Public Health Digest

Ethiopian Pubic Health Association (EPHA)

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Public Health Digest

Editor-in-Chief: Kindalem Damtie (PhD)

Producer: Zewdie Teferra

Ethiopian Public Health Association
(EPHA)

Tel: 251 114 16 60 41
251 114 16 60 83
Fax: 251 114 16 60 86

Email: info@etpha.org
Website: www.etpha.org
P.O.Box 7117
Addis Ababa, Ethiopia

Objectives of the Digest

- *To improve the knowledge, and practices of public health professionals*
- *To introduce latest research findings, best practices and success stories to the general public*
- *To motivate health professionals to engage themselves in operational studies*

Target Audiences

The target groups for the Digest are health professionals in general; and trainers in training institutions, public health practitioners at Woreda health offices, in health centers and hospitals, in particular. This Digest is also intended for non-health professionals who are interested on the subject on a demand-basis for free subscriptions.

Strategy

Three thousand copies of the Digest is published biannually. Distribution follows the modalities of other EPHA publications. In addition, regional, zonal and Woreda offices, institutions of the FMoH and EPHA website serve as channels for distribution. The Digest is bilingual (Amharic and English).

Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
CDC	Center for Disease Control and Prevention
CD4	Cluster of Differentiation 4
CSA	Central Statically Agency
DHS	Demographic and Health Survey
DR	Drug Resistance
FHAPCO	Federal HIV/AIDS Prevention and Control Office
EMA	Ethiopian Medical Association
EPHA	Ethiopian Public Health Association
EPHI	Ethiopian Public Health Institute
EPHIA	Ethiopia Population Based HIV Impact Assessment
FMoH	Federal Ministry of Health
HCW	Health Care Workers
HEP	Health Extension Program
HEW	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HSTP	Health Sector Transformation Plan
ICAP	International Center for AIDS Care and Treatment Programs
MSM	Men having Sex with Men
PMTCT	Prevention of Mother to Child Transmission
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PHIA	Population Based HIV Impact Assessment
PLHIV	People Living with HIV
PWP	Prevention with Positives

RH	Reproductive Health
RHBs	Regional Health Bureaus
SBC	Social and Behavioral Change
STIs	Sexually Transmitted Infections
SW	Sex Workers
TWG	Technical Working Group
UNAIDs	United Nations Program on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
VLS	Viral Load Suppression
WHO	World Health Organization
UNICEF	United Nations Children's Fund

Editorial Note

Highlighting Communication in the Context of Health

Communication is essential in all facets of development work (health, education, economy, environment…) How does communication enhance or hinder the attainment of the desired level of participation of actors toward realizing organizational goal? This synthesis provides key lessons on the importance of communication in facilitating operational success. Notwithstanding the level of participation, communication can contribute to increasing awareness, fostering behavioral changes, facilitating mobilization, and establishing partnerships in pursuit of common goals. However, the lack of communication can also break down negotiations, limit alternatives to addressing problems, constrain benefit distribution of development interventions, lead to marginalization of stakeholders and, in due course, restrict the attainment of desired outcomes.

The use of various types of communication media enables stakeholders (i.e., government, the private sector, and civil society, …) to participate in the development process, and hence, allows them to influence or contribute to the design, implementation, and monitoring of a development activity. Here, what is important is to contextualize the existing and potential communication options as all forms may not be applicable in different settings.

Health is one of the key development indicators and investing in health has become a priority across nations including development agencies. Nevertheless, efforts to improve health systems will have little effect on health if these systems are not in place. Because human behavior is a major factor in

health outcomes, devoting to health must focus on behaviors as well as health facilities and services. Solving health problems and creating enabling environment requires that people understand and motivated to adopt or change certain behaviors. Thus, effective communication must be a key part of any investment strategy in health.

Inside and outside the field of communication, interest in health communication has grown over the past two decades. Health communication as a multidisciplinary pursuit is concerned with 'the powerful roles performed by human and mediated communication in health care delivery and health promotion'. It is an extremely broad research area, examining many different levels and channels of communication in a wide range of social contexts. Undoubtedly, the different contexts require us to analyze the suitability of channels as well as ways of presenting/conveying our message.

Authorities in the field agree that one can didactically speak about three main spheres of influence in the case of communication and health: societal, expert discourse and lay discourse. At the same time, the levels for health communication analysis include intrapersonal, interpersonal, group, organizational, and societal communication. In addition, health communication inquiry involves examination of a broad array of communication channels, including face-to-face and mediated communication between providers and receivers, among members of health care teams, and among patients (e.g., via support groups). This requires close scrutiny of the background and level of understanding of our communicators.

A number of studies unveiled that health-related messages are effective devices of 'social learning', the people being able to learn what it means to be healthy with the help of media and other options. Moreover, health public policies can be modified sometimes by the transmission of messages relating to health.

Incorrect or unrealistic information from medical reports may mislead the people working in public health policy and may contribute to the admission of unfair laws and regulations, the latter being regarded by many scientists and health advocates as true threats to public health. Health-related news from the media functioned largely as a factor that can influence the actions of doctors, patients, lawyers, and politicians and they have become the main target in the discussions between researchers in the medical field, the information related to health and in the field of communication. Hence, effective communication helps to advance health research, practice and policy.

Hoping that the tips published here will give readers a multifaceted perspective of communication in general and health communication in particular. Besides, this part will focus on multiple discourses in health communication and health marketing including research in an interdisciplinary context as it combines and applies important theories, concepts, and methods from diverse areas of communication science (such as language and discourse behavior, interpersonal communication, group/organizational communication, intercultural communication, persuasion, media studies and new communication technologies), integrated with the diverse disciplines of public health, behavioral and social sciences.

Through our health communication work, we endeavor to achieve our vision: a world in which all people actively use accessible, accurate, relevant, and timely health information and interventions to protect and promote their health and the health of their families and communities. Like the application of communication to public health, more research, evaluation, and accumulated experience are required to effectively translate and apply the principles of strategic communication to public health.

To this end, it is important to recognize that participation is a means to achieving improved healthcare results, rather than an objective in itself. Ensuring participation requires effective communication, which creates an environment where stakeholders are able to acquire and share knowledge, develop understanding, enhance engagement, and take action. The appropriate communication channels and media, clarity of messages (information), identification of receivers and senders of information, and the determination of an appropriate level of interaction between various actors and stakeholders can significantly contribute to building an environment for knowledge acquisition and sharing. Ultimately, when this process is done meaningfully, participation enhances ownership, which promotes accountability and transparency, and helps ensure equitable and sustainable distribution of project benefits.

If you want to go fast, go alone; if you want go far, go together!

Updates

EPHIA

Ethiopia Population Based HIV Impact Assessment

Introduction

Ethiopia is the second most populous country in Africa. Projections from the 2007 housing and population census estimate the total population for year 2017 at 94 million. The age structure shows: 47% less than 15 years old, 49% between 15 and 64 years old and 4% above 64 years old. The median age is 16.8 years; the population growth rate is 2.6% (the eighth highest in the world); the total fertility rate is 4.8 children per women; and the crude birth rate (live births per 1,000 population) is 34.5 .

