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According to the UNICEF,every year, close to 11 million children are dying due to preventable diseases.

The figure is indeed a distress call. But it is just one of the worrisome epidemiological data being collected and analyzed by health experts from around the world.

The article "Code blue for global health situation' provides an overview of the health status of the global population. For the past 30 years or so, new diseases have emerged while diseases that have been eradicated or controlled before are resurging. The global community also got a scare when the Severe Acute Respiratory Syndrome first appeared in China and quickly spread to other parts of the world. Authorities are also keeping a tight watch on the possible mutation of the bird flu virus.

It is ironic that the century that saw a number of significant achievements in the field of medicine is also characterized by too much death and sufferings. For example, despite the development of effective anti-retroviral drugs, thousands are still dying of HIV/ AIDS especially in sub-Saharan Africa. To explain this irony, Dr. Prem John touches on the socio-economic and political determinants of health. Often, these determinants are deliberately ignored since discussing these would mean shaking the prevailing world order. He contends that unhampered globalization results in social inequities and injustices and compromises the people's health.

The editorial provides a framework for an alternative discussion of health issues, such as the migration of health professionals and the impact of wars on people's health. Dr. Wim de Ceukelaire also provided a critique of the Millennium Development Goals and compared these with the ideals of the Alma Ata Declaration.

Amidst the over-all gloomy scenario in the health front, there are also positive undertakings that are worth mentioning. An example of this is the effort of the Social Assistance for the Rehabilitation of the Physically Vulnerable (SARPV) to rehabilitate rickets patients in Bangladesh. The discovery of a high incidence of rickets in several districts in Bangladesh came almost by chance, but the research and rehabilitation programs that followed saw the participation of experts from around the globe.

Solving the global health crisis requires more than the realignment of funds and resources, or sophisticated technological advances. More importantly, there must be a strong will to confront and solve the social inequities and injustices that condemn the people to lives of abject poverty.

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Staying alive in an unjust world

by Prem Chandran John

The world today, especially for the poor and disadvantaged, is an infinitely more difficult place to remain healthy or to have access to factors that contribute to health such as food, clean water, and shelter. All these are essential for decent lives, along with other basic rights. However, these have been deliberately and systematically denied to large masses of people, especially in the Third World, by uncaring governing classes. This is accentuated by the emerging processes of globalization. '*Freedom from'* want (of basic subsistence and educational needs, for instance) as well as '*freedom to'* undertake activities of one's choice to achieve personal goals and to develop *capabilities* to undertake such activities, are at stake.

The Problem

Poverty is increasing worldwide, triggered in part by an unjust economic system that is skewed in favor of a handful of powerful multi-national corporations. This injustice is perpetrated by developed nations and multilateral institutions such as the IMF-WB and the World Trade Organization (WTO).

Today, two billion people live on less than $2 dollar a day, while one billion more make do with less than $1 a day. With extreme poverty comes a life characterized by illiteracy and squalid living conditions. Another major problem is the outbreak of both sporadic and long-term wars, which are often waged to protect the vital interests of only a few. Consequently, the health of the people is the first to suffer.

Root cause of poverty

Throughout the history of human kind there has been only one basic cause of poverty – lack of access to and control over resources. The wealth and income generated by this access were unequally distributed. This was the root of global poverty. The theory of neo-liberalism, fiercely espoused by IMF-WB and WTO, calls for free enterprise unhampered by state controls and regulations.

The poor always bear the brunt of globalization. *Two boys scrounge for scrap materials in a pile of garbage.*

Photo by April C. Alojado

There are three main areas of impact of globalization: its impact on environmental quality, its impact on the quality and accessibility of health services and its promotion of unhealthy lifestyles. At each historical stage in the globalization process, the people most vulnerable have been the poor and the disadvantaged. There has been a spread of various communicable diseases, global promotion of unhealthy products and practices, global diffusion of technologies and production processes harmful to health and environment, global promotion of inequitable forms of private health care and global diffusion of western norms, practices, power relationships and social inequities.

All available evidence suggests that policies associated with globalization in the last two decades have had strongly negative implications for developing countries. Primary health risks posed by globalization are: perpetuation and exacerbation of income differentials, fragmentation and weakening of labor markets, consequences of global environmental challenges (as a result of climate change, in sub-Saharan Africa, South and South East Asia and Pacific Islands, the number of people at risk of hunger is projected to rise from 38 to 300 million by 2050), spread of smoking-related diseases as tobacco industry expands, diseases of dietary excess, spread of urban obesity, international drug trade exploiting inner-urban under class, spread of disease through increased travel and increasing depression and mental illness.

