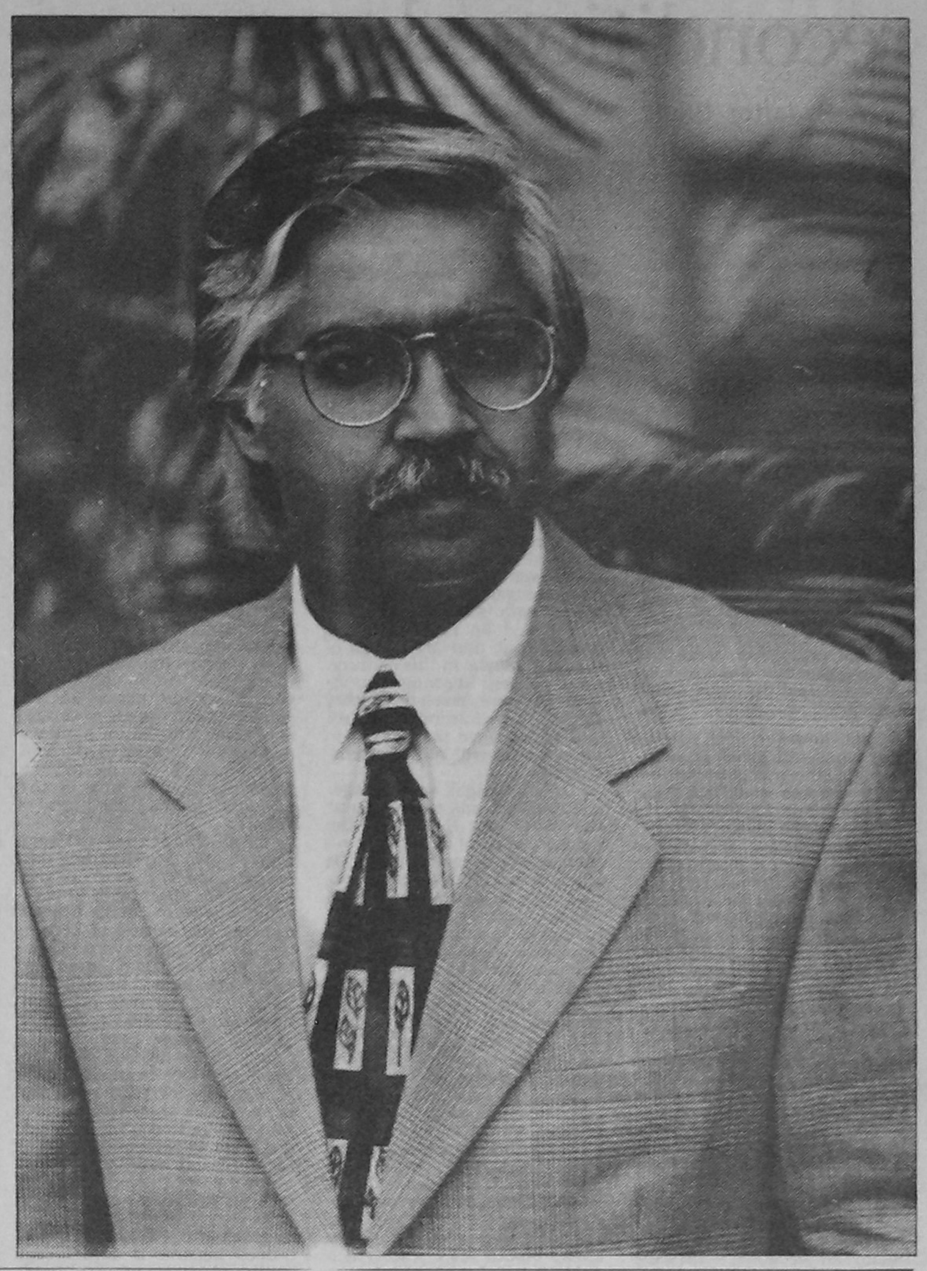
Bangladesh lags way behind in cardiac care