Burden of disease

Ethiopia is one of the sub-Saharan African countries heavily affected by the AIDS epidemic. The 2011 Ethiopian Demographic and Health Survey estimated the national HIV prevalence rate among adults (15-49 years) at 1.5%, varying by sex, age, geography, and socio-economic status. HIV prevalence is higher among women (1.9%) compared to men (1%), and peaks in the 20-34 age group for women and in the 35-39 age group for men. For both women and men, HIV prevalence is somewhat higher among those who are employed than those who are not employed. HIV prevalence is higher in urban areas (4.2%) than in rural areas (0.6%). Among regions HIV prevalence is highest in Gambela (6.5%) and in Addis Ababa (5.2%). A higher proportion of Ethiopians who attended secondary school (3.1%) are HIV positive than those with less education or with more than a secondary school education.

Men and women in the highest wealth quintile have the highest HIV prevalence (3.9%).

HIV related estimates and projections for Ethiopia released by the Ethiopian Public Health Institute/Federal Minstry of Health for 2015 indicate that there were a total of 741,500 people (657,300 adults 15+ years and 84,200 children 0-14 years of age) living with HIV in country. The projection also indicated that some 16,900 AIDS related deaths would occur and estmated AIDS related orphans at 373,500. HIV continues to pose challenges to public health and the fast-changing socio-economic landscape in Ethiopia. The epidemic is prevalent in the most productive age group of 15-49 years and new infections in this age group were estimated at about 21,300 in 2015. Despite persistent efforts to halt the epidemic, HIV transmission continues, particularly among the urban population, and predominantly through unprotected heterosexual sex. The HIV epidemic remains one of the most critical issues contributing to Ethiopia's low life expectancy of 54 years and to overall health and development challenges in Ethiopia.

The following practices are considered key drivers of the epidemic: multiple and concurrent sexual partners; low and inconsistent use of male and female condoms; low levels of male circumcision in most areas; mother to child transmission (which accounts for more than 90% of HIV infection in children aged 0-14 years); and mobility and labor migration. There is limited information and data regarding sex workers (SW) and men having sex with men (MSM), in part due to the legal status of sex work and same-sex relations.

HIV control efforts

Government efforts to prevent the spread of HIV started in 1988 when the first cases of HIV in Ethiopia were identified in a serological survey. Since then the Government of Ethiopia has systematically put in place

plans and resources to address the challenges of HIV.

Intervention areas include Social and Behavior Change (SBC), Condom marketing and distribution, Voluntary Medical Male Circumcision (VMMC), Prevention of Mother to Child Transmission (PMTCT), Prevention with Positives (PwP), Post Exposure Prophylaxis (PEP), Sexually Transmitted Infections (STIs) and blood safety. Services to increase the availability of comprhensive HIV care and treatment, including voluntary counseling and testing and antiretroviral treatment (ART), have increased significantly in the past 10 years and acceptability and uptake have been high. In addition, community and facility-based programs have been implemented to decrease stigma surrounding HIV infection and to provide care and support for those infected.

Ethiopia has implemented a public health approach to service delivery, including its Health Extension Program, which has contributed to the success of ART scale-up and improvements in access to other basic health services. Ethiopia implemented an accelerated PMTCT plan with Option B in 2011 and switched to Option B+ in 2013, which places all HIV-positive pregnant and breastfeeding women on long-term ART regardless of CD4 count or clinical staging. Option B+ has provided a platform to aggressively scale-up ART access; the number of facilities providing ART increasing from just over 353 in 2006 to 880 in 2013 and 1,043 by end of 2014. However, the impact of the facility-based PMTCT program in reducing rates of HIV transmission from mother to child at a population level has not been assessed.

Key achievements include a reduction in the estimated (through modeling) number of new infections in adults aged 15 years and above by 65% from 2001 and 2012. Overall, Ethiopia has experienced a decline in HIV prevalence. Prevalence has been measured through population-based surveys and antenatal clinic (ANC) sentinel surveillance among young women. The number of AIDS-related deaths in adults has decreased by an estimated 46% from 2011 to 2016, and by almost 30% in children under 14 years of age during the same period. This decline is thought to be associated with increasing access to and utilization of comprehensive ART and PMTCT services. The number of facilities dispensing ARV has increased and exceeded current targets. By end of 2014, a total of 1,043 health facilities were dispensing ARVs in Ethiopia, which is an increase from 353 facilities dispensing ARVs in 2006 and there was an increase of eligible adults and children receiving ART. By the end of 2014, a total of 339,043 (65%) of eligible adults and and 22,955 (below 15%) of children had received ART.

HIV survey and surveillance efforts in the general population

The goal of HIV surveillance and surveys in Ethiopia is to provide high-quality data on HIV prevalence, and viral suppression, risk behaviors, and morbidity to support evidence-based decision making for program management and policy formulation. These surveys align with the objectives of the country's Health Sector Transformation Plan (HSTP) 2016-2020 to strengthen the response of HIV prevention and control programs by providing high quality data. In addition to several valuable ongoing limited-scope surveys and special studies, the major source of

data on HIV infection in Ethiopia comes from the antenatal sentinel surveillance program. This has been implemented by the Ethiopian Public Health Institute (EPHI)/ Federal Ministry of Health (FMoH) and the Regional Health Bureaus (RHBs) since 1989; in the early years this surveillance was mainly restricted to urban areas. In 2014, ANC-based sentinel surveillance was expanded to a total of 122 sites, 43 urban and 79 rural. This data has been used to monitor trends in HIV prevalence as well as syphilis prevalence among pregnant women and has served as the main data source to estimate and project trends for HIV in the general population. ANC surveillance data, however, are not representative of the general population because they exclude men, non-pregnant women, pregnant women not attending ANC, sexually inactive persons, and the elderly. In addition, ANC surveillance efforts collect only a limited number of demographic and programmatic variables that are routinely collected for the purpose of ANC.

A series of population-based household surveys in Ethiopia have provided data concerning HIV knowledge and attitudes, as well as sexual behaviour. A Health Management Information System (HMIS) has been used within Ethiopia since 2008 and is well established in all regions, districts and facilities. Such as pediatric and adult ART patient monitoring as well as ART drug resistance monitoring. Data is collected through a standardized set of patient record cards, tally sheets, activity sheets, Under 5 cards, registers such as safe motherhood registers and ART registers, and Aggregation Forms used to complete monthly reports, which are sent quarterly to district offices.

Ethiopia's first included HIV testing in the Demographic and Health Survey (DHS) in 2005. The next survey was conducted in 2011 and a subsequent DHS is currently in progress. The data provided by these surveys have been used to calibrate national estimates and have resulted in a better understanding of HIV distribution and trends by linking HIV results with demographic and behavioral data.These surveys covered an increasingly broad set of topics including knowledge of HIV transmission, age at first sex, number of sexual partners, condom use with various types of partners, and attitudes towards people living with HIV. The surveys have documented a moderate level of knowledge about HIV and its means of transmission, with modest increases over time. In 2005, 35% percent of women knew that HIV could be prevented by using a condom and by limiting the number of sexual partners. In 2011, this knowledge increased to 43%. Among men, knowledge increased from 57% in 2005 to 64% in 2011. However, these relatively high levels of knowledge do not translate into consistent reductions in HIV transmission risk behaviors. The EDHS also contains a population-based estimate of HIV prevalence among adults over the age of 15. Although both the sentinel surveillance and population-based surveys conducted to date have provided useful insight on Ethiopia's HIV epidemic and HIV control efforts, information critical to understanding the current status of the epidemic and steering future interventions is still lacking. The Population-based HIV Impact Assessment /PHIA/ Survey was developed to enable countries, including Ethiopia, to obtain HIV-specific indicators, including the impact of the expansion of HIV prevention and treatment pro-

effective monitoring of their national HIV program. EPHIA is designed to obtain population-based estimates of HIV indicators in adults and children to compliment routine data in informing strategic planning and evaluation of relevant control programs.

