Health Not for All by the Year 2000

by Nizam Ahmad

THE Bangladesh Medical Association (BMA) protects and promotes the interests of the doctors. But, which association is there to protect the interests of the patients?

In a recent question and answer session parliament, was told that 90 per cent of the medicine required in the country is made in the country. But, who is recording the fact that, 90 per cent of the patients have no confidence in our doctors and in our locally produced medicines?

The huge local drug industry producing drugs worth Tk 800 crore annually (not including the profits of the clinics, doctor's income etc) is running without the consent of the people and in conflict with market forces. Local drug producers make fabulous sum of money, thanks to government's policy of protectionism and their abnormal profits are quickly diverted into cosmetic and toiletries manufacturing (also under protectionism policies) instead of getting invested into research and development activities, as it happens in case of any reputed international pharmaceutical manufacturer for its staying in a competitive market. Over three hundred children died using locally produced paracetamol syrup and only God knows how many more are silently perishing using other local medicines!

All these developments including the general lack of confidence in our doctors, nurses and laboratory technicians, as well as the insufficient resource allocation by the bureaucracy to the health sector, compel thousands of desperate patients and their jittery relatives to flee to Calcutta, Vellore, Delhi, Bangkok, Hongkong, Singapore and to the West. The quality of health care in these foreign lands is worth the trip as the expenses incurred bring about a healthy cure or a correct diagnosis. There are thousands and thousands more who cannot afford the treatment abroad or who foolishly spend thousands of Taka in trying to get a cure here. There are many more caught in an emergency situation and left at the mercy of our medical service or in a situation where proper drugs or related equipment are simply not available.

The BMA's bias towards foreign medical expertise should no longer be entertained. Our doctors and our drug producers can qualitatively improve only under stiff competitive conditions. The opposite is true under protective formulas and prejudices as tragically evident now.

Despite all these shortcomings, our health specialists are fabulously rich and busy. They have a limitless list of patients which obviously indicates there is an acute shortage of specialists in the country.

When majority of the people do not have any confidence in our doctors and in our national health care system, then why our elected representatives or the government is paralysed in doing something about it?

Firstly, there must be an association to protect the interest of the patients to improve our health service. The NGOs must have a free hand and be encouraged to mobilise external resources to provide cheap and reliable health service throughout the country. Non-NGOs such as the private health entrepreneurs require liberal conditions to make investment in this sector.

Easing foreign currency rules, lowering tax and tariff rates can lure foreign and local money in providing high quality healthcare in our own country. Financial deregulation and liberalisation can help develop an insurance market to finance treatment costs.

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A free individual should be free to receive treatment of his choice, be it local or foreign. The government's job is to permit that to happen cheaply and easily in its own country. This is one security a citizen or an investor would want as a priority.

Despite competition from satellite Star TV, CNN, BBC, Zee TV etc., the people here still switch on BTV and heartily relish BTV drama programmes etc. Our good doctors would have the advantage of the language for a start a foreigner would not enjoy but, the present practice of shielding foreign competition by law or by fiscal measures allows the bad doctors to thrive at the expense of the helpless patients.

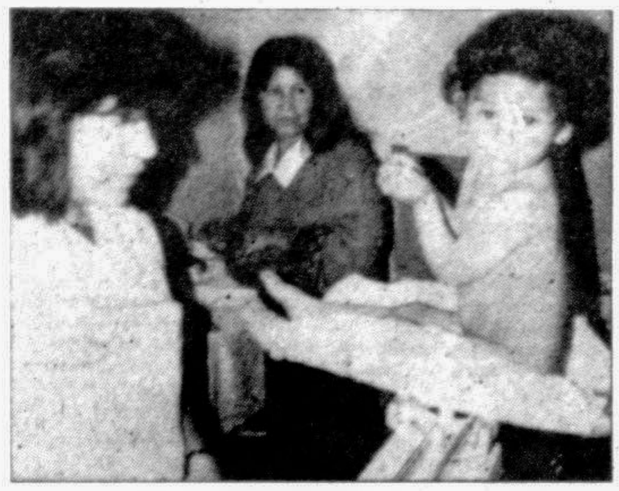
Our drug manufacturers too must find their competitive edge to survive and prosper in the local or foreign market by spending more on research and nothing on toiletries and cosmetics unrelated to medicine. Three hundred children need not die before a local manufacturer closes down in an open competitive condition as the market mechanism pushes out bad products and producers before the authorities wake up. Independent drug and health administrators, a sovereign judiciary separated from the executive, free press, autonomous Radio and TV, and the consumers' associations can collectively keep an effective watch on the health industry and ensure due punishment to negligent doctors and manufacturers.

