Economic Integration and Cooperation

The Gloomier Side for the Third World Countries

by Dr. Munim Kumar Barai

Liberalization and integration of the economy with the international order has not paid the dividend at least in the short run. However, time has not entirely run out of Bangladesh's reach.

THE issue of integration and cooperation between the states of the same region and with the countries afar has become very much important at the onset of the World Trade Organization (WTO) and the proliferation of regional trade blocs (RTBs) all over the world. While WTO has taken the charge of looking for the development of trade by taking a global approach, various RTBs are formed to foster trade by taking a regional approach. We are experiencing the simultaneous progress of the two at the very same time. The European Union (EU), the North American Free Trade Area (NAFTA), the Association of the South East Asian Nations (ASEAN) and our own South Asian Association for Regional Cooperation (SAARC) and SAARC Preferential Trading Arrangement (SAPTA) are few of the examples of the RTBs that are operating at different levels of development in different parts of the world. The European Union has reached at a very unique stage of integration and cooperation as the member countries have agreed to part away with their sovereign right in many areas, particularly in the area of currency and finance.

But let me open my mind about the process of integration and its pitfalls on the countries of third world stature. Before going to the point, I like to make it another clear that I am not an opponent of the integration and globalization. Rather I am a supporter of the process. But what my contention is that each country has its own set of dynamics that should be kept in mind while going for opening up of the economy. This is particularly true to a country like Bangladesh. Failure in this regard could bring some of the unwarranted outcomes that could harm the economy in short term to long term.

First, I would like to concentrate on the issue of regional integration among the countries in the first world and the emerging effects of such move particularly on the flow of aid to the developing countries. The Pearson Report of 1969 called upon the donor countries to provide 0.7 per cent of their GNP as official aid to the developing countries by the end of 1970s. Though the target was never reached but during the Cold War era there was a regular flow of aid to the third world countries. Many may argue that the motivation of providing aid to the poor countries was more political than philanthropic. Controversies are there whether the aid actually did help the receiving countries to increase their rate of GDP growth or development. But the fact is that the flow was a regular phenomenon and aid came in different forms. The end of the cold war has dealt the first blow to the flow of aid to the poor countries. During the 1990s the aid flow is declining on a regular basis.

For why is the decline happening? Actually a lot of reasons are there for it. But we can mention some of the important reasons for the present declining phenomenon. A shift to the market oriented development models and the surge of private capital flows to the developing countries have tended many to think foreign direct investment as an alternative and all purposive recipe for third world development. This has resulted in the misperception that aid in support of public investment programmes is no longer needed or desirable.

In this set up a potential threat is coming from the growing trend of regional integration among the developed countries as well. The fact is that out of 24 Development Assistance Committee countries 14 are tied up with the EU and two are with the NAFTA. Both of the organizations have the plan to extend the blocs by enlisting members from the poor neighbours. If that happens, it is expected that a substantial sum of fund will flow to the newly included members for the overall development of those countries. This might result in the diversion of aid flow from the developing countries to the neighbourhood members. We can mention the example of the European Development Fund. Under this Fund, the poorer members like Greece, Spain, Portugal, and Italy of the EU are getting development assistance from the developed partners of the organization. The effect of this extra care for the regional poor members is becoming evident from the declining aid flow from Europe to the developing world. Probably, Bangladesh will not be an exception in this regard. If NAFTA expands towards the Latin America a similar trend is expected and that will put further pressure on the already affected aid flows from the United States.

The impact of integration in the global level under the leadership of the WTO on the developing countries is yet to emerge in a more concrete way. The fact is that the developing countries have a lot to lose in the coming days. The GSP benefit offered by the developed countries including the EU members to the developing countries is got to go from trade in the new arrangement of trade under the WTO. The market access coverage of WTO in the areas of industrial, agricultural and textile products is lop-sided to the developed countries.

