

Food for Thought:
Summaries of Lunchtime Seminars
(2007-2009)



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From disability to mobility¹

This presentation on prosthetics and orthotics (P&O) devices is based on a story of a child. It may also give ideas on the importance of prosthetic and orthotic devices to anyone working in closely related fields, such as physiotherapy, occupational therapy, orthopaedic surgery, community-based rehabilitation and in the provision of other assistive devices (wheelchairs, crutches, etc.) in different conditions.

It's a story of a child who is disabled. Sayantani is a 18 month-old girl with a total Amelia of the lower left limb. The absence is similar to the hemipelvectomy amputation. To rehabilitate such a small child with unique disability requires a multifaceted approach by rehabilitation professionals. Since children have a greater need for adjustable devices than fully grown adults, the concept of this new endoskeleton prosthesis meets some of their requirements. A modular prosthesis designed for Sayantani. It comprises a conventional hip disarticulation socket with anterior opening, a hip joint, a knee joint, pylons and a modified foot. The pylon system consists of a telescopic design to accommodate the child's rapid skeletal growth. The pylon is covered with foam and a sturdy cosmetic cover. It is light-weight, adjustable and the cosmetic cover is compressible. The prosthesis met the basic requirements of the child to stand. It is very comfortable, stable, and has fewer manoeuvres. It is functional in that it may be lengthened and aligned without time consuming and hazardous manipulations. Unfortunately, the components of the modular prosthesis such as the pylon-hip connector, the pylon and the pylon-ankle connector are not commercially available for children under the age of three.

This example demonstrates that an Endoskeleton prosthesis was able to address the needs of a very young child with a unique disability. It needed a multifaceted approach by rehabilitation professionals; adjustable devices; creativity in using available materials; a caring family and social environment; and some cost considerations of affordability.

¹ Mr Vimlesh Kumar, Department of prosthetic and orthotics, N.I.O.H, Kolkata - intern with Dr Chamaiparn Santikarn, Regional Adviser - Disability, Injury Prevention & Rehabilitation, Department of Noncommunicable Diseases & Mental Health, 10 September 2009.

The prosthesis met the basic requirements of the child to stand. It is very comfortable, stable, and has fewer manoeuvres. It is functional in that it may be lengthened and aligned without time consuming and hazardous manipulations.

Comment

The socio-economic condition of the patient is also an important consideration while prescribing the prosthesis. The cost of the prosthesis must be within the reach of the person's income and resources. The alignment of the prosthesis changes as the child grows. The prosthesis has the alignment variation options to accommodate the needs of the patient. Family support and responsibility of the society is necessary to rehabilitate the child. Furthermore, effective training with the prosthesis and a comprehensive approach empowers the child and tells us of a successful journey from disability to mobility.

Commission on Social Determinants of Health Recommendations – an analysis²

The determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances most of which are social are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. Thus, we could say that social determinants of health are primarily responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

The Commission on Social Determinants of Health was set up by WHO in 2005, to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The Commission presented its report to the WHO Director-General in August 2008, with recommendations on the key areas in which action is needed. The Commission's overarching recommendations are:

- (1) Improve the conditions of daily life.
- (2) Tackle the inequitable distribution of power, money, and resources.
- (3) Measure and understand the problem and assess the impact of action.

Improvement of daily life can be achieved by

- Realizing that the health-care system benefits go beyond just treating diseases;
- Health-care institutions and services are organized around the principles of universal coverage and primary health care;
- Health-care is a concern for all countries at all levels of socioeconomic development;
- Public health care emphasizes on community engagement and empowerment;

² Ms Prerna Kuckreja, Intern with Dr. Davison Munodawafa, Regional Adviser, Health Promotion and Education, Department of Noncommunicable Diseases and Mental Health, 6 August 2009

- Advocates from political, economic, social, and cultural fields acting together towards promotion of a better health care system;
- Increasing Global Health Initiatives (GHI) for new resources brought to international development and health.

With regard to health equity in all policies, programmes, and systems, every aspect of government and economy has the potential to impact health and health equity. The markets bring health benefits in the form of new technologies, goods and services, improved standard of living and political empowerment gives inclusion and voice and so very important for the well-being of the people and to achieve health equity.

For good global governance and health equity, addressing the risk of inequity in globalization, and managing the potential of globalization for better and fairer health, there is a need for new forms of global governance. Liberalization and market integration between countries, increasing trade within the ecological imperatives of sustainable resource use is desirable, adoption of health equity between and within countries as a core measurement of development are some of the crucial steps that can improve the coherence of actions on the social determinants of health across sectors of the government and the UN agencies.

Health equity cannot be achieved only by looking at the health aspect. Social, political, economic, and cultural aspects also need to be considered and immediate action needs to be taken on them. Each country should address the social determinants of health conditions, according to their needs and resources available. Particularly important here is public education that can significantly change habits of daily living thereby influencing health equity. Although health of the people has improved significantly through rational initiatives taken by the countries, health problems will not be addressed without acknowledging these other conditions that cause these problems in the first place. The WHO Regional Office for South-East Asia can help in facilitating countries to work on the process of categorizing the conditions into Immediate, Intermediate, and long-term concerns.

Gender-sensitive health care ³

There is a need to understand how gender norms and roles as well as gender disparities affect the demand and supply side of health care and the interaction between the two. We know by now that wealth conditions can affect women and men differently, and that human rights issues may influence the right to health. But, is the health work-force aware of these issues? Gender-sensitive health care to be available, we need to address these concerns.

The World Health Assembly passed a resolution WHA 60.25 in 2007 and also SEARO worked on regional strategic direction to integrate gender into health policies and programmes, in 2007.

Gender-sensitive health care is needed to improve the quality of health services that consider gender disparities which influence health outcomes. Health care workers need to be aware of these aspects.

The practice of human rights and, exercise of cultural sensitivity help make patients comfortable and maintain their dignity. Unfortunately, some gender issues have been ignored because of insufficient data to prove their truth, and thus did not pass through the screening policy.

We need to avoid 'gender-blind' health care by being aware, for example, that the reasons for lack of access to care or the experience of a catastrophe may have been due to gender biased reasons. A woman should not die because she did not have permission to leave home to go to the clinic or she could not avail the services of her neighbourhood clinic because the clinic was closed for business by the time she was done with her house-hold chores. By being aware of these social determinants (caused by the result of gender roles in society), we will avoid gender-blind care.

Primary Health Care may provide a "sweet and sour" situation at the same time; women's participation is increased but at the same time, the burden of house/ family care also increases and influences women's health.