Only under these combined conditions will our doctors and their practice stop the exodus of local patients, possibly attract foreign ones and, be in competition with medical institutions in India or Singapore, and consequently the Tk 800 crore annual health market can expand, double or treble, and thereby, achieve health for all by the year 2000.

In a gradual global situation where market principles decisively dominate every sphere of our life, governments and their ambitious plans are left with scanty resources to provide social infrastructures, as in the health sector. The task can now be handed over to the NGOs and the private health entrepreneurs who possess far superior management skills, the will and the ability to generate adequate resources to provide a reliable social infrastructure.

Chile's Rural Nurses

by Isabel Ringeling and Gerardo Herrera



OBSERVING the work of a rural nurse within the health system of Chile is a real challenge for anyone who wants to understand her role and her contribution towards improving the level of health of the rural population.

Til Til, a traditional Chilean village 30 kilometres from the nearest town, is where two such nurses, Francis Molina and Jessica Pinto, work. To reach it involves crossing a beautiful valley rich with farms, grazing herds and even mineral resources (though they are very little exploited). The drive to the village is on dirt roads and crosses the River Polpaico, which in rainy winters regularly leaves a large part of the area isolated.

The community has 12 677 inhabitants within an areas of 650 square kilometres. Some 4500 people are concentrated in the village of Til Til itself, and another 3600 in several small communities with no more than 600 inhabitants each. The rest of the population is scattered. The indicators reveal the vulnerability of the population to major health risks: 11% are illiterate, 10% live in extreme poverty, 19.4% of children aged under six years are at high risk from disease and 12.9% of the same group suffer from malnutrition; 34.6% of pregnant women are underweight, and 8% of all children were born with low birthweight. All these indicators are higher than the national average.

To arrive at the Hospital of Til Til, we cross the village, which does have electric lights, a swerage system, drinking water and telephone, thanks to the programmes of rural development which the government has carried out with international support.

The people live principally from farming, whih has been modernized and diversified; so they have switched from growing mainly fruits such as olives and prickly pear, which thrive on the dry soil, to cultivating grapes and other fruits for export. This labour generates seasonal employment with all the advantages and drawbacks which that signifies for the economic stability of the families.

They also work as miners, either individually, in the constant hope they will strike it lucky, or for a large extracting company involved in producing cement and stones.

The Til Til hospital performs mainly primary health care activities, also serving other remote areas. The main health problems in both children and adults are respiratory diseases in winter and digestive problems in summer. Cardidvascular disorders are also important in adults.

During her rounds of the local neighbourhood, Jessica undertakes regular visits (weekly, fortnightly or monthly depending on the distance) to the health posts, together with the doctor, the matron and the dentist whenever possible. In each post an auxiliary nurse lives permanently, hard at work and coordinating her activities with the other sectors concerned with community development.

The work done by these rural health posts conforms to a national programme which puts special emphasis on the focal points of hazards to health, and is supervised by the nurse. The rest of the team contribute by overseeing specific activities. To meet the health needs of the communities with less than 300 inhabitants and of the scattered inhabitants, Jessica has to go out to meet them at the so-called rural nursing stations, which are places arranged by the community as consulting rooms, usually in the community hall or in a classroom of the local school.

One sunny day in the month of August we went with Jessica on her rounds to the posts of Polpaico and Huertos Familiares, some 15 to 25 km from Til Til. In the far north and far south of Chile, where people live in extremely isolated conditions, the health posts and rural nursing stations are so far apart that to make the rounds involves using a variety of means of transport: light aircraft in Aysen, motorboats to cross the channels and reach the many islands of the south, or four-wheel drive vehicles to get u to the villages of the northern altiplano. In such cases t rounds can last five days or more and the nurse has to sleep overnight at each place.

In the posts that we visited we could appreciate the work that the nurse does: acting as a team with the auxiliary nurse, diagnosing the total health situation of the community, paying special attention to health promotion, prevention and treatment of deseases, treatment of chronic patients, epidemiological surveillance of communicable diseases, education of the community, home visits to families, and coordination with the community organizations and local institutions.

