are based on Western interests, on certain economic rationales, as well. So with regard to Africa, and other regions as well, hopefully some boundaries will be set, but I can't see a different way forward. Greater integration with other parts of the world will provide tools to make the wheel of growth spin faster.

o **You said that development cooperation is not enough on its own. Overall, what role do you think NGOs like Doctors with Africa CUAMM play in Africa, and what role should they focus on in order to foster the development of African countries in these times of unremitting emergencies?**

Looking at it from the perspective of development processes, these are – and need to be – specific niche roles; to be successful they have to be integrated into what actually *is* in a given country. Vis-à-vis climate phenomena, I envision continually expanding roles, at least in terms of the increasing frequency of such crises. My hope is that the current phase will segue into a more positive, virtuous one in terms both of economic growth, which needs to become more sustainable, and of the current spread of conflicts, *coups d'état* and authoritarian regimes, which are having a bit of a renaissance. It's my hope and expectation that over the medium-long term, the previous path forward will be resumed.





## EXPERIENCES FROM THE FIELD

# A STRATEGIC VISION FOR EMERGENCY MANAGEMENT

More and more already fragile nations in sub-Saharan Africa are being forced to face the hardships brought by sometimes concurrent climate-, politics- or health-related emergencies. CUAMM's response is a long-term strategic approach based on solid networks and knowledge of local realities, to continue to foster resilient forms of development.

TEXT BY / ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

In 2011, 22 of sub-Saharan Africa's 48 countries were classified by the World Bank as fragile, i.e., states whose institutions or governments are so unstable that they are incapable of guaranteeing their populations essential public services or security<sup>1</sup>.

This fragility is one of the main obstacles to Africa's development. Despite the continent's overall rapid growth, many communities are being held back by extreme poverty, governmental instability, persistent socioeconomic inequality, conflicts and other forms of violence.

It is aggravated by the emergencies that have been impacting Africa with increasing frequency, including natural disasters, epidemics and the current Covid-19 pandemic, with both direct and indirect effects on its population. Conflicts are another driver of fragility: 2019 saw 25 state-based conflicts in Africa, four more than the prior year, as well as a record number – 13 – of conflicts due to interstate territorial disputes, and nine African countries experienced Islamic State-related conflicts within their territories<sup>2</sup>.

The consequences of natural and environmental disasters – for example, rainfall variations in some areas – exacerbated food insecurity, which in turn worsened poverty and migration. In 2021, the African Development Bank (AfDB) reported that seven of the 10 countries most vulnerable to climate change are in Africa, with Mozambique topping the list<sup>3</sup>.

The situation has been made even more dire by the fact that most African countries are having to face one or more such crises concurrently, experiencing what is known as a “complex emergency”, where critical situations of a political, environmental, health or demographic nature occur in parallel<sup>4</sup>. One such example is Mozambique, where not long after the country was battered by two tropical cyclones (Idai and Kenneth) in 2019, a severe humanitarian crisis broke out in Cabo Delgado in 2020<sup>5</sup>.

Against this backdrop, Doctors with Africa CUAMM has continued working in the countries where we are present based on a long-term vision of development, while also responding to the critical situations that arose in some of them. Over the past three years,

as the COVID-19 pandemic raged on, CUAMM was compelled to intervene in:

- Ethiopia, providing basic health services to South Sudanese refugees in the Gambella region and in Tigray, the site of the ongoing civil war;
- Mozambique, providing basic health services and a response to the humanitarian needs of the international displaced persons (IDPs) fleeing Islamic terrorism in the Cabo Delgado area, as well as responding to the crisis following the Idai and Kenneth cyclones;
- Angola, where child malnutrition rose following protracted drought in the Cunene Province;
- countries such as the Central African Republic and South Sudan, where conflicts are causing growing instability and the interruption of services.

From day one, CUAMM has invested in the creation of resilient health systems with strong connections to the local resources needed when crisis strikes. Our approach involves considering each new crisis on four different levels<sup>6</sup>: 1. preparedness; 2. onset of trauma and alarm signals; 3. shock impact and management; 4. recovery and learning.

It's a matter of having the ability to be prepared – i.e., having a system whose financial, logistic and human resource capabilities are ready the moment an emergency strikes – on through knowing how to respond to its consequences, capable of absorbing, adapting to and positively transforming them<sup>7</sup>.

This is why CUAMM deploys its resources to strengthen health systems over the long term, working in the field on an ongoing basis to foster strong relationships with communities and civil networks and strategic and positive partnerships with local authorities, as well as investing in operational research as a tool for making our interventions more efficient and equitable.

Confronting Africa's instability and crises requires a far-sighted approach that understands how long-term development work and investments are the best way to lay the groundwork for rapid and effective emergency responses.

