News

Crisis in East European health systems — "Europe's best kept secret"

Where might you be treated by a doctor who'd worked 1000 hours of overtime in the past year, who was earning $ 15 a month but hadn't even been paid for the past five months, who was working without medications or bandages, with leaking roofs in operating theatres, no running water, no heating in winter, and where there's been no investment in the infrastructure in years?

Perhaps a remote corner of Africa? No, it's Eastern Europe, according to Ellen Rosskam, a Senior Work Security Specialist at the International Labour Organization (ILO). "This is Europe's best kept secret" said Rosskam.

According to new ILO studies of health workers' views of the health systems of East Europe and the former Soviet Union, just published, such conditions are widespread. General working conditions have greatly declined for health workers across the region since the collapse of the old Soviet system, which — while unlamented in many ways — did support a nationwide public health system designed to be big enough to meet epidemics as well as day-to-day health care.

But wide-ranging economic and political reforms have shrunk the health systems dramatically.Varying degrees of responsibility and funding have been passed from the state to local authorities, creating great disparities between richer and poorer areas. "For example there's a great under-provision in many of the rural areas, leaving large sectors of the population without access" says Rosskam, while under the old system "there were polyclinics and village health clinics in every region".

Now "there's no money going into the rural areas, plus you can't get the doctors to go there."

As a result of these and other failures, there have been great increases in TB, HIV/AIDS and STDs all over the region, with "soaring levels of stress-related illness in the population due to ten years of having to work two or three jobs just to survive," says Rosskam. "So the life expectancy of men, for example, has dropped by ten years."

Last year the ILO People's Security Surveys found that 88% of families in Ukraine and 82% in Hungary were unable to afford basic health care. According to the new studies, in the Republic of Moldova, the poorest country in Europe, the health service is close to collapse and workers are paid months late, if at all. In the Czech Republic and Lithuania, most health care workers said their working conditions and pay had worsened in the past five years. Even in relatively prosperous Poland, 5% of hospitals have closed in the last three years.

According to the ILO studies large proportions of the health care workers in such countries as Kyrgyzstan, Armenia and the Republic of Moldova simply fail to come to work because hospitals and clinics can't pay them. Other countries are suffering "presenteeism", where sick workers stay on the job for fear of losing their posts — or their tips from patients.

According to the ILO, health workers in many of the East European countries now depend for their living on tips.

"Tipping is common practice, now", making income unreliable, Rosskam told the *Bulletin*. "You have to pay to get any services ... but tips are unofficial, gratuity payments ... And the biggest tips go to frontline workers — particularly doctors, while support staff, technicians and administrative staff, who form the backbone of any health system, fall through the cracks" said Rosskam.

Health workers in the region are seriously demoralized, according to the ILO surveys. "The word 'humiliation' has come up more than once during workshops where we've presented our conclusions to affiliates from the region" said Rosskam.

ILO's solution? Apart from proper funding for an effective public health system, which is the primary need, health workers' trades unions need greater recognition and capacity-building, says Rosskam. Paradoxically, the concept and practice of collective bargaining is new in this ex-"socialist" region; in the past trades unions only had to deal with the state. Now there's a multitude of private organizations to deal with — organizations which themselves show little interest in collective bargaining and maintaining social dialogue, according to Rosskam.

"The health unions also need to address very complex issues, such as the legislation arising from countries' applications to join the European Union, privatization, and economic and political restructuring. Another major challenge is how to face the huge wealth gaps in the region," says Rosskam.

ILO's goals now are to make more information, such as the results of these studies, available to the trades unions; to help develop the capacity of the unions to negotiate; to work with WHO; and to work with the World Bank, which is "the main influence on these countries with a direct impact on the health sector," Rosskam argues. "Health workers must not not be mistreated with impunity, exploited or oppressed" says Rosskam. "We need to shake up the policy-makers who may be offended at hearing these words. It's what you've got to do in countries where problems such as TB are as bad as in sub-Saharan Africa and there is no public health system to respond to them." ■

Robert Walgate, *Bulletin*

HIV does cause AIDS but it's hard to prescribe the drugs, says South Africa's ANC

The highest decision-making body of South Africa's governing African National Congress (ANC), the National Executive Committee (NEC), has published a long statement on HIV and AIDS, saying that while it agreed HIV caused AIDS, antiretroviral drugs (ARVs) "could not be provided in the public health system because of prohibitive costs and the complexity of management".

The ANC also stressed that "socioeconomic conditions, particularly poverty, play a critical role in both the transmission and the progression of the disease". Both of these are defendable points, potentially taking some of the confusion out of the current political storm in South Africa over HIV/AIDS.

