

Food for Thought:
Summaries of Lunchtime Seminars
(2004-2006)



**World Health
Organization**

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Regional Office for South-East Asia

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Some food for thought!!

Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia, wished to provide an informal forum for SEARO staff to showcase vignettes of their experiences through informal presentations. As a result, the Thursday lunchtime seminars began to be organized at the South-East Asia Regional Office (SEARO) in June 2004. A mix of both external and internal presenters volunteered, with SEARO staff comprising the majority. The lunchtime seminar setting offered SEARO's busy staff an occasion to listen to informal presentation on some of the current issues, while still enjoying their lunch. The arrangement saved on staff's worktime and helped us all to reap the benefit of sharing practical wisdom through discussions that followed these presentations. The seminars are an opportunity to share lessons from real-life experiences from across SEARO's several technical units. The informal nature and setting of the forum elicited lively discussion and debate.

This internal publication is a collection of short textual synopses or abstracts of presentations made during the first two years. The publication is accompanied with a CD-ROM containing relevant PowerPoint presentations made during these seminars. We hope this collation of memories will provide some food for thought for the future, besides encouraging incoming staff to share their experiences through this forum.

Special thanks go to the secretarial staff of the SDE department and the Informatics Systems Management (ISM) unit for making timely preparations for the seminars. We are enthused by the appreciative response that we continue to receive from staff who attend the presentations and participate in the discussion that follow.

*Abdul-Sattar Yoosuf, DrPH,
(Seminar Coordinator)*

Avian Influenza: What should the public know?¹

Background/the problem/issues

Four countries in the Region namely; Indonesia, India, Myanmar and Thailand have reported cases of avian influenza. While India and Myanmar have not reported any human cases, Indonesia and Thailand together have accounted for 93 human cases with 69 deaths. Between July 2005 and September 2006, Indonesia reported 68 confirmed human cases of avian influenza, with 52 deaths. Since December 2003, Thailand has reported 25 confirmed human cases and 17 deaths, including three new cases that were reported between July and September 2006.

Avian Influenza (AI) is caused by the H5N1 virus which is primarily a poultry pathogen which is showing adaptability to cause human cases with high case fatality. AI virus is present in droppings, respiratory secretions and in the blood of the infected birds. Human beings get accidentally infected. In adults, most infections have occurred among those who have removed feathers or slaughtered infected chickens, or children playing around sick or dying chickens. The purpose of the presentation was to provide information about AI so that adequate preventive measures can be taken by the public to prevent a pandemic.

Description

The H5N1 virus is present in the excretions and secretions of affected poultry. It can survive four days on contaminated surfaces at 22 °C and can contaminate eggs and poultry meat. It can also survive in frozen carcasses and blood for three weeks. It can be destroyed by high temperatures, acidic PH, UV rays, disinfectants like Lysol, formalin, sodium hydrochlorite etc. and soaps. Disinfection and personal protection are significant preventive measures against AI.

Conclusions

Personal hygiene is a most cost-effective intervention.

¹ Dr Rajesh Bhatia, Regional Adviser, Blood Safety and Clinical Technology, Department of Communicable Diseases, 20 January 2006

Recommendations (what Lessons learnt)

Unnecessary contact with live, sick and dead birds should be avoided. Suspect bird cases should be reported immediately to the concerned authorities. Adequate precautions need to be taken while handling, preparing and cooking poultry. Personal hygiene should be improved. Consumption of semi-cooked or raw products should be avoided. A pandemic preparedness plan should be in place. An emergency kit should be kept ready for urgent needs. National authorities should take adequate pharmaceutical and non-pharmaceutical measures for prevention of a pandemic.

Women-centred or Gender-sensitive: Changing Perspectives, Policies and Programmes – Where do we stand?²

Background/the problem/issues

A women-centred perception of development means looking at women's needs/issues or putting women at the centre of the analysis. Whereas a gender sensitivity perspective to health development means the ability to perceive existing gender differences, issues and inequalities and incorporating these differences into strategic actions.

Description

Practical gender needs are immediate in nature and are concerned with inadequacies in living conditions, access to health care and employment. Addressing these practical needs do not change the position of either men or women in society. On the other hand, strategic gender needs relate to gender divisions of labour, power, control and addressing these needs helps women to achieve greater equality, challenge their subordinate position and begin to exert control over their bodies, their lives and livelihoods.

The gender policy followed by WHO is that the Organization, will, as a matter of policy and good public health practice, integrate gender considerations into all aspects of its work. WHO is also committed to advance gender equality in its own workforce, as well as in its scientific and technical advisory bodies. Gender analysis examines the difference and disparities and must be carried out at every stage of an intervention – from risk assessment, priority setting, and data collection to design, implementation, and evaluation of a programme.

Conclusions

Gender analysis helps in achieving quality health sector responsiveness. It avoids stale-mate/maintenance of inequality and further marginalization. It

² Ms Della R Sherratt, Ag. Regional Adviser-Gender and Women's Health, Department of Family and Community Health, 27 January 2006

is cost-effective and guides effective implementation. Lack of gender awareness, however exists in some settings. Commitment and resources have been sparse. In 2006-07, only five countries had included gender issues in their WHO collaboration work plans. These too were mainly Reproductive Health and Research (RHR) focused.

Recommendations

Health service personnel (programme managers, policy-makers) need to acknowledge the adverse effects of stereotyping sex roles in healthcare policy-making and practice. They should also examine the values and assumptions they hold to move effectively from analyses to strategic action.

Effective meetings³

We spend a lot of time in meetings of different kinds. The cost of the meetings is not just the time spent there but also the opportunity cost and cooling off period before one can get back to productive work. Meetings are, thus, quite a heavy drain on our only real resource- people's time. This expensive activity needs to be critically analyzed and genuinely worked upon to improve our workplace effectiveness. What is it we could do before, during and after the meetings to make it worth our while and efforts?

Some of the elements that need to be looked at are: avoiding a meeting if the same objective could be met otherwise; setting objectives for the meeting, providing an agenda before hand, assigning meeting preparation, taking up roles at the meetings, assigning action items, examining our meeting process etc.

The management of meetings tends to be a set of skills often overlooked by leaders and managers. The talk is a rather "Cadillac" version of meeting management suggestions. We might pick which suggestions best fit our particular culture and our own needs. The process used in a meeting depends on the kind of meeting we plan to have. However, there are certain basics that are common to various types of meetings. These basics are the agenda for the presentation.

³ Mr Kamlesh Vyas, Head, Advanced Centre for Management Excellence (ACME) & Supreme Quality Services, 17 February 2006

Monitoring Immunization services and experiences with Data Quality Self Assessment⁴

Background/the problem/issues

The presentation focused on monitoring, tools for improving data monitoring and the experiences with Data Quality Self Assessment (DQS).

Description

Monitoring is an integral part of the immunization system. It involves monitoring of processes as well as outputs. The Reach Every District (RED) approach involves re-establishment of outreach services, planning and management of resources, supportive supervision and training, regular meetings between the community and health staff and monitoring and use of data for action.

Poor quality district micro-planning, low quality of service and inadequate monitoring systems are some of the common barriers affecting the RED approach. Monitoring involves compilation and analysis of data/information, prioritizing activities and geographic areas, adjusting workplans at all levels and planning resources at all levels. The quality of the monitoring system can be assessed from the standards of performance i.e. completeness and timeliness. Supervision, accuracy and coherent checks, data quality audit, coverage surveys and data quality self assessment can be used to assess the quality of the monitoring system.

Conclusions

DQS is a flexible way of evaluating the immunization monitoring system mainly at district level and below. It assesses the quality, data accuracy and timeliness/completeness of the monitoring system. It has helped map out clearly the immunization data flow, forms used and timeliness. It has

⁴ Dr Craig Burgess, *Immunization Systems Strengthening, Immunization and Vaccine Development*, 23 February 2006

strengthened the links between programme implementation and data usage for planning and has highlighted the need for supportive supervision practices to better use data for action.

Recommendations

Elements of DQS training should be incorporated into state or national training. It can also be included in micro-planning or district-based indicators. The DQS has benefits that not only link with Mid-Level Manager (MLM) training, supportive supervision practices and strengthened monitoring of other health programmes, but may also improve them. The use of monitoring charts that are easily displayed and regularly reviewed can make huge differences in awareness of programme outputs.

Fielding a Mobile Health Team Approach in Maldives⁵

In May 1985, on a windy and overcast monsoon morning in Maldives, six pioneering health workers set sail on a month-long journey to the country's outlying islands to embark on one of the most innovative experiments in health service delivery that the Maldives has ever crafted.

Health service delivery to the scattered islands in Maldives has always been an extremely difficult task. The monsoon weather, the distances in time and cost of travel, and shortage of health workers in both quantity and quality were significant disadvantages the country had had to deal with. With the advent of PHC in 1978, the concepts and practice although espoused in its entirety by Maldives, still found the logistics of supervision, supplies replenishment and the building of a cohesive team approach which PHC so strongly advocated a daunting issue within the spate of government action.

Using the post-1978 excitement of PHC and the enthusiasm provided by a new national political leadership in the country (the present President Maumoon Abdul Gayyoom was first elected to the presidency in 1978), Maldives formulated its first national health plan in 1980. In this effort, the government sought the assistance of the World Health Organization (WHO) with which the country had had good collaboration since the late 1950s. In this new national plan, health policy was well aligned with the concepts of PHC, and community involvement and responsibility was to be the backbone of service delivery and management, while the MoH and its support organizations would provide the technical backstopping. The main challenge for health service access was the issue of reaching the scattered population of Maldives.

To address this daunting health services access and supervisory support factor, the innovation of a multi-purpose Mobile Health Team (MMNT) approach was suggested as a prime strategy in the new National Health Plan. This was a strong challenge indeed; to move from single-purpose delivery travel that was being done by the vertical health

⁵ *Dr Abdul Sattar Yoosuf, Director, Department of Sustainable Development and Healthy Environments, 2 March 2006*

programme staff (like TB, leprosy, malaria, filariasis etc.) to one that required cooperation by many segments of the health sector. This was perhaps the ultimate challenge that PHC posed to national health systems; that of cooperating, and seeing health as one entity rather than isolated juxtapositions of many disciplines.

The next five years since the formulation of the first National Health Plan in 1980 passed with little input to this process. The policy focus and programme priorities in the plan implementation during this period incorporated well the principles that the PHC concept provided. Training and deploying multi-purpose health workers and strengthening the peripheral health services delivery network through atoll-based health centres and island-based family health posts got prime emphasis and attention. With only a handful of physicians available in the country, who could best be deployed at the referral level in Male, the only immediate option for service delivery to the outlying islands was indeed the multi-purpose health worker. But this expansion of health centres and staffing to remote islands would take a lot of time, and meanwhile much of the outlying islands would be left neglected. The mobile team approach was to provide the link to bridge this gap of service delivery, supervision and intelligence gathering support to these neglected locations. The missing link could not be bridged for the next five years. A multi-purpose mobile team option, being an innovation, needed rational planning, thorough preparation, and efficient management. Most of all however, it needed dedicated promoters; those willing to be challenged with an untested idea. Until now, the supervisory and supply support link of the islands with the central health system had been through a costly, single-purpose programme approach.

It was only in 1985 that the Ministry of Health made genuine attempts at operationalizing the mobile health team approach. Two factors enabled this move. Motivated senior staff members with relevant technical and managerial and visionary zest for carrying the process, and a multi-lateral donor climate that was conducive to supporting the initial trial funding. WHO and UNICEF pledged support to making the mobile team approach happen. It was WHO that assisted Maldives in the formulation of its 1980 National Health Plan. Now, together with UNICEF they provided the needed support both technically and financially to stand by the rationality of the mobile team approach. Consequently, the Ministry of Health provided the critical thrust for going ahead by assigning a special task force

comprising various departments within the health sector to plan and manage the mobile team's operational strategy.