## NOTES

<sup>1</sup> <https://blogs.worldbank.org/developmenttalk/what-fragile-state>

<sup>2</sup> <https://reliefweb.int/report/world/conflict-trends-africa-1989-2019>

<sup>3</sup> *Climate change triggers mounting food insecurity, poverty and displacement in Africa*, Published 19 October 2021, Press Release Number: 19102021

<sup>4</sup> David Keen, *Complex Emergencies*, Cambridge, UK; Malden, MA: Polity Press, 2008

<sup>5</sup> <https://reliefweb.int/report/mozambique/mozambique-humanitarian-crisis-grows-cabo-delgado-conflict-continues>

<sup>6</sup> [file:///C:/Users/aa/Desktop/SG-NAEC\(2019\)5\\_Resilience\\_strategies.pdf](file:///C:/Users/aa/Desktop/SG-NAEC(2019)5_Resilience_strategies.pdf)

<sup>7</sup> [https://www.who.int/healthinfo/systems/WHO\\_MBHSS\\_2010\\_full\\_web.pdf](https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf)

<https://www.afdb.org/en/cop25/climate-change-africa>

<https://apps.who.int/iris/bitstream/handle/10665/332441/Policy-brief%2036-1997-8073-eng.pdf>



## EXPERIENCES FROM THE FIELD

# AFRICAN HOSPITALS IN THE FACE OF EMERGENCY

How did the 23 African hospitals that CUAMM works with respond to the COVID-19 pandemic? By implementing processes designed to ensure both a prompt response to cases of emergency and “ordinary” continuity of care, thus keeping the crisis from bringing health services to a standstill. A model learned during Ebola, it will prove useful in future scenarios as well.

TEXT BY / FABIO MANENTI / DOCTORS WITH AFRICA CUAMM

Doctors with Africa CUAMM supports 23 hospitals in 8 African countries. Each has been affected by, and tackled, the COVID-19 pandemic in different ways, in terms both of containment measures and diagnostic capabilities. Thus the data available on numbers of suspected and confirmed cases and deaths due to the virus also do not generally reflect the realities on the ground, as they depend on the availability of diagnostic resources rather than the actual need for them.

In the initial phase the hospitals set up triage systems at their entrances, having people wash their hands and taking their temperatures; they also provided specific training and quickly made personal protective equipment (PPE) available to staff. The triage and isolation models for suspected COVID-19 patients were implemented using existing know-how and international guidelines, notwithstanding the hospitals' awareness that it would be difficult to obtain diagnostic tests for them.

Broadly speaking, the degree of capacity and preparedness to respond quickly and effectively to the crisis shown by the hospitals pointed up their extreme fragility in terms both of organization and resource availability. Given the lack of appropriate testing capacity and the similarity of the symptoms of the two diseases, it also immediately became evident that it was going to be very difficult to distinguish between the many cases of malaria, particularly in adults, and COVID-19 infection.

It should be noted that due to the low number of cases of the latter, especially complicated ones, in the first few months, the strong focus on triage and other protective measures gradually diminished. Even so, the personnel protection measures put in place ensured the continuity of services, although overall access to them still fell due to fears among the population and government-implemented containment measures.

It was only in 2021 that we saw a significant increase in recorded cases of COVID-19, including complicated ones and a number of deaths, at least in our hospitals.

**Table 1** shows a comparison of data from five hospitals for the years 2020 and 2021. Trends were very different from one setting to the next, undoubtedly due in part to each hospital's diagnostic capacity and/or focus on the matter.

The most significant data, in terms of severity, were 5 deaths in Wolisso, Ethiopia, in April 2021 and 82 adult deaths involving acute respiratory failure in Tosamaganga, Tanzania (only 18 of which were confirmed through tests\*\*) from June to August 2021. In fact, the capacity for treating acute respiratory failure due to COVID-19, primarily through the use of oxygen concentrators with a maximum flow capacity of 5 litre/minute, is very limited in these settings. The same goes in terms of the availability of space in which to organize isolation areas for the safe care of COVID-19 patients beyond what is already generally available (2-3 beds).

Therefore, while undoubtedly helped by the relative lower severity of cases compared to settings in other parts of the world, the hospitals proved able to respond to the crisis to a certain extent even despite the difficulties, containing infection at least within their own facilities. The triage and filtering systems organized at each of their entrances are now readily available in the event of future epidemics; however, the ability to secure and maintain a supply of protective materials is very unlikely due to a lack of resources.

Thus the pandemic has taught us how to respond to a potential threat while attempting to maintain service continuity. However, it has also highlighted the limitations of health systems where even access to essential services is based primarily on the choices of users, which in this case have been guided by fear and mobility restrictions.

**TABLE 1 /** COMPARISON OF DATA FROM 5 HOSPITALS, 2020 VS. 2021

COUNTRY	HOSPITAL	2020			2021		
		SUSPECTED CASES	CONFIRMED CASES	%+	SUSPECTED CASES	CONFIRMED CASES	%+
ETHIOPIA	WOLISSO	30	1	3%	130	56	43%
SIERRA LEONE	PUJEHUN	306	28	9%	223	24	11%
SOUTH SUDAN	RUMBEK	61	29	48%	287	82	28%
TANZANIA	TOSAMAGANGA	41*	5	12%	286	18**	6%
TANZANIA	SONGAMBELE	1*	0	0%	5	1	20%

\*Suspected and test-confirmed cases reported only until May 2020, when the late former President, a coronavirus denier, banned the sharing of figures on the country's coronavirus infections. \*\*Only 20 suspected cases could be confirmed through testing due to a lack of tests linked to recent service reorganization following the death of the coronavirus-denying former President.



## EXPERIENCES FROM THE FIELD

# SEEKING REFUGE IN ONE'S OWN COUNTRY: MOZAMBIQUE

Insecurity phenomena set in in Cabo Delgado, Mozambique, in October 2017 and rose dramatically in 2020; the U.N. estimates that 744,949 people have had to flee their homes to seek refuge elsewhere. Officially known as “internally displaced persons”, these are Mozambicans forced to migrate within their own country. CUAMM works to provide them with health care, supporting a hosting model that is integrated into local communities.