³ *Dr Adepeju Olukoya, MD, MPH, Gender and Women's Health, WHO Headquarters, 16 July. 2009.*

Questions and answers:

- (1) Gender sensitivity and understanding based on different ethnic/cultural factors will influence gender-sensitive health care. It is not a question of right or wrong but the focus is on health consequences and how we are going to help.
- (2) How gender frames our health care culture applies to men and women. The gender perspective explains how an existing culture of health service provision may create gender disparities and influence health outcomes. It is recommended thus not only to change bad norms in community but also to maintain good ones of health behaviour. Health workers must be ready to give advocacy and gender sensitive services.
- (3) It is true women have higher life expectancy than men mediated by lifestyle, but women suffer more disabilities and diseases.
- (4) Why we are still slow on gender issues – political and scientific lessons learned; while historically gender issues were focussed on women, nowadays given these new lessons and paradigm shift, without men also in the equation, we cannot solve gender problems.
- (5) WHO-HQ performed gender capacity building for planning officers and other technical units in May 2009. It is hoped that SEARO will conduct capacity building on gender analysis/ gender sensitive health care for regional/ country staff next year/ biennium.

Protecting our health from climate change: a training course for public health professionals⁴

This presentation is about a just completed training course on the above.

Due to the emergence of issues pertaining to climate change, global warming, etc., there is an urgent need to make the public aware of its health affects. The general public and intervening institutions will require some basis for preparing their lessons and thus, it is hoped that the conduct of this presentation will have given rise to some thoughts that can be included in such a design. Eminent researchers and experts in the field of climate change prepared the course content.⁵

The objectives of this training course are: to improve the knowledge of health professionals on the association and implications of climate change on human health, and to enhance stronger and more efficient participation of the health sector in addressing challenges posed by climate change. The course is designed for public health professionals who are actively involved in the management and decision-making process related to medical programmes. The course will also give a good foundation for non-medical professionals involved in addressing the health challenges posed by climate change.

The course will enable participants to understand the principles and basic concepts of global warming and climate change; understand how climate change impacts health and know the major health effects of climate change; become aware of the special vulnerability of the South-East Asia Region; better analyze the health sector's vulnerability to climate change

⁴ Mr Alexander von Hildebrand, Regional Adviser – Environmental Health & Climate Change, Department of Sustainable Development and Healthy Environment. 28 May 2009

⁵ Included are experts such as, Dr. Kristie L. Ebi, ESS, LLC, Executive Director, IPCC; Dr. Paul Wilkinson, London School of Hygiene and Tropical Medicine, England; Dr Diarmid Campbell-Lendrum, Public Health and Environment, World Health Organization; Mr David Mills, Stratus Consulting Inc.; Dr. Erin Lipp, University of Georgia, USA; Dr. Nicholas Ogden, Université de Montréal, Canada; Dr. Lea Berrang Ford, Dr. Rose Eckhardt, Dr. Valerie Hongoh, McGill University, Canada; Dr. Colin Butler, Australian National University, Australia; Dr. Patrick Kinney, Columbia University, USA; Dr. Alistair Woodward, University of Auckland, New Zealand; Mr Alexander von Hildebrand, Environmental Health, World Health Organization, Regional Office for South-East Asia; and Ms Fiona Gore, Public Health and Environment, World Health Organization, Geneva.

effects; know epidemiologic methods for analyzing associations between climate change and health outcomes; be aware of adaptation and mitigation policies to manage the risks of climate change; develop skills in critical thinking for making management decisions to reduce the potential adverse impacts of climate change on health; understand the role of the health sector at the national, regional and global level for dealing with climate change mitigation and adaptation; identify knowledge gaps and know where to find further sources of information; be in a position to help incorporate the health dimensions of climate change in local and national workplans; facilitate the training of other health professionals; and enhance stronger and more efficient participation of the health sector in addressing climate change challenges.

There are several pathways along which Global Change affects Human Health. Some of these are: epidemiological, demographic change leading to aging; change in family structures and urbanization; social change through institutions, and governance; and economic activities through trade, wealth creation and distribution. However, environmental degradation, ecosystem disturbances and geophysical changes also create changes that affect human health.

In the past 100 years, CO₂ concentrations have increased by about 100 parts PPM; from 280 to 290. This is half of what had accumulated over the past several millennia. Energy, industry and transport account for about 60% of the green house gas (GHG) of the world; agriculture and forestry about 30%; and the residential and water sectors 10%. Four scenarios on GHG reductions indicate a worst case scenario of temperature rise to about 4 degrees at least by the end of this century. This may affect health and other concerns of life on this planet in unforeseen ways.

With climate change and the consequent disruption of the ecosystems, many biological niches will be disturbed. Malaria and vector-borne diseases will increase, heat stress will kill many, those hungry in this world will increase due to crop failures from droughts and floods and other extreme weather events, water quality will deteriorate or be stressed, air quality in cities will deteriorate with SPM and PM₁₀ reaching health stressful levels. Candidate diseases resulting from climate change that may be ready for epidemic early warning systems are: cholera, malaria, dengue fever, Japanese encephalitis, influenza, leptospirosis, rift valley fever (major zoonoses), borreliosis (tick-borne), and still others.

Public health practitioners will be called upon to assess the health co-benefits of mitigation activities, including equity aspects. We need more on health at the United Nations Framework Convention on Climate Change (UNFCCC)

The following thoughts were expressed in the discussions that followed:

- Currently, not much knowledge about this topic; this course is really the first step;
- It appears to be quite heavy for a four-day training; need to know the relevance of the course for the intended audience; need to make this course an interactive one;
- Climate change needs a cross-sectoral approach; each chapter should be related to the group (or sector); very good material as a start, but thinking long-term, we need to institutionalize the course through some universities;
- Training course must identify “what actions can be taken practically at the community level” and “how can the health sector take charge”;
- Get a group of national experts for the first few courses;
- What does the health sector do? There is a need to clarify what the health sector can do; if we talk of communities getting involved, need to emphasize this aspect in the course material;
- Need to make the course different for different settings and different level of people;
- To have the course adapt to local conditions; some kind of flexibility to be built in chapter-wise in order to make the course look more locally beneficial for the community health professionals and to be able to relate better;
- If it is possible, WHO must explore the possibility of having the course as a distance learning course.

Gender-based violence in the South-East Asia Region⁶

Gender-based violence (GBV) was highlighted by nine out of 11 Member States in the South-East Asia Region. It was noted that 1 to 3 -5 women in the Region were subjected to violence in their lives. Some typical examples of GBV are: rape, sexual harassment, female genital mutilation (FGM), female foeticide/ sex selection, sexual harassment in the workplace, intimate-violence, spouse abuse, elderly abuse, and child abuse. It affects mostly women (60-70%); children (about 30%) and men (about 6%). The perpetrators are mostly husbands (73%).

Violence against men is also found in some of our countries. Women who believe in patriarchal culture think they deserve to be spoiled by the husband but feel they are being exploited through toiling for the family. In such cases, women perpetrators are often more powerful financially compared to their husbands. Growing ideologies and philosophies of social development and interpretation of gender spur inevitable conflicts and lead to increased violence when these are acted upon.