Commerce has also extended its grip on health policies. The IMF-WB's Structural Adjustment Program calls for a reduction in budget allocation for social services, including health. This has resulted in a global downward trend in health budget allocations that further exacerbates the worsening delivery of health care services. It is not a mere coincidence that the health care industry is booming as private health care providers scramble to fill the gap.

Countervailing strategies

The effects of globalization have to be fought at various levels. At the *Global Policy Level*, public health should be at the center of development approaches. The spirit of paragraphs four to six of the Doha Declaration has to be revived and implemented.

Revenue for development has to be increased through taxation. There are several pending global taxation schemes that could bring in much-needed fund for global development programs. A prime example would be the Tax on Energy. Even at $1 a barrel, this will bring in a large revenue and comply with the emission standards under the Kyoto Framework Convention on Climate Change. There is also the Tax on Arms Trade which could generate $62.6 billion. Money is there for the asking but we need political will to raise it for development.

There are several other policy options which we must seriously consider. These are grounded on three cores: democracy, a humanistic political culture and an economy oriented to meeting the needs of human scale development in the widest sense.

Fast Facts

- Ratio between the poorest and richest 20%
  - 1900 : 9:1
  - 1990 : 70:1
- Life expectancy world average : about 68
  - Sub-Saharan Africa : 35 and falling
- GNP per capita
  - Of richest country $ 35,000
  - Of poorest country 200

As we stand up to be counted among activists who want to fight the status quo, there are several avenues and several levels where we can play a constructive role in not merely building coping strategies but in playing a transforming role. We all have an obligation to stand on the side of the poor and oppressed as against the rich and the powerful and with the profound hope that good will ultimately prevail. We must also call for and work towards developing a *global state of mind* characterized by inclusion, détente, engagement, diplomacy that is cooperative, compromising, multilateral, magnanimous and reciprocal as opposed to exclusion, confrontation, domination, enmity, diplomacy that is adversarial, intransigent, unilateral and exploitative; power that is used to maintain superiority through compulsion and punishment.

Some other values that should prevail are: *solidarity*, a concept that is at the heart of African philosophy and unifying worldview as enshrined in the maxim "*umuntu ngumuntu ngabantu*" which translates as 'a person is a person through other persons', accepting *human rights* as civilizational standards keeping in mind that "Western ownership of human rights poses risk to the global success of the human rights movement" and working towards equity as a value in itself – (the provision of equal shares for equal needs or the provision of unequal shares for unequal needs as long as proportionality is maintained).

Finally, we work towards two procedural goals: (1) the development of a coalition of social forces with a global agenda such as the People's Health Movement (PHM) which represents what can be termed as globalization from below -- the kind of global solidarity and collaboration that occurs when groups of people at the grassroots level around the world link up to protect their interests against the forces of globalization from above; (2) building and holding accountable multi-lateral governance structures in which people will have a central role. This means grassroots level participatory democracy, a populace that is alive to its common needs and potential, intervention into local governance, holding local governing structures accountable and the ability to form coalitions quickly to right the wrongs of the ruling classes. This is the agenda for activists and the roadmap for radicals if we truly believe that another world is possible.

Dr. Prem John Chandran, is a former coordinator of the Asian Community Health Action Network (ACHAN) and the People's Health Movement (PHM). He is one of the WHO Regional Facilitators for Civil Society in Asia looking at the Social Determinants of Health.

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Code blue for global health situation?

by Ross Mayor

Given the technological advances in the field of medicine, the possibilities for a healthy population are endless. However, given the current scenario, all these would remain just that – possibilities.

Communicable diseases

The prevalence of communicable diseases is a key social determinant as its occurrence is often concentrated in poor countries where sanitation, access to health care facilities, and nutrition are often problematic.

Tuberculosis (TB), for example, remains to be a public health concern in most developing nations. According to the World Health Organization (WHO), one-third of the world's population is infected with TB bacillus. In 2004, the Southeast Asian region recorded the highest number of new cases, accounting for 33 percent of recorded cases. The sub-Sahara African region, meanwhile, had the highest per capita incidence estimated at 400 cases per 100,000 population. WHO also put to 1.7 million the number of deaths caused by TB.