After the establishment of the WTO the share of global trade of the 48 LDC countries, with a quarter of world population, has declined to 0.4 per cent from the pre-Uruguay Round volume of 0.5 per cent. The opening up of the services sectors but not the natural service providers again will put the developing countries on defensive. For Bangladesh the phasing out of the Multi Fibre Agreement (MFA) by 2005 poses a serious challenge. The readymade garment sector has become the most vibrant export sector in recent time. But without the quota benefit the open for all competitive environment is expected to pose a threat to the sector in the post-MFA context.

The magnitude of the effects of the recent financial crisis on trade and growth of the economy of the East Asian countries has logically brought into focus one question — how far has the integration of these countries regionally and internationally aided and aggravated the problem? Around 30 per cent of the trade of the Association of the South East Asian Nations is among the regional partners. The thing is that in the handling of the crisis they have totally failed to take any joint action plan to mitigate the effect of the problem. The Asia watchers and the believers of "the 21st Century as the Asian Century" would be greatly disappointed to see that excepting Malaysia all of the affected countries had to approach the International Monetary Fund (IMF) for their bail out packages at the time of need.

A few words need to be devoted to the case of Bangladesh in the context of integration with the world economy. It is a well known fact that Bangladesh has gone far ahead of its neighbours in respect to the liberalization process. Actually, she has opened most of the sectors of the economy for private local and foreign investors. The list of banned and restricted items for import has been pruned down to a negligible level. Tariff and non-tariff barriers have been reduced to a greater extent. Industries have been made open to 100 per cent foreign ownership. But the effort has not so far resulted any big gain in terms of growth and employment generation or even drawing foreign investment. In the 1990s when the process of opening up has gathered momentum, the economy has maintained a growth of about 4.5 per cent on an average.

The liberalization of the agriculture sector and the massive reduction of all kinds of subsidies have resulted in a sort of stagnation in the production of agricultural output. The manufacturing sector has become the single largest affected sector due to the fast and imprudent deregulation of the sector. A large number of small and medium sector enterprises has become sick and many have gone out of existence in the meanwhile. Since 1990-91 to 1995-96 the employment in the manufacturing sector has declined by 6.2 per cent on an annual average basis. The finance and business service sector has also been affected negatively in the process of liberalization as the sector has seen a decline of employment at the rate of 5.6 per cent on an annual average during the period. What seems to be true in case of Bangladesh is that the liberalization of the country's economy has exceeded the pace of its development. With the exception of India, cooperation among the regional members of SAARC is yet to reach even the normal level that exits between the physically proximate countries.

So liberalization and integration of the economy with the international order has not paid the dividend at least in the short run. Time has not entirely run out of Bangladesh's reach. Still the policy planners of the country might be cautious to draw a line of liberalization to match her pace of development in the areas of agriculture, manufacturing, business and finance. Otherwise a great long-term economic injury could result in these sectors. This does not mean that Bangladesh has to abandon the reform process she has already initiated. But it is entirely desirable that the policy planners would find out some way so that the economy could be liberalized and integrated with global order in a less harmful way. This is also the expectation of the people of the country.

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Liberation and Beyond by J N Dixit

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1973: Beginnings of Disillusion

Part-IV

BANGLADESH'S paranoia and the revival of Pakistani attitudes towards India in its political and bureaucratic establishments and India's resentment about the lack of Bangladesh's appreciation of its role in its liberation struggle prevented rational and practical negotiations on issues dividing them. This was a situation which both countries could have avoided with practical wisdom and a measure of historical vision. Communal parties, backed up by resources from intelligence agencies of Pakistan, had reappeared in Bangladesh. The Jamaat-e-Islami and other religious groups had commenced playing a behind-the-scenes role in political processes. The twin objectives behind this were pressuring and isolating Sheikh Mujibur Rahman and the Awami League, and creating a distance between India and Bangladesh. The left-of-centre opposition led by the Jatiya Samajtantrik Dal unwittingly lent strength to these pernicious orientations in Bangladesh's domestic and foreign policies.

Sheikh Mujibur Rahman failed to fashion Bangladesh's foreign policy in a manner that would ensure a positive equation with India. Simultaneously, his authoritarian approach towards the opposition exacerbated tensions in domestic politics.

