The twenty-first century dawned with remarkable economic, political and technological potential for the over 1.83 billion people in the 11 countries of the World Health Organization's South-East Asia Region. Along with the opportunity, the Region faced several public health challenges, including epidemiological transition characterized by a high burden of communicable diseases and a rising incidence of noncommunicable diseases, the unfinished agenda of high maternal and child mortality, and demographic transition. Added burdens included the threat of pandemics with new and emerging pathogens, the ageing population, lifestyle changes, rapid urbanization, high burden of injuries, effects of globalization and climate change, and the global economic crisis. This document showcases our efforts at meeting these challenges and moving towards "Health for All".
A DECADE OF PUBLIC HEALTH ACHIEVEMENTS
IN WHO’S SOUTH-EAST ASIA REGION
The twenty-first century dawned with remarkable economic, political and technological potential for the over 1.83 billion people in the 11 countries of the World Health Organization’s South-East Asia Region. Along with the opportunity, the Region faced several public health challenges, including epidemiological transition characterized by a high burden of communicable diseases and a rising incidence of noncommunicable diseases, the unfinished agenda of high maternal and child mortality, and demographic transition. Further, added burdens included the threat of pandemics with new and emerging pathogens, the ageing population, lifestyle changes, rapid urbanization, high burden of injuries, effects of globalization and climate change, and the global economic crisis.

The first decade of the new millennium was marked by unprecedented global interest and action in public health. The Millennium Development Goals provided enormous momentum around global health issues; the Commission on Social Determinants of Health reminded the global public health community about taking multisectoral action on the social determinants of health for health equity; the Commission on Macroeconomics and Health emphasized the primacy of health for national development and called for increased public spending on health; the Framework Convention on Tobacco Control and the International Health Regulations, 2005 are watersheds in global public health history.

I had the privilege of serving as the Regional Director of the WHO South-East Asia Region during the decade beginning 2004. This publication is a brief account of the impressive progress made by the countries of the Region during this period and the contributions that WHO made towards these. WHO’s Regional Office for South-East Asia continued its partnership with governments of Member States, policy-makers, academic institutions, public health professionals, researchers, donor organizations, civil society organizations and several others to contribute to national efforts by Member States towards improving the health status of our people.

Our work with countries was guided by the principles of primary health care with the twin goals of health equity and social justice – the hallmark of the Alma-Ata Declaration on primary health care. The focus of our collaboration with countries was strengthening public health – whether it be capacity-building for formulation of evidence-based health policies and strategies; strengthening public health education, workforce and public health infrastructure; health system readiness for tackling disease outbreaks, emergencies, disasters and climate change; or evidence generation for improving the effectiveness of public health delivery.

It is well accepted that attainment of good health for all is not the sole preserve of the health sector. It requires dedicated and coordinated action by multiple players and sectors. Health outcomes are affected by a complex interplay of sociocultural, economic, political and environmental factors. Our work transcended the confines of the health sector. Indeed, our work with countries advocated for and adopted a multisectoral approach for addressing current and emerging health issues through strengthening “health in all policies”.

The people of South-East Asia are known for their enterprise and innovations. The Region has an impressive repertoire of public health experiences. I am happy that we were able to provide a platform for intercountry collaboration and experience-sharing through a wide range of activities, including various public health networks. It is gratifying to note that on several occasions, Member States have taken a united stand on public health issues in international forums in the spirit of regional solidarity. This is further reflected in the creation of the South-East Asia Regional Health Emergency Fund.
The many public health accomplishments of the Region are described in the succeeding pages. These are the result of the ceaseless efforts of many players led by the national governments. I consider it a privilege and honour that the WHO Regional Office for South-East Asia was a partner in the long march for Health for All peoples in Member States of the Region during the decade gone by. I believe the public health work done in the opening decades of the twenty-first century has laid strong foundations for intensified action in the ensuing decades, which will strengthen the South-East Asia Region’s effort towards universal health coverage.

DR SAMLEE PLIANBANGCHANG

Regional Director, WHO South-East Asia
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Enjoyment of good health is an intrinsic human right. This right is entrenched in national constitutions and in the Universal Declaration of Human Rights. The World Health Organization (WHO) in its Constitution considers that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

A human rights approach to health translates into the right to health; it embodies the right to equitable access to health care, including the underlying determinants of health. Hence, the right to health includes the rights to access safe drinking-water, proper sanitation and an adequate supply of safe and nutritious food, healthy occupational and environmental conditions, access to information, and others.

There is a compelling economic argument as much as a human rights one for ensuring the highest attainable standard of health for all. The importance of health in economic development has been acknowledged by the Commission on Macroeconomics and Health established by WHO in 2000. The Commission states that “ill health undermines economic development and efforts to reduce poverty. Investments in health are essential for economic growth and should be a key component of national development strategies. The greatest achievements can be made by focusing on the health of the poor and on the least developed countries.” This has been further recognized with three health-related goals being included in the Millennium Development Goals (MDGs).

This is the ultimate objective for WHO in South-East Asia: that conditions are created so that all people are able to lead healthy,
productive lives. However, there are some unique challenges to achieving this in this Region. The 11 Member States have great geographical diversity, with the world’s highest mountains, many large, flood-prone rivers, thick forests, heavy monsoon rains, frequent cyclones, earthquakes and other natural disasters, placing formidable natural barriers to reaching all people. In 2003, the Region had a population of over 1.5 billion, accounting for 25% of the world’s population but 40% of the world’s poor. Most countries in the Region are still developing, with low incomes, and have competing demands on the national budget. The proportion of national budgets allocated to health is relatively small.

The health situation reflects these challenges. At the dawn of the century, although life expectancy had increased significantly in all countries, maternal mortality was unacceptably high. Even though child mortality had been declining, the Region lost over 3 million children under five years of age in the year 2000. What made the tragedy all the more unconscionable was the fact that a large majority of these deaths were due to a handful of causes that can easily be addressed by cost-effective public health interventions.

The burden of disease due to communicable diseases, including malaria, tuberculosis, diarrhoeal and respiratory diseases, was high. The Region was struggling to eradicate polio and eliminate leprosy. Additionally, the Region was witnessing alarming rates of increase in HIV/AIDS – indeed, the epidemic was considered to be spreading faster in Asia at that time than in any other continent. Further, the tsunami of 2004 when the Region lost 200,000 people, the emergence and outbreak of a new virus that caused severe acute respiratory syndrome (SARS) in 2003, and later the influenza A (H1N1) pandemic in 2011, as well some of the world’s most devastating cyclones, volcanic eruptions and earthquakes, underscored the need for strengthening public health systems to meet natural and human-induced calamities.

Many countries continue to be overly focused on management of disease when it occurs rather than on preserving, promoting and maintaining health. The impressive health achievements of the Region at aggregate level achieved in the past few decades masked an unfortunate reality. Stark inequities in access to health-care services and health status were evident within and among countries.

A clear road map was therefore charted out to meet these challenges. Fundamental to this was good health policy and planning, and the need for well-developed health systems that deliver effective, efficient and equitable health care, which is affordable and of good quality, and without which good health of the population cannot be achieved.

Health systems provide both individual care through medical care and community care through various public health actions or interventions. Both are complementary. While medical care is the individual care a person seeks when confronted with illness, public health services focus on maintaining, preserving and promoting the health of the population. There is ample evidence to show that public health is more cost effective than medical care. Yet, in almost all countries of the South-East Asia Region, the health resources allocated are skewed towards medical care. Put differently, health interventions in many countries continue to be overly focused on management of disease when it occurs rather than on preserving, promoting and maintaining health. This imbalance needs correction.

The ultimate aim is an equitable health status within and among countries resulting from equitable access to health care.

Public health, through its focus on health promotion and primary prevention, significantly reduces the disease burden, in particular, among the poor, vulnerable and marginalized segments of the population, thereby improving health equity. Equity and social justice are seminal values of the primary health care approach. Primary health care, which is essentially a tool for implementing public health, also improves the quality of life of the population,
an element that is necessary for a socially and economically productive and satisfying life, and the aspirational goal of achieving “Health for All”. It was therefore necessary to refocus on health systems development through the primary health-care approach.

It would be pertinent to recall the Calcutta Declaration adopted by the Region in 1999. Triggered by concern about the resurgence of plague, malaria, meningococcal meningitis, leptospirosis, as well as the growing incidence of hunger and obesity, diabetes, cardiovascular diseases, HIV/AIDS, tuberculosis and cancers, a Regional Conference on Public Health was held in December 1999, and its recommendations, known as the Calcutta Declaration, promoted public health as a discipline and, importantly, also as an essential requirement for national development. It recognized the need to strengthen and reform public health education, training and research, supported by networking of institutions and the use of information technology for human resource development.

Inspired by the tenets of the Calcutta Declaration, the Public Health Initiative was launched according to the vision of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, with emphasis on development of capable human resources through strengthening public health education and practice.

The Public Health Initiative led to the formation of networks of public health teaching institutions at the Regional and national levels, collaboration with associations of medical education, emphasis on teaching of public health in medical schools and advocacy to parliamentarians on public health systems. These are some of the public health initiatives that have taken place till date. Emphasis on a community-based health workforce such as community health volunteers is another salient feature of the Initiative. In addition to improving access and equity in access to health-care services, the role that these workers can play in education and empowerment of individuals, families and health needs to be emphasized.

The living environment determines health, and therefore good health depends on a number of social, cultural, economic and environmental factors. In cognizance of this, the Commission on Social Determinants of Health was established by WHO in 2005. This Commission recommended tackling the socioeconomic and political aspects of health to improve health and health equity. Neglecting these social determinants, which are considered as the root causes of health inequity, will negate our efforts to improve health equity. Environmental determinants such as pollution, poor housing conditions, urbanization, migration and environmental changes brought about by climate change are also crucial in influencing health equity. It is thus imperative that a multisectoral approach to health development be adopted. Close coordination and collaboration between related sectors is mandatory for attaining well-developed health systems, for example, by the establishment of Health in All Policies or Healthy Public Policies. This becomes all the more important in view of the looming epidemic of noncommunicable diseases which, by their very nature, necessitate a multisectoral approach that addresses, among other things, the social determinants of health.

The use of appropriate technology was promoted to improve the efficiency of health systems. Health technology assessment is a tool to assess the appropriateness of technologies from the perspective of cost–effectiveness and social acceptance.

The initiatives charted out and undertaken in the past decade were to improve health systems, and build capacity, so that universal health coverage could be achieved. Universal health coverage is the overarching goal of health for all, and aims not only to provide financial and social protection against catastrophic
health expenditure to the whole population, but also to provide equitable access to necessary health care, including public health interventions. This was particularly relevant for this Region as a large number of people incurred high out-of-pocket expenditure on health, frequently becoming bankrupt and sinking deep into debt in the process, with dire social and economic consequences.

Following the course set out in 2004 has led to considerable successes in public health in the Region. Indeed, some achievements are historic, such as the elimination of leprosy, and the polio end-game in the Region. Less pronounced, but nevertheless credit-worthy achievements, include better health systems; healthier mothers and greater chances of survival for newborns; improved quality of life for the elderly; fewer people suffering from HIV, malaria, and other communicable diseases; and more effective responses to public health emergencies, among others.

Two major, historic, legally binding international regulations have come into force in the past decade, with far-reaching impacts on public health: the International Health Regulations, 2005 and the WHO Framework Convention on Tobacco Control, 2005.

All countries in the Region have learnt from each other’s experiences as intercountry collaboration has increased, as have partnerships with a wide range of stakeholders. As a consequence, the Region has now begun to speak with one voice.

This book highlights our journey as we strived to achieve these. However, the agenda is unfinished, and there is no room for complacency. This is only the beginning of a long journey in public health in South-East Asia.
Gearing up: health systems development
We have to ensure that our health systems are well prepared to face current challenges. Obviously, we need to invest more in preventive and promotive care, and we have to devote much more effort to the development of effective community-based and population-based health care and services in order to keep people healthy in their communities as much as possible.

With this perspective in view, we need to spend more resources on the development of our public health systems. We need to double our efforts in implementing the primary health-care approach to support community-based health care and services. We need to move forward towards more effective education and empowerment of all people in the community. Multisectoral and multidisciplinary actions in the most coordinated manner are required for the success of all these. Equally important, development policies of all sectors other than health should explicitly reflect “human health concerns” and “people’s health” should be promoted and protected as an integral component of their sectoral development efforts.

—DR SAMLEE PLIANBANGCHANG

Excerpt from speech delivered at the Regional Conference of Parliamentarians on strengthening of national public health systems for emerging health challenges, 19–21 March 2012, Bangkok, Thailand

Health systems development

Health systems are the bedrock on which countries base their health development efforts. Health systems are conglomerates of individuals, organizations and processes that work together to promote, protect and preserve the health of the population. The goals for health systems are good health, responsiveness to the expectations of the population, and fair financial contribution.

As defined by the World Health Organization (WHO), “….A health system is [therefore] more than the pyramid of publicly owned facilities that deliver personal health services…." Health systems are people centred. A good health system delivers quality services to all people, when and where they need them. This includes provision of well-organized, tertiary-care services at a hospital, or a community health worker reaching a remotely located community and the challenges she faces in delivering care. In all cases, health systems must be responsive to the needs of people. To deliver quality health care, health systems require robust financing mechanisms, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, well-maintained facilities, and logistics to deliver quality medicines and technologies.

Today, health systems have to be prepared to meet current and future health challenges. These include rapid advances in biomedical technology, the effect of social and environmental determinants on health, demographic and epidemiological transition, urbanization, globalization, climate change and the ever-increasing importance of intellectual property rights.
The South-East Asia Public Health Initiative was launched by Dr Samlee Plianbangchang in 2004 to help countries define an appropriate package of essential public health functions tailored to each country’s situation and needs.

Several public health networks of educational institutions and organizations have been created for sharing knowledge and experiences.

The South-East Asia Primary Health Care Innovation Network (SEAPIN) was established as a knowledge management platform for primary health-care innovations for member institutions, countries and beyond.

The Regional Office launched the Regional Health Observatory (RHO) in 2013, an online integrated database of all important health issues in the Region.

e-Health strategies and telemedicine have been developed in many Member States.

India, Indonesia, Nepal, Sri Lanka and Thailand all participate in the WHO Programme for International Drug Monitoring. Maldives is an associate member.

A web site called HerbalNet was launched in 2009 to establish a mechanism for information-sharing among Member States on traditional medicines.

Several new digital information repositories were established at the WHO Regional and country offices and at partner institutions in Member States to facilitate effective information-sharing.

Publication of the WHO South-East Asia Journal of Public Health provides an important platform for health professionals in the Region to express and share their research findings and health-care experiences. An e-journal publishing initiative has also been introduced in the Region.

The Regional Director’s special initiative led to the establishment and promotion of public health schools in the Region. New public health libraries were set up together with the schools to enhance equitable access to health information.
Public health initiative

Strengthening health systems and public health services is at the core of WHO’s work with countries and with the regional and global health community. Today, most governments recognize the importance of public health programmes in reducing the incidence of disease, disability, the effects of ageing and health inequities. However, public health generally receives significantly less government funding compared with medical care. This is reflected in the disproportionate allocations in national health budgets to curative care vis-à-vis public health measures for health promotion and disease prevention.

In a significant step towards strengthening public health in the Region, the South-East Asia Public Health Initiative was launched under the leadership of Dr Samlee Plianbangchang in 2004. This Initiative aims to position public health high on regional and national agendas, and generate strong commitment from national policy-makers. It helps countries to define an appropriate package of essential public health functions tailored to each country’s situation and needs, and supports them in implementing these functions.

Improving education in public health

Under the aegis of the Initiative, intensive efforts were undertaken to revitalize public health education and training of the public health workforce. The Regional Office has given high priority to balancing the preventive and promotive aspects of health care with the curative and rehabilitative aspects, and taken several initiatives to strengthen the public health component of the curricula of medical and nursing graduates to better equip medical doctors for service needs. Various educational modules were also developed, such as the Module for Teaching Medical Ethics to Undergraduates (2009). Other areas in which countries were supported include programme development, institutional capacity-building, establishing or strengthening teaching–learning resources and libraries, and faculty development.

A major development was the creation of several public health networks of educational institutions and organizations. Of particular importance is the Network of Medical Councils, which provides a regional platform for continuous reforms in medical education to attune medical education to the public health needs of Member States. The main purposes of these networks are to provide a platform for exchanging information, experience and resources, and to work together on common concerns. Other networks include the South-East Asia Regional Association of Medical Education (SEARAME), the South-East Asian Public Health Education Institutes Network (SEAPHEIN), the South-East Asian Nursing and Midwifery Educational Institutions Network (SEANMIEN), and the Asia Pacific Action Alliance on Human Resources for Health (AAAH).

Health workforce development

A competent and motivated health workforce forms the core of a high-quality and efficient health system. Countries need to have adequate numbers and types of health workers with the appropriate mix of skills and required competencies. These health workers should be equitably distributed to provide high-quality and responsive health services that meet the needs of the individuals, families and communities.

Most countries of the South-East Asia Region are challenged with problems of health workforce shortages, maldistribution, inappropriate skills mix, and limited capacity for the production, management and deployment of human resources for health. The Regional Office has collaborated with Member States to address their health workforce challenges and advocate for high-level commitment to strengthen health workforce development.

To effectively address the crisis in human resources for health, the Regional Office supported countries to develop and implement national health workforce strategies and plans. In 2006, the health ministers of the Region adopted the Dhaka Declaration on “Strengthening Health Workforce in Countries of the South-East Asia Region”, in which they reaffirmed their commitment to an effective and motivated health workforce. A regional consultation on “Strengthening human resources for health management in countries of the South-East Asia Region” was convened in February 2012 to review the progress made in implementing the recommendations of the Dhaka Declaration. The Regional Office also supported countries to strengthen their information systems for national human resources for health, including development of their country human resource profiles to provide comprehensive and up-to-date information for informed policy- and evidence-based decisions. In addition, countries were encouraged and supported to establish a national human resources for health “Observatory” and strengthen existing mechanisms to provide a forum for generating evidence, monitoring progress and policy dialogue on human resources for health.

The Regional Committee in its Sixty-fifth Session in September 2012 adopted a resolution on “Strengthening health workforce education and training in the Region” to draw the attention of Member States to the urgent need for improving health workforce education and training. In pursuit of this resolution, a regional strategy on strengthening health workforce education and training in the Region is being developed, and will be submitted to the Sixty-seventh Session of the Regional Committee.
Strengthening the community health workforce

Given the ubiquitous role that the community-based health workforce plays in public health activities and the strong tradition of community-based health care, special efforts were undertaken to revitalize this segment of the health workforce. The changing epidemiological and demographic profile of Member States in the Region also necessitates an upgrading of their skills set. The Regional Office developed comprehensive strategic directions and plans to strengthen the community-based health workforce, both in terms of their numbers and types, and the quality of their training and work environment. Several regional meetings and seminars were organized to galvanize Member States to reform their health systems to promote people-centred health services.

Strengthening of community-based health workers such as the Female Community Health Volunteers (FCHVs) in Nepal, the Accredited Social Health Activists (ASHAs) in India, the household doctors in Democratic People’s Republic of Korea, the Health Volunteers in Thailand, and the community health workers and volunteers who run the Community Clinics in Bangladesh are but a few examples of the initiatives that were undertaken to strengthen the community-based health workforce. However, despite these initiatives, the full potential of this area in furthering the objectives of equitable universal health care remains to be realized.

Family physicians play an important role in providing quality primary care to the community. The Regional Consultation on the Role of Family/Community Physicians in Primary Health Care (2011) provided a forum for Member States to explore how best to utilize this category of the health workforce for improving the efficiency and effectiveness of primary health-care delivery.

Decentralization of health care

Decentralization of health-care services is an essential element of health systems strengthening. The aims of decentralization are to improve the efficiency and effectiveness of health service delivery and the equity of outcomes. Consultations and meetings have resulted in the identification of strategic actions that need to be undertaken to address the challenges of capacity-building and management of human resources for health in the context of health systems decentralization and urban health. A regional seminar on “Decentralization of health care services in the South-East Asia Region: perspectives and challenges” was held in July 2010 to guide countries in this effort.

UPGRADING THE SKILLS OF THE COMMUNITY-BASED HEALTH WORKFORCE: BHUTAN LAUNCHES THE BACHELOR’S IN PUBLIC HEALTH PROGRAMME

WHO’s Regional Office for South-East Asia provided technical assistance to the Royal Institute of Health Sciences, Thimphu, Bhutan, to launch the Bachelor’s in Public Health Programme (BPH) for health assistants. The BPH is a modular two-year programme offered in four semesters. The intake capacity is 25 students per batch. It incorporates the principles of adult learning; 50% of the course is devoted to self-study and problem-based learning. A substantial amount of time is spent on practical and field exercises. After successful completion, the graduates are expected to take a leadership role in health. The course is designed to enable community-based health workers:

- to empower people to take care of their own health;
- to communicate effectively with clients and stakeholders;
- to manage information and its use in evidence-based decision-making;
- to plan, implement and evaluate public health programmes;
- to build partnerships and collaboration with relevant agencies;
- to promote health and prevent diseases, injuries and disabilities;
- to think systematically and critically in their everyday duties.