TEXT BY / GIOVANNA DE MENEGHI / DOCTORS WITH AFRICA CUAMM

### NEXUS: AN INTEGRATED APPROACH TO EMERGENCIES

Both in and outside the world of development cooperation, “emergency” is a word that can no longer be linked to exceptional events alone. Ever more frequently, in fact, we hear emergencies being described as “deep-rooted”, “protracted” or “chronic” in settings where, in order to be effective, humanitarian emergency responses must go hand in hand with peace and development work. This is known in technical terms as “the humanitarian-development-peace nexus”, i.e., an integrated approach between various humanitarian sectors that seeks to respond to crises holistically rather than vertically, with full engagement of the setting through constant dialogue and exchange among authorities, populations and humanitarian actors, in order to devise solutions that address the diverse factors driving/fueling an emergency<sup>1</sup>.

In fact, against the backdrop of the climate crisis and attendant environmental disasters (cyclones, famines, etc.), entrenched civil wars and endemic infectious diseases that re-emerge cyclically, many low-middle income countries (LMICs) are having to respond to constant emergencies even as they try to maintain routine activities. Governments, local populations and humanitarian actors have been adapting to the situation by proposing emergency initiatives still aimed at strengthening existing systems, shunning unsustainable vertical structures in favor of more spontaneous forms of response based on the needs of the population, needs to which the latter respond on their own, as well, thereby enhancing community hosting dynamics.

### INTERNALLY DISPLACED PERSONS IN MOZAMBIQUE

Cabo Delgado, in northeastern Mozambique, has been back in the headlines since 2017 both because of the vast gas reserves identified in the northern districts that have led large foreign multinationals to invest in the country and because starting in October of that year, the area became the site of armed attacks against civilians and government targets. In early 2020 the attacks began to escalate both in number and brutality, with throat-slittings, kidnappings, the burning-down of homes and all sorts of other violent acts. To date, there have been 1,081 attacks and 3,578

fatalities, 1,575 of which among civilians alone<sup>2</sup>, generating, according to United Nations estimates, 744,949 internally displaced persons (IDPs)<sup>3</sup> in a province with just over 2 million inhabitants. The southern districts of the Cabo Delgado Province are the primary destination of those seeking refuge, but they are also fleeing to the Niassa, Nampula, Sofala and Zambezia Provinces. To date, the reasons for the conflict have never been made explicit by the non-state armed groups (NSAGs) carrying out the attacks.

Against this difficult backdrop, we at Doctors with Africa CUAMM, which has been active in Cabo Delgado since 2014, have continued to implement our normal health care activities, adapting them to ensure that IDPs, as well as the indigenous population, have access to basic health services. We have also expanded our efforts in order to respond to numerous other emergencies that have come along, including COVID-19 and cholera outbreaks, working above all, thanks to the support of UNICEF, with community actors – health activists and community health workers (CHWs) who are often IDPs themselves – on awareness-raising activities.

Conscious of the enormous burden weighing on an already fragile health system such as Mozambique's, CUAMM also decided to institute temporary advanced medical posts (TAMPs), first aid centers that we have set up in partnership with Mozambican health authorities inside mobile tents in the most densely populated IDP reception sites, which are more than 10km from the nearest government health facility. This support helps the government provide IDPs and surrounding host communities with basic health services in isolated areas of the Province without impacting negatively on its current service provision capacity.

### INTEGRATED ASSISTANCE FOR PSYCHOSOCIAL WELL-BEING

Finally, in partnership with UNHCR, CUAMM is also committed to providing psychosocial aid to victims of gender-based violence and to IDPs with special psychosocial support needs due to the post-traumatic stress experienced following attacks. Our approach is a holistic one that envisions the health system from various perspectives aimed at improving the well-being of both the



IDPs and the host communities that frequently welcome them into their homes and, more generally speaking, into their communities. At the center are the IDPs, who often become directly involved in the provision of health services as CHWs or activists or, in some cases, as doctors and nurses at TAMPs or government health facilities. Indeed, those who have had to flee are *people* who formerly held a range of jobs and are now forced to start their lives anew in completely new settings.

## THE HOST COMMUNITY MODEL

Working closely with the authorities and population in the Cabo Delgado Province, the humanitarian actors present in the area have seen how most of the IDPs looking for safe haven are taken in by the so-called host communities, i.e., the local population – families, institutions, governments and so forth<sup>4</sup>.

This makes it possible to develop forms of intervention better suited to the context, eschewing the setting-up of enormous accommodation camps to instead support IDP-hosting by local families. It is noteworthy that IDPs fleeing from attacks in the northern districts are often hosted by relatives, family members or friends in the southern districts or in other provinces where they have sought shelter.

This spontaneous solidarity is something the humanitarian world should espouse and support, since a household normally consisting of six members clearly needs outside help to ensure that the six additional people they have chosen to host in their home have the bare minimum with which to nourish themselves and live in a decent environment.

The humanitarian sector is beginning to adopt such forms of integrated reception, where international organizations are merely the means by which such an approach can be made viable, while the community is absolutely key.

## NOTES

<sup>1</sup> Inter-Agency Standing Committee and UN Working Group on Transitions, Workshop, 20-21 October 2016

<sup>2</sup> ACLED, 22-28 novembre 2021 (<https://www.cabolidado.com/reports/cabolidado-weekly-22-28-november-2021>)

<sup>3</sup> IOM, DTM Round 13 Report, settembre 2021

<sup>4</sup> UNHCR, UNHCR-NGO Toolkit for Practical Cooperation on Resettlement. Community Outreach - Outreach to Host Communities: Definitions and FAQs, June 2011.