There were other trends in Indo-Bangladesh relations worth recalling. Despite incipient antagonisms emerging in these ties, cooperation between them and general political relations was satisfactory primarily because of two reasons. Though about 82 countries had recognised Bangladesh by the end of 1972, political relations with them were at best tentative. The US, China and Pakistan were still distant and non-responsive. Therefore, Bangladesh continued to need Indian economic assistance. Secondly, though the Shimla Agreement was signed in July, 1972 the residual problems to be resolved under the terms of the agreement were yet to be tackled. Bangladesh was yet to take a final decision on putting 195 or 118 Pakistani army officers on war crime trials. Bangladesh's application for admission to the United Nations was vetoed by China in 1972 and early 1973. Bangladesh was taking back all the refugees, but India continued to contribute to their rehabilitation. I have already mentioned the transfer of Indian aircraft to the Bangladesh. Bangladesh made a request for establishing the Bangladesh Navy after the formation of the Bangladesh Shipping Corporation. India agreed to this suggestion. It transferred a seaward defence craft, INS Akshey, to the Bangladesh Navy on April 12, 1973 which was renamed BNS Padma. The Chief of Staff of the Bangladesh Navy, Commodore Nurul Haq, received this ship at Visakhapatnam.

Keeping in view the issues to be tackled in Indo-Bangladesh relations, the Bangladesh Foreign Minister, Kamal Hossain, visited New Delhi from April 13 to 17, 1973. Important results of this visit were the two sides agreeing to discuss the Farakka issue in a more flexible manner; Bangladesh consenting to the time table for the repatriation of Pakistani prisoners of war and Bangladesh urging India to persuade Pakistan to accept the Bihari repatriates. It was a follow up of this visit, and of the negotiations that N P Haksar had with Sheikh Mujibur Rahman in the second half of 1972 and in the first half of 1973 that India and Pakistan signed an agreement on August 28, 1973 on solving the humanitarian problems resulting from the liberation of Bangladesh. These negotiations were undertaken by P.N Haksar and Aziz Ahmed, Minister of State for Defence and Foreign Affairs of Pakistan. The agreement laid down the general time table for the repatriation of the Pakistani POWs and the repatriation of Bangladeshis still interned in Pakistan. Pakistan agreed to receive a "substantial number of Biharis" in Bangladesh who wished to be repatriated to West Pakistan. It was agreed that Pakistan and Bangladesh would hold discussions to resolve the pending questions affecting Bangladesh relations with Pakistan. Bangladesh also confirmed that it would not hold war crimes trial in the immediate future. It was agreed that tripartite talks between India, Bangladesh and Pakistan would be held to take a final decision on the question of holding these trials (this was the first formal indication that Bangladesh resiling from its intention of holding the war crime trials).

Signing of Indo-Bangladesh visa agreement

Controversies which characterised Indo-Bangladesh discussions on sharing of waters of the Gangetic basin had been signalled during the meetings of the Joint Rivers Commission held between December, 1972 and July, 1973. The leader of the Bangladeshi delegation, B M Abbas, Adviser to Prime Minister Mujibur Rahman ensured that the commission did not deliberate on the substantive issues but got involved in procedural details on how to go about the work. Press notes issued at the end of these meetings held on December 13, 1972 and March 31 and July 18, 1973, clearly indicate that apart from persuading Bangladesh with great difficulty to accept that the sharing of the water resources should be based on a joint survey of the water flows by experts of the two countries, no concrete decisions on objective criteria emerged. Of course, there was the additional procedural suggestion that both sides should study the river systems in Bangladesh and India for exploring possibilities of augmenting the Ganga water flows below Farakka. This was very reluctantly agreed to by BM Abbas. The only positive outcome of the deliberations of the Joint Rivers Commission was the agreement to jointly deal with the problems of flood control, drainage and soil erosion.