Cardiologists in Bangladesh, in terms of advance technology, are far behind. In fact, they are now at a stage where India was about 15 years ago, leading Indian cardiologists **Dr. Ashok Seth** tells **Naimul Haq**



DR Ashok Seth is a senior consultant cardiologist and chief of invasive and interventional cardiology at the Escorts Heart Institute and Research Centre in New Delhi, India, a leader in providing cardiac care in the Asia-Pacific region. In fact, the wing he now heads is his own brainchild. Upon his return from Birmingham, England, where he held a prestigious position at the Department of Cardiology at the Queen Elizabeth Hospital until October 1988, he planned and executed invasive and interventional cardiology programme at the hospital. Also, he has also introduced newer devices in coronary intervention programme.

A member on the British Cardiovascular Intervention Society, the Asia-Pacific Intervention Society, the Asia-Pacific Society of Interventional Cardiology and several other prestigious association, he also holds honorary faculty positions in premier international cardiology seminars and workshops spanning several countries including the United States, France, Australia, Malaysia, Japan, Singapore, China, Pakistan, Bangladesh and of course India. Dr also serves on the board of several national and international high-tech advisory panels on newer devices and quality control assurance.

Dr Seth provides regular training and guidance in interventional and invasive cardiac procedures to numerous cardiologists from all over the subcontinent including Bangladesh.

He holds many distinguish fellowships that include fellow of Royal College of Physicians, UK and Ireland, Fellow of the American College of Cardiology and fellow of the International Medical Sciences Academy.

Recently, he was on a five-day visit to Bangladesh during which he delivered a series of lectures on interventional cardiology as a visiting professor to the Bangladesh Medical College. Also, he attended several critical heart patients free of cost.

Dr. Seth squeezed some time out of his hectic schedule during his stay in Bangladesh for a brief conversation with The Daily Star. Excerpts:

The Daily Star (DS): What is your purpose of visit to Dhaka?

Dr Ashok Seth (AS): I want to help people of Bangladesh in whatever way I can. I can facilitate transfer of technology to cardiac centres in Dhaka and help enable them develop cardiac treatment facility and elevate to international standard. These cardiac centres can hunt and hone new talents.

My main goal is to try and reverse the number of patients going abroad particularly those who are seeking treatment in this field mostly in India. My biggest challenge and satisfaction would be to create a system that would lead to the creation of excellent centres here in Bangladesh so that people would gain confidence for treatment at those centres here. Gradually, a time would come when they would no longer seek treatment abroad. You see the important thing here is that people go abroad to seek 'better treatment' and, of course, they trust and have confidence in doctors abroad. We must work out to beat this and create the right environment to stop such exodus of patients.

DS: You have visited some of the cardiac centres here, both private and public. What do you think of their standard?

AS: Doctors here, in terms of advance technology, are far behind. In fact, you are now at a stage where India was about 15 years ago. There was a time when doctors started to return to India from abroad. I myself came back from England after 12 years and together with other expatriate Indian doctors developed one of the best heart centres in the Asia-Pacific region. In the same manner experienced Bangladeshi doctors need to come back and develop medical treatment facilities.

DS: What needs to be done to achieve this goal?

AS: One approach would be to train doctors. Help from Indian experts can be sought in this regard. We at Escort through the South Asian Association of Regional Cooperation (SAARC) Cardiac Society allocated one position in both angioplasty and cardiac surgery each year for Bangladeshi doctors. We may increase the number of positions.

The second aspect is to develop specialised fields like cardiac surgery. Technology is changing very fast and things are becoming less complicated. Doctors coming to Escorts would be trained in such high-tech interventions as well as surgery. The doctor taking training would be working in his own setting so that he is capable of working in an environment where the trained doctor once back in Dhaka is capable of carrying out specialised jobs without experts around. We at Escort are ready to provide this backup service required for the local doctors.

The third aspect is making surgery and treatment products or devices available at cheaper rates in Bangladesh. In that we can influence companies to supply disposable at a low cost. I would like to state that I have helped some doctors at the National Heart Foundation and requested US-based major companies in Boston for free supply of products like stents and catheter for treatment of at least four patients during my stay here.