GBV is associated with physical, psychological, sexual and economic aspects including threat to freedom in private or public life. The cause is male-dominated culture and lack of inter-spouse communication. The health impact is felt through effects to mental health, disturbance during pregnancy, injury, trauma, etc. GBV is thus both a public health concern and a crime; perpetrators need to be addressed through harmonization of law. There should be zero tolerance to discrimination against women, with a categorical “no” to violence.

GBV, while found in many societies; educated/ non-educated; rich/poor; many religions, etc. can be prevented by minimizing the male dominated culture and increasing communication between spouses, family and partners.

Trauma of GBV among affected adolescents make them prefer living a single lifebeing and this needs to be resolved through proper advocacy and

⁶ *Dr Erna Surjadi, Regional Adviser, Gender & Women's Health, Department of Family and Community Health, 09 April 2009*

primary prevention methods. School health education towards understanding more about gender disparities and the need for gender equality will help. Prevention needs to start at an early age.

Thus, the health sector is a prime location to find cases. Where considering GBV for secondary prevention and protection to victims, the health sector is a prime location to find cases. Thus, training of health workers is very important for developing gender-sensitive health care; reducing violence during pregnancy; and avoiding the effects of violence and mental health implications.

Health interventions that may be attempted are:

- Training health workers.
- Gender-sensitive health care for in- and out-patients
- One Stop Crisis centre services (OSCC)
- Promoting primary prevention with multi-sectoral approach
- 3 P: Prevention, protection and prosecution with networking
- Mapping the cases with sex-disaggregated data collection

Recommendations

- A multi-sectoral and rights-based approach may promote primary prevention starting from early education (school health programme); adolescent counseling; pre-marriage counseling and antenatal programme.
- Developing National action plans on elimination of GBV in the South-East Asia Region is encouraged.
- Preventing GBV needs certain methodology; thus an inter-country meeting on GBV prevention planned by SEARO is considered important for delivering the appropriate methodology and information. Primary prevention exercised by Thailand needs to be shared and discussed among countries in the Region involving other related technical units; such as: Make Pregnancy Safer, Mental Health and Partnerships.

Intellectual Property Rights and public health: why all the fuss?⁷

Patents are a public policy tool; they were designed to promote and reward innovation, while at the same time ensuring disclosure of the invention, in order to make it widely known and available. Before TRIPS, countries could -and did- devise a patent regime that was in line with their level of development and their overall, national priorities.

The TRIPS Agreement has to a large extent harmonized the standards for patents. For developing countries, compliance with TRIPS standards generally means they have to increase the level of protection provided to inventions. This will delay the marketing of generic versions of new drugs (generics can only enter the market after patent expiry), and the competition they entail. As a result, prices of new medicines are likely to remain high for a longer time, which will reduce access to medicines. However, TRIPS does contain some flexibility, as well as some safeguards, which can be used to mitigate the anticipated negative impact on drug prices and on access to drugs. The most important safeguards are compulsory licensing and parallel importation.

In the South-East Asia Region, Indonesia and Thailand have used compulsory licensing for medicines; Indonesia in 2004 for ARVs, Thailand for ARVs, a cardiovascular drug and some cancer drugs. Thailand's use of compulsory licensing for medicines for non-communicable diseases has been criticized – though Thailand's actions were allowed under TRIPS. The criticism however shows that there still is considerable confusion about compulsory licensing. Notably:

- it is **not** true that compulsory licensing can only be used in case of an emergency;
- it is **not** true that compulsory licensing can only be used for (certain) communicable diseases;

The TRIPS Agreement leaves governments free to decide the grounds (reasons) for issuing a compulsory license.

⁷ Ms Karin Timmermans, *Intellectual Property Rights and Trade & Health (IPT)*, Department of Sustainable Development and Healthy Environments. 12 March 2009

Recently, however, we increasingly see “TRIPS-plus” provisions in bilateral and/or regional free trade agreements. It is important to recognize the inherent dangers of this, and to alert governments to it. The same is true for some of the recent global initiatives against counterfeits that confuse counterfeit, substandard and generic medicines. Recent seizures of generic medicines in the Netherlands that were in transit from India to other developing countries demonstrate that this can result in real problems.

Another final point relates to innovation: of 1,400 new drugs approved between 1975 and 1999, only 13 were specifically for tropical diseases/diseases of the poor. This has led to an intergovernmental process and the adoption of a Global Strategy and Plan of Action on Public Health, Innovation and IPR (World Health Assembly 2008). The strategy is comprehensive, but also creates a huge agenda.

Questions and discussion

Several questions focused on the situation in the Region. The SE Asia Region is very diverse; some countries are not WTO members, while others are, and one country is negotiating accession. Moreover, some countries have no patent law, others have had a patent law since long, others are drafting or amending their patent law. All patent laws in the Region have some safeguards, but often these could be strengthened.

Other issues raised during the discussion related to patenting of diagnostic, surgical and therapeutic methods (often exempt from patentability), the issue of patents for a new indication of an existing medicine and the importance of appropriate criteria for patentability of pharmaceuticals.

Community involvement in influencing policy change through evaluation of community-led total sanitation⁸

"Lack of sanitation breeds the so-called diseases of filth. These are diseases caused by the faecal contamination of food, water, or soil, or spread by flies that feed on filth. In the absence of sanitation, huge numbers of people are, in effect, being sickened by ingestion of infected excrement. This is intolerable amidst the collective wealth of the 21st century", said Dr Margaret Chan, WHO-Director General on the occasion of World Water Day, 2008.

Readers of the British Medical Journal (BMJ) voted the introduction of clean water and sewage disposal—"the sanitary revolution"—as the most important medical milestone since 1840, when the BMJ was first published. However, inadequate sanitation remains a major problem in developing countries. Only 62% of the world population has access to improved sanitation. In the South-East Asia Region (SEAR) with a population of approximately 1.7 billion, only about 59% have access to improved sanitation. In 1990, 40% of people in SEAR practiced open defecation which decreased substantially to 20% in 2006.

Community-led total sanitation (CLTS) was pioneered in 2000 by Kamal Kar, a development consultant from India. It is an innovative methodology for mobilizing communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of OD and take action to become open defecation-free (ODF). It ensures total use of hygienic latrines without open defecation combined with good personal hygienic practices, hand washing at critical times, use of safe water and maintaining a clean environment.

The CLTS approach recognizes that merely providing toilets does not guarantee their use, nor does it result in improved sanitation and hygiene. Earlier approaches to sanitation prescribed high initial standards and offered subsidies as an incentive. But this often led to uneven adoption, problems

⁸ Ms Payden, Regional Adviser – Water, Sanitation and Health, Dr Salma Burton, Regional Adviser – Occupational Health, Department of Sustainable Development and Healthy Environments, 29 January 2009

with sustainability and effective use. It also created a culture of dependence on subsidies.

CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – investing in community mobilization instead of hardware, and shifting the focus from toilet construction for individual households to the creation of “open defecation-free” villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community’s desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability.

Since then, various NGOs and development partners have implemented CLTS in Bangladesh as well as in other countries such as India, Indonesia, Nepal and parts of Africa.

TB – Tobacco pilot project in Nepal: Practical Approach to Lung Health (PAL)⁹

The problem/issues

There is no standardized management procedure for patients five years and older with respiratory symptoms with the exception of TB at any level of the health infrastructure. At the primary health care level, 20% to 30% of patients over five years of age have respiratory symptoms. Antibiotics are prescribed for two-thirds or more of patients with respiratory symptoms. In Nepal, tobacco smoking is the chief risk factor for Chronic Obstructive Pulmonary Disease (COPD) and lung cancer. Also, tobacco use is a risk factor for six of the eight leading causes of death in the world. Standardization of case management of respiratory diseases improves the quality and efficiency of respiratory care within Primary Health Care (PHC) by using the Practical Approach to Lung Health (PAL).

PAL strategy is a syndromic approach to the management of patients who attend Primary Health Care (PHC) Centre services for respiratory symptoms with focus on priority respiratory diseases for under 5 years old, (TB, ARI, pneumonia, CRDs: mainly asthma, COPD).

PAL has two objectives: that of (1) improvement of the quality of care for every respiratory patient in the PHC setting and (2) improvement of the efficiency of health care delivery system for respiratory diseases in general.

Components of PAL strategy are (1) standardization of health care procedures: management and follow-up through the adaptation and development of clinical guidelines and (2) coordination among:

- health care levels
- the components of the health system particularly at district level.

Activities in progress are

- National working group in place in Nepal.

⁹ Dr Md. Kamar Rezwan, TIP-Tobacco Free Initiative, Department of Noncommunicable Diseases & Mental Health, 22 January 2009

- Training guidelines and smoking cessation materials available.
- TOT conducted and a pool of 17 trainers available in the central and western regions.
- A total of 134 (90%) DOTS staff trained from 24 health facilities of two districts and NTC.
- Respiratory case detection increased from 6% to 15%.
- Percentage of smokers among reported respiratory cases found during piloting - approx. 60%
- Smokers who have been given brief routine counseling to quit smoking - 22%.

Recommendations

It is recommended that the PAL activities be well integrated in to health system rather than be a stand alone approach. As such, it needs to be integrated into the health system with respect to equipment and drugs, with HMIS for reporting, and also with the smoking cessation component of the PHC system.

Six thinking hats – looking at decisions from all points of view¹⁰

What is it? In summary this is a powerful technique to look at decisions from many perspectives. Especially useful as a process for conducting short, efficient and effective meetings that can force us to move out of our habitual thinking style that is too mixed up for crisp solutions to emerge. This approach is based on a simplified, tactful and discreet way of asking for opinions of the participants without the usual emotional baggage being brought into the discussion, and seeing that all points of view are given credence.

What is the basis? Many successful people think from a very rational and positive viewpoint, but have their specific assumptions that colour their viewpoints – thus subjectivity comes into the discussion from the beginning. We fail to look at a problem from all points of view. Perhaps one may say that this is the role of the chairman to synthesize. But the concern is that even the chair, being human, has his/her idiosyncrasies that negate objectivity. This approach helps to look at issues from all angles - emotional, intuitive, creative or negative viewpoints, providing positive, negative and neutral viewpoints to prevail; optimists and pessimists have an opportunity for airing views that will not be thrown away but looked at systematically. Thus, the “Six Thinking Hats” technique uses all these approaches so we get a well-rounded viewpoint.

What are the hats? The hats denote a metaphor on the type of information that is being sought. It helps to separate the speaker (metaphorically “wearing the hat”) with the spoken word – i.e., separate the idea from the person. This is often the sticky issue in a discussion – that of the speaker being too attached to the thought he/she expresses – the situation when a viewpoint is guarded too closely and stubbornly that negates arriving at a solution or compromise. When the speaker is wearing the hat, the idea too can seem linked to the hat and not to the person. So the feeling of personal attachment is minimized. This way, allround

¹⁰ *Dr Abdul Sattar Yoosuf, Director, Department of Sustainable Development and Healthy Environments, 4 December 2008 (inspired by book “Six Thinking Hats” by Edward de Bono, 2005)*

viewpoints can be gleaned without any one person dominating or “guarding the turf”.

Colours for the hats denote the temper of the thoughts being expressed when wearing that colour. The **white** hat focuses on the data and information available; the **red** looks for intuition, gut-reaction, and emotion about the issue; the **black** looks at bad points (negative) aspects of the issue, but by having considered that viewpoint, would make plans rational and more resilient; **yellow** looks at positive viewpoints; **green** stands for creativity – out of the box thinking (but no criticism!); and **blue** for process control and coordination of this thinking process during the meeting. The chairman wears the blue hat most of the time, but he can give that hat to a participant if a point of order of process is to be voiced.

Why use the technique? This is a good technique to look at the effects of a decision before it is taken – policy analysis; and even when a new policy is to be established – to see how its consequences could be visualized. The technique allows for emotions and skepticism to be included into otherwise dry rational thinking or help control emotionally charged meeting discussions that can hinder mutually acceptable outcome. This opens opportunities for creativity; and ensures that the decisions taken will be sounder and more resilient. It will also help avoid public relations mistakes – why not to go ahead with a given decision or plan.

Community-directed interventions for major health problems in Africa: what lessons for South-East Asia?¹¹

Community involvement is the key to the success of sustaining Community-directed intervention (CDI) programmes and, it is observed that community involvement is higher in the CDI programme as compared with other programmes.

The African experience indicates that in communities where community-directed treatment for ivermectin was implemented a significant decrease in onchocerciasis (river blindness) infection and associated blindness is reported by community members which was also confirmed by rigorous external evaluation. Furthermore, in communities where the CDI process was used to distribute (a) medicines (vitamin A, antimalarials for home management of malaria-(HMM), ivermectin; (b) product ((Insecticide treated nets (ITNs), and tuberculosis case detection through Directly Observed Treatment (DOTS), HMM coverage was two times higher and largely exceeding the roll back malaria (RBM) target; ITN coverage was two times higher and vitamin A and ivermectin coverage were significantly higher. Thus, CDI ensures extended access by rural and poor populations to quality health care at low cost.

In CDI, the communities identify their health problems and decide about interventions from their own perspective and take responsibility for the design, implementation, supervision, monitoring and adjustment of the implementation strategy accordingly. Total community involvement is important for success and sustainability of CDI interventions.