## EXPERIENCES FROM THE FIELD

### CLIMATE CHANGE AND NUTRITION

It is estimated that some 1.3 million southern Angolans live in a state of acute food insecurity driven by the climate crisis and consequent prolonged drought, with cause and effect fueling one another including a lack of both food and dietary diversity, as well as poor hygiene. CUAMM's aim in the region is to identify the malnourished and provide them with treatment.

TEXT BY / MARIA BRIGHENTI / DOCTORS WITH AFRICA CUAMM  
MARTA PICCOLO / DOCTORS WITH AFRICA CUAMM

#### FROM CLIMATE CHANGE TO DROUGHT

In the southern provinces of Angola, climate change is all too real, with visible and concrete consequences for the local population. In the past the region alternated between the dry season and the rainy season (the latter running from November to March), but the lack of significant rainfall from 2018 on has led to the fourth consecutive year of drought – the worst recorded in 40 years. A report issued by the National Institute of Meteorology and Geophysics (INAMET) showed below-average rainfall in the final quarter of 2021.

The impacts of drought are multi-faceted, with cause and effect fueling one another. The direct consequences of water scarcity include a lack of both food and dietary diversity, as well as poor hygiene. The lack of food inflates market prices and the lack of crop surpluses, in turn, weakens the purchasing power of families. In addition, in 2020 IDP camps were set up in some areas of the south to host the internally displaced (IDPs), mainly pastoralist populations who move with their livestock in search of pastureland and water sources for the herds and themselves. According to a recent study by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), more than 1.3 million people in the provinces of Cunene, Huila and Namibe are experiencing acute food insecurity, a number that was expected to rise to 1.58 million between October 2021 and March 2022<sup>1</sup>.

#### NUTRITIONAL SCREENING IN THE FIELD

Doctors with Africa CUAMM has been active in one of these provinces, Cunene, since 2000, working on an intervention aimed at strengthening the health care system both at the hospital level – especially the maternity and pediatric wards and the malnutrition unit – and at the community level, with prevention and awareness-raising initiatives on topics such as safe childbirth, malaria, hygiene and nutrition.

In response to the current crisis and to mitigate the adverse effects of drought, CUAMM, alongside local authorities, continues

#### NOTES

<sup>1</sup> [https://reliefweb.int/sites/reliefweb.int/files/resources/IPC\\_Angola\\_FoodSecurity%26Nutrition\\_2021July2022Mar\\_Snapshot\\_English.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/IPC_Angola_FoodSecurity%26Nutrition_2021July2022Mar_Snapshot_English.pdf)

**FIGURE 1 / THE FOOD INSECURITY SITUATION, JULY- SEPTEMBER 2021**



to provide essential health services primarily through the following two interventions.

The first is the identification of cases of malnutrition at the community level, thanks to a mobile health team composed of three nurses who travel to 33 areas in the province to undertake the nutritional screening of children and pregnant women, reporting cases of moderate and acute malnutrition to the nearest health centers when necessary. Support supervision is also provided every month to the health technicians working at the latter, to help bolster their knowledge regarding the management of malnutrition. The distances that need to be traversed from one area of intervention to the next are significant, but it is imperative that we reach those living in the most remote areas.

#### FOOD KITS FOR MOTHERS AND CHILDREN

The second intervention involves the distribution of food kits to the families of the children being cared for in the hospital's malnutrition unit, to avoid their interrupting treatment; to children in outpatient treatment at peripheral centers, so that their families will have food support and avoid sharing nutritional supplements with other family members; and to the women staying at the *casa d'espera*, an area next to the hospital where expectant mothers in their final weeks of pregnancy, usually accompanied by young children, can lodge until they give birth, receiving ante-natal checkups and support in the event of an emergency.



## EXPERIENCES FROM THE FIELD

# SOUTH SUDAN: CAUGHT BETWEEN WAR, FLOODS AND EPIDEMICS

South Sudan exists in a state of chronic instability, which makes a purely emergency or vertical approach inadequate. Even in this time of growing humanitarian distress, CUAMM's approach is a collaborative one, working hand in hand with local authorities to build a system capable of responding to primary health needs.

TEXT BY / CHIARA SCANAGATTA / DOCTORS WITH AFRICA CUAMM

At the start of 2021, two years after the signing of South Sudan's most recent peace agreement, OCHA<sup>1</sup> noted how the country remains in a state of crisis, with mounting humanitarian needs. The persistence of political instability, high levels of internal conflict and severe climate events have forced over one million people to continue to migrate internally, most obliged to seek refuge among communities they come upon as they travel – people they deprive of a portion of the already scant resources available. There is severe food insecurity, a social fabric far too weak to protect the most vulnerable and health services that are incapable of guaranteeing basic care, and certainly not of containing an epidemic. At the moment, pursuing development seems impossible.