DS: Heart treatment is usually for the rich. Poor virtually do not get proper access to treatment here whereas a large section of poor patients are now found to have heart diseases. How do you think this problem can be addressed?

AS: Well, I have already thought about that. In fact, I want to create a fund in Dhaka for treatment purpose. The aim is not just to reach the affluent in Bangladesh but to reach out to the people who really need it.

DS: How do you intend to achieve it?

AS: The best way to achieve this would be by making contribution for those who cannot afford treatment. There are a lot of affluent people here who come to seek my advice that I will give to my patients free of cost. I will be devoting my time and energy for the benefit of these affluent people. Instead if these people agree to make contribution to the fund I can help those patients who cannot afford such expensive treatment. The funds management will be done locally.

DS: Can government develop high-tech cardiac centres and maintain them?

AS: Quality treatment from high-tech cardiology centres can come from only private sector not government. Government cannot afford and maintain such expenses and examples can be found in the UK and the USA. Private medicine can bring good facility as well.

DS: How does people pay for expensive treatment?

AS: This is where insurance schemes called the third party payment system come in. Employers or government can also pay for treatment by way of subsidies so a commoner does not have to take the heavy burden of paying for expensive treatment like heart surgery. Here I like to mention that there is a boom in medical insurance in India and there are examples in other countries, too.

DS: What about establishing a sub-centre of Escort in Dhaka?

AS: We at Escort would be more than happy to set up one sub-centre here. The purpose is not to make money but to transfer skill through training among young and talented doctors in Bangladesh. This sub-centre will be known as Bangladeshi Escort heart centre. It would act as a centre of excellence for trust instrumental in giving it a reality.

DS: As technology is developing do you think cost of treatment would come down substantially in the new millenium?

DAS: Advancement in technology does not necessarily lead to higher cost. It may be expensive but can be made cheaper through competition amongst the providers and the companies manufacturing the disposable which can make treatment process cheaper. I once stated that life saving devices should be imported free of tax to allow advancement in technology particularly in developing nations. Those, which influence common man's survival, should be given priority in healthcare system. Encouragement should be given to industries manufacturing medical products.

DS: Is heart disease on the rise in this part of the continent?

DAS: Research in this field indicates that it is not really increasing but there is certainly more diagnosis due to awareness among people and, of course, treatment facilities.

DS: Thank you very much for your time.

It's time to brace for the worst

Prevalence of HIV/AIDS in the country is low. Still, the deadly disease can spread at a frightening pace; therefore, there is no reason to feel safe, writes **Dr Nizam U. Ahmed**

AIDS (acquired immunodeficiency syndrome) was first recognised in 1981 when the Centres for Disease Control and Prevention in Atlanta reported unusual clusters of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia among homosexual male populations in Los Angeles and San Francisco and among injecting drug users in New York City. Within the next four years, human immunodeficiency virus (HIV), the virus that causes AIDS, was recognised and surveillance systems for HIV infection and AIDS cases began to emerge.

Currently there are 33.6 million people living with HIV/AIDS world-wide, a figure which represents infection among one in every 100 adults between the ages of 15 and 49 years. At the end of 1999, 12.8 million people had died of HIV infection. Over two million died in 1999 alone. An estimated 5.8 million new infections occurred in 1999, is corresponding to 16,000 new infections each day. Over 95 per cent of these new infections occurred in the developing countries, 1600 are in children under 15 years of age. About 14,000 are aged between 15 and 49 years, of whom over 40 per cent are women and over 50 per cent are in 15-24 age group.

Asia and the HIV Epidemic

Just over one in every five HIV/AIDS cases can be found in South and Southeast Asia. While this pales in comparison to the current epidemic in sub-Saharan Africa, the epidemic in Asia is on the rise. It is expected that one in every four cases will occur in this region by the end of the year 2000. The epidemic in South and Southeast Asia began in the late 1980s, and being a newer epidemic than those in North America and Africa, monitoring systems are still inadequate. An estimated six to 10 million people in this region are currently living with HIV/AIDS, correlating with an adult prevalence of 0.69 per cent, equal to that of North America and much lower than the eight per cent prevalence of sub-Saharan Africa. HIV/AIDS claimed lives of 250,000 people of South and Southeast Asia in 1997, and 220,000 children have been orphaned in this region since the epidemic began. Approximately 1.3 million new infections occurred in South and Southeast Asia in 1997 alone. Although levels of infection and routes of transmission differ greatly within the region, the main mode of transmission is heterosexual contact. Approximately 30 per cent of HIV positive persons in the region are female.

