BHEW

Equity Dialogue

CENTRE FOR HEALTH AND POPULATION RESEARCH

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Table of Contents

QUOTATION

As long as there is life in me, I shall continue to remove the filth around with all my strength, and make this world liveable for the child- this is my firm commitment to the new-born.
Sukanto Bhattacharya, Bengali Poet

KNOWLEDGE BASE

Verbal Autopsy

In developing countries, where most deaths are neither attended by doctors nor medically certified, information on causes of death is usually incomplete and of poor quality. To alleviate the problem in resource poor countries, an indirect method called verbal autopsy (VA), which makes use of lay reporters, has been adopted to identify causes of death. It uses information on the circumstances leading to death, symptoms and signs during the terminal illness, obtained from the family of the deceased, to assign cause of death. VA data are generated through retrospective questioning in surveys or in demographic surveillance systems.The VA technique is based on the assumption that most causes of death have distinct symptom complexes that can be recognized, remembered and reported by lay respondents. It assumes that it is possible to classify deaths based on the reported information into useful categories of causes of death. The validity of VA is influenced by the type of illness leading to death, characteristics of the deceased person, and other factors related to the classification of causes of death, as well as the design and content of the questionnaire and field procedures.

Lulu K, Berhane Y: The use of simplified verbal autopsy in identifying causes of adult death in a predominantly rural population in Ethiopia. BMC Public Health 2005

Tokai at Kamalapur Railway Station, Dhaka

Photograph by: Jesmin Akter

Tokai- a name given to street children in Bangladesh symbolizing the conditions of extreme negligence and utmost deprivation in which they live. The name was coined by Rafiqun Nabi, a renowned cartoonist of Bangladesh who has made Tokai cartoons his trademark. The fate of a huge number of children in Bangladesh depends on the street. The street is their shelter and ultimate destination. Malnutrition, hazardous environments and hardship hinder their development in their growing age. They are manipulated into taking risks, hazardous work and political activity for obtaining food. Other basic needs like education, clothing, shelter, and medicine are a dream for them. These street children are engaged in different works of adult people i.e. rickshaw pulling, begging, prostitution, factory work, domestic work, etc.

The suffering stranger: Medical anthropology and international morality

Butt L.
Med Anthropol. 2002 Jan-Mar; 21(1): 1-24; discussion 25-33.

Abtract:
Addressing global inequities has come to define a domain of activist medical anthropology called social justice studies. In a recent flagship volume, Dying for Growth: Global Inequality and the Health of the Poor, contributors describe the effect of global economic trends and neoliberal policies on the destitute and disadvantaged. In their advocacy, they use the voices and stories of the poor to explain the impact of structural adjustments. This paper uses Dying for Growth as an example through which to comment on the wider scholarly trend of using the local to validate global claims. The term "suffering stranger" describes those iconic figures whose experiences are presented in truncated first-hand accounts of suffering in order to validate broader theoretical aims. I argue that the suffering stranger masks the real absence of the voices of the poor and their suffering on the world stage. There is no international public sphere within which these voices might be heard; rather, there is a set of claims about justice and human rights. These claims, however, are themselves rooted in cultural values and are inextricably woven into global capital. I argue that, in using the voices of suffering to further a theoretical agenda, social justice activists assume the existence of a public, international domain within which those voices might be heard and that, in so doing, they further integrate the poor into destructive economic systems. Alongside the work of documenting health inequities, a truly effective activism may require assessing and critiquing existing claims of international morality.

Forum 8 on Health Research for the Millenium Development Goals, Mexico City, November 16-20, 2004

The Global Forum for Health Research hosted the Forum 8 conference on Health Research for the Millenium Development Goals in Mexico City from 16-20, November 2004. The conference was attended by 900 participants from 450 institutions in 109 countries. The theme of the conference was health research to achieve the Millenium Development Goals and to help correct the 10/90 gap worldwide.

The topics deliberated upon included Poverty, the foundation of inequity: War and unrest, and the disabled; Knowledge and power: The question of political will, access to knowledge, and a grassroots perspective; Maternal and child health: Maternal morbidity-its interface with other diseases, child deaths, Integrated Management of Childhood Illnesses (IMCI)- a test of implementation; HIV/AIDS, malaria, TB: Malaria's toll- a child every 30 seconds, Tuberculosis- the "comeback disease", and other diseases; The changing patterns of the burden of disease: Cardiovascular diseases, diabetes, neglected diseases, and deaths on the road; and One goal to reach the others: Public-private partnerships, and research networks.

