Health at Warwick update

Local Voices, Global Health

The focus of this issue of *Update* is on global health research at the University of Warwick. The three fields of research profiled explore aspects of influencing health policy. Gillian Hundt, an anthropologist, Shaheen Ali, a lawyer and Maria Stuttaford, a geographer have all journeyed from different disciplinary backgrounds to contribute to global health research.

Health Sector Reform in North-West Frontier Province, Pakistan

One dark evening in November 1999, Shaheen Sardar Ali, Reader in the Department of Law at the University of Warwick was sitting with colleagues in her office at the University, preparing a grant proposal, when the phone rang. It was her daughter, who told her that the Chief Secretary of the North-West Frontier Province of Pakistan had been trying to contact her – 'and he says it's very urgent!'

Shaheen was mystified to know what was going on, just as she had been earlier in the week when her sister rang from Pakistan to ask whether she had done something wrong, because the intelligence agencies there had been asking questions about her. When, a few moments later, she spoke directly to the Chief Secretary, she discovered that she was being offered the position of Minister of Health in the Cabinet of the new military government that had recently seized control in Pakistan.

He wanted a quick decision, and making it was not easy. Although Shaheen's husband was serving in the government in Pakistan at the time, her youngest daughter had just started university in the UK. Shaheen says: 'It was also hugely problematic for me – a member of the human rights movement – because this government was not representative of the people, it was a military government that had taken power. Yet they had a reform agenda, and this was the first time in Pakistan that a government had given such a high profile to women.'

A rare opportunity to make a difference

In the end, she took the advice of her friends, who told her firmly that she had the opportunity to make a difference by being the

first woman to become a government minister in the North West Frontier Province. Her daughter also agreed to interrupt her university course and go with them to Peshawar.

Shaheen had been born and brought up in the North-West Frontier Province, a highly conservative and underdeveloped region of Pakistan that shares a border with Afghanistan. She came from a privileged background, receiving, she says, one of the best educations available in the country and rising to become

Shaheen Ali

probably the only female professor of law in Pakistan. But many of her compatriots are not so fortunate: according to the World Bank, the literacy rate of the North-West Frontier Province in 1995 was below 22 per cent. Standards of health care are similarly low, with the infant mortality rate for Pakistan as a whole standing at 84 deaths per 1000 live births in 2001.

The new government wanted to appoint ministers who were educated, professional people who could push through the reforms that were needed. Shaheen recognised that, because she was a woman, she could open doors that would have been shut to a man. She says: 'Pakistan is such a segregated society. It is just not done for men to saunter into people's homes or even talk to women they are not related to.'

Knocking on doors

To the consternation of the civil servants who surrounded her, Ali would take trips deep into the countryside, to villages that had never before been visited by any government minister. She

would visit the health facilities, encourage local health workers and would knock on doors to ask people about their doctors and where they received their medical care. 'Being able to talk to the women was such a huge advantage,' she says, 'particularly because so much health care begins with maternal health care and child health care.'

Shaheen quickly identified many of the causes of the malaise that seeped through the health services provided in the Province. One major gap was lack of monitoring and supervision of staff, she says, so that doctors and other health professionals tended to simply absent themselves from their work posts, leaving vast swathes of the Province without any health care at all. Related to this problem was the lack of an even-handed policy on postings and transfers.

One of her most important innovations, Shaheen says, was her introduction of merit-based postings, together with a system of interviewing applicants for each job. This replaced the existing system where people would be given jobs according to whom they knew and whom they could put pressure on. It also meant she made lots of enemies and lost friends. She says: 'It required me to be deaf, dumb and blind to any pressures that came upon me. I ended up alienating friends and family because if anyone asked me to get them a job, I had to say we would do it according to the rules: if someone deserves the job, he or she will get it.'

The private practice problem

This measure was unpopular with the most influential health workers, who could no longer push or bribe their way into the best jobs. But its unpopularity was as nothing compared to her assault on the working practices of the members of the medical profession. Shaheen realised that although the doctors and surgeons gained their basic status and reputation from their posts in state hospitals, they spent most of their time doing private practice.

She says: 'Their aim was to see as few patients on the state system as possible, and divert the rest to their private clinics, where they would see 60 to 80 patients a day and charge horrendous amounts. When these patients needed to be admitted, they would take them in to their state hospital beds, because there were very few private beds.'

