Dealing with disease: evaluating global and local responses in the developing world.

Bristol GA October 2017

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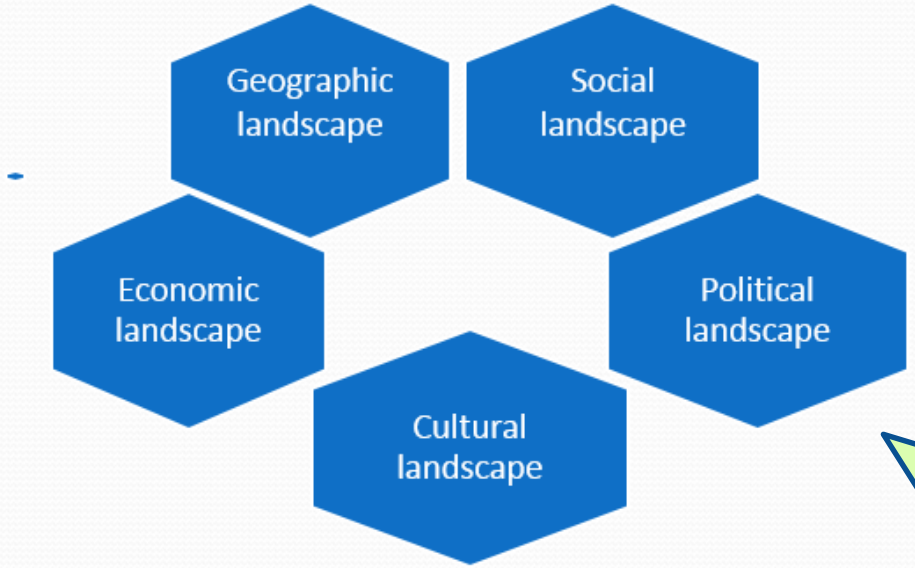
Opportunity to explore health issues in the developing world.

- Role of global and local players in delivering health
- Assess effectiveness of top down and bottom up strategies
- Think in particular about the role of women in delivering health care

- Illustrate some of these issues with reference to the 2014-15 Ebola crisis in West Africa and Jiggers in Kenya

An overview of the geography of health: a therapeutic landscape

Brings together and integrates all aspects of health to help us understand how health service equality, delivery and effectiveness can lead to progress.



Holistic approach

Synoptic – links between people and environment, people and policies, global and local, top down and bottom up etc

Key players in delivering health

Global

- WHO
- World Bank
- UN
- GAVI
- Global Fund
- Development banks
- Philanthropists
- INGOs

National

- Government Ministry of Health

Local

- Community leaders
- Health professionals
- Local NGOs
- Teachers
- Women

What can global players contribute?

- WHO – advocacy, policy advice. Eg International Health Initiatives in 2005 - tools for surveillance of disease. Aim to protect spread of disease – but no support given to poor countries to implement.

  + recent challenges to its mandate.

- World Bank , Global Fund, GAVI, Gates, + MSF, Mercy Corps, Save the Children, UNICEF etc – contribute more money and more action. Galvanise global response.

BUT

- Challenge = coordination of multiple agencies, each with their own priorities & purpose.
- Delayed response
- Sometimes lack of local knowledge

What role for local players?

- Understanding of local situations
- Have confidence and trust of local people
- Immediate response

BUT

- Ignorance
- Embedded cultural attitudes and practices, especially for women

- Women often marginalised, ‘conspicuously invisible’

A word about women …….

- Women underpin health systems in the developing world
- Dominate reproduction, care-giving, running of households
- Major contributors to local economy – informal work, traders, farmers. Vital for food security.

… a gendered perspective…

BUT

- Women are rarely visible among global players in health.
- Lack of value placed on what women contribute to home, income generation, even reproduction
- Global health policies rarely explicitly recognise role of women
- Concerns reduced to maternal health and family planning
- Women are ‘conspicuously invisible’

Harman, S, 2016

The few Women leaders in health….