Since Doctors with Africa CUAMM began working in South Sudan in 2006, we have witnessed a civil war that lasted for over five years, continuous and violent clashes between clans for control of the territory, outbreaks of cholera, measles and now COVID-19, and extensive flooding. We have had to rebuild and/or re-equip looted health facilities, organize mobile clinics to reach displaced families and refugees in remote areas, launch mass vaccination campaigns and deal with problems of insecurity and logistics, all while continuing to provide routine health and nutritional assistance. We build, distribute drugs and food supplements, get ourselves around in the region to provide and supervise services, but everything becomes even more difficult and costly, in terms of both time and resources, when most roads are impassable and there are attacks and ambushes in the surrounding area. All of this complicates not only our immediate response to emergencies in the most hard-hit areas, but also our efforts to keep existing services fully functional and operational throughout the territory. And the need for those

services also continues to grow, due both to the emergencies themselves and to the closure of facilities in neighboring territories and the termination of humanitarian programs launched, then abruptly shut down, in the most acute phases.

A purely emergency approach is not sufficient to respond to a state of what is now chronic instability. Limited in time, fragmented, vertical and sectorial, and focused on specific problems for the benefit of specific groups of individuals as dictated by the priorities of major international donors, humanitarian interventions are unable to create the conditions that would make it possible to overcome the crisis and create a new and lasting local system, and indeed, end up further weakening what is already in place.

Doctors with Africa CUAMM responds to emergencies as they arise in the areas where we are present by taking the same approach we use to support the development of the local health system. In other words, we make our emergency response a *component* of the latter, an opportunity to further enhance it, integrating the development and emergency facets together. Based on hand-in-hand work with state and district authorities, it is an approach that restores decision-making and leadership responsibilities to them, rather than to the donors and NGOs to whom they have been delegated for years.

The aim is to help the authorities to identify a few clear priorities toward which to channel both their own resources and those that their partners can allocate to them, scaling back expectations vis-à-vis outside support and taking on a more active role both in everyday life and crisis situations.

## NOTES

<sup>1</sup> Humanitarian Needs Overview 2021, OCHA





## WHAT'S LEFT AFTER A CYCLONE HITS?

An image shows what was left after Mozambique was battered by a cyclone. CUAMM responded swiftly, mindful of the lessons learned during the Ebola crisis and lucky to be able to count on a network of activists who worked tirelessly to bring the most vulnerable to safety.





## REVIEW

# CRITICALLY ILL PATIENTS IN AFRICA

In Africa as elsewhere, growing attention is being focused on critically ill patients. The Critical Care Asia Africa initiative aims to systematize the use of computerized clinical registries, adapting intensive care registries to low-resource hospitals to provide epidemiological and clinical data in real time.

TEXT BY / LUIGI PISANI AND RASHAN HANIFFA / CRITICAL CARE ASIA AFRICA NETWORK, MAHIDOL OXFORD TROPICAL RESEARCH UNIT (MORU), BANGKOK, THAILAND

### THE CHALLENGE OF CARING FOR CRITICALLY ILL PATIENTS

Critical illness is defined as a state of health characterized by severe impairment of vital organ function and a high risk of imminent death, a situation that arises very often in African hospitals<sup>1</sup>. Obstetric emergencies, severe malaria, trauma, postoperative complications and sepsis are all potentially reversible conditions that can be very difficult to manage in Africa due to a lack of intensive care units. Here too, though, there is now a growing focus on critically ill patients and the identification of simple, effective, low-cost interventions to treat them<sup>2-3</sup>.

### THE CRITICAL CARE ASIA AFRICA INITIATIVE

Doctors with Africa CUAMM has joined the challenge. In September 2020 we were one of the organizations to join Critical Care Asia Africa (CCAA), an international initiative aimed at creating a mutual assistance network through the use of a digital platform-based critical care registry, a sort of computerized clinical registry. Although registries have been given little consideration in the clinical evidence hierarchy, things are now changing. The CCAA project involves an initial focus on four groups of patients: women with obstetric complications, pediatric patients with severe clinical situations, newborns with complications and surgical patients. The platform is currently active in seven African countries<sup>4</sup> and eight Asian ones<sup>5</sup>, and is coordinated by an interdisciplinary group of clinicians and researchers from the University of Oxford. Doctors with Africa CUAMM joined the project with two pediatric wards in Sierra Leone's Pujehun Hospital and South Sudan's Rumbek Hospital, an intermediate care obstetric unit at Princess Christian Maternity Hospital in Freetown, Sierra Leone, and two neonatal intensive care units at hospitals in Wolisso, Ethiopia, and Beira, Mozambique.

### NOTES

<sup>1</sup> Adhikari NKJ, Fowler RA, Bhagwanjee S, Rubenfeld GD. Critical care and the global burden of critical illness in adults. *Lancet Lond Engl* 2010; 376: 1339–46

<sup>2</sup> Losonczy LI, Papali A, Kivlehan S, et al. White Paper on Early Critical Care Services in Low Resource Settings. *Ann Glob Health* 2021; 87: 105

<sup>3</sup> Schell CO, Khalid K, Wharton-Smith A, et al. Essential Emergency and Critical Care: a consensus among global clinical experts. *BMJ Glob Health* 2021; 6: e006585

<sup>4</sup> Pisani L, Waweru-Siika W, Sendagire C, Beane A, Haniffa R. Critically ill

