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Short Communication

Special report: Silent disasters

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Abstract Disasters occur not only in war and conflict or after natural events, such as earthquakes or floods. In fact, the death of hundreds of thousands of children in Niger every year, often for treatable conditions, could just as well qualify as a disaster situation. A lack of funding for health care and health-care staff and user fee policies for health care in very poor or unstable settings challenge international agreements that make statements about the right to health and access to health care for all people. This paper argues that although sustainable development is important, today many are without essential health care and die in the silent disasters of hunger and poverty. In other words, the development of health care appears to be stalled for the sake of sustainability.

Key words access to health care, disaster, sustainability, the right to health.

Often when we think of a humanitarian crisis and the work in environments hit by disasters, it is the work after flooding and earthquakes or the care of people affected by conflicts and violence that comes to our mind. In this article, I would like to focus on other kinds of disasters, the silent ones that go on unnoticed, often year after year. Sometimes, like in Niger in 2005, they get some short-lived attention.

In 2005, I worked as a nurse for Medécins Sans Frontières in an emergency nutrition project on the border of the desert in Niger. My role was to open a nutrition center to treat children suffering from severe acute malnutrition.

This year, the "hunger gap" was worse than usual and among the smallest children there was an epidemic of acute malnutrition, with levels of acute malnutrition reaching 20% among the youngest children in some areas (UNICEF, 2005). During the first 8 months of 2005, food relief had been delayed with political and economic arguments. The government and international partners, such as countries in the European Union, as well as United Nations agencies, explained the food shortage as limited and maintained that relief assistance would risk disturbing the market and even be contraindicative to more long-term development goals (Medécins Sans Frontières, 2005a). Obviously, Medécins Sans Frontières' nutrition clinics would not solve the problem of poverty and other underlying causes of the food shortage. But, severe malnutrition is a deadly condition and for many of the > 60 000 children that were treated for severe acute malnutrition that year, it most likely meant the difference between life and death (Tecdonidis, 2006).

In our program, we also faced an epidemic of malaria and, during some weeks in October, more than half of the children admitted to the nutritional program also tested positive for malaria. The connection between disease and malnutrition became very obvious. Was it in fact so that the user fees for health care and the cost of medicines were obstacles that made care and treatment inaccessible for the poorest, a big part of the population in Niger?

Niger is one of the poorest countries in the world, with over two-thirds of the population living on < $US1 per day. As many as 40% of the children under five years of age suffer from chronic malnutrition. Nearly half of Niger's population lack access to health care. The child mortality rate is among the highest in the world, where one in four children will not live to see its fifth birthday. Most of the children die of conditions that are easy to treat or prevent, such as diarrhoea, respiratory tract infections, measles, and far too many due to acute malnutrition. The lifetime risk for a woman to die of complications from pregnancy or delivery is one in seven (UNICEF, 2007).

Of course, there are many factors that contribute to the high mortality rate among children under five years and pregnant women. In General comment No. 14 by the United Nations Committee on Economic, Social and Cultural Rights, the connection between health and access to food, decent living conditions, clean water, sanitation, education, and other factors is raised. At the same time, it is underlined how important it is that health care, vaccines, and essential medicines are accessible and acceptable for people. Therefore, it is crucial to secure access to health care for poor people regardless of their capacity to pay for their care (United Nations, Economic and Social Council, Committee on Economic, Social and Cultural Rights, 2000).

In 2006, in recognition of the high child and maternal mortality figures, the government of Niger passed a law that should make health care free for children under five, as well

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as for pregnant women (IRIN, 2006). The system still needs to be set up and financed, though.