The numbering of the houses on the map coincided with the numbers on such official forms as the family survey, the summary of family surveys and the classification of family risk — basic tools for planning the work of the nurse as well as the auxiliary nurse. As we watched, Jessica set to work checking the growth rate and development of children, vaccinations, delivery of milk and all the corresponding educational activities. We saw with what care she filled in the registry forms and noted down each individual and family who had attention.

The knowledge that nurses who work in the rural areas have gained of the problems faced by the community encouraged them to contact certain nongovernmental organizations and initiate a new educational project which is contributing positively to integrated rural development - that of hydroponic farming of vegetables, which will permit families to improve their diet.

Our visit to Til Til was highly rewarding, and we were able to confirm, once again, the immense professionalism and enthusiasm with which the public health nurses of Chile are carrying out their work in the remote countryside. — WHO

New Vaccine Helps to Save Infant Lives

by Veronica Rose

After 20 years the first safe and effective vaccine has been developed to save infants from the deadly effects of bacterial meningitis. In Britain the incidence of the disease has been considerably reduced and now The Gambia, in West Africa, has taken part in trials. It is planned to start a programme to vaccinate 30,000 babies over three years.

NOW that infectious diseases like measles, poliomyelitis and smallpox are preventable, the global spotlight is turning on another deadly foe of humankind, bacterial meningitis.

Meningitis is inflammation of the meninges, the delicate layers or tissues protecting the brain. It can be caused by either bacteria or viruses.

Viral meningitis is invariably less devastating than bacterial meningitis, though no less unpleasant. Bacterial meningitis is caused by a wide range of bacteria and creates the same fear associated with poliomyelitis. Parents dread the autumn when it tends to strike.

It has taken 20 years to develop the first safe and effective vaccine to offer protection to infants. Haemophilus Influenza Type B (HIB) vaccination was introduced for babies and widely promoted last October.

HIB is the commonest form of meningitis among infants between six and 15 months, and is rare in children over four years. The mortality rate is high.

For many babies the vaccination has come too late. The experience of the parents of Sarah Thompson illustrates how desperately important it is for vaccination to be offered and accepted wherever possible. Six-months-old Sarah developed a fever early one afternoon five years ago. As the day progressed and she did not improve, her father, Trevor, called the doctor. He suggested cooling her down.

Bouts of sickness persisted throughout the night. At 3 am the doctor was contacted again. He thought it was probably gastro-enteritis. At 8 am Sarah had deteriorated considerably. She was awake, but her eyes were glazed over and the fontanelle (the small indentation on the top of the head) was swollen. She was moaning "a strange, unidentifiable cry," said her mother, Rosemary, "which I had never heard before."

The doctor was called again and by 10.45 am Sarah was in hospital. Meningitis was diagnosed. She was given essential drugs and put on a life support machine. Next morning, Sarah's brain scan showed extensive damage. Her life support was turned off. "The consultant took her off the respirator and gave her to me," said Rosemary, "She died in my arms".

Statistics from the Medical Research Council indicate that there has now been a drop of 70 per cent in the number of young children contacting this form of the diseases. Campaigns in Norway, Iceland and Finland have had the same dramatic effect.

In April, the Council took the HLB vaccine to The Gambia, the first developing country to take part in trials. In The Gambia, HLB causes influenza as well as meningitis, so a new generation of vaccines has had to be developed. Work on this yaccine programme has been underway since the mid-1980s. It will involve vaccinating 30,000 babies over three years.

Another organisation in the front-line of the battle for elimination is the National Meningitis Trust founded in 1986, when the incidence of the diseases in Britain was at its highest. About 1,000 babies a year had been developing the disease. Many who survived were left with handicapping defects, such as blindness, bilateral deafness and often mental retardation.

The Trust funded research that has played a significant role in the development of the HLB vaccine. One of its medical advisers, Norman Noah, presented data at its latest conference showing wide differences in the incidence of meningococcal disease within Europe. Countries such as Ireland, Iceland, Russia, Norway and Denmark are reporting high statistics.

Dr Norman Begg, from the Communicable Disease Surveillance Centre, London, confirmed through laboratory reports that in Britain HLB disease was virtually eradicated within a year of the beginning of vaccination. Meningococcal meningitis (caused by a bacteria known as *neisseria meningitidis*) is the commonest form in Britain, accounting for about half of all known cases. In this type of meningitis, septicaemia is most likely to occur. It develops rapidly, sometimes in a few hours and the fatality rate is 20 per cent.