The BPH programme is a step towards professionalizing the community-based health workforce and a significant step towards revitalization of primary health care in Bhutan. The programme was launched by Dr Samlee Planbangchang, WHO Regional Director for South-East Asia, on 13 April 2010 in a simple ceremony presided over by Lyonpo Zagley Dukpa, Honourable Health Minister of Bhutan.
VILLAGE HEALTH VOLUNTEER SCHEME IN THAILAND

The proposal for a Village Health Volunteer (VHV) force to provide basic health care for every village in Thailand was first made some 30 years ago. It seemed impossible. How could volunteers be recruited from every single village in the country? With a desired critical ratio of 1:100 – 1 volunteer for every 100 people – the force would have to number in the hundreds of thousands to cover the whole country.

Thirty years on, Thailand has a world-renowned VHV scheme. It has over 800,000 members today, serving a population of 65 million. From humble beginnings of giving simple care for diseases and injuries in the village, their role has been expanded to cover other essential primary health-care work such as water and sanitation, nutrition, and maternal and child health. The volunteers have also played key roles in the surveillance and control of communicable diseases such as HIV/AIDS, tuberculosis and avian influenza. And yes, they have been doing all of this for no pay. This is possible because voluntarism has deep cultural roots in Thailand.

Revitalizing primary health care

The Alma-Ata Declaration adopted at the International Conference on Primary Health Care in 1978 recognized the gross inequality in health status within and between countries. It stressed that health is essential to social and economic development, and identified primary health care as a key approach to attaining the goal of “Health for All”.

Through the decade, the Regional Office strived to build in primary health-care principles in health systems strengthening in the Region. The thirtieth anniversary of the seminal Alma-Ata International Conference on Primary Health Care provided a platform for further accelerating revitalization of primary health care. In the Region, a Regional Conference on Revitalizing Primary Health Care was held in 2008 to review the past and present of primary health care and reinforce these principles in the regional context. Member States of the Region recognized the primacy of primary health care as a public health tool to achieve “Health for All” and reaffirmed that one of the basic principles of Health for All is that health is a human right. One of the important conclusions of this Conference was the need to orient health development efforts towards adopting a comprehensive community development approach rather than an exclusive focus on medical care delivery. This approach was piloted and implemented in Thailand under the title “Strategic Route Map (SRM)”. The SRM is essentially a tool that ensures community participation and empowerment to implement comprehensive health development initiatives.

A regional consultation on “Health of the Urban Poor” in 2010 helped to bring to the forefront the challenges that confront governments in providing primary health-care services to this segment of the population, and reducing health equity gaps between the various quintiles of the population.

Promoting self-care and family health

An empowered populace can take care of a significant proportion of their health needs. To encourage Member States to promote actions to facilitate individuals, families and communities to take responsibility for self-care, a Regional Consultation on self-care in the context of primary health care was organized in 2009. A handbook was also developed on how to practise self-care for health. Policies, strategies and plans in support of this workforce should be strengthened to enhance the utilization of this workforce as a change agent and equip it with the necessary skills to meet existing and emerging health problems to realize national and international health goals.

Families play a seminal role in health development. To empower families and enable them to make informed choices for health, a Regional Meeting on Family as Centre for Health Development (2013) provided suggestions for multisectoral actions to empower families for health.

Promoting innovations in primary health care

Many activities were carried out through the decade to motivate and support Member States to develop innovative methods for revitalizing primary health care, and move the health system’s orientation from service delivery to health development. To disseminate these innovative initiatives, a Regional Consultation on Innovations in Primary Health Care was organized in 2010. The innovations and rich experiences were published in Glimpses of innovations in primary health care in South-East Asia. To clarify primary health-care concepts for the new generation of policy-makers and health programme managers, a booklet was produced entitled Primary health care: the basis for health systems strengthening.

The South-East Asia Primary Health-care Innovation Network (SEAPIN) was established as a knowledge management platform for primary health-care innovations for member institutions, countries and beyond.
Health policy and planning

There are many complex influences on national health systems and health outcomes. Health systems need to be resilient and respond to the challenges of health emergencies, climate change, sociopolitical context and the persisting global economic crisis through a coordinated, multisectoral effort. Although countries in the Region are committed to a primary health-care approach to universal health coverage and strengthening service delivery, the challenge has been to transform this into strategic processes that respond adequately to health needs and give ministries of health strong leadership in a multisectoral context. National health policies, strategies and plans are effective means for ministries of health to lead a multisectoral national health agenda. However, a review of the national health plans of Member States showed that, at present, national health planning appears to be equated to planning for the ministry of health rather than population health, as linkages beyond health remain persistently weak. The plans are also constrained by their inability to either measure resource allocation gaps, or identify the resources required internally or externally to fill these gaps. Coupled with the emphasis on medical aspects, this may pose a serious constraint to the primary health-care approach.

Health financing and universal health coverage

Health financing

Health financing is a key building block of a primary health care-oriented health system and plays a critical role in advancing towards the goal of universal coverage. In the Region, health financing is subject to five main constraints: high and even impoverishing out-of-pocket expenditures by households; inadequate public investment in health; a large informal sector in the economy where the poor are mainly located; a substantial share of service provision by a largely unregulated private sector; and an increasing burden of high-cost noncommunicable diseases.

Government revenue is the most equitable means to financing health, especially the public health needs of the poor. It allows resources to be pooled and allocated to priority health areas and target groups, which is the most effective way to strengthen health systems within a primary health-care approach. However, government revenues may be limited in developing countries and health is only one of many sectors competing for scarce public resources. Additionally, there is the pressure of an increasing burden of noncommunicable diseases, which require high-cost, personalized care but fall in the domain of public health.

Some Member States have explored innovative alternative health financing mechanisms. In Thailand, health is financed through multiple contributory pools, including Government subsidies targeted at providing access for the poor to essential and referral care. Indonesia’s Jamkesmas includes the poor in the national social insurance effort through a publicly subsidized scheme managed as an insurance fund, and targets the poor with free health care. The Self Employed Women’s Association, or SEWA (India), is an example of successful health financing based on empowerment of women and income generation.

PRIMARY HEALTH CARE IN ACTION IN DEMOCRATIC PEOPLE’S REPUBLIC OF KOREA

In the Democratic People’s Republic of Korea, the universal free medical care system enables all people to have equitable and fair access to health care, irrespective of age, sex, occupation and position. The Public Health Law emphasizes commitment to a health-care system that is equally preventive and curative, with special priority for the needs of women and children through the household (HH) doctor system, whereby a trained medical doctor provides clinic-based and outreach health services for 130 households backed by a network of health facilities. The Democratic People’s Republic of Korea has one of the highest ratios of health workers to population in the Region (7.2/1000).

Through the HH doctors, substantial gains in health and development have been achieved, for example, in maternal mortality (81 per 100 000 live births) and infant mortality (18.6 per 1000 live births), high immunization coverage (>90% for primary immunization), >98% coverage of births by skilled attendants and institutional deliveries, provision of curative services and timely referral.

The HH doctor performs the roles of educator, communicator and advocate for hygiene and healthy lifestyles, organizes community-based activities, facilitates data collection and reporting, acts as health service provider at households and clinics, conducts screening and early detection of cases, emergency care and referral, ensures registration of vital events and visits households regularly.
It embodies the essence of the primary health-care approach: it is anchored at the community level and is responsive to its specific health needs, operating in the context of the overall socioeconomic structure.

**Universal health coverage**

The Health for All movement initiated in the early 1970s has metamorphosed into the universal health coverage paradigm. The Regional Office assisted countries in developing a strategy for universal health coverage. Meaningful conversion of the strategy into ground-level action will go a long way in helping countries achieve their national and international health goals.

Countries in the Region have made significant progress towards universal health coverage with respect to both conceptual thinking as well as implementation. Member States have demonstrated that universal health coverage can be achieved at low cost and in resource-constrained settings, and are taking the pragmatic way forward of phasing in universal health coverage starting with primary health-care priorities to eliminate avoidable systems inequities and inefficiencies. They then plan to provide more comprehensive coverage as requisite systems and institutional capacities are developed. The current focus in countries is on equity and efficiency in health systems, with most countries reviewing the health financing function as a lead area of reforms for universal health coverage.

Member States are strengthening both the process and content of national health policies and plans so as to use the national health policy strategy and plan better for universal health coverage. However, countries need to provide better financing for universal health coverage for social protection and equity in health. They also need to provide better service delivery by enforcing cost containment and changing the incentive structure in health systems to improve public and private sector performance and partnerships. Country capacities and institutions need to be strengthened for evidence-based advocacy, development of policy, strategies and plans, and monitoring and evaluation.

Five countries in the Region have made good progress in placing primary health care-oriented health systems strengthening at the centre of universal health coverage – Bhutan, Indonesia, Maldives, Sri Lanka and Thailand. The others have “islands of success” and are now preparing to scale up.

**Data and information**

Sound information plays an increasingly critical role in the delivery of modern health care and efficiency of health systems. In 2004, a WHO bi-regional Consultation on Strengthening Health Information Systems in Asia and the Pacific was held to discuss and formulate a framework for strengthening the health information system in the South-East Asia and Western Pacific Regions of WHO. The key challenge in this area is to strengthen country health information systems to facilitate evidence-based decision-making at the national and subnational levels. Other challenges include the limited use, quality and availability of data, poor analytical capacity and fragmented support for harmonizing information-related initiatives at the country level. These challenges were discussed and addressed during the formulation of the Regional Strategy on Strengthening Health information systems in the South-East Asia Region through various meetings, workshops and the Fifty-ninth session of the Regional Committee for South-East Asia held in 2006. Based on the feedback from the Member States, the Regional Strategy for Strengthening Health Information Systems was further amended and endorsed by the Sixty-third session of the Regional Committee in 2010.

From 2007 to 2009, WHO, together with the Health Metrics Network (HMN), collaborated with Bangladesh, Bhutan, Indonesia, Myanmar, Sri Lanka and Timor-Leste to assess their health information systems and encouraged them to realign their country systems with the regional strategies as well as the HMN framework and Standards for Country Health Information Systems. Bangladesh, Bhutan, Indonesia, Myanmar and Thailand have, to some extent, realigned their national strategies for health information systems with the HMN framework.

Assessment in countries was initiated on the 10 recommendations of the Commission on Information and Accountability for Women’s and Children’s Health (COIA) established in 2010. Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Myanmar and Nepal have made a commitment to implement the 10 recommendations and have finalized their action plans by using the country accountability framework (CAF) tool. The Regional Office has been engaging with countries, utilizing different platforms including the COIA to implement the 10-point Regional Strategy to strengthen health information systems. Countries are at various stages of strengthening their health information systems.

Reliable information on the supply and quality of health services is necessary for health systems management, monitoring and evaluation. Several countries in the Region have taken measures to map their health facilities and assess the availability of the services at these facilities. The Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector, and to generate evidence to support the planning and management of a health system. The Regional Office engaged in discussions to implement SARA in all six COIA countries. Currently,
SARA has been taken up in Democratic People’s Republic of Korea and Nepal. Other WHO tools for data quality are also being applied in countries with technical support of the Regional Office.

**Strengthening vital registration systems**

Availability of up-to-date and good-quality health information is the *sine qua non* for health policy, strategy and planning. All births and deaths, as well as causes of death, must be registered for producing vital statistics, as many health indicators use these as denominators. To facilitate the collection and reporting of vital statistics, a Regional Consultation on mortality statistics was held in 2007. WHO headquarters developed a tool to assess country vital registration systems, which was pilot-tested in Sri Lanka in 2009 with technical support from the Regional Office.

Since 2010, comprehensive assessment of civil registration and vital statistics (CRVS) systems using the WHO tool has been completed or is in the process of being completed in 7 of the 11 countries of the Region, and strategic plans are being developed for improvement of the CRVS system in these countries. In April 2013, WHO in collaboration with the Health Metrics Network, hosted a Global Summit on CRVS, at which 10 of the 11 Member States participated. The Regional Office is working closely with Bangladesh and Nepal to develop an integrated cause of death and birth reporting system for hospital- and community-based data collection, and facilitating funding from development partners to implement this in both countries.

The Regional Office is promoting the use of the WHO Family of International Classification (WHO-FIC) and the ICD-10 (International Classification of Diseases and Related Health Problems, Tenth Revision). Work on the implementation of the ICD-10 in Bangladesh, India, Indonesia, Maldives, Nepal and Sri Lanka has been supported since 2004.

**Generating health information**

As many countries in the Region have decentralized their health systems to district level, they need health status indicators to assist in
resource allocation, health service coverage, and access to and quality of health services.

In 2007, health system profiles of all 11 Member States were posted on the Regional Office web site. To facilitate exchange of knowledge among all 11 countries of the Region, a health system mini-profile, entitled 11 Health questions about the 11 SEAR countries, was published and disseminated. This publication has been updated in 2013 along with Core Health Indicators for Member States. The web site includes links to related web sites of relevant and respective governments, technical departments of WHO, and development partners.

The Regional Office launched the Regional Health Observatory (RHO) in 2013, which is an online integrated database of all important health issues in the Region. The RHO addresses the growing demand for health information at regional and country levels. It not only increases access to available data but also stimulates future collection of complete, reliable and accurate data. National Health Observatories (NHOs) focusing on key health indicators at the national and subnational levels will be developed using the RHO platform.

The Regional Office assists Member States in monitoring and reporting on the health-related Millennium Development Goals. Since 2000, all countries in the Region have conducted exercises on monitoring progress and measuring achievements towards the Millennium Development Goals and prepared country Millennium Development Goal reports. Millennium Development Goal data sheets were updated in 2011 based on the new monitoring framework. The Regional Office has developed an Millennium Development Goal Information Kit, presenting health-related Millennium Development Goal data from country reports showing the trends of key indicators at country level as well as a regionwide analysis across countries of some key indicators.

The Regional Office has also developed training manuals on health information systems and hospital information management system, and plans to produce an e-learning platform for Member States.

**e-Health, m-Health and telemedicine**

Globally, e-Health and m-Health are gaining importance and increasingly being used for all aspects of health. The Regional Office provided technical inputs for the development of e-Health strategies in countries.

The WHO Global Observatory for e-Health has studied the evolution and impact of e-Health and telemedicine in Democratic People’s Republic of Korea, the SEARO Integrated Data Analysis System (SIDAS) in Maldives, Monitoring of Vital Events through Information Technology (MOVE-IT) in Bangladesh and Indonesia, the mother and child tracking system (MCTS) in India, the district health information system in Bangladesh, and electronic medical records in Sri Lanka. The Regional Office is working to promote health information systems (HIS) training, integration and strengthening of national HIS in the Region, and building the capacity of countries to adopt health data standards and interoperability.

Many countries of the Region have implemented various projects in the area of e-Health: some notable examples are telemedicine in Bhutan and Democratic People’s Republic of Korea, the SEARO Integrated Data Analysis System (SIDAS) in Maldives, Monitoring of Vital Events through Information Technology (MOVE-IT) in Bangladesh and Indonesia, the mother and child tracking system (MCTS) in India, the district health information system in Bangladesh, and electronic medical records in Sri Lanka. The Regional Office is working to promote health information systems (HIS) training, integration and strengthening of national HIS in the Region, and building the capacity of countries to adopt health data standards and interoperability.

Telemedicine services are increasingly providing equitable access to a high quality of medical services for large pockets of remote and unreachable populations. Bhutan, the Democratic People’s Republic of Korea, India, Maldives, Nepal and Sri Lanka are implementing telemedicine activities.
Essential medicines

Countries have made considerable progress towards the availability of and accessibility to essential medicines for primary health care. This became possible through the recommendations of three Regional Committee resolutions over the past 10 years, on Accessibility to Essential Medicines, Measures to Ensure Access to Safe, Efficacious, Quality and Affordable Medical Products, and National Essential Drug Policy. The Regional Office has been supporting Member States in implementing these.

Improving drug regulation

Drug regulation through national drug regulatory authorities is important for the provision of quality drugs. The Regional Office provided technical support to all the national drug regulatory authorities of the Region. Bhutan and Democratic People’s Republic of Korea have established new drug regulatory authorities and Timor-Leste is in the process of doing so.

The Bureau of Drug and Narcotics under the Department of Medical Sciences, Ministry of Public Health in Thailand is a WHO collaborating centre and provides training to regulators from all Member States in drug quality testing and tests drug samples on request. Training for drug regulators in good manufacturing practices has been provided by sending regulators to training programmes run by good national drug regulatory authorities. Technical support on pharmacovigilance has also been provided to many countries of the Region and many of them now have their own pharmacovigilance systems in place. India, Indonesia, Sri Lanka, Nepal and Thailand are all participating in the WHO Programme for International Drug Monitoring. Maldives is an associate member.
Bi-regional cooperation between the South-East Asia and Western Pacific Regional Offices to combat substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products has been ongoing since 2003.

Ensuring drug availability

While the quality of drugs is important, access to drugs is equally important, particularly in light of the goal of universal access. Technical support has been provided to all countries of the Region to strengthen drug supply systems and ensure access. Situational analyses of the pharmaceutical sector have been conducted in 10 out of 11 Member States to date, which found that much of the drug procurement and distribution relied on manual systems with insufficient monitoring of consumption. Many countries are now working on establishing electronic logistics management information systems for procurement, distribution and monitoring of consumption.

Formulating essential drug lists and national medicines policies

All Member States have a national essential drugs list and technical support has been provided to most countries to update their lists. In addition, workshops have been held on evidence-based drug selection, including the use of pharmacoeconomic criteria. All countries have a national medicines policy, which sets the objectives and framework for government action in the pharmaceutical area. However, many of these policies still lack a workplan for implementation and are thus only partially implemented.

Promoting the rational use of medicines

Irrational use of medicines remains a problem in the Region. Most countries lack a dedicated unit in the government to monitor the use of medicines and coordinate policies to promote their rational use. The Regional Office has held regional training courses on promoting rational use of medicines in the community and by hospital drug and therapeutic committees, and published monographs on the subject. A regional meeting on the role of education in rational use of medicines was held in Bangkok, Thailand, following which a number of research projects were supported in the Region. A second regional meeting was held in 2010, at which the results of the research projects were presented and discussed. The meeting concluded that irrational use of medicines was a multifactorial problem requiring a coordinated health systems approach and
national situational analyses to identify the way forward in each country.

An analysis in 10 of 11 countries on rational use of medicines recommended the establishment of drug-use monitoring systems, strengthening of drug and therapeutic committees, and inclusion of national essential drug lists and standard treatment guidelines in the curricula of pre-service and in-service training of health professionals, and public education on the safe use of medicines.

Traditional medicine

Member States of the Region have a rich heritage of traditional medicine. Recognizing the key role that this system of medicine has played in the provision of health care since ancient times, in 2003, health ministers agreed that the traditional systems of medicine should be included as part of the national health-care system, with patient safety as the overriding consideration for use.

The WHO Regional Committee for South-East Asia in September 2003 gave strategic directions for the development of traditional medicine in the Region. A meeting of the Working Group on Traditional Medicine in 2004 recommended the development of evidence-based information on the quality, efficacy and safety of traditional medicines, and collaboration between Member States for research, evaluation and development of traditional medicines. A consultative meeting on Development of Traditional Medicine in the South-East Asia Region helped to finalize the outline and format of monographs on the use of traditional medicines in primary health care. Various books on traditional medicines in primary health care have been published.

Strengthening mechanisms for intercountry cooperation and research

In 2008, the Regional Office compiled a list of traditional medicine institutions in the Region. These are the core institutes for intercountry/multicountry collaboration for the development of herbal/traditional medicine in the Region and exchange of information. From 132 institutions in 2008, a revised list in 2011 had 153 institutions.

In order to support the establishment of a mechanism for sharing information among Member States, the Regional Office launched a web site called HerbalNet in September 2009. An Intercountry Workshop on Management of HerbalNet Digital Repository was organized in June 2011 to train country officials responsible for HerbalNet to efficiently manage information. Training for researchers was also supported by the Regional Office.

Quality of care

The quality and safety of health care is a serious concern for both service recipients and providers. During the past decade, the Regional Office made concerted efforts to improve the quality and safety of health care and appointed a Regional Adviser to better help Member States. The Regional Office supported Member States to develop their quality assurance programmes in health care, and policies and guidelines on patient safety. The Regional Office is also assisting Member States to prevent health care-acquired infections and antimicrobial resistance. Several meetings were held to bring patient safety on the agenda of countries.

To build in the concept of patient safety at an early stage of learning, the Regional Office assisted Bhutan, Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand to introduce patient safety curricula in the undergraduate medical, nursing and paramedical training courses, as well as conduct training of trainers programmes. It also helped these countries to establish quality and safety policies and strategies, and supported implementation.

