

Need for Reorganisation of Health Service

by A M Zakir Hussain

THE strategy and the avenue that we must traverse to reach 'Health For All', we all know, is the approach that is known as primary health care since 1978. The fundamental policy that guides the approaches of primary health care is also familiar and intellectually appealing. These approaches are: equitable distribution of health care service (which means equitable service to every recipient when she/he needs it), appropriate technology (which means technology which is locally suitable, i.e., usable and affordable), inter-sectoral cooperation (since health is not a unique and independent entity or commodity), of course the most important of all is community participation (so that in the face of the government's failure the beneficiaries themselves may organise for their health care, i.e., putting 'people's health in people's hands').

It has been felt that unless the potential beneficiaries, i.e., recipients of the health care delivery system are themselves interested in the system and its network, the goal will remain ever elusive. The government may create 'disease palaces' (hospitals) but the people may not be interested to use them because they may feel daunted culturally to go to a palace or their priority may not be a building but good, skilled staff or logistics. When there is clash of interests in the mind of the people, they will alienate themselves from such a facility and organisation.

Since primary health care exhorts the community to participate in the organization of its own health care delivery system, so people's willing participation and cooperation

in running the system at local levels — through their advice (about their needs), monitoring and evaluation (of the benefits that they are deriving), planning and programming (so that they may contribute their workforce — logistical and monetary support at least in the form of registration fee and the cost of medicine on a staggered rate as per capability of the recipient) etc — are implied.

The problem, however, is our health care providers are not open to welcoming the community representatives' poking nose into the executive

Because the governments are so poor and burdened with so many problems in these countries that they cannot provide by themselves 'Health For All' to all of their citizenry. In the same breath, at this stage, we must appreciate the fact that both unbridled privilege and unauthorised responsibility are dangerous and ridiculous. This philosophy should be equally applicable to the health care providers as well as to the public representatives.

If the burden of providing primary health care is shouldered by the community, then

not appreciate the approach of primary health care, the government must give more emphasis on this level of the health care delivery system.

For a newly conceived target, new strategies and policies are warranted. Fortunately although primary health care is a relatively new concept, the infrastructure that has been established in Bangladesh for providing health care to a people has corroborated well with the infrastructural facility that has been envisaged in the gamut of primary health care in a macro sense. At micro level, however, we need some

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ing and administration of the health care delivery system at local levels. Definitely there are some merits in the contention that health is a very technical issue which is beyond the level of understanding of our commoners. It is, however, partly true. In fact it is a question of attitudinal and behavioural accommodation. An intermediate point must be found out where the providers and the recipients must meet.

Since health has been declared as a right and not a privilege, the fact that the relationship between a provider and a receiver of health care is not that of a donor and mendicant must be borne in the mind of all concerned. An orientation to this effect is therefore sine qua non for the success of primary health care — the approach that must succeed in the developing world for ensuring at least a better state of health.

the government may provide secondary and tertiary health care more effectively and meaningfully. The government at no stage should completely abandon the responsibility of providing primary health care to its people. Conversely, if people take care of their secondary and tertiary health problems, government may devote more attention to primary health care. Sprouting and sprawling of private clinics is an indication of this approach. But to control the unscrupulous in this sector government cannot afford to abandon the tertiary and the secondary health care system in their entirety in the private sector. A happy blending therefore will be to share equally the responsibility of providing all levels of health care both by the private as well as the public sectors. One thing must be emphasised, however, since the public may

improvisation, structural adjustments and modifications. Discussion on the problems and meeting the need of health care provision will remain incomplete if they are ignored.

With a broad policy of primary health care that Bangladesh, as a signatory of the Alma Ata Conference of 1978, has adopted, comes some responsibility. It is true that primary health care approach may be adjusted to some extent to suit the situation of a country and a society but the four approaches mentioned above might not be compromised.

After a goal has been set, we now need the appropriate and the necessary logistics in adequate amount along with other inputs and resources, e.g., manpower and a suitable system wherein the actors may act with the help of provided

logistics within the limits of a certain set avenue to reach the goal. Let us ask ourselves the following questions in this regard.

Do we have appropriate logistics, adequate in quantity and quality [which also includes technology as well]? Do we have enough motivated, skilled and appropriate manpower in right places for functioning at right time in right direction? Manpower is a more important issue, for once a right man is found he may himself create, arrange or devise the appropriate logistics and technology and/or use them judiciously. If an appropriate hand has not been found then we have to create one first of all.

In conclusion let us all believe in and inculcate an attitude of support towards primary health care as a strategy to 'Health For All' and prepare ourselves towards working with the recipients of health care in unison through people's representatives for symbiotic benefit of the providers as well as the recipients. Mutual trust, respect and accommodative attitude on the part of both of the providers and recipients of health service are the pre-requisites for the success of the programme. It needs biaxial motivation and orientation which is a question of time. Tenacity in this respect is called for. Anything thrust through state machine without considering these facts will only give way to hiding of facts and creation of inaccessible mirages.