Justification for the survey

PHIA surveys similar to the one proposed here have been carried out in several countries, including Uganda (2004) and Tanzania (2003) and Kenya (2007), SHIMS-Swaziland (2011) and Kenya (2012). However, to date, no national-level, population-based studies in Ethiopia have included viral load suppression (VLS), pediatric HIV prevalence, or ART coverage. Lack of reliable population-based prevalence data to estimate the pediatric HIV burden in the country is a major gap. Data for children living with HIV using Spectrum modeling estimation needs to be reinforced by a more robust and reliable approach for better programming. Ethiopia PHIA will therefore address these gaps by estimating VLS among HIV -positive individuals, and pediatric HIV prevalence as well as other HIV-related measures, including CD4 T-cell count distribution, and HIV drug resistance (DR) that will characterize the HIV epidemic in urban Ethiopia and provide greater clarity on the impact in urban areas of the national HIV program. The survey will focus on urban areas across all 11 regions, as the HIV epidemic is largely concentrated in these parts of Ethiopia (urban prevalence of 4.2% vs rural prevalence of 0.6%). The PHIA survey will, therefore, permit the country to assess the UNAIDS 90/90/90 treatment targets in urban Ethiopia.

In addition, the survey will collect information on uptake of and access to HIV-related services and will estimate the prevalence of selected behaviors typically associated with HIV acquisition and/or transmission, and on common HIV co-morbidities and other health conditions. The PHIA survey also affords opportunities for doing biomarker testing for selected country priority health conditions to fill gaps in available information. EPHIA will include Hepatitis B testing to assess the prevalence of HIV/Hepatitis B co-infection among HIV-positive adults and conduct syphilis testing to estimate prevalence of syphilis among HIV- positive persons in urban areas.

Stakeholder Participation

Stakeholders include the Government of Ethiopia, non-governmental partners involved in HIV prevention, care, and treatment, other donors, and the population of men, women and children of Ethiopia. This survey is an endeavor of the Ethiopia FMOH, the United States Government PEPFAR program in Ethiopia, CDC in Ethiopia and Atlanta, ICAP at Columbia University, and Westat. Westat will work in partnership with ICAP to support data management. CDC Ethiopia and ICAP staffs have worked closely with the FMoH and other national stakeholders during the develop ment of this survey. A Steering Committee comprised of EPHI, CDC, ICAP, and Central Statistical Agency (CSA) will oversee the Project and assist in high level coordination activities. A national Technical Working Group (TWG) has been formed to provide technical guidance to the planning and implementation of this survey.

The TWG will continue to meet regularly to provide continuous technical guidance to investigators. The TWG includes representatives from the FMoH, CDC-E, ICAP in Ethiopia, UNAIDS and CSA. The Investigator Team includes individuals from the [Ethiopia], EPHI, FMoH, Federal HIV/AIDS Prevention and Control Office (FHAPCO), CDC and ICAP.

After completion of the survey, findings will be communicated with key stakeholders and information disseminated as appropriate.

Funding: The survey will be supported by the United States Governmoiuent, which will provide technical assistance and funding from the PEPFAR,

Survey goal & objectives

The goal of the survey is to assess the coverage and impact of HIV services on the population level, examine the distribution of HIV disease among children and measure HIV-related risk behaviors using a representative sample of adults and children in urban Ethiopia.

Primary Objective

To estimate the proportion PLHIV with suppressed HIV viral load (<1000 copies/mL) in a household -based survey among adults 15-49 years of age in urban Ethiopia.

Secondary Objectives

- To estimate the proportion PLHIV with suppressed HIV viral load among adults 50-64 years of age in urban Ethiopia
- To estimate HIV prevalence in urban children 0-14 years of age
- To estimate HIV prevalence among adults aged 15-64 years in urban Ethiopia
- To describe the prevalence of HIV-related risk behaviors, knowledge and attitudes in a household-based, representative urban sample of adolescents 12-14 years and adults 15-64 years of age
- To examine the correlation of demographic characteristics and HIV prevalence among adults 15-64 years and children 0-14 years of age
- To determine the distribution of CD4 T-cell counts among HIV infected adults 15-64 years and chilldren 0-14 years of age
- To estimate coverage of HIV-related services including HCT, knowledge of HIV status, coverage of care & treatment services among adults (15-64 years) and children (0-14 years)
- To estimate the prevalence of detectable ARVs in HIV-positive children, ages 0-14, and adults, ages 15-64 years
- To estimate the level of transmitted drug resistance in adults, age 15-64 years and children age 0-14 years with evidence of recent HIV infection
- To estimate the prevalence of syphilis amongst HIV positive 15-64 years of age
- To estimate the prevalence of Hepatitis B co-infection amongst a subpopulation of HIV positive adults 15-64 years of age
- To estimate HIV incidence among adults aged 15-59 years in urban Ethiopia

Findings

የፓርኪንሰን ህመም ምንድነው?

የፓርኪንሰን ህመም ጉዞ ነው። የተጀመረ ጉዞ ግን ማብቅያ የሌለው፤ እሰከ ሕይወት መጨረሻ የሚቀጥል ጉዞ ነው። ይህ ጉዞ ለብቻ የሚከናወን አይደለም። በፓርኪንሰን ጉዞ

የሚሳተፉ ብዙ ተጓዦች አሉ፡- ቤተሰብ፣ ጎረቤት፣ ዘመድ፣ ጓደኞች አብረው ይጓዛሉ። በርካታ የፓርኪንሰን ህኪም ዶክተሮችም መንገዱን እየመሩ አብረው ይጓዛሉ። የእነርሱን ምክር መስማት አስፈላጊ ነው። ምክንያቱም ችግሮችን እንዴት እየፈቱአቸው እንደሄዱ ልምዳቸውን ያካፍላሉ።

የፓርኪንሰን ጉዞ ወደን የምንመርጠው አይደለም። ነገር ግን የአንድ ሰው ችግር ብቻ አለመሆኑን ማወቅ ሌሎቹን ያፅናናል።

ፓርኪንሰን ሲጀምር በጣም በትንሹ ከመሆኑ የተነሳ ታማሚው በፓርኪንሰን መያዙን ላይገነዘበው ይችላል። በፍጹም በፓርኪንሰን እያዛለሁ ብሎ መገመት አይቻልም። መጣ ሄድ የምትል ትንሽ የእጅ መንቀጥቀጥ ተገንዝቦ የአስቸጋሪው ህመም ምልክት ናት ብሎ ማን ሊገምት ይችላል።

ለምን ፈገግ እንደማትል/እንደማትስቅ ወይም ለምን ቀስ ብለህ እንደምትራመድ ላይታወቅህ ይችላል። ሁሉ እንደ ተራ ነገር ሊቆጠር ይችላል። ምልክቶቹ እየበረቱና እየተደጋገሙ ሲሄዱ ብቻ ነው በጥርጣሬ ሰውነቴ ልክ አይደለም መመርመር አለብኝ ተብሎ ህኪም ማማከር የሚጀመረው። ፓርኪንሰን መሆኑ ግን የሚነገረው በህኪም ነው።

ፓርኪንሰን ምንድነው?