This past spring, I went back to Niger, this time to the district of Dakoro, where Medécins Sans Frontières was setting up a project aimed at providing health care free-of-charge for children under five years and to pregnant women in line with the government's policy. We also were addressing the ever-present problem of malnutrition with a nutritional program for children suffering from acute malnutrition. I worked in this distant district at a health center in a village called Sabon Machi. Together with my colleagues from Niger, I started the activities in this center, initially focusing on child health care, and, in collaboration with World Vision, on nutrition. The small health center used to have ≈ 10 consultations per day. In our first 3 weeks, we saw > 1500 sick and/or malnourished children.

In the whole program, only a few weeks after opening the project, we were treating > 3000 children suffering from acute malnutrition, still with the "hunger gap" in front of us. This is the "normal" situation and, yet, there is nothing normal about it. How can the death of almost 200 000 children each year, year after year, in Niger be anything but a catastrophe? How can the grandmother's shudder, as a gesture of resignation, seem trivial, when she tells about her four daughters, where three have died in complicated pregnancies? She had brought her grand-daughter to us, a 15 day old baby, weighing a little over 1 kg.

People's right to life and right to health – and right to access basic health care – is established in human rights conventions ratified by most of the world's countries. For the rich countries, the donor countries, these conventions also establish a duty to help poor countries to live up to their responsibility (United Nations, 1966). Despite this responsibility, the same donor countries are supporting poverty reduction strategies that are keeping social costs at a very low level in many of the poorest countries. These strategies are owned and developed by poor countries with support and guidance from the International Monetary Fund and the World Bank. Some of the reasons for keeping the public spending at low levels are to avoid financial imbalance and indefinite aid dependence (IMF, 2005). The World Health Organization-initiated Commission on Macroeconomics and Health has estimated the minimum budget required in order to finance adequate levels of health care in poor countries to be $US35 per person per year (CMH, 2001). Still, government expenditure on health in many countries is very much lower. Actually, at least 29 countries in sub-Saharan Africa spend < $US10 per person per year on health (Ooms, 2006).

The financial development of a country is crucial. In a situation of deep poverty, development and poverty reduction are needed. However, when "sustainable development" of the health sector requires user fees that make health care inaccessible for many and keep the government's expenditure on health care at levels under $US10 per person per year, it seems that the development of health care actually is being stalled for the sake of sustainability.

Several times in my work with Medécins Sans Frontières, I have been part of the reopening of hospitals and health centers that have been looted and abandoned in the midst of war and fighting. These projects have been important and, in many ways, obvious. People affected by war and catastrophes have a right to humanitarian aid. Our work has aimed at sustaining health care until peace comes and development and reconstruction bring back the normal, everyday life. In far too many places, this does not seem to happen and normality seems far away, even when the war is over and peace has been in place for several years. The health indicators stay at disastrous levels and access to health care is limited in many ways. One important obstacle is the cost of care and treatment. In the Democratic Republic of Congo, a study in 2005 showed that the financial cost is a main barrier for access to health care and that there are areas where as many as 40% of people lack access to health care (Medécins Sans Frontières, 2005b). In Sierra Leone and Liberia, surveys show similar situations (Medécins Sans Frontières, 2007a).

Another disaster that might not be considered as forgotten or silent, but is still ignored, is the HIV/AIDS crisis. In countries with a high prevalence of HIV/AIDS, it is evident that despite access to medicines increasing as a result of lower prices, the lack of trained staff is still making treatment inaccessible. In a report published in May 2007, Medécins Sans Frontières sounded the alarm over the human resources crisis for health care across southern Africa. If we want to be serious about providing treatment to much higher numbers of people who live with HIV, nursing staff need to be given more responsibilities. The governments in the region also need to do much more to retain their nurses by addressing inadequate salaries and poor working conditions. Arguments of sustainability cannot be used for imposing limits on investment in health staff (Medécins Sans Frontières, 2007b).

When working as a nurse in a small health center in Sabon Machi, Niger, facing a silent disaster, it might be difficult to grasp the full picture or understand the arguments around aid dependence. In the middle of reality, I cannot help asking how it can be possible to sacrifice the life of these children in the name of sustainability or development?

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