As regards issues, inadequate and delayed supply of necessary medicines and products e.g. ITNs to CDI implementers by the health workers was the major salient problem.

Community implementers in CDI deliver health services without being paid as they are generally contented with intrinsic incentives (e.g. recognition, status, knowledge and skills gained). This is part of African

¹¹ Prof. Oladimeji Oladepo, TIP- Health Promotion and Education, Department of Non-Communicable Diseases and Mental Health, 06 November 2008.

cultural traditions in community development programmes. Monetary payment for services rendered in CD is a western tradition. Cash payment by health workers to people hired to deliver immunization services in CDI communities, created a desire for extrinsic incentives by CDI implementers. In fact, monetary incentives can endanger the sustainability of the CDI programme in the African Region.

Comments

- Ownership is a must in CDI programmes, whether community-driven or in community partnership where community health workers choose volunteers like groups of mothers or female and male groups to perform some health tasks. Ownership will sustain the programme.
- Co-ordination of programmes is important before taking them to communities for implementation to ensure better success, which was not achieved with DOTS in a CDI study.
- CDI should be used in the SEA Region also, because community involvement brings much more sustained results.

Revitalizing Primary Health Care: what next?¹²

A few basic questions that come to the mind are what is PHC and what needs to be done in order to revitalilze it?

PHC is a universal concept of essential health care based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community through their full participation. PHC reflects and evolves from the economic, sociocultural and political characteristics of the country which should include at least: education concerning prevailing health problems and methods of prevention; promotion of proper nutrition and food supply; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; provision of essential drugs. (The Alma-Ata Declaration. 1978).

To address the issue of how to make a new beginning on this, a regional conference on PHC was held in Jakarta in what your works when to help achieve MDGs and Health for All. The conference called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with the New International Economic Order. It urged governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries.

Some recommendations were:

- WHO – to provide global leadership in orienting other development partners towards PHC.

¹² *Dr Ilsa Nelwan, Regional Adviser, Health System Information, Department of Health Systems Development, 29 August 2008*

- All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.
- All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people, especially the poor.
- Community participation should be made active by innovating and motivating community-based health workers, and more health volunteers.
- There should be effective empowerment of communities especially women to advance PHC.
- There should be decentralization of health management (financial and administrative) in the country-specific context with effective capacity building.
- There is a need to Identify indicators as well as monitor progress towards national goals and health-related MDGs.

MDG3: call for action in SEA Region countries¹³

The issue is on how to make MDG3¹⁴ a health goal.

Gender equality and empowerment of women is the goal of MDG3. The focus is on eliminating gender disparity in primary and secondary education, and thus seen primarily as an educational goal. How can we tweak out the issue of health and make this also a health goal. This may not be difficult if we can look into how the girl child's and women's vulnerability in poverty, and in employment, particularly in informal workplaces with little benefits and security are being treated, and how low levels of enrollment in school, all affect their health. MDG3 must be linked to health action for real effect of women's plight to be improved and empowered. Therefore, some basic questions must be asked about how countries hope to link these education goals to health goals. Is there enough education and promotion to achieve equality and equity? Is there enough bargaining power for women to have access to health, opportunity in jobs and the benefits of control in their lives to demand the health and social benefits they require for a healthy life?

Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual base on his or her sex. Similarly health outcomes are also influenced by social, economic, cultural and even political aspects. Given these two scenarios, a gender sensitive health service to society requires a multi-sectoral and multi-disciplinary approach.

Measuring the status and position of women is not easy. The issue of equality and equity are rooted in culture and an individual woman or man cannot go against culture; institutional power is needed to change it. Education and health promotion for children, adolescents and adults is an important essence of MDG3.

A combined education and health approach can together track key elements of women's social, economic and political participation and the building of gender-equitable societies. Education will empower the mind

¹³ *By Dr Erna Surjadi, Regional Advisor, Gender and Women's Health, Department of Health Systems Development, WHO/SEARO, 22 August, 2008*

¹⁴ *Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015*

and health will empower the body and mind. The education-related goal of MDG3 reflects the weight of evidence that ties women's and girls education to heightened levels of self-determination and thus to improved health, social and economic status.

The World Health Assembly Resolution WHA60.25 urges Member States to perform gender analysis in their health planning, build national strategies into these, include related research and educational modalities and carry out gender sensitization and promotion of gender and women's health. Also, to ensure that the gender equality perspective is incorporated in all levels of health services delivery.

In response, countries in South-East Asia have developed seven regional strategic directions on creating national action plans. The use of sex disaggregated data is a key aspect in these plans for undertaking gender analysis that can clarify gender disparities and inform good programming.

It is recommended that WHO SEAR build capacity for gender analysis and planning for staff and for stakeholders and networks, and support the use of sex disaggregated data and gender analysis for health programme decision making.

Health and human rights: possibilities and challenges¹⁵

The problem/issues

The presentation examined the concept of human rights-based approaches to health development as well as the possibilities and challenges of the promotion of human rights-based approaches in public health.

Description

All public health programming is based on subjective values. While human rights are somewhat vague and politically sensitive, they nevertheless provide WHO and other UN agencies a universally agreed legal and moral framework.

Human rights are closely related to health. First, human rights violations, say, torture and discrimination, worsen health. Second, the promotion of human rights, such as the rights to education and information improves health through, for instance, raising awareness of health issues. Third, health and human rights are mutually dependent: the realization of the right to privacy depends on the confidentiality of HIV test results and vice versa.

Findings/discussions

Human rights are no more subjective and utopian than other public health policies. Human rights provide an effective advocacy means for public health experts. Human rights approaches are, however, new in the public health context and this may explain some of the frustrations surrounding the topic. Human rights are, for instance, felt to be overtly abstract. Also, their perceived Eurocentricism is a challenge in Asia and in Africa. It is, nevertheless, better to use human rights as a framework for public health policies than one's unconscious personal preferences.

¹⁵ *Mr Samuli Seppanen, JPO-Health and Human Rights, Department of Sustainable Development and Healthy Environments , 10 July 2008*

Recommendations

- Raise human rights awareness among the general population through public information campaigns;
- Cooperate with national human rights institutions;
- Facilitate seminars and workshops on human rights-based approaches for health professionals;
- Emphasize governments' accountability for human rights obligations;
- Collect evidence on the positive correlation between health and human rights.

Preventing disease through healthy environments: a shift in focus¹⁶

This presentation is about WHO's shift in terminology; that of changing the label of the WHO programme from Protection of the Human Environment to Public Health and the Environment. Why the shift in thinking? For several reasons! We are moving from the elements of public health to looking at the bigger picture of health – thus its holism. Since the Rio conference, the health and development link is also being better established and advocated. There are new global challenges of cross-border exchange of diseases being ever more dynamic, and the entry of many players into the field of health that span beyond the traditional health sector, and the emerging awareness of the environment as both risks and benefits. Even in the health sector, many different skills are being invoked into the practice of environmental health. Within all this change in the issues dimension, the provider dimension also that in the past was more within the domain of engineers, who fixed the environment through their engineering, the present focus is more on health promotion that is the vista of many partners. Thus, a migration to a label that denotes public health and the environment is now more relevant.

