News

Getting health care to vulnerable communities

More research is needed into why vulnerable communities fail to access public health-care services even when these are available. This lack of access proved to be tragic for Mumbai slum-dweller Savita Das and her family.

On 26 July 2005, when Mumbai was flooded within hours, Savita Das, 35, faced a decision no woman should have to make. Savita's 10-month-old daughter had fallen into the dirty floodwaters and urgently needed to be taken to hospital. The child was already suffering from severe malnutrition and the floods made her diarrhoea and respiratory infection even worse.

But as a widow living with her six children in a slum on the edge of the city, Savita had no choice but to watch her youngest child die. She recalled with sadness how she named that child "Lucky" in defiance of the family's already bad fate.

> "Those who have money prefer going to private doctors or quacks. The rest, like Savita, give up hope."
>
> *Sangita Kamble, a social worker in Mumbai.*

"I knew my baby had to be taken to a hospital. But I have five other small children. Who would look after them if I am away for more than a day?" Savita said, referring to her daughters: Sujata, 9, Supriya, 6, and Kantari, 5; and sons: Amar, 4, and Chaman, 2, who were also malnourished and unwell before the floods.

"If I take time off from work, how will I feed them?" said Savita, who earns around 50 rupees (about US$ 1) a day, after eight hours of back-breaking work at a scrap warehouse, separating plastic and other products that are used by the recycling industry.

Savita's story illustrates one disconnect, among many, that sometimes exists between public health policy and practice. While the Indian government's health policy is aimed at helping women like Savita, in practice such people often fail to access available health-care services for a number of reasons.

Addressing this disconnect is vital for making public health services more equitable in developing countries. This was a core issue at the annual meeting of the Global Forum for Health Research in Mumbai, 12–16 September, attended by 700 international researchers and public health experts whose theme was "poverty, equity and health research".

The Geneva-based nongovernmental organization (NGO) campaigns for more research and development funding for the diseases of the poor and more funding for research into how to improve service delivery to vulnerable communities like Savita's.

Just weeks before the flood hit Mumbai, a local NGO, the Society for Nutrition, Education and Health Action (SNEHA), demonstrated how, in practice, such research can indeed come to the aid of vulnerable and impoverished communities. They and others involved in similar work believe that research into health systems and how they function on the ground can save lives in such communities.

In a study of six wards in Mumbai, the NGO identified Bhim Nagar as one of the most vulnerable communities because of its lack of access to basic shelter, hygiene and health care.

In the absence of these basic services, the group knew that — even though the slum was not one of the worst flood-affected areas — its people were likely to suffer more than those living in better-served parts of the city.

A team of doctors and social workers from SNEHA reached Bhim Nagar on the third day after the deluge. They brought food, medical aid and counselling, but it was too late to save Lucky, who died on 4 August.

The group's research findings ring true for Savita. When Savita's mother died because the family could not afford medicines to treat her high blood pressure, Savita's children lost their support system while she and her husband were out working.

Seven months later, Savita's husband Kewal, a construction worker, died of gastric-related problems. His daily pay of 60 rupees barely provided the family with a frugal diet of rice and lentils and certainly not enough to buy the drugs prescribed for him by government hospital doctors.

"Savita's inability to access timely health services for her child is a consequence of her circumstances," said Dr Armida Fernandez from SNEHA, calling for the provision of mobile health services to such communities.

Savita's family are Bengali speakers who came to Mumbai from Assam.

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Rupa Chinai

Widow Savita Das and her five children live in the sprawling Bhim Nagar slums.

They are among some seven million urban poor who constitute 60% of Mumbai's population of 12 million. They live on the streets, in slums, tenements and dilapidated buildings.

Communities living in slums established before 2000 are provided with basic health-care services, but unregulated ones like Bhim Nagar that have sprung up since then are subject to evictions and are not provided with basic services, such as clean water, health services, schools, electricity and ration shops.

Bhim Nagar is built on a vast marshy swamp, and patients requiring medical care must be carried for 30 minutes along a dirt track before they reach the road and transportation.

"Reaching a government hospital does not save their lives. They are asked to purchase expensive drugs from outside, made to run from pillar to post and wait in long queues," said Sangita Kamble, a social worker who works in Bhim Nagar. "Those who have money prefer going to private doctors or quacks. The rest, like Savita, give up hope."

