The Centre for Counseling, Nutrition and Health Care (COUNSENUTH)

"Care is Our Duty"

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SCALING -UP NUTRITION IN RUVUMA REGION

Summary results of the rapid appraisal in Songea and Tunduru Districts

Introduction

Tanzania has made progress in reducing child under-nutrition with reduction of child underweight to 16 percent in 2010 from 27 percent in 1996, and child stunting to 42 percent in 2010 from 48 percent in 1996. Still, but still the prevalence of child underweight and stunting is unacceptably high.

The 2010 Tanzania Demographic and Health Survey reported that 42 percent of children aged 0-59 months are stunted, while 5 per cent are wasted (too thin for height), and 16 percent are underweight (too thin for age). About 40 percent of women of reproductive age (15-49 years) and 53 percent of pregnant women are anaemic.

Ruvuma region is a food rich region. However, despite the favorable conditions for agriculture and livestock keeping, 46 per cent of children below five years of age are stunted and 59 percent are anemic. Anemia in women of reproductive age (15-49 years) is 33 percent

Under the support of the Irish Aid, COUNSENUTH will work with the local government and the community in Ruvuma to scale-up high impact nutrition intervension addressing childhoood stunting. In December 2012, COUNSENUTH carried out a rapid situational assessment of health and nutrition which focused on two districts in Ruvuma region; Songea Rural and Tunduru.

The assessment aimed at investigating factors that influence the nutritional well being of the population in these two districts, as a preliminary step in developing a programme proposal to scale up high impact nutrition interventions to reduce malnutrition and especially childhood stunting in Ruvuma.

This assessment made use of secondary district data; checklists for key informant interviews with district and service providers and focus group discussions with pregnant and lactating women.

Table1: Demographic Facts

	Tunduru	Songea Rural
Population	315,051	193,202
Women Child Bearing Age	77,906	46,948
Live Births	12,372	7,156
Children<5yrs	54,303	31,269
Children <2yrs	17,854	10650
U5MR	30/1000	73/1000
MMR	193/100,000	89/100,000

Source: Regional and District offices 2012.

Table 2: Major Causes of Mortality

	Tunduru	Songea
1.	Malaria	Asphyxia
2.	Anemia	Severe Malaria
3.	ARI	Anemia
4.	Diarrhea	Postpartum Hemorrhage
5.	Malnutrition	Eclampsia

Source: Regional and District offices 2012.

Tunduru District Council leaders with a team from Counsenuth and TFNC

Table 3: Women and children nutritional status and uptake of maternal care services in Ruvuma in comparison to other food rich regions

Nutritional status of children	National	Ruvuma	Iringa	Mbeya	Rukwa
Stunting 0-59 months (%)	42.3	46.2	51.9	49.8	50.4
Wasting 0-59 months (%)	4.6	4.8	3.5	1.2	3.8
Severely wasted 0-59 months (%)	1.1	0.7	0.8	0.0	2.0
Underweight 0-59 months (%)	15.7	15.8	18.2	9.7	13.5
Any anaemia by Hb 6-59 months (%)	58.3	58.9	45.6	54.6	41.7
LBW among reported birth weight (%)	6.9	9.9	10.9	10.2	11.9
Nutritional status of women aged 15-49 years					
Height < 145 cm (%)	3.4	5.7	6.8	1.9	3.1
BMI %< 18.5 (%)	11.3	11.2	5.0	4.5	8.2
Any anaemia by Hb (%)	39.5	33.1	28.3	32.1	21.7
Any anaemia among pregnant women (%)	52.7	-	-	-	-
Up-take of Maternal Care Services					
Women who took iron tablets (90+) during last pregnancy (%)	3.1	1.5	1.4	4.1	1.6
Women who took SP/ Fansidar2+ dose at least one during ANC visit (%)	25.7	24.4	23.7	14.1	20.5
Assisted delivery (by skilled provider) (%)	50.5	83.0	80.8	42.9	29.5
No post-natal check-up	64.6	39.8	28.1	69.0	78.0

Source: ***TDHS 2010***

Possible factors contributing to Malnutrition in Songea Rural and Tunduru Districts

Key Findings

1. Inappropriate breastfeeding practices

Although breastfeeding for six months is desirable, it is considered impractical due to the high workloads of women in Songea rural. Women are involved in farming activities and often go back to faming as early as 40 days after giving birth leaving their infants behind. Women and health workers in Tunduru also considered exclusive breast-feeding challenging and impractical due to the women's intensive work in the farm where they cannot bring their infants along.

One clinical officer commented that;

"…ideally it is possible but, unfortunately, in these areas most women are involved in farming activities so they don't get enough time to eat well and produce adequate milk for the child."

There is also a common perception among women and health workers that breastfeeding alone is incapable of providing adequate nourishment for infants.

UNICEF and WHO recommend that children are exclusively breastfed (no other liquid, solid food, or plain water) during the first six months of life in order to prevent malnutrition. Unfortunately, in Tanzania and Ruvuma Region in particular, most mothers do not practice exclusive breastfeeding for the first six months.

2. Unsatisfactory complementary feeding

Due to their heavy farm workloads and the presumption that breastfeeding alone does not fully nourish infants in the fist 6 months, women in Songea rural and Tunduru result in the early start of complimentary feeding for infants (as soon as three days after birth). In Songea rural, complimentary feeding consists of porridge made from *lishe* flour, some mothers add cow's milk if they can afford it.

In Tunduru, most infants are given a light cassava porridge mixed with salt or sugar, if affordable, and after five months they are given a thick cassava porridge known as *kondoole*. The only affordable high-energy food given to infants is groundnuts. Vegetables are sometimes included, but rarely fruit as only a few families can afford it.