There are many links to public health for the environmental health practitioner. Ultimately, it is the diseases that we in the health sector hope to mitigate, and for us, the environmental intervention is the process. The link to diarrhoeal disease through polluted water, unsafe sanitation, food contamination, personal hygiene; cancers are from the misuse or abuse of chemicals in everyday use, in ambient air and in food; respiratory infections from polluted air, closed spaces, and lack of personal hygiene; and injuries from the workplace, roads, playgrounds, homes etc.

There is a growing change in the transition of risks from traditional and low-income communities to those of high income and more “developed” so to say. The classical risks from environmental degradation is decreasing in high-income countries. There is, however, a concomitant higher risk being experienced in these countries related to development itself – that of chemicals, electromagnetic radiation, and atomic energy related concerns. Overall, it is now also revealed through burden of disease studies that about a quarter of the burden of disease that we are exposed to is from

¹⁶ *Dr Abdul Sattar Yoosuf, Director, Department of Sustainable Development and Healthy Environment, 14 June 2007*

preventable environmental sources such as unsafe water, polluted air (indoor and outdoor), unsafe work practices, unsanitary solid and hazardous waste disposal (municipal and clinical waste).

Now, climate change concerns are also exacerbating the already unsatisfactory conditions of the environment. The floods, droughts, storms, cyclones and fires that it brings in its wake make our predicament worse. There is more water scarcity, more garbage is left uncollected, and crowded settlements with no physical amenities abound as the gap between the rich and the poor is ever widened.

Action is indeed slow – in our communities, and there are many reasons. Political interest competes for space; there is lack of technical and financial capacity to manage as public health interest takes second place to both clinical practice and economic development; endeavours that are overtly visible and those that can show results in the short term; neglect of public health in the workplace; and intransigent concerns of the health system infrastructure and process arrangements that are more focused on high tech; weak opportunities for public health practice; skewed governance and the primacy of the economic paradigm. The overall advantage of the shift is that we see the bigger picture, focus on disease reduction as the main focus, better connect with other WHO programmes with a view towards a common agenda, a rationale for connecting with other development sectors of Member States, and also connecting with other donors.

What is the scope of this shift? Our attitude will be the limiting factor. This is the hope of a mindset change towards prevention rather than cure, the information on burden of diseases will help national policy makers move towards objective decision making on health issues. We connect within WHO because of IHR, avian influenza, vector-borne diseases, child health, hospital safety, cancer, injuries, TFI, diarrhoeal diseases etc. At the national level, this can help ministries of health link with other ministries much better than at present.

Within the Environmental Health and other clusters of WHO, programmes such as water and sanitation, chemical safety, food safety, climate change agenda, PHC revival and its relationships with healthy settings, public health workforce strengthening, studies on the burden of diseases, and the change in planning within WHO towards strategic objectives that are linked more horizontally than vertically, provide the gist for ministries of health and other partners to come together.

Partnering skills for strategic engagement with gender perspective¹⁷

The world is presently faced with complex health problems which cannot be solved in isolation. Partnerships between the concerned governments, UN agencies, the private sector, nongovernmental agencies, communities, etc. can help resolve these complex health problems.

Gender as a developmental concept is overarching. Its scope pervades all sectors and actions of development. A gender perspective can be conceived for any project or programme. For example, in a program, for promoting equitable access to health services, concerns of access to a clinic, laboratory, or any such source of care must be considered from the point of view of facilitating its reach by both men and women. The travel time to the clinic, the routes available, the working hours of the facility, and the types, training and orientation of the staff there, etc., have to be considered from an angle of gender sensitivity. This example can be extrapolated to programs of water and sanitation, occupational health, nutrition, and various disease control programmes too.

Thus, the complexity of many agencies or disciplines having to work together comes into this function of gender mainstreaming. It is never a vertical programme when the pervasive concern of gender and health is to be considered. It has to be a partnership.

Partnering is more than just a cross-sector dialogue or a service delivery contract. It must encompass clearly delineating roles and responsibilities, equity, transparency and mutual benefit. The partnering cycle comprises four phases namely: scoping and building partnership; managing and maintaining partnerships; reviewing and revising partnerships; and sustaining the partnerships.

Partnering is an art as well as a science and requires specific skills like interpersonal skills, communication skills, analytical thinking, administrative skills etc. Partnerships are often formalized through various kinds of agreements like letters of intent, memoranda of understanding, contracts

¹⁷ *Dr Erna Surjadi, Regional Adviser, Gender & Women's Health, Department of Health Systems Development, 26 April 2007*

etc. Based on the scope of the partnership, it has various operational forms like working groups, task groups, networking, society, agency, foundation etc.

This way, partnerships are efficient tools for tackling complex health problems including gender concerns, and are the need of the present times.

More recently, global partnerships in health programmes are also being advocated for achieving sustainable development goals.

Fetal alcohol syndrome (FAS) – preventable birth defect¹⁸

Fetal Alcohol Syndrome (FAS) is the leading cause of preventable mental retardation in western countries. It is one of the many priority public health problems found in high risk groups in western countries and Africa.

Birth defects in infants can be caused by genetic and environmental factors, or a combination of both. Environmental substances that cause birth defects are called teratogens. Alcohol is a teratogen and its consumption by pregnant women can give rise to birth defects in the newborn. The effects of alcohol on fetus development vary based on the stage of pregnancy. Alcoholism in the first trimester of pregnancy leads to major morphological abnormalities in the fetus. There is increased risk of spontaneous abortion in case of alcoholism in the second trimester of pregnancy. Alcohol consumption during the third trimester of pregnancy leads to decreased fetal growth. Thus, the timing and dosage of exposure to teratogens has varied effects on fetus development. Prenatal alcohol exposure can lead to growth retardation, CNS abnormalities and facial abnormalities in the newborn. In males, chronic alcoholism can result in diminished potency, failure of spermatogenesis or failure of fertilization.

FAS is a preventable birth defect. There is a dire need to sensitize the public on the ills of alcohol consumption during pregnancy and its effects on fetus development.

Advocacy measures to sensitize women regarding FAS and its prevention should be taken up in SEAR countries vigorously to prevent the Asian continent in falling a prey to the problem of FAS.

¹⁸ Ms Karen Hymbaugh, Technical Officer, Surveillance, IVD Unit, 18 April, 2007

Public health – the overriding goal in municipal solid waste treatment and disposal¹⁹

There are nearly 5100 municipalities across India wherein the problem of treatment and safe disposal of municipal solid waste (MSW) has become extremely challenging, reaching critical dimensions. It is estimated that an urban population of 285 million in India (28% of the total) is generating almost 120,000 MT/d of MSW.