However, there were also several forces that militated against this move. Most field supervisors and project staff were just too used to managing their separate programmes; over time, turf issues had emerged as a paramount concern. A work-method change would mean compromising some of the power they exercised both technically and managerially. Even financially, there may have been the potential for personal loss. The mobile team approach meant initiating a team approach. And, working as a team was something to be learnt and nurtured. It meant having to consider the other person's point of view and having team interests and a common goal at the forefront of action. It meant clear procedures and tight schedules to be followed, with little room for individual controlled flexibility or maneuverability, as decisions would be made in consultation among team members. This work process was indeed new to those who had had until now relatively sequestered project responsibilities with little if any mandated cooperation with other programmes within the health system. Being a new and challenging proposal, the mobile health team approach also needed to be strategized and planned for innovatively. For this, it needed believers in a method as yet untested; those with conviction and optimism to think differently, and venture on a journey to uncharted territory. The challenge was to move away from this let-things-be-as-they-are mindset to one of positive anticipation of change. The senior leadership struggled with this change process through two main paths. One was by seeking out influential health workers who appeared to be on the middle path as regards this change and influencing them on the benefits of the strategy both to themselves and for the program. The other was through a formal ministerial policy directive requiring that a mobile team approach was to be undertaken in line with the strategy outlined in the national health plan. This combination proved adequate to bring all staff to the table for further planning.

The planning was conducted involving all potential parties that would ultimately contribute to the team effort; senior staff, management and support persons, and project managers (essentially the representative of the health worker constituency). This process helped build an atmosphere of transparency and confidence among the players to be in the game. The extensive field knowledge and experience of the health workers and project managers, pitched in well with the knowledge of available health

technology and support service needs the senior staff could provide. Past familiarity with each other among the staff (having worked together for long periods, and the consequent confidence generated) also helped with the speed with which the strategy was well accepted from the planning stage. Thus, all involved brought to bear a positive frame of mind. The objective was clearly stated: the mobile team to provide a set of critical health service delivery tasks during their visits to each inhabited island of the country. These included:

- Immunizing the cohort of children under 5 years of age.
- Following up on the TB, leprosy, and malaria cases in the island.
- Larval survey of all drinking water wells in the island for malaria vector breeding.
- Conducting an ante-natal clinic for all the pregnant mothers.
- Growth monitoring of children under 5 years of age, and also helping mothers understand the use of the growth card.
- Distributing health education material, and talking to the community about health.
- Replenishing drugs and supplies to the island-based Family Health Worker (FHW).
- Demonstration on nutrition (food preparation, and showing types of food that can be grown on the island).
- Supportive supervision of the work of the island-based FHW.
- Collecting needed data on each of the above (for subsequent monitoring and evaluation).

Procedures for each of the above were clearly written out by the planning team. Consideration was given to effective ways of approaching the community and planning out the logistics of the service delivery function embodied in each of these activities. The health workers' past experience within the community provided very practical knowledge to framing truly implementable procedures. Other significant aspects of implementation had to be equally scrupulously planned and organized. These included assessing the technical needs of the team such as equipment, IEC material for health education, identifying team members,

their training and orientation to the work procedures. On the managerial front, scheduling of the mobile team trips, assigning specific work responsibilities to team members, organizing the logistics of contact with the island communities, and the general management of the team process as a continuing event needed meticulous preparation. These were all done in this collective planning mode. Yet another concern was the sustainability of the Mobile Health Team approach. For this to happen, team leaders would have to play a very significant role in the continuity and survival of this initiative and perhaps ultimately towards its institutionalization as a part of the regular health services management strategy of the country. However, the immediate concern was on demonstrating the efficiency and effectiveness of the approach. Continued trust and faith in the ability of the health workers were established through the open process of planning, choosing health workers with a proven record of ability and leadership, and nurturing the spirit of team ownership. However, to make the process still more binding on each other and ensuring a corporate responsibility, the mobile team coordinator role for each successive trip was decided to be on the basis of rotation among six senior health project managers. This brought in a facet of necessary partnership and cooperation by all six in preparing for each of the trips. Reticence for mutual support by any one of them could be held against him when his turn for organizing the trip came up. This arrangement proved very useful as learned subsequently. Thus, the first trip of the Mobile Health Team took to sea on that windy morning in May, 1985.

As envisaged, the MHTs continued to function efficiently and effectively as evidenced by the significant improvement on many fronts. Reductions in travel costs from Male to the islands, the continuity of replenishments of supplies and equipment to the health centres in the atolls and islands were notable improvements with respect to costs and logistics. With respect to service delivery, case finding and case holding for priority communicable diseases like tuberculosis, malaria and leprosy, the regularity of information gathering from the periphery, the immunization of children, mothers and adolescent girls all showed improvements and consistency. Most of all, the MHT process paved the way to regular supportive supervision of peripheral health workers, and for all health sector staff to feel truly cohesive as a team. It helped bridge the neglect of the atolls and its resident health workers with the ongoing dynamics of continuity of a national health system.

End note

By the 1990s, a system of regional hospitals had been established in the country, and the mobile team fielding was coordinated from these regional health service referral hubs. Thus, a decentralization of sorts had emerged, and the model provided by the MHT approach was adapted to a limited set of tasks. At the time of this writing in 2000, each atoll health centre has at least a doctor, two community health workers, half a dozen auxiliary nurses, and bedspace for not less than a dozen in-patients. A significant change from the situation in 1985 when the health centre had only one CHW doing myriad tasks. Presently fielded from atoll health centres, mobile health team tasks have now been reduced to providing only the regular rounds of immunization to the atoll community.

National AIDS Programme Review, Methodology and Application⁶

Background/the problem/issues

Programme review is a systematic assessment of a programme including its relevance and adequacy. The decision to undertake the National AIDS Programme (NAP) review should be made by the national authority. During late 1980s to early 1990s, the progress of national AIDS programmes was assessed through reviews of their implementation. While some judgements can be made about the management capacity and the logistics of programmes during reviews, leading to problem solving decisions, more formal mechanisms of evaluation are also required to guide programmes between alternative courses of action and help answering the question "do the intervention strategies make a difference". These mechanisms include studies designed specifically for evaluating programmes implementation and effectiveness.

Since the early 1990s, the WHO Regional Office for South-East Asia has conducted many reviews of national AIDS programmes, in collaboration with several national governments. During 2005 – 2006, programme reviews were conducted in Myanmar, Sri Lanka and Thailand.

Description

The purpose of the external programme review is to estimate the burden of HIV/AIDS (necessary for some countries), to assess the adequacy of policies and procedures for prevention, care and treatment, and to provide recommendations to improve organizational, technical and administrative measures. The review will benefit the programme in improving effectiveness, raise awareness about the HIV/AIDS situation for increasing political commitment, promote partnerships with Government Organizations, NGOs, the private sector and international organizations including donors, and increase skills of the NAP staff participating in the review.

⁶ Ms Laksami Suebsaeng, Technical Officer, HIV/AIDS, 9 March 2006

The preparatory phase of the review includes establishment of task force and working groups to define the purpose and set objectives, set review dates, develop the programme and prepare logistics and budget, as well as background materials including data collection and analysis.

Review team members comprising of experts and representatives from various organizations and various fields should be selected and appointed.

The methodology of the review includes briefing the review team, desk review of the reports and available materials, interviews, field visits, preparations of review report, preparation of summary of findings and recommendations, briefing to disseminate review findings and recommendations and finalization of the review report. Review reports should be disseminated to all concerned institutions/organizations and implementation of the review recommendations followed-up.

An example was presented on the programme review conducted in Thailand in May 2005.

Conclusions

The national programme's commitment, team work, good preparations, presentation of observations to the policy makers and effective follow-up were key to the success of the NAP review in Thailand.

Recommendations

The Thai programme review results were presented in the meeting of SEAR AIDS Programme Managers organized in Kathmandu in 2005. This resulted in requests from Bhutan, Indonesia, Myanmar and Sri Lanka for similar reviews to be conducted in these countries in 2006. Based on these experiences, guidelines for conducting the programme review should be developed and shared with other health programmes.

Challenges in the development of vaccines against pandemic influenza⁷

Background/the problem/issues

Since 2003 the avian influenza virus, H5N1, has spread across three continents namely Asia, Europe and Africa affecting more than 48 countries and territories. Since January 2004, starting from Viet Nam and Thailand, to date more than 208 people have contracted H5N1 infection, while 115 have succumbed to the disease. As avian influenza spreads across the globe, the threat of a human pandemic replicating, if not exceeding, the 1918 outbreak of Spanish Flu looms large. Of the nine countries where deaths from H5N1 have been reported, two are in the South East-Asia Region. However, they account for almost 40% of the total fatalities reported so far. The threat of pandemic influenza is therefore grave for countries of the South-East Asia Region.

Current scenario

Influenza is a vaccine preventable disease. Every February and September, the World Health Organization (WHO) issues guidelines for the antigenic composition of influenza vaccines for the Northern and Southern Hemispheres respectively. The decision on the strain composition for the vaccine is based on the analysis of the viruses isolated by the global surveillance laboratories. Approximately 300 million doses of influenza vaccine are produced and used annually, mostly in the industrialized countries.

Almost all the production capacity for influenza vaccine is in Western Europe and North America, with a few producers in Australia, China and Japan. The South-East Asia Region is a major producer of vaccines used in routine immunization programmes. However, not a single manufacturer produces influenza vaccine in this Region. This has implications on the availability and access to pandemic influenza vaccine.

⁷ Dr Pem Namgyal, *Vaccine Preventable Diseases, Immunization and Vaccine Development*, 30 March 2006

First, the total production capacity globally is limited. Therefore, even by diverting all of the current seasonal influenza vaccine production capacity, it is not possible to produce sufficient doses of potential pandemic influenza vaccine to meet the global needs. Second, even if a pandemic vaccine becomes available, access to it will most likely be limited to countries with domestic vaccine manufacturers or through advance purchase agreements possibly linked to a seasonal influenza vaccine programme. Therefore, one way for a country to enhance access to pandemic vaccines is to increase domestic influenza vaccine production (linked with a national vaccination programme or for export) or else to contract pandemic vaccine delivery to a foreign manufacturer.

The challenge in making a vaccine against pandemic influenza is the difficulty of predicting the final influenza virus strain that will trigger the pandemic. Most expect that a variant of H5N1 would be the causative agent but no one can be sure. There are also other technical challenges in the development of vaccines against H5N1. Therefore, the possibility of having a viable vaccine and that too in time and in sufficient quantities for the world is bleak indeed.

Despite the challenges, at least in the developed world, with support from national governments vaccine manufacturers are working to develop and register H5N1 pandemic vaccines. In addition, there is currently considerable discussion on the stockpiling of a pre-pandemic vaccine against H5N1 which, however, might be risky. While the use of pre-pandemic vaccine for priming is feasible, the evidence lacking on the level of protection that such a vaccine would provide against a pandemic virus strain. The process of developing and registration of such H5N1 vaccines provides valuable insights into the process, the potential technical hurdles and the regulatory issues that need to be addressed in order to prepare for mass production and distribution of pandemic influenza vaccine in the future.

Conclusions

Despite the South-East Asia Region being a large vaccine producing area, there is very little work either on influenza or avian influenza or pandemic influenza currently going on in any of the countries. Some of the reasons for this are:

- Most state-owned companies are either too inefficient or too backward to compete in a modern world
- Most private companies are small with very little money for R&D
- Most governments provide very little, or no support to private industries for R&D
- In developed countries, governments invest in R&D and provide upfront funding for secure supplies. Unfortunately, none of the governments, except for Thailand, has given any serious thought to the need to invest in this critical area.