እንደ ቫይረስ ተላላፊ ህመም አይደለም። አብሮ በመኖር፣ አብሮ በመብላትም ሆነ በመተኛት ከሰው ወደ ሰው አይተላለፍም። ፓርኪንሰን ልክ እንደ ስኳር ህመም በኬሚካል እጥረት የሚከሰት ህመም ነው።

የስኳር ህመም ኢንሱሊን በሚባል ኬሚካል እጥረት የሚከሰት ህመም ሲሆን የፓርኪንሰን ህመም ደግሞ ዶፓሚን በሚባል የኬሚካል እጥረት የሚከሰት የህመም አይነት ነው። ልዩነቱ ኢንሱሊን በምርመራ የሚገኝ ሲሆን ዶፓሚን ግን በምርመራ አይታይም። ከፍተኛ ስኳር በደም ውስጥ ካለ በመለካት የሚታወቅ ሲሆን የዶፓሚን መጠን ግን በደም ልኬት አይታወቅም፤ አይለካም። የሚታወቀውም ምልክቶቹን በማየት ነው። ለምሳሌ መንቀጥቀጥ፣ ሰውነት ጨምድዶ መያዝ፣ የሰውነት ሚዛን መሳትና የመሰሰሉት ምልክቶች ናቸው።

አንዳንድ ጊዜ የፓርኪንሰን ተጠቂው በእረፍት ላይ በሚሆንበት ወቅት እጅ ብቻ ወይም እጅና እግር አንዳንድ ጊዜ ምላስና አገጭ ሊንቀጠቀጥ ይችላል። የሚንቀጠቀጠው እጅ ሥራ ሲሰራ ነው። ለምሳሌ:- ቡና ለመቀበል በሚዘረጋበት ጊዜ መንቀጥቀጡ ይቆማል። ወዲያውኑ እጅ ሲያርፍ መንቀጥቀጡ ይጀምራል። የፓርኪንሰን ህመም የሚንቀጠቀጠው በእረፍት ወይም በመዝናናት ላይ ሲሆኑ ብቻ ነው።

መንቀጥቀጡ በአንድ እጅ ወይም በሁለቱ እጆች ሊጀምር ይችላል።

ሌሎች ህመሞችም የፓርኪንሰን የሚመስል መንቀጥቀጥ የሚያስይዙ ህመሞች አሉ። በጣም የሚመሳሰል ኢሰንሻል ትሪመር (essential tremor) ነው። ነገር ግን የዚህ ህመም መንቀጥቀጥ የሚጀምረው ሥራ ለመስራት በሚንቀሳቀስበት ጊዜ ሲሆን እረፍት በሚሆንበት ገዜ መንቀጥቀጡ ያቆማል። የፓርኪንሰን መንቀጥቀጥ የሚጀምረው በእረፍት ላይ በሚሆንበት ጊዜ ነው።

የሰውነት መገታተር/ ጨምድዶ መያዝ (rigidity) የሚጀምረው መንቀጥቀጥ በጀመረው ጎን በኩል ያለው የእጅና የእግር ጡንቻ ነው። ይህ ስሜት ከሪህ ህመም ጋር ሊምታታ ይችላል። ግን የፓርኪንሰን ህመም የማበጥ ችግር ጋር አይያያዝም። በተጨማሪም የሪህ ህመም እግርና እጅ በሚያዝናኑበት ጊዜ መገታተሩ ሲያቆም የፓርኪንሰን ህመም ግን እረፍት በሚኮንበት ጊዜ ለውጥ አያመጣም። ሁል ጊዜ ጡንቻ እንደተገታተረ እንደሚኖር

ዓይነት ነው።ፓርኪንሰን የእንቅስቃሴ መገደብ ችግር ወይም (bradykinesia) ተብሎ ይታወቃል። ይህም የሚገለጸው እንቅስቃሴ ለመጀመር በመቸገር ወይም ለመጀመር በማመንታት፣ ዘገምተኛነት ወይም ቀስ ብሎ በመራመድ፣ እንቅስቃሴ/መሄድ ከጀመሩ በኋላም ለመቀጠል መቸገርን ይመለከታል። በአጠቃላይ የፓርኪንሰን ችግር በብዙ መንገዶች መግለጽ ይቻላል፤ ለምሳሌ ስሜት የማይገልጽ ፊት (masked face) ገጽታ፣ የማይርገበገብ የአይን ቆብ፣ በሚንቀሳቀሱበት ጊዜ የማይወዛወዙ አንድ ወይም ሁለቱም እጆችና በሌሎችም ይገለጻል።

ሰው በእድሜ እንደሚለያይ ሁሉ የፓርኪንሰን ምልክቶችም ከሰው ሰው ይለያያሉ። በአንደኛው የፓርኪንሰን ታማሚ በመጀመርያ የታዩ ምልክቶች በሌላው ታማሚ በስተመጨረሻ ሊታዩ ይችላሉ።

እንዲሁም ምልክቶች በአንዱ ታማሚ ጠንከር ብለው ሲታዩ በሌላው ግን በመጠኑ ቀለል ብለው ሊታዩ ይችላሉ። ለምሳሌ:- ዋናው የፓርኪንሰን ምልክት ተብሎ የሚጠቀሰው መንቀጥቀጥ 30 በመቶ በሚሆኑት ህሙማን ላይ አይታይም።

ፓርኪንሰን የእድሜ ባለጸጎች/ ሽማግሌዎች ህመም ነውን?

በእርግጥ ፓርኪንሰን በአብዛኛው የሚያጠቃው እድሜያቸው ከ60 አመት በላይ የሆናቸው ሰዎችን ነው።

ነገር ግን እስከ አስራ አምስት ከመቶ የሚሆኑት ከዛ ባነሰ እድሜ ማለትም ከ50 በታች ባለው እድሜ ላይ ሊጠቁ ይችላሉ። 10 ከመቶ ደግሞ ከ40 አመት በታች ሆነዉ ይጠቃሉ።

ፓርኪንሰን ሁሉን አገር በእኩል ደረጃ ያጠቃል። ልዩነቱ በበለጸጉ አገሮች ተመዝግበው ቁጥራቸው ምን

ያህል እንደሆነ የሚታወቅ ሲሆን በማደግ ላይ ባሉ አገሮች የሚኖሩት ግን ቁጥራቸው ምን ያህል እንደሆኑ አይታወቅም። በሰሜን አሜሪካ ብቻ ከ1.2 ሚልዮን በላይ የፓርኪንሰን ህሙማን ይኖራሉ።