As the Region is increasingly becoming a hub for medical tourism, the Regional Office is helping Member States to adopt guidelines and standard operating procedures for cell, tissue and organ transplantation, and management of medical waste, drugs, devices and technology.

Intellectual property rights and trade and health

A number of new challenges in the management of public health have emerged as a result of the interdependence of trade and health, and accession of Member States to various international trade agreements. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) of the World Trade Organization has had far-reaching consequences on access to medical products, medicines and medical technologies for the developing world. TRIPS requires countries to comply with certain minimum standards for protecting and enforcing intellectual property rights. Health authorities often find it difficult to keep up with the evolving and intricate developments in this area, which fall outside the scope of their normal area of work and responsibility. The Intellectual Property Rights, Trade and Health (IPT) Unit in the Regional Office provides technical, operational and capacity-building support to Member States to frame coherent policies to address the relationship between intellectual property rights, trade and public health. Training and capacity-building activities have
Knowledge management

Knowledge gained through formal training and a continuous learning process followed by years of practice in real-world scenarios resides in the minds of staff members and is considered as an invaluable asset of an organization. Systematic preservation, archiving and dissemination of organizational information resources forms an integral part of the knowledge management activities of an organization. However, a major portion of the knowledge and experiences of professionals remains untapped. It is therefore important to create environments and provide forums to stimulate expression and sharing of untapped knowledge assets.

Starting from the new millennium, existing organizational information archives in the Region were remapped to conform to common standards and dissemination protocols to facilitate effective information-sharing. Several new digital information repositories were established at the WHO regional and country offices and at partner institutions in Member States. The scope of digital repositories was expanded from metadata-only archives to original full-text repositories, including multimedia information materials such as images, audios and videos. Numerous publications of the WHO Regional Office for South-East Asia dating back from its inception in 1948 to the present are among the information assets that have been preserved, archived in full-text and made publicly accessible over the Internet.

The WHO libraries at the Regional office and at country offices have long been functioning as primary sources of WHO information in the Region. Library systems at the country offices were upgraded to achieve seamless integration of information assets between library resources and digital repositories. In addition, as part of the Regional Director’s special initiative in establishing and promoting “public health schools” in the Region, new public health libraries have been set up together with the schools to enhance equitable access to health information. Lists of information materials for different types of libraries have been regularly reviewed, updated and disseminated to the libraries to be used as guidelines for library collection. Whenever feasible, textbooks, serials and related information materials are acquired and distributed to the libraries. Several health science libraries in the Region have also been designated as “reference libraries for WHO publications” and provide free access to WHO publications.

In order to disseminate regional knowledge to a wider audience, Member States in the Region publish several health science journals, mostly in hard-copy formats. An e-journal publishing initiative was introduced in the Region in collaboration with ministries of health, national medical associations and academic institutions. As a result, several health science journals in the Region are now openly accessible online. E-journal publishing communities have also been established, together with online facilities for experience-sharing and technical support.
Publication of the WHO South-East Asia Journal of Public Health, one of the initiatives of the Regional Director, provides an important platform for health professionals in the Region to express and share their research findings and health-care experiences. Another important publication of the Regional Office initiated by the Regional Director, Sasakawa Health Prize: stories from South-East Asia is a compilation of “best practices” in the health-care sector.

One of the most powerful methods of knowledge management and sharing is “face-to-face communication”. Interpersonal communications between WHO and policy-makers in Member States have been organized and online interpersonal communications have also been strengthened.

Moving forward

One of the basic principles of Health for All is that health is a human right. The primary health-care values to achieve health for all require health systems that put people at the centre of health care and respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways in which health systems operate.

Today, overall, people are healthier and live longer than ever before. There have been significant improvements in health indicators throughout the Region. The technological revolution has increased the potential for improving health. This shows that progress is possible.

However, there are other trends. The progress in health has been deeply unequal. There are growing health inequalities among and within countries. The nature of health problems is also changing in unexpected ways. Ageing and the effects of rapid, unplanned urbanization and globalization accelerate worldwide transmission of communicable diseases, and increase the burden of chronic and non-communicable disorders. Climate change, challenges to food security, and social stress all have implications for health. In addition, economic and political crises challenge the capacity of health systems to ensure access, delivery and financing of health care. Lack of and maldistribution of human resources for public health and health care, finance, infrastructure, information systems, all add to the burden on health systems.

Achieving universal coverage of health care across socioeconomic groups is the cardinal principle of the primary health-care approach. To this end, intersectoral collaboration needs to be pursued vigorously in dealing with the risk factors and social determinants of health that lie beyond the health sector. Aligning the “Health for All” vision and mission in strategic frameworks for strengthening health systems using the primary health-care approach will facilitate the understanding of all stakeholders in working together and, eventually achieving “Health for All”.

MALDIVES: A SUCCESS STORY

Maldives has made important gains in providing primary health care since the Alma-Ata Declaration. All health indicators show steady gains and the health status of the population has improved significantly. Major communicable diseases, such as malaria, and vaccine-preventable childhood diseases have been eliminated. Prevalence of TB and HIV/AIDS is low, and some diseases, such as filariasis and leprosy, have reached the regional elimination targets.

Infant, maternal and under-five mortality rates have all decreased over the past decade, along with increased life expectancy at birth for both sexes. For a country that is so widely geographically dispersed, Maldives is unique in having achieved a credible record of sustaining 98% vaccine coverage over the past five years.

Access to maternal and child health and family planning have also increased. The number of health-care facilities has grown, along with the availability of competent human resources. Special attention is being paid to adolescent sexual and reproductive health, focusing on both men and women and reproductive-age girls and boys.

The commitment of the Ministry of Health in providing services of an obstetrician at atoll level is a tremendous achievement. Improvements have been made in the coverage and quality of maternal and child health services, which includes antenatal care coverage and births attended by skilled professionals. Institutional deliveries have reached more than 80% in the country, which could be one of the reasons for reduced maternal and infant mortality rates.
Caring for the most vulnerable
Healthy mothers: a boon for humankind

Child-bearing is one of the biggest health risks for women worldwide. Globally, approximately 287,000 women continue to die needlessly each year. In 2005, the South-East Asia Region alone accounted for approximately 170,000 maternal and 1.3 million neonatal deaths (infant deaths before 28 days of life), which accounted for 32% and 35% of the global figures, respectively. In addition, nearly a million stillbirths occur in the Region every year. Most of these deaths could be prevented through known cost-effective interventions responsive to the needs and demands of individuals and communities.

The global vision for maternal and neonatal health is a world in which skilled care at every birth is ensured for all women and in which mothers and their newborn babies, notwithstanding their social, cultural, ethnic or religious backgrounds, have assured access to comprehensive quality care services throughout all phases of their lives.

Reducing the maternal mortality ratio

The dramatic reduction in the maternal mortality ratio (MMR) from 270 in 2005 to 200 per 100,000 live births in 2010 became possible because of strong political will and commitment to maternal and newborn health in all Member States. Millennium Development Goal 5 targets a reduction in MMR of 5.5% from the 1990 levels. The Region as a whole is just short of this target, as the reduction in MMR translates into a regional annual reduction of 5.2%. By 2015, when this target is to be achieved, it is likely that the Region as a whole will reach it. The Democratic People’s Republic of Korea, Maldives, Sri Lanka and Thailand have already achieved the target, while Bangladesh, Bhutan, India, Indonesia and Nepal are on track. Nepal has shown what can be done even in a continuing climate of political turmoil and lack of resources. It has received two awards for its efforts to contain maternal deaths – in 2010 by the Millennium Development Goals review summit and the 2012 Resolve Award. Myanmar and Timor-Leste are lagging behind and need special attention.

The fall in maternal mortality has largely been due to the increase in the number of births attended by skilled birth attendants. However, there are inequities in access to skilled birth attendants between and among countries. Indonesia and Sri Lanka have made progress in narrowing the gaps, while in Bangladesh and Nepal the progress has been slow over the years.
To address this inequity in access, several countries have taken the help of the community, as community-based health workers are an integral part of the health system in many countries of the Region. The Government of India is training auxiliary nurse midwives to become skilled birth attendants. Bangladesh has initiated a six-month training course in midwifery, and will soon launch a three-year midwifery course.

Sociocultural issues have a critical bearing on maternal and neonatal health outcomes, and need to be urgently addressed to reach the Millennium Development Goals. The WHO Regional Office for South-East Asia, in collaboration with the Western Pacific Regional Office and WHO headquarters, organized in 2009 a Bi-regional Consultation for the Application of Sociocultural Approaches to Accelerate the Achievement of Millennium Development Goals 4 and 5. The outcome was a “Strategic Framework for Sociocultural Approaches to Accelerate the Reduction of Maternal and Neonatal Mortality”. The South-East Asia Regional Office provides support to countries to develop and implement action plans based on the Framework, including an agenda for research on the sociocultural aspects of maternal and neonatal health.

We all know the role of access to quality maternal and neonatal health care, including antenatal care, childbirth, postpartum and newborn care, to mention but a few, in improving maternal and child health. Have we done enough in these areas while taking into account the social and cultural aspects surrounding them? Have we provided responsive care according to their legitimate needs to the whole population and particularly to the poor, the vulnerable and the marginalized?

—DR SAMLEE PLIANBANGCHANG

Excerpt of speech delivered at the bi-regional consultation on Application of sociocultural approaches to accelerate the achievement of Millennium Development Goals 4 and 5, Tanah Lot, Bali, Indonesia, 11–13 August 2009

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**Key achievements in the past decade**

- The most significant achievement over the past decade has been the dramatic reduction in the maternal mortality ratio (MMR). This reduction in MMR is one of the biggest human rights achievements in the Region.
- Several countries have implemented innovative demand-side financing schemes to encourage the use of skilled services for delivery. This is one of the most powerful strategies for improving maternal and neonatal health.
- Over the past decade, almost all Member States have been conducting reviews of maternal deaths to know why mothers die and make pregnancy safer.
- The South-East Asia and Western Pacific regions have made a commitment to not just reduce but to eliminate mother-to-child transmission of HIV and sexually transmitted infections.
Keeping mothers alive

Maternal deaths are preventable to a large extent through known, cost-effective interventions. Direct causes such as obstetric complications account for 80% of maternal deaths, and can often be effectively treated in health facilities that provide emergency obstetric care. Therefore, skilled birth attendance at delivery, backed by timely emergency obstetric care, is important. To reduce the indirect causes of maternal mortality such as pre-existing conditions and poor nutritional status, attention should be paid to the health of the mother before and during pregnancy. Evidence shows that a large number of maternal and neonatal deaths can be prevented if women have access to basic health-care services.

In order to keep mothers alive, it is important to understand why mothers die. One of the major reasons for maternal and neonatal mortality is delay in seeking treatment. This delay occurs at three time-points. To prevent the first delay, caused by unwillingness to seek care during pregnancy, awareness is being generated of the importance of seeking care early. The second delay – delay in reaching a health facility for delivery – is being tackled by the introduction of innovative mechanisms to improve physical access and transportation, as well as financial schemes to reduce monetary barriers to accessing appropriate health care. Several countries have implemented innovative demand-side financing schemes, one of the most powerful strategies for improving maternal and neonatal health. The two best-known schemes are from India, the Janani Suraksha Yojana under the National Rural Health Mission, which is a conditional cash transfer scheme, and the Chiranjeevi scheme in Gujarat, which makes a direct payment to obstetricians for conducting deliveries. Bangladesh gives vouchers to eligible poor and vulnerable women to access maternal health services for three antenatal care visits, delivery and one postnatal care visit by designated providers. The third delay, delay in providing effective services, is being reduced by strengthening health systems.

Making pregnancy safer

Several technical guidelines developed by WHO, such as the four cornerstones of family planning and the Integrated Management of Pregnancy and Childbirth (IMPAC) modules for making pregnancy safer are used by countries. Despite these measures, maternal and neonatal deaths do occur. It is vital to understand the circumstances that surround these deaths, and design strategies to prevent such deaths. Although reliable data on the MMR and neonatal mortality are lacking at present, all Member States have demonstrated increased commitment towards collecting more reliable data.

Over the past decade, almost all Member States have been conducting reviews of maternal deaths. The WHO guideline Beyond the numbers – reviewing maternal deaths and complications to make pregnancy safer helped countries in this effort. A study in five countries (India, Indonesia, Myanmar, Nepal and Sri Lanka) showed that Sri Lanka has the most established system of maternal death audits, where a maternal death is notifiable by law. In India, the states of Kerala and Tamil Nadu have implemented maternal death audits, the results of which have led to systemic changes. In the Maldives, which has a small population and a small number of maternal deaths, a “near-miss” review was conducted in 2011 with support from the Regional Office.

The Regional Office also supported countries in developing road maps, putting in place or strengthening civil registration systems, and moving from maternal death review (MDR) to the more holistic and in-depth maternal death surveillance and response (MDSR).

Ensuring better reproductive health

Ensuring maternal and reproductive health is a compelling human rights dimension to reducing illness and death associated with pregnancy and childbirth. Universal access to key reproductive health services could help avert up to 35% of maternal deaths. Meeting the Millennium Development Goal 5b of...
“achieving universal access to reproductive health” has been particularly challenging; the global reproductive health strategy provides guidance on this by defining five components: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infection, cervical cancer and other gynaecological morbidities; and promoting sexual health.

In the area of family planning, the gains in the Region have been modest at best. The contraceptive prevalence rate has remained stagnant for several years in most Member States. To improve the situation, in 2012, WHO convened a regional meeting, which recommended expansion of the methods of contraception in countries where choices are limited.

The high cost of treatment for infertility at rapidly growing and largely unregulated centres is a cause for concern. The Regional Office addressed this concern by working with WHO collaborating centres in India to develop guidance on the prevention and management of infertility, focusing on the primary-care level of services. This will be a useful template for other countries to adapt.

Trends in the area of provision of safe abortion services have been encouraging, with Nepal and Bangladesh expanding provision of services to mid-level providers, which has brought down the number of maternal deaths considerably. In Democratic People’s Republic of Korea, India and Nepal, abortion is legal on broad grounds and safe services are easily accessible. Bangladesh provides a culturally sensitive menstrual regulation programme in the very early stages of pregnancy.

Preventing mother-to-child transmission of HIV and sexually transmitted infections is crucial for both maternal and child health. The South-East Asia and Western Pacific regions have made a commitment to not just reduce but to eliminate mother-to-child transmission. This led to the development of an “Asia-Pacific Conceptual Framework for Elimination of New Paediatric HIV and Congenital Syphilis 2011–2015” in 2011.

Cervical cancer is one of the leading causes of cancer among women. Early detection through screening has met with little success in the few countries where it has been introduced. The Regional Office organized a meeting in November 2012 to assess the magnitude of infection with Human papillomavirus (HPV), the main cause of cervical cancer, and the current status of prevention and control activities. Primary prevention with vaccination against HPV entails high costs and is currently provided only in Bhutan. The Regional Office made efforts in 2012 and 2013 to support countries to strengthen their programmes on control of cervical cancer.

Improving the quality and coverage of services

Merely providing services is not enough; their quality must also be assured. For this, it is important to conduct periodic reviews of programmes. The Regional Office built capacity for conducting reviews in Bangladesh, Bhutan, India, Maldives, Myanmar and Sri Lanka. Countries are also monitoring and evaluating their programmes, and using the findings to design strategies that include the development of standards and guidelines, continuous quality improvement mechanisms, accreditation of service provision, and considering incentives for both users and providers of care.

To ensure that interventions for maternal health are working optimally, WHO, with ExpandNet introduced a tool for planning pilot projects so they can be successfully scaled
A series of workshops were held from 2007 to 2011 to build capacity for using this tool to scale up specific interventions.

The coverage of services is as important as the quality. Despite the considerable progress made in improving the coverage of maternal and newborn health services over the past decade, there are disparities in access among and within countries. These deny women their human rights. The Regional Office aims to strengthen its support to countries that are not performing well, and advocate with governments to reduce disparities within countries. The high neonatal mortality rate continues to be a cause for concern. The inadequate numbers of, and uneven access to, skilled birth attendants is another area that needs to be addressed.

Moving forward

To sustain the gains made over the past decade, much remains to be done. The stagnant contraceptive prevalence rate is worrying and may lead to unwanted pregnancies. Provision of safe abortion services to those who need them may call for changes in the laws of some countries, highlighting the need for conducting advocacy with governments.

More work is needed to address the sociocultural determinants of maternal and newborn health. Countries need to maintain and strengthen the existing best practices and initiatives, and give due consideration to addressing sociocultural barriers in both supply- and demand-side interventions within the context of revitalized primary health care for delivering responsive services.

Linkages between programmes can help in delivering better services and economize on resources, both human and financial. For example, maternal health and HIV/sexually transmitted infection services can be integrated for delivering prevention of mother-to-child interventions. Such linkages need to be strengthened where possible.

Above all, adequate and sustained funding by governments is crucial to sustain the achievements in maternal and neonatal health.

For countries that have already achieved a low MMR (Democratic People’s Republic of Korea, Sri Lanka and Thailand), it will be difficult to reduce it further. For such countries, improving overall maternal health and reducing maternal morbidity will be the focus in future.

We couldn’t have done it alone!

Public–private partnership in the menstrual regulation programme in Bangladesh

Unsafe abortion is a major cause of maternal deaths in Bangladesh. The menstrual regulation (MR) programme was initiated in 1974 to provide services to women who might be in the initial stages of pregnancy. The service involves a safe manual evacuation of the uterus after undergoing a pregnancy test. This programme, which is provided in Government health facilities through the family planning programme, has been shown to reduce maternal mortality. However, the Government’s capacity to provide this service is limited.

Since 2008, a donor-funded MR programme has been initiated to improve equitable access to services for unwanted pregnancy and prevention of unsafe abortion, especially for poor women. The main strategy for this is investing in a public–private partnership (PPP) within the framework of the health, nutrition and population sector programme. The private partners are eight NGOs who are involved in scaling up of delivery of quality MR services and generating demand from underserved women for these. These NGOs deliver services in different geographical areas of the country and, in this way, complementary with the services provided by the Government, the whole country is covered.

This programme has undergone an external evaluation in 2010 and again in 2011, and the findings are very encouraging. The NGO partners operate in 6 of the 7 divisions of Bangladesh across 16 districts and 36 upazillas, benefiting more than a million women. Women have expressed satisfaction with the services provided, and men have become more aware of and committed to women’s health, especially reproductive and maternal health. Complementary services such as health education, awareness on women’s health and their rights have led to demand generation, and have shown a positive impact on the status of women’s health in Bangladesh.

This PPP, which complements the Government’s efforts, enhances the delivery of an important reproductive and maternal health service in Bangladesh, and will contribute to the achievement of Millennium Development Goals 4 and 5.
Children: our future

The period between conception and the first few years of a child’s life is recognized as one of greatest risk and greatest opportunity. The early years of a child’s life are the most critical for growth and development. Children do not reach their full human potential if they do not receive adequate nutrition, care and opportunities to learn. In the South-East Asia Region, more than 88 million children do not achieve their full potential, resulting in about 20% loss in adult productivity.

Inability to provide support for health and development of children is a violation of their human rights, according to the Convention on the Rights of the Child. Evidence shows that early intervention efforts that target disadvantaged children can lead to improvements in survival, growth, and cognitive and social development. It is the right of every child to both survive and develop.

Reducing child mortality

The progress made in the Region in reducing under-five mortality can be seen by the falling rates over the past two decades, from 109 deaths per 1000 live births in 1990 to 55 deaths per 1000 live births in 2010. The annual rate of decline has also increased, from 1.9% a year from 1990 to 2000 to 2.5% per year from 2001 to 2010. This became possible largely due to expansion of child health and immunization services. Bangladesh, Maldives, Thailand and Timor-Leste have already achieved the Millennium Development Goal 4 target, which calls for “reducing by two thirds, between 1990 and 2015, the under-five mortality rate”. Bangladesh has received the United Nations Secretary-General’s award for progress towards reaching the Millennium Development Goal 4 target. Bhutan, Indonesia, Nepal and Sri Lanka are on track for attaining it. However, the Democratic People’s Republic of Korea, India and Myanmar have not progressed as rapidly. At the present rate of progress, the Region as a whole is unlikely to achieve the Millennium Development Goal 4 target.

There has been significant progress towards the achievement of Millennium Development Goal 4 in the Region. Since 1990, the WHO South-East Asia Region has reduced under-five mortality by 50%. Unless the progress is accelerated, Millennium Development Goal 4 is not likely to be achieved in the entire Region within the deadline of 2015.

Fortunately, evidence-based interventions to address the major causes of child mortality are well known and Member States have been implementing these. However, there have been serious challenges to implementation at scale and to maintaining quality.

In addition, a substantial proportion of children who survive do not develop to their full physical, cognitive and social potential due to disease, undernutrition and inadequate care for development in their first crucial years of life.