Recommendations

In order to prepare the Region better for a lethal pandemic in future, some important steps that national governments, the scientific community and pharmaceutical industries need to take together are:

- Understand the epidemiology of seasonal influenza through better surveillance and make appropriate immunization policies to reduce the burden of the disease
- Invest in seasonal influenza vaccine production capacity in the Region
- Encourage R&D for pre-pandemic vaccine (H5N1) to learn the processes so that when a pandemic actually strikes, the country is geared to produce a pandemic vaccine.

Knowledge Management-Knowledge Sharing – Solution Exchange for Maternal and Child Health Practitioners in India⁸

Dr Paramita Sudharto, PHA, WRO, India explained the concept of Knowledge Management and provided an overview of the activities of Solution Exchange. While 'expert' knowledge was well documented, she said, valuable 'tacit knowledge' gained through practical experience was typically lost or ignored. Furthermore, practitioners could not always have access to knowledge they needed, such as whether a particular idea was tried before or where to turn when facing a bottleneck. She explained that Knowledge Management referred to facilitating the flow of knowledge and experiences, and enabled people to learn from others' experiences and helped avoid 'reinventing the wheel'.

To harness this knowledge pool and enable practitioners to benefit from the cumulative experience of others, United Nations offices in India had created Solution Exchange – a free, impartial space where professionals are encouraged to share their knowledge and experience. Members represent a wide range of sectors from the government, NGOs, donors, the private sector and academia; and various geographical locations in India. They are organized into Communities of Practice built around the framework of the Millennium Development Goals. Members interact on an ongoing basis, building familiarity and trust, gaining in knowledge that helps them contribute more effectively – individually and collectively – to development challenges.

Mr Meghendra Banerjee, Resource Person and Moderator of Health Communities, gave an introduction to the functioning of one such community led by WHO, the **Maternal & Child Health Community**. He explained how, communities' initial operations begin with Solution Exchange's personalized 'Research Service': individual members post questions on the Community's mail group about development challenges they face, which are responded to by other members and researched by

⁸ Dr Paramita Sudharto, Public Health Adviser, WHO India

Mr Meghendra Banerjee, Resource Person and Moderator of Health Communities,
WHO India

Dr Arvind Mathur, NPO, Family & Community Health, WHO India, 4 May 2006

the moderation team. The tacit knowledge and expert knowledge is brought together in a summarized 'Consolidated Reply' which is circulated to the Community, normally within 10 working days.

The Maternal & Child Health Community is facilitated by WHO, UNICEF & UNFPA country offices in India and is focused on implementation issues facing the Tenth Five Year Plan of India, the National Population Policy 2000, Rural Health Mission and Phase II of the Reproductive and Child Health Programme (RCH II), which correspond closely to the globally endorsed Millennium Development Goals (essentially 4 & 5) and targets therein, leading to reduction of maternal and child mortality.

The MCH Community is over a year old with its membership growing from 130 to over 800 during the period. Discussions have been held a wide ranging topics like skilled attendance at birth, setting up telemedicine centres, exclusive breastfeeding and complementary feeding, operationalizing urban health and nutrition programmes, medical termination of pregnancies etc.

Another activity of the MCH Community is the ongoing e-discussion. Members met in October 2005 to identify priority topics. These guest moderated e-discussions will be taking place through out 2006, which would result into publication and ideally feed into policy documentation.

Dr Arvind Mathur, NPO, Family & Community Health, WHO India, illustrated the utility of such a knowledge sharing community using an example from the queries discussed in the MCH community. He described the responses received to a query on Medical Termination of Pregnancy (MTP) wherein the community of practitioners provided insights into the implementation of the MTP Act at the ground level and suggested practical ways to decrease the number of illegal abortions in the country, which could be used to initiate a discussion about field realities with policy makers.

Water Safety Plans – A New Approach to Water Quality Management⁹

The presentation covered the “Water Safety Plans” (WSPs) risk management tools developed by the water industry, international experts and WHO. These tools are designed to aid water suppliers assess risks systematically throughout a drinking water supply chain and identify ways in which these risks can be managed. WSPs are based on the Hazard Analysis Critical Control Point (HACCP) model that has been used in the food industry for the last two decades.

HACCP is recognized internationally as the most cost-effective method for ensuring food safety. This tool has been endorsed by governments, food industries and professional organizations and is incorporated into Codex guidelines.

The traditional approach to assuring the safety of water relies heavily on sampling the end product. However, evidence from many outbreak reports shows that sampling has several limitations when carried out for the protection of public health. Ensuring the safety of a supply requires monitoring, not only of the drinking water, but of parameters which indicate whether the key control measures in a given supply chain are working i.e. process monitoring.

In the late 1990s the Australians developed and implemented a comprehensive quality management system for water safety, incorporating HACCP, and later into their guidelines on drinking water quality in 2002. It was found that this approach could ensure that effort is made at points in the system where hazards are being controlled and not at the end of the system where it is too late to manage risk.

The potential for HACCP application was evaluated in a series of WHO expert review meetings between 1998 and 2003. The experts agreed that an HACCP-type approach should be introduced the third edition of the WHO Guidelines on Drinking Water Quality. The new WHO guidelines show a significant departure from previous editions because they place emphasis on risk assessment and risk management approaches and place less emphasis on the analysis of water quality.

⁹ Dr Roisin Monica Rooney, *Water Sanitation and Health*, 24 May 2006

Approaches similar to this framework are also employed in New Zealand through their Public Health Risk Management Plan and the approach has been accepted by the EU as the preferred approach to water safety management in Europe. Work has also been undertaken in developing countries, such as Bangladesh, India, Maldives and Uganda to apply some of this thinking.

Working with NGO; Confrontation or Cooperation!¹⁰

The presentation highlighted the role and responsibilities of government health services in the past and in the context of globalization and democratization. Similarly, six major issues to be dealt in with the 21st century for health sector reform were presented which envisaged an alternative approach for enhancement of community participation.

Although WHO is working with ministries of health of Member States as the sole health sector development partner, it was pointed out that the government also has limitations particularly during disasters and conflict situations and therefore partnership among Government Organizations and NGOs is essential to achieve 'Health for All' and MDGs by 2015'. The strengths and weaknesses of NGO activities as well as the success story of NGOs in countries of the Region were discussed in detail. The following suggestions were made for public private partnership and involvement of NGOs in health promotion and primary health care.

- (1) It is time to change government policy and strategy for health partnership.
- (2) There should be a new definition of the role, responsibility and practices to address the new challenges.
- (3) NGOs/educational institutions are true partners for public health promotion and development and are not enemies.
- (4) Confrontation between Government Organizations/NGOs, in terms of command area, funding and policy matters is inevitable but it can be managed through a Memorandum of Understanding and joint planning meetings at central and field levels.
- (5) WHO may act as a facilitator for Government Organizations/NGOs or INGO/NGO partnership.
- (6) NGOs will have to play a proactive role in disaster management, health promotion and community based health activities (PDS/Healthy village initiative through partnership).

¹⁰ Dr Gyanendra Gongal, *Veterinary Public Health*, 9 June 2006

It was concluded that positive thinking leads to cooperation and partnership whereas negative thinking generates conflict of interest and mistrust. The presentation generated a lively discussion among participants on the role of government, NGOs and WHO in the health sector and it was agreed that all development partners should work together in a coordinated manner. It is good to involve NGOs as partners in health sector promotion but there should be a strong government health sector which can coordinate, facilitate, monitor and evaluate the activities of NGOs.

Sewage Treatment through UASB Technology – Expectations and Reality¹¹

Introduction

Upflow Anaerobic Sludge Blanket (UASB) technology was introduced in India in the late 1980s during the Ganga Action Plan (GAP). A set of pilots were installed at Kanpur initially for treatment of a mix of sewage and tannery effluent and later exclusively for sewage. This development took place when a strong need for an appropriate 'low cost' technology was felt subsequent to the experience of conventional aerobic technology based sewage treatment plants (STPs) where the running costs were perceived to be unaffordable. At that point of time, UASB which was still an evolving technology was positioned as an affordable option with potential for 'resource recovery'. It was argued that this technology will be advantageous for sewage treatment due to its following unique features:

- Low energy requirement
- Less operation and maintenance cost
- Lower skill requirement for operation/supervision
- Less sludge production, and
- Potential for resource recovery through generation of electricity from biogas and utilization of stabilized sludge as manure.

Based on the limited experience of the two pilots at Kanpur and the above considerations, UASB was the most preferred technology option under the Yamuna Action Plan (YAP-I) which was implemented during 1993-2002. Under this Plan, 16 UASB-based STPs were constructed in towns in Haryana and UP with combined treatment capacity of almost 600 mld.

Subsequent to this up-scaling and wide replication, a large number of STPs based on UASB technology have been constructed in the country and

¹¹ Dr Vinod Tare, Professor, Dept. of Env. Engg., IIT Kanpur, India and Asit Nema, Foundation for Greentech Environmental Systems, 22 June 2006

considerable experience has been gathered on the technology which points in other directions. This paper brings out a range of inherent lacunae of this technology and attempts to raise questions pertaining to the policy of its wide-scale adoption specifically for sewage treatment. The findings are based on (a) a set of comprehensive case studies covering 25 STPs of nine different technologies (b) effluent data of eight UASB-based STPs and (c) a long-term monitoring of the performance of pilots at Kanpur.

Technology performance

UASB technology has been very effective for treatment of high strength industrial effluents particularly from distilleries, pulp and paper, tanneries, and food processing industries. For high organic loads, it certainly offers advantages in terms of almost insignificant energy consumption, low O&M cost and recovery of a significant amount of bio-energy. Consistent production of fairly large quantities of biogas from industrial effluents makes electricity generation for captive consumption an attractive financial proposition. Other features of the technology i.e., lower skill requirement and sludge production; perhaps add to its attractiveness under the industrial context to a certain extent. For instance, in the distillery industry the suitability of the technology has been amply demonstrated where due to bio-energy potential, the pay back period has been found to be less than three years.

However, when applied for sewage treatment (where the undiluted Biological Oxygen Demand (BOD) is between 200-300 mg/l), the cumulative experience has shown that these 'unique' features are not convincing for a variety of reasons. In retrospect it may be stated that for low strength wastewaters, there are more disadvantages than the upfront perceived advantages listed earlier. The issues related to effluent characteristics, requirement for secondary treatment, effluent suitability for disinfection, power generation and resource recovery are discussed in the sections that follow.

Effluent characteristics

- The UASB reactor is able to bring down BOD of sewage only to 70-100 mg/l and it therefore requires second stage aerobic treatment to enable compliance with discharge standards.

- The effluent from UASB is highly anoxic and it exerts a high immediate oxygen demand (IOD) on the receiving water body or land. If discharged into a water body, it immediately sucks up the dissolved oxygen and undermines survival of aquatic life.
- If the raw sewage carries sulphates, it gets reduced to sulphides in the UASB reactor and upon release into an aquatic body it contributes in exerting immediate oxygen demand due to its conversion back to sulphate.
- While the UASB technology is perceived to require low skilled manpower and none or lower instrumentation system for operation control, its performance is characterized by frequent solids washout from the reactor due to these inadequacies. As a result the effluent BOD is found to be higher than what is normally claimed.
- While theoretical biogas yield is 0.35 cum/kg of Chemical Oxygen Demand (COD) removed, the actual yield is not more than 25-30% of this value (0.08-0.1 cum/kg of COD removed). The remaining gas goes out in dissolved form with the effluent, raising its BOD and COD.
- The effluent has a dark brown or blackish colour which represents high concentration of dissolved and suspended humic substances in the effluent. This also leads to poor aesthetic value of the effluent.
- There are no reliable data correlating (a) BOD removal with biogas generation, (b) effluent BOD with COD and (c) effluent BOD with immediate oxygen demand.
- While the effluent BOD after final polishing unit (FPU) at various STPs covered in the study is reported to be under 30 mg/l, an independent study carried out during 2002-03 found COD concentration to be above 200 mg/l.