(The writer is a national consultant of WHO)

AIDS Campaign Targets Sex Trade

THE short, pixie-faced bar girl in Bangkok's Patpong red light district smiles proudly as she relates that she has spoken at international AIDS conferences in Britain, Germany, Canada and the Philippines.

"I went overseas with Empower," said the 23-year-old Noy, referring to one of Thailand's human rights groups helping prostitutes. "I went to AIDS conferences and talked with women working in bars, with government officials and many organisations working to stop AIDS."

Noy's bleak, often gritty testimony is direct from the front lines as Thailand continues to fight the deadly transmission — the brothels and nightclubs of Thailand's notorious sex industry.

Health experts say the Thai male's tendency to go to bars and brothels is the main factor in the virus' transmission throughout the country and across social classes. An estimated 450,000 men, both local and foreign, visit brothels every night throughout Thailand, generating four billion dollars a year for Thailand's sex industry.

There are an estimated 20,000 brothels and massage parlours in Thailand. A quarter of the country's estimated one million prostitutes is suspected of carrying the HIV virus.

Thailand has brought its AIDS awareness campaign into the centre of transmission — the brothels and bars of the country's notorious sex industry. Richard Ehrlich reports.

The condom is the enemy of these prostitutes because it prolongs ejaculation and wastes the prostitute's valuable time which she could be using to entertain more clients, said Noy.

The government will soon present in parliament a bill that would legalise prostitution in order to regulate the sex industry and make it easier for prostitutes to obtain medical care.

Authorities have discovered children and adults who have been kidnapped, threatened or tricked into becoming sex slaves by brothel owners and traffickers. Victims have included women and children from Burma, Laos, Cambodia and China.

The new law would allow only those prostitutes who are at least 18 years old and have passed a scheduled medical examination by a government-appointed doctor to legally sell sex for money. Sexually infected people and child prostitutes will be barred.

Critics say the law will simply create an underground market for prostitutes who don't qualify but who can still sell their services — with or without their consent.

Cosial activists and human rights groups are opposing the bill, which they say would curtail the rights of AIDS patients and prostitutes. They say that a bill that would mete out stiff penalties to traffickers in women and children as well as pimps and brothel owners would be difficult to enforce because of police involvement in the sex industry.

The bill calls for imprisonment of up to 15 years for people who force others into prostitution.



quired Immune Deficiency Syndrome (AIDS).

An estimated 570,000 Thais, or about one per cent of the population, are infected with the HIV virus which causes AIDS, though private organisations estimate the true number could be many times higher. Experts warn the number of HIV-infected people could grow to two to four million by the year 2000.

The Thai government has brought its AIDS awareness campaign to what is believed to be the centre of AIDS

Nutrition Fizzles as Mexico Bubbles up the Cola Ladder

by John Ross

AS the string of burrows climb the slender jungle trail and pad into the tiny squatter settlement of Nuevas Maravillas, audible cheers come from the thirsty crowd. Strapped to the backs of the straining beasts are cases of Coca Cola, Fanta and Orange Crush, beverages that gladden the hearts and each day, slake the thirsts of 70 million Mexicans.

Mexicans consume more soft drinks than any other developing nation. Indeed, they drink more pop — popularly known here as "refrescos" or just plain "checos" — than any people anywhere beyond the United States borders.

The soft drink industry here registered 7 trillion pesos in 1990 sales with consumption at 390 bottles a person — a little more than one a day.

The financial daily "El Financiero" reported recently that the industry is seeking to up per capita consumption to more than 400 by the year 2000.

In a land where disposables are still a relatively unpursued avenue of modernisation, Mexico's enormous thirst for "checos" is also a source of profitable enterprise for lords of industry and garbage pickers alike.

But refresco sales are not merely a matter of dollars and cents in some southern Mexican communities. Amongst certain Mayan cultures, the soft drink one guzzles can be an object of religious veneration.

In the Chiapas highland village of San Juan Chamula, for example, sodapop preference is a sort of cult among townspeople.

In a town fueled by a potent sugarcane alcohol called "Posh", what one mixes with one's liquor is fraught with religious and cultural significance.

Local "tushones" or chiefs, who control the religious and political institutions of Chamula, also control both the flow of the Posh and the soft drink franchises.

In his book "Chamulas in the World of the Sun," Gary Goasen explains that poor families ally themselves with certain tushones in clan-like relationships for protection, and are then obliged to use the tushone's choice of soft drink.