—DR SAMLEE PLIANBANGCHANG

Excerpt of speech delivered at the South-East Asia Regional Programme Managers’ Meeting, Kathmandu, Nepal, 15–18 November 2011

Key achievements in the past decade

- The under-five mortality rate has fallen by 32% in the Region (2000 to 2011). The annual rate of decline has also increased.
- Bangladesh, Maldives, Thailand and Timor-Leste have already achieved the Millennium Development Goal 4 target, and Bhutan, Indonesia, Nepal and Sri Lanka are on track.
- Interventions such as immunization have reached more than 80% coverage in all countries.
- There has been a dramatic decline in deaths from neonatal tetanus to 1%.
- Nine out of the 11 Member States have implemented the Integrated Management of Childhood Illness (IMCI) strategy as the main vehicle for their child health programmes.
To track progress towards Millennium Development Goal 4, the Regional Office is working with countries to strengthen vital registration systems and health management information systems. Most countries register births but deaths are not recorded as regularly, and the cause of death is often not assigned. Only a few countries register stillbirths.

Promoting child health

Well-known and cost-effective interventions that promote child health are available and grounded in evidence. The Regional Office has supported countries to scale up such interventions across various levels of health care, such as promoting childbirth by skilled attendants, and providing home- and facility-based care of newborns. Interventions such as immunization have reached coverage levels of more than 80%. The dramatic decline in deaths from neonatal tetanus to 1% is a success story of immunization. However, the coverage of other important, proven, cost-effective interventions such as provision of oral rehydration solution and zinc for diarrhoea, and antibiotics to treat pneumonia needs to be stepped up. Exclusive breastfeeding for six months also protects children and needs to be actively promoted. Another cause for concern is the stagnant undernutrition rate in the Region. Exclusive breastfeeding for the first six months of life can save the lives of 210 000 Indian children, and reduce the rates of malnutrition and diarrhoea.

Bangladesh, India and Nepal have developed newborn and child health strategies and plans with technical assistance from the Regional Office. Recently, WHO, in collaboration with the United Nations Children’s Fund (UNICEF), supported Myanmar to develop a five-year strategic plan for child health (2010–2014). To review the progress made by various programmes and identify strengths and weaknesses, the Regional Office introduced the WHO Child Health Short Programme Review tool, which has been used in Bangladesh, India, Maldives, Nepal and Sri Lanka. Bangladesh and Indonesia have also introduced WHO tools for the assessment of quality of care in hospitals, which would result in a cyclical quality improvement process.

Over the past decade, several regional strategies have been developed on various aspects of child health and development. These include the Regional strategies for Newborn Health (2004), Early Childhood Development (2010), Newborn and Child Health and Development (2012), and Prevention and Control of Birth Defects (2013). The Regional Office has also helped countries to strengthen programme planning and management capacity, and progressively adopt data-informed and need-based planning.

Implementation of the WHO package for early childhood development would have a positive influence on child survival, growth and development. The Regional Office is supporting India to pilot implementation, following which interventions would be introduced in other Member States.

Care for children should be available at the first point of contact with health services so that they can be attended to without delay. The Integrated Management of Childhood Illness
(IMCI) is a strategy jointly developed in 1997 by WHO and UNICEF to improve newborn and child health services at the first level of care. The Regional Office has provided technical assistance to countries to implement this strategy. Nine out of 11 Member States have implemented this strategy as the main vehicle for their child health programmes. Bhutan, Nepal and Timor-Leste have covered all the districts in their countries with IMCI, while the other countries have expanded implementation to more than 50% of their districts. The progress, however, has to be accelerated for full impact.

In order to improve the knowledge of healthcare providers, pre-service IMCI training has been introduced in Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Myanmar and Nepal. A distance-learning model has been used for IMCI in India and Indonesia, through the IMCI Computerized Adaptation and Training Tool (ICATT).

Motivating active participation by the community

Facility-based and hospital care may be difficult to access for children living in hard-to-reach areas. Some Member States have overcome this problem by training community health workers (CHWs) to identify and treat sick newborns and children nearer to their homes and refer them to a facility if needed.

Moving forward

It is the right of every child to survive and reach their full potential. An equity-focused approach that targets disadvantaged and marginalized children will not only address disparities but also accelerate progress towards the Millennium Development Goals. The WHO–UNICEF Regional Newborn and Child Health Strategy takes this approach.

Although Member States are committed to improving newborn and child health, much remains to be done. For instance, India’s malnutrition rates are among the worst in the world, with nearly half of all children affected. More emphasis needs to be placed on improving the nutritional status of children through populationwide approaches. Sectors such as nutrition, water and sanitation (“whole of government”), which have an effect on child health, would need to integrate their work with that of the health sector to maximize benefits for newborns and children. The private sector also needs to be co-opted in countries with a shortfall of human resources.

Coverage of effective and relatively inexpensive interventions has to be scaled up to improve child health. The need of the hour is to create awareness among the community of the benefits of breastfeeding and target social customs that prevent exclusive breastfeeding through innovative means such as role models and religious leaders.

Although some countries have attained the Millennium Development Goal 4 target, there are large disparities in newborn and child health among and within even these countries. Child mortality is observed to be

Harnessing the community for delivering maternal and child health services in Nepal

In Nepal, the majority of its 29 million people live in rural and remote areas, far from any health service facility. Despite this, Nepal’s Ministry of Health and Population has succeeded in bringing maternal and child health services and information to every community in the country. Nepal has used its own resources to deliver services innovatively. The female community health volunteer (FCHV) programme covers all 75 districts. Initially, these 48 000 FCHVs selected from within the community provided health education to mothers and distributed family planning devices and support during campaigns. Their role has now been expanded, and they act as both service providers and health-care promoters. They diagnose and treat pneumonia in children, diagnose diarrhoea and provide ORS and zinc, support immunization campaigns, create awareness about the importance of vitamin A in the community, and refer severe cases. FCHVs are the key players in the recently expanded Community-Based Neonatal Care Programme. In addition, they also identify and register pregnant women, promote institutional delivery, are present during home delivery, provide services for immediate newborn care and counsel on essential newborn care, manage birth asphyxia, assess and manage neonatal infections, manage hypothermia and low birth weight, conduct four postnatal follow-up visits, and refer severe cases to health facilities.

An increasing percentage of pneumonia cases have been treated in programme districts each year since 1995. In these districts, nearly 70% of pneumonia cases were treated compared with only 30% in other districts. FCHVs were 98% accurate in their assessment of patients. Nationally, 88% of vitamin A and 82% of deworming is provided by FCHVs.
higher in the rural areas, among poor people and among children whose mothers have received little education. Thus, to bring about sustained improvement in child health, the social factors that prevent children from achieving good health must be addressed.

Neonatal mortality rates have not declined to the same extent as child mortality, and account for about half of all child deaths. Countries need to make skilled birth attendants available to all women, and put referral systems in place for those with complications.

As the infant/child mortality rates decrease in the Region, birth defects as a proportional cause of mortality would become significant. Preventing birth defect-related mortality will contribute to further reductions in child mortality. Simple interventions in this area can have dramatic results. The Regional Office has initiated activities for the surveillance and prevention of birth defects and developed a regional strategy for the prevention and control of birth defects in collaboration with Member States and partners.

SRI LANKA’S MULTISECTORAL APPROACH: A SUCCESS STORY

Sri Lanka has achieved one of the lowest child mortality rates among lower-middle-income countries. The country has made continuous progress over the past four decades due to a combination of cross-sector public policies that have ensured universal access to education for women, clean water and improved sanitation to the majority, and health system developments that have guaranteed universal coverage of essential preventive and curative health interventions to all women and children. The coverage of deliveries by skilled personnel is 98%, coverage with measles, diphtheria, pertussis and tetanus vaccine 97%, and the country has the highest breastfeeding rates in the Region.

We couldn’t have done it alone!

Prevention of birth defects in South-East Asia Region

The WHO Regional Office for South-East Asia has collaborated with the Centers for Disease Control and Prevention (CDC, Atlanta, United States), National Center for Birth Defects and Developmental Disabilities to develop a regional strategy for prevention of birth defects to reduce morbidity and mortality among newborns and children.

The Regional Office initiated the work on prevention of birth defects in response to resolutions adopted on the subject of birth defects by the World Health Assembly Board in 2010. These resolutions are based on the health transition that many countries are currently undergoing, which has resulted in birth defects assuming a greater proportional cause of newborn and infant mortality. This transition is happening because the initial decline in infant mortality was due to control of infectious diseases and malnutrition, and improved care, while the mortality from birth defects remained constant.

The Regional Office developed the Regional Strategic Framework for Prevention and Control of Birth Defects in consultation with Member States, which was released in April 2013. The framework provides strategic directions for Member States to adopt while developing their national programmes for prevention of birth defects.

With the ongoing collaboration with CDC, the Regional Office is now building national capacities for the development of national strategies and plans for prevention and surveillance of birth defects in selected countries of the Region. A regional network of national institutions is being established to support surveillance activities for birth defects, and develop guidelines and tools to implement prevention interventions for selected birth defects.
Adolescence: making the transition to adulthood

Adolescence is the phase of transition from childhood into adulthood, and is characterized by rapid physical, sexual, psychological and social changes. It is a period of promise, when opportunities beckon. It is also a period of anxiety, when adolescents must learn how to cope with the psychological stress of growing up, deal with emotions, resolve conflicts, develop self-confidence, and learn to resist peer pressure.

Adolescents are generally considered to be a “healthy” population, as mortality is low in this age group. However, adolescents face numerous public health challenges, which are different from the ones they faced as children, and are unique to their age group. This is the phase of life when behaviours that have serious health consequences in adulthood take root. Nearly two thirds of premature deaths and one third of the total disease burden in adults is associated with conditions or behaviours initiated during adolescence. In addition, their health and nutrition status is important, as this has an effect on their future. Adolescents are thus a vulnerable population with special needs that must be fulfilled for them to reach healthy adulthood.

Adolescents deserve a sound public health response within national programmes. It is a common observation that, although health services may be available in countries, adolescents and young people hesitate to use them due to lack of privacy and confidentiality, in addition to many other sociocultural and financial barriers.

—DR SAMLEE PLIANBANGCHANG
Excerpt of a speech delivered at the Regional Programme Managers’ meeting, Bangkok, 11–14 October 2011

Key achievements in the past decade

- Ten Member States are implementing adolescent health programmes, with dedicated budgets as well as a focal person in the ministry of health.
- Member States have developed adolescent profiles and country fact sheets on adolescent health and adolescent pregnancy.
- Member States have undertaken special surveys among adolescents such as the Global School-based Survey and the Global Youth Tobacco Survey.
- The Regional Office has developed a situation report on adolescent nutrition for the Region, and an evidence base for weekly iron and folic acid supplementation for the management of anaemia.
- Ten Member States have initiated adolescent-friendly health services. The Regional Office has also developed tools for the assessment of quality and coverage of such services.
- The Regional Office is developing a “Healthy Transitions” package in collaboration with Member States, which would cover nutrition, healthy lifestyles, mental well-being, immunization, pre-conception counselling, and sexual and reproductive health.
Common health problems in adolescence

The 350 million adolescents in the Region comprise nearly 19% of the population. To reach healthy adulthood, the many health and psychological needs of this population must be taken care of.

Some cultural practices in the Region are harmful to their health, such as early marriage and child-bearing among girls. Societal and cultural norms do not allow open discussion between parents/teachers and adolescents on the subject of sex. As a result, adolescents do not have adequate knowledge on protecting themselves. Sexual debut before they acquire adequate knowledge and skills for protection exposes adolescents to the risks of acquiring sexually transmitted infections and HIV, which have far-reaching consequences. Unintended pregnancy is another likely consequence of unprotected sex, which may be followed by the risks of an unsafe abortion and social censure. Many may have to leave school, which reduces their employability and thus has long-term economic implications. Undernutrition and anaemia are other health conditions that are prevalent among adolescents in the Region.

Peer pressure is another issue adolescents have to deal with. The pressure to initiate substance use is often high among this population and, once initiated, poses serious, lifelong health risks. Other issues are violence, accidents and injuries that are a common cause of mortality, especially among adolescent boys.

Meeting the challenges to adolescent health

Many Member States have made considerable progress in meeting the challenges to adolescent health. Ten of them are implementing adolescent health programmes, with dedicated budgets as well as a focal person in the ministry of health. The Regional Office has provided technical support that has enabled countries to move from implementing projects to programmes that provide a defined quality of services to adolescents through a variety of service delivery models to cater to the special needs of adolescents. These include a clinic-based approach, in which health facilities have separate and convenient timings for adolescents, as well as outreach services through trained health workers, counsellors and peers.
**Strategic directions for improving adolescent health services**

The work of the Regional Office in improving adolescent health services in the Region is guided by the “4S” framework. This focuses on four strategic areas: strategic information, supportive policies, strengthening services, and strengthening collaboration with other sectors.

In the area of strategic information, the Regional Office has supported Member States to collect and analyse data disaggregated by age and sex to understand the situation of adolescents and monitor trends. Countries have been supported to develop adolescent profiles and country fact sheets on adolescent health and adolescent pregnancy. The Regional Office has also provided technical support to countries for special surveys among adolescents such as the Global School-based Survey and the Global Youth Tobacco Survey.

To ensure supportive, evidence-informed policies, the Regional Office has developed a tool to assess relevant laws and policies to determine whether these support the provision of health services to adolescents, and whether there are any barriers for adolescents to access the needed health services. The Regional Office has supported application of this tool in Bangladesh, India and Sri Lanka.

The Regional Office has developed a Regional Strategy for Adolescent Health in consultation with Member States and the United Nations Population Fund (UNFPA), and provided technical assistance to Member States to develop their national adolescent health strategies.

The Regional Office has also developed a situation report on adolescent nutrition for the Region, and an evidence base for weekly iron and folic acid supplementation for the management of anaemia. Most countries are implementing the weekly supplementation programme. The Regional Office is tackling the other common public health issues of early marriage and early child-bearing through the development of guidelines for the prevention of adolescent pregnancy.

Services for adolescents are distinguished by well-known physical and functional attributes, the methods adopted by health-care providers for delivery of services, and by the approaches to create a demand for such services. The Regional Office has provided technical support to countries to put in place such services, and develop national standards and guidelines for adolescent-friendly health services. All countries, except the Democratic People’s Republic of Korea, have initiated adolescent-friendly health services, some of which have been scaled up considerably. The Prime Minister of Bangladesh expressed commitment at the United Nations Special Session on Millennium Development Goals in September 2010 to transform one third of the maternal and child health clinics into adolescent-friendly clinics. The Regional Office has also developed tools for the assessment of quality and coverage of such services, and has supported Bangladesh, Bhutan, India, Indonesia, Sri Lanka and Thailand to carry out these assessments. A rapid programme review tool has also been developed to carry out a quick assessment of the performance of adolescent programmes in the health and other sectors. This tool has been used in Bhutan and India.

Sensitization and education goes a long way in bringing about change. Technical assistance by the Regional Office has led to the integration of adolescent health in the pre-service medical education in India. The distance-learning maternal and child health programme conducted by the Indira Gandhi National Open University, India, has updated its course content to include adolescent health.

To ensure that the health of all adolescents is taken care of, including those who are hard to reach, the Regional Office has supported the development of a life-skills based health education package to promote the health of out-of-school adolescents.

Collaboration between sectors must be strengthened to maximize their contributions to adolescent health and development. Strengthening school health programmes and linkages with adolescent health services is one such area.

For many adolescents who need sexual and reproductive health services, such as appropriate information, contraception and treatment for sexually transmitted infections, these are either not available or are provided in a way that makes adolescents feel...
unwelcome and embarrassed. This prevents them from accessing health services. HIV is a highly relevant issue for adolescents, and they need to be provided with both information and services to protect themselves. The Regional Office has worked closely with UNFPA and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to develop guidelines and tools to improve access to HIV services for adolescents in the Region. To strengthen management capacity, the Regional Office has developed a regional programme managers’ course on adolescent health and HIV-young people with the collaboration of UNFPA and the London School of Hygiene and Tropical Medicine.

**Moving forward**

The Region can be justifiably proud of what it has achieved over the past decade. However, resources, both human and monetary, are a challenge. The adolescent health programme has to compete with other public health programmes of pressing priority such as maternal and child health. For adolescent health programmes to receive priority attention, further advocacy is needed.

Another issue is the uptake of services by adolescents. Despite much greater availability, the utilization of these services remains low, perhaps due to lack of awareness. Awareness generation and community mobilization will help to increase knowledge of the existence of these services. In addition, service delivery approaches that catch and sustain the interest of adolescents must be considered. The menu of services for adolescents needs to be broad-based to address all the priority public health issues.

The skills needed to deliver adult and adolescent health services are different, and thus programme managers need to be trained to plan, manage and review these services.

To maintain the quality of services, periodic assessments are needed.

Services for adolescents must be systematically scaled up to reach a wider audience. Working in close collaboration with other sectors will help to maximize gains. Operational research will be needed to understand what would generate demand, as well as what will attract and work for younger adolescents (10–14 years).

In view of the expanding health needs beyond sexual and reproductive health of adolescents, the Regional Office is developing a “Healthy Transitions” package in collaboration with Member States. This would cover nutrition, healthy lifestyles, mental well-being, immunization, pre-conception counselling, and sexual and reproductive health. The package is expected to contribute to the overall health and well-being of adolescent boys and girls as well as ensure a smooth transition to healthy adulthood.

**IMPROVING UPTAKE OF SERVICES BY ADOLESCENTS IN INDIA**

Adolescent-friendly health services were provided to a village in the Indian state of Haryana under the aegis of the National Rural Health Mission. The village has a small health subcentre. The facility was reorganized to make it adolescent friendly, as per the guidelines of the Ministry of Health and Family Welfare. Two major strategies were adopted; demand generation by communicating with the community and adolescents, and service provision by improving the quality of services delivered to adolescents. Village health workers, teachers and four peer educators were trained according to the national guidelines, and essential supplies stocked at the subcentre. An “adolescent action group” comprising five care providers and five care recipients was formed, who served as volunteers. They meet once a month to develop plans for the next intervention and review ongoing interventions.

In three months, peer educators addressed the problems of 141 adolescents, while the village health worker saw 92 adolescents. Some of the successful interventions include a weekly coverage of 92% with iron and folic acid supplementation to both schoolgoing and out-of-school youth, provision of toilets and drinking-water in the school, provision of footwear to those who were barefoot to prevent hookworm infestation, and provision of sanitary napkins to girls. Many other projects are in the pipeline.
The elderly: a hidden resource

Healthy ageing is the process of optimizing opportunities for physical, social and mental health to enable older persons to take an active part in society without discrimination, and to enjoy an independent and good quality of life. WHO’s emphasis is on “continuing participation in social, economic, cultural, spiritual and civic affairs, and [not] just the ability [of the elderly] to be physically active or participate in the labour force”.

Ageing populations have their own unique health problems, apart from their need for social and economic security. While the increase in life expectancy can be seen as a success story of medical advancement and technology, it poses a challenge to society to maximize the health and functional capacity of older people, as well as their social participation and security.

The journey into uncharted realms of old age is an adventure of continual learning, adjustments and, most important of all, mentoring what is good and admirable. This journey begins even before a person is born, right from the mother’s womb. An encouraging physical, social and mental environment that ensures the well-being and growth of the infant will lead to healthy adolescence, adulthood and eventually, old age. A continuum of care and support that follows a life course will ensure that ageing remains a healthy and fruitful experience and a journey of self-transformation, education and contribution.

—DR SAMLEE PLIANBANGCHANG

Message in Health in South-East Asia, April 2012

Key achievements in the past decade

- A wide range of innovative and situation-specific projects and programmes targeting the elderly population has been formulated in Member States.
- A Regional Strategy for Healthy Ageing was introduced in 2012, which has four strategic elements.
- Bangladesh, India, Indonesia, Sri Lanka and Thailand have national policies and comprehensive legislative measures to ensure the rights of the elderly and their priority access to health care, and other social and economic services. In Thailand, long-term care for the elderly has been integrated into the health and social services through a multidisciplinary approach.
Traditional values and practices still occupy a key position in the South-East Asia Region, where long-term care of the elderly is concerned. However, with nuclear families replacing traditional joint families and with large rural-to-urban migrations, often the old and infirm are left at home to fend for themselves. These changing patterns of society are now affecting the age-old balance of care for the old at home. For poor people growing old in low- and middle-income countries, the continuing ability to work and remain productive is perhaps the single most important defining issue in active ageing.

**Trends in ageing**

Worldwide, populations are growing older. In the Region, about 157 million (8.5%) are above the age of 60 years. It is estimated that by 2025, the proportion of the elderly will be twice that in 2000, and three times as much in 2050. From the current average life expectancy at birth of 67 years, by 2050, it is estimated that the average life expectancy at birth in almost the entire population of countries of South-East Asia will be above 75 years. Less developed countries are experiencing more rapid ageing, and have only a short timeframe to put in place the infrastructure and policies needed to meet the needs of the elderly.