WHO D-G
Margaret Chan

MSF President
Joanne Lui

Melinda Gates
has high profile

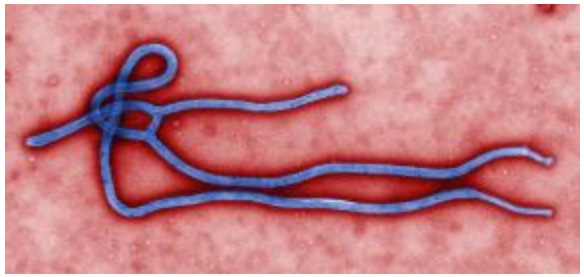
… a gendered perspective e.g. World Bank

- WB strategy focuses on improving maternal health *so that* women can participate in development
- Women have a role in delivering development
- Women's health is not an end in itself but *a means to enable* them to fulfil their expected role as care givers

- Women NOT seen as key players in informal care economy, although at high risk as 1st responders to disease

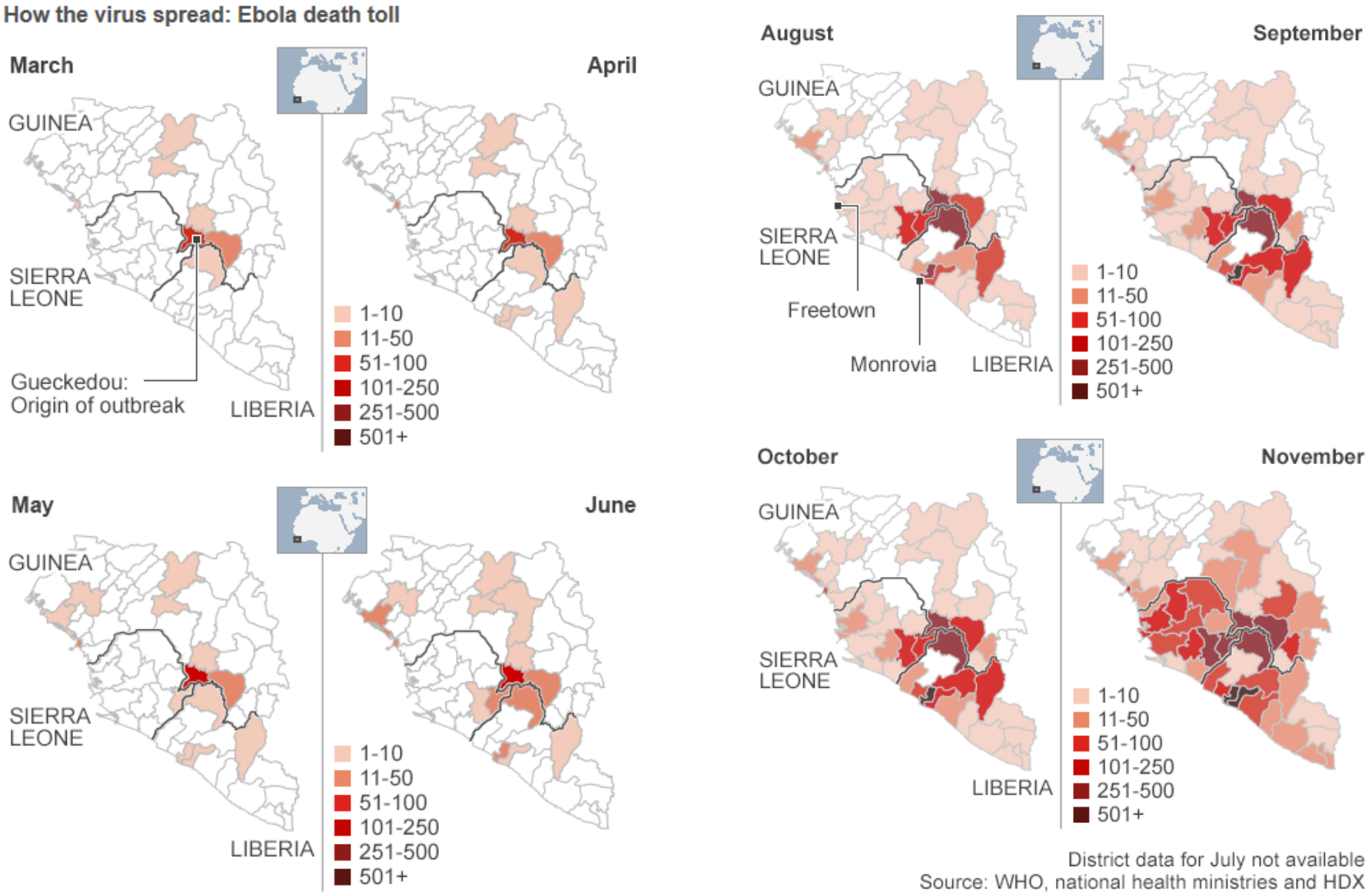
Examples of diseases with global/national and grassroots responses