A number of municipalities have established treatment plants and many more are planning to establish similar facilities in the near future under the ongoing centrally sponsored programmes. The technologies that have been used during the last three decades are windrow composting, mass burn, combustion of refuse-derived fuel, biomethanation, and, on a small scale, numerous vermicomposting initiatives.

However, time and again it has been seen that the technology-driven initiatives close down in a rather short- to medium-term period due to a combination of technical and institutional risk factors and therefore do not bring the desired environmental and public health benefits, least of all the financial benefits. The conventional 'low cost' technology of windrow composting runs the risk of odour nuisance and objections from the community. Secondly, with mixed municipal waste there are quality concerns related to pathogens, weed seeds, glass, sharps, needles etc. Thirdly, the nutrient value of compost is moderate and its shelf life is found to be less than three months. For the combustion- and refuse-derived fuel technology options, the major determining factor is the calorific value of the feedstock. Open disposal on street corners, scavenging of combustible recyclables, high moisture content, especially during monsoon are the contributing factors. Also with warm climatic conditions, there is virtually very little scope for utilization of waste heat and thereby the revenue model remains weak. Issues related to emissions as well as capital and operating costs for pollution control mechanisms are other factors which do not create an encouraging situation. In case of biomethanation reactors, their sensitivity to temperature variations and the need for mixing a large

¹⁹ Mr Asit Nema, Director, Foundation for GreenTech Environmental System, The Foundation aims to bring sustainability considerations in environmental planning and technology initiatives.

quantity of water for 'low dry solids' systems are seldom perceived to be critical risk factors but they turn out to be so. The former factor exhibits itself through disruption in biological process in uninsulated reactors (a major part of the country is characterized by wide variations in seasonal temperatures) and the latter entails very large reactor size as well as adversely affects its heat balance.

Above all technology options, the constraints in the initial separation system itself are rather challenging when it comes to mixed municipal waste. The available systems are unable to handle large daily and seasonal variations in quality and quantity of waste and are therefore unable to produce a consistent quality of feedstock for subsequent processing in the downstream units. The presence of abrasive and corrosive materials and consequently high wear and tear and corrosion compel operators to replace plant and equipment once every 5-6 years. This is a worldwide feature of almost all solid waste treatment plants which entails a high expenditure which is typically not factored in during the initial planning stage. Finally it all boils down to the fundamental Second Law of Thermodynamics according to which the feedstock with a high degree of entropy requires a fairly high input of energy and resources, and if the output is not fetching revenue in surplus of the inputs, it is not a financially viable proposition.

In recognition of this basic feature a set of fiscal and financial incentives have been evolved in some of the developed economies in the form of 'tipping fee', 'gate fee', 'green energy premium', etc. In the absence of such incentives, it is understandable that the initiatives could not be sustained.

Treatment of municipal solid waste is only a means to an end. The end objective of an integrated operation is safeguarding public health which is to be achieved through a combination of waste reduction, collection, removal, processing and safe disposal in sanitary landfills. However, due to a variety of reasons e.g., desire to recover part of the operating costs, make the initiative attractive for private sector participation, promotion of particular technology solutions, etc. the component of solid waste treatment has in general got projected to be an end in itself under the apparently attractive paradigms of 'waste to energy' and 'waste to wealth'.

Thoughts on alcohol²⁰

The textbook definition of alcohol addiction, also referred to as alcoholism, is the dependence on alcohol, the consumption of which is marked by obsession and compulsion and adversely affects behaviour and social or work functions. It produces withdrawal symptoms when intake is stopped or greatly reduced.

Alcohol addiction affects, more than a person's state of mind, his or her whole life. The dependency on alcohol can become uncontrollable; in fact addiction is the loss of control.

Alcohol, specifically ethanol, is a potent central nervous system depressant, with a range of side effects. The amount and circumstances of consumption play a large part in determining the extent of intoxication, for example, consuming alcohol after a heavy meal causes alcohol to absorb more slowly. Hydration also plays a role, especially in determining the extent of hangovers.

Initially, alcohol generally produces a feeling of relaxation and cheerfulness, but further consumption can lead to pharmacological, metabolic and behavioral disorders, damaging the heart, etc. An alcoholic person is without inhibitions, has little self control, will power, develops euphoria and dulling of attention. His automatic movements get affected, there is excessive sweating, stupor, disturbed equilibrium, slurred speech. Heavy drinking, particularly over time, can damage the heart and lead to high blood pressure, alcoholic cardiomyopathy, (enlarged and weakened heart), congestive heart failure, and stroke. Heavy drinking puts more fat into circulation, raising triglyceride levels. The action of alcohol on the brain is like that of a narcotic drug that produces pathological changes (cirrhosis) in liver tissue and can cause death.

Alcohol addiction has four characteristics:

- (1) Alcoholism carries an overwhelming urge to repeat the experience of getting high on alcohol. At times, this urge will go beyond the strength of a person's will to resist, no matter how much risk or harm may be involved.

²⁰ *Dr Sanjeeva Ranaweera, STP- Mental Health and Substance Abuse, Department of Noncommunicable Diseases and Mental Health, 29 March 2007*

- (2) Satisfying the urge to drink becomes the top priority in the alcoholic's life. This urge can become stronger than sexual needs, stronger than the need to satisfy hunger, stronger even than the need for survival.
- (3) The urge to get high with alcohol becomes linked to all other aspects of life. Tension, depression, anger and excitement can all trigger the desire to take a drink.
- (4) No matter how long an alcoholic has been sober, he or she will always be at risk for alcohol abuse. As time passes with sobriety, the urge to drink weakens and occurs less often, but it can return with ferocious and overpowering strength at any time.

When alcohol problems are portrayed as the result of an individual's genetic or other predisposition, we tend to forget the harm to people from other people's use. Most victims of alcohol's damaging side are probably children and, in many cultures, women. Their suffering is camouflaged by the overall mood of fun, or freedom from oppressive norms, created around intoxication. The most important indirect harm from alcohol on family and community wellbeing in poorer settings is probably through its economic impact. In the poorest families the money spent on alcohol is rather a large proportion of the family's earnings. Alcohol dependence is associated with suicide. But the proportion to which it can be causally linked is indeterminable. So, these deaths do not figure in the usual calculations.

Non-celebratory or non-event based alcohol use (namely regular or day-to-day use) is subsidized in many ways. Much of 'irregular income' such as through lotteries, bribes, fraud and cheating, gets immediately channeled into the alcohol pool. 'Loans' taken and not repaid, forcible donations gathered from various sources and collections for alleged community activities and good deeds are other channels through which regular drinking gets subsidized by people who are not in the regular heavy drinking group. A large contribution to the daily alcohol purchases of heavy drinkers comes from their wives, who contribute part of their earnings for the man's alcohol, generally to keep the peace within the home.