በአለማችን በአመት በአማካይ 50,000 ሰዎች በፓርኪንሰን ይጠቃሉ።

ወንድና ሴት በፓርኪንሰን የመያዝ ሁኔታ የወንዶች ቁጥር በትንሹ ከፍ ይላል (ወንዶች 45% ፤ ሴቶች 35%) አካባቢ ነው። የመኖር የእድሜ ጣራ በጨመረ ቁጥርም በፓርኪንሰን የመያዝ እድሉ ይጨምራል።

የፓርኪንሰን ምልክቶች በጣም በትንሹ በማይስተዋል መልኩ ይጀምርና እየበረታ የሚሄድ ህመም በመሆኑ አብዛኛው ሰው ወደ ህክምና በመሄድ ችግሩ የፓርኪንሰን ህመም መሆኑን ለማወቅ ከ2 እስከ 5 አመት ድረስ ይወስድበታል። አንዳንዴም እስከ 10 አመት ድረስ ሊቆይ ይችላል። በአጠቃላይ ህመሙ በሚጀምርበትና ፓርኪንሰን መሆኑ እስከሚታወቅበት ድረስ ቢያንስ የሁለት አመት ርቀት ይኖራል።

ፓርኪንሰን በምን ይከሰታልን ?

ፓርኪንሰን ዶፓሚን የሚባል ኬሚካል ሰብሰታንሺያ ኔግራ (substantia nigra) በተባለው የአንጎላችን ክፍል ውስጥ እየቀነሰ ሲሄድ የሚከሰት ችግር ነው። ዶፓሚን ለምን እንደሚያልቅ ወይም ዶፓሚን የሚሰሩ ሴሎች ለምን እንዲሚሞቱ አይታወቅም። ዶፓሚን የሚሰሩ ሴሎች ማን እንደሚገድላቸው ወይም ለምን ሞት በእነዚህ ሴሎች ላይ እንደሚከሰትና ፓርኪንሰን በነዚህ ክፍሎች ለምን እንዳነጣጠረ በውል የሚታወቅ ነገር የለም። አንዳንድ ግምቶች ግን አሉ:- የጭንቅላት ጉዳት፣ የፋብሪካ ዝቃጮች፣ የፔትሮልም ዝቃጮች፣ የጉድጓድ ውሀ መጠቀም ፓርኪንሰን እንደሚያስከትሉ ፍንጭ ታይቷል።

እነዚህና የመሳሰሉት ነገሮች ለፓርኪንሰን እንደሚያጋልጡ ቢገመትም በትክክል በምን ምክንያት ለፓርኪንሰን ሊጋለጡ እንደቻሉ የሚያውቁ ህመምተኞች ቁጥር ከ3 በመቶ አይበልጥም።

የፓርኪንሰን ህመም ተላላፊ አይደለም። ባልና ሚስት አንድ ላይ እየኖሩ ከህመምተኛው ወደ ጤነኛው ሰዉ አይተላለፍም።

ፓርኪንሰን በዘር ይተላለፋል ማለት ይቻላል?

ዘር ሚና ሊኖረው ይችላል። በፓርኪንሰን የተያዙ ሰዎች 15 አስከ 25 በመቶ የሚሆኑት በቤተሰባቸው ሌላ በፓርኪንሰን የተያዘ ሰው እንዳለ ገልጸዋል። አንድ በመቶ በሚሆኑት የፓርኪንሰን ህሙማን ደግሞ ብዙ ዘመዶቻቸው አያት ቅድመ አያቶቻቸው በዚህ ህመም የተጠቁ መሆናቸው ታውቋል።

እነዚህን ቤተሰቦች ለፓርኪንሰን ህመም የሚያጋልጥ አንድ ተመሳሳይ አይነት ዘረ መል ተገኝቷል።

ነገር ግን በፓርኪንሰን በተጠቁ ህሙማን ይህ መልስ ነው ብሎ ማጠቃለል አይቻልም። ምክንያቱ ደግሞ የሰውን ዘረ መል ለማወቅ ብዙ ጊዜ ስለሚወስድ ነው። ዘረ መል ከወላጅ ወደ ልጅ የሚተላለፍ ሰው የመሆን ጸባያት የሚያስተላልፍ ህዋስ ነው። እያንዳንዱ ሰው23 ጥንድ ዘረ መል (chromosomes) ይኖሩታል። ከ23 ጥንድ ዘር መል ውስጥ አንድ ዘረ መል ጤነኛ ካልሆነ ወይም ኖርማል ካልሆነ የሚያስተላለፈው ፕሮቲን ጤነኛ አይሆንም። የጃፓን ተመራማሪዎች ከፓርኪንሰን ጋር የተያያዘ አንድ ዘረ መል አግኝተዋል። ስሙንም የፓርኪን ዘረ መል ብለው ሰይመውታል። የፓርኪን ዘረ መል ስራው ያረጁ ፕሮቲኖችን ማጥፋት ነው። የፓርኪን ዘረ መል በትክክል ካልሰራ ፕሮቲኑ ይጠራቀምና ሌሎችን የሚጎዳ መርዛማ ንጥረ ነገር ይፈጥራል። ስለዚህ ዶፓሚን የሚፈጥሩ ሴሎች ይሞታሉ። ፓርኪንሰን የሚፈጠረው በዚህ መልኩ ብቻ ቢሆን መድሃኒት ይገኝለት ነበር። ነገር ግን ፓርኪንሰን የሚከሰተው በብዙ ዘረ መልና በብዙ የአካባቢው ሁኔታዎች ውህዶች/ ቅይጦች አማካይነት ነው ተብሎ ይገመታል።

ተመራማሪዎች እንደሚገምቱት በዘር ብቻ የሚተላለፍ ሳይሆን ለፓርኪንሰን ተጋላጭ የሆነ የዘር መል (በዘር የሚተላለፍ ህዋስ) ከአካባቢ መርዛማ ኬሚካሎች ጋር ሲገናኝ የሚፈጠር ህመም ነው። ስለዚህ በዘር የሚተላለፍ ቢባልም የአካባቢ ሁኔታዎች ተስማሚ ካልሆኑ ፓርኪንሰን አይፈጠርም።

ጸረ አረም የፓርኪንሰን ህመም ያስይዛል?