While highlighting the need for a comprehensive TB program, the report also put a positive spin on the control of the disease. It noted that in five out of six WHO regions, TB incidences were either stable or falling. The exception was sub-Saharan South Africa where the rising incidence of HIV/AIDS contributes to the growing number of TB cases.

Ten countries with the most number of TB cases

Country	Incidence
India	3,394,040
China	2,892,422
Nigeria	683,847
Bangladesh	606,106
Indonesia	605,759
Pakistan	508,754
Ethiopia	403,098
Philippines	378,094
South Africa	316,260
Democratic Republic of Congo	307,554

The Centers for Disease Control and Prevention (CDC) also noted the re-emergence of vector-borne diseases such as malaria. In "Resurgent Vector-Borne Diseases as a Global Health Problem," the CDC's Duane J. Gubler pointed to a number of reasons leading to the emergence or resurgence of vector-borne diseases. These are "the changes in public health policy, insecticide and drug resistance, shift in emphasis from prevention to emergency responses, demographic and societal changes, and genetic changes in pathogens."

Malaria accounts for an estimated two million deaths every year, and the problem is compounded by drug and insecticide resistance. Like malaria, dengue is another vector-borne disease that has a wide global scope. According to the CDC, the disease threatens the health of 2.5 billion people.

HIV/AIDS

In its 2006 Report on the Global AIDS Epidemic, the UNAIDS reported that 2.8 million people died of the disease while more than four million contracted it. Of the 38.6 million people living with HIV/AIDS, 24.5 million live in sub-Saharan Africa.

The report also brought to fore the impact of HIV/AIDS on women and children. It put to 17.3 million the number of women with HIV/AIDS, 76 percent of which live in sub-Saharan Africa. In low- and middle-income countries, mother-to-child transmission remains a problem. The report stated that only 9 percent of pregnant women in these countries were offered services to prevent transmission. The result is downright tragic: everyday, 1800 children get infected, most of whom are new-borns.

The accessibility of services and facilities is another concern. It said that less than one in five high-risk people has access to prevention facilities, while only one in eight people has access to testing facilities.

China is also in the radar scope of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The latest figure released by UNAIDS, WHO, and the Chinese Health Ministry showed that China registered an estimated 70,000 new cases of HIV last year. This brings to an estimated 650,000 the number of Chinese living with HIV.

When it comes to funding, there has been a significant increase in resource allocations. Available resources in 2005 reached US$8.3 billion, up from US$ 1.6 billion in 2001. However, there is still a projected financial gap since an estimated US$55.1 billion is needed within the next two years to combat the menace.

Non-communicable diseases

Cases of non-communicable or chronic diseases continue to spike. In "Preventing Chronic Diseases – a Vital Investment," WHO estimated that around 35 million people would die of chronic diseases in 2005. It identified the diseases as cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes. It warned that mortality rate would increase by 17 percent between 2005 and 2015 if no action is taken to stop this trend.

Belying the assumption that chronic diseases are more common in developed countries, the report stated that 80 percent of death would occur in low-income and lower-middle income countries.

The report also highlighted the growing problem of obesity. In 2005, the number of obese people hit 1 billion. This is expected to rise to 1.5 billion by 2015. WHO noted that the problem is most serious in the Pacific islands of Nauru and Tonga where nine in ten adults are overweight.

On the other end of the spectrum, there has been a modest drop in the number of malnourished since the 1980s. However, one in three children in developing nations remains undernourished. Together with nutritional deficiency, obesity and malnutrition are the underlying causes of more than half of diseases.

> A healthy world will come if – and only if – abject poverty and social injustice are addressed.

Threat of pandemic diseases

The new millennium witnessed the emergence of new diseases, as well as the mutation of known diseases into more lethal forms. In 2003, Severe Acute Respiratory Syndrome, a lethal form of pneumonia, first appeared in China. Within a few months, the disease has spread globally, affecting 8,098 patients. Of the figure, 774 died.

In May 2005, WHO declared that the disease has been eradicated. Nevertheless, the outbreak gave a glimpse of the global community's preparedness – or lack of it – in handling potential pandemic diseases.

Also on the warning radar is the possible mutation of the avian influenza virus into a more potent strain. As of October 2005, 67 people from Asia and Europe died of bird flu. While experts are yet to declare the flu as a pandemic, there is an urgent appeal to prepare for a mutation, which can affect 20 percent of the world's population.

Flat line effort?

Why is it that the world remains to be threatened by ill-health? Why is it that the poor and marginalized seem to take all the brunt?