Meanwhile the latest ruling from the country's highest court — the Constitutional Court — has temporarily allowed hospitals and clinics to provide nevirapine to their pregnant HIV-positive patients, to reduce the risk of their infecting their babies.

The government's top HIV/AIDS official Dr Nono Simelela added that "what is possible in terms of antiretrovirals is continuously under interrogation", but "a real, honest analysis of the health service shows that we are nowhere near providing an antiretroviral service where we could be comfortable that no harm would be done."

This is a departure from President Thabo Mbeki's earlier more combative approach to HIV/AIDS, which led him to invite AIDS dissidents to sit on his advisory panel and refer frequently to the toxicity of ARVs.

In April, Mbeki said in a letter to ANC members: "Some in our society and elsewhere in the world seem very determined to impose the view on all of us that the only health matters that should concern especially the black people are HIV/AIDS, HIV, and complex antiretroviral drugs, including nevirapine."

Shortly after the court ruling, the influential ANC MP and former youth leader Peter Mokaba stirred up the fire further by stating publicly that HIV does not cause AIDS. He has since distributed a paper to ANC members in which he argues that ARVs themselves make people sick. But judging by the latest ANC statement this is not the majority view.

Significantly, it is the courts, not the government, that have opened the door to the first mass provision of ARVs in South Africa.

At present, a large number of health facilities are using the legal hiatus to give nevirapine to their patients. The hiatus has come about as a result of two government appeals against an earlier High Court execution order, made in December 2001. This order was granted after the Treatment Action Campaign (TAC), an AIDS activist group, took legal action against the government to force it to expand its 18 prevention of mother-to-child transmission (PMTCT) pilot sites. TAC's action succeeded and the High Court ruled that health facilities that had the capacity for it should be able to give nevirapine to patients.

The government appealed energetically against the order, as well as against the entire judgement, which it argued was inappropriate as it believes such policy decisions are its domain, not that of the courts. The Constitutional Court dismissed the government's application for leave to appeal against the execution order. However, at the time of going to press the Constitutional Court has yet to rule on the government's appeal against the entire judgement.

In the interim, hospitals and clinics that feel they have the capacity to run a PMTCT programme may simply order nevirapine from their provincial stores. The TAC is monitoring the drug supply and has threatened to take further court action if it believes the government is stalling.

Even if the court finally rules that health facilities should not have the power to prescribe nevirapine, it will be very difficult for the government to turn back the clock and deny patients access to the drug that can cut HIV transmission to babies by up to 50%. One of the stipulations of the court is that, in order for a health facility to be deemed ready, it must be able to properly test and counsel pregnant women. This is probably a bigger stumbling block to the expansion of PMTCT than the drug supply, as there is a lack of rapid HIV tests and trained counsellors.

Speaking on radio immediately after the Constitutional Court ruling, former president Nelson Mandela said he welcomed the ruling, and reiterated his call for the government to find a way to supply antiretroviral drugs to all citizens.

"That is not a question from which I can retreat," said Mandela. "When people are dying — babies, young people — I can never be quiet."

There is growing international support for ARV therapy for pregnant women and mothers to prevent HIV transmission to their babies, a position supported by WHO and UNAIDS. ■

Kerry Cullinan, *Durban*

AIDS growth in India can be stopped in five years, claims government

More than 16 years after the first case of HIV/AIDS was detected in India, the Indian government announced on 3 April a National AIDS Prevention and Control Policy that seeks to "contain" the virus in five years. According to the national policy document the goal is now "to achieve zero level of new infections by 2007" — an extremely ambitious target.

J. V. R. Prasada Rao, Director of the Indian National AIDS Control Organization (NACO) told the *Bulletin* that the policy was prepared by NACO and submitted to the government two years ago, and has since been under consideration by many departments and ministries.

"The new national policy is for every ministry and the entire country," says Rao, explaining that the government felt AIDS was so important that it needed to involve every state and ministry. "This is not just a public health issue, it's a national issue," he said.

So how big is the problem? According to NACO, in 2001 the proportion of women who tested positive for HIV (the HIV prevalence) in antenatal clinics varied from 0% in Assam (North India; measured in three clinics) to 1.75% in Maharashtra and Mumbai (West India; measured in 14 clinics). The average prevalence works out as a low 0.7%, but with more than 500 million adults in the country, NACO calculates that 3.8 million people in India are infected.

The government admits that the virus has spread from commercial sex workers and injecting drug users in a few parts of the country in its initial phase to the general population. Given India's large population, even a 0.1% rise in the prevalence rate would increase the number of people with HIV by half a million.