A brief reference to India's economic assistance to Bangladesh during 1972-73 is called for. India gave commodity assistance to the tune of Rs 25 to 30 crore. Another £5 million of aid was given to Bangladesh to meet its foreign exchange requirements. The Indian Railway Board and the Corps of Engineers of the Indian Army repaired 247 bridges and restored 1,714 miles of railway tracks. Sappers from the Indian Army and engineers from the Public Works Department restored river communications and repaired all the major airfields of Bangladesh between 1972 and 1973. The purpose here is not to quantify the trade and assistance figures but to underline the fact that India was the most important economic partner of Bangladesh almost till the end of 1973 despite the emergence of trends negative to India's interests.

In overall terms, three factors were affecting Bangladesh's politics. First, it was gradually getting international political recognition but was still being prevented from joining the United Nations. Its relations with Pakistan and China were still to be restored. In domestic politics Bangladesh was becoming subject to divisive tendencies due to Mujibur Rahman's political attitudes on matters of governance. Bangladesh's economy was experiencing slow recovery, but the processes of economic management were such that the acquisitive inclinations of the urban and political elite were growing unchecked. The imperatives of social and distributive justice of the highest priority in a poor country like Bangladesh, were not being attended to. This, in turn, was generating incremental tension in Bangladesh's politics. These were to crystalise in 1974.

(Continued)

Liver Disease — in the Context of Bangladesh

by Dr Mohammad Ali

The nucleus of a liver centre and liver transplant unit could well be started in a central government hospital. It needs organisation of the existing facilities and addition of relevant gadgets and facilities.

THE prevalence of liver disease is very common in our country. In addition to the already existing multiple factors related to liver diseases present in other countries, we have our won factors, which contributes largely to its occurrence here. The common liver diseases are different types of Hepatitis, Liver Cirrhosis, Liver Tumours and Cancers, Biliary and Gallbladder Cancers, Liver Cysts and Liver Abscesses. About 10 per cent of the population of Bangladesh are chronic carriers of Hepatitis B and about 4 per cent chronic Hepatitis C carriers. About eighteen million of our population are effected by two liver viruses only. Some are having double and triple viral infections. About 15 to 25 per cent of Hepatitis B virus infected patients die of cirrhosis or liver cancer. The liver cancer is the second leading cause of cancer deaths in men. About 80 to 90 per cent of liver cancers are related to cirrhosis.

Liver diseases become more complex when the already diseased liver due to other causes develop super infection with many liver viruses. At that time liver functions deteriorate very quickly. It is unfortunate that deaths due to Hepatitis and cirrhosis are most among patients aged around 40 years. Which is the prime active period of life. Mortality caused by so many other liver diseases is unknown.

I like to highlight the various factors known to prevail in our country, related to the high incidence of various liver diseases. The aim is to create awareness and prevention of the liver diseases by every possible way, and its early detection and adequate treatment if the disease has started.

* Poor health education and lack of awareness about liver diseases;
* Limited health care facilities for Screening, Diagnosis and Treatment of both medical and surgical diseases of the liver;
* Polluted environment, poor hygienic condition, contaminated as well as adulterated foods and drinks;
* Various types of superstitions about liver disease and jaundice. Treatment by untrained quacks and traditional healers;
* Drug abuse — any body can prescribe, sell, and use drugs, which have got toxic effects on liver;
* Alcohol abuse — consumption is very fast increasing in our country as indicated by repeated liquor tragedies — very often published in the newspapers.
* Poor socio-economic conditions compound all the factors and play the key role.

Lack of awareness about liver diseases: It is unfortunate that our common people are mostly uneducated and unaware about the functions of the different organs of their own body. Common people have got the idea that the liver is a big and strong organ. It is not easily affected by the diseases or may be the last organ to be affected. Such an idea is not true.

Liver is a complex and central organ for metabolism and chemical reactions of the body. Like any other organ it is very easily affected by all sorts of agents of diseases. On top of everything, it has to bear the effects of various metabolic, chemical and drug reactions in the body. It must have to detoxify the toxins and poisonous substances in our food.