አንዳንድ ጥናቶች እንደሚያመለክቱት በእርሻ የሚተዳደሩና ገጠር የሚኖሩ ሰዎች በሌላ የስራ መስክ ከሚተዳደሩ ሰዎች በበለጠ በፓርኪንሰን የመጠቃት ዝንባሌ ይታያል። ምክንያቱም ለእርሻው አስፈላጊ ከሆኑ ጸረ አረምና ጸረ ተባይ ኬሚካሎች ጋር ግንኙነት ወይም ንኪኪ ስለሚኖራቸው ነው። ትንሽ ጸረ አረም ኬሚካሎች በአይጥ ላይ በተደረገ ሙከራ ፓርኪንሰንን አስከትለዋል።

አጀንት ኦረንጅ የሚባለው ኬሚካል ከሁለት ኬሚካል ቅልቅል የተሰራ ጸረ አትክልት ኬሚካል ነው።

የተሰራውም ቲሲዲዲ እና ኬሮሲን (TCDD and kerosene) ከተባሉት ኬሚካሎች ተቀምሞ በአይሮፕላን ወደ ቬትናምና ወደ ካሞቦድያ ጫካ እንዲረጭ የተደረገ ነው። የተረጨውም በጦርነት ወቅት ነጻ አውጪዎች በጫካው እንዳይደበቁ ቅጠልና ቅርንጫፎች ለማራገፍ ነው። በርግጥ አጀንት ኦረንጅ በተረጨበት ቦታ በቁጥር ከፍ ያሉ የፓርኪንሰን ህሙማን ተገኝተዋል።

ነገር ግን ከኬሚካሉ ጋር ያላቸው ግንኙነት ምን እንደሆነ ሊታወቅ አልቻለም። በዛን ጊዜ በተረጨው ጫካ አካባቢ የተገኙ ሰዎች ከ7 ሰዎች 1ሰው የፓርኪንሰን ምልክት አሳይቷል። አንዳንድ ተመራማሪዎች የፓርኪንሰን ችግሩ እዛ በነበሩበት ጊዜ የነበረው ጭንቀትና ሰቆቃ ሊሆን ይችላል ሲሉ አንዳዶቹ ደግሞ ከጸረ ተባዩ በነበራቸው ንኪኪ መሆኑን ይናገራሉ። ያም ሆነ ይህ ትክክለኛ መልሰ ሊገኝ አልቻለም።

ፓርኪንሰን በቫይረስ ሊከሰት ይችላል?

ፓርኪንሰን በቫይረስ አማካኝነት ሊከሰት ይችል ይሆናል የሚል ግምት አለ። በአንድ ወቅት (1916-1917) ተከስቶ የነበረና ለ10 አመታት በቀጠለው ስሊፒንግ ሲክነስ (sleeping sickness) የተያዙ ሰዎች የፓርኪንስን ህሙማን ሆነው ተገኝተዋል። ይህ (sleeping sickness) ለተለያዩ ህመም አጋልጧቸው አልፏል።

ይህ ህመም በድንገት መጥቶ በሞላው አለም 15 ሚሊዮን ህዝብ ካጠቃ በኋላ ሳይታሰብ ጠፍቷል። ከተያዙትም አንድ ሶስተኛ (1/3ኛ) የሚሆኑት ሞተዋል።

በዚህ ቫይረስ ከተያዙት መካከል አንድ ሶስተኛ የሚሆኑት የፓርኪንስን ህሙማን ሆነው ተገኝተዋል። የተቀሩት ደግሞ መንቀሳቀስና መናገር የማይችሉ በጣም ታማሚ ሆነው ተገኝተዋል። ይህ ብቻ ሳይሆን የኢንፍሉዌንዛ ቫይረስና የዌሰት ናይል ፓርኪንሰን ህመም ሊያስከትሉ ይችላሉ።

ለህመም መፈወሻ የሚወሰዱ መድሃኒቶች የፓርኪንሰን ህመም ሊያስከትሉ ይችላሉ?

መድሃኒቶች ፓርኪንሰን ሳይሆን ፓርኪንሰን የመሰሉ ምልክቶች ሊያመጡ ይችላሉ። በመድሃኒት የሚከሰቱ ፓርኪንሰን መሰል ምልክቶች መድሃኒቱን መውሰድ ሲያቆሙ ምልክቶች ይጠፋሉ። አንዳንድ ጊዜ ለሌላ ህመም የሚወሰዱ መድሃኒቶች የፓርኪንሰን ምልክቶች እያሳዩ ቆይተው መድሃኒቱ በሚቆምበት ጊዜ ምልክቶች ሳይጠፉ ይቆዩና ወደ ፓርኪንሰን ይለወጣሉ።

የፓርኪንሰን ህመም የሚያስከትሉ መድሃኒቶችም አሉ። ለምሳሌ ሀሮይን ከMPTP ከሚባል ኬሚካል ጋር ንኪኪ ካለው ፓርኪንሰን ሊያስከትል ይችላል። ይህ ኬሚካል በአይጦች ተሞክሮ ፓርኪንሰን ተይዘው ተገኝተዋል። ልዩነቱ በፓርኪንሰን ህመም የሚከሰተው ሊዊ ቦዲ የሚባል ክብ ቅርጽ ያለው ነገር ሲፈጥር በሀሮይን የሚከሰተው ግን ይህንን አያሳይም።

በመድሃኒት የሚከሰቱ ፓርኪንሰን መሰል ምልክቶቸ ከፓርኪንሰን ምልክቶች የሚለዩት፡-

- ◊ ፓርኪንሰን መሰል ምልክቶች የሚጀምሩት በሁለት ጎን በአንድ ጊዜ ሲሆን ፓርኪንሰን ግን የሚጀምረው በአንድ ጎን ብቻ ነው። ወደ አልታመመው ጎን ቀስ በቀስ ይተላለፋል።
- ◊ ፓርኪንሰን መሰል ምልክቶች የሚንቀጠቀጠው ሁል ጊዜ ሲሆን ፓርኪንሰን ግን በእረፍት ላይ በሚከንበት ጊዜ ብቻ ነው።
- ◊ ፓርኪንሰን መሰል ምልክቶች ከጊዜ በኋላ ወደ ፓርኪንሰን ህመም የሚቀየር ወይም የማይቀር መሆኑ አይታወቅም።

በደም ግፊት ምክንያት የሚከሰት strokes ፓርኪንሰን ህመም ሊያስከትል ይችላል?

ይህ ችግር የሚከሰተው አርተሪስ ወይም ከልብ ተቀብለው ደም የሚያመላልሱ ቱቦዎች መጠንከር ወይም መዘጋት ነው። የደም ስር በተለያዩ ምክንያቶች በስኳር ህመም፣በደም ግፊት፣በኮሎስትሮል ወይም ሲጋራ በማጨስ ሊዘጋ/ሊጠነክር ይችላል። በዚህ በታማሚው የደም ስር አጠገብ ሌላ የሚተካው የደም ስር ከሌለ በዚህ የደም ስር የሚጠቀም የአንጎል ክፍል ይሞታል። በዚህ ጊዜ ፓርኪንሰን መሰል ምልክቶች ይፈጠራሉ። የፓርኪንሰን መሰል ምልከቶቹ በቅጽበት ይከሰታሉ እንጂ እንደ ፓርኪንሰን ምልክቶች ቀስ ብለው በአንድ ጎን አይከሰቱም። እነዚህ የፓርኪንሰን መሰል ምልክቶች አንድ ጊዜ ከያዙ በኋላ እየባሱ አይሄዱም። ፓርኪንሰን አንድ ጊዜ ከተከሰተ አይድንም በደም ሴል መዘጋት ወይም መጠንከር የሚከሰተው ግን ሊድን ይችላል። በደም ሥር ችግር ምክንያት ፓርኪንሰን አይከሰትም። የፓርኪንሰን ህመም መድሃኒት ቢወሰድ ለውጥ አያሳይም። በደም ሥር ችግር ምክንያት የሚከሰት ፓርኪንሰን መሰል ምልክቶች በምርመራ (MRI) ይታያሉ። እንዲያውም ይህ ችግር stroke በፓርኪንሰን የተያዘ ሰውም ሊያጠቃ ይችላል። እንዲሁም አንድ በደም ሥር መዘጋት ምክንያት የታመመ ሰው በፓርኪንሰን ሊያዝ ይችላል። በአንዱ ስለተጠቃሁ ሌላው አይይዘኝም ማለት አይደለም። ሁለቱም የተለያዩ በሽታዎች ናቸዉ ማለት ነዉ።

በስራ ምክንያት ፓርኪንሰን ሊይዝ ይችላል?