Feeding frequency is also inadequate; mostly twice or three times a day because mothers are predominantly occupied with farm work.

3. Poor household food security

Families keep little food after harvest season and sell the rest as cash crops. Therefore, families run out of food during the dry season and throughout the cultivating season from November to April. During dry season, families can only afford two meals a day compared to three meals during harvest season.

Residents are rarely engaged in horticultural and animal keeping activities thus have limited variety of fruits, vegetables and foods of animal origin for their meals.

4. Poor food utilization

This is mainly due to a lack of awareness of nutritional needs and poor diversification of dietary intake. Food preparation practices in Tunduru also leach out nutrients from food. Cassava and maize flower is soaked in water for a day or two, remove all solids before preparation. This process washes a significant amount of important nutrients from food. The myths around food choices for pregnant women in Tunduru also contribute to limiting nutritional products needed during pregnancy.

5. Trends on traditional crop markets

Negative shifting trends on traditional crop markets have caused food to be sold in compensation of income. lack of backyard gardens and competing priorities cause families to sell harvests and end up with food shortages. During dry season, families can only afford to eat two meals compared to three meals eaten during harvest season because the yields reserved for food are lower than household needs.

6. Inadequate food and hygiene practices

Despite good access to water, most families only wash hands , before eating (without soap), and not after visiting toilets. Residents in Songea Rural use tap water and rarely treat or boil. Tunduru residents mainly use well water. Domestic pit latrines in these districts are located close to the house. Community health workers have been working towards improving them to quality pit latrines.

7. Little evidence of multi-sectoral and integrated efforts in horticultural programs and education

There is a lack of local context social marketing for nutrition programs for women of reproductive age, pregnant and breastfeeding women including children. Women are not provided with sufficient information on iron supplements, exclusive breastfeeding, appropriate complementary feeding practices and growth monitoring of children.

8. Serious gender disparities and limited male involvement

Women have minimal say on decision on family resources. Teenage pregnancies are very high in both districts, which even lead to establishment of district by-laws. However, no measures to foster communication between parents and children.

More women than men cannot read and write (**women 17%; men12%);** Women have little access to newspapers (**women 11, men 53%**); low access to radio time (**women 55%, men 90%)** and no access to any media (**women 43%, men 8%).** Men are not actively involved in support of women and children's welfare. Notable increases have been observed in the attendance of couple HIV testing however, women still do not get enough support when they are pregnant or during lactation. The promotion of male involvement in this is taking place but is yet to be successful.

9. Poor quality of services for nutrition

There is inadequate number of personnel in Songea particularly in RCH departments, which leads to overloading during outreach services. Tunduru also suffers from a shortage of trained staff; medical attendants run 18 out of 57 clinics with no support from senior staff. Funding from UNICEF (CSPD program) previously helped support village health workers in linking women and children to health facilities. This support is no longer available and it is not possible to retain village health worker activities for most villages.

Tunduru District Headquater: Banner displaying their Vision and Mission

Table 4: Essential Health Care Services

	TUNDURU	SONGEA RURAL
Total number of health facilities	**57**	**39**
Health facilities with RCH	**55**	**38**
Health facilities with FANC (Focused ANC)	**41**	**36**
Heath facilities with ANC (Regardless of FANC)	**55**	**38**
Health facilities with FP Services	**55**	**26**
Health facilities with immunization services	**54**	**38**
Health facilities with PMTCT	**43**	**37**
Heath facilities with HIV early infants diagnosis	**33**	**29**
Heath facilities conducting delivery services	**51**	**38**

Recommendations

The following recommendations have been made to facilitate development of a nutrition programs proposal.

- Development and promotion of a framework for multi-sectoral integrated efforts to target community level structures. District Nutrition Committees provide an opportunity to integrate effort from agriculture, microfinance, and community income generation schemes and projects for women empowerment.
- Capacity building for leadership at local level and community level structures to translate nutritional policies and structures at local levels.
- Capacity building to address post harvest challenges, improve food storage, processing and preparation practices.
- Promotion of horticultural activities to encourage vegetable and fruit production and poultry and small animal keeping for improving access to vegetables, fruits and animal based food.
- Designing of social marketing strategies sensitive to the local market in promoting nutrition and well being specifically promoting exclusive breastfeeding, appropriate complementary feeding and early booking to ANC for pregnant women.
- Addressing alternative income generating activities that can improve household income and food security.
- Evidence based advocacy in areas that impact the relationship between nutrition and male involvement. Opportunity exists through promoting best practices such as improving male involvement in ANC, breast-feeding, complementary feeding and child nutrition.
- Implementing interventions based on baseline nutritional indicators and proven effective interventions for example, breastfeeding, micronutrient supplementation for pregnant women and children as well as other relevant community based practices, including life skills fore girls.

Final Note

These two districts included in this report have unique characteristics that influence their nutritional status in varying ways. Both districts are made up of small-scale peasants who depend on agriculture production for household food needs as well as income generation, but they have different characteristics pertaining to food production, consumption, feeding and care of children and women and food security.

The existing differences in these districts have to been taken into account in the designing of effective interventions for each district. Gender disparities and gender related practices are some of the key factors that lead to the cause of malnutrition in the two districts.

For more information contact:

The Centre for Counseling, Nutrition and Health Care (**COUNSENUTH**)
44 Galu Street, Ada Estate, P.O. Box 8218 Dar es Salaam,
Tanzania | Tel: +255 22 2664756 | Fax: +255 22 2664757
Email:info@counsenuth-tz.org | Website: www.counsenuth .tz.org

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