But India's health minister, C P Thakur, is optimistic. "With this policy, we want to provide care for HIV-positive people, spread awareness on AIDS and HIV and bring the level of new infections in the general population to zero by 2007."

The national policy pledges support and care for people living with HIV/AIDS and protection of their human rights. The 43-page booklet presenting the policy admits that people living with HIV/AIDS have been denied access to medical treatment and care. There have been instances of people being turned out of government hospitals and losing their jobs because of HIV/AIDS. "The effects of stigma

are devastating," it says, and the government will strengthen anti-discrimination laws to protect vulnerable groups "such as people living with HIV/AIDS" from discrimination.

The policy stresses that an HIV-positive person should enjoy the same rights to education and employment as others. HIV-positive women should be enabled to take their own decisions regarding pregnancy and childbirth, and no one should be forced to have an abortion or be sterilized.

Doctors, nurses and other medical staff will be sensitized to ensure that people living with HIV/AIDS are not discriminated against. The government says it will also build up — by generating resources from the private sector coupled with its own funds — a comprehensive system of medical care with adequate counselling and psychological support for people with HIV or AIDS.

The government also plans to unfurl a national awareness campaign on AIDS and HIV. According to a study carried out by the government in 2000 and 2001, over 76% of men and women in the 15–49 year age group had an "overall awareness" of AIDS and HIV. "But to be aware of AIDS or HIV — as the government survey indicates — and to have information about it are two different things," says Irfan Khan of Naz India, a nongovernmental organization (NGO) dealing with AIDS. "Going by the people who come to our clinic in New Delhi, I would say that the level of information about HIV/AIDS is still very low," he says.

The new policy will focus on implementation. "We are dealing with this issue by decentralizing the process of implementation," Health Minister Thakur says. Every state will have an HIV/AIDS committee to be headed by a civil servant with representation from the districts. Every district will have at least one testing and counselling centre. In Pune, a city in western India, for instance, a committee has been formed with local businessmen, prominent citizens and parliamentarians. "This will be a highly effective way of ensuring the implementation of the policy," Thakur maintains.

The policy deals with advocacy, surveillance, and control of sexually transmitted infections, and says that condoms — the use of which prevents the virus from spreading through sex — will be distributed at hospitals, clinics, counselling centres and private medical centres.

The policy document even tackles indigenous systems of medicine. It says that there is an "urgent need" to look for cost-effective alternatives to antiretroviral drugs in indigenous systems of medicine such as Ayurveda, Unani and Siddha — ancient Indian medicinal systems using plants and herbs. It also supports homoeopathy, an alternative medical system that is popular in India.

The document claims that government research in the homoeopathic and the Siddha systems has been "encouraging... Some of the medicines in these systems have the potential of reducing the viral load in the body of the patient thus ensuring a healthier and longer life with the infection".

The government, however, also voices a note of caution against "unscrupulous persons" claiming a cure for HIV/AIDS by "magic remedies". All claims would be checked out by institutions such as the government-run Ayurveda Council and the Homoeopathic Council. "A massive awareness campaign has also been launched to make people aware of the dangers of such medication by unqualified persons indulging in quackery", it says.

The policy welcomes the role played by NGOs in dealing with HIV/AIDS and promises to involve them in decision-making through regular interactions. NGOs, for their part, have cautiously welcomed the policy, though most of them stress that they are still studying it. "We believe that a policy that combines prevention and cure is the best way of controlling HIV," says Irfan Khan non-committally.

Another activist working for an HIV/AIDS NGO says that while the policy deals with health care, it primarily focuses on prevention. "It is still very much a prevention policy," he said, preferring to remain anonymous till his NGO publicly reacts to the policy. He is also wary of the policy's resolve to reinforce "traditional Indian moral values" among the country's youth. "Since there is no one tradition in India, it would have been better if the policy had upheld pluralism in Indian society instead," this activist says.

Giving moral overtones to HIV/AIDS, he says, is counterproductive. "Showing up someone as immoral often stops a person with HIV/AIDS from coming out in the open for treatment or care," he says. He thinks that once NGOs and health workers have honed their arguments, they will be able to pressure the government into making changes in the policy. "Policies change all the time," he says. ■

Bishakha de Sarkar, *New Delhi*

Nepal deworming programme ready to go worldwide

A pilot project in Nepali schools, giving deworming tablets, a hot meal for the children and food gifts for girls to take back to their parents, has created such a virtuous circle of success — getting girls to stay in school, eliminating helminths and feeding children and families — that the World Food Programme say they would like to expand the programme worldwide, if only donors would support them.