እስከ አሁን ፓርኪንሰን የሚያጋልጡ ሁለት የስራ መስኮች እንዳሉ ታውቀዋል። እነሱም የቦክስ ስፖርትና ብረት ብየዳ ሥራ የሚሰሩ ናቸው።

ፓርኪንሰን ገዳይ ህመም ነው?

ከ1967 የፈረንጆች አመት በፊት እንዲሁም የተለያዩ መድሃኒቶች ከመፈልሰፋቸው በፊት በፓርኪንሰን የታመመ ሰው አማካይ የሚኖርበት እድሜ ፓርኪንሰን ከተያዘ ጀምሮ ከ5 እስከ 15 አመት ነበር።

ፓርኪንሰን በራሱ ገዳይ ስላልሆነ ህመምተኞች የሚሞቱትም በተለያዪ ምክንያት ነው።

በፓርኪንሰን ህመም የተያዘ ሰው እንቅስቀቃሴው የተገደበ ነው። ጊዜዉ እየረዘመ ሲሄድ መንቀሳቀሱ ይበልጥ ይቀንሳል:: በዚህ ምክንያት አንዳንዶቹ ለመዋጥ ይቸገራሉ። በጣም ተጠንቅቀው እንኳን ቢመገቡ ይታነቃሉ ወይም ትንታ ይይዛቸዋል። ይህም የሚሆነው ምግብ ሳምባቸው ውስጥ ስለሚገባ ነው። የፓርኪንሰን ህመም የጉሮሮ ጡንቻና የመተንፈሻ አካላትን ያጠቃል። እነዚህ ጡንቻዎች ወደ ውጭና ወደ ውስጥ ለመተንፈስ የሚረዱ ናቸው። የነዚህ ጡንቻዎች መገታተር ወደ ውጭና ወደ ውስጥ መተንፈስ ያስቸግራል። ምግብ በሚመገቡበት ጊዜ ቀጥታ ወደ ጨጓራ ከመሄድ ይልቅ ወደ መተንፈሻ አካል ይገባል። ይህ ምግብ ወደ ሳምባ በሚገባበት ጊዜ ኒሞንያ የሚባል የሳምባ ህመም ያስከትላል። ሰውነቱ የተገታተረ ስለሆነ ኒሞንያው በራሱ ሂደት ሊከላከለው አይችልም። ምንም እንኳን ኒሞንያ የሚያጠፉ መድሃኒቶች ቢወሰድም እንኳን በሰውነት መገታተር ምክንያት ለመዳን በጣም ያስቸግራል። ኒሞንያ መተንፈስ በጣም ከባድ ያደርጋል።ለሰውነት የሚያስፈልግ የኦክስጅን መጠን በጣም ይቀንሳል በዚህ ምክንያት ህመሙ ለሞት ይዳረጋል። አንዳንደ ጊዜ በኦክስጅን እጥረት ምክንያት የደም ኢንፌክሽን ሊከሰት ይችላል። ይህ የተበከለ ደም ወደ ልብ ጉበትና ኩላሊት በሚዘዋወርበት ጊዜ መመረዝ ሊያስከትል ይችላል። በዚህ በደም መመረዝ ምክንያት ታማሚው ሊሞት ይችላል።

በፓርኪንሰን የተጠቁ ህሙማን በእንቃስቃሴ ችግር ምክያት ለብዙ (ከ5-15) አመት የአልጋ ቁራኛ ሆነው ይኖራሉ። በዚህ ጊዜ በየሰአቱ የሚገለብጣቸው ሰው ከሌለ ወይም ሰው ቀንና ሌሊት ካላገላበጣቸዉ ሰውነታቸው ይላላጣል። በደረታቸውና በመቀመጫቸው በኩል ያለ ስጋቸው ይቆስልና ይነሳል። በዚህ ጊዜ በኢንፌክሽን ምክንያት ለሞት ይዳረጋሉ። የፓርኪንሰን ህሙማን ያለ እንቅስቃሴ ከ5 እስከ 10 አመት አልጋ ላይ ተኝተው ሲያሳልፉ እግራቸው ይገታተራል።

በእንቅስቃሰሴ እጥረት ምክንያት በእግራቸው የደም ዝውውር ይቀንሳል። በዚህ ምክንያት በእግር ደም መርጋት ይጀምራል። ይህም ሁኔታ ኢንፌክሽን በማስከተል ለሞት ይዳርጋል።

ፓርኪንሰን ያጠቃው ሰዉ በሚዛን አለመጠበቅ ምክንያት የመውደቅ አደጋ ያጋጥመዋል። በዚህም ወገቡ ወይም ሌላ አጥንት የመሰበር ጉዳት ሊከሰት ይችላል። ይህም ለሞት ሊጋለጥ ይችላል።

የፓርኪንሰን ህመም ምልክቶችን የሚያስታግሱ ብዙ መድሃኒቶች አሉ። የእነዚህ መድሃኒቶች መፈልሰፍ የፓርኪንሰን ህሙማን አልጋ የሚይዙበትን ጊዜ አራዝሞታል። በዚህ ምክንያት በእንቅስቃሴ እጦት የሚከሰቱት ችግሮች በመጠኑ ተቀርፈዋል። ሌሎች መድሃኒቶች እንደ አንቲባዮቲክ ዓይነቶች መፈልሰፋቸውም በኢንፌክሽን ምክንያት የሚከሰትን ህመምን በመቀነስ ረገድ የተሻለ እንዲሆን አድርገውታል። በአሁኑ ጊዜ የተሻሻለ ምቾት ያለዉ ፍራሽ ስለተሰራ በመተኛት የሚከሰተውን የመቁሰል ችግር ቀንሷል። በሀኪም ትእዛዝ የተሰራ ካልሲ ወይም እስቶኪንግ በማድረግ በእግር የደም መጓገል ችግርም ቀንሷል። በተጨማሪ የተቋጠረ ደም የሚያቀጥን መድሃኒት ተፈልስፏል። በአሁኑ ጊዜ እድሜ ለቴክኖሎጂ በፓርኪንሰን ከተያዙ መድሃኒቶች በመጠቀም በአማካይ ከ15 እስከ 25 አመት መኖር ይቻላል።

Source :- ስለፓርኪንሰን ህመም 100 ጥያቄዎች
ደራሲ፡ አብርሃም ሌበርማን
ተርጓሚ፡ ወ/ሮ ክብራ ከበደ

The Issue

World Breastfeeding Week

World Breastfeeding Week is celebrated every year from 1 to 7 August to encourage breastfeeding and improve the health of babies around the world.

It commemorates the Innocenti Declaration signed in August 1990 by government policy-makers, WHO, UNICEF and other organizations to protect, promote and support breastfeeding.