Health and living conditions of the street children of Dhaka City

Jesmin Akter, Fellow, Poverty and Health, ICDDR,B

UNICEF defines street children as, "those who are of the street and on the street." In this study, the term street children refers to those children of 5 to 14 years of age who earn their living on the city streets and stay there for most, or all, of the day. They may or may not have parents or legal guardians. For the purpose of the study, street children were categorized into four groups: children of 5-14 years of age who work on the streets the whole day and a) live on the streets without any family b) live on the streets with their family c) return to another family; and d) return to their own family.

The analysis presented here is based on the unpublished dissertation of the author titled "Street Children of Dhaka City: Origin Migration and Rehabilitation" conducted in 2002. In the study, 300 street children were randomly selected and interviewed from 15 places of Dhaka City for a questionnaire survey. Due to limitations of time, money and manpower the selected sample size was small. As the street children come from a similar socio-economic background the findings of the study, although the sample size is small, should have considerable value.

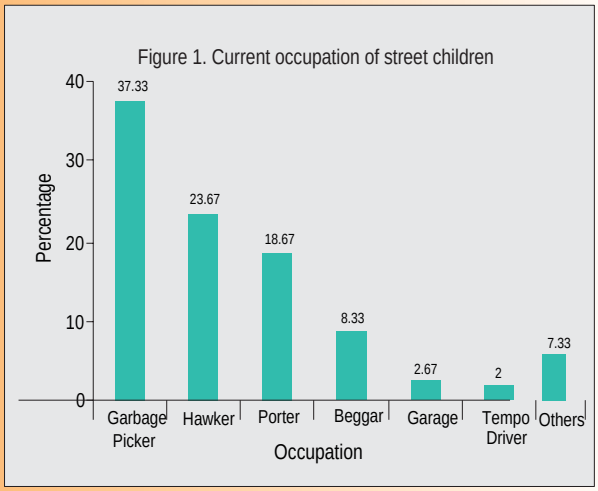
Of the 300 street children 84% were boys and 16% were girls. The median age for boys was 12 years and girls was 7 to 8 years. The younger age for girls was largely because of the sexual harassment that the adolescent girls usually face, which force them to work in other sectors. Most of the street children work in the informal sector and their working hours vary widely (Figure 1). An elucidating point worth noting is that most of the children report their working times to be from 'morning till night' and express the existing strenuous conditions. An important observation from the survey was that 91% of these street children who generally work for the whole day are virtually dependent on their income on a daily basis. Less than a third of the children are able to earn a poor sum of 20-30 taka per day. Almost all of their income is usually spent for food with little or no savings. A significant number of the respondents (65%) contribute towards the income of their family.

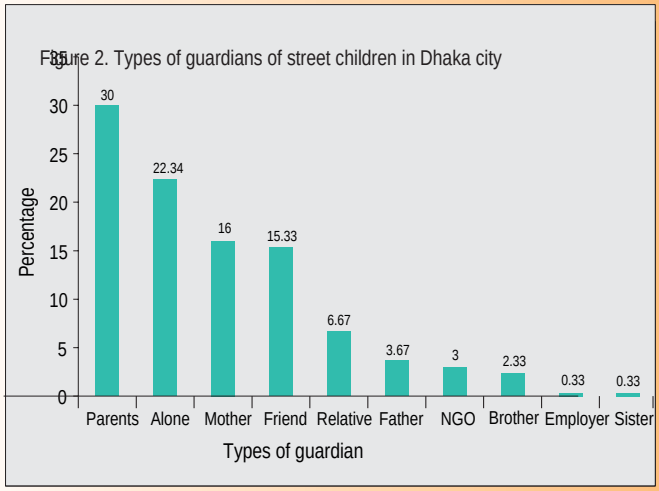
The reasons for becoming street children were mostly economic, half of which was described as poverty, and other reasons include familial hardships such as absence of an earning member in the family, death of a parent etc. A majority of the street children (30%) live with their parents in Dhaka City. However, poverty compels them to work long hours on the streets during the day and eventually return to their families at night. Figure 2 shows the types of guardians of the street children in Dhaka City.