Mumbai has one of the wealthiest municipal authorities in India. Its health-care services are, however, stretched beyond capacity because of a rapidly growing population and a state government freeze on recruitment of new health staff over the last six years, said Jairam Thanekar, Deputy Executive Officer of the Mumbai Municipal Corporation.

This situation is severely affecting primary and secondary care services where limited staff shoulder the burden of having to implement all "vertical" or single-disease programmes, said Dr Girish Ambe, Deputy Executive Health Officer for Tuberculosis. The main vertical programmes are on family planning, polio, AIDS, tuberculosis, malaria and immunization.

Thanekar said the city would benefit from research into a number of disconnects in the health system. For example, research on how to develop human resources because low motivation and morale among health staff are major obstacles faced by patients seeking public health-care services.

Ravi Narayan of the People's Health Movement, an international NGO, said an important message that emerged from the Global Forum's meeting, Forum 9, was that communities need to become more involved in shaping research agendas. Evidence from Africa and Asia shows how research that brings together statistical data with information on what communities want, based on interaction and sharing knowledge with them, can spur more active involvement of communities. This would make health policy and service delivery more effective, he said.

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> *Dr Armida Fernandez from a Mumbai-based nongovernmental organization.*

Lot Nyirenda, a scientist with Research for Equity and Community Health Trust in Malawi, agreed that it is vital for local research to help determine what are the priority concerns of a developing country: "Policies for research and equity need to be developed in a manner that is participatory and relevant to local needs. It should aim at reaching the most marginalized segments of the population by ensuring mechanisms that provide proof of delivery".

Bhim Nagar is one of many communities across Asia that would benefit if user fees for health-care services were eliminated and if budgets were increased to strengthen the public health system. Savita's poignant story of failing to access life-saving health care is repeated in many places across the world.

A study called Equity in Asia-Pacific Health System (EQUITAP) looking at 15 Asian countries — including India — that was presented at Forum 9 found that charging user fees and withdrawing public sector money to fund health care for the poor were resulting in catastrophic out-of-pocket expenditure for the poor, plunging them into indebtedness and deeper poverty.

WHO estimates that worldwide 180 million people suffer financial catastrophe every year because of user fees for health care and because of these fees, some 105 million people are impoverished.

Stephen Matlin, Executive Director of the Global Forum for Health Research, said that many countries fail to provide universal access and free services, and the limited resources that are spent on health are not well targeted. "A relatively large proportion of the public resources benefit the better-off rather than the poor in society," Matlin told the *Bulletin*.

"The research challenge lies in how to redirect public resources to the poor," Matlin said. ■

Rupa Chinai, *Mumbai*

Rupa Chinai

Savita's five children outside their makeshift home in Bhim Nagar.

Fighting genital mutilation in Sierra Leone

Activists in West Africa say mass literacy campaigns and education are the best way to stop the harmful traditional practice of female genital mutilation in Sierra Leone.

Rugiatu Turay still remembers the pain she felt the day she and four of her sisters were sent to Freetown, Sierra Leone's capital, on the pretext of visiting their aunt.

"They used a crude penknife, it was so painful. I bled excessively for two days and fainted when I wanted to walk," Turay said, describing how at the age of 11 she was subjected to female genital mutilation.

Afterwards the scar itched and got infected. As a result she developed severe menstrual pains, blood clots and a cyst, she said.

When Turay heard her younger sisters were due to undergo genital mutilation too she tried, in vain, to intervene. The death of a cousin, who bled to death after being subjected to the practice, triggered her activism.

Today Turay leads the Amazonian Initiative Movement (AIM), one of several nongovernmental organizations that campaign in West Africa against the harmful traditional practice of female genital mutilation. She formed the group in 2002 with other women she met in refugee camps in Guinea during Sierra Leone's 1991–2001 civil war.

> "Educating people is empowering them. It is only through their minds that you can change the attitude of people,"
>
> *Rugiatu Turay, campaigner from Sierra Leone*

Turay is one of an estimated 100–140 million girls and women worldwide who have undergone female genital mutilation — the removal of all or part of the female external genitalia as part of traditional initiation rituals or marriage preparation customs. According to WHO, every year two million girls are at risk of being subjected to the practice which is sometimes referred to as female genital cutting or female circumcision.