Secondary treatment

- Under YAP-I, all UASB reactors were followed by a final polishing unit (a pond) of one day retention for second stage treatment. While this limited retention capacity while minimized

land requirement, from the treatment point of view it at best offered only removal of solids washed out of the reactor.

- Retention of only one day does not allow growth of algal cells in the FPU as the time is too short of the minimum requirement of three days.
- The FPU does not lead to re-aeration of wastewater as there is no energy input for turbulence and neither is there growth of algae which can facilitate this process naturally through the phenomenon of photosynthesis.
- As the settled solids are not removed regularly from the FPU (due to lack of O&M), the bottom depth for sludge storage quickly gets filled up, undermining its efficiency and leading to higher suspended solids/BOD in the final effluent.
- Even though a secondary treatment plant (aerobic system) will be required to bring down BOD from 70 to 30 mg/l, it would not be in any way cheaper than bringing down the raw sewage BOD from 250 to 30 mg/l, since the systems invariably need to be designed on the basis of hydraulic loading rather than organic loading.
- Secondly, with input BOD less than 70 mg/l, there is not enough food for micro-organisms to grow in the secondary aerobic system.
- Typically the power rating of an aeration system in an aerobic reactor is determined by requirements for keeping the solids in suspension and not on the basis of actual oxygen requirements. Therefore the perception of lower operating cost in the secondary stage after primary treatment in a UASB reactor is also not valid.

Unsuitability of effluent for chlorination

Due to anaerobic conditions, removal of total and faecal coliforms in UASB is about 1-2 on log scale and it entails tertiary treatment for disinfection. However, unlike other technologies, effluent from a UASB plant can not be readily sent for chlorination as it carries a much high concentration of humic substances that lead to formation of trihalomethanes and entail

higher chlorine consumption towards satisfying a part of the COD and IOD. Incidentally, chlorination emerged as the only cost effective disinfection technology among a variety of options tried out under YAP-I.

Power generation

Resource recovery in the form of bio-energy was perceived to be a major factor in favour of a UASB for sewage treatment. However, a number of limitations as listed below have been identified which prevent realization of the claimed benefits.

- Among others, biogas generation is dependent on the quantum of raw BOD and subject to ambient and wastewater temperature and their variations. The anaerobic bacterial culture is adversely affected with even a 3-5°C fluctuation in reactor temperature. Therefore biogas production is found to go down significantly in winter in North India.
- The quantity of biogas produced in a small to medium sized UASB is not adequate to guarantee favourable economics of bio-energy generation.
- The dual fuel engines which are generally installed due to their low cost invariably require a large quantity of diesel as supplementary fuel. Apparently, the cost of diesel turns out to be not only high but disadvantageous as electricity is made freely available to the STP operating agency. The Economics of environment and resource utilization apart, it does not make business sense for the operating agency to run the dual fuel generators on externally purchased diesel.
- State-of-the-art technology based gas engines are not yet made in India and the imported engines are rather expensive. Their deployment for small scale applications turns out to be unviable. Secondly, utilization of waste heat from such cogeneration systems is not a techno-economically feasible option under the setting of an STP, which otherwise makes such systems financially attractive in colder countries.
- As the energy requirement of the UASB plant is low and the process is not vulnerable to power cuts; and energy bill of the

STP is linked to the installed load any way, there is no incentive for the operating agency to generate bio-energy in-house by incurring extra expense on diesel. (These conclusions are corroborated by field observations of a typical 1-2 hour operation of dual fuel engines or none at all as against the originally perceived full utilization of biogas over 24 - hour period.)

- Lastly, there is a risk of corrosion of the engine parts as the biogas typically contains hydrogen sulphide. The technology for desulphurization is on one hand not widely available in India and on the other it entails additional recurring expenses. There have been cases of gas engines being taken off due to severe corrosion and the desulphurization plant being abandoned due to lack of required chemicals and resources.

Resource recovery

- Another 'resource recovery' option through the sale of sludge has found no takers and its potential to serve as a reliable and major revenue generating stream has not fructified.
- 'Resource recovery' through bio-energy generation and sludge, which was the guiding principle of the promoting and implementing agencies at the time of launching the UASB technology, turns out to be a myth as none of the plants have been able to contribute in any significant way towards the cost of operation and maintenance in any form.

Others

- Performance of the UASB based plants is, in general, adversely affected by mixing industrial effluents that contain some toxic materials or high levels of sulphate.
- In general, corrosion of structures in and around a UASB based plant is found to be higher compared to other technology based STPs.

Conclusion

It is evident that partial primary treatment through a UASB reactor makes the raw sewage more problematic to treat. Such systems neither deliver the required effluent quality nor produce the expected bio-energy. Considering all the pros and cons of the technology, especially the need for an elaborate secondary and tertiary treatment, the rationale for adopting a UASB for sewage (and especially diluted sewage under the Indian context where the flows are intercepted in open drains) is debatable. In retrospect the less 'ambitious' conventional technologies e.g., activated sludge process, trickling filter or facultative aerated lagoons would still be able to perform much better compared to the UASB. The biogas potential of sludge digesters in conventional activated sludge process plants is perceived to be more promising and consistent and therefore it is recommended that this conventional option should be preferred for sewage treatment.

Drug information – does it really matter? (But then, the life you save may be your own)¹²

Background/the problem/issues

A drug is not simply a formulation (i.e. a tablet, capsule or syrup) but the formulation and the information to use the drug properly. Inadequate/partial/biased information can lead to poor use of the product and sometime can lead to harm. This greater potential of harm due to inadequate information distinguishes drugs from other commodities.

Description

Drug Information includes information about the drug, its contents, dosage, what it is used for, side-effects, cautions, in which cases it should not be used, etc. Doctors should be able to provide the drug information. But most doctors do not do so due to various reasons. These reasons include ignorance about drug information, too little time available during consultation, not wanting to scare the patient etc. But, some doctors think that there is no need for the patient to know about the side-effects or it is not the doctor's duty to provide the information. In either of these cases, it is the patient who has to suffer ultimately in case there are any side effects.

Patients should ask for this information from the doctor; if that for some reason is not possible, they should ask the pharmacists. It is also possible to get information from the product information leaflet although on some occasions the text is too technical. If they have access to the internet, that is a good source for drug information though it often can be biased.

Conclusions

Sometimes, the drug information is difficult to find but in the end it is a very useful exercise as it can help avoid the adverse effects. The life you save maybe your own!

¹² Dr. K Weerasuriya, Regional Adviser-Essential Medicines, Department of Health Systems Development, 29 June 2006

Recommendations

Patients should always check the drug information before taking any medicine. Depending on doctors is not always reliable and hence one should read through the drug information before taking any drug. If there are any doubts about the information, then one can get them clarified from the doctor. Some websites also provide reliable drug information.

Behaviour Change Intervention Overview: Implications for AI Control and Prevention¹³

Background/the problem/issues

Health promotion is a process of enabling people to increase control over their health and its determinants and thereby improving their health. The purpose of the presentation was to examine limitations of linear communication popularly used to create public awareness and behaviour change. Further, a comprehensive Behaviour Change Intervention (BCI) strategy was presented.

Description

Information, Education and Communication (IEC) is a process of developing and disseminating information. One important lesson learnt from IEC or linear communication is that acquisition of information or knowledge alone does not translate into action. The linear communication (radio, television and newspapers) often use an issues-based approach and population-based approach and ignore the settings in which people live, work and play.

BCI contains elements namely communication situational analysis, communication policy, capacity building, evidence gathering, resource mobilization, expectations, cultural beliefs, values and personal experiences of the target group. Situational analysis, as an element of BCI, takes cognizance of the impact of historical continuity by explaining how complex humans produce health in diverse settings.

Conclusions

Linear communication whose primary purpose is to give information/content remains useful and should not be totally discontinued. Knowledge gain or change is the minimum acceptable standard for behaviour change and is considered the building block for BCI strategy.

¹³ Dr. Davison Munodawafa, Regional Adviser-Health Promotion and Education, Department of Non-communicable Diseases and Mental Health, 17 August 2006

The BCI minimum package should include situational analysis, planning, implementation, governance issues (policy coherence and advocacy), capacity building, cultural beliefs and values. It should also include evidence gathering for policy and programmatic decisions, resource mobilization and management of change in health promotion. All these are essential if health promotion interventions are to yield the desired behaviour change.

Recommendations

Behaviour change interventions require integration of multiple elements into ongoing activities to address complex human behaviour. The use of linear communication should always be complemented and not allowed to stand alone.

An Analysis of selected Daily Media Coverage on Avian Influenza in Indonesia¹⁴

Ms Nicole Maeder, a university student from the United Kingdom, was attached to HPE unit six weeks. During this period, one of her tasks was to analyse media reports on the avian influenza in Indonesia. The presentation was based on the daily analysis conducted by Ms Nicole, under the supervision of RA-HPE, from June 12 to July 24, 2006.

Background/the problem/issues

Indonesia reported 63 confirmed human cases of avian influenza, with 48 deaths, between July 2005 and July 2006. This selection based on a sample of news clippings provided by the CDS Department from the internet. In order to analyse the information, a constant comparative approach was used to generate labels or themes commonly occurring in the media reports. Only media reports on Indonesia for the period June – July 2006 were included in the study. The review is based on media reports appearing on the internet and does not include news media using local language.

Description

In the first week, the media coverage on Indonesia emphasized the World Bank's (WB) report which was published in the previous week. The report argued that the Indonesian government needs to improve their vaccination and surveillance system. During the second week, the media reported about the meeting initiated by the government to gain international support against AI. WHO supported Indonesia in the organization of this conference. During this week, many articles were written about the apparent incapacity of the government due in part to devolvement of responsibility to local levels, but also recognized the fact that the country lacked resources.

¹⁴ Dr. Davison Munodawafa, Regional Adviser-Health Promotion and Education, and Ms Nicole Maeder (HPE Intern), Department of Non-communicable Diseases and Mental Health, 31 August 2006

The cluster in Sumatra was the main topic during the third and fourth weeks. WHO was cited for its laboratory results and questions regarding whether the human-to-human transmission in Sumatra cluster had been proven. Reports during the fifth week commented on the ineffectiveness of the government's programmes, such as vaccination, early detection research, eradication and public awareness campaigns because they were not conducted simultaneously. During the sixth week, the death toll in Indonesia increased to 43 and the media was critical about decentralization stating that it had led to a lack of administrative control from Jakarta, which further increased the spread of AI.

Conclusions

The media is considered an inexpensive "megaphone" because it can reach many people in various settings. Specifically, the internet can provide volumes of information from multiple sources and can be accessible to all age groups. News on the internet also shapes global opinion and is therefore a valuable source to gauge the global mood. According to the review, the media felt that Indonesia had a huge AI problem and not enough was being done. However, the media did not report on other factors that are likely to fuel AI transmission such as transportation, wet markets or cultural beliefs and values. The media focused more on sensational news and did not inform the public adequately regarding transmission and prevention.

Recommendations

There is a need for training media on reporting emerging diseases such as AI. Training reporters on the sensitivity of AI will contribute to reducing situations where the government becomes defensive. WHO should support periodic training of media persons as well as briefing of media on emerging issues such as AI. WHO should maintain its credibility by not giving conflicting information. During outbreaks, health professionals should avoid making statements that demonstrate fear or discrimination. As the world remains anxious to learn more about AI in Indonesia or any country of the world, the internet is a major player in shaping global public opinion. The internet competes for space in shaping public opinion with radio and television and therefore cannot be sidelined. Ultimately, the media has a social responsibility to inform and educate the general public. In order to do so effectively, the media requires training.