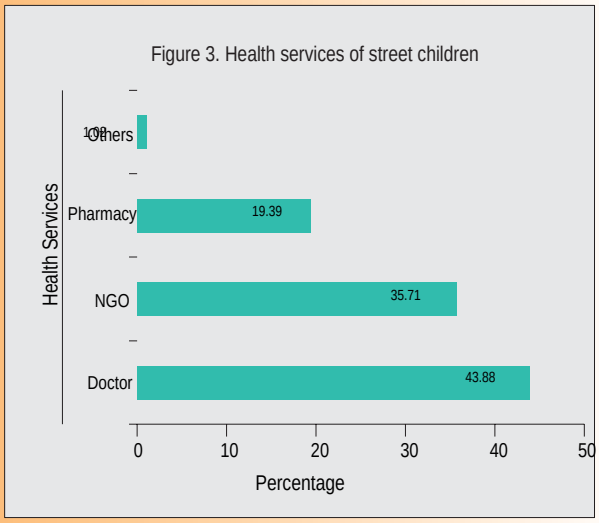
Street children are generally exposed to dangerous and unhealthy conditions and were reported to suffer from a variety of illnesses. Fever is the most common illness among the street children. The other prevalent illnesses included accident injury, jaundice, chicken pox, allergy, measles, asthma, and diarrhoea. About 99% of the respondents reported that they did fall ill seriously on one or more occasions. Among them three quarters sought health care services and a third did not. They were asked whether a medical professional was contacted for the illness and about half of them reported that they sought services from medical professionals (Figure 3).

In relation to places of slumber about three fourths of the children mentioned that they sleep in a station, slum, market area, footpath, stadium area, NGO, park, mosque and majar (shrine). The remaining stated that they sleep at home (Figure 4). The children who do sleep in homes and the slums live with either parents or other family. These children who sleep outdoors (station, market, footpath, NGO etc.) do so with other street children.

Lack of sanitation and hygiene is a major health hazard for street children. About half of them bathe in different public places. Use of public toilets was mentioned by a majority of the street children. A significant number of street children use open spaces for toilets and have to pay occasionally for some of these facilities, such as the market toilet (Table 1).







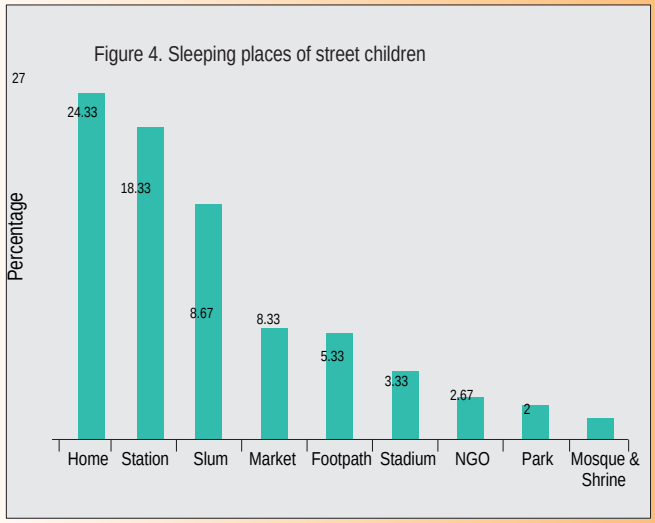


Table 1. Type of toilet used

Place	Number	%
Home	91	30.34
Railway Station Toilet	57	19.00
Market	53	17.67
Mosque	16	5.34
Train	16	5.34
Street	14	4.67
Park	11	3.67
Dhaka University Toilet	8	2.67
Others (wherever, rail line, parliament area, shop, bank of river, launch, shrine, stadium, NGO)	34	11.34
Total	300	100.00

NGOs working with street children appear to provide easy access. Around more than a third of the children get health services from NGOs, and a fifth of the children reported that the NGO officials take care of them during their illness. However when asked organizational assistance almost all (96.67%) said that they did not get any assistance from any governmental organization that work with street children and are thus unaware of their role and existence.