### THE VALUE OF DATA IN AFRICA

What is the point of experimenting with the implementation of an intensive care registry in the hospitals supported by Doctors with Africa CUAMM? First, to accurately describe the specific population in question, understanding their epidemiological characteristics and underlying clinical conditions. The data will be used to understand how critically ill patients are currently being managed. For example, by examining the registry data at the Princess Christian Maternity Hospital we saw that at the time of admission, obstetric patients with complications affected by sickle cell anemia presented a level of severity similar to that of patients not affected by this blood disorder, yet their mortality was more than twice as high. Second, the interpretation of registry data are expected to help guide local quality improvement initiatives through the reassessment of post-intervention data. In the example described above, for example, the local team's response was to improve triage by administering a rapid sickle cell anemia test to patients at the time of admission; work is also underway to optimize access to transfusions by severely anemic patients. Outcome and process data will be reevaluated in upcoming months. Third, an intensive care registry will make possible clinical trials at the local, national or international levels known as registry-embedded trials. One concrete example involves the well-known RECOVERY and REMAP-CAP randomized evaluation studies of COVID-19 therapies carried out by various CCAA teams using the same platform<sup>6</sup>. Other observational analyses involving the participation of CUAMM's Africa-based sites are also underway, and efforts are being made to understand how to carry out randomized studies as well.

The initial phase of the project has shown how an intensive care registry can be adapted to a low-resource hospital to provide epidemiological and clinical data in real time. Both now and in the future, the challenge will be to promote the use of such patient-level data to concretely improve clinical processes in a sustainable manner.

COVID-19 patients in Africa: it is time for quality registry data. *Lancet Lond Engl* 2021; 398: 485–6

<sup>5</sup> CRIT CARE ASIA. Establishing a critical care network in Asia to improve care for critically ill patients in low- and middle-income countries. *Crit Care Lond Engl* 2020; 24: 608

<sup>6</sup> CRIT Care Asia, Hashmi M, Beane A, Murthy S, Dondorp AM, Haniffa R. Leveraging a Cloud-Based Critical Care Registry for COVID-19 Pandemic Surveillance and Research in Low- and Middle-Income Countries. *JMIR Public Health Surveill* 2020; 6: e21939



## REVIEW

# WHY ARE MOTHERS HESITANT ABOUT BREASTFEEDING?

In many parts of the world, breastfeeding is still not widely practiced. A study by CUAMM in Sierra Leone identified some of the reasons why – such as women's fear of not producing enough breast milk and a lack of support by family members – as well as possible interventions.

TEXT BY / ADRIANO CATTANEO / TRIESTE-BASED EPIDEMIOLOGIST

A study published in the *International Breastfeeding Journal*<sup>1</sup> shows how rates of exclusive breastfeeding in the first 6 months of a baby's life continue to fall far short of what is recommended by the WHO. Conducted in Sierra Leone's Pujehun District, the study involved a random sample of 194 mothers (average age 25; 43% with no formal education; 56% farmers or small traders) and sought to discover the factors underlying inadequate breastfeeding to devise effective ways of countering the phenomenon.

The mothers included in the sample were selected during routine visits for their children to health posts in the Pujehun District's five chiefdoms. 113 had children under 6 months of age and 81 had children aged 6-23 months. After providing their informed consent, the women were asked to respond to a questionnaire in their local language. In parallel, 20 mothers selected based on their breastfeeding practices were asked to respond to an in-depth semi-structured interview on the factors influencing their decision-making. Six health care workers were also selected from each of the 5 facilities for in-depth interviews about their and the health system's roles in promoting and supporting breastfeeding. Finally, to get further details, the researchers organized 7 focus group discussions: 2 each with mothers, fathers and community members and 1 with health care workers.

All but 2 of the mothers surveyed had delivered their babies in a health center or hospital, and all of them had breastfed their child at least once. Seventy-two percent had initiated breastfeeding within an hour of delivery and 22 (11%) had experienced difficulties, including 18 (9%) with nipple pain. Of the 113 mothers with children under 6 months of age, 63% reported having fed them breast milk alone in the previous 24 hours: 74% in the 0- to 1-month group, 66% in the 2- to 3-month group, and 33% in the 4- to 5-month group. The in-depth interviews and focus groups enabled the researchers to identify the factors facilitating breastfeeding, i.e. receiving information on its benefits during pregnancy, being assisted by nurses after delivery and in the postnatal period, receiving support from husbands, and knowing about the breastfeeding practices of family members and friends. The research found that the main barriers to breastfeeding were lack of encouragement by women's husbands, their perception that their infants' stools were abnormal, and their belief that they were not producing enough breast milk.

The study helped the researchers to identify interventions to be included in future breastfeeding promotion programs. The most

Breevoort et al. *International Breastfeeding Journal* (2021) 16:42  
https://doi.org/10.1186/s13006-021-00390-4

International Breastfeeding Journal

### RESEARCH

### Open Access

## Determinants of breastfeeding practice in Pujehun district, southern Sierra Leone: a mixed-method study

Dorothee van Breevoort<sup>1,2\*</sup>, Francesca Tognon<sup>3</sup>, Arne Beguin<sup>1</sup>, Amara S. Ngegbai<sup>4</sup>, Giovanni Putoto<sup>2</sup> and Ankie van den Broek<sup>5</sup>

### Abstract

**Background:** It is well established that exclusive breastfeeding can play a critical role in reducing child morbidity and mortality. Limited research has been done thus far on the practice and perceptions of breastfeeding in Sierra Leone, where more than 10 % of children die before the age of five. This study aimed to gain understanding into and explore both matters in order to develop recommendations for effective strategies to promote breastfeeding practice in Pujehun District, Southern Sierra Leone.