In order to document the health of the ageing population in the Region, the Regional Office published a report *Health of the elderly in South-East Asia: a profile* in 2004. Demographic trends and characteristics, and the social and economic determinants of healthy ageing were examined at a regional consultation on active and healthy ageing organized by the Regional Office in 2007. As healthy ageing depends not just on the health sector but also on various other sectors, the consultation identified the need to involve stakeholders from all sectors to promote healthy ageing in the Member States.
To put in place processes and systems, in 2009, a strategic framework for active healthy ageing in the South-East Region was proposed through a regional consultation. In continuation of its past efforts, in 2012, the Regional Office organized a meeting of managers of national healthy ageing programmes, at which a Regional Strategy for Healthy Ageing was introduced. The goal of the strategy was to encourage Member States to initiate, develop and sustain a multisectoral approach, and measures for the promotion of healthy ageing among all population groups following a life-course approach.

Progress in Member States

Provision of age-friendly primary health care minimizes the consequences of noncommunicable or chronic diseases through early detection and prevention, and provides long-term palliative care for those with advanced disease and for those who can no longer retain their independence.

All Member States are now examining the various options available to them to respond to this demographic challenge with its significant economic, social, health and political implications. A wide range of innovative and situation-specific projects and programmes targeting the elderly population has been formulated in Member States. Bhutan has launched a pilot project to determine the feasibility of providing community-based health care for elderly citizens to promote productivity, vitality and happiness among them. The Democratic People's Republic of Korea, Maldives and Timor-Leste provide financial and social benefits to the elderly population. Provisions to ensure priority access of the elderly to health services have also been established in these Member States.

In the Maldives, the national policy for the elderly, which is under formulation, has identified inputs from several sectors such as gender, family and human rights; family and child development; and health. In Myanmar, there are “elderly health care” projects in 88 townships, which provide a wide range of health and related services. Bangladesh, India, Indonesia, Sri Lanka and Thailand have national policies and comprehensive legislative measures to ensure the rights of the elderly and their priority access to health care, and other social and economic services. In Thailand, long-term care for the elderly has been integrated into the health and social services through a multidisciplinary approach in the community referred to as “model tambol project”. Data-gathering mechanisms and social support activities such as elderly clubs and community-based home care of the elderly have been instituted. Countries have also collaborated to share experiences and ideas.

Moving forward

World Health Day 2012 focused on ageing as its theme to highlight the fact that ageing was a rapidly emerging priority that most Member States were yet to realize and address adequately. The message for World Health Day was “Good health adds life to years”. This can be achieved through a well-articulated combination of healthy lifestyles across the life course, age-friendly environments, and improved detection and prevention of disease. The focus would be on how good health throughout life could help older people lead full and productive lives, and remain valuable resources for their families and communities, irrespective of their functional ability.

Building an age-friendly society requires actions across a variety of sectors other than health, such as education, employment, labour, finance, social security, transportation, justice, housing and rural–urban development. This would call for the involvement of policy-makers in national governments, cities and municipalities; civil society groups and senior citizens' forums; academic and research institutions; private sector enterprises; community leaders and youth groups.

WHO continues to work with its Member States towards a healthier, productive world that taps the vast potential of the elderly.

DEALING WITH AGEING IN ASIA

The rise in the elderly population in Asian countries means that these countries will have to import health workers to take care of their elderly. Public pension plans will have to be re-examined to account for the millions of workers who will need retirement funds even as they continue to work into their seventies. The number of Alzheimer patients is expected to double every two decades and, as longevity extends, insurance and retirement saving plans will need to be reconceived as ageing populations need to stretch benefits for longer periods.

Provision of age-friendly primary health care minimizes the consequences of noncommunicable or chronic diseases through early detection and prevention, and provides long-term palliative care for those with advanced disease and for those who can no longer retain their independence.

All Member States are now examining the various options available to them to respond to this demographic challenge with its significant economic, social, health and political implications. A wide range of innovative and situation-specific projects and programmes targeting the elderly population has been formulated in Member States. Bhutan has launched a pilot project to determine the feasibility of providing community-based health care for elderly citizens to promote productivity, vitality and happiness among them. The Democratic People's Republic of Korea, Maldives and Timor-Leste provide financial and social benefits to the elderly population. Provisions to ensure priority access of the elderly to health services have also been established in these Member States.
Getting rid of old scourges and tackling new threats
Getting rid of old scourges

For the South-East Asia Region, the past decade has been a period of spectacular successes in the area of communicable diseases, perhaps more than in any other decade. There have been substantial reductions in mortality and morbidity due to communicable diseases. Many old scourges have been eliminated or identified for elimination. These successes are contributing to overall social, economic and health-related benefits.

However, communicable diseases continue to be one of the most important public health problems in the Region. Ancient diseases such as kala-azar and lymphatic filariasis continue to take a heavy toll on the poor, while the burden of HIV, tuberculosis (TB) and malaria remain high. Dengue fever has spread to previously unknown geographical areas and has also become more virulent. New and emerging diseases, such as avian influenza and severe acute respiratory syndrome, tax already overburdened health systems to the utmost. Development of resistance to effective drugs for malaria and TB in a limited arsenal is another serious threat. The Regional Office is striving to respond effectively and efficiently to these challenges.

Diseases targeted by Millennium Development Goal 6

Tuberculosis and malaria have been known since ancient times, and remain public health concerns in the Region. The emergence of HIV towards the latter part of the twentieth century is seen as one of the biggest threats to survival. Because of the huge toll taken by these three diseases, they have been targeted for action in Millennium Development Goal 6.

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Key achievements in the past decade

- The HIV epidemic has been halted and reversed in several countries, notably India, Myanmar, Nepal and Thailand.
- The number of new HIV infections has fallen by 31% in the past decade.
- The number of people receiving antiretroviral therapy (ART) has increased substantially over the past decade, from 55,000 people in 2004, to more than 814,000 people at present.
- The Region has adopted an ambitious target to eliminate new paediatric HIV infections by 2015.
- Treatment success of TB has remained above 85% since 2005, and was 88% in the 2010 cohort, which saved more than 100,000 lives every year.
- Over the past decade, the number of malaria cases per 1000 population at risk reduced by almost one third, and the mortality rate by 29%. Of the 10 malaria-endemic countries in the South-East Asia Region, five have reported ≥75% decreases in malaria cases and incidence rates between 2000 and 2011.
- The progress made during the decade in mitigating the impact of lymphatic filariasis is likely to culminate in elimination of this disease in the Region by 2020.
- A memorandum of understanding was signed between Bangladesh, India and Nepal to eliminate kala-azar or visceral leishmaniasis by 2015, with the aim of reducing the incidence to less than one in 10,000 population.
- India succeeded in eliminating yaws in 2006.
- Polio has been eradicated in the Region, with India reporting the last case in 2011.
- The Region has succeeded in eliminating leprosy as a public health problem.
- Countries have been able to keep the mortality due to dengue to less than 1%.
HIV/AIDS

Just a decade ago, having HIV infection meant certain death. Now, with greater awareness, strong policies and increased access to drugs, it is fast becoming a chronic, manageable disease.

During this decade, the HIV epidemic has been halted and reversed in several countries, notably India, Myanmar, Nepal and Thailand. This achievement would not have been possible without commitment at the highest level. The number of people living with HIV in the Region decreased from 6.2 million in 2004 to 3.5 million in 2011, reducing the overall prevalence from 0.7% to 0.3%. The number of new HIV infections has fallen by 31% in the past decade. The number of people receiving antiretroviral therapy (ART) has increased substantially, from 55 000 people in 2004, to more than 814 000 currently. The availability of generic, quality and affordable antiretroviral drugs produced in the Region (mainly India) has played a critical role in saving thousands of lives, not only in this Region but also in several other developing countries such as in Africa.

Thailand was the first resource-limited country to integrate interventions for preventing mother-to-child transmission of HIV into its existing strong antenatal care programme in early 2000. With support from the Regional Office, strong political commitment and an affordable ART regimen, Thailand has successfully reduced mother-to-child transmission of HIV, and prevented more than 20 000 children from acquiring HIV infection. The Region has now adopted an ambitious target to eliminate new paediatric infections by 2015.

Thailand is also the only country in the Region to have achieved universal coverage of testing and counselling for HIV for all pregnant women. Over 90% of women who test positive receive antiretroviral prophylaxis. Almost all babies born to HIV-positive women receive ART. This has resulted in a reduction of the perinatal HIV transmission rate.

Over the next few years, the Regional Office plans to support Member States to provide quality care through primary-care services, work towards elimination of new paediatric infections and congenital syphilis, strengthen the capacity for surveillance of risk behaviours, develop national plans, strengthen capacity to manage co-infection with TB, and mobilize and implement donor funds.

The Regional Health Sector Strategy for HIV/AIDS, 2011–2015 has been endorsed by
Member States. It calls for “zero new infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives”.

**Tuberculosis**

The South-East Asia Region has almost half of the world’s TB cases. Half a million die every year, and five of the 22 high-burden countries are in this Region. But the news is not all bad. A larger number of cases are being detected due to better access to health care, introduction of newer diagnostic technologies and strengthening of national TB programmes. From 1.8 million cases detected per year in 2004, the number of cases detected per year was 2.3 million in 2011. Treatment success has improved from 85% in 2005 to 88% in 2010, which has saved more than 100 000 lives every year.

With WHO support, laboratory capacity for TB diagnosis has also been strengthened. The Regional Office rolled out a new diagnostic test, Xpert MTB/RIF, for the rapid and simultaneous detection of TB and rifampicin resistance. The test, which takes 100 minutes, has been launched in Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Myanmar, Nepal and Thailand.

Public–private partnerships have played a critical role in making standardized treatment using quality drugs accessible to all patients.

A major concern is the emergence of multidrug-resistant TB (MDR-TB) in the Region. With no new drugs to treat TB, this is a serious threat. In 2011, about 9000 such patients were on treatment, but this is a fraction of the estimated 90 000 cases who need treatment.

**THE ROLE OF PUBLIC–PRIVATE PARTNERSHIPS IN ENHANCING ACCESS TO QUALITY TB SERVICES**

In the Region, public–private partnerships have played a vital role in providing care and treatment to patients with TB. The partnership includes over 1000 medical schools, 25 000 private practitioners, 1800 large public and private hospitals, 250 corporate institutions, 2500 NGOs, 100 faith-based organizations and over 900 prisons.

Nepal provides a unique example of public–private partnerships for the treatment of drug-resistant TB. Nearly half of the treatment centres operate through partners, which include public and private hospitals and international NGO clinics, while an NGO partner GENETUP (German Nepal Tuberculosis Project) provides the services of a national reference laboratory.

**NONGOVERNMENTAL ORGANIZATIONS COME TO THE RESCUE IN BANGLADESH**

Bangladesh has tackled the problem of TB through excellent coordination and collaboration with NGOs. Community-based health volunteers, such as Shasthya shebikas from BRAC, deliver health information, education and communication messages on TB through interpersonal engagement and help to evoke community interest in TB prevention and treatment. The NGOs also help in early case detection and treatment.

The Damien Foundation plays a key role in referring suspected cases of TB, diagnosing them and providing directly observed treatment, short-course (DOTS) near the patient’s home.

**BATTLING DRUG-RESISTANT TUBERCULOSIS IN MYANMAR**

Thirty-year-old Ma Thin Thin Wai of Hlaing township, Yangon, Myanmar, is a housewife with two children, and married to a trishaw driver. Like most Asian women, her primary concern was for them when she found she had to battle against a dangerous enemy – multidrug-resistant tuberculosis. After a course of medicines, tests showed that she was resistant to all the first-line TB drugs, and she was enrolled in the directly observed treatment, short-course (DOTS)-plus programme and hospitalized. Like DOTS, DOTS-plus is based on the strategy that every patient has to be observed while taking medication. With support from the TB programme of Myanmar and WHO, she was finally declared cured two years after she was hospitalized. What seemed like a miracle to her was actually a combination of sound technical guidelines developed by WHO and implemented well by the country, the dedication of nurses and other service providers, and Ma Thin Thin Wai’s own courage and determination.
Malaria

Malaria remains a major threat to socio-economic development in South-East Asia, although over the past decade, the reported (confirmed) number of malaria cases per 1000 population at risk has reduced by 31%.

The reported mortality rate has come down by 72%. The absolute number of people reported to be receiving antimalarial treatment has come down slightly, but this could be attributed to a significant reduction in incidence (Bhutan, Democratic People’s Republic of Korea, Indonesia, Nepal, Sri Lanka and Thailand).

Interventions to control malaria have been scaled up considerably. For example, the number of rapid diagnostic tests conducted to diagnose malaria has gone up from 1.2 million in 2004 to 15.2 million in 2011; the number of insecticide-treated nets distributed has increased from 3.35 million in 2004.

We couldn’t have done it alone!
Partnerships in tuberculosis control

It has long been recognized in the Region that public health systems alone cannot deliver health care to all. Health systems in the Region are already overstretched and countries do not have sufficient sustainable resources to meet the basic health needs of their populations. Many are also undergoing a difficult process of health sector reform in order to address these challenges. Partnership building is therefore a priority for countries in the Region.

Joint efforts of national programmes, funding agencies, technical agencies, NGOs and grass-roots organizations have led to considerable success in the Region in combating tuberculosis (TB).

Success stories from the Region

One deliberate and important strategy within the Region to increase case detection and treatment success rates has been the inclusion of public health-care providers operating outside the ministry of health, such as the railways, military, corporate sectors and prison health services, as well as private providers in TB management. In some countries, the percentage of patients seeking services through the private health sector is very high. Currently, all Member States have clear policies and strategies to involve other sectors, and their contribution to TB case notification stands at about 25%.

A recent initiative has been the formal inclusion of the principles and practices of TB control in pre-service training and the establishment of referral mechanisms through providing lists of centres that provide directly observed treatment, short-course (DOTS) to teaching institutes. Indonesia has intensified training of staff in private and public hospitals and laboratories. The country has also introduced coordination meetings between community health facilities and hospitals to improve transfer mechanisms between lung clinics and puskesmas (health centres). In Myanmar, TB services are provided throughout the network of Sun Quality Clinics and further expansion of public–private mix services is planned through the Myanmar Medical Association.

Universities and medical schools in the Region are contributing to evidence-based policies and strategies through technical advisory groups at the national level.

The International Standards of TB Care have been endorsed by professional bodies and medical associations in Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal and Thailand. Intersectoral collaboration and public–private partnerships for delivery of services have been further scaled up in eight Member States (Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste).

Partnerships with international and national NGOs have enabled TB service delivery outreach in remote areas and among marginalized populations in several countries of the Region.

Business alliances in the Region such as the Thai Business Coalition and the Business Alliance in India are emerging as players from the nonhealth private sector in introducing TB services into their workplaces.
to 29 million in 2011; and the number of treatment courses administered from 4000 in 2004 to 4 million in 2011.

The Regional Office is supporting Member States to reduce malaria cases and deaths by 75% by 2015 (from the year 2000) and contain resistance to the antimalarial drug artemisinin (mainly in Myanmar and Thailand), with the long-term goal of eliminating the disease. Of the 10 malaria-endemic countries in the South-East Asia Region (all except Maldives), five have reported ≥75% decreases in malaria cases and incidence rates between 2000 and 2011, and another (Bangladesh) is on track to achieve a decrease in malaria case incidence of 75% by 2015. India, the country with the largest number of cases in the Region, is projected to achieve decreases of 50–75% in malaria case incidence by 2015. To achieve this ambitious target, the Regional Office is promoting high-level political collaboration, finding mechanisms to bridge the financial gap, expanding access to quality medicines and technologies, ensuring universal coverage of key malaria interventions in priority areas, and accelerating research and development.

SURPASSING THE MILLENNIUM DEVELOPMENT GOAL FOR MALARIA IN TIMOR-LESTE

Malaria is a public health problem in Timor-Leste. The number of clinical and confirmed malaria cases reported in the country decreased from 223,002 in 2006 to 36,155 in 2011. Technical support from the Regional Office helped to bring down the incidence of malaria from 220 per 1000 population in 2006 to 31 per 1000 population in 2011, achieving the Millennium Development Goal for malaria.
Diseases targeted for elimination and eradication

This decade has seen enormous changes in the epidemiology of many communicable diseases. For the first time, countries have succeeded in eliminating age-old diseases such as yaws, polio and leprosy in some countries. Buoyed by these successes, the Region has taken on the challenge of targeting some other diseases for elimination, such as lymphatic filariasis and kala-azar.

Lymphatic filariasis

Although the Region accounts for 65% of the global burden of lymphatic filariasis, the progress made during the decade in mitigating the impact of this disease is likely to culminate in elimination of this disease by 2020. This was largely due to the coverage of mass drug administration (MDA) with diethyl carbamazaine and albendazole, which increased from 56 million in 2004 to 365 million in 2011. This became possible through WHO’s partnership with GlaxoSmithKline, which supplied 1800 million albendazole tablets free of cost to the South-East Asia Region. As a result, the microfilaria rate declined to less than 1% in 2011 in 575 implementation units.

Maldives and Sri Lanka have stopped MDA and are now undergoing the process of verification of elimination. Thailand will soon join these two countries. Many implementation units in Bangladesh, Maldives, Myanmar, Sri Lanka and Thailand had discontinued MDA by the end of 2010.

Elimination of lymphatic filariasis has the added benefit of controlling soil-transmitted helminthic infections, such as those caused by roundworm, hookworm and whipworm. This helps in reducing morbidity, especially among school-age children, and in improving their nutritional status and physical/cognitive growth.

WHO continues to supply albendazole to Member States. It plans to provide technical assistance for countries to scale up MDA where required, and implement transmission assessment surveys to stop MDA. Implementation of disability alleviation services is also planned.

Kala-azar

About 150 million people in the Region are at risk of contracting kala-azar. India and Bangladesh are among the most severely affected countries in the world. The disease is endemic in 109 districts (52 in India, 45 in Bangladesh and 12 in Nepal) in the Region.

Cases and deaths have reduced in Bangladesh and Nepal, and India has strengthened surveillance, case detection and treatment. A new rapid diagnostic test, along with improved surveillance, has enhanced case detection. Replacement of injectable drugs with an effective oral drug (miltefosine) has reduced the number of deaths to less than 100 per year at present.

Yaws

The elimination of yaws from India in 2006 was a major milestone in the control of communicable diseases. Technical and other support by the Regional Office for the yaws eradication programme helped the Government of India to achieve this monumental goal. Early case detection, continued surveillance and mass therapy with penicillin to the remotest corners of India resulted in a dramatic decline in the number of cases. From 3571 cases in 1996, the number of cases fell to 46 in 2003, followed by zero cases thereafter. Surveillance is ongoing, especially among children below the age of five years, to generate evidence of continued elimination.

THE STORY OF E’S BATTLE WITH LYMPHATIC FILARIASIS

E.*, now 70 years, was a strapping young man in an island in the Maldives, looking forward to a full life of farming and fishing when, at the age of 20, he developed fever. Initially, he did not take it seriously, as he was fit and healthy. Little did he know that his life was about to change forever. For, after the fever, his feet began to swell. His family took him to Kerala, India, for treatment. “I was treated with tablets for six months,” he recalls. His fever subsided, but the swelling on the feet – the most visible sign of lymphatic filariasis – has remained with him all his life. Now at the age of 70 years, he has no regrets, but wonders what life would have been like without his swollen feet.

[Name withheld to protect patient's identity.]
Yaws is still a significant public health problem in Indonesia and Timor-Leste. These countries have accelerated their public health actions to see the end of this neglected tropical disease before 2020. To do this, the Region has adopted the new global strategy of treatment with oral azithromycin, and has put forward a revised regional strategic plan to eliminate yaws: 2012–2020.

The Regional Office is educating the affected population on personal hygiene measures, and advocating with ministries of health and other sectors for resource mobilization and clean water supply.

**Polio**

The success of polio eradication in the Region has been tied to the success of polio eradication in India. For the past several years, India remained the only country in the Region with endemic transmission of wild poliovirus. From 2009, increased and concerted efforts were made to break transmission. From 2009 to 2011, the number of wild poliovirus cases decreased by 99%. On 25 February 2012, India was removed from the list of polio-endemic countries, marking more than a year that a wild poliovirus case was detected in the eleven countries of the South-East Asia Region.

However, all countries in the Region remain susceptible to importation of wild poliovirus from endemic and reinfected countries. This situation poses a threat not only to the polio-free status of the Region, but also the goal of regional certification by early 2014.

Member States will need to continue to make polio eradication a national priority. In order to sustain their polio-free status, adequate finances will need to be made available for a number of years. WHO will need to maintain efforts through 2013, continue to develop innovative strategies, ensure adequate technical support and vaccine supplies, and finalize a technically and scientifically sound end-game strategy in close consultation with Member States. In the past two years, the efforts of the polio eradication partnership have seen their hard work move closer to achieving polio eradication the Region and polio-free certification in January 2014.