The answer may lie in the prevailing band-aid solution to global health problems. Governments and health institutions are scrambling to cure the symptoms, without getting to the bottom of the issue.

A healthy world will come if – and only if – abject poverty and social injustice are addressed. As such, there is a need to reexamine the prevailing world order and make it more responsive to the people's needs.

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Migration of health professionals: boon or bane

by Ross Mayor

The current wave of health professional migration sweeping developing countries is another black spot in the global health system. Today, the high number of health professionals leaving for more lucrative jobs abroad is straining the public health care systems of the affected source countries.

Exporting Health Professionals

The migration of health professionals is not an entirely new phenomenon, but the latest wave is producing a more pronounced adverse impact on source countries due to the unusually high number of migrating health professionals.

In the Philippines, 85 percent of registered nurses are working abroad. The demand has also spawned a phenomenon unique to the Philippines: doctors are leaving their profession to become nurses. There is an estimated 4,000 Filipino doctors who are currently enrolled in nursing course. In Fiji, the number of registered nurses leaving for jobs abroad exceeds the number of new nursing graduates. According to Fiji Nursing Association secretary-general Kuini Lutea, the Pacific island produces between 150 to 160 new nursing graduates, but almost 50 percent of these are migrating to other countries.

Doctors are also prime labor export. India is currently the top exporter of doctors; there are more Indian doctors in America than in India. The ratio of Indian doctors to American patients is 1:1325, while the ratio of Indian doctors to Indian patients is 1:2400. Pharmacists, medical technologists, and other allied medical professionals are also in demand.

Impact on source countries

On the upside, remittances from migrant workers are keeping the source countries' economies afloat. The downsides, however, far outweigh the benefit. The mass migration of health professionals is further worsening the already dismal health care delivery of the source countries.

In the Philippines, data from the Philippine Hospital Association showed that 200 hospitals have already closed down due to lack of medical personnel and 800 more are partially closed down. As a result, health services become even more inaccessible. The National Statistics Office 2003 Report stated that seven in ten Filipinos are dying without ever receiving medical treatment.

The gap also affects the quality of health services since those who have left are often experienced nurses and doctors. Today, it is no longer unthinkable to have novice nurses assigned to sensitive posts, such as in the operating room or intensive care units.

Medical personnel who are left behind also feel the pinch since they have to take the slack. At the Asia Pacific Nursing Congress held in Australia, Lutea reported that in 2004 alone, they have documented eight cases of nurses who have died due to stress-related diseases caused by their almost impossible workload.

Causes

The primary push factor for the migration of health professionals is finances. Source countries are often developing countries that present limited opportunities. Health professionals in these countries are often underpaid and overworked. In the above-mentioned countries, the average monthly salary of health professionals is between US$200 – US$300. In contrast, host countries offer as much as US$ 4000 per month. Another often cited push factors is the lack of opportunity for career growth in the source country. Lynnette Baquial, a Filipino medical technologist working at Florida Hospital Ormond Memorial, cited this factor. She said that in the US, there is a compensation for hard work, unlike in the Philippines where health professionals can only get a raise if they are promoted.

For host countries, the shortage is due in part to ageing population, as well as the sharp decrease in the number of people entering the medical profession.

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Collateral Damage

Wars do not only lead to loss of lives and limbs; it contributes immensely to the further deterioration of the global health care system.

In recent years, with the development of more sophisticated and deadlier weapons, mass killings have become common place. In Iraq alone, the estimated number of civilian deaths since the 2003 US-led invasion was more than 100,000. Civilian injuries, meanwhile, was placed at ten times the death toll. According to Med Act, the number is expected to rise due to an estimated 10 million land mines planted in northern Iraq alone.

The mental and emotional costs of wars cannot also be ignored. The United States Department of Veterans Affairs reported that 1/3 of its service personnel often seek help for mental stress caused by their exposure and participation in a conflict. Both combatants and civilians are prone to experiencing post traumatic stress disorder. For children, the effects can be long-lasting. Psychosomatic symptoms of their trauma include

within its territory, doctors have sounded the alarm for dwindling supplies and medicine. In Palestine, meanwhile, 22 hospitals are currently relying on generators since Israel have bombed many of Palestine's electrical plants. The results are catastrophic: data from the Palestinian Statistics Bureau showed that 200 operations are postponed daily. Premature newborns hooked on life-support machines are also threatened.