There are several things we can do, if we notice someone either has an alcohol addiction or is on their way to developing an alcohol addiction. The first step is to talk with the person. Speak calmly and clearly, it's best if we do not try to talk to them when they are intoxicated. Alcoholics are usually

victims of a life changing event, crime, or some sort of violent or traumatic experience. We can let them know that they can talk to us and depend on us to be there for them. Then we should try to address the problem. We can express our concerns with the issue in hand. One can work together with the affected person to develop strategies and alternatives to deal with the problem. If these steps do not seem productive, speaking with another family member may be more beneficial. Most importantly, we always have to follow through. We should not attempt to help someone if we can not truly dedicate ourselves for the long run. Alcoholism is an illness and the only way to eliminate an illness is to treat it.

In attempts to reduce alcohol-related harm, the role that a community can play is not greatly emphasized. But communities have a major role. The community as a whole has to shift in a particular direction. Communities, more than policymakers, are effective in achieving locally the changes needed. Some are, of course, more difficult to achieve than others. But responses to reduce alcohol-related problems should not be left to remote 'policymakers' alone. All community-based activities should follow the principles relevant to this kind of work. The factors that will lead to delayed initiation, reduced aggregate consumption and so on, apply to the community as a whole. Changes in determinants that communities can strive to achieve, for a start, could be as follows:

- (1) Reducing the attractiveness of the image of alcohol
- (2) Reducing unfair privileges attached to alcohol use
- (3) Improving recognition of the real harm from alcohol use
- (4) Encouraging quitting or reduction or change in pattern of alcohol use
- (5) Counteracting the forces that promote consumption
- (6) Preventing the 'alcoholization' of all social events and activities
- (7) Appropriately restricting availability
- (8) Encouraging implementation of useful policies, locally and beyond.

The state health, education, and social service sectors have a direct responsibility to deal with aspects of alcohol problems. Alcohol control-related work is very appropriate for government agencies dealing with poverty reduction or community development. The possibility of engaging such agencies is worth exploring.

Resource convergence mantra²¹

For a sustainable and effective health plan, the mantra suggested is convergence of resources and improvement in the delivery of public/private services in the social sector especially to achieve the results for health care with proper planning, effective implementation, monitoring etc.

There are many challenges while utilizing the available budget optimally. There could be a plethora of schemes/manpower and a number of agencies for each of these activities which are supply-services based rather than demand based e.g. polio eradication vs routine immunization. Lack of access to information and lack of systematic tools become limiting factors in appropriate implementation.

To overcome these restricting issues in achieving the desired results for basic health delivery, there needs to be a paradigm shift from merely planning for schemes to detailed planning for activities. National, State and Panchayati Raj personnel need to be given adequate training and assistance to identify thrust/priority activities and matching them with schemes. Guidelines for different thrust/priority activities could then be worked out.

It may be possible to have the basics of the resource convergence mantra for sustainable and effective health plans by defining the objectives clearly. This means that all relevant resources need to be tracked, the right type of manpower identified and strategies/alternatives well defined. All the available resources should be tied together along a system-based approach leading to a holistic plan. There should be decentralized planning and empowered planners knowledgeable about system based approach to planning.

Health care should include social inclusion, sanitation, hygiene, preventive health care, nutrition, diet and no child marriage, etc. Also a shift should be made from the vicious cycle of poor health – lack of nutrition – unemployment – lower income and poverty leading to no health care to a circle of income – nutrition – health – education – participation – public action – gender issues – equality.

In a programme situation, we begin with a subsistence level of resources which need to be worked out towards sustainability, and then towards surplus. At every stage the need is to optimize the resources to improve the quality of life that we have planned for.

²¹ Ms Aruna Sharma, IAS, Joint Secretary, NHRC, Government of India. 15 March 2007

Addressing Social Determinants of Health²²

Background

WHO recognizes the existence of inequities in health among and within Member States of the WHO South-East Asia Region. Threats related to climate change, globalization and urbanization could further worsen these inequities by differentially affecting vulnerable population groups resulting in premature deaths and disabilities. To effectively tackle the negative impact of social determinants of health, participation of multiple stakeholders including those outside the health sector is highly recommended.

The Report of the Commission on Social Determinants of Health presents three overarching recommendations namely:

- improve daily living conditions,
- tackle unequal distribution of power, money and resources; and,
- routine monitoring of health inequity.

During a regional consultation, delegates called upon Member States, civil society, academia, development partners, the private sector, WHO and other relevant stakeholders to reduce the equity gap through action on social determinants of health. The ultimate goal is to obtain political commitment on “closing the equity gap in a generation”. The delegates resolved to consider the current global concerns such as food and energy security, water availability, economic crises, and climate change as an opportunity to take action on the social determinants of health and prioritize investment in effective inter-sectoral actions to reduce the burden of diseases among the vulnerable population. It was agreed that the technical capacities of SEAR countries to address social determinants of health require strengthening.

Several SEAR countries are engaged in initiatives to address social determinants of health. Sri Lanka has established a National Task Force to spearhead the work of the Commission on Social Determinants of Health,

²² Dr Davison Munodawafa, Regional Adviser–Health Promotion and Education, Department of Noncommunicable Diseases and Mental Health, 2 March 2007

specifically, the implementation of the Commission's recommendations. Six country case studies on health inequities have been documented and discussed at the regional forum. In addition, community empowerment of women to address health inequities was documented from the Self Employed Women Association (SEWA) experience. The structural determinants such as housing, access to financial support, etc. were also discussed.

Conclusion

In conclusion, the need for evidence regarding the causes of ill-health and premature deaths is critical to developing policies and legislation that seek to halt or reverse the trend. There is a need to advocate for the inclusion of health equity and social determinants of health in national policies and programmes; foster inter-sectoral collaboration, expand partnership, and strengthen health systems and financing.

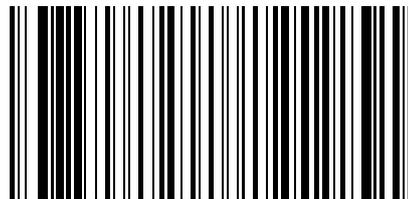
The Thursday "Lunch Time Seminars" held in the Goa Room of the Regional Office for South-East Asia began in June 2004 and are meant to provide an informal forum for staff to share vignettes from their experiences through informal presentations. Presenters were both external and internal, with SEARO staff comprising the majority. This informal setting continues to offer SEARO's busy staff the opportunity to participate in 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 discussion. 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 continues to elicit lively discussion and debate.

This internal publication is the second in the series and includes 21 presentations, with short textual synopses or abstracts on each of these and discussion points.



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