**Leprosy**

The Region has succeeded in eliminating leprosy as a public health problem. This means that countries have successfully reduced national prevalence rates to less than 1 case per 10 000 population. At the beginning of 2012, the regional prevalence was 0.66 cases per 10 000 population, with 120 456 people affected by leprosy on treatment. Elimination of the scourge of leprosy from the Region is a testimony to strong political commitment, implementation of an effective, evidence-based strategy, primary health-care approach and sustained support from the global community, especially the Nippon Foundation and Novartis Foundation for Sustainable Development.

However, there is no room for complacency. Greater attention and investments are required to eliminate the disease at subnational levels, especially among hard-to-reach populations. Sustained commitment and continuous vigilance are crucial in order to detect and treat cases as early as possible to cut transmission and prevent disabilities, which will consequently remove stigma due to leprosy.
BATTLING LEPROSY: FROM DISTRESS TO HOPE

Thirty-five-year-old Duarte Mendonsa’s story begins in 1992, in the Ainaro district of Timor-Leste. He was 17 when he noticed that his fingers had become numb. Initially, he could not feel the heat when he touched hot objects. Gradually, the sensation of pain disappeared. More distressing was the fact that his hands began to ooze pus, followed by swelling of his legs and arms, and nodules near his ears. He did not know that he had developed leprosy, but came to know from his community members.

He lived in a rural area, where treatment options were limited. “Sometimes I would go to the health facility, but they did not have medicine. At that time, it was difficult to get treatment and information about the disease,” he said. Meanwhile, the disease slowly, inexorably took its toll, and his fingers became disfigured from constant trauma.

Life changed when he came to the city of Dili looking for work in 2008, 16 years after the appearance of the first symptoms. He visited a health centre for treatment. He was put on multidrug therapy (just two tablets each day), and had to visit the health centre once every three months to collect his free medicines. “Treatment was not difficult, and I am feeling much better now,” he says. He is, in fact, cured.

Dengue

Dengue fever is one of the most important public health threats in the Region. Dengue cases increased from 64 000 in 2000 to 356 000 in 2010. The increasing incidence, severity and frequency of dengue epidemics are linked to trends in human ecology, demography and globalization. The disease has now spread to areas where it was historically unknown, such as Nepal and Bhutan. The Democratic People’s Republic of Korea is the only country that has not reported indigenous cases of dengue.

Factors responsible for the spread of dengue fever include the lack of availability of antiviral drugs to treat the disease, changing vector dynamics, geographical expansion of the vector due to climate change, community ignorance, and weak public health actions and response to outbreaks. Several of these factors are beyond the control of the health sector.

WHO has been striving to keep the mortality due to this disease to less than 1%. With support from the Regional Office, countries have been able to do this. This target was not breached even during the massive outbreaks that hit Indonesia, India, Maldives, Sri Lanka, Thailand and Timor-Leste. This reflects the increased capacity of the health services to manage clinical cases effectively.
Tackling new threats

The war between microbes and humanity is unending. It is a continuous fight between the versatility of microbes and the wit, technology and knowledge of humans. Outbreaks of known epidemic-prone diseases continue to occur in the Region. In addition, newly emerging diseases such as avian influenza A(H5N1), Chandipura virus, Nipah virus and Crimean–Congo haemorrhagic fever posed serious public health threats to the Region over the past decade.

These new threats challenged the capacity of countries to the utmost. The beginning of the millennium saw global outbreaks of diseases with pandemic potential; severe acute respiratory syndrome (SARS) was the first caused by a hitherto unknown pathogen, while the second was a pandemic of influenza, similar to the three pandemics in the previous century.

Another emerging threat was caused by outbreaks of highly pathogenic avian influenza (AI) among poultry in Thailand and Indonesia in 2004, India and Myanmar in 2006, Bangladesh in 2007, Nepal in 2009 and Bhutan in 2010. The disease is deeply entrenched in poultry in Bangladesh and Indonesia, while occasional outbreaks are reported in the other countries. The South-East Asia Region has reported a total of 226 human cases of influenza A(H5N1) with 178 deaths since 2004. Although the number of reported human cases has been decreasing over the past five years, the fatality rate is very high (>80%). A “stamping out” policy has been adapted for containment of poultry AI outbreaks in all countries. Vaccination of poultry is also done extensively in Indonesia. All countries have established functional surveillance and response mechanisms through intersectoral collaboration. As the virus continues to evolve, continuing vigilance is needed for early detection, control and treatment.

WHO declared the first influenza pandemic of the twenty-first century in June 2009. All countries of the Region reported outbreaks at different times and a total of 76,302 laboratory confirmed cases with 2054 deaths were reported. All countries were better able to respond to this pandemic as WHO support had helped them develop institutional and technical capacity by supporting implementation of their national avian and pandemic influenza preparedness plans.

The International Health Regulations (IHR) 2005 were responsible in large part for the swift and effective control of these epidemics. The purpose and scope of the IHR (2005) are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” A multidisciplinary team has been stationed at the Regional Office for South-East Asia under the Disease Surveillance and Epidemiology unit to provide normative and technical support to countries to strengthen national “core capacities” for preparedness, surveillance, risk assessment and outbreak response, as required by the IHR, 2005. Member States are expected to develop minimum core capacities for implementation of the IHR, 2005 by June 2014.

The Regional Office has invested its resources to initiate and develop programmes such as the Field Epidemiology Training Programme, and Early Warning Alert and Response Systems (EWARS). In addition, Member States have appointed district surveillance officers to improve surveillance capacity. Improvement of the laboratory network performance in 2012 was apparent after the establishment of an external quality assessment network.

Moving forward

This decade has conclusively shown that with strong political support and efficient health systems, the challenge of communicable diseases can be met. Tested strategies and tools are available and so is the willingness of the international community to work together. Perhaps the greatest support has been provided by the Global Fund to Fight AIDS, control of avian influenza in Indonesia

Indonesia has had the largest number of avian influenza cases in the world. The first outbreak was in 2004 in birds, and started in humans in 2005. In 2006, the number of cases peaked at 55 with 45 deaths. By 2010, the number fell to 9 cases with 7 deaths. In 2012 there were just 9 cases.

This was achieved by strengthening surveillance and laboratory capacity, as well as health promotion and case management. Since 2007, the Regional Office has been providing technical and financial assistance to the Ministry of Health in implementing the International Health Regulations, 2005 and utilizing the bi-regional (South-East Asia and Western Pacific regions) Asia Pacific Strategy on Emerging Diseases as a mechanism for its implementation.
Tuberculosis and Malaria. This has helped Member States to scale up interventions and reduce the impact of these diseases.

However, more needs to be done. To optimize control, development and spread of resistance needs to be prevented to drugs for HIV, TB and malaria. Concerted efforts must be made to give a final thrust to eliminate old scourges such as yaws, lymphatic filariasis, kala-azar and leprosy from the Region. To do this, health must be brought at the centre of the development agenda and mainstreamed in all national plans.

The Regional Office, in collaboration with other United Nations partners, offers funding for research that will contribute to the prevention, control and treatment of communicable diseases. WHO has also developed generic research protocols to study the impact of climate change on vector-borne and diarrhoeal diseases, which are being used by Member States.

Over the next two years, the Regional Office plans to support countries to achieve universal access to early case detection and treatment, scale up treatment for drug-resistant TB with provision of adequate second-line drugs, and expand TB–HIV interventions to cover 50% of the population. The Regional Office is also planning to achieve a funding gap of less than 5% for TB programmes.

The need of the day is continuous vigil and harnessing of national and international resources to protect humankind from the onslaught of emerging infectious diseases.
Lowering risks for better health
A fter several movements around “health promotion” and “social determinants of health”, the idea of health in all policies is rapidly gaining global attention. ... Because of environmental, economic and social changes as well as demographic and epidemiological transitions in recent years, we have witnessed many more health challenges that need to be tackled through multidisciplinary and multisectoral actions. ... Other sectors can contribute to health through their “collective efforts” by using central and pooled resources.

—DR SAMLEE PLIANBANGCHANG

Excerpt from opening remarks at the Meeting of Experts on Health in All Policies in South-East Asia, 18–20 December 2012

### Promoting health to reduce disease

Health is affected by biological, psychological, chemical, physical, social, cultural and economic factors in people’s normal living environments and lifestyles. Achieving a state of good health depends not only on preventing disease but also on promoting health. Health promotion empowers people to take charge of their own health. Some of the factors that promote health are regular physical activity, eating a healthy diet and living in a clean environment.

Healthy populations live longer and are more productive, thereby contributing in large measure to economic progress. The concept of health promotion places health at the centre of the development agenda. It is thus a comprehensive and integrated approach to address the risk factors of disease and the underlying determinants of health to prevent disease.

### Progress in promoting health

Promoting people’s health is the most cost-effective measure to reduce the disease burden of the people and costs to the nation due to the increasing cost of treatment of diseases. It must be the joint responsibility of all social actors, as health promotion is not the purview of the health sector alone. To facilitate multisectoral actions for health and development, a Regional Strategy for Health Promotion for the South-East Asia Region was developed in 2006. The Regional Strategy is grounded in the actions and commitments contained in the Bangkok Charter for Health Promotion, 2005, which was articulated at the Global Conference on Health Promotion in August 2005. The Strategy endeavours to tackle the broad social, economic, environmental and political determinants of health that lie outside the health sector. Strategic directions have been laid out to promote healthy public policies across all sectors. At present, evidence-based policy development for health promotion is advocated and implemented in most of the

### Key achievements in the past decade

- Five Member States of the Region have evaluated and reported on the Bangkok Charter for Health Promotion, 2005.
- Global school-based health surveys (GSHS) have been conducted in India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand, which led to the development of evidence-based school health programmes and policies in these countries.
- Global Youth Tobacco Surveys (GYTS) have been regularly conducted in all Member States, except the Democratic People’s Republic of Korea.
- By 2010, most countries of the Region had included promotion of healthy lifestyles in the school curriculum. Some countries went further and made their schools health-promoting schools by 2011.
- The Thailand health impact assessment was recognized as one of the most comprehensive procedures that could be replicated to promote multisectoral actions for health and used as a tool to achieve healthy public policies.
countries. Five Member States of the Region (Bangladesh, India, Indonesia, Sri Lanka and Thailand) have evaluated and reported on the commitments of the Bangkok Charter.

Specific national health promotion policies, plans or strategies have been developed over the past two years in at least six Member States (Sri Lanka 2010, Maldives 2011, India 2011, Thailand 2011, Bangladesh 2012, Indonesia 2012, and Bhutan 2013). Some countries, such as Democratic People’s Republic of Korea, Myanmar and Timor-Leste, have integrated their health promotion plan in national health policies.

Leadership is a vital component of the infrastructure for health promotion. ProLead (Leadership programme for health promotion and management) is a tool that aims to produce leaders with a sustained interest to effect significant changes in health promotion strategies in their respective countries. To strengthen the capacities of partners from all sectors in practical skills, from 2005, the Regional Office launched training in ProLead module 2, which focuses on governance for health.

Making an early start

A comprehensive school health programme can be one of the most cost-effective investments a nation can make to simultaneously improve education and health. School health programmes are a strategic means to prevent important health risks among the youth and engage the education sector in efforts to change the conditions that affect risk. Conducting surveys helps countries to measure and assess the behavioural risk factors and protective factors among young people. Following a capacity-building workshop by the Regional Office in 2008, global school-based health surveys (GSHS) were conducted in India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand, which led to the development of evidence-based school health programmes and policies in these countries. In addition, to monitor tobacco use and develop and implement tobacco control programmes, Global Youth Tobacco Surveys (GYTS) have been regularly conducted in all Member States, except Democratic People’s Republic of Korea. The findings have helped to shape policies in these countries.

By 2010, most countries of the Region had included promotion of healthy lifestyles in the school curriculum. Some countries went further and made their schools health-promoting schools by 2011, in which students, teachers, school administrators and families help to promote community health.

Ensuring healthy public policies

The policies of several sectors such as transport, agriculture and housing have profound impacts on health. Health impact assessment is a means of assessing the health impacts of policies, plans and projects in diverse economic sectors, so that health is institutionalized as a part of the national agenda. Due to political commitment at the highest level, Thailand put in place an important movement to ensure healthy public policies through health impact assessment. In 2012, the Thailand health impact assessment was recognized as one of the most comprehensive procedures that could be replicated to promote multisectoral actions for health and used as a tool to achieve healthy public policies. Further guidance on proactive healthy public policies/health in all policies was generated through an expert meeting on health impact assessment and health equity measurement in the Region in 2012.

Health promotion in all areas where people live and work is known as the healthy settings approach, which aims to maximize disease prevention. To advocate for healthy settings such as healthy cities and health-promoting schools and hospitals, the Regional Office

In Sri Lanka, changes in the lifestyles of children are evident. The Global Youth Tobacco Surveys conducted in 1999, 2003 and 2007 show that in Sri Lanka cigarette smoking among 13–15-year-old students has decreased from 4.0% in 1999 to 1.2% in 2007. This became possible because of the school health programmes.
organized a series of national, regional and international meetings and prepared a set of modules to train coordinators. This was followed by a “healthy cities initiative” in 2009, which laid the ground for other intersectoral actions for urban health, such as promoting health equity in urban areas and creating smoke-free cities. An important milestone towards this was a Regional conference on Health of the Urban Poor held in Mumbai in 2010, which adopted a strategic framework to improve the health of the 600 million urban poor in the Region.

**Moving forward**

There has been a paradigm shift in how health promotion is perceived in the Region. A situation analysis conducted in 2011 showed that the approach to health had dramatically changed, from the earlier one of health education that targeted individual behaviour to holistic health promotion.

Health promotion needs to be further expanded to address the increasing threats of chronic illness from communicable and noncommunicable diseases, and the “causes of the causes” or determinants of health that rest in other areas beyond health. Health and well-being need to be promoted throughout the life course for individuals, families, the community and society. Community empowerment, public–private partnerships, healthy public policies, and health in all polices need to be strengthened across countries and implemented with multisectoral collaboration at multiple levels and through diverse approaches. Innovative and sustainable financing for health promotion and disease prevention will be needed to place health firmly within the development agenda.

**WHO collaborated with the**

**Government of India and states in piloting healthy city plans and preparing tools and guidelines for capacity-building of local bodies for setting up healthy cities.**

**WHO collaborated with**

**the Bangalore civic bodies for setting up the Bangalore Healthy Urbanization Project. This partnership project tried to address the social determinants affecting the health of the underprivileged and/or disadvantaged groups in the urban area, through Healthy Urbanization Learning Circles.**

**THE OTTAWA CHARTER**

The Ottawa Charter for Health Promotion of 1986 adopted a new approach to health by accepting “Health Promotion” as the guiding principle for the propagation of health. Health promotion was defined as a “process of enabling people to increase control over and to improve their health”.

This concept went beyond the traditional boundaries of health education, which largely focuses on information and education to enable people to adopt healthy lifestyles and prevent disease.

**SOCIOCULTURAL APPROACH TO HEALTH PROMOTION IN THAILAND**

Sustainable sources of funding for health programmes have been explored by many countries. In Thailand, the Health Promotion Foundation (ThaiHealth) was established in 2001 as an innovative state agency for funding health promotion from the 2% surcharge on alcohol and tobacco excise tax.

ThaiHealth explicitly pursues a “sociocultural” rather than a “biomedical” model of health. The “collective impact” includes a decline in smoking among the more-than-15-year-olds from 25.47% in 2001 to 23.7% in 2009, and harmful alcohol drinkers from 9.1% in 2004 to 7.3% in 2009.
Water and sanitation: the basis for life

Access to safe and adequate water and sanitation is a basic human right. Lack of access to these most basic of needs is an assault on human dignity. Since its inception, WHO has recognized that sanitation is vital to global health. The economic benefits of sanitation are persuasive. Every US$ 1 invested in improved sanitation translates into an average return of US$ 9. These benefits are experienced specifically by poor children and the disadvantaged communities that need them most. In the South-East Asia Region, if water, sanitation and hygiene are improved, the burden of disease can be reduced by 8.4%. Interventions to improve water, sanitation and hygiene could save 1.3 billion productive days and 139 million schooldays lost due to diarrhoeal diseases among children.

The quality of each human life is impacted by the quality of water. And our lifestyles and behaviours, individually and collectively, have an important impact on water quality.

...The health and well-being of future generations will be determined by our will and commitment today, the will and commitment to the preservation of precious freshwater.

—DR SAMLEE PLIANBANGCHANG

Excerpt from a speech delivered on World Water Day, 22 March 2010

Key achievements in the past decade

- Governments in the South-East Asia Region have provided drinking-water coverage to about 90% of the population. In doing so, the Region has already met the Millennium Development Goal target for drinking-water (88%).
- In the past decade, an additional 26 million people have been provided with access to improved sanitation.
- Good progress has been made in instituting sound and safe practices for the management of health-care waste in the Region.
- National legislations on health-care waste were amended in five Member States to bring them in line with WHO guidelines.
- WHO and the Indira Gandhi National Open University (IGNOU), New Delhi, India have developed and launched a six-month health-care waste management distance-learning certificate course.
At the start of this decade, more than 20% of the population in Member States did not have access to safe water. Much progress has been made, especially with the launch of the United Nations International Decade for Action “Water for Life” in 2005. In the past 10 years, governments in the Region have provided improved drinking-water supply to an additional 37 million people, bringing drinking-water coverage to about 90% of the population. In doing so, the Region has already met the Millennium Development Goal target for drinking-water (88%).

Member States have developed water and sanitation policies and mobilized resources to expedite implementation. They have also developed or revised national drinking-water quality guidelines and standards, and set up institutional mechanisms for monitoring water quality. Drinking-water quality guidelines published in 2004 introduced water safety plans to ensure water safety through appropriate risk management practices. With technical support from WHO, the AusAID-funded water quality project focusing on water safety plans has been pilot-tested and scaled up in several rural water supply schemes in Bangladesh, Bhutan and Nepal, and in urban water supply systems in India. The water safety project is an example of multisectoral collaboration, as the health, water, sewerage, forestry and agriculture sectors work together.

With the increasing paucity of freshwater sources, the use of rainwater provides a good alternative. The Regional Office has provided support to Maldives, Nepal and Sri Lanka for improving water quality through designing systems for the safe collection and storage of rainwater.

Arsenic contamination of the ground water is a concern in five Member States (Bangladesh, India, Myanmar, Nepal and Thailand). The Regional Office helped in conducting surveys to estimate the number of people affected and the health impacts of this, and prepared a field guide to train health personnel. Arsenic removal units have been installed in the affected countries, and some have switched to the use of surface water sources.

In Bhutan, the challenge is to provide safe water to rural communities living in remote, scattered areas. To make people feel they own the water, the Government provides technical support while the local people provide free labour. With technical help from WHO, AusAID-funded water safety plans are being implemented. Rural water safety plans have been implemented in three regions and then scaled up to six, and urban water safety plans have been implemented in five towns.
Sanitation

Sanitation is a key component of primary prevention. Public health interventions that secure adequate sanitation in communities prevent the spread of disease, save lives and raise the quality of life for many.

At the beginning of this decade, about 50% of the population in the South-East Asia Region did not have access to sanitation facilities. Various international initiatives have helped to boost sanitation programmes in the Region. These include the International Year of Sanitation, 2008 and the ministerial conferences on Sanitation in South Asia and East Asia. In the past decade, an additional 26 million people have been provided with access to improved sanitation; however, the regional sanitation coverage remains at 44% of the population. The Region is unlikely to achieve the Millennium Development Goal related to sanitation by 2015.

The WHO–UNICEF Joint Monitoring Programme is the institutionalized mechanism for monitoring the Millennium Development Goal targets for safe drinking-water and basic sanitation. Regional and intercountry workshops and national consultations have helped to integrate core indicators for water and sanitation into national census and demographic health surveys in India, Sri Lanka and Timor-Leste.

“...In the 1960s in India, no house in rural areas had a toilet. Women suffered the most because of lack of privacy and dignity. To overcome the problem of safe disposal of human waste, on the basis of WHO’s research findings, I developed a toilet for individual rural households that is scientifically appropriate, affordable, culturally acceptable and conserves water. Sulabh has contributed significantly to the improvement of urban health in India by providing household and public toilets which are used by about 10 million people every day. This has improved the conditions of millions of people, particularly the poor and underprivileged in urban slums.”

—Dr Bindeshwar Pathak, Founder of Sulabh Sanitation and social reform movement

Health-care waste

Health-care waste is a byproduct of health care and may be hazardous as well as infectious. Good progress has been made in instituting sound and safe practices for the management of health-care waste in the Region. Several regional training courses, meetings and national-level workshops have been organized over the past 10 years, and almost all Member States have national policies, guidelines and programmes. National legislations in five Member States were amended to bring them in line with WHO guidelines. The Regional Office has supported Bhutan, Nepal and Indonesia to develop model health facilities for health-care waste management, which will be expanded to other Member States.