Business as usual

Wars are being waged either in the name of democracy or religion. However, one thing is certain. Gruesome as it may be, wars mean a healthier global arms trade that generates US$900 billion annually. The US remains to be the leading supplier of killing machines, followed by Russia, France, and Britain. Not surprisingly, global military spending have hit the US$1-trillion mark in 2004. The spending is boosted primarily by the US, which launched two major wars in the last three years.

Another practical business application of war is in opening new markets and generating new business opportunities. For example, major reconstruction works in Iraq were awarded to predominantly Western-based firms. One of these firms is Halliburton, which has ties to US Vice President Dick Cheney. The Iraq Revenue Watch reported that US and UK firms cornered 85 percent of the value of

, while Iraqi firms accounted for

ne remains to be profit. It is a
le's lives and health are among
ed. As weapons become even
bal community faces a bleaker
, the threat does not only come from pathological organisms; it comes, literally, from the barrel of a gun.

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Solutions

The migration of health professionals is a complicated issue as it encompasses socio-political and economic factors. Despite the alarm sounded by health experts in source countries, most governments are only too eager to export its highly-skilled workers.

One of the most often discussed solution is to compensate the source countries for the costs of educating its health professionals. However, this solution alone will not address the basic problem of inaccessible health care. A lasting solution would only come when governments would start to respect the people's inherent right to health and start to take care of its own health professionals.

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Health for Half

by Wim De Ceukelaire

While the promises of the Millennium Development Goals are welcome, its inadequacies, shortcomings and limitations are only too evident when comparison is made with the 1978 Alma Ata Declaration.

THE Millennium Development Goals (MDGs) are high on the agenda of summits and conferences and are heavily influencing the development discourse of multilateral agencies and NGOs. Health figures prominently in the MDGs as almost half of them relate directly to health and health is an important contributor to the other goals. According to the late Dr Lee Jong-Wook, the last director-general of the World Health Organization (WHO): 'Improvements in health are essential if progress is to be made with the other Millennium Development Goals.'

As health is so important for the MDGs and the goals are so intimately related with health, we have ample reason to take a closer look at them and at their background.

Where do the MDGs come from?

The Millennium Development Goals are the result of the United Nations Millennium Summit that was held in September 2000. This summit was an attempt to put the UN back at the forefront of international political and economic relations in the new century after the organization had lost much of its influence during the 1990s. At the end of this meeting, the 147 heads of state and government who were present adopted the Millennium Declaration that is supposed to reflect their commitment to development and poverty alleviation. This commitment was summarized in eight goals related to poverty alleviation and development that are to be attained by 2015. For each of these eight goals, the UN has formulated targets that are made measurable by a set of 48 indicators.

Although the MDGs are a UN project, it was the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD), the club of rich countries, that pioneered the idea of 'International Development Goals' in 1996. After approval of the International Monetary Fund (IMF) and World Bank, they were adopted as the MDGs in the Millennium Declaration. To a large extent, the MDGs are the goals of the industrialized countries.

What is to be eradicated?

Since the MDGs largely reflect the development agenda of the industrialized world, it is not surprising that they are criticized for lack of ambition. Indeed, a closer look at the goals reveals they are far less ambitious than they seem. For example, the first goal is to 'eradicate poverty and hunger'. According to the corresponding target, however, this will be achieved by halving the proportion of people living on less than US$1 a day and the proportion of people who suffer from hunger by 2015. Take note that the plan is to halve the proportion of the poor and not the actual number. Because of population growth, absolute numbers will not be cut in half. Moreover, the base year is not the year 2000, as one would expect, but 1990, which makes the plan even less ambitious.

Although they are supposed to be development goals, the MDGs refer to hunger, poverty, child mortality etc. These are the consequences of mal-development but that doesn't mean that development will be brought about by their eradication. The absence of poverty and hunger, even if it would be possible, doesn't necessarily mean that society is developed, let alone that a sustainable state of development has been brought about.

	Alma Ata
Goals	Health for All
Targets	The attainment by all peoples [of] the world by the year 2000 of [a] level of health that will permit them to lead a socially and economically productive life.
Moral framework	Health is a fundamental huma[n] right
Strategy	Comprehensive primary healt[h] care
General objective	Equity and economic justice
Economic context	Economic and social development, based on a Ne[w] International Economic Order
International context	A genuine policy of independence, peace, détent[e] and disarmament.
Peace	Make better use of the world'[s] resources, through the re-allocation of spending on armaments and military confli[c]...

Are these development strategies?