Leprosy Elimination Programme – Lessons Learnt¹⁵

There are several lessons from the past dozen years of programme action, and many related to the amelioration of operational factors, better partnerships, as well as better definition of goals and outputs. Clearly, the success has also indicated that multi-drugs chemotherapy can be more effective than with single drug.

Disasters make heads turn and for people to take notice. Day-to-day events do not make headlines. For people to pay attention, something new has to be put in their span of vision. The public awareness of the disastrous consequences of leprosy to the community, family and individuals made possible by the campaign was what made countries put this on their priority health agenda. This paradigm may be applicable to any campaign that wants to succeed.

Among the concerns voiced by the audience was on how programme success can be maintained when the fund from donors dry up. The answer was to ensure the effectiveness of programme integration into the mainstream activities of national health systems. This will then not require the vertical attention that was needed in its campaign phase, but nevertheless be seen as part of an institutionalized set of actions to be carried out best at the peripheral levels where case detection and treatment can be carried out.

The government should not stop the activities even with the drying up of donor funds. Knowing the consequences of complacency and with being aware if its responsibility of the system will help keep the programmes actions alive. Good integration requires good supervision. Thus, supervision of the programmes at the periphery is of prime concern. This may be a lesson for other similar programmes too, as we progress towards elimination-such as for malaria, and polio which are in line.

¹⁵ *Dr Derek Lobo, Regional Adviser, Leprosy and Diseases Targeted for Elimination/Eradiation, Department of Communicable Diseases, 7 September 2006*

Strategizing for Nutrition Advocacy and Communication in South-East Asia¹⁶

Background/the problem/issues

Nutrition is a fundamental prerequisite for human and national development. The South East Asia Region ranks lower than other regions in terms of nutrition levels. Our Region has the largest number of malnourished people and almost every third child is malnourished at birth. Malnutrition causes an enormous drain on human and economic development; our Region lacks capacities for advocacy and communication for improving nutritional status. Also, the budgetary allocation for health is low and the budget allocated for nutrition is only a fraction of the budget allocated for health.

About half of child deaths are associated with malnutrition. Nearly 30% of the neo-natal deaths are pre-term deaths which are again due to maternal malnutrition. There is a new double-burden of malnutrition as in addition to the under-nourished population, the population suffering from obesity and nutrition - related chronic diseases is increasing.

Description

There is a dire need for advocating and investing in nutrition. This is because under-nutrition is affecting the productivity of our people. Improved nutrition is also essential for achieving all the health – related Millennium Development Goals. There is a strong correlation between poverty, human resources and nutrition. Lack of nutrition causes anemia and iodine deficiency disorders which in times can cause stunting, mental impairment, and reduced IQ etc. Nutrition is not only essential for preventing these deficiency disorders and some others but is also necessary for developing adequate immunity to fight diseases like HIV-AIDS, TB etc.

¹⁶ Dr Rukhsana Haider, Regional Adviser, Nutrition for Health and Development, Department of Family and Community Health, 15 September 2006

Essential Nutrition Actions taken to address the problem include advocacy to promote six months exclusive breast feeding to infants, appropriate complementary feeding thereafter with continued breastfeeding for two years, nutritional care of sick and malnourished children and improving diets for women. In terms of monetary gains to the economy, improved nutrition has direct impact on worker productivity gains and gains from fertility delay.

Conclusions

The global/national strategy for infant and young child feeding, which facilitates optimal growth and development of children, should be included in the national plans of action. Nutrition should be stressed at every stage of the life cycle. A complete package of nutrition and health interventions to attain cumulative nutritional impact needs to be provided. There is a real need for massive mobilization of resources and manpower to expand coverage with basic health and nutrition services. There is also lack of progress in implementing effective solutions due to insufficient motivation, inadequate performance, lack of focus and lack of awareness. This needs to be addressed as well.

Recommendations

There is a need for formulation of effective communication strategies which are comprehensive, integrated, operational, living (regularly reviewed), evidence-based and focused. The aspect of adequate logistics should also be included. Advocacy strategies should support behaviour changes at household level, improve community participation, ensure good practices and enable appropriate allocation of limited resources. Collectively, we must advocate for nutrition, develop and disseminate technical guidelines and frameworks for improving nutrition, build capacity for nutrition advocacy and coordinate with national governments and partner agencies for a multi-sectoral approach towards nutrition development.

“Empowering women” the Springboard way¹⁷

Background/the problem/issues

Mrs Radha Swaminathan, AA-DAF, made a presentation on the Springboard Women’s Personal Development Programme, tracing its history and development in the last 15 years, with special emphasis on its evolution in the context of India. Springboard is a three-month, distance learning personal development programme specifically designed for non-management women by Liz Willis and Jenny Daisley, two leading management consultants in UK. The programme uses a 300-page workbook supported by four one-day workshops. All programmes are run through Springboard licensed trainers who are specially chosen, trained and licensed to conduct the programme through a standardized methodology. It is delivered through a network of 600 trainers and so far, over 150,000 women all over the world from different races, backgrounds, organizations and sectors have participated in the programme. Usually, the Springboard programme is suitable for women who have had some life experience – typically above the age of 25 years.

The workbook is customized to the cultural context of the country before the programme is introduced in it. Extensive research is undertaken to change the statistics, stories, role models, examples, exercises and illustrations. The programme has received international acclaim for its unique design and its reach which is now in 21 countries including the USA, countries of the Middle East and the African continent.

The programme is a simple intervention to empower women to take better control of their lives and realize their full potential. In view of WHO’s commitment to increasing the participation of women staff, Springboard training for women would be a good investment and would motivate them to give of their best. We can maximize the productivity of women staff and help them integrate into a multicultural set up. They would be able to contribute more effectively to the tasks given to them. It would also develop job aspirations, making them work harder and better.

¹⁷ Ms Radha Swaminathan, Administrative Assistant to Director, Administration and Finance, 12 October 2006

Description

Several women GS staff members from the Regional Office had attended the pilot programme in the early 1990s and over the years, sporadically, a few more had participated. All of them had come back positively charged and provided excellent feedback.

- Some women spoke of the concept of 'me-time' – which simply means special time for the women themselves – a few minutes every day – spent in doing something to please them, without feeling guilty, which helped to re-energize them.
- One staff member said she was very impressed with the speeches of guest speakers and interactions with them, in particular, a journalist with a handicapped child who explained how she managed her personal life and career.
- One staff member had been motivated to take up further studies and had been obtaining high marks in the course she was pursuing through better time management and organizing.
- Another staff member said that after participating in Springboard she had realized that the problems faced by women were universal and she felt she was not alone in the world. They were able to network with women from different backgrounds.

Conclusions

- The design of the programme is for 'women only' and this raised some questions. It was explained that since the programme addressed both work and personal issues in their lives, women tended to learn better through sharing and exchanging of experiences in a women-only setting and felt constrained in the presence of men. A similar personal development programme for men called Navigator had also been created by the Springboard Consultancy in UK.
- The programme design was such that it could be tailored to suit not just working women, but housewives, part-time workers and people from disadvantaged sections also.

- With some modifications, the programme could perhaps be customized for rural women also, so that they could also equip themselves with skills necessary for decision-making and empowerment.
- The concept of gender was also discussed and the role of men and women in leading a life of better quality and productivity was stressed.

Recommendations

A simple intervention like sending women for a training programme like Springboard could result in a tremendous surge of self-confidence, enthusiasm and positivity in women. They learn to be more productive members of society and strive to attain their fullest potential.

In view of the large number of young women inducted into the Organization, the need of the hour is to introduce simple, focused programmes such as Springboard to enable them to harmoniously balance their home and work lives in order to be more productive at work.

Closing the Mental Health Gap: Developing Community Mental Health Services¹⁸

Background/the problem/issues

The presentation was on the mental health gap and community mental health services. In the South-East Asia Region (SEAR), the mental health activities have generally concentrated on hospital-based psychiatry and neurology. However, there is increasing awareness of the need to shift the emphasis to community-based mental health programmes. The mental health gap is the gap between the demand for and availability of services for mental health problems.

Description

The mental health gap includes the lack of well-being programmes, high treatment gap, rampant stigma, lack of rehabilitation services, high prevalence of alcohol abuse and widespread barriers to optimum mental health. Nearly 80%-90% of the population in SEAR suffers from neuropsychotic conditions like epilepsy and psychosis are inadequately treated indicating the magnitude of the treatment gap in the Region. The mental health gap is due to various reasons including limited treatment and rehabilitation services, alcohol and drug abuse, minimal well-being programmes, social stigma, lack of understanding of the medical nature of the disease, patients taken to faith healers rather than doctors, etc.

Conclusions

Community health does not include only the mobile camps/weekly visits organized by psychiatrists or one-time training of community health workers. It is a concept which has to be operationalized and should include activities related to promotion of well-being and mental health, stigma removal, psychosocial support, rehabilitation, prevention of harm from

¹⁸ *Dr Vijay Chandra, Regional Adviser-Mental Health and Substance Abuse, Department of Non-Communicable Diseases and Mental Health, 23 November 2006*

alcohol and substance use, treatment of sick people through primary health care system etc. It must reach out to each and every person. Thus, it is much more than just treatment.

Recommendations

There is an urgent need to sensitize governments on the importance of mental health and to clearly define the goals and objectives of a community-based mental health programme. Mental health services should be integrated into the overall primary health care system along with innovative community-based programmes. There is also an urgent need to sensitize governments on the importance of substance dependence, including the ill-effects of alcohol, and to clearly define the goals and objectives to control substance dependence. Impact indicators like reduction of treatment gap, reduction in stigma, patient satisfaction with treatment, reduction in the use of alcohol and reduction in violence should be used in assessing the impact of community mental health activities.

The case of Asbestosis – How much do we know about it?¹⁹

Background/the problem/issues

Asbestos (Asbestos is a Greek word - *asbestos*: a, "not" and sbestos, "extinguishable") describes any of a group of minerals that can be fibrous, many of which are metamorphic and are hydrous magnesium silicates. Asbestos fibers have great tensile strength, and possess important physical properties like resistance to heat, electricity and chemicals, which gives rise to a large number of industrial uses. In all, asbestos has about 3,000 applications or product types. The most widely known are asbestos cement products. Over time, asbestos has been honoured for its "service to humanity" and called a "boon to humanity" and "faithful servant of mankind", "the most important of the non-metallic mineral products of the world—and certainly one of the most wonderful" and even the "magic mineral". However, with the knowledge of its harmful health affects it lost its place as a most favoured mineral.

Description

Since the 1920s, there was a steady increase in the use of asbestos all over the world till the 1980s. Public knowledge of the carcinogenic effects of asbestos and huge compensation claims led to the decline of its use in most of the industrialized nations. Now, the industry has shifted from developed to the developing nations. The developing nations including countries in the South East Asia Region show a steady increase in the use of asbestos-related products. Inhalation of asbestos fibers leads to development of fibrosis (scarring) of lung tissues, and increased risk of lung cancer and mesothelioma (cancer of lung membrane). Epidemiological studies have shown that all types of asbestos are carcinogenic and there is no threshold limit (known minimum safe levels). The use of asbestos by a country for 15-20 years is invariably followed by a rise in the incidence of mesothelioma. A situation similar to one observed in developed countries is expected to

¹⁹ Dr Habibullah Saiyed, Ag. Regional Adviser, Occupational and Environmental Health, Department of Sustainable Development, 7 December 2006

occur in developing countries if no action is taken immediately. Asbestos cannot be handled safely because of its non - threshold health effect. Safe substitutes for asbestos are available for almost all the uses. WHO has issued a clear policy statement on asbestos which recommends a ban on asbestos by Member countries.

Conclusions

- Health problems due to asbestos are likely to assume epidemic proportions in the next 15 to 20 years in the South East Asia Region and other developing countries.
- All types of asbestos cause asbestosis, mesothelioma and lung cancer.
- No safe threshold level of exposure has been identified.
- Safer substitutes exist.
- Exposure of workers and other users of asbestos - containing products is extremely difficult to control.
- Asbestos abatement is very costly and hard to be carried out in a completely safe way.