This system neglected the interests of patients, who had to pay extra for private consultations, tests and diagnostic procedures, and who might in the end simply be admitted to the state hospital. Meanwhile, although the government had invested millions of rupees in equipping the state hospitals, these facilities were barely being used.

Shaheen's answer was to force the consultants to sign new contracts that meant they would work solely in the state sector. There was frantic resistance to the idea. Shaheen says: 'The biggest problem was that these consultants were hiding their income from tax. If you have 80 patients a day, and multiply that by a fee, you get a horrendous amount, but on paper each of them is seeing only perhaps six patients a day.'

The consultants 'did their level best to bring about the collapse the health sector', Shaheen says. Many of them resigned.

Backing from the Governor

Her compromise was to enforce the new contracts for just one day a week. Six months after she left Pakistan, however, the Governor of the Province, who had recognised how this measure could rejuvenate the health service and provide better services to poorer patients, decided to make the new system compulsory on a full-time basis. The result was the generation of a huge amount of income by the state sector, and the highest tax returns from health professionals that the country had ever seen.

Shaheen has described some of her experiences as Minister of Health in the North-West Frontier Province in the electronic law journal, *Law, Social Justice and Global Development*[1,2,3]. She could have stayed in her position for three years, but decided to return to the UK after only two. A major reason for her decision was the need for her daughter to continue her university education in the UK.

A year later, following elections, a new government came to power in Pakistan, and reversed many of the policies that had been put in place. Shaheen says: 'I do feel upset that all this work has gone down the drain, but at least the seeds have been sown of a lot of initiatives that people can pick up whenever the time is right. People can see now that there are alternatives that they can struggle for.'

Nor are the male civil servants, who used to blush and fidget uncomfortably when the Minister of Health, of all people, used to talk to women on the postnatal ward about breastfeeding her own children, or when she insisted on inspecting the lavatories wherever she went, likely to forget Minister Shaheen Sardar Ali in a hurry.

References

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Enacting local voices

If a researcher working in one of the less developed countries has no Internet access, she might never know that an international funding body is offering grants to support the kind of research she does.

If she has no email, she may not receive notification of the important conference that would allow her to meet others who are investigating similar topics in other countries. She may not, of course, have any funds to allow her to attend that conference.

The late El Hajja Wadfa Abu Aysha, with whom G.H. lived in the '70s doing field-work amongst Palestinian Bedouin in The Negev, Israel.
Photo: K. O. Hundt

If she comes from a society where there is no tradition of asking and listening to what users think about their experiences of health service provision, then her research findings may never see the light of day – which will make it easier for local policy makers in her country to ignore them.

These are just some of the reasons why the management of international research collaborations is so important, says Gillian Lewando-Hundt, Professor of Social Sciences in Health at the University of Warwick, and Director of the University's Institute of Health. A recent report from the Nuffield Council for Bioethics on the *Ethics of Health Research in Developing Countries* (2002) has highlighted reasons why such collaborations must be approached sensitively.

Gillian's experiences have taught her the importance of conducting research in partnerships that allow the institutions and individuals concerned to build up their own research capacity. She says: 'For many researchers in other countries, particularly in developing countries, it is an uneven playing field. Even getting the information about the call for research can be difficult, although with the Internet it is getting easier. One research centre I worked with initially, prior to obtaining funding, had just one laptop, no staffing, no bank account, and no email, even though it was a World Health Organization Collaboration Centre.'

Yet, she adds, the participation of collaborative partners is often vital. 'They often have the local knowledge and expertise that you don't have,' she says.

Even once a collaborative project has been funded and is under way, numerous difficulties can remain. Gillian advises that it may be necessary to make regular trips to visit collaborating centres, to train the team and support the process of data collection, analysis and dissemination. She says: 'It is really important to disseminate results to local policy makers, and to the community – not just to academics. We have taken our time on projects in order to develop interventions in partnership with local providers and policy makers.'

She emphasises that a clear publication policy is vital, to ensure that all research participants benefit from the findings. Sometimes, Gillian has extended a study by a whole year in order to complete the local dissemination, writing up and publication process in such a way that all parties are happy.