Pneumococcal meningitis is the form most commonly seen in younger children, teenagers and young adults. It accounts for about one-tenth of reported cases in Britain and has a high mortality rate — about 20 per cent. The bacteria are found in the noses and throats of about 5-10 per cent of healthy adults, who are unaffected by them. They are spread by coughs, colds or middle ear infection and can be transferred through the bloodstream.

Tubercular meningitis is also becoming more common. In 1975, the World Health Organisation forecast that eradication of tuberculosis would be almost impossible, despite the advent of antibiotic chemotherapy. This has proved correct.

It is proving more complicated to handle, because poverty, malnutrition and poor environmental factors expose people to the tubercle bacilli which settles in the lungs and can spread to the meninges of the brain.

It occurs mostly among the elderly and Asian immigrants. Since its progress is slow, it can be difficult to diagnose. Despite the enormity of the disease, prompt diagnosis and treatment can effectively alter its outcome.

— Gemini News

VACCINATING A CHILD IN MAURITANIA
It hurts but saves lives

A Bleak Prospect

Ethiopia is on the brink of a major AIDS crisis, writes ***Laurence Zavriew,*** *fuelled by years of civil unrest, famines and political upheavals.*

Bar girls in Addis Ababa.

As many as three million Ethiopians — or 15 per cent of the sexually active population — could be infected with HIV, according to Dr Juerg Bluemel of Ethiopia's Organisation for Social Services for AIDS (OSSA). Years of civil war, drought and crop failures have helped spread the virus throughout the country, and prospects are bleak in the new Ethiopia.

"In Addis Ababa," said OSSA's Mesfin Lissanu, "some of the hospitals are filled up to 80 per cent with patients with HIV or AIDS." With only 11,000 beds for a population of more than 50 million, Ethiopia's fragile health care system is unlikely to be able to cope with a widespread epidemic.

The scale of the problem is difficult to assess — there are few figures, and the Ministry of Health is not keen to publicise estimates of HIV infection. "We admit that we lack good information," says Negussie Yitbareq, head of AIDS Information at the Ministry of Health. "But in any case it would be counter-productive to announce the true figures. People would despair and think there was nothing they could do. We tend not to mention figures at all."

Bluemel disagrees with this. "All these years we underestimated the AIDS figures," he says. "It is only by publicising the real extent of the spread of the virus that we will get a response from the public and from politicians."

One reason for the lack of figures is that many HIV positive people die of opportunistic infections without ever being diagnosed. "We are one of the poorest countries of this continent," said Abba Tsegaye Kenneni, OSSA's chairman, "with the lowest per capita income in our region. Many of our people are weak and malnourished."

"If they become infected with this virus, they will not live long enough to develop AIDS. They will die earlier, their lowered resistance combined with opportunistic diseases such as TB or gastrointestinal infections. This makes or statistics misleading, with figures which are too low."

Bluemel also points out that, like neighbouring Uganda, Ethiopia has a history of civil war and unrest, a mixed population with different ethnic groups and languages, and widespread poverty. "It is difficult to understand how the official HIV/AIDS figures for each country differ so," he adds.

Bluemel's estimate of the situation is based on alarmingly high rates of HIV infection shown by surveys in various parts of the country. In the northwestern town of Bahir Dar, 17 per cent of a group of pregnant women tested positive for HIV. "Because nobody believed these figures," says Bluemel, "the test was repeated in another group in the same town. This time, 18.9 per cent tested positive."

In the southern town of Arba Minch, a survey among blood donors revealed 20 per cent had HIV. In Nek'emte, west of Addis, the HIV rate was close to 30 per cent. Bahir Dar, Arba Minch and Nek'emte are all sizable towns (20-30,000 inhabitants) situated on main traffic routes — along which troops were stationed during the regime of Mengistu Haile Mariam, and where much of the fighting occurred during the revolution which overthrew Mengistu in 1991.

"During the 17-year-long socialist government of Mengistu," says Bluemel, "Ethiopia had the largest military force in Africa. Army, navy and air force totalled at least half-a-million soldiers. After the change of government two years ago, these 500,000 soldiers were sent home without money, condoms, AIDS information or warnings about the disease. According to clinic health workers, being an ex-soldier is already a 'major risk factor' for HIV.