Recommendations

Use of asbestos for any purpose should be banned.

Overview of Immunization Financing²⁰

Background

Sustainable financing for immunization systems is essential for programmes to have an impact on mortality and morbidity due to Vaccine Preventable Diseases (VPD). The cycle of financing decision making (disease burden and cost effectiveness analysis leading to policy making) is becoming more complex due to:

- Increased availability of newer, and more expensive vaccines and newer cold chain technologies
- Increased campaign approaches to deliver vaccines (which are generally less cost effective)
- Renewed focus on increasing access to immunization services by the hard-to-reach
- Increased complexity and unpredictability of funding arrangements and broader health budget cycles

Although increased external funding is one option for increasing sustainability, financial sustainability may be defined as: '... the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve target levels of immunization performance in terms of access, utilization, quality, safety and equity.'^{*} There is therefore a need for planning financial sustainability by:

- (1) improving the accuracy of estimating programme resource requirements
- (2) ensuring advocacy for these needs reaches the highest levels
- (3) increasing programme efficiency (e.g. reducing vaccine wastage rates or improving district micro planning)

²⁰ Dr Craig Burgess, *Immunization Systems Strengthening, Immunization and Vaccine Development*, 13 April 2005

* Global Alliance for Vaccines and Immunization (GAVI) board 2002

- (4) increasing domestic contributions and
- (5) reviewing and improving fund flow mechanisms.

SEAR Process

As part of its drive to encourage financial sustainability, the Global Alliance for Vaccines and Immunization (GAVI) encouraged eligible countries to draft financial sustainability plans (FSPs). Bangladesh, Bhutan, DPR Korea, Indonesia, Myanmar, Nepal and Sri Lanka received support from IVD/SEARO to draft these plans in 2004-2005. India also drafted a fully costed Multi - Year plan, which has helped mobilize appropriate resources in 2005.

Results

A recent WHO publication* documents the main results. The cost drivers of immunization programmes in most countries are shared personnel costs and vaccine procurement. Annual immunization programme costs vary from \$1 million in Bhutan to \$500 million in India. The regional average cost to immunize a child up to DTP3 is \$25 (varying from \$40 in Bhutan to \$7 in Myanmar).

Strengths and weaknesses of the FSP process

Strengths	Weaknesses
<ul style="list-style-type: none"> • Make good use of a standard costing tool • Bring ministries together for planning processes • Gives a clear overview of needs to health planners and donors 	<ul style="list-style-type: none"> • Training government staff directly as rotation of staff • Weak sustainability part of the plans • Low government buy - in to processes

* Planning for Immunization Programme Sustainability in the South-East Asia and Western Pacific Regions. SEA-Immun-35, WHO SEARO, 2006.

Strengths	Weaknesses
<ul style="list-style-type: none">• Stimulates interest and possible research• Low use of consultants and stimulated the creation of a regional immunization financing network that strengthens institutional and inter-agency linkages.	<ul style="list-style-type: none">• Lack of awareness of importance of FSP principles

Way forward

The FSP process of costing, planning and looking at ways of increasing sustainability has now been integrated into the comprehensive Multi - Year Planning (cMYP) process. Each GAVI - eligible country will be required to draft a cMYP if applying for GAVI phase two funding. The creation of the regional immunization financing network has helped stimulate possible research projects and training opportunities in 2006.

Does the Integrated Management of Childhood Strategy Work? – The evidence so far²¹

Background

Integrated Management of Childhood Illness (IMCI) is a broad strategy for the improvement of child health that includes sets of complementary interventions at health facilities and in communities. The Multi-Country Evaluation of IMCI Effectiveness, Cost and Impact (MCE) was designed to determine the impact of IMCI on child health and its programme implications. The study conducted in diverse scenarios (Bangladesh, Brazil, Peru, Tanzania and Uganda) provides valuable insights.

MCE Results

IMCI was successfully introduced in many countries. IMCI training led to rapid and sustained improvement in health workers' performance. In many countries, utilization rates of health services were too low to allow an impact of IMCI on child mortality. Countries faced difficulties in maintaining the stock and quality of trained staff during expansion and in increasing coverage of interventions to improve key family practices. *Where IMCI was implemented with adequate system support, it led to under-five mortality reduction.*

Conclusion

MCE results highlight the need for change if we are to achieve our child survival goals. Greater emphasis is needed on achieving intervention coverage at the community level, particularly of interventions to improve care seeking, nutrition and correct home care. Scaling up of IMCI requires local adaptations based on health system capacity and epidemiological profiles, stronger management structures and increased funding, and implementation targeted to the areas with the highest burden and synergistic at the community and facility level.

²¹ Dr Sudhansh Malhotra, Regional Adviser, Child Health and Development, Department of Family and Community Health, 21 April 2005

The Integrated Management of Childhood Illness is an evidence - based strategy that has the home but also has a significant impact on reducing child mortality. Country programmes need to consider making IMCI a core strategy for achieving the Millennium Development Goal for reducing child mortality.

TB Control through Partnerships²²

Background/the problem/issues

The South-East Asia Region (SEAR) has the highest burden of tuberculosis cases among all the WHO Regions. Five countries—Bangladesh, India, Indonesia, Myanmar and Thailand, together contribute to 95% of the regional burden. The overall goal for TB control is to reduce morbidity, mortality and transmission of TB until it is no longer a public health problem in the Region. The objectives for tuberculosis control in all Member countries in the Region are to reach and thereafter sustain the 2005 targets—achieving at least 70% case detection and 85% treatment success among all TB cases under DOTS (Indicator 24), in order to then reach the targets of halving TB deaths and prevalence (Indicator 23) by 2015, in turn to “have halted and begun to reverse the incidence of TB” as implicitly stated under Goal 6 of the MDGs.

Description

The Stop TB Partnership is a global social movement to stop TB. It has a vision of a TB-free world and its mission is to ensure that every TB patient has access to effective diagnosis, treatment and cure and transmission of TB is stopped. It is also working towards developing and implementing new preventive, diagnostic and therapeutic tools and strategies to stop TB. This programme has been effective and has shown significant progress. It involves strong partnerships between government, NGOs, private practitioners, employers, medical schools, communities, donors, the media and other stakeholders.

A Global fund was created in January 2002 to fill a substantial global financial shortfall to fight AIDS, TB and malaria (GFATM).

²² Dr Nani Nair, Regional Adviser, Tuberculosis Control, Department of Communicable Diseases, 28 April 2005

Conclusions

In the South East Asia Region, there is a high commitment at the national level for TB control.

There is also a strong private health sector and dynamic corporate sector. The Region has received enhanced finances in the form of increased funding from national budgets, World Bank loans, support from traditional bilateral donors and additional support from GFATM and Global Drug Facility (GDF). The programme is progressing well despite numerous barriers because of the solutions timely identified and implemented on time and the strong global partnerships involved in the programme.

Recommendations

An evidence-base needs to be created by documenting on-going initiatives and disseminating the information for wider acceptance/application. The development of clear strategies and operational guidelines based on the lessons learnt should be promoted. Enhanced supervised, monitoring of PPM-DOTS initiatives is the need of the hour. All these have already been included in the plan of action for 2005-06.

Social determinants and the Commission on Social Determinants of Health²³

Background

While biological factors, the physical environment and health care systems play important roles in the health of an individual, social factors contribute significantly to one's health or ill health.

The Commission on Social Determinants of Health with 17 commissioners was established by the Director-General of WHO in 2005, as a strategic mechanism to promote a global health agenda to improve equity in health and health care through action on the social determinants of health at global, regional and country levels. The Commission believes that inequalities in health across different social groups and countries cannot be addressed unless the causes of the causes or the underlying determinants of health are tackled. The Commission, therefore, will lead a global effort to protect vulnerable families and secure the health of future generations by tackling disease and suffering at their roots.

Situation

Currently, less than 2% of the governments globally have developed mechanisms for continually ensuring policy coherence in the social determinants of health and 1% of families globally experience catastrophic expenditures because of existing health systems. Poorer populations are twice more likely to have TB, three times less likely to access care for it and four times less likely to complete the treatment.

This state of affairs is despite the fact that the social dimensions of health are affirmed in the WHO Constitution. While the social dimensions of health received major attention under the Health for All agenda in the 1970s their importance was downplayed during the 1950s era of disease campaigns. Fresh opportunities have opened up to address them with the

²³ *Dr Sangay Thinley, Coordinator, HIV/AIDS, Tuberculosis and other Communicable Diseases, Department of Communicable Diseases, 18 August 2005*

pronouncement of the Millennium Development Goals and scaling up efforts to address health inequities after the 1990s paradigm of health as a "private" issue.

The Commission's main focus is on the themes of women and gender, diseases of public health importance, early child development, health systems, urban settings, social exclusion etc. to promote health equity.

Conclusions

The establishment of a Commission on Social Determinants of Health is commendable. The Commission will develop a community of actors with shared values working together to assemble evidence which will catalyze action on social determinants at country level, motivate change in global policy and practice and develop a mechanism for sustaining this work within and outside of WHO.

A few things about bombs... and what they can do...²⁴

Background/the problem/issues

The presentation provided information and promoted awareness about explosives and bombs, their types, their effects, type of injuries caused by them and what can be done against them.

Description

Explosive matter is of two kinds namely explosives and chemicals for non-explosive purpose. The former include high explosives (like tetrazene, RDX and gelatin powders), propellants (gun powder, liquid fuels for rockets) and pyrotechnic (fume generators, fireworks). The latter include fertilizer grade ammonium nitrate, chlorates (weed killers), organic peroxide (catalysts), NTG and PETN solutions (used for pharmaceuticals). Examples of conventional (military) explosives are blast mines, bounding fragmentation mines, scatterable mines, armour piercing mines and off-set mines. Non-conventional explosives include Improvised Explosive Device (IED), suicide bomber vest, car bombs and intermezzo. Explosions cause various types of injuries like primary, secondary, tertiary and quaternary injuries.

Conclusions

Bombs and explosions cause extensive damage to human lives and property. Advance information about them can be useful in adequately preparing oneself in preventing their occurrence and dealing with the circumstances when they do occur.

Recommendations

To avoid these injuries, countermeasures like adequate measures for surveillance, establishment of detection teams, posting of security guards, exercising staff vigilance, maintaining physical barriers and adoption of preparedness measures like evacuation procedures and first aid trauma kit should be used.

²⁴ Mr Peter Koopmans, Ex-Regional Field Security Officer, 22 September 2005

Mongar Health Services Development Project, 1986-1990, Bhutan²⁵

Background/the problem/issues

Primary Health Care (PHC) as outlined in the Alma-Ata Declaration of 1978 was the principal approach adopted by the Royal Government of Bhutan to provide modern health care services to its people. In the early 1980's Bhutan was just beginning to establish the infrastructure and systems to deliver the services to its people. Bhutan's rugged terrain and its widely scattered population were major challenges to the development to health services in the country. WHO, in collaboration with the government, decided to choose a typical district where health care infrastructure and services were relatively under developed and implement a pilot health services development project; Mongar district in Eastern Bhutan was selected for the project.

The main objectives of the project were (i) to gain policy commitment to foster intersectoral collaboration in health services development, (ii) to promote community participation, (iii) to extend primary health care services to all people in the district, and (iv) to establish a system of referral from the periphery to the district hospital and beyond.

Current Scenario

Some of the key strategies adopted in this pilot project were:

- Establishment of a development organization at the district (Dzongkhag Yargye Tshogchung, DYT) and block (Gewog Yargye Tshogchung, GYT) levels. The DYT was headed by the dzongdag or the district commissioner, and the GYT, by the block leader of the village (Gup). All activities were discussed and consensus sought at these levels prior to implementation.