1. Ebola



2. Jiggers

Ebola: 2014


How the virus spread: Ebola death toll
March
April
May
June
August
September
October
November
GUINEA
SIERRA LEONE
LIBERIA
Gueckedou: Origin of outbreak
Freetown
Monrovia
1-10
11-50
51-100
101-250
251-500
501+
District data for July not available
Source: WHO, national health ministries and HDX

Ebola – global response

- MSF flagged up 1st cases in Dec 2013 but ignored by WHO.
- March 2014 - WHO gave advice about Ebola. But its priorities were NCDs (non-communicable diseases) because that's what donors wanted.
  - Later WHO was heavily criticised for lack of foresight. Poor emergency response.
- Ebola treated as public health emergency rather than a humanitarian crisis. National governments couldn't cope.

- September 2014 – UN used its leverage for huge international campaign. World Bank gave US$1bill….
  - UN Global Ebola Response Coalition GERC
  - UNMEER – UN Mission for Ebola Emergency Response 19 Sept 2014 – 31 July 2015

Ebola – global response

- March 2015 'Get-to-Zero ' campaign
  - Vaccination – ring vaccination, herd immunity. GAVI gave $5mill to fast track and stockpile vaccine devel from Merck

- July 2015 UNDP conference on rebuilding and recovery. (+ EU, World Bank, AfDB, African Union)
  - Aim – to ensure that recovery efforts built better and greater resilience

Ebola – global response

UNMEER GLOBAL EBOLA RESPONSE

In the end: Too many players / hugely complex

UNITED NATIONS

smac

MEDECINS SANS FRONTIERES

Save the Children

Caritas Makeni

Gavi The Vaccine Alliance

WFP World Food Programme wfp.org

USAID

UKaid from the Department for International Development

Vehicle donated by UNICEF using DfID funding

Fuel paid for via Caritas, funded by CAFOD, funded by World Vision funded by DfID

Food for driver provided by GOAL as part of ERC funded by DfID

Driver paid by MoHS
Risk pay paid for by World Bank or DfID

Vehicle serviced by local mechanics paid for by World Vision

Ebola – role of global players

√ scale

expertise

mobilisation

advocacy for funding

logistics / capacity of military

X Response time –

personnel, plan, develop strategy.

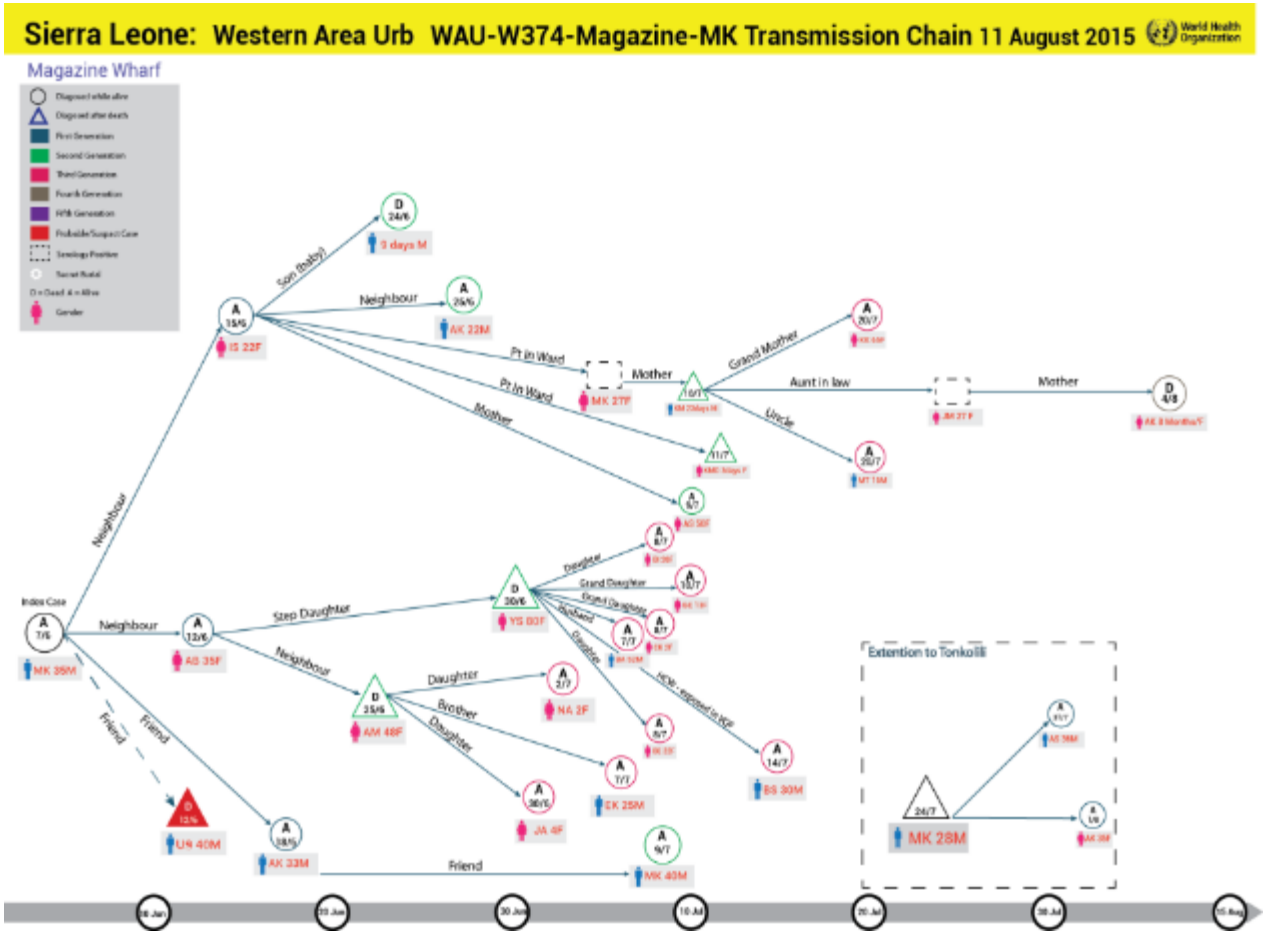
Motives? Self protection?