"We teachers cook the midday meal for the children" said Sita Ram Thakur, Assistant Headmaster of Saraswoti Primary School at the little town of Ghadi. "So they regularly come to school and teachers teach them, so they learn at least something every day — and regularly taking deworming tablets, because they have seen how the tablets make the worms come out in their faeces and from their mouths".

"We've had remarkable progress in health, education and awareness among the students — and their parents" said Haribol Khanal, Programme Director of the Primary School Nutritious Food Project (PSNFP), launched in 1998 by the Ministry of Education (MOE) with the financial and technical assistance of the United Nations World Food Programme (WFP) and WHO.

The helminths commonly found in Nepal are roundworm (*Ascaris lumbricoides*), whipworm (*Trichuris trichiura*) and hookworm (*Ancylostoma duodenale* and *Necator americanus*). In June 1996 a WHO survey in Parsa, Surkhet and Dailekh districts in Central Development Region and Mid-Western Development Region indicated that 65% of children were infected with hookworm, followed by 21% with roundworm and 19% with whipworm.

But a mid-term review of the PSNFP schools in November 2000 indicated

WFS, Kathmandu

Students receiving deworming tablets from health personnel.

that the proportion of children with any worm infection at all had fallen from 74% to 48%, while intensive worm infections, which used to be found in 9% the schoolchildren, could now be found in just 2%. On top of that, anaemia had vanished, while the enrolment rate in PSNFP schools had grown by 39%, with girls' enrolment growing by 43%. The PSNFP now covers 21 of the 75 districts of Nepal, with US funding chanelled through the WFP.

The programme was a clear success. So it needed to be expanded, not only in Nepal but worldwide. Experience-sharing meetings between the Nepalese project implementation team and representatives from several African countries were organized in April 2001 in Uganda and in December 2001 in Ivory Coast, resulting in an African extension of the programme.

Arlene Mitchell, Chief of the School Feeding Support programme at the World Food Programme (WFP) told the *Bulletin* "We are now preparing a grant proposal to allow us to continue this effort, and to ensure that it is implemented worldwide, wherever intestinal parasites are a problem".

"In April, we are hosting the second annual meeting of the 'Partners in Parasite Control', a group of UN agencies, NGOs and other interested parties that WHO put together to cooperate in activities like this."

"We started the African effort with US$ 250 000 from a Canadian/CIDA grant. WFP added some of its own money for the workshops, and the World Bank funded US$ 21 000 to help with the last workshop."

"Although the treatments are not expensive per child, they are when we are talking of treating millions of children. WFP fed 15 million school-children last year."

Moreover, said Mitchell, "the treatments do not cure the parasite problem, they rid the child of the worms for a while, until the child is reinfected. Even with decent health education, children in parasite-endemic areas get reinfected."

"So we need funding to:

- continue "pilot" programmes (the first treatments, in WFP-assisted schools) for those countries which have not yet been funded;
- fund repeat treatments in countries which have begun but which have no resources to continue;
- expand treatments to all schools in countries which have only been able to treat WFP-assisted school-children;
- train personnel and pay for treatments in countries which have not begun deworming programmes but where there is a parasite problem; and
- provide technical support and health education materials to all the countries to ensure that the treatment is being done effectively and with the appropriate accompanying lessons.

"We have not had to stop our work yet. But we are running out of money for this work, which is not a core WFP activity. We normally only provide food and enough money to manage the food's storage and distribution, monitoring, etc., so this cannot come from WFP's core budget."

According to Lorenzo Savioli, coordinator for parasitic diseases at WHO, "In Nepal we raised support from UNICEF, Japan and other sources — we shouldn't expect WFP to do this alone. In every country we will need to put together a collection of partners to help support the project".

In Nepal "We've seen remarkable trends," said Prem Narayan Chaudhary, Chief of the PSNFP in Doti. He says more and more girls are seen in the classes. "They used to escape in the afternoon or earlier, but now they stay the whole day."

Deworming is having a positive impact because the children feel immediate relief from pain, the worms come out in bundles, and the children gradually become healthier. The students are so impressed they also ask for tablets for their brothers and sisters as home. "Even the teachers take extra medicine for their family members," added Chaudhary.

But on the world scale, the project is on a knife-edge. According to Arlene Mitchell "We are squeezing the last dimes out of the Canadian grant, and are trying to find new sources of funds (Canadian or other) to support the continued work. We've had a grants proposal writer write a proposal that we will now "market" in hopes that we can find outside funding to support the deworming programmes." ■

Prakash Khanal, *Kathmandu* and
Robert Walgate, *Bulletin*