Breastfeeding is the best way to provide infants with the nutrients they need. WHO recommends exclusive breastfeeding starting within one hour after birth until a baby is 6 months old. Nutritious complementary foods should then be added while continuing to breastfeed for up to 2 years or beyond.

Infant and young child feeding

Key facts

- Every infant and child has the right to good nutrition according to the *"Convention on the Rights of the Child"*.
- Undernutrition is associated with 45% of child deaths.
- Globally in 2017, 155 million children under 5 were estimated to be stunted (too short for age), 52 million were estimated to be wasted (too thin for height), and 41 million were overweight or obese.
- About 40% of infants 0–6 months old are exclusively breastfed.
- Few children receive nutritionally adequate and safe complementary foods; in many countries less than a fourth of infants 6–23 months of age meet the criteria of dietary diversity and feeding frequency that are appropriate for their age.

* Over 820 000 children's lives could be saved every year among children under 5 years, if all children 0–23 months were optimally breastfed.
* Breastfeeding improves IQ, school attendance, and is associated with higher income in adult life.
* Improving child development and reducing health costs through breastfeeding results in economic gains for individual families as well as at the national level.
* Undernutrition is estimated to be associated with 2.7 million child deaths annually or 45% of all child deaths. Infant and young child feeding is a key area to improve child survival and promote healthy growth and development. The first 2 years of a child's life are particularly important, as optimal nutrition during this period lowers morbidity and mortality, reduces the risk of chronic disease, and fosters better development overall.
* Optimal breastfeeding is so critical that it could save the lives of over 820 000 children under the age of 5 years each year.

WHO and UNICEF recommend:

◊ early initiation of breastfeeding within 1 hour of birth;

◊ exclusive breastfeeding for the first 6 months of life; and

◊ introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.

However, many infants and children do not receive optimal feeding. For example, only about 36% of infants aged 0–6 months worldwide were exclusively breastfed over the period of 2007-2014.

Recommendations have been refined to also address the needs for infants born to HIV-infected mothers. Antiretroviral drugs now allow these children to exclusively breastfeed until they are 6 months old and continue breastfeeding until at least 12 months of age with a significantly reduced risk of HIV transmission.

Benefits of Breastfeeding

Exclusive breastfeeding for 6 months has many benefits for the infant and mother. Chief among these is protection against gastrointestinal infections which is observed not only in developing but also industrialized countries. Early initiation of breastfeeding, within 1 hour of birth, protects the newborn from acquiring infections and reduces newborn mortality. The risk of mortality due to diarrhea and other infections can increase in infants who are either partially breastfed or not breastfed at all.

Breast-milk is also an important source of energy and nutrients in children aged 6–23 months. It can provide half or more of a child's energy needs between the ages of 6 and 12 months,

Additionally, they perform better on intelligence tests and have higher school attendance. Breastfeeding is associated with higher income in adult life. Improving child development and reducing health costs results in economic gains for individual families as well as at the national level.

Longer durations of breastfeeding also contribute to the health and well-being of mothers: it reduces the risk of ovarian and breast cancer and helps space pregnancies–exclusive breastfeeding of babies under 6 months has a hormonal effect which often induces a lack of menstruation. This is a natural (though not fail-safe) method of birth control known as the Lactation Amenorrhoea Method. Mothers and families need to be supported for their children to be optimally breastfed. Actions that help protect, promote and support breastfeeding include:

adoption of policies such as the International Labour Organization's *"Maternity Protection Convention 183"* and *"Recommendation No. 191"* which complements *"Convention No. 183"* by suggesting a longer duration of leave and higher benefits;

adoption of the *"International Code of Marketing of Breast-milk Substitutes"* and subsequent relevant World Health Assembly resolutions;

implementation of the *"Ten Steps to Successful Breastfeeding"* specified in the Baby-Friendly Hospital Initiative, including:

- skin-to-skin contact between mother and baby immediately after birth and initiation of breastfeeding within the first hour of life;

- breastfeeding on demand (that is, as often as the child wants, day and night);
- rooming-in (allowing mothers and infants to remain together 24 hours a day);
- not giving babies additional food or drink, even water, unless medically necessary;
- provision of supportive health services with infant and young child feeding counselling during all contacts with caregivers and young children, such as during antenatal and postnatal care, well-child and sick child visits, and immunization; and
- community support, including mother support groups and community-based health promotion and education activities.
- Breastfeeding practices are highly responsive to supportive interventions, and the prevalence of exclusive and continued breastfeeding can be improved over the course of a few years.

Complementary feeding

Around the age of 6 months, an infant's need for energy and nutrients starts to exceed what is provided by breast milk, and complementary foods are necessary to meet those needs. An infant of this age is also developmentally ready for other foods. If complementary foods are not introduced around the age of 6 months, or if they are given inappropriately, an infant's growth may falter. Guiding principles for appropriate complementary feeding are:

⇒ continue frequent, on-demand breastfeeding until 2 years of age or beyond;

⇒ practice responsive feeding (for example, feed infants directly and assist older children.

⇒ Feed slowly and patiently, encourage them to eat but do not force them, talk to the child and maintain eye contact);

⇒ practice good hygiene and proper food handling;

⇒ start at 6 months with small amounts of food and increase gradually as the child gets older;

⇒ gradually increase food consistency and variety;

⇒ increase the number of times that the child is fed: 2–3 meals per day for infants 6–8 months of age and 3–4 meals per day for infants 9–23 months of age, with 1–2 additional snacks as required;

⇒ use fortified complementary foods or vitamin-mineral supplements as needed; and

⇒ during illness, increase fluid intake including more breastfeeding, and offer soft, favorite foods.

Feeding in exceptionally difficult circumstances

Families and children in difficult circumstances require special attention and practical support. Wherever possible, mothers and babies should remain together and get the support they need to exercise the most appropriate feeding option available. Breastfeeding remains the preferred mode of infant feeding in almost all difficult situations, for instance:

* low-birth-weight or premature infants;

* mothers living with HIV in settings where mortality due to diarrhea, pneumonia and malnutrition remain prevalent;
* adolescent mothers;
* infants and young children who are malnourished; and
* families suffering the consequences of complex emergencies.

HIV and infant feeding

Breastfeeding, and especially early and exclusive breastfeeding, is one of the most significant ways to improve infant survival rates. While HIV can pass from a mother to her child during pregnancy, labour or delivery, and also through breast-milk, the evidence on HIV and infant feeding shows that giving antiretroviral treatment (ART) to mothers living with HIV significantly reduces the risk of transmission through breastfeeding and also improves her health.

WHO now recommends that all people living with HIV, including pregnant women and lactating mothers living with HIV, take ART for life from when they first learn their infection status.

Mothers living in settings where morbidity and mortality due to diarrhoea, pneumonia and malnutrition are prevalent and national health authorities endorse breastfeeding should exclusively breastfeed their babies for 6 months, then introduce appropriate complementary foods and continue breastfeeding up to at least the child's first birthday.

Source :- www.who.int

Dear readers,

Ethiopian Public Health Association once again Respectfully calls upon readers of this Public Health Digest to send your valuable suggestions and comments which significantly make a difference on the quality of the Digest. Likewise, the editors solicit researchers and health professionals to provide your research endeavors. These are vital in providing substantial and up-to-date information to those who are engaged in safeguarding of the public health.

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