The health-care waste management programme at Bir hospital, Nepal has three pillars: waste management, injection safety and mercury elimination. All wards have a waste management trolley with colour-coded bins for collection of risk and non-risk waste. The trolleys are designed to protect the waste handler. Infectious waste is stored separately, treated and disposed. Nurses have been trained in WHO’s safe injection criteria that focus on safe handling of sharps and safe disposal of cotton. Discarded mercury-containing equipment (sphygmomanometers and thermometers) is collected, sealed and stored in a designated collection house till disposal options are available.
Moving forward

Though the Region has met the Millennium Development Goal target for water, the quality of water remains an issue. More research is needed to understand the impact of exposure to food grown with arsenic-contaminated water and develop an integrated strategy to protect the health of the people who are exposed.

The Region is unlikely to reach the Millennium Development Goal for sanitation coverage. Intensive steps need to be taken to increase funding, sanitation coverage and improve facilities in the Region. Advocacy is needed at the highest level, along with raising awareness among the community and behaviour change interventions to adopt hygienic practices.

As we approach the 2015 target date for achieving the Millennium Development Goals, WHO and UNICEF are addressing current monitoring challenges and those that lie ahead. In the future, the availability and quality of freshwater is likely to decrease due to various factors such as population growth, rapid urbanization, climate change, poor sanitation and rapid industrial growth. Concerted efforts will be required to address this growing problem and make safe water available in adequate quantities. Recycling wastewater could be a solution.

Countries will need to urgently develop strategies to improve measures for safe disposal of increasing quantities of waste generated from lifestyle changes, globalization and population growth. Hazardous waste, such as e-waste, is also likely to increase.

Health-care waste will continue to grow with the expansion of health facilities and medical services in countries. The challenge would be to integrate sound management of health-care waste as part of the health-care services through expansion of the model health-care waste management that has been developed in a few Member States.
Environmental health and climate change

Environmental hazards are responsible for as much as a quarter of the total burden of disease worldwide, and more than one third of the burden among children. The health impacts of environmental hazards run across more than 85 types of disease and injury. Worldwide, as many as 13 million deaths could be prevented every year by making our environments healthier. This disease burden is much higher in the developing world. Each year, environmental factors cause 6.6 million deaths in Asia.

The direct health effects of climate change are obvious… Other consequences are less obvious; floods kill but they also destroy homes, harvests and livelihoods, leading to hunger and the migration of populations – which in turn results in psychosocial stress and conflicts. As the climate warms, new areas become hospitable to vectors such as mosquitoes, making the spread of malaria, dengue and other such diseases more likely.

—DR SAMLEE PLIANBANGCHANG
Excerpt from Message in Health in South-East Asia, June 2008

Key achievements in the past decade

- Member States have established offices of focal points on climate change and have mainstreamed health and climate change concerns in health sector activities, and in the overall national intersectoral plans.
- A regional tool for assessing health vulnerability, and a regional strategy for protecting health from the impacts of climate change were developed and a training programme based on these tools was piloted for future replication.
- Vulnerability assessments, including health and health sector vulnerability, have been conducted, and adaptation policies and workplans developed.
- Three research studies on children and environmental health, and two pilot studies on indoor air quality were supported by the Regional Office in Bangladesh, India and Nepal in 2005, and a generic research protocol was developed in 2010. Three research studies were conducted on the association between climate variability and diarrhoea, malaria and dengue; one study on the impact of cyclones on the health problems, livelihood and living pattern. A fifth study was done to estimate a comparative health vulnerability index in defined populations and geographical regions.
- A Regional Framework for Action to Protect Human Health from the Effects of Climate Change was formulated in 2008. At the Regional Director’s initiative, a Regional Working Group on Protecting Health from Climate Change has been formed.
- Health concerns from climate change were taken up strongly at the Sixteenth Conference of Parties (COPs) of the United Nations Framework Convention on Climate Change.
The countries of the South-East Asia Region, spread across archipelagos, river basins, and forests, are home to some of the world’s most spectacular natural and cultural diversity. With much of the population and infrastructure located in coastal and river delta areas, hundreds of millions of people are at great risk from the impacts of climate change. The Region’s aggressive economic development plans in turn could further exacerbate the problems. Sprawling megacities and spreading agricultural lands lead to land use conversion and forest loss, which will continue to be a major source of greenhouse gas emissions.

—Asian Development Bank

The malaria vector, which was traditionally not found above elevations of 1500 meters, is now found in Bhutan, Kashmir in India and Myanmar at heights of 2000 meters or more. Dengue has also been reported for the first time in Nepal and Bhutan in the past few years, while it was unnoticed in the Region except Thailand, even about two decades ago.

Widespread deforestation, other land-use changes, migration, change in occupation and increased human crowding are likely to influence the patterns and magnitude of occurrence of infectious diseases. The risk of cross-species infection has also increased, as is evident from the spread, emergence and re-emergence of malaria, dengue, scrub typhus, Nipah virus infection and neoplastic diseases in the Region. Indiscriminate use of chemicals due to an increase in pests and insects bring additional health problems, such as congenital diseases, poisoning and diarrhoeal deaths.

Climate change is a harbinger of poverty, death and injury through various direct and indirect manifestations. Health threats include the advent of new diseases (e.g. Nipah virus and severe acute respiratory syndrome) as well as the emergence of new strains of viruses (e.g. avian influenza), besides changes in the incidence, range, intensity and seasonality of other diseases.

The malaria vector, which was traditionally not found above elevations of 1500 meters, is now found in Bhutan, Kashmir in India and Myanmar at heights of 2000 meters or more. Dengue has also been reported for the first time in Nepal and Bhutan in the past few years, while it was unnoticed in the Region except Thailand, even about two decades ago.

Garnering political commitment

The World Health Organization advocates for and supports action to reduce human-induced changes in climate. As a result, in 2007, ministers and high officials of the ministries of environment and health endorsed the Bangkok Declaration on Environment and Health. Further efforts by the Regional Office resulted in the formulation of a Regional Framework for Action to Protect Human Health from the Effects of Climate Change in 2008. At the Regional Director’s initiative, a Regional Working Group on Protecting Health from Climate Change was formed.

In 2008, a meeting of the health ministers in the Region resulted in the New Delhi Declaration on the Impacts of Climate Change on Human Health, at which they committed to a number of specific actions. To garner political support for taking up adaptation measures in Member States, in October 2010, the Regional Office organized a Regional Parliamentarians’ Conference on Protecting Human Health from Climate Change. The Regional Office also convened a high-level meeting for the health and environment ministries in October 2010 to prepare the focal points of the ministries on climate change to take up health concerns from climate change strongly at the Sixteenth Conference of Parties (COPs) of the United Nations Framework Convention on Climate Change.

Developing policies and plans for climate change

Member States have established offices of focal points on climate change and have mainstreamed health and climate change concerns in health sector activities, and in the overall national intersectoral plans. Member States have conducted vulnerability assessments, including health and health sector vulnerability, and developed adaptation strategies and workplans. National environmental health action plans that engage other sectors were supported by the Regional Office in Indonesia, the Democratic People’s Republic of Korea, Myanmar and Thailand. Partnerships have been forged with nongovernmental organizations and research institutes. In addition, people are now more aware of the need for reducing, reusing and recycling measures at homes and offices. A sizeable market has been created in some of the Member States to adopt alternative and sustainable sources of energy.

In 2011, the Regional Office developed a Regional Strategy for Protecting Health from Climate Change. The strategy document elaborated on the areas and processes of the impacts of climate change on health, and how to adapt to those impacts by building resilience and adopting effective and
efficient plans. A regional training module on “Protecting our Health from Climate Change” for public health officials and practitioners was finalized in 2013. A generic research protocol was developed in 2010, and a Regional tool for assessing health vulnerability in 2012.

The effect of climate change on children

Children in developing countries are among the hardest hit by climate change, despite being the least responsible for it. Climate change denies children their rights to health, education, and a childhood, and has already impacted on agriculture, leading to an increase in malnutrition among children. The WHO-led Healthy Environments for Children Alliance is a worldwide alliance to reduce environmental risks to children’s health that arise from the settings where they live, learn and play. To understand the effects of climate change on the health of children in the Region, three research studies on children and environmental health, and two pilot studies on indoor air quality were supported by the Regional Office in Bangladesh, India and Nepal in 2005.

Moving forward

Climate change and variability will cause a serious survival problem for about 1.5 billion South Asians. It will increase migration, poverty, malnutrition, mental problems and other diseases. Global warming will increase the prevalent endemic diseases, both spatially and in magnitude. This situation will be further complicated by a decline in the quality of the environment and ecodegradation due to climate change, in addition to the prevalent anthropogenic practices.

Countries need to be oriented towards developing healthy public policies, and develop effective research capacity to assess the present and future impacts of climate change and variability on health. Plans that harness the co-benefits of measures to improve the environment need to be developed and implemented by the relevant sectors, for which strong collaborative arrangements between relevant agencies, actors and sectors is essential. Adaptation measures that reduce the projected negative health impacts of climate change need to be identified and adopted. Such measures would require sizeable amounts of funding, for which global collaboration would be expected.

Children are highly vulnerable to the negative health consequences associated with many environmental exposures. Children receive proportionately larger doses of environmental toxicants than adults, and the fact that their organs and tissues are rapidly developing makes them particularly susceptible to chemical insults. Research in children’s health looks at the effects of air pollution on respiratory diseases such as allergies and asthma, the impact of lead, mercury, and other environmental contaminants on cognitive development and behaviour, and the influence of prenatal and early life exposures on growth and development.

http://www.niehs.nih.gov/health/topics/population/children/
Dealing with noncommunicable diseases (NCDs) is not the task of ministries of health alone. It needs multisectoral and multidisciplinary cooperation and collaboration. Education and empowerment of people in the community is an important strategy towards long-term achievements in NCD prevention and control. In order to prevent and control NCDs, a well-balanced development between promotive/preventive care on the one side and curative/rehabilitative care on the other is needed.

—DR SAMLEE PLIANBANGCHANG

Excerpt from a speech at the Regional meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, 24–26 April 2012, Yangon, Myanmar

The threat of non-communicable diseases

At one time, it was believed that noncommunicable diseases (NCDs) were diseases of the rich. Now we know better. NCDs have made their presence felt and taken root in the poorer sections of society. They are among the greatest threats to good health in the South-East Asia Region and cause an estimated 7.9 million deaths each year, accounting for 55% of all deaths in the Region. And that is not all. Over the next decade, the number of deaths from NCDs is projected to increase by 21%. Sadly, one third of these deaths is premature and occurs before the age of 60 years, when people are at their productive best. This loss of productivity, either from death or illness, has an adverse effect on the overall economy. Individually, the majority of cases of NCDs require expensive, long-term or lifelong care, and the continuing expense on treatment combined with the lack of ability to earn due to illness pushes families into poverty. These diseases are also driven by forces that include ageing, rapid unplanned urbanization, globalization of unhealthy lifestyles such as unhealthy diets, and lack of opportunities for exercise.

Acquiring NCDs depends to a large extent on the presence of four major behavioural risk factors – tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol. The presence of these risk factors leads to overweight/obesity, high blood pressure, raised blood sugar and raised blood lipids, which are conducive to the development of NCDs. The diseases they cause are cardiovascular disease, various cancers, chronic obstructive pulmonary disease, asthma and diabetes. The magnitude of the problem can be envisaged by the following facts: every year, hypertension accounts for 1.5 million deaths, diabetes for 305,000 and tobacco use for 1.3 million deaths in the Region. About 30% of cancer deaths are due to five leading behavioural and dietary risks: high body mass index (overweight), low fruit and vegetable intake, lack of physical activity, and tobacco and alcohol use.

Key achievements in the past decade

- The South-East Asia Network for NCD Prevention and Control (SEA-NET), launched in 2004, reviews progress towards the control of NCDs in Member States, and provides a forum for sharing best practices. In 2011, a meeting of SEA-NET identified 10 key messages for the United Nations High-Level Meeting on NCDs in September 2011, which was attended by high-level delegates from the South-East Asia Region.
- WHO has developed a package of essential NCD interventions (PEN) consisting of sets of protocols designed for non-physicians and medical doctors, and a packet of tools to facilitate their application. These are being implemented in five countries of the Region.
- There are NCD units within the ministries of health of nine countries, and funding of NCD programmes is through the government budget. All Member States provide at least one NCD-related service at the primary health-care level in public facilities.
- Legislation has been adopted as a strategy to limit tobacco and alcohol use in the Region.
- Perhaps the greatest achievement of WHO in recent years is the Framework Convention on Tobacco Control (WHO FCTC), the first international treaty negotiated by WHO to reduce the enormous burden of deaths and disease from the use of tobacco.
What is worrying is that all of these risk factors are highly prevalent in the Region, and are even increasing. A large number of adults in the Region do not exercise enough. Nearly 250 million people smoke in the Region, and an equal number use smokeless tobacco. Eighty per cent of the population does not eat sufficient quantities of fruits and vegetables, which protect against colon and other cancers. In addition, childhood and adult obesity are increasing in the Region. However, the good news is that these risk factors are modifiable, and development of disease can be prevented, delayed or alleviated through simple, lifestyle changes.

Guidance for the control of NCDs

Work in the area on NCDs is guided by the Regional Framework for Prevention and Control of Noncommunicable Diseases developed in 2006. The Framework lists key strategies; these include raising awareness of NCDs, conducting surveillance to map the risk factors for NCDs, and promoting primary prevention through health promotion and legislation. Other aspects are early detection and treatment at the primary-care level, and conducting research to gather evidence on how best to control NCDs. Guidance has also been provided by the World Health Assembly and the United Nations General Assembly. In May 2012, the World Health Assembly committed to a target of reducing premature mortality due to NCDs by 25% by 2025.

Actions taken towards prevention and control

Interventions to prevent NCDs on a populationwide basis are both achievable and cost-effective. Such low-cost solutions or “best buys” are based on evidence from research. They work anywhere and include measures such as protecting people from exposure to tobacco smoke by banning smoking in public places, raising taxes on tobacco and alcohol, reducing salt in the diet, replacing trans-fats in food with polyunsaturated fat, and promoting awareness on diet and physical activity through the mass media. Vaccination against hepatitis B, which causes liver cancer, is also a “best buy”.

Risk assessment is a logical first step towards control. With technical assistance from the Regional Office, countries have adapted tools developed by WHO to conduct surveillance activities (WHO STEPwise approach to...
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL, 2003

Perhaps the greatest achievement of WHO in recent years is the Framework Convention on Tobacco Control (WHO FCTC), the first international treaty negotiated by WHO to reduce the enormous burden of deaths and disease from the use of tobacco. The WHO FCTC was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. It was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. It has since become one of the most rapidly and widely embraced treaties in United Nations history. Till date, 168 countries worldwide have ratified and become signatories to the WHO FCTC, and a total of 176 countries are Parties to the FCTC. The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation. The WHO FCTC requires each Party to submit to the Conference of the Parties (COP), through the Convention Secretariat, periodic reports on its implementation of the Convention. The objective of reporting is to enable Parties to learn from each others’ experience in implementing the WHO FCTC. The treaty sets an international floor for tobacco control with provisions on advertising and sponsorship, tax and price increases, labelling, illicit trade and secondhand smoke.

Surveillance of NCD Risk Factors (STEPS) and InfoBase). The Regional Office has supported STEPS surveys in Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Maldives, Myanmar and Nepal and Sri Lanka. InfoBase compiles and stores country-level data on important NCD risk factors. These collective efforts culminated in a report entitled Noncommunicable diseases in the South-East Asia Region: situation and response. The Regional Office is currently working with Member States to provide inputs for the global NCD monitoring framework and finalize the indicators and targets.

The South-East Asia Network for NCD Prevention and Control (SEA-NET) reviews progress towards the control of NCDs in Member States, and provides a forum for sharing best practices. The outcomes of its biennial meetings provide inputs for WHO initiatives. In 2011, the SEA-NET meeting identified 10 key messages for the United Nations High-Level Meeting on NCDs in September 2011, and identified follow-up actions from the Political Declaration of the United Nations High-level Meeting on NCDs in 2012.

The Regional Office is supporting countries to integrate NCDs with the primary healthcare system as a move towards achieving universal coverage. For this purpose, WHO has developed a package of essential NCD interventions (PEN) consisting of sets of protocols designed for non-physicians and medical doctors, and a packet of tools to facilitate their application. These are being implemented in five countries of the Region.

Following concerted advocacy efforts, there are NCD units within the ministries of health of nine countries, and funding of NCD programmes is through the government budget. All Member States provide at least one NCD-related service at the primary health-care level in public facilities. Legislation has been adopted as a strategy to limit tobacco and alcohol use in the Region.

In the Region, 10 countries have ratified the WHO FCTC. The Regional Office provided support to Member States to participate in the four-year long process of negotiating the Convention, and technical support for drafting and adopting national tobacco control legislations and enforcing the law. Strong surveillance systems have been established in these ten Member States. During this past decade, there has been an increase in the implementation of policies and public health interventions on tobacco control.

Moving forward

Several obstacles stand in the way of effective control of NCDs. These include the need for further strengthening of surveillance systems to monitor the outcome of interventions; engaging the non-health sectors actively, as many determinants of NCDs lie outside the health sector; improving access to services for NCDs through primary health care; and involving the private sector and civil society. A cross-cutting issue is the lack of adequate human and financial resources.

In order to ensure that evidence-based actions are taken to address NCDs, the Regional Office has developed a research agenda that focuses on operational and translational research to adapt globally proven cost-effective strategies that address the socioeconomic aspects of health.

On the anvil is the development of a regional plan of action for NCDs, which includes indicators and targets, salt/sodium monitoring and reduction strategies, and engaging with other sectors, including the food industry, to reduce the risk factors for the development of NCDs.
Immunization: a cost-effective public health intervention

Immunization is one of the most cost-effective public health interventions for vaccine-preventable childhood illnesses and death. Between 2004 and 2013, immunization has moved centre stage as one of the driving forces behind the progress in meeting Millennium Development Goals 4 and 5 – the reduction of child deaths and maternal mortality.

Some spectacular successes make this decade stand out as one of the most important in the history of the South-East Asia Region. Notable among these are polio eradication, the feasible goal of measles elimination, elimination of maternal and neonatal tetanus, and development of new vaccines.

India is the last country in the Region that was removed from the WHO list of polio-endemic countries. Practically speaking, all countries in South-East Asia are now polio-free. However, as long as there still is circulation of wild poliovirus anywhere in the world, the countries in the Region remain susceptible to importation of the virus.

A high coverage of routine immunization is critically needed to ensure sustainability of polio eradication in the long term, and for the national immunization services to be integrated into general health services to ensure sustained, long-term “immunization services” in the most “cost-efficient” manner. While focusing on such integration, an attempt should be made to ensure continued effectiveness of acute flaccid paralysis surveillance. All in all, attention should also be paid to improvement in hygiene and sanitation in the community.

—DR SAMLEE PLIANBANGCHANG

Speech delivered at the Regional Consultation on Polio End-Game Strategy in SEAR, Bangkok, Thailand, 14 December 2012

Key achievements in the past decade

- On 25 February 2012, India was removed from the list of polio-endemic countries, marking more than a year since a wild poliovirus case was detected in the 11 countries of the South-East Asia Region. The Region is clearly on a path towards polio-free certification in January 2014.
- A regional target for measles elimination by 2020 appears feasible.
- In the past decade, India and Indonesia have become the largest producers of vaccines and account for the manufacture of more than 70% of the global need for some vaccines.
- A conjugate meningococcal A vaccine was developed in India and received authorization for marketing. A vaccine for Japanese encephalitis produced in Thailand also received market authorization.
- One of the most remarkable achievements in the past decade was the enforcement of safe injection practices with the introduction of auto-disable syringes in the national immunization programmes of all Member States.
- An important milestone has been the elimination of neonatal tetanus from 9 of the 11 Member States and progress is being made in the other 2 countries, India and Indonesia.
Polio eradication

For the past several years, India was the only country in the Region with endemic transmission of wild poliovirus. However, starting in 2009, increased and concerted efforts broke the transmission chain. The number of polio cases declined significantly resulting in a polio-free status by 2012. Nepal was the only other country with polio. The last case of polio in Nepal was reported on 30 August 2010 and, since then, Nepal has remained polio free. With the last case of wild poliovirus in the Region reported from India on 13 January 2011, and removal of India from the list of polio-endemic countries in February 2012, the Region is clearly on a path towards polio-free certification in January 2014.

However, persistence of wild poliovirus transmission in Afghanistan, Pakistan and Nigeria, and reinfection in several countries of the African continent poses a threat not only to the polio-free status of the Region, but also to the goal of regional certification by early 2014.

Reduction in measles mortality

In the past decade, measles immunization experienced a period of scaling up as never before. In the South-East Asia Region alone, an estimated 160 million children were immunized between 2000 and 2010. Spawned by an upsurge in donor funding between 2003 and 2012, governments implemented campaigns designed to provide catch-up immunization to population cohorts who had not received the vaccine earlier.