Situation of HIV/AIDS in India

The current HIV/AIDS epidemic in India is representative of the increasing epidemic in South Asia and is reminiscent of the early pattern in Africa, where a sharp increase in prevalence among high risk groups was followed by transmission to the general population. An estimated 5-7 million people in India are living with HIV, making it the country with the largest number of HIV-infected people in the world. Ninety per cent of these cases occur among people aged 15-45 years of age, most of whom are from socio-economically disadvantaged groups. The male to female infection ratio is five to one, with female cases occurring mainly among commercial sex workers (CSW). One study conducted among CSW in India found a rise in HIV prevalence from 1.6 per cent in 1986, to 18 per cent in 1995 and 51 per cent in 1996. A similar study among STD clinic attendees and injecting drug users found a 1.4 to 40 per cent increase among the attendees and a zero to 70 per cent increase among drug users. HIV rates among drug users in Manipur were as high as 73 per cent in 1996-97. Other important vehicles of spread include bridge populations such as long-distance truck drivers and migrant labourers. One study of truck drivers in Madras found a rise in seroprevalence among the study population from 1.5 per cent in 1995 to 6.2 per cent in 1996. Unfortunately, the high-risk groups and bridge populations are not the only communities affected by HIV in India. Prevalence among these groups has reached such a high level that transmission is now rapidly occurring in the general population. An indication of this spread is the infection rate among women attending antenatal care centres. A 1996 study among pregnant women in Mumbai found an infection rate of 2.4 per cent, while a similar study in Maharashtra found that 3.5 per cent of pregnant teens were HIV positive. With such high rates of infection now being seen among all populations, India alone is expected to account for one eighth of the world's HIV infections by the year 2000.