**Methods:** This exploratory mixed-method study included a cross-sectional survey of 194 mothers, semi-structured interviews and focus group discussions. Logistic regression analysis was used calculated odds ratios of factors associated with primarily breastfeeding practice, defined as 'Children under six months of age who are fed with breast milk only and children older than six months of age that were exclusively breastfed up to six months', based on recall from birth. Exclusive breastfeeding rate was based on breastfeeding practice 24 h prior to the survey. Qualitative data was analysed through a deductive approach, using a pre-determined framework on determinants of breastfeeding.

**Results:** This study revealed an exclusive breastfeeding rate of 62.8% (95% CI 53.9, 71.7); dropping from 74% in the 0–1-month age group to 33% in the 4–5 months group. Triangulation of qualitative and quantitative data revealed enabling factors for primarily breastfeeding practice included mothers receiving support during their first breastfeed, pregnant women being provided with information on the benefits of the practice, counselling by nurses, support from husbands, and women's awareness of how their friends and family members fed their own babies. The main barriers were a lack of encouragement by husbands, women's perception that their infants' stools were abnormal or that they were not producing enough breast milk.

**Conclusions:** Although the exclusive breastfeeding may have risen over recent years, a gap remains compared to World Health Organization recommendations. According to the breastfeeding determinants identified in this study, promotion of counselling by a nurse, encouragement of husbands' support, and improve knowledge of mothers on breastfeeding are recommended to be incorporated in the design of future health programs.

**Keywords:** Breastfeeding, Determinants, Sierra Leone, Child health, Mix-method

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important seem to be improving nurses' breastfeeding awareness and counseling skills, encouraging husbands to take part in child-feeding practices, and raising future mothers' awareness about breastfeeding to debunk false beliefs.

### NOTES

**1** Van Breevoort D. et al., *Determinants of breastfeeding practice in Pujehun district, Southern Sierra Leone: a mixed-method study*, in *International Breastfeeding Journal*, May 2021





## REVIEW

# EPIDEMIC ILLUSIONS ABOUT PUBLIC HEALTH

A reflection on Eugene Richardson's new book, *Epidemic Illusions*, which offers far more questions than answers. Too often influenced by trends and ready-made models, public health risks losing its true meaning and – as has so often been the case – leaving behind the most vulnerable.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

Critical to the point of mockery, grating in tone and unsettling in its logic, *Epidemic Illusions: On the Coloniality of Global Public Health* is a difficult book to read, accept and “file away”<sup>1</sup>. Its author, Eugene Richardson, is a wanderer impassioned about global health and social justice, a man constantly on the move who studies biology, anthropology, public health, Eastern religions and Western philosophy while at the same time working in Sierra Leone, the Peruvian Andes, South Sudan and Congo. His focus is on public health, social research and epidemics including HIV, cholera, Ebola and COVID-19, and while he roams the world he stays in touch with Harvard Medical School, where he teaches global health and social medicine.

The book offers up a harsh thesis: that current public health practices – especially new epidemiological tools such as mathematical and computational modeling, the use of Big Data and causal inference – are permeated with concepts, considerations and logic shaped by a colonialist and patriarchal system. In short, beneath the sophisticated, apparently neutral scientific apparatus that presents itself as the only interpretative truth vis-à-vis the causes and mechanisms of infectious disease transmission, lies a racist, inequitable power system that perpetuates itself and is powerfully propagated by Western universities and the medical journals industry.

To back his arguments, Richardson adopts an ironic, “carnavalesque” literary style full of imaginative takes and semantic curiosities, using caustic prose to dismantle and demystify the aura of scientificity and intellectual rigor that circulates around those working in global public health. But his writing is also grounded on and features connections and concrete references to political thinkers, critics of colonialism and anthropologists including Mikhail Bakhtin, Bertolt Brecht, Antonio Gramsci, Richard Rorty, Edward Said and Franz Fanon.

Of the eight short stories, or “redescriptions”, that make up the core of the book, the sixth and seventh are the least ironic and get straight to the point. Regarding the 2014-15 Ebola epidemic in Sierra Leone, Richardson contends that the prevailing application of epidemiological studies based on causal inference fostered a univocal interpretation focused exclusively on downstream bio-

logical/medical causes (for example, individual risk factors, funeral practices, etc.). The exclusion of upstream causes from analyses did not permit the structural racism, network of political interests, unequal distribution of resources and lack of accountability of local and international institutions that manifested prior to, during and after the epidemic to be clearly identified and called out.

One need only do a search on the PubMed platform to prove his point. No results are generated if one inserts words like “colonialism” or “racism” alongside the keywords “Ebola”, “disease”, “death” and “mathematical models”. Richardson condemns this short-sighted vision of epidemiology as a form of hermeneutic, interpretative injustice that, even though developed by staunch advocates of global health, actually helps spread a hegemonic ideological model – the North’s – based on still unassailable power relationships.

In the eighth story, the author makes use of an empirical study published after the book itself to link in epidemiological terms the yet-to-be-paid political, monetary and social reparations to the descendants of American slaves with the transmission of SARS-CoV-2, with the potential generation of beneficial effects both for the health of black communities in the U.S. (those hit hardest by the epidemic) and for society as a whole<sup>2</sup>.