The focus on measurable indicators reflects a certain attitude towards development. It considers development as a ‘technical’ problem that should be solved by ‘technical’ solutions. It is exactly because of this erroneous focus on ‘technical’ approaches that the solutions that have been offered are likewise focusing on ‘quick wins’. In fact much effort is wasted on calculating how much money would be required to solve this or that problem as if it is only a matter of money. In 2001 there was the WHO Commission on Macroeconomics and Health that called for US$27 billion in annual donor funding. In January 2005, Jeffrey Sachs’ Millennium Project called for an extra US$73 billion in 2006, rising to US$135 billion in 2015 to achieve the MDGs.

What global partnership?

The ‘global partnership’ is touted as the linchpin of the MDGs but it might be its Achilles’ heel instead. The governments of the rich and the poor countries are supposed to work hand in hand with the multinationals in order to bring about a better world. It sounds like a fairy tale and it might as well be one. Is it really realistic to expect the plunderers to repent and help their victims?

This kind of reasoning is only possible because the MDGs are focusing on the consequences instead of the causes. The whole Millennium Declaration does not make any reference to the causes of poverty and hunger. It is not surprising therefore that the MDGs fail to provide any hint of a solution. In reality, the poor and the hungry are the products of historical processes of marginalization, mal-development and exploitation. Addressing poverty and hunger requires addressing these forces and processes that are at the root of inequity and marginalization.

It does not help that the World Health Organization, the main global agency tasked to monitor the people’s health, is failing in its mandate. The tentacles of capitalism have health care provision in its deadly grip.

The people’s goals for health

In 1978, at the Alma Ata Conference, ministers from 134 countries in association with the WHO and UNICEF called for ‘Health for All by the Year 2000’. The Alma Ata Declaration reaffirmed the WHO’s holistic definition of health as ‘a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity’. Moreover, it went on to signal that the ‘existing gross inequality in health’ was unacceptable, that people have a right to participate in the organization and implementation of health care, and that primary care should be universally available. Finally, signalling the responsibility of governments for health, the declaration launched the ambitious goal of ‘health for all’ by the year 2000.

Despite its ambitious aims, Alma Ata did not exactly go off the ground. It did not fail to deliver; it was never properly implemented as it was a real challenge to the existing world order. Imperialist powers have succeeded in supplanting the radical views of the Alma Ata with the “harmless” principles behind the MDGs.

For the people’s movement, however, the year 2000 was an occasion to come up with the People’s Charter for Health that reaffirms the principles of the Alma Ata Declaration. A comparison between both approaches reveals why the Alma Ata Declaration could also be called the people’s millennium goals for health (see table).

With all the hullabaloo about the MDGs, we have to keep our priorities right. Of course the promises of the Millennium Declaration are welcome but they are also too little too late. Moreover, the MDGs should not make us forget that the people are not contented with ‘health for half’ when ‘health for all’ is possible. The Alma Ata Declaration and the People’s Charter for Health are leading the way.

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Solving the rickets puzzle in Bangladesh

Rickets is no longer thought of as a major global health issue since the disease has been virtually eliminated. However, there is now a growing awareness that rickets is re-emerging as a public health threat, especially in developing countries.

In Bangladesh, the issue of rickets was brought to the fore in 1991 when the Social Assistance for the Rehabilitation of the Physically Vulnerable (SARPV) visited the district of Cox's Bazaar after a cyclone. More than the devastation, SARPV founder Shahidul Haque also noticed that there were a high number of children with leg deformities. The symptoms point to rickets, but there was an initial hesitation since the disease rarely appears in temperate countries such as Bangladesh.

Puzzled by the occurrences, SARPV conducted a series of studies and rapid assessment surveys. Initially, the studies were limited in Cox's Bazaar, but it soon encompassed other districts. In 1994, Dr. Cimma diagnosed the condition as calcium-deficiency rickets. Four years later, the diagnosis was confirmed by a consortium of international experts composed of SARPV, Cornell University, France's AME, and UNICEF – Bangladesh.