Another legacy of the war years is the high number of prostitutes in the country — up to 500,000, estimates Bluemel — a high proportion of whom are feared HIV positive. Figures for Addis Ababa indicate seroprevalence rates of up to 75 per cent among prostitutes.

"Our work is starting to have an effect," says Yitbareq. "The number of clients for bar-ladies is decreasing, and women are refusing to work in bars, to the extent that some bars report they cannot get enough staff." Hotels in Addis are also starting to provide condoms in their rooms and souvenir shops.

Several other AIDS initiatives are also planned, including an AIDS information hotline and training for counsellors and teachers. Home-based car has been prioritised to shore up the ailing health care system. Refugees in the east and west of the country — who numbered three-quarters of a million last year — are seen as another essential target group. But according to journalist Tseganesh Gudeta, AIDS still carries too much of a stigma for home-based care to be successful. "People will not come forward for assistance," she suggests. And the new administrative division of the country into 14 separate regions — each with its own health service — may increase problems, says Helge Espe of Redd Barna (Norwegian save the Children). There are too few resources, a lack of qualified staff and condom supplies to clinics are poor, he warns. — World AIDS

Addressing the Vital Health Issues

BOOK REVIEW

Title: *Bangladesh — Yesterday, Today, Tomorrow (Selected Articles on Health and Population Issues.)*
Author: *Heide Richter*
Publisher: *Ankur Prakashani, Dhaka*
Year: *1993*
Pages: *88*
Price: *Tk 150.00*

Reviewed by Ahmed Helal

IT is true that Sophia Loren has many admirers in Bangladesh. But it is unexpected to find the title of one of her most popular films on the cover page of a book about Bangladesh: "Yesterday, Today, Tomorrow".

"Bangladesh — Yesterday, Today, Tomorrow" is the title of a book written by a German author Heide Richter. It has been published recently by Ankur Prakashani, Dhaka. The sub-title, "Selected Articles on Health and Population Issues" reveals the specialisation of this book. It is addressed to all those who are interested in the fields of health, family planning and women's promotion, particularly to programme planners and implementors.

While Sophia Loren, in the well-known film, benefits from having one child after another (because that is how she can legally evade being sent to prison for some trivial offence), this book is concerned with the benefits of family planning in relation to health and well being of the present and future generations.

Apart from preface and acknowledgements, the books consists of four articles, covering the areas "Population Growth", "Women's Status and Health," "Local Governments in Health Care", and "Health Education Strategies". As it is mentioned in the preface, these articles have originally been written as term papers at the Harvard School of Public Health. This is reflected in the style of writing: It is at times demanding on the reader, requiring a high degree of concentration and willingness to cope with technical terms (which are, however, well explained).

Yet, the motivated reader will be amply rewarded by a thorough and concise analysis of burning problems and issues, important information and fresh perspectives. For example, the author's representation of the phenomen that women live longer than men in all countries of the world, except in Nepal, Pakistan and Bangladesh may be revealing to many readers.

An attractive book cover, layout and overall production do their part to make the reading and handling of the book a pleasant experience.

The author is a doctor and public health specialist who has spent several years in Bangladesh, working in a district-based health and family planing project. Her book reflects the view of some on who looks at the country from outside, as an observer, but with a very intimate knowledge of structures and realities in Bangladesh. This is to be marked by the depth of her analysis, but also by the meticulous details revealing close knowledge of everyday life, including conversational terms and expressions.

It does not matter that the erstwhile "Kuwait Wallah" referred to in the first article (in connection with the subject of migration trends) has been turning to other countries recently. Likewise, the pun "Upazilla"/"Upazalla" (turning the administrative unit into an "extra burden"), which is quoted as a complaint of dissatisfied government officers, is no longer applicable, as the term "Thana" has been re-introduced in the meantime. Changes have taken place, and are still ongoing, but the author's close analysis of scope and limitations of local governments in the areas of health, family planning and women's promotion is still valuable.

The fact that the articles reflect the situation several years ago (they were first written in 1988/89) is a limitation. However, "old" figures and information have been updated by footnotes, and it is quite interesting to make the comparison today. Above all, this comparison reveals the impressive progress that has been made in the fields of maternal and child health and family planning during the last few years.