The book concludes with an appeal to contemplate with eyes wide open the epidemiological phenomena behind which a hidden but powerful and still unredressed legacy of historical inequalities, inveterate racism and social injustices persists. But, Richardson adds, awareness is not enough; it is critical that we move beyond that, exploring new dimensions and applying new lexicons, making space for a new heuristic, for creative forms of investigation and research that eschew easy answers to complex problems. As was to be expected, his book has been both praised and criticized. But once the reader finishes it, setting aside some of the author’s stylistic eccentricities and personal contradictions (by his own admission, he himself is a white epidemiologist and scholar from the rich North!), s/he is left with a powerful and shareworthy proposition that we avoid warping global public health according to the models and fads of the moment.

## NOTES

<sup>1</sup> Eugene T. Richardson. *Epidemic Illusions: On the Coloniality of Global Public Health*. Cambridge, Mass.: MIT Press, 2020. 224 pp.

<sup>2</sup> Richardson et al., “Reparations for American Descendants of Persons Enslaved in the US and Their Potential Impact on SARS-CoV-2 Transmission”, *Social Science & Medicine* (Feb. 2021): 113741



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Founded in 1950, Doctors with Africa Cuamm was the first non-governmental organization focused on healthcare to be recognized by the Italian government. It is now the country's leading organization working to protect and improve the health of vulnerable communities in Sub-Saharan Africa.

Cuamm implements long-term development projects, working to ensure people's access to quality health care even in emergency situations.

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- **2,100** individuals have worked on our projects;
- **43** countries have partnered with our organization;
- **239** hospitals have been assisted;
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  - 955 health facilities;
  - 3 nursing schools (in Lui, South Sudan; Matany, Uganda and Wolisso, Ethiopia);
  - 1 university (in Beira, Mozambique);
- **4,581 health workers**, including 493 from Europe and abroad.

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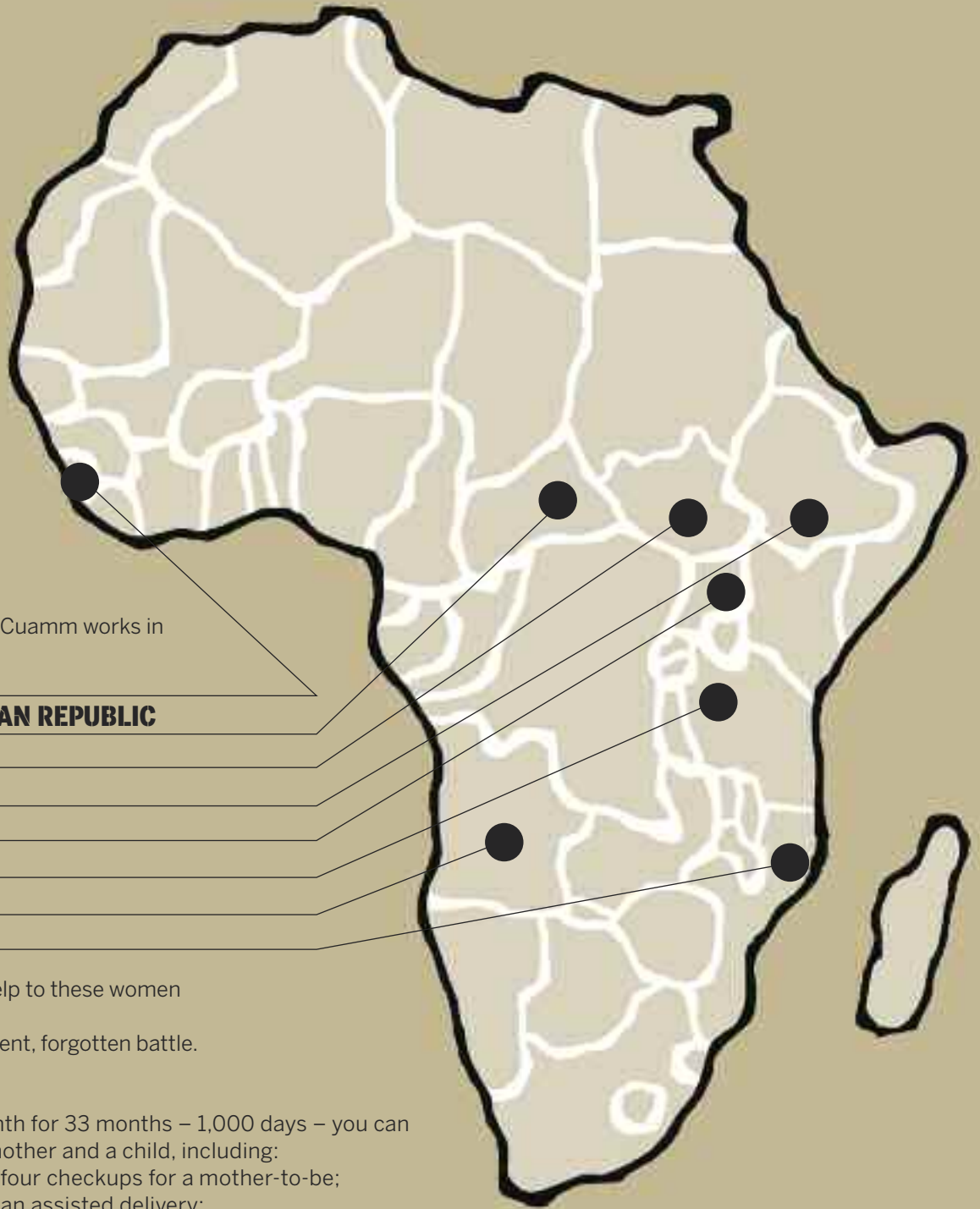
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