²⁵ Dr Pem Namgyal, *Vaccine Preventable Diseases, Immunization and Vaccine Development*, 6 October 2005

- Establishment and reorganization of service infrastructure. The existing service infrastructure such as basic health units (BHU) and dispensaries were either upgraded or relocated to ensure the closest proximity to the communities they serve. In addition outreach service points were established whereby, on fixed dates each month, the health staff of the nearest BHU or the dispensary provided a package of preventive and promotive services including treatment for common ailments.
- Village Health Workers (VHW). From each village a volunteer was trained and given a simple treatment kit. They acted as the advocacy focal points in the village for health promotion and as well as provided immediate first aid and simple treatment such as oral rehydration salts and anti-worm tablets. They kept records of pregnant women and children in their villages and motivated them for antenatal, postnatal and immunization services.
- Promoting sanitation and safe water supplies through water source protection, piping water supplies where feasible, and promoting pit latrines for all households.
- Establishing a referral system. The VHW played a vital role in referring patients from the village to the district hospitals for illnesses that cannot be dealt at home. Traditionally, people sought local practices and cures and did not usually opt to come to a hospital.

Conclusions

The Mongar Health Services Development Project helped consolidate the delivery of a package of health care services, appropriate to the countries settings and affordability. Within a short span of initiation the project made a visible impact on the morbidity and mortality and the level of services provided to the rural people of Mongar District. Some of the key achievements are as follows:

Indicator	1986	1990
Crude birth rate (per 1000 live births)	45.8	39.4
Crude death rate (per 1000 live births)	12.3	10.8
Infant mortality rate (per 1000 live births)	144.6	70.7
EPI coverage	54%	80%
Sanitation (pit latrines)	2.9%	76.9%

Following the success of the Mongar Project, primary health care services modeled on the Mongar experience were implemented nationwide and continues with improvements and adaptations as needed. In addition to the improvement of coverage of basic health services, the District Development Committee and the Block Development Committee became accepted as permanent governance structures for the country; the village health worker programme and outreach services were expanded nationwide.

Recommendations

Some of the key lessons from the Mongar Health Services Project are:

- (1) That it is possible to implement a package of essential health services at minimal cost, and yet have a significant impact improving of the health of rural communities.
- (2) Intersectoral coordination and collaboration are important and necessary for the success of such a project and leadership is critical to ensure such collaborative efforts.
- (3) Communities can understand their need and, if led appropriately, can also rise to collectively address their own needs with minimal support from the government.

If there is one important recommendation for the future and it is for WHO to ensure that the results of such projects are published. Not having a published paper on this interesting experiment is a lost opportunity to record the lessons and results of such initiatives.

Genetically Modified Foods (GM Foods) – An outline²⁶

Background/the problem/issues

The presentation provided a balanced perspective on the main issues related to the debate on Genetically Modified Foods (GM Foods). Genetically modified organisms (GMOs) are organisms in which foreign genetic material has been introduced through man-made recombination. These organisms are used to create GM plants to grow GM crops and produce GM foods.

Description

GM foods are developed for their perceived advantages either to the producer or consumer of these foods. For the producer they translate into longer durability whereas for the consumer they translate into products with a lower price or higher nutritional value. These foods are also produced to introduce genes resistant to plant diseases caused by insects or viruses and/or genes showing tolerance towards certain herbicides. GM plants are patented and are generally hybrids. Their second generation is sterile. The benefits of these foods is high nutrient value, decreased allergenicity potential, more efficient food production and less adverse effects from agrochemicals. However, they have some associated risks like outcrossing and increasing control of agriculture by biotechnology corporations. Marketing of GM foods and GMOs in general are subject to extensive legislations, thus creating a potential for legal dispute.

Conclusions

Public health could benefit enormously from the potential of biotechnology. According to WHO estimates, the GM foods currently available in the international market have passed risk assessments and do

²⁶ Mr Alexander Hildebrand, Regional Adviser, Food and Chemical Safety,
Department of Sustainable Development and Healthy Environments, 13 October 2005

not do currently present risks for human health. But WHO has found problems related to equal access to genetic resources and sharing of benefits in the context of gene technology in medicine.

Recommendations

Individual GM foods and their safety should be assessed on a case-by-case basis. There should be equal access to genetic resources and sharing of benefits with reference to gene technology in medicine. Problems of monopolization have to be strictly dealt with. Environmental impacts from GM foods like loss of biodiversity need to be looked into. There should be a multi-stakeholder holistic evaluation of GM foods to encompass health, environmental safety, social and ethical aspects. An inter-sectoral holistic approach also needs to be adopted and full food safety systems should be developed instead of a segmented system.

Tuberculosis control: challenges and realities at the ground level – A study from Kathmandu²⁷

The Medical Officer (TB) presented the findings of a research undertaken by a Nepalese PhD student at the Nuffield Institute, Leeds, U.K.

After a quick overview of the objectives of TB control programmes and the strategies to achieve those objectives, as determined by planners and advocated to policy makers, a more critical look was given to the impact of TB control activities on the lives of the immediate beneficiaries, i.e. the patients, was looked at more critically.

The link was demonstrated between TB control and the broader social determinants of health, which are often overlooked in the fairly narrow thinking of health policy makers. The presentation reiterated the vicious circles of TB and poverty.

While the proposed interventions do address the overall needs of TB control programmes, the public health approaches of the interventions primarily focus on cutting the transmission and benefiting the community at large. This is a justifiable reasoning, but needs to be corrected to address the additional suffering created by the programme on the patient. The free treatment provides only a fraction of this compensation.

Attempts are being made to strengthen the multiple sub-strategies in TB control, e.g. urban TB control, discrimination, community participation, TB/HIV. These efforts are yielding some positive results but need to be scaled up and institutionalized in order to have an impact. While National TB Control Programmes (NTPs) in collaboration with WHO monitor performance of programmes by analysing the macro-picture compiled with statistics, plans and reports, the overall picture of TB control can be more complete if the complementary information provided by grassroots organizations or obtained through in-depth research is systematically considered.

The researcher called for treating patients, and not merely diseases and for not treating health as a commodity.

²⁷ Ph.D. Research undertaken by Dr Sushil Baral, presented by Dr Erwin Cooreman, Medical Officer, Tuberculosis, Department of Communicable Diseases, 20 October 2006

Setting Organization wide priorities for Staff Development in SEARO²⁸

The Regional Personnel Officer explained the concept of a learning Organization where learning takes place at every level apart from the structured/formal training courses/workshops/programmes. Her presentation highlighted:

- Staff Development Learning (SDL) activities held in SEAR (group/individual/others) and briefings/debriefings conducted during 2004-2005.
- Global priority areas for SDL in 2006-2007.
- Draft SDL Plan for SEAR for the fourth quarter of 2005 and for 2006-2007 (quarter-wise) comprising on-going activities as well as foreseen specific/identified activities endorsed by SEARO SDL Committee.
- Some recent important developments, viz.
 - Creation of Global SDL Fund,
 - Establishment of Global Learning Committee,
 - Reconstitution of SEAR SDL Committee,
 - SDL policy for SEAR being developed, etc.
- Status of SDL funds for the Region – used funds and available balance.

While the lunchtime seminar on 10 November was attended by 15 professional staff members, the presentation on 11 November was attended by 10 professional and 51 GS staff members.

The subject evinced great interest among the attendees who offered productive comments and suggestions which are summarized below:

- (1) The presentation created awareness and appreciation among staff about hitherto little-known activities of SDL.

²⁸ Ms Ulrika Martinius, Regional Personnel Officer, 10 November 2005

- (2) A two day Workshop on induction for new staff members could be organized within the first year, and on a regular basis (perhaps twice a year).
- (3) Media training for 'P' staff should be included in the SDL plan for the next biennium.
- (4) The DVD briefing package (administration and finance), currently under preparation by PER, may be provided, when ready, to all staff.
- (5) A refresher course in French language training for interested staff may be considered.
- (6) A language training course in Hindi for interested professional staff in SEARO/WR-India can be conducted.
- (7) Review of dictation/typing skills support needed by certain 'P' staff and appropriate training organized for administrative staff as required.
- (8) Periodic refresher training courses in relevant areas be organized on a regular basis.
- (9) Four Workshops on Resource Mobilization were conducted during 2004-2005 and this is an on-going activity.
- (10) Emerging health issues could be included in the SDL Plan.
- (11) The suggestion made for training on issues related to occupational health/ergonomics vis-à-vis handling of office equipment could be handled under staff health promotion.
- (12) On the issue of allocation of 5% of staff time for SDL activities, some staff felt that all training should be organized within office hours unlike the French language training course for which staff have to devote one hour of their own time after office hours. Although SDL was considered to be a shared responsibility, staff members' concern on this issue was noted.
- (13) Regarding retreats, staff were advised to contact their respective departments to explore the possibility of organizing such events and that SDL funds could be provided for that.
- (14) Evaluation/impact assessment of SDL activities such as the course on Writing Effectively for WHO should be undertaken to measure the benefits to the Organization.

The Heat is on: An introduction to Human Health Impacts from Climate Variability and Climate Change²⁹

Background/the problem/issues

The scientific evidence for climate change and its impacts is assessed by the Intergovernmental Panel on Climate Change (IPCC). According to their latest report, by 2100, the average global temperature will have increased by 1.4 - 5.8 degrees. Due to this global warming, there will be significant rise in the sea level. These are expected to speed up coastal erosion.

Description

The Potential impacts on health determinants from climate change include loss of life and injuries from floods, storms, cyclones and fires; Glacial Lake Outbreak Flooding (GLOFs); mortality and morbidity from heat waves and air pollution; health consequences of altered freshwater supplies; change in range and seasonality of infectious diseases; change in agricultural food productivity and increased population displacements.

Conclusions

Measures to protect human health from the consequences of climate change need immediate attention. Reducing green house gas emissions remains the most important step towards fighting climate change.

Recommendations

Industrialized countries must take steps to quickly reduce the enormously high levels of emissions. The countries that have contributed the majority of greenhouse gas emissions must take the lead in reducing emission levels.

²⁹ Mr Alexander von Hildebrand, Regional Adviser, Food and Chemical Safety, Department of Sustainable Development and Healthy Environments, 24 November 2005

They must support mountain and other affected regions in developing countries to adapt to health impacts from climate change and help ensure their long-term development. WHO should continue creating awareness on the potential impact of climate change to human health and promote corrective action through national health systems.

Motorcycle Helmet for Kids, with Love and Care³⁰

Detailed problem/background

Deaths and economic loss from transport crashes; especially involving motorcycles were a serious problem in Thailand. Since 2002, Thai motorcycle riders have been killed in crashes with average of one person per hour. Among children less than 15 years, 68% of deaths from transport crashes were of vehicle users and 72% of the child vehicle users died from riding on motorcycles.

As per estimates from death registry and ~~the~~ Thailand National Injury Surveillance of 2003, approximately 12,000 children were admitted to provincial hospitals for treatment at an average of 33 per day or 1.4 persons per hour. There were 1.5 child deaths every day, approximately four times the numbers of DHF deaths. In 2006, the information was presented to the Deputy Prime Minister as the Chairman of the Road Safety Directing Centre (RSDC), together with the proposal to prohibit children from riding on Motorcycles. After a three-month consideration, the RSDC Board decided not to prohibit but to seek for the protection of the children instead.

Wearing of a motorcycle helmet is an important safety behaviour for motorcycle riders. If a 90% helmet wearing rate among motorcycle riders on the road is achieved, deaths and severe head injuries among motorcycle riders would be decreased by 30%. Since 1996, the motorcycle helmet law has been enforced in Thailand (for the whole country). This law did not exempt children. However, from the National Injury Surveillance report, 99.9% of the child motorcyclists who got severely injured did not wear motorcycle helmet. The causes of the problem were inadequate knowledge and lack of enforcement. This resulted in the helmet industry not producing motorcycle helmets for 3-5 year old children and helmets for 6-15 years old were difficult to find especially outside of Bangkok.