With the identification of the disease, the consortium shifted its focus on the food consumption pattern of the affected districts. Nazmul Hassan of the University of Dhaka and Gerald Combs of Cornell University conducted a year-long study entitled "Household Risk Factors for Rickets in Bangladesh." Six villages in Chakaria were selected; three with the lowest incidences of rickets, and three with the highest. The study investigated the food consumption pattern of a total of 480 households, 199 of which were found to have at least one child with signs of rickets. Preliminary analysis of the data obtained showed the following:

- The probability of having a child with rickets increased based on the following: women with repeated pregnancies, large family size, higher number of children below five years old;
- The use of colostrums, breastfeeding, and late weaning decreased the probability of rickets;
- There was no correlation between the incidence of rickets and consumption of rice, fresh and dried fish, and leafy vegetables;
- Families who grew their own poultry had less incidences of rickets than those who did not own fowls;
- Rickets households reported a higher incidence of respiratory illness

In another study conducted by SARPV, the focus was on tribal communities where there is a lower incidence of the disease. Their food consumption pattern was also compared with that of the lowlanders to determine a correlation. Thirty-five ethnic households from two districts (Banderban and Cox's Bazaar) and seven villages and 35 households from the lowland were selected for the study.

With regards to food intake, it was found out that ethnic households consume more vegetables than lowland households, but lowlanders eat more chilies and spices. Ethnic households also consume less dry fish, but the study did not establish a correlation between the consumption of dry fish, which is preserved with chemicals, and incidences of rickets.

Other noteworthy data obtained from the studies were the following:

- Ethnic households dress less than lowlanders, exposing more body areas to sunlight;

Rickets as a global health problem

by Nick Bishop
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The true global prevalence of rickets remains unknown, although it has been suggested that it is the commonest non-communicable disease of children. Obtaining a true estimate is complicated by the different criteria used by investigators to identify cases of rickets. However, even where the “hard” diagnostic criteria of characteristic radiological and biochemical abnormalities are used, population-based data are hard to find. Surveys of vitamin D sufficiency in the United Kingdom show that 25 percent of children of South Asian origin start winter with low vitamin D stores as assessed by measuring 25-hydroxy vitamin D in serum. The use of “softer” clinical criteria such as craniotabes, ribs beading and at least one of hypotonia or excessive perspiration – the criteria currently used in studies in Mongolia - are likely to over-estimate rickets prevalence. Over 50 percent of children and infants were reported as showing one or more of the clinical signs of rickets in studies undertaken in Mongolia in 1997.

There have been reports of rickets from every continent during the last two years, indicating a truly global problem. The reports identify a series of common aetiological strands. Rickets occurs

- where maternal and child exposure to sunlight is limited by atmospheric pollution, by clothing for warmth or for cultural reasons;
- in dark-skinned populations in temperate regions where there is prolonged breast feeding and no oral supplement of vitamin D is given;
- where there is good exposure to sunlight, but there is malnutrition and minimal intake of milk and other dairy products.

It can be seen from the above that one can predict that rickets will be prevalent in specific areas:

- where rapid industrialization is leading to increased atmospheric pollution;
- where social, cultural or climatic factors preclude skin exposure;
- where consistent access to primary medical care and advice is problematical;
- where poverty means that malnutrition is a major problem for the whole population;
- where the above factors are combined.

Rickets is increasingly recognized as a failure of health education and health care delivery in many countries. It is not a complex disease – the causes can be clearly identified in the great majority of cases. There are major problems in delivering vitamin D and calcium to many of the “at risk” populations, but the challenge is one which must be met. It is a worthwhile and achievable aim.

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- There is a wider birth spacing among ethnic households, allowing for longer time for breast-feeding

These studies have afforded the consortium important glimpses into the extent of the disease’s prevalence in Bangladesh, as well the causes. However, the results of the studies barely scratch the proverbial tip of the iceberg. Experts are still looking for an explanation for the re-emergence of the disease, as well as its prevalence in Chakaria. The district’s food consumption pattern alone is not enough to explain ricket’s prevalence in Chakaria since other districts also have a low-calorie diet. Moreover, Combs noted that the at-risk children are not necessarily the most malnourished in Bangladesh.

Treatment

SARPV’s rickets studies definitely require a postscript as more questions still need to be answered. However, for the meantime, it is conducting a treatment program to rehabilitate the affected children and reintegrate them into the mainstream society.

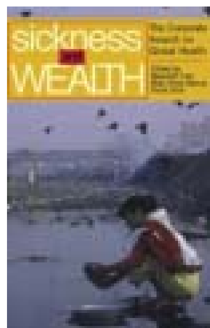
In 2001, KDM, together with SARPV and AMD trained four physiotherapists in Chakaria. The actual treatment started in 2003 in the districts of Chakaria, Kurushkul, and Moeshkali. The treatments include physical therapy sessions, surgery, and nutrition. Until 2005, there were about 200 children whose nutritional requirements were closely monitored. SARPV, with the aid of AMD, established an Assistive Device Center where braces, crutches, walkers, and other equipment are produced.