Sierra Leone is one of 28 African countries where female genital mutilation is practised. It is also a custom in parts of the Middle East and Asia.

The procedure is usually performed by an elderly woman of the village who has been specially designated this task, by a village barber or by a traditional birth

Liliane Bitong

A group of women and children gathered in Lunsar in Sierra Leone to listen to anti-female genital mutilation campaigners urging practitioners to give up the practice. Campaigner Rugiatu Turay is the woman in light brown on the centre right of the picture.

attendant. But in some countries more affluent families seek the services of medical personnel to avoid the dangers of unskilled operations in unsanitary conditions. WHO has consistently condemned this medicalization of the harmful traditional practice as "wilful damage to healthy organs for non-therapeutic reasons."

In the past, studies have suggested that the practice of female genital mutilation can result in infertility, pregnancy and childbirth complications, and psychological problems through inability to experience sexual pleasure.

But in a study published in August this year in the *Lancet*, researchers made the strongest link yet between extreme forms of female genital mutilation and female infertility. Their findings provide the most compelling evidence to date that girls who have undergone genital mutilation in childhood could be at risk of infertility later in life.

The new findings have given activists like Turay a much-needed credibility boost.

"We want people to drop their knives; we want parents and girls to become more open about the practice; we want the victims to talk about the practice and to be ready to say 'no', so that the government knows women are ready for a change!" Turay said.

In Sierra Leone, female genital mutilation usually takes the form of a crudely performed operation to remove the clitoris — sometimes with razor blades, penknives and even with broken glass — as a key part of the initiation ceremonies that prepare girls for marriage and motherhood. UNICEF estimates that some 90% of Sierra Leonean women are subjected to genital mutilation.

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Rugiatu Turay, campaigner from Sierra Leone.

Turay and her fellow campaigners in Sierra Leone believe the best way to raise public awareness about the risks of female genital mutilation is to teach the women designated to perform the procedure to read and write — in Sierra Leone these are often illiterate older women — and provide them with an alternative source of income.

But convincing people that this ingrained tradition is wrong is an uphill struggle in a country emerging from a decade of civil war, where people long to return to traditional values and where 66% of the population is illiterate, she said.

Since AIM was founded in 2002, four activists have left after receiving death threats. Turay said that despite a powerful pro-genital mutilation lobby in Sierra Leone, the campaign is making progress.

"Educating people is empowering them. It is only through their minds that you can change the attitude of people," Turay said.

Turay and other AIM activists visit villages and talk to the women who earn a living from genital cutting to try to persuade them to give it up. "We have been able to get about 700 practitioners from 111 villages to drop the practice," she said.

AIM has received funding from donors in the United States to provide 40 of 700 women who perform genital mutilation with alternative employment, but Turay said she did not know how her group would help the remaining 660.

AIM would like to set up a skills training centre to teach the former genital mutilators and girls intent on escaping the practice to read and write, operate computers and make money from agriculture or tie-dying cloth.

Turay said there were other positive developments in Sierra Leone and that religious leaders there had started to oppose the harmful practice. "Two imams have made a public declaration to say that their daughters will never be initiated and other imams and pastors have started preaching about the practice in their prayer meetings," she said. ■

Liliane Bitong, *Freetown*

Can a new UN emergency fund help southern Africa?

The United Nations is set to overhaul its humanitarian response system, but will this be enough to tackle complex emergencies such as the evolving crisis in southern Africa?

A new Humanitarian Emergency Fund, which received initial pledges of US$ 175 million towards a US$ 500 million target at the Millennium Summit in September, is due to be operational by early next year, subject to final approval by the UN General Assembly.

The fund should speed up delivery of relief supplies in the event of natural disasters, like the tsunami, and allow for more timely interventions in crises such as those in Niger and the Darfur region of Sudan. But with its launch planned for next year, the fund may be in place too late to alleviate the situation in the southern African nations of Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe.

Under-Secretary General for Humanitarian Affairs Jan Egeland said he regretted that the fund was not already operational as this would have allowed the UN to jump-start its aid operations in southern Africa, where an estimated 12 million people face malnutrition.