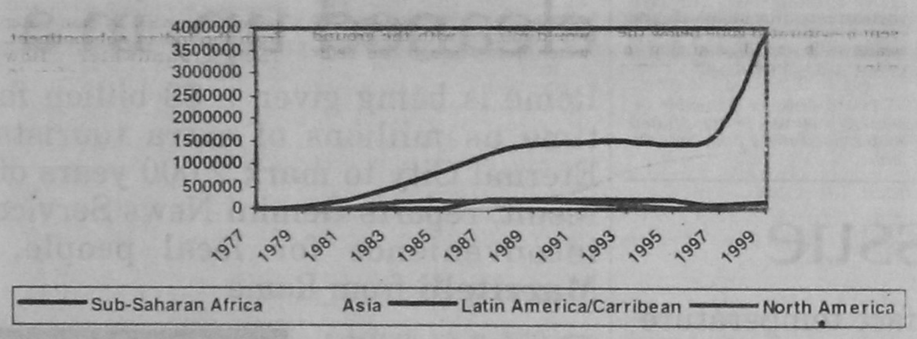


Figure 1. New Adult HIV Infections by Region, 1977-1999

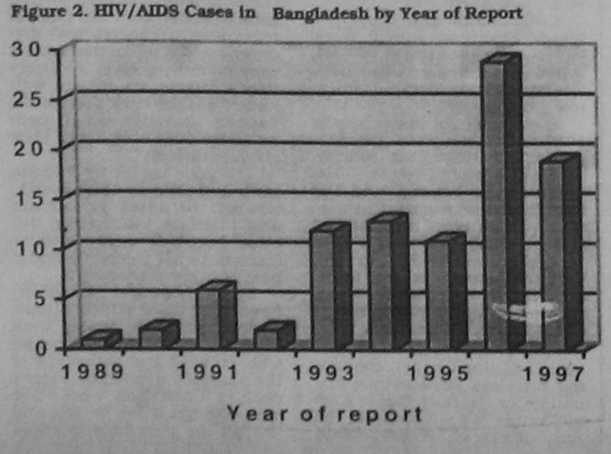
Situation of HIV/AIDS in Bangladesh

The first case of HIV in Bangladesh was reported in 1989, and the first case of AIDS followed in 1990. The number of people living with HIV reported in November 1999 is 126, 83 per cent (104) of them are male. The rest 22 female, out of which 46 per cent (10) are housewives infected by their husbands, followed by five commercial sex workers of whom three are below the age of 16 years. Most of the HIV-infected males are emigrant workers sent back home upon diagnosis. Majority of PLHA in Bangladesh resides in three divisions - Sylhet and Dhaka followed by Chittagong. More than 50 per cent of the infected individuals in the Bangladesh are below 35. The number of AIDS cases is 12, and 10 person already died, the most common cause of death were tuberculosis (5) while others being candidial infection (2), malaria (1), diarrhoea (1), enchephalitis (1).

Prevalence of HIV in Bangladesh is still low according to the First National Sentinel Surveillance for HIV and Syphilis 1997-98, which was conducted by ICDDR,B in collaboration with the government. The results have also shown that HIV is also present in considerable number among high risk groups of the people surveyed, such as CSW 0.6 per cent, intravenous drug users (IDUs) 2.5 per cent, STD patients 0.1 per cent. Men having sex with men 0.2 per cent and overall prevalence among these selected groups was 0.4 per cent. Prevalence of Syphilis is high particularly among sex workers (60-70 per cent) both brothel-based and floating. Although overall prevalence of HIV is low but it is present in considerable numbers among IDUs (2.5 per cent), HIV is also present in brothel-based sex workers. Relatively high HIV prevalence among IDUs (2.5 per cent) suggests that Bangladesh is at the beginning of an HIV epidemic, which has the potential of spreading rapidly.

The estimated number of HIV-infected people is 21,000 according to WHO and UNAIDS (1992). The number of reported cases in males greatly outweighs the number of reported cases in females. For example, of the 29 cases detected in 1996, 23 were male and 6 were female. Of the 17 infected women in the BAPCP data file, 10 are housewives and two are SWs. Of the 68 males in this same data pool, 30 are migrant labourers, two truck drivers and 29 categorised as of 'occupation unknown'. For a graphic representation of the growing epidemic in Bangladesh, see Figure 2.

Figure 2. HIV/AIDS Cases in Bangladesh by Year of Report



Although the HIV/AIDS epidemic is currently nascent or not fully understood in Bangladesh, this country exhibits several risk factors, which could facilitate rapid spread of HIV within its borders. One major problem is a common porous border with India and Myanmar, both of which are currently experiencing HIV epidemics. Bangladesh's risk factors also include premarital sex among approximately 50 per cent of youth, 74,000 migrant workers who leave their homes for long periods of time each year, approximately 225,000 truck drivers and their assistants, 50 per cent of whom have sex with non-regular partners on their journeys. Besides, blood transfusion is a major risk factor. Some 200,000 units of blood are required per year of which almost 80 per cent are drawn from professional blood donors. Among them 20 per cent of professional blood donors are from IDUs who share needles (up to 97 per cent), and over 100,000 CSW, many of whom have a history of STD. One study among CSW in Bangladesh found that 95 per cent had contracted genital herpes and 60 per cent had syphilis. Such diseases not only facilitate transmission of HIV but also indicate presence of risky sexual behaviours such as sex without a condom. If the prevalence of HIV infection in Bangladesh can be limited to less than five per cent in high-risk groups such as CSW, then an epidemic among the general population can be averted. However, control of the epidemic in these groups requires immediate action by government and NGOs in establishing appropriate targeted interventions and STD treatment services for national response in Bangladesh.