Public awareness is a must about this vital organ and its diseases. Mass media like newspapers, radio, television should arrange programmes on different liver diseases for public awareness.

The presentation should be in such a way that even uneducated people can understand the functions of liver. Health education curricula are to be to introduced in the upper classes of schools and madrashas.

Health care facilities: The liver diseases like diseases of other organs is divided into two groups — Medical and Surgical. The surgical conditions happen to be there either from beginning or is developed as a sequel to or complication of medical conditions. These surgical conditions and the surgery on liver is usually complex in nature. Apart from the surgery of organ there are many other modalities of treatment of a diseased liver condition when direct surgery is not possible. All these treatment modalities need a teamwork and well-organised centre for the purpose.

We have only a few Hepatology units in some central hospitals for dealing with the medical conditions of the liver. Their number is too scanty to deal with the large number of liver disease patients of the country and unfortunately we don't have any liver surgery unit in the whole country where the vast number of patients suffering from the different surgical conditions of the liver could be treated. Most of the patients die for want of facilities for surgical treatment while only some affluent patients can afford treatment abroad.

At the final stage of the liver disease a patient needs liver transplantation. It is a life saving measure. This complex surgery needs a teamwork. Almost every country of the world has Liver Transplant center of its own and only a few including Bangladesh are exceptions! However, these centres abroad are highly expensive for foreigners and hardly any one from a poor country like Bangladesh can afford to pay for treatment there. There is acute shortage of donor organs in these centres too. Many patients die while in the waiting list.

Another important thing is that the facilities at those foreign centers are basically for their own citizens and they always get top priority over any foreign national. Many foreigners remain in the long waiting list for new liver and waiting do they often die. I don't know yet whether any Bangladeshi was fortunate enough to receive a liver transplant anywhere in the world. But it is possible if a liver surgery and transplant unit is started in Bangladesh, and then only Bangladesh patients can get the liver transplant and in their own soil too.

Health care pattern:

Blood transfusion: Blood is usually transfused for emergency or sometimes for routine purposes. In our country blood is generally transfused from unknown professional donors or sometimes from relatives. Most of the time it is not screened for different Hepatitis and other viruses. Such blood can easily transmit Hepatitis B and Hepatitis C to the receiving patient. Many times it has been seen that the emergency situation is well managed by such blood transfusion but after a few years the patient develops cirrhosis and liver cancer leading very often to his or her death. It should be made mandatory by law to transfuse only the hepatitis virus screened blood.

Health care workers: Surgeons, blood bank technicians, operating room staff, clinical chemistry, hematology technicians, dialysis unit staff, ICU staff, interventional radiologists, dental assistants are repeatedly exposed to patient's blood, saliva and other body fluids. Needle stick injuries to surgeons, dentists and nurses are very common in surgical practice. They can be easily infected by hepatitis viruses. All these personnel must have prophylactic vaccination and regular booster doses. After injury they should take Hepatitis B Immunoglobulin.

Medical equipment: The same syringe, needle, knife, blade, screw are repeatedly used in some health care facilities in our country, particularly in rural areas. Their use should be made one time to minimise the transmission of diseases.

Disposal of hospital waste: Hospital wastes like syringes, blood or body fluid soaked gauzes, linens, packs, and tubes, bandages, plasters etc. should never be thrown into public places. It should be burned or incinerated.

Unhealthy practices: Shaving of many persons with same razor or blade, making tattoo, cautery and cutting with dirty sharp weapons may transmit hepatitis viruses from one person to another.

Close contact with dogs: Dogs are an important source of the parasite called Echinococcus. It causes Hydatid cyst in the liver. It may lead to many serious complications. Close contact with the dogs should be minimised. Pet dogs should be frequently dewormed.

Gallbladder cancer and gallstone: Cancer of the gallbladder is three times more common in females than males. It kills the patient by its involvement of liver and biliary tree. About 70 to 80 per cent cases of gallbladder cancer is related to gallstones. These stones may initiate and promote cancer. Gallstones should not be kept untreated for long time especially in elderly persons.