The UN launched a flash appeal in August for US$ 88 million to provide food aid, seeds and fertilizers for the hardest-hit country, Malawi, where up to 5 million of the 12 million population are at risk following failure of the all-important maize crop. But responses trickled in too late to buy agricultural inputs for the October planting season, which would have reduced Malawi's dependency on emergency relief next year.

"Some win and some lose, and Malawi is now losing," Egeland said at

a recent press conference. "It drowned in the drama of so many other things," he said in reference to disasters, such as the hurricanes in the Americas.

With an average four-month time lag before aid pledges actually reach recipients, the World Food Programme (WFP) has warned of a race against time in raising funds to avert starvation. Villagers in worst affected areas have already started eating water lily roots, which lack nutritional value but are one of the few sources of food available.

> "My children have all suffered from diarrhoea as a result of eating the water lillies. But I have no choice but to dive for them because there's nothing else."
>
> *Dona Kijani, a mother in southern Malawi.*

"My children have all suffered from diarrhoea as a result of eating the water lilies. But I have no choice but to dive for them because there's nothing else [to eat]," said Dona Kijani, a mother of three young children in the village of Chigayeni in southern Malawi. Her husband died last year, leaving her to cope on her own.

Malawi's Ministry of Health in the capital Lilongwe was due to conduct a nutrition assessment in October in the most vulnerable regions of the country. But even before the latest crisis, some 48% of children aged under five were classed as stunted — an indication of long-term chronic malnutrition — and 5% suffered from wasting as a result of acute malnutrition.

More than 1000 acutely malnourished children were admitted to nutrition rehabilitation units (NRUs) in August, compared to 775 children in the same month last year.

The Saint Montfort NRU in the southern district of Chikwawa, for instance, admitted 23 children in August, a rise of 130% over during the same period in 2004. Nursing officer Gertrude Mkwapu said admissions rose further in September and were expected to climb in the looming "lean season" ahead of harvest next March.

Malawi's high rate of HIV infections — an estimated 14.2% of adults aged 15 to 49 live with the virus — has intensified the crisis. Mkwapu said almost half the acutely malnourished children in her wards were HIV positive. She and other health professionals said that complications due to malaria were likely to surge in the November rainy season.

The village of Napasha in southern Malawi provided a snapshot of the crisis. Around 48 of the 400 households contained AIDS orphans dependent on humanitarian aid and a further eight households had chronically sick people. Local government officials said the pandemic was depriving Malawi's rural community of the necessary manpower to tend the fields, which were in any case barren because of the drought.

Some people living in Napasha were in despair. Monica Kasitomu said she had to look after her three grandchildren since their mother and father died last year and was totally dependent on WFP distributions of maize and oil handed out to the most vulnerable families in the village.

"I'm getting older and older and soon I won't be able to take care of them," she fretted. "There's not enough food and there's no money to buy clothes so they can go to school."

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> *UN Under-Secretary General for Humanitarian Affairs Jan Egeland.*

Dr Emilienne Anikpo, Senior Adviser for WHO's Department of Health Action in Crises, said the "triple threat" of the deteriorating HIV/AIDS situation, food insecurity and the eroding institutional capacity to deliver basic social services in Malawi and neighbouring countries — partly because of the lack of human resources — was reversing southern Africa's development gains and leaving it more vulnerable to disasters.

After the severe drought of 1992, short-term humanitarian interventions helped the region back onto the road of development. In comparison, after the large-scale interventions in 2002, some 5 million people remained extremely vulnerable and unable to provide their own food needs. The current drought can only increase this vulnerability, warned Anikpo. "There is a need for a combination of short-term response and long-term prevention measures," Anikpo said.

AP Photo/O. Zilwa

A 14-month-old with HIV/AIDS being fed by his grandmother at the Saint Montfort feeding centre in Nchalo, Malawi. About half the children admitted to the intensive feeding ward are HIV positive, complicating efforts to treat their malnutrition.

The proposed UN humanitarian emergency fund should at least smooth the way for short-term response by allowing for a greater degree of predictability. It is intended to replace the existing Central Emergency Response Fund, whose loan facility of US$ 50 million, was shown to be woefully inadequate to cope with the urgent demands of the Asian tsunami of December 2004 and a crisis like the one in Darfur in Sudan.

Although details are still to be finalized, Egeland said most of the fund would be in the form of grants which could be released within three to four days of a request. ■

Clare Nullis Kapp, *Lilongwe*