Ebola – community response

- Sierra Leone, Liberia, Guinea were unprepared to respond to crisis.
- Infrastructure problems – mapping epidemic was difficult because stigma in communities. E.g. deaths hidden, bodies buried without reporting.
- Govs set up *cordons sanitaires.*

Ebola – community respopnse

- Importance of family links
- Cultural activities associated with burial
- Families refused to obey new by-laws



Ebola in the community

- Critical influence of local leaders to lead prevention message
- Fear /mistrust of national gov, foreigners who arrived with layers of protective gear, and who took loved ones away.
- Problem of closing porous borders. Needed community support to be effective.
- Importance of collaboration between global, national and local organisations.

Local responses to Ebola

- Sierra Leone – NGO *Focus 100* used public address system, Facebook & Twitter to mobilise messages from religious leaders.
- Liberia – NGO *People Empowerment Programme* worked with Scout Movement – sensitisation campaign, street plays to highlight safe practices.
- Local responses - check points, road blocks,
- Financial support from diaspora

Local responses to Ebola: part of 'Get to zero' campaign

Collaboration was critical

- National campaign supported by UN. Required local action – in Liberia run by Mercy Corps.
- Month long social mobilisation to get grassroots support
- 3-day sit-at-home exercise to stop people interacting.

Health messages:

✓ Safe burials
✓ Report the sick
✓ Clean toilets
✓ Wash hands
✓ Call 11 for ambulance for sick people

Ebola and women = adverse impacts

Women are key players in health care and combating disease, but also especially vulnerable:

- More women work as nurses, cleaners, laundry workers in hospitals & clinics.
- Women assist in childbirth therefore very exposed to Ebola. Became unwilling to care for pregnant women.
- Pregnant women turned away from clinics – fear of contamination. Turned to unsafe traditional birth attendants instead.
- Mothers passed infection on to new-borns.
- Increased sexual exploitation & violence against girls displaced by Ebola.

Ebola and women – wider impacts

- Economic losses – self employed, cross border trade stopped, restricted movement.
- Microfinance firms substantially reduced their lending – women affected most
- Fall in income - women vulnerable to disease and hunger.
- Farming – new crops not planted. Future food security?
- Schools closed therefore gender gaps in education.
- Women took responsibility for orphaned children.

In conclusion

- Global players and their policies, strategies, decisions were fundamental in combatting Ebola, despite challenges of coordination
- But ineffective without cooperation at grassroots level

Jiggers

- Not on global health agenda
- Lack of engagement by global organisations despite debilitating effects….