Unhygienic conditions and contaminated foods: Contaminated foods, drinks and poor sanitation are mostly responsible for spreading Hepatitis A and E. Foods, drinks are very often prepared and sold in open places, road sides, in unhealthy places full of dust, fumes and flies. On top of which these foods and drinks may be adulterated with toxic materials which may be directly poisonous to the liver.

Fungus containing foods: Old and stored foods like betel nuts, peanuts, rice, pitha (cakes) or any soft and moist food materials grow a kind of greenish layer called fungus (Aspergillous). It liberates a toxin known as Aflatoxin. Taking these fungus-containing foods may cause liver damage and even liver cancer.

Superstitions about liver diseases: There are various types of indigenous treatment pattern for jaundice especially in rural areas: The traditional healers use Zhar, Fuk, Panipora, Tabiz, herbal ointments on forehead and abdomen over the liver area, Mala (garland) of roots, tonic of crude materials and many more things. They don't know that some cancers in the liver, pancreas and biliary system may be responsible for that jaundice. The end result is the delayed diagnosis and therefore delayed treatment of the actual cause of jaundice, which are mostly responsible for many untimely deaths.

Drug abuse: Many drugs have damaging effects on the liver. Drugs are prescribed, sold and used randomly in our country. Anybody can suggest any drug to any body even without any knowledge about that. In the rural areas most of the time it is prescribed by quaks and pharmacy owners. The common liver damaging drugs are paracetamol, erythromycin, tetracycline, iron preparations, chlorpromazine, nitofurantoin, anabolic steroids, etc. These drugs are randomly used for headache, body pain, fever, sleep disturbance and infection control. They may cause hepatitis, jaundice, cirrhosis and even liver cancer.

Contraceptive pill: Contraceptive pills are used by about 17 per cent married woman of our country. These pills usually contain Oestrogens and Progesterone hormones. Oestrogen has got toxic effects on liver cells. It may cause jaundice and scattered hepatocellular necrosis. Long time use may cause liver tumour, focal nodular hyperplasia (tumour like condition) and even liver cancer. Progesterone only pills should be preferred. Pills should never be used continuously for long time.

Alcohol abuse: Alcohol has got the direct toxic effects on liver. Its use is increasing particularly in adulterated and contaminated form. There has been a number of liquor tragedies with deaths of many peoples in the last few years. The poor and uneducated are taking those liquors. Continuous use of such toxic materials is definitely harmful for one's liver.

Sexual contact: Hepatitis B can be transmitted by sexual and related contact with Hepatitis B carriers. Transmission of Hepatitis C by this easy is still doubtful. Hepatitis B carrier pregnant mothers can transmit this to the neonates. Promiscuous populations like prostitutes are important sources of spreading this viral disease, like AIDS, among the different grades of people in our society.

Socio-economic condition: All the factors are compounded by our poor socio-economic conditions. It contributes adversely in multiple ways, like under nutrition and malnutrition, over crowding, lack of education and finally the overall healthcare inadequacy. The end result is initiation and spread of different liver diseases.

Conclusion: To combat this dreadful circumstances, the following courses of action should be taken at national level

* Take up Hepatitis B immunization programme as a national immunization programme with the sole target to ensure routine vaccination of all infants and adolescents.
* Reduce price of Hepatitis B vaccine, so that the vaccine is available to the common people at low cost.
* Ensure mass screening programme, health education and public awareness regarding prevention and correct way of treatment of various medical and surgical diseases of the liver in time.
* Establish national centre for treatment and study of both medical and surgical conditions of the liver. Arrangements should be made for the various types of liver transplantation so that the patients having end stage liver diseases can get immediate proper treatment and other life support in their own country.

All these courses of action will need government initiative, co-operation and support. The nucleus of a liver centre and liver transplant unit could well be started in a central government hospital. It needs organisation of the existing facilities and addition of relevant gadgets and facilities. It does not cost too much in consideration of the cost and sufferings involved due to many liver diseases affecting millions of people of the country.

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