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The effects of low human security on the health status of a struggling population. Do health indicators matter?

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LIST OF ABBREVIATIONS Internal displaced persons (IDPs), Médecins du Monde (MDM)

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One of the cover pictures of the current issue of the *Journal* draws attention to a paper by IM Izzeldin and EA Nagi[1] describing healthcare in Darfur, Sudan.

Two years ago I was a practising physician in Darfur working for the medical humanitarian organisation Médecins du Monde (MDM). We provided primary care services in a large camp for internal displaced persons (IDPs). Each day the effects of the work were visible in the clinic as the prevalence of malnutrition and diseases with outbreak potential decreased. The clinical and management skills transferred to local medical assistants promised some sustainability of services in an area ravaged by conflict. It was even possible to provide some outreach services in villages that were accessible to aid.

Unfortunately, the ethos of the clinic had to change. Increasing security concerns forced the organisation to leave the villages and eventually to abandon its presence in Darfur. Recently, in early 2008, the situation has not improved substantially. The cumulative excess mortality since the 'beginning' of the conflict in 2003 is subject to debate. It ranges from 130,000 to 400,000 deaths, depending on the source.[2,3] These data are difficult to interpret since there have been no significant mortality surveys since the summer of 2005. Moreover, this surveillance data does not cover health information from areas where no health services are currently offered to the IDPs in Darfur. The World Health Organisation monitors mortality and morbidity via its Early Warning and Alert Response System. As the humanitarian access to IDP settlements and camps throughout Darfur plummets, the target of 85% surveillance coverage has not been met.[4] Furthermore, the hybrid United Nations and African Union mission (UNAMIS) is facing serious difficulties in this enormous region,[5] with the result that the security of the population remains fragile and hence prone to a decline in health outcomes.

The impact of (emergency) healthcare in such a crisis is considerable, but should be seen in a larger context, where security improvement is paramount and indeed mandatory to stabilise mortality and morbidity. A study published in 2007 highlighted the association between recent conflict and higher rates of under-five mortality, malnutrition and maternal mortality.[6]

Even in an area without overt conflict, socioeconomic inequalities might leave groups impoverished and in low human security. (Human security is a term used within the UN framework[6a] that combines economic, food, health, environmental, personal, community and political security. It is a concept that comprehensively addresses both 'freedom from fear' and 'freedom from want'.)

This is the case with the Indonesian province of Papua and is illustrated by its disparity with the country's capital, Jakarta. In Jakarta 3·4% of the population is poor, while about half of Papua's population lives below the poverty line. In addition to low local human resource and geographical constraints, distrust between different parties hinders services in the villages. Availability of health data is limited. Médecins du Monde works in the remote highlands of Papua to strengthen primary healthcare and access to basic services. The native Papuan inhabitants are slowly being outnumbered by immigrants from the rest of Indonesia and face the same fate as the aboriginals in Australia, that of becoming a marginalised minority group. Demographic data indicates that Papuan indigenous groups comprised 96% of the population in 1971; this had fallen to 59% by 2005. Using the estimated growth rates for the Papuan and non-Papuan populations, 1·7% and 10·5% respectively, by 2011 the population will be 3·7 million, and Papuans will be a minority of 47·5%.[7]

Public health indicators, although incomplete, suggest that the general health of Papuans is poor. Malaria, upper

respiratory tract infections and dysentery are major causes of childhood morbidity, with infant mortality ranging from 70 to 200 per 1,000 live births a year. More than 50% of children under the age of five are undernourished, and immunisation rates are low. Maternal mortality is three times the rate of women in other parts of Indonesia.[8] A generalised HIV/AIDS epidemic is unfolding in the province. The cumulative AIDS case rate in Papua of 60·9 per 100,000 inhabitants is 15·4 times higher than the national average. Prevalence of HIV among ethnic Papuans is almost twice as high as the prevalence among non-ethnic Papuans – 2·8 percent compared with 1·5 percent.[9]

A health system is a reflection of its society. Healthcare is only one of the multiple variables that influence the health outcomes of a population. Mass displacement in Darfur and socioeconomic inequalities in Papua are among the main causes of ill health. Comprehensive primary healthcare is the basis for sustainable health services. This concept, described in the Alma Ata declaration in 1978, is currently being rehabilitated by the World Health Organisation as the key to qualitative long-term public health outcomes.[10] Comprehensive primary healthcare encourages communities to define their own strategies for improving health. It links healthcare with social and economic development. The possibility to strengthen healthcare while at the same time actively promoting human rights has been demonstrated by the US physician and anthropologist Paul Farmer, whose work in central Haiti is groundbreaking.[11] The combined epidemic of tuberculosis and HIV/AIDS in Haiti's impoverished rural population resembles the current outbreak in Papua. One of the differences is that Haiti is much more densely populated than Papua,[12] hence the spread of the epidemic in Papua is slower.

Health indicators are used as service monitors and provide data about the health status of a population. Colleagues argue that 'the international medical profession can play a part in bringing about change, e.g. by engaging with and supporting progressive Papuan health professionals in their efforts to improve services, establish training programs, and improve standards of care in the region. Furthermore, gathering more comprehensive data that focuses on the public-health results of conflict and socioeconomic neglect is essential.'[8]

My belief is that without durable peace and social equality, gains in health status already achieved can easily be lost. Health indicators can be used as an advocacy tool in the political arena to defend the right to health for all. This is the weapon health professionals should use worldwide to assist our cause.

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