Another aspects of risk generating factor are the borders with India and Myanmar. In these two countries HIV/AIDS had already spread in frightening proportions. So considering this situation the conditions of Bangladesh seems to be rather vulnerable because movements of people to and from these two countries exist both legally and illegally. The situation in these countries is more serious than Bangladesh. Any time the situation here could be like that. It has been found that 0.6 per cent of commercial sex workers are HIV-positive in Bangladesh, but there is nothing to feel happy about because when the number was zero there was no multiplication and now when we got a figure no matter how small it may be, it will multiply and the speed of that is very rapid. For example, in 1988 in Thailand one per cent of intravenous drug users were HIV-positive and in 1989 that figure reached 39 per cent. Here in Bangladesh in 1998 we found the figure in the same population as 2.5 per cent, but this figure may have increased many times in 1999. In Myanmar, in 1988 the percentage among drug users was zero, but in 1991 it reached 71 per cent. In India, in 1986 only one per cent of commercial sex workers were positive, in 1995 the figure rose to 18 per cent and in 1996 to 51 per cent. So it is evident from these figures of HIV-positive Indian commercial sex workers as to how fast HIV/AIDS can spread. For that reason we must be cautious about our neighbouring countries. The percentage of HIV-positive people is relatively high in the Indian State of Manipur. But these Monipuris enter our country without any hindrance, without any passport or visa. For that reason we should take special care of that region.

HIV/AIDS is the area of communicable disease control, and arguably of health and human development, where Health Population Sector Program (HPSP) of government needs to demonstrate its ability to act quickly, effectively, and wisely in dealing with high priority. There is still time to avert a catastrophic epidemic. HIV could at any time increase exponentially among and within groups of injecting drug users, commercial sex workers, and their contacts. We are running out of time.

Listen and learn to live

To protect our young generation from the scourge of AIDS, we need to create awareness among them, writes **Dr Shahida Rahman**

TODAY'S children are tomorrow's adults. In our fight to eradicate HIV from the face of the earth, it is of paramount importance that the young generation be protected through incorporating them into fold of activities towards achieving this goal. Our next generation has the right to live in a clean world free from all kinds of blight.

The slogan or the theme of this year for the world AIDS campaign with children and young people is 'Listen, Learn, Live!' which is very timely and accurately chosen as children are more impressionable and have the capacity to learn quicker than the adults. Children have their own way of thinking and also have the capacity to resolve problems, so we should listen to them about their concern. We can confabulate with them to make it easier for them to understand values, respect and realise the profundity of HIV and support them to take up necessary steps towards preventive action. We may also learn something in the process.

The rights of children and young people must guaranteed and those who have HIV/AIDS are to be seen that they are not victimised of stigma. If anybody suffers from any disease, he, in any way, is not to be accused. Medically accusation tantamounts to crime. The medicos in health care are to relieve pain and give comfort and try to alleviate physical and mental sufferings.

Proper knowledge of infection dissemination will help the younger generation to adopt safer sex behaviour as has been observed. By young people we mean people who are below the age of 25 years and children means up to the age of 18 years.

One-third of the 33.4 million people living with HIV as on December 31 1998 were people aged between 15 and 24 years. In 1998, five young people, men and women, became infected every minute. Three million contracted infection with HIV of all new infections, of whom half belonged to this group. HIV itself is a dangerous phenomenon, and on top of that the children issue is even a greater headache. What happens to a family when elders suffer from the incurable disease in a country where large section of adult community die of the ailment, the children became orphans as has happened in Uganda and Ethiopia. In Uganda 1.7 million children are orphans. Zimbabwe is another one where in 1997, seven per cent children under 15 lost their mothers.

Gender discrimination even with young girls are usual. Due to negligence and denial of their rights, they hardly have control on sexual exposure and thereby HIV infection. Child trafficking has been unveiled to behold a grisly scene. It revealed that one million children were in sex trade all over the world in 1996.

About 100 million children in the world do not have shelter and live on streets in violent and dangerous situation. Even in their own houses children are being mentally and physically abused which may make them prone to high risk sexual behaviour which causes vulnerability to HIV.

HIV and AIDS affected people need significant amount of health care as it is a special issue encircling a number of problems. HIV infection gradually progresses to even more serious complications and eventually death.