While there is some home-grown sodapop in Mexico, with lulling names like "Miranda" and "Jarritos" (Little Jars), it accounts for only one per cent of all sales. The rest is controlled by Coca Cola and Pepsi and their respective products.

In Mexico City, the world's largest soft drink market, where 18 million thirsty throats cry for relief day and night, Coke holds more than half the sales. In 1990, the company reports selling 263 eight-ounce servings to the average Mexican in one year. US citizens still reign the cola world, with 292 Coke products

consumed by each person every year.

But Pepsi is a newcomer in the Mexican market. Its 45 per cent share in the capital is far greater than in most of the developing world and PepsiCo is now flooding the nation with plastic, recyclable "family-sized" servings, touted as giving the consumer "greater savings and more quantity."

As on other fronts in the international cola war, the two US-based giants go head to head on television, but the advertising blitz is not without its critics. Two years ago, the National Consumers Institute blasted soft drink advertisers for pushing their products un-

der false pretenses.

In a report that analysed 31 soft drink commercials aired in the Mexico City area over an 18-month period, the Institute found that cola ads were directed exclusively at young people, featuring youthful actors, 62 per cent of whom had an "Anglo-Saxon" appearance.

The videos often spotlighted rock and roll, a music that, the Institute complained, promoted "rebelliousness." Both Coke and Pepsi commercials implied that drinking their products would bring young people love, happiness and health, according to the Consumers Institute.

Mexico's surging "checo" consumption has also been a frequent concern for the nation's nutritionists. In a country where 40 per cent of the population has no access to milk, a breakfast of a Coke and a "Ganso" (the equivalent of a Twinkie) is a diet that many poor people follow with gutwrenching frequency. But breakfast isn't the only time for Coke.

"Mexicans drink refrescos at all three meals," says National Polytechnical Institute researcher Sylvia Zarate, explaining that soda pop with its high sugar and caffeine contents, produces quick energy for poverty-stricken schoolchildren, day labourers and market women.

An annual survey conducted by the National Institute of Nutrition places soft drinks among the top 10 foods consumed in each of the institute's 19 survey regions. The study indicates that "checo" consumption is far ahead of meat and milk everywhere in the country — the disparity is greatest in the impoverished and highly Indian south.

Nonetheless, the Institute's Hector Borges does not consider soft drink consumption to be Mexico's most pressing nutritional problem. "In many places, refrescos are the only source of potable water," he says. "This is particularly true in tropical zones where people doing hard labour need to continually replace their liquid intake."

The reality is that soft drink sales often provide a necessary income for the working poor — Mexico's most nutritionally-needy sector — and gives them the wherewithal to put food on the family table.

Antonio Lopez does a brisk business in empties at his neighbourhood "deposito" in Mexico City's Historic Centre. Such deposits can be found every few blocks in the capital — readily discernable by the mountains of empty cases stacked up on adjacent sidewalks.

The empties trade is a good measure of the real value of the refresco: a case of empties brings 18,000 pesos, only 6,000 pesos less than a case of filled bottles.

The Lopez family is doing its best to hold up its end of per capita consumption. Almost hidden behind a wall of empties, teenager Edgar boasts that he drinks "about five checos a day" and one family-sized two-litre jug of Pepsi at "comida" — the big Mexican lunch.

Nonetheless, the newfangled, family-sized plastic containers trouble his father. These bottles are currently refundable but the price is very low and Antonio Lopez fears that the distributor with soon reclassify them as disposable, removing them from his stock of returns.

If this happens, says one industry observer, the returns business will drift down to the

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"pepinadores", the garbage pickers who sift through the city dumps, recycling whatever materials can be resold, no matter how low the price.

— Gemini News
About the Author: JOHN ROSS is based in Mexico City.

Improving Health Through Social and Political Measures

by David Werner

TODAY it is popular to focus on the survival of children, and to pretend that it depends primarily on a few simple interventions.

But the health and survival of children depends on many, many factors: on the health of their fathers and mothers; on the survival skills of their families; on the relative peace or violence in their communities; on the economic and political status of their nations; on whether the wages people earn or the land they till provides enough to eat; on the availability, quality and cost of education, health services, water, shelter and transportation; on the ability of people to organise and defend their rights; and on local consumption of alcohol, tobacco and narcotics.

It also depends on who has power over whom; on war; on the nine lives of the Cold War; on military expenditures relative to public service expenditures; on international trade relations; on the preservation or destruction of the environment; on how far mother has to walk to get firewood or cow manure for cooking; on covert mining of harbours and undermining of grassroots movements; on whether the US President can get away with lying to Congress; and on whether the banks will be permitted to continue protecting their billions by taking food from the mouths of millions of children.

Although it is easy to blame 'natural causes' such as bacteria, viruses, earthquakes, drought, and an 'inhospitable environment' for high rates of illness and death, man-made cause play an increasingly prominent role. Many of these causes relate to human greed: the efforts of some to prosper at the expense of others.