Case history: Rokon (age 12)

Kamalapur is a busy railway station in Dhaka. Rokon, a lean and thin boy of 12 years of age, works at this station as a 'Cooli' (a porter). His mother died when he was seven. Eventually, his father remarried. His stepmother had problems accepting him as a member of the family. Consequently, a childless family of the same village (Brahmanbaria) adopted him. However, unfortunately for him, when the couple were blessed with two children of their own, Rokon became a burden to them. Incidentally, his stepfather accused him of stealing rice one day. This hurt the boy a lot and he decided to go back to his father's house. However he was not able to stay there for long. He eventually came to Akhaura. He sold water and worked at a shop that sold lakree (firewood). Sometimes he used to sell phensidyl (an addictive drug) to customers. Eventually he moved on again and came to Dhaka. He has been living in Kamalapur railway station since then. He works from morning till night to earn about 50 to 60 taka per day. The small amount he earns is spent entirely on food and leaves him with no savings. He sleeps in the station with a friend of his. He bathes at the station and uses the public toilet. Once in a while for recreation he does manage to go to the movies.

Although Rokon's father is still alive he is still forced to live on the streets like a vagabond. He blames his stepmother for his ill fate. However he dreams of a better future. His dreams are to be able to study and become a doctor. He hopes that someday somebody would take responsibility of him so that he could spend his time studying. He realizes that his dreams of becoming a doctor is probably an impossibility. He knows that to survive on the streets he would have to work in the station. He believes that the only realistic dream that probably may come true is to be able to work hard and to save enough money to buy a taxi and become a taxi driver.

Linking cultural beliefs in Bhut/Jinn with healthcare-seeking behaviour

Authors: K. Prenger; S. Williams;
LAMB Project, PO Parbatipur, Dinajpur 5250, Bangladesh and
Monash University, Clayton Campus, Clayton, Victoria, Australia

Abstract:
Background: The formal Bangladesh healthcare system (government/NGO providers) has had much secularizing input the years which can down-play some significant cultural barriers to seeking care. This report highlights one area where strengthening one positive cultural belief may help overcome another more negative belief. Objective: Explore how family attribution of bhut/jinn/dushi as cause of death among children aged less than 5 years reveals a need for health staff to respectfully address these to improve infant care. Methodology: Verbal autopsies document family and health background, circumstances (in narrative) and biomedical causes (by questionnaire) of deaths of children aged less than 5 years. Verbal autopsies collected from October 2001 to February 2003) were analyzed for statements that bhut/jinn/dushi contributed to death. A sample of the population was surveyed in the LAMB Hospital and community clinics to determine belief prevalence and content. Focus-group discussions (FGDs) further explored whether a healthcare service provider could mitigate this influence. Results: Of 111 verbal autopsies analyzed, 48% of deaths were perinatal. Twelve (10.8 %) implicated bhut, 10 of 12 occurring within 1 month old, and 7 within one week. Outside treatment sought in 9 of 12 was predominantly of a traditional nature (7 homeopathic or kabiraji, 2 of 12 allopathic). High medical risk of newborns was consistent with the cultural belief of vulnerability to bhut at that age. FGDs demonstrated that a substantial proportion of people acknowledged the superiority of a Creator God (Allah/Isshor) over bhut/jinn and also uncovered a community-identified link between medicine (daowa) and prayer (dowa). Conclusion: Spiritual beliefs affect help-seeking behaviour of rural Bangladeshis. Attribution of death to bhut was linked to not accessing qualified healthcare, especially for newborns. Results suggest that emphasizing the link between medicine and prayer could help overcome barriers to newborns and their mothers accessing care during the critical perinatal period. Further investigation to develop culturally-relevant interventions with perceived spiritual benefits by health workers could reduce child mortality by utilizing rather than minimizing significant "superstitions of uneducated persons". Acknowledgements: The village health volunteers who entrust us with their knowledge of their own communities.

The Equity Dialogue is a joint initiative of the Bangladesh Health Equity Watch and the Poverty and Health Programme of ICDDR,B. Bangladesh Health Equity Watch is a collaborative initiative of four organizations that share a common concern for equitable health and development in Bangladesh. The organizations are the Bangladesh Bureau of Statistics (BBS), Bangladesh Institute of Development Studies (BIDS), BRAC and ICDDR,B. The Rockefeller Foundation currently funds the project. The goal of the Poverty and Health Programme of ICDDR,B is to generate relevant knowledge to improve the health of the poor to reduce poverty. The project is presently being funded by the Department for International

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BHEW Secretariat, Social and Behavioural Sciences Unit
ICDDR,B: Centre for Health and Population Research
Mohakhali, Dhaka 1212, Bangladesh
Telephone: (880-2) 8810021 Fax: (880-2) 8826050
Email: bhew@icddrb.org Website: http://www.icddrb.org

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