HIV/AIDS is a multi-sectoral and multi-disciplinary issue. Time has come when AIDS campaign exclusively for children and younger people is to be carried out. Nearly three million children died of AIDS world-wide ever since the epidemic started. One million children are living with HIV. Child mortality has been increasing due to the child birth of HIV infected babies. Apart from that the child may get infection by breast feed.

Instead of the infection being reduced, more people are falling into the grip of HIV which is utterly frustrating. HIV is slow in its action. Carriers look normal and healthy who are unaware of their carrier state till they became confirmed by blood or saliva examination, once infected, remains infected for life.

Then, what is to be done? The answer is prevention, prevention from HIV. Utmost importance is to be emphasised on women. Women are to be protected from being infected with the virus, family planning services to be provided in places where it is not available, and if unwanted pregnancy occurs, then to void the already infected foetus (when law permits).

So awareness strategy is to be established. Advocacy and awareness campaign are to be undertaken in every aspect of community. Antiretroviral therapy and replacement feeding to be made available for the women who still wants the baby to be born. In the awareness process, already infected mothers are to be informed that they are HIV positive. Voluntary counselling and testing are to be arranged.

If nothing is done to reduce mother and child transmission, then prevalence of HIV/AIDS will go up. It is calculated in the areas (most sub-Saharan countries) where the 20 per cent of the pregnant women HIV-positive, the cost for caring of HIV infected and dead children will be extremely high. The sick parents will be struggling to take care of their sick children on top of their own ill health.

Today's HIV infected people are AIDS patients of yonder years. More than 8,500 children and young people become infected with HIV daily, six every minute.

Therefore, we are to prepare ourselves with preparedness. The danger is imminent. With adequate fund accumulations, research trial centre with health professionals and biomedic engineers to be opened from where community based prevention and treatment programmes are to be conducted.

The hard-earned child survival in many countries for example in sub-Saharan countries has had a setback. Life expectancy between 10-15 years has declined and mortality rates are increasing as more babies are born with HIV.

Socio-economic impact is unbelievably high. HIV creates a great pressure especially in countries where economic factor is acute.

The 1997 AIDS Campaign was for "Children living in a world with AIDS". Those children are to be incorporated and amalgamated in HIV/AIDS epidemic assembly. UNDP supports governments to strengthen and expand the capacity building programmes of HIV/AIDS epidemic. UN theme group works through Resident Coordinators of the countries. It helps to initiate in the community to undertake ethical, legal, human rights, gender sensitive issues, and empower people.

The estimated number of children newly infected with HIV under 15 years in 1998 was about 590,000 globally. In South and South-East Asia was 55,000 and Sub-Saharan Africa, 530,000, the highest number in the world. The newly infected of young people with HIV are to take control of their problems that arise in their own set-up based on the local values and knowledge to create favourable political, economical and social environment. Under 15-24 years was more than 2.5 million during the same period. 700,000 were in Asia and Pacific and 1.7 million in sub-Saharan Africa whereas in North America where AIDS was first spotted was more than 25,000 as the country has been able to stall the intensity of HIV. The Latin America and Caribbean islands had more than 65,000, Eastern Europe and Central Asia, more than 25,000 and Middle East and North Africa above 5000.

Children estimated to have been orphaned by AIDS at 14 years or younger at the end of 1997 was 200,000 in South and South Asia, 2,200 in East Asia and Pacific and in Sub Saharan countries was 7.8 million. Total cumulative number was 8.2 million around the world.

To contain HIV infection a healthy rapport between children and parents/guardians is a necessity. Communication between them is very important, and for that the adults must provide a healthy and congenial surroundings for their progeny. Parents and children should know each other, they should know themselves, their likes and dislikes, what they are, their desires, their habits and what hurts them.

The alarm bell is ringing in the atmosphere of Bangladesh to expedite the action against the oncoming epidemic explosion. It is all the more important as Bangladesh is a poverty stricken country. Right now, what we are in need of is more sustainable funding on HIV/AIDS sector and evaluation on the positive aspect of the intervention already done.

The writer, former National Consultant, HIV/AIDS, BAPCP & MOH & FW, is Chairman, Rotary District 3280 (BD), AIDS & Drug Abuse Committee.