In today's world there are a number of giant profit-making ventures that are taking an extraordinary toll on the health and lives of billions of people and that have an enormous negative impact on the well-being and survival of children. These health-destroying multinational industries include:

- Alcoholic beverages
- Tobacco
- Illicit narcotics
- Pesticides
- Infant formula
- Unnecessary, dangerous, over-priced pharmaceuticals
- Arms and military equipment

International money lending

Each of these represents a huge, powerful, enormously profitable multi-billion-dollar industry. Their cost in terms of human life and health is incalculable. The weakened physical resistance and the economic, mental and social problems provoked by these unscrupulous businesses add enormously to the impact of infection and malnutrition.

And as usual, it is the poor that bear the brunt of the damage, especially since the alcohol, tobacco, pesticide, infant formula, pharmaceutical, arms and banking industries have all increasingly targeted the Third World as their new, most vulnerable market.

Attempts have been made by non-government organisations, the UN and the governments of various countries to try to limit the damage caused by these powerful industries. But in the case of each and every one of these killer industries, the US government has defended their interests at the expense of the health, quality of life, and often survival of millions.

Clearly, in view of all these huge, officially-condoned assaults on life and health, ranging from the IMF-mandated hunger to poisoning for profit, technological answers like the Green Revolution and the Child Survival Revolution are not enough.

In fact, with their apparent simplicity of coping with the biological causes of poor health, they lure us away from confronting the far more deadly social causes.

In order to design strategies for improving overall health, it is important to first have a clear picture of firstly what causes widespread illness and early death, and secondly what causes far-reaching improvements in levels of health.

A wealth of evidence shows that the major determinants of health are not medical or technological, but rather social and political. Historically, far-reaching improvements in the health of populations have not coincided with medical or technological breakthroughs.

Rather, they are equated with gradual improvements in the basic standard of living: everything from fairer wages and improved working conditions to better water supply, public education, and social guarantees to meet people's basic needs.

There is clearly a close relationship between poverty and poor health. But a wealthy nation is not necessarily a healthy nation, nor is a poor nation necessarily unhealthy. In recent decades, global planners made the unfortunate assumption that the solution to widespread poverty and poor health was economic development. The strategy imposed on poor countries by the foreign aid agencies and Northern banks was to foster national growth through large-scale in-

dustry and agribusiness. While they realised this would mostly benefit big land holders, industrialists and bureaucrats, they theorised that by stimulating the growth of a poor nation's total gross national product (GNP), benefits would 'trickle down' to the poor.

But in many countries, this did not happen. As the economy and production grew, the gap between rich and poor got wider. More trickled down than trickled up, and in the process the problems of poverty, undernutrition, underemployment, homelessness and the diseases of poverty got worse.

If neither medical technology nor economic growth guarantee better health, what does determine the health of a population?

In 1985 the Rockefeller Foundation sponsored a study called 'Good Health at Low Cost.' Its purpose was to explore 'the reasons why certain poor countries have achieved acceptable health statistics in spite of very low national incomes', and specifically, 'to verify whether China, Kerala State of India, Sri Lanka, and Costa Rica did indeed attain life expectancies of 65-70 years with gross national products per capita of \$300-\$1,300.'

The investigators concluded that the four states did achieve good health at low

cost.' Furthermore, they concurred that 'four' intersectoral factors appear to have played a major role in the marked decline in infant and child mortality', commensurate with life expectancy approaching that of wealthy nations. The four determinants of this Southern paradigm for 'good health at low cost' proved to be:

- Political and social commitment to equity.
- Equitable distribution and access to public health and health care, beginning at the primary level and reinforced by secondary and tertiary systems.
- Uniform access to the educational system with a focus on the primary level, and
- Availability of adequate nutrition at all levels of society in a manner that does not inhibit indigenous agricultural activity.

Certainly, this study provides one of the arguments for an approach to meeting health needs that courageously addresses social and political issues.

It is clear that our present top-down Northern paradigm for health and development brings neither. It further entrenches inequity and perpetuates the unjust systems that decimate the health, deteriorate the living conditions, and violate the basic rights of the large and increasing proportion of the world's people. It is a model not for development and health, but for underdevelopment and disease.

Let's we think that this sad state of affairs is limited to poor countries, we would do well to remember that in both the USA and England, the so-called 'pinnacles of democracy' and the prototypes of successful 'free market economy', the number of homeless people has doubled in the last 10 years. In both countries the rich are gaining greater privileges while the growing number of poor have fewer benefits.

— Third World Network Features

David Werner has authored numerous books on health and society; his most famous being 'Where There is No Doctor, which has been translated into more than 20 languages.