Her account of some of the sensitive issues that can occur during the final stages of a collaborative project appears in *Social Policy & Administration*[1].

Gillian describes her own research as having two themes. She aims to elicit local voices; and she strives to engender change based on those views – which are often the views of marginalized groups.

Much of her work has been carried out in the Middle East among Negev Bedouin, who are Palestinian Israelis, and among Palestinians living in the Gaza strip in the Palestinian Autonomous Territories. She has also participated in other research projects and networks involving additional countries in the region.

In terms of bringing about change in the light of research findings, several locally led model interventions were developed during the 1990s, following research funded by the European Community, with the aim of improving health care provision. An irregular supply of drugs in Ministry of Health primary care clinics in Gaza[2] was addressed by setting up area depots that would supply primary care clinics directly. There was also an absence of postnatal care[3], which was addressed in Gaza by providing post-natal checkups for women at clinics when they brought their babies for BCG vaccinations within a month of delivery – although a recommendation for 40-day check-ups in the Negev was not taken up. In Gaza City, a lack of accurate recording of birth weights on birth certificates[4] was addressed by training the scribes and clerks.

Gillian is currently disseminating findings from a regional study on how Palestinian young people cope with prolonged conflict[5,6], and on the health needs of female heroin users in Kenya. She says: 'The aim of my work is to focus clearly on eliciting the voices of both marginalised groups and collaborative research partners, in order to engender systemic change in policy and practice'.

References

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Health and housing in South Africa

Organising a supply of clean water and a means of disposing of sewage and refuse in a country where everyone, according to that country's Bill of Rights, has the right to such services is not a simple matter.

Especially in a country in transition, such as South Africa, as Maria Stuttaford, Research Fellow in the Institute of Health at the University of Warwick, discovered. Her research for her Ph.D. thesis[1] examined what factors influence how and whether local community organisations get involved in sanitation provision. It led to her asking questions about rights and responsibilities to health.

Maria says: 'South Africa has a forward-thinking Bill of Rights, which says that people have the right to a healthy living environment. I wanted to know, if people have that right, who is responsible for it? If there is a shared responsibility for delivering health, who are those people who share that responsibility, and how is that right upheld in a context where there is shared responsibility?'

Capetown, South Africa. Homes self-built by a housing federation.

This not being her main research question, the evidence she gathered during her study, reported in *Social Science & Medicine*[2], tended to inform these questions rather than answering them, she says. Nevertheless, she gathered some illuminating examples of how and why people's constitutional rights may be difficult to translate into practice.

For this research, Maria used a four-dimensional framework of governance to explore the provision of environmental health services. Governance is the pattern of interaction between civil society and government, and Maria explains that it can be considered in terms of four dimensions: political, institutional, technical and cultural. Each one of the four dimensions is present at many different levels – at community level, at local government level, at provincial government level, at national government level, and so on.

Some examples will help to explain this concept. Considering the political dimension, it may be clear that, at a national level, there is the political will to provide people with healthy housing. At the local level, however, the local government might be dominated by white, conservative people, and have a history of wanting to remove the community without services, so that they would not be interested in debating how housing should be provided.

The cultural dimension, by contrast, explores the impact of people's interests and beliefs. For example, council officers had complained that, in one community, although they had provided a skip for people's garbage, the garbage was always left next to the skip, not in it. Maria discovered that this was because it was the children's job to take the rubbish to the skip, and they were not tall enough to put the rubbish in it. She suggested that perhaps the council should build some steps next to the skip so that the children could throw the rubbish in. But she also points out that, in a previously white area, it would be unthinkable for people to have to do this; they would expect a garbage truck to come round and collect their rubbish from the back door.

In her paper, Maria examines the need to distinguish between community and individual rights, and the extent to which there is a shared interest in community rights. She says: 'It's not always useful in terms of public health to talk about individuals. It's sometimes much more useful to talk about communities. For example, when you are trying to decide what form of sanitation to put in, not every individual can have the sort of sanitation that they want, because everyone has to have the same.'

There is another side to this coin, she warns. 'We must not ignore the rights of the individual either. Often the voices that you hear in the community are those of the most powerful or the most outspoken, and not those of the most vulnerable. It is important to strike a balance between the voice of the community and the voices of individuals.'

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