- *NB distressing images……*

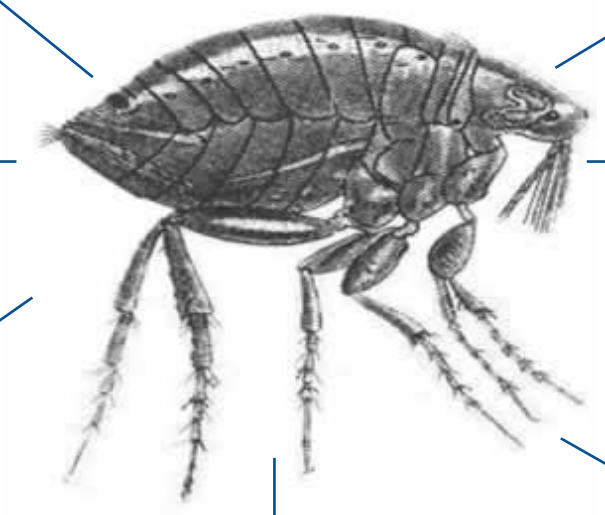
What are Jiggers?

Arrived in Africa from South America via sand ships in the 19th century

Found in dry soils and poor hygienic conditions

The jigger flea penetrates the skin and feasts on blood

Jiggers are small sand fleas (1mm)



Once the female flea embeds into the skin, it produces hundreds of eggs over two to three weeks inside the skin

Eggs drop off the skin and hatch in dry dust and earth, increasing infestation in the environment

The penetration of the flea can leave severe ulceration and inflammation, gangrene…

Throughout this process the abdomen of the female jigger flea increases up to 1cm in size

Treatment

- Cut off the thickest pus
- Clean with soap and water and hydrogen peroxide
- Vasoline
- Dodo dust

Impacts of jiggers

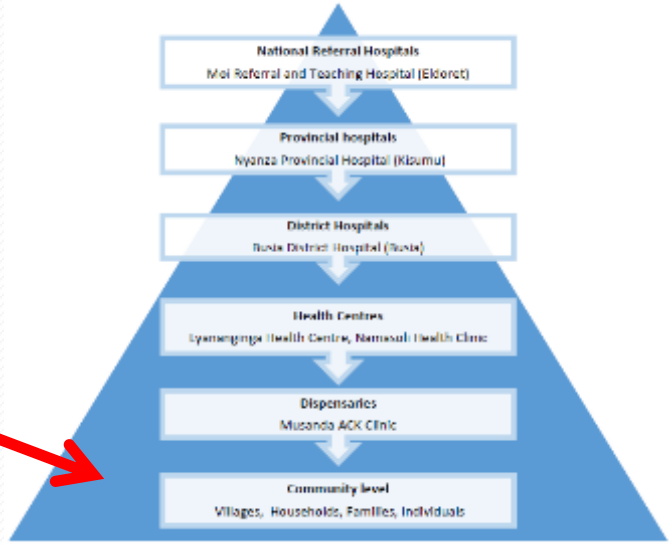
- Physical discomfort leading to hindered mobility
- Economically inactive
- Weaker immune system
- Secondary infection (Tetanus, gangrene, fibrosis)
- Marginalisation and stigmatisation (such as Witchcraft)

Consequences:

- Poor or no education
- Discrimination
- Psychological impacts

In Kenya

- There is an established provision of health facilities..



BUT

- An estimated 1.4 million people infected with Jiggers
- Neglected health problem
- Affects mostly rural areas
- Has to compete with other diseases (HIV/AIDS, TB, Malaria, etc.)

An example:

- Family of 6 severely infected. Had treatment 3x day for 3 weeks.
- Home fumigated with Dodo dust + instructions on how to keep home clean. Cost: 5000KSHS £35.50.
- Family failed to keep to treatment regime.
- CHW did not have time to continually help the family.
- Home became slightly cleaner & more hygienic.
- None of patients were cleared of jiggers
- Unclear whether prescribed drugs were given to family or passed on to others in village.
- Continued treatment depends on finance and attitude of family.

Responses:

- 2 million sufferers. 10 million at risk.

Grassroots :

- Work done by small NGO Ahadi Trust . Grassroots in clinics, community education. Very limited funding. Small scale therefore limited impact.