The rickets program also has an advocacy component to raise the people’s awareness on this disease. The component utilizes live and video dramas to provide the public with information on rickets and how to prevent it.

*This article is condensed from three abstracts published in www.sarpv.org: **“Rickets in Bangladesh: rapid assessment of tribal communities”** by Shahidul Haque, SARPV founder; **“Household risk factors for rickets in Bangladesh”** by Nazmul Hassan, University of Dhaka, and Gerald Combs, Cornell University; and **“Rickets: an international perspective”** by Combs.*

For more information about SARPV’s rickets campaign, visit its website at www.sarpv.org

Resource List



Books

Sickness and Wealth: The Corporate Assault on Global Health. Edited by Meredith Fort, Mary Anne Mercer, and Oscar Gish (South End Press, 2004, 0-89608-716-6, 250 pages)
A collection of essays, the book examines how multinational corporations, the IMF (International Monetary Fund) and World Bank, the World Trade Organization, and "first world" governments limit medical access and promote diseases and death for many in the poor world. The authors examine the history of world health and development strategies, reveal the grim consequences of these policies, and highlight the activities of those working for improved global health. Available from Hesperian Foundation, 1919 Addison Street, Suite 304, Berkeley, CA 94704, USA. hesperian@hesperian.org, Code: B801, Price: $18.00

Global Health Watch 2005-2006
The Global Health Watch is a call to all health workers to broaden and strengthen the global community of health advocates who are taking action on global ill-health and inequalities, and their underlying political and economic determinants. It looks at some of the most important problems, suggests solutions, and monitors the efforts of institutions and governments concerned with promoting health world-wide. Download from http://www.ghwatch.org or write to Global Health Watch, Cape Town, Riverside Centre, 1st Floor, Cnr Belmont & Main Road, Rondebosch 7700, South Africa. ghw@hst.org.za

Health Alert, Issue 1- The Politics of Health: The 25th Year Anniversary of Alma Ata Declaration
This issue focuses on the politics of health as it discusses the successes and the pitfalls of the Alma Ata Declaration and the setbacks in the declaration's implementation Download from http://www.hain.org/PUBLICATION/hardcopy/HAAP_PHC.pdf or write to HAIN (please see editorial box)

The World Health Report 2006 - Working Together for Health
The report reveals an estimated shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide. The shortage is most severe in the poorest countries, especially in sub-Saharan Africa, where health workers are most needed. Focusing on all stages of the health workers' career lifespan from entry to health training, to job recruitment through to retirement, the report lays out a ten-year action plan in which countries can build their health workforces, with the support of global partners. Download from www.who.int/whr or contact your local or regional WHO office.

State of the WORLD'S MOTHERS 2006: Saving the Lives of Mothers and Newborns
Save the Children, May 2006.
In commemoration of Mother's Day, the report focuses on the 60 million mothers in the developing world who give birth every year with no professional help and the 4 million newborns who die in the first month of life, this report helps to bring attention to the urgent need to reduce infant mortality around the world. The report also identifies countries that are succeeding in improving the health and saving the lives of mothers and babies, and shows that effective solutions to this challenge are affordable – even in the world's poorest countries.This report examines the causes of newborn mortality and the solutions available to save lives. It highlights countries that are making significant progress and shows what they are doing right. Most important, this report challenges us to do as much to protect mothers and children in poor countries as we do in rich countries. Download from http://www.who.int/whr/2006/en or write to your local or regional WHO offices.

Article

Honor Thy Mother. By Esther Pan
Half a million women die each year during pregnancy or childbirth. Reducing the maternal mortality rate is one of the UN's Millennium Development goals, but experts say not enough is being done to safeguard the lives of mothers. Download from http://www.cfr.org/publication/11031/honor_thy_mother.html. A copy of the article may be requested from HAIN for fair use only.

Websites

http://www.hesperian.org
The Hesperian Foundation is a non-profit publisher of books and educational materials that help people take the lead in their own health care and organize to improve health conditions in their communities

http://www.talcuk.or
TALC's main objective is to promote the health of children and advance medical knowledge and teaching in the UK and throughout the world by providing and developing educational material

http://www.haiweb.o
An informal network of groups involved in health and pharmaceutical issues around the world. An important watchdog group that monitors the pharmaceutical industry and promotes an Essential Drug Policy

Note to readers: The Intern ... a wide range of information, if you need assistance in locating the right information, please contact

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