The "Motorcycle Helmet for Kids, With Love and Care", was a pilot project to create awareness about the risks faced by children in riding on motorcycles without appropriate measures for protection in Thailand. It

³⁰ Dr Chamaiparn Santikarn, *Disability and Injury Prevention*,
Department of Non-Communicable Diseases and Mental Health, 15 December 2005

promoted helmet wearing in 3-14 year old children but did not accept driving by under 15-year-old children. The concept of the project was to deal with the predisposing factor (knowledge regarding risks and protection, the enabling factor (the distribution of child helmets and the reinforcing factor (behavioural control by the major leaders in the province).

Objectives

- (1) To raise awareness at the national level of the risks of children riding on motorcycle and the importance of wearing helmet at all times on a motorcycle.
- (2) To increase the helmet wearing rate of the child motorcyclists on the streets of the central district of the 15 pilot provinces to 90%.
- (3) To obtain concerns regarding the problem among related organizations in the pilot provinces.

Method

- (1) Fund raising from the private sector to support the production of helmets for 3 -5 year old children and for project implementation was tried. Finally the first lot of 15,000 child motorcycle helmet was produced for the Thai government that purchased through bidding. The budget for activity was from the Thaihealth (Thai health promotion foundation revenue derived from two percent of the excise taxes on tobacco and alcohol).
- (2) A contract was to be signed by the governors, the chief of police and the education chief of each province with the RSDC director in order to apply to be included as the pilot provinces.
- (3) Project manager held a meeting with a multi-sectoral team from the province to discuss the project concept, and planning for activities at the central and provinces at the beginning and again at the middle of the project to exchange experience and lessons learned.
- (4) Setting up an internal monitoring system.
- (5) Empowering visit to the province by project manager.

- (6) Educational campaign within the pilot provinces and between the provinces.
- (7) Enforcement on helmet wearing, by children within each province.
- (8) Evaluation by external evaluator.

Results and conclusion

The evaluation report would be submitted in March and the result would be reported in the coming Asia-Pacific conference on Injury Prevention.

Health awareness for rural mothers – A novel approach from Maldives³¹

The issue

Weak delivery of the health awareness is a major concern in most PHC programmes. In Maldives too this is a cause for concern. While community health workers (CHWs) are deployed in many atoll settings, their health actions gravitate more towards providing medications and first aid, and often neglect the health promotion element. Even when they do, it is confined to individual home visits and one way communication with the recipient. There is therefore a need to adopt a more effective method.

Description

The presentation introduced the effectiveness of a group approach versus an individualized approach to promoting health awareness mothers in community, and to share the experience of how the group approach was carried out in an atoll-based experiment in PHC delivery in Maldives.

In Maldives, where the PHC approach has been the operational model for health service design and delivery since the early 1980s, the use of multi-purpose health workers (community health workers) has been the mainstay of the local level health system. A huge segment of their work relates to promoting the health of mothers and children. In any community setting, mothers are always a good target group for efficient health service because providing them with access to services and health awareness will more often than not, translate into improved health of their children too.

This operational research activity conducted in Maldives looked at the effectiveness of an intervention that promoted awareness among mothers' through teaching mothers in groups (a group approach) versus providing this same knowledge through regular health visits by CHWs to individual mothers in their own households (individual approach). This was an

³¹ *Dr Abdul Sattar Yoosuf, Director, Department of Sustainable Development and Healthy Environments, 22 December 2005*

experimental design with the experimental intervention (the group approach) implemented in Thaa atoll of Maldives, and a control setting provided by Laamu atoll (individual approach). In the experimental setting, groups of mothers met together once a week for eight weeks to study a set of eight modules on PHC - related knowledge given by the CHW. After each eight week session, the groups dismantled, and formed new groups of mothers from those not exposed to the lessons. In both settings, the community leaders assumed ownership to oversee the conduct of the activities, and older and respected community mothers supervised the conduct of the group formation and dismantlement after each round. During the one-year experiment, all mothers with children under 5 years of age (in the islands of the experimental setting) had been exposed to the lessons.

Conclusions

By the end of the year, the mothers who were exposed to the group approach to teaching retained a far superior level of knowledge from the lessons than mothers in the control setting. This was clearly shown by the differences in indicator knowledge levels between the pre - and post - test knowledge scores taken in each setting. This result points to the group approach being a more effective way of conducting teaching than an individualized approach. Perhaps the dynamics of the group provided a more stimulating learning environment among participating mothers in the experimental setting. Theories on learning and motivation also attest to this possibility of the group approach's superiority as a setting for better learning. This result points positively for using the group approach for effective and efficient delivery of health promotion activities in local settings. Coupled with active community leadership, the group approach can be a dynamic and powerful mover of change for community health development. Health efficiency and effectiveness is guaranteed by cooperative action.

The HIV/AIDS epidemic: From Crisis to Opportunity³²

Background/the problem/issues

Although the HIV prevalence rate is still low in South-East Asia, it is one of the most rapidly growing HIV/AIDS epidemics globally. Because of the large population base and presence of several factors that enhance the spread of HIV, including poverty, gender inequality and social stigma, the South-East Asia Region is likely to increasingly suffer the brunt of the epidemic.

Description

While HIV/AIDS cases are now being reported by all countries in the Region, four countries, namely India, Thailand, Myanmar and Indonesia, account for 99% of the total burden in the Region. India has the highest number of cases in the Region. The majority of HIV infections in the Region occur through unprotected sex between men and women. Throughout the Region, injection drug use is adding to the rapid spread of the epidemic.

The estimated number of people living with HIV/AIDS (PLWHA) are based on nationally reported surveillance data and on some assumptions and available tools. These estimate therefore, reflect the completeness and quality of data in each country.

WHO and its partners have announced the "3 by 5" initiative, which is to provide antiretroviral treatment to 3 million people with HIV/AIDS by the end of 2005, covering 50% percent of those in need. This is an interim target towards ultimately providing universal access to treatment to all people with HIV/AIDS who need it. Achievements in scaling up art are exceptional, and Thailand leads the way in the Region. India, Indonesia, Myanmar and Nepal have started treatment programmes. Low HIV burden countries, such as Bangladesh, Bhutan, Maldives, Sri Lanka, and Timor-Leste have also started treatment programmes.

³² Dr Ying-Ru Lo, Regional Adviser-HIV/AIDS, Department of Communicable Diseases, 30 September 2004

Conclusions

In view of the apparent threat of HIV/AIDS epidemic, the current crisis situation is being converted into an opportunity to effectively deal with the situation. This is evident from the modified vision of health, mainstreaming HIV/AIDS through all levels of the health sector and beyond, HIV/AIDS being addressed in health systems reform. There has been full involvement from civil society, people living with HIV/AIDS, NGOs, governments and the corporate sector.

Recommendations

Scaling up ART treatment presents an opportunity for countries to strengthen the capacity of their health sector to provide a spectrum of chronic care. A lot has already been done but much remains to be done.

Lessons learned from Roll Back Malaria Mekong: Implications for inter-programme cooperation³³

Malaria is an acute disease caused by parasites in human blood transmitted by anopheles mosquitoes. The epidemiology of malaria varies greatly and transmission of the disease depends on socio-economic factors and environmental changes. Sub-Sahara Africa reported most malaria in the world. It is estimated that 90% of malaria occurs in Sub-Sahara Africa whereas 10% occurs in Asia, South and Central Americas and other places. In Africa, the disease affects vulnerable groups, *i.e.*, children under five and pregnant women. There are three inter-programmes related to malaria control; integrated management of childhood illness (IMCI) in countries where infant mortality rates are high; implementation of intermittent preventive treatment (IPT) in pregnant women during antenatal care as a part of the "Making Pregnancy Safer" initiative; collaboration with Essential Drug and Medicine (EDM) programme by establishment of a quality assurance programme for antimalarial drugs.

Experiences with regard to the RBM Mekong programme were presented with special focus on the disease pattern in the Greater Mekong Sub-region (GMS), malaria-related occupations, behavioural risk factors of malaria and the importance of multidrug resistant *P falciparum* which is a unique feature of Mekong malaria. The strategy of Roll Back Malaria in Mekong countries consisted of: (a) increased partnership; (b) increased coverage of malaria prevention through insecticide-treated nets, and long lasting insecticidal nets; (c) improved access to rapid diagnosis and appropriate treatment. Cambodia has extensive experience in packing of rapid diagnostic tests and artemisinin-based combination therapy to increase access of quality drugs. The high prevalence of counterfeit antimalarial drugs was presented. All Mekong countries have established a network of antimalarial drug quality monitoring through support of WHO, US Pharmacopeia and several development partners. Public-private partnership and increased coverage of bed net through social marketing were also highlighted.

³³ Dr Krongthong Thimasarn, Coordinator, RBM Mekong, Ag. RA MAL,
Department of Communicable Diseases, 14 October 2004

NCD – Community-based experiences and lessons learnt³⁴

Background/the problem/issues

Globally, noncommunicable diseases (NCDs) are increasingly recognized as a major cause of morbidity and mortality. The total deaths due to NCDs, 75% occur in developing countries. The countries of the South-East Asia Region are thus facing a double burden, with a heavy load of infectious diseases and an increasing burden due to NCDs.

Description

The changes in the economic, social and demographic determinants of health and adoption of unhealthy lifestyles are contributing to a progressive and accelerated rise in morbidity and mortality due to NCDs in the Region. NCDs including cardiovascular diseases, cancer, chronic pulmonary diseases and diabetes are linked to a cluster of major risk factors such as tobacco use, unhealthy diets, physical inactivity, obesity, high blood pressure, cholesterol and glucose levels that are measurable and largely modifiable.

The majority of NCDs are preventable and the knowledge on cost-effective interventions for NCDs and their risk factors at population, community and individual levels is available. However, the application of this knowledge is hampered by inadequate recognition of the impact of NCDs on economic development. Also, the lack of financial support retards capacity development for the prevention and control of NCDs in the Region. WHO/SEARO is supporting community-based intervention (CBI) projects for integrated prevention of NCDs in Bangladesh, India, Indonesia and Sri Lanka. The CBI project in Depok, near Jakarta has gained considerable recognition and paved the way to initiating further CBIs in Indonesia.

³⁴ *Dr Jerzy Leowski, Regional Adviser, Non-communicable Diseases, Department of Non-communicable Diseases and Mental Health, 7 October 2004*

Conclusions

A community-based approach for prevention of NCD is feasible and appropriate for implementation in countries of South East Asia Region. STEPS is the WHO recommended tool for NCD risk factor surveillance.

Recommendations

The lessons learnt on design and implementation of pilot projects should be incorporated in the proposed extension of projects. The framework provided by WHO - STEPS is suitable for estimating the level of risk factors in the areas where community-based interventions are applied.

The "Thursday Lunchtime Seminars" held in the Goa Room of the Regional Office for South-East Asia began in June 2004 and are meant to provide an informal forum for staff to share vignettes from their experiences through the informal presentations. Presenters were both external and internal, with SEARO staff comprising the majority. This informal setting offered SEARO's busy staff an opportunity to participate in to current-issue-related presentations while enjoying lunch. This arrangement saved on work time and helped reap the benefit of morsels of practical wisdom shared in the discussions. Thus, it was a chance to share each other's lessons from real life experiences that have staff appeal across SEARO's several technical units. The informal nature of the forum setting, elicits lively discussion and debate.

This internal publication includes presentations from the first two years of the seminars, with short textual synopses or abstracts on each of these presentations and discussion points. The document is accompanied by a CD-ROM which includes the relevant Power Point presentations made during these seminars.



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