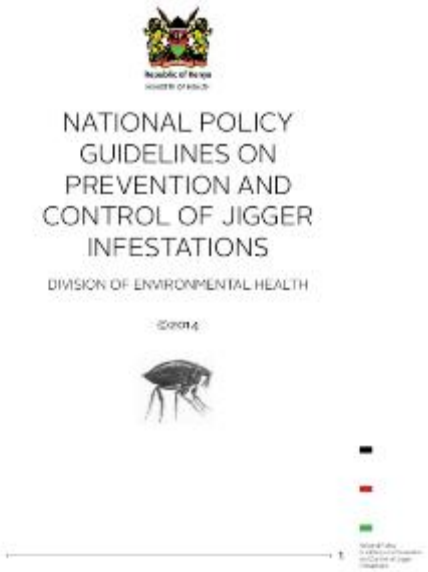
Critical role of Advocacy.

- 2011 Beauty Queens from Kenya, Botswana & Venezuela + Miss World (US) visited Mathira & Nyeri districts - worked with Jiggers volunteers to raise awareness.

  Children were given shoes.

National

- Eventually Kenyan government agreed to national campaign in 2015 to educate and eradicate jiggers in collaboration with Ahadi Trust.
  - National Jiggers day March 3.
  - Campaign directed towards healing in clinics & educating women to clean their houses.



Challenges:

- Effective medical treatment
- Hygiene education.
- Following up treatment.
- Attitude towards treatment.

- Slow and limited progress because limited gov funding and no global initiatives
- Fighting poverty is more a priority for women
- Ultimately, poverty reduction will lead to reduction in jiggers.

- Treatment is only ever going to eradicate *if there is progress in other areas of development.*

Good news story

- Since 2011 a Women to Women group in Kasese have become educated about Jiggers. (Group established by AICD Allied Initiative for Community Development)
- Fought against cultural norms and stigma
  - e.g. men build the houses, and smear homes with mud and animal faeces. But they do not smear regularly.
  - Women do the health care.
- These women have taken over men's role in maintaining the house.
- Now act as role models

The solution is evident. Why so little progress?

There are clinics…but..

- Who is setting the healthcare agenda?
- Lack of political will / funding
- Poor strategy / Jigger infection underestimated
- Global donors - are not aware. Diseases like HIV/AIDS, malaria attract funding whereas Jiggers does not.

- Cultural issues - the root of the problem - are not being addressed
- Ignorance - families do not prioritise sweeping their houses.
- Occasional treatments at schools or dispensaries. Need to focus on regular treatments in homes and local villages.

Conclusions: global and local responses

Important to have global responses to help governments to address disease at local scale:-

- Improve local health facilities – transport, electricity, data reporting
- Advocate against & raise awareness of harmful traditional cultural practices. Strengthen local community education
- Collect gender disaggregated data
- Reduce gender gaps in education for girls & orphans
- Establish social protection safety net

Conclusions

Global and national top-down policies and responses are crucial

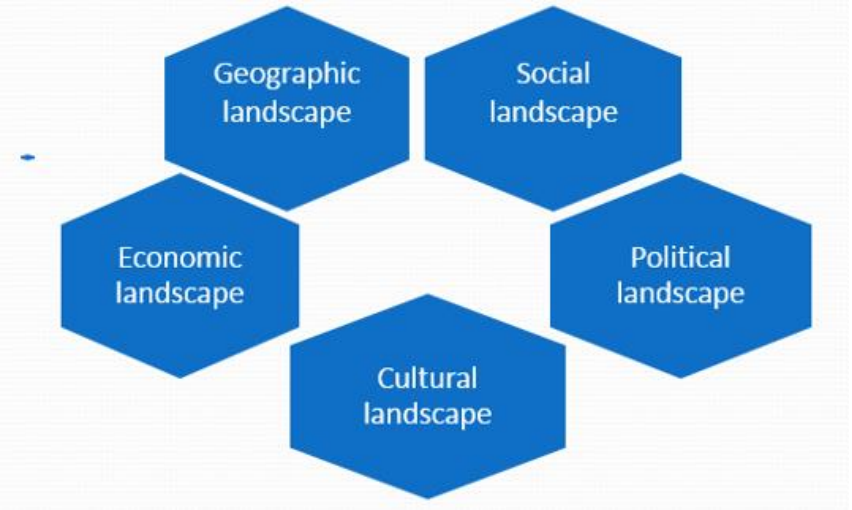
- to enabling coordinated approach to health
- to help make cultural change acceptable & overcome stigma

Grassroots action needed

- to empower people & communities to help themselves
- to overcome stigma, ignorance

Need to recognise role of women & include them in leadership & policy making

Therapeutic landscape



Dealing with disease needs

- Global *and* local action
- Effective global *and* local stakeholders
- Holistic response across the therapeutic landscape.

Whose responsibility is it for dealing with disease?
And where do you start?