All countries in the Region, except Thailand and Sri Lanka, have conducted several rounds of measles campaigns during the past five years. These two countries have introduced second opportunity for measles vaccine for more than ten years and have achieved a very high level of coverage with routine immunization. India, with the largest number of measles-related deaths, targeted
over 135 million children (aged 9 months to 10 years) between 2010 and 2013.

A proposal to eliminate measles by 2020 will be taken up at the Sixty-sixth session of the Regional Committee in September 2013.

**Elimination of maternal and neonatal tetanus**

Yet another success of immunization was the elimination of neonatal tetanus from 9 of the 11 Member States. Progress is being made in the other two countries, India and Indonesia. By 2010, Indonesia achieved elimination of maternal and neonatal tetanus in 31 out of 33 provinces (except Papua and Maluku). India has till date validated elimination status in 18 states.

**Vaccine-preventable diseases and routine immunization**

By 2010, more than 28 million children were immunized in the South-East Asia Region as compared to a little more than 25 million children in 2005. However, more than 8 million children miss out on routine immunization in the Region. On 2 August 2011, the Regional Director convened a high-level ministerial meeting to advocate for increased efforts to address the issue of varying access to routine immunization services throughout the Region, as well as variable coverage within countries. The Delhi Call for Action in September 2011 encouraged all Member States to endorse and declare 2012 as the Year of Intensification for Routine Immunization in the South-East Asia Region. Member States rose to the challenge by developing highly focused acceleration plans for increasing vaccination coverage in hard-to-reach and least-served areas. At the same time, countries also used the opportunity provided by the introduction of new vaccines to further increase and strengthen routine immunization services.

During the past decade, the regional coverage with three doses of diphtheria, tetanus and pertussis (DTP) vaccine reached 90%, though in India, Indonesia and Timor-Leste, the coverage remained below the 90% national-level target.

**Development of new vaccines**

The past decade has been the most productive in the history of the South-East Asia Region and globally in vaccine development. With support from the Regional Office, a conjugate meningococcal A vaccine was developed in India and received authorization for marketing. Similarly, a vaccine for Japanese encephalitis produced in Thailand received market authorization. The Regional Office also supported countries to implement WHO

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**MENAFRIVAC, AN ASIAN VACCINE TO THE AID OF SUB-SAHARAN AFRICA**

The sub-Saharan Africa meningitis belt, comprising 22 countries with more than 400 million population, spans the African continent from the Atlantic Ocean in the west to the Indian Ocean in the east. Meningococcal meningitis yearly brings untold devastation in this so-called “meningitis belt”. Between 1995 and 2004, WHO estimates that more than 700 000 cases and over 60 000 deaths resulted from meningitis outbreaks. A large outbreak in 1996 caused 250 000 cases and about 25 000 deaths. The most recent outbreak occurred in 2009 with more than 80 000 cases, mostly in Nigeria.

An innovative partnership between the Bill and Melinda Gates Foundation, Programme for Appropriate Technology for Health and WHO was formed in 2001 to search for a vaccine to combat this scourge. A world-class vaccine manufacturer in the South-East Asia Region, the Serum Institute of India, rose to the challenge and developed and successfully licensed a meningitis A conjugate vaccine with a price tag of $0.5 only. Mass vaccination targeting people from 1 to 29 years of age began in 2010 with 20 million immunized in 2010 itself, another 54.5 million in 2011, and more than 100 million by December 2012 across 10 countries with a combined population of more than 300 million. By 2016, all countries in this belt are expected to complete mass campaigns with this new vaccine against meningococcal meningitis.

WHO’s epidemiological surveillance reported for the meningitis season of 2012 a total of 22 673 cases and 1931 deaths across 13 countries. Laboratory surveillance indicates that there were almost no Neisseria meningitidis A cases in those countries where vaccination was carried out, and the outbreaks were predominantly due to Neisseria meningitidis W134 and not A. A new vaccine developed fully by a developing country vaccine manufacturer has the potential to eradicate meningitis A epidemics from the sub-Saharan meningitis belt of Africa!
guidelines for the production of oral polio vaccines to become WHO pre-qualified for these.

**Injection safety and vaccine management**

One of the most remarkable achievements in the past decade was the enforcement of safe injection practices with the introduction of auto-disable syringes in the national immunization programmes of all Member States. National programmes have also strengthened their vaccine management processes by upgrading the cold chain infrastructure, and ensuring good storage and distribution practices. This was made possible by the establishment of a training centre on vaccine management in partnership with the Khon Kaen University, Faculty of Nursing, Thailand.

**Introduction of new vaccines and monitoring adverse effects**

Over the past decade, new vaccines have been introduced into national immunization programme schedules. All countries have introduced the hepatitis B vaccine, 9 countries have introduced the *Haemophilus influenzae* type b vaccine, 1 country has introduced the human papillomavirus vaccine and 4 countries have introduced the Japanese encephalitis vaccine. Nine countries have established a national committee for immunization practices, which advises the ministry of health on the issue of new vaccine introduction and other immunization-related technical issues.

With the introduction of new vaccines, the risk of adverse effects following immunization and their reporting have proportionately increased. Following capacity-building by the Regional Office, all Member States have established national committees for adverse events following immunization, which monitor, investigate and conduct causality assessment.

**Strengthening national regulatory authorities**

The South-East Asia Region has grown to become the most important WHO Region in manufacturing and supplying vaccines to immunization programmes globally. In the past decade, India and Indonesia have become the largest producers of vaccines and account for the manufacture of more than 70% of the global need for some vaccines.

The national regulatory authorities in the three vaccine-producing countries, i.e. India, Indonesia and Thailand, have become functional in the past 10 years. The Regional Office also ensured that national regulatory authorities enforce good manufacturing practices for vaccine production and provided technical expertise to develop and

**VACCINE BRINGS HOPE TO END THE SCOURGE OF JAPANESE ENCEPHALITIS IN NEPAL**

Japanese encephalitis is one of the commonest causes of acute encephalitis, a viral infection of the brain that often results in death. Those who survive are left with serious neuropsychiatric sequelae such as paralysis, seizures, blindness or even coma. About 47% of Nepal’s 27 million population resides in the 24 districts of the terai region. Explosive outbreaks of Japanese encephalitis are most common in this region but the disease is prevalent throughout the country except the very high altitude northern region. From 2005 to 2007, there were 5899 cases of acute encephalitis reported, of which 1306 were laboratory confirmed.

A limited effort at vaccination was initiated in 2006. But from 2007, Nepal began an intensive programme of vaccination against Japanese encephalitis using the live attenuated SA14.14.2 vaccine as a single injection. By 2009, all 24 districts in the terai were covered; in 11 districts, all persons aged 1–15 years were immunized, and in 12 other districts, all those aged 1 year or older were immunized. Following the initial mass campaign, the vaccine is now offered to children aged 1 year and above as part of routine immunization and is available almost nationwide.

A review of that vaccination drive showed a tremendous impact on disease epidemiology. In the 4 high-risk terai districts, the observed incidence of Japanese encephalitis was 84% lower than expected; in the 16 moderate-risk areas the observed reduction in the post-vaccination incidence was 45% lower than expected, and was 43% lower in the hill districts. If high coverage of vaccination is sustained, there is every chance that Japanese encephalitis will be a rare occurrence. In the words of a senior government official (in 2010), “Now we can relax and enjoy our puja time in October. Before vaccination began, we were always burdened with Japanese encephalitis outbreaks around this time.”
implement vaccine-regulatory procedures. The Regional Office assisted the national regulatory authorities of Member States to develop institutional development plans that are constantly monitored and updated, and mobilized resources for implementation of these plans. Working reference standards in the Region were established for the production of reference material for the testing of pertussis and Japanese encephalitis.

Moving forward

In order to further increase immunization coverage throughout the Region, access to services needs to be improved for populations located in remote areas and in difficult geographical terrain. Human resource constraints in these areas also need to be addressed. Stronger integration of surveillance systems is an area where synergies need to be mapped to take advantage of existing systems and adapt them to benefit other programmes. Storage capacity for vaccines, distribution systems, inventory control and management plans need to be strengthened so that immunization campaigns and routine immunization activities can be implemented as per schedule.

Adequate funding, both domestic and external, needs to be ensured to support immunization activities, so that shortages or delays in supply do not occur. Growing opportunities through new funding as well as research and development initiatives should be prioritized in the coming years as more immunization programmes mature and the number of basic vaccines offered through routine immunization schedules increases.

Research is an area that needs to be prioritized. Although biotechnology companies, pharmaceuticals and industry are actively engaged in various important research projects throughout the Region, a clear and well-thought out research agenda setting out priority areas and covering different stages is needed.

As new technologies and predictable funding improve manufacturing capacity to increase the production of new vaccines, we must continue to emphasize the importance of ensuring that routine immunization is equitable and its coverage is uniform throughout each country as well as across the Region. Simultaneously, the Regional Office will need to ensure that it continues to provide Member States with technical assistance and access to evidence-based data and disease burden surveys to establish the feasibility of introducing new vaccines while assessing their financial sustainability. Efforts will also be needed to increase public awareness and ensure that the general public understands the benefits and safety of vaccines and how immunization saves lives.
Emerging from the haze
Towards a tobacco-free world

Tobacco use is the single largest cause of preventable death globally. The global tobacco epidemic kills nearly 6 million people each year, of which more than 600,000 are non-smokers dying from breathing secondhand smoke. In the South-East Asia Region, tobacco use causes about 1.3 million deaths annually. It harms nearly every organ in the human body and increases manifold the chances of developing coronary heart disease, stroke, lung and other cancers, and chronic obstructive pulmonary disease. It also has adverse effects on reproductive health and early childhood development.

The Region is among the major producers and consumers of tobacco, and has about 250 million smokers and roughly the same number of smokeless tobacco users. Controlling and preventing the use of tobacco is thus an urgent public health concern. Present and future generations must be urgently protected from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to secondhand smoke.

Public education on the hazards of tobacco as well as on national policies on tobacco control is very important. People should also be made aware of the techniques adopted by the tobacco industry to interfere with tobacco control in our countries.

Understanding the tobacco industry’s practices is crucial for successful tobacco control policy formulation. In this context, it is important also to understand that tobacco products are the only legally available products that can kill up to one half of their regular users if consumed as recommended by the manufacturer.

—DR SAMLEE PLIANBANGCHANG

Excerpt from a speech on World No-Tobacco Day, 31 May 2012

Key achievements in the past decade

- Ten of the eleven Member States have ratified the WHO Framework Convention on Tobacco Control, the first international treaty negotiated by the World Health Organization.
- Ten Member States have adopted comprehensive tobacco control legislations and one Member State is in the process of doing so.
- Ten Member States have established Global Tobacco Surveillance Systems. These include the Global Youth Tobacco Survey, the Global School Personnel Survey, the Global Health Professions Students Survey and the Global Adult Tobacco Survey. Data on tobacco use among youth and adults and its trends are available for many countries. Country-wise and regional estimates for tobacco attributable mortality have been estimated.
- Since 2012, countries are using standard Tobacco Questions in Surveys (TQS) in national health surveys.
- Bangladesh, India, Indonesia and Thailand now have legislation that requires large pictorial health warnings on tobacco packs.

The WHO Framework Convention on Tobacco Control (WHO FCTC)

Tobacco control is based upon an underlying ethical framework that recognizes the rights of persons to life, health and freedom. Alarmed by the growing use of tobacco worldwide and to reduce the enormous global burden of tobacco-related diseases and deaths, WHO successfully negotiated its first international treaty, the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2003, which entered into force on 27 February 2005. This evidence-based treaty reaffirms the right of all people to the highest standard of health and sets an international floor for tobacco control. By implementing the tobacco control measures in the WHO FCTC, governments can reduce the heavy burden of disease and death that is attributable to tobacco use.
or exposure to secondhand smoke. Parties to the Convention are obliged to implement the WHO FCTC by adopting tobacco control laws, regulations, administrative decisions and other actions as enforcement measures.

**Adopting tobacco control legislations/policies and measures**

The Regional Office supported countries in the four-year long process of negotiating the WHO FCTC. Till date, 10 of the 11 Member States have ratified the Convention. To implement the WHO FCTC, the Regional Office developed a Regional Strategy for Tobacco Control, which was adopted by Member States in 2005, and updated in 2012. Ten Member States have adopted comprehensive tobacco control legislations and one Member State is in the process of doing so. Implementation of policies and public health interventions on tobacco control have increased and gained momentum during the past decade.

**The Global Tobacco Surveillance System**

In 1998, WHO, the Centers for Disease Control and Prevention and the Canadian Public Health Association initiated the Global Tobacco Surveillance System (GTSS) to assist countries in establishing surveillance and monitoring programmes for tobacco control.

**REDUCING THE USE OF SMOKELESS TOBACCO IN INDIA**

In many Member States, smokeless tobacco use is high among both men and women. In India, nearly 90% of oral cancer is caused by SLT use, and it has also been found to contribute to cardiovascular diseases. A commonly used form of SLT in the Region is gutkha, a preparation of crushed areca nut, tobacco, catechu, lime and flavouring agents. Gutkha is widely sold across India in small, low-cost, individual packets.

In 2010, the Supreme Court banned the use of plastics in gutkha packaging after determining that it was an environmental hazard. This decision, upheld in March 2011, paved the way for banning gutkha itself, since most gutkha is sold in plastic sachets. The government and civil society came together to plan an approach for banning gutkha for health reasons. The Supreme Court also directed the Government of India to undertake an analysis of the contents and harmful effects of SLT. The Ministry of Health and Family Welfare (MoHFW), in consultation with experts, prepared a comprehensive report on SLT and areca nut and submitted it to the Supreme Court in February 2011. In April 2011, the MoHFW and WHO organized a national consultation on SLT, which recommended progressive restrictions, including bans on all SLT including gutkha.

A firm basis for banning gutkha was established when the Supreme Court ruled in 2004 that products such as gutkha and pan masala are indeed food products. To support implementation of these regulations, the MoHFW sent letters to state governments to initiate action at their end. Civil society has played a catalytic role in advocacy to create support for implementation of the regulations. Advocacy by Voices of Tobacco Victims (VOTV), comprising individuals suffering from the visible effects of tobacco use, provided a much-needed impetus. Directors of all Regional Cancer Centres also sent letters to the Prime Minister seeking a gutkha ban. Political support was garnered through the Chief Ministers of 11 states and hundreds of other leaders who signed pledges to ban gutkha. Members of legislative assemblies were sensitized by VOTV on the harms of gutkha, and sustained media coverage was generated.

The State of Madhya Pradesh became the first state to issue orders to implement Regulation 2.3.4, thereby banning the sale and storage of gutkha from April 2012, and has since cancelled the licenses of gutkha manufacturers and confiscated vast quantities of gutkha. As of April 2013, 28 States and Union Territories have banned gutkha. In some states, the ban also extends to pan masala. Further, three High Courts have dismissed petitions challenging the ban and have ruled in favour of the implementation order.

Measures to ensure effective enforcement of the ban are crucial. Enforcement efforts in states that first adopted the ban are being studied so that lessons can be shared. There can be no doubt that the success of these measures will have a wide-ranging impact on reducing mortality and morbidity in India from diseases such as oral cancer, and may also be a model that other countries in the Region can replicate.
control. The GTSS aims to enhance a country’s capacity to design, implement and evaluate tobacco control interventions, and monitor key articles of the WHO FCTC and components of the WHO MPOWER technical package.

The GTSS includes the collection of data through four surveys: the Global Youth Tobacco Survey (GYTS); the Global School Personnel Survey (GSPS); the Global Health Professions Students Survey (GHPSS) and the Global Adult Tobacco Survey (GATS). The first three are school-based surveys, while the GATS is a nationally representative household survey that monitors tobacco use among adults aged 15 years and older.

The WHO FCTC requires Parties to regularly collect national data on the magnitude, patterns, determinants and consequences of tobacco use and exposure. To fulfil the obligations of the WHO FCTC, 10 Member States have established GTSS. The Regional Office built the capacity of Member States and helped them to implement the questionnaires of the GYTS, GSPS, GHPSS and GATS. A Regional Strategy for utilization of the GYTS data, developed by the Regional Office, was adopted by Member States in the Region in 2005. The Regional Office helps countries to analyse the data obtained from these surveys using standard global protocols, following which they are widely disseminated and used for action. Data on tobacco use among youth and adults and its trends are available for many countries. Country-wise and regional estimates for tobacco attributable-mortality have been estimated. Since 2012, countries are using standard Tobacco Questions in Surveys (TQS) in national health surveys on the basis of the Regional Strategy to Utilize Standard TQS.

**USE OF PICTORIAL HEALTH WARNINGS ON CIGARETTE PACKS BY COUNTRIES**

Thailand has mandated graphic health warnings since 2005, starting with 50% of both sides of a cigarette pack. In 2010, a third set of 10 pictorial health warnings, used in rotation, was implemented, which covered 55% of the front and back of cigarette packs, with five pictorial warnings, used in rotation, on cigars covering 50% of the packet. Two pictorial warnings on roll-your-own cigarettes will soon be implemented. Since 2006, a warning of toxic substances in cigarette emissions is required on 50% of both sides of the lesser sized panels of cigarette packs. In 2010, the national quitline number was required to be printed on the pack. In 2013, new regulations were passed, which require health warnings that would occupy 85% of the tobacco package. Implementation will commence by the end of 2013 and, once implemented, Thailand would have the distinction of having the largest health warnings on cigarette packs of any country in the world.

Other countries in the Region have also taken similar measures. Nepal has recently passed legislation mandating pictorial warnings that cover 75% of the front and back of all tobacco products, including smokeless tobacco. In India, pictorial health warnings have been implemented since 2009. From December 2011, the warnings have been strengthened, particularly for smokeless tobacco products, and the next set of warnings will be even more graphic. Currently, the warnings are required to cover 40% of the package and appear on the front of the package. In December 2012, legislation was passed in Indonesia which requires health warnings that cover 40% of each side of the package. WHO has helped to facilitate sharing of images among countries, and several of the pictorial health warnings that Indonesia has chosen for use are from Thailand. Other countries in the Region are also in the process of implementing pictorial health warnings.
Countering the health and economic costs of tobacco use

The costs of tobacco use are measured by its enormous toll of disease, suffering and family distress. Tobacco products are the only legally available products that can kill up to one half of their regular users if consumed as recommended by the manufacturer. Economies also suffer from increased health-care costs and decreased productivity. Understanding the tobacco industry’s practices is crucial for the success of tobacco control policies.

Health warnings on tobacco packages that combine text and pictures are one of the most cost-effective ways to increase public awareness of the serious health risks of tobacco use and to reduce tobacco consumption. Use of graphic images demonstrating the harm
of tobacco use can be especially effective in convincing users to quit. Several Member States have adopted pictorial health warnings on the tobacco packages.

There is now a better understanding of how to reduce the economic costs of this deadly epidemic. Demand-reduction policies such as higher taxes and comprehensive bans on tobacco marketing and smoking in public places are among the principal cost-effective means to reduce tobacco use and its consequent harms to health and economic development. The Regional Office has provided technical support to Member States to strengthen their tax structures and increase tax on tobacco products harmoniously for all forms of tobacco products and adjust to inflation. While tax on manufactured cigarettes has been considerably increased, increasing taxes on bidis and smokeless tobacco remains a challenge. An expert group consultation was organized by the Regional Office on smokeless tobacco use and its implications, innovative health financing through tobacco taxation, and tobacco and trade.

**MPOWER package**

To reduce the health and economic costs of tobacco use and counter the tobacco industry’s practices, WHO introduced MPOWER, a package of technical measures and resources, each of which corresponds to at least one demand-reduction provision of the WHO FCTC. The six components of MPOWER are – Monitor tobacco use and prevention policies, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce bans on tobacco advertising, promotion and sponsorship, and Raise taxes on tobacco. MPOWER package

A very important advocacy tool is the annual “World No-Tobacco Day” on 31 May. This provides an opportunity to focus on raising awareness on different aspects of tobacco control. Technical and information materials on the consequences of tobacco use are prepared and widely disseminated. For 2013, the theme was “Ban tobacco advertising, promotion and sponsorship”.

**Moving forward**

Community awareness of the dangers of tobacco use, benefits of quitting and of existing tobacco control laws in Member States must be promoted much more energetically, so that everyone is aware of these. Tobacco control legislations must be strictly and widely enforced, and swift and strict action taken against offenders.

In Member States, National Tobacco Control Committees include sectors other than health such as education, finance, home, legal offices, customs, trade, information and broadcasting, youth and sports, among others. Strengthening such intersectoral collaboration will help to extend the reach and efficacy of tobacco control programmes.

Countries should continue to conduct the various global tobacco surveys and identify trends in tobacco use, so that corrective action can be taken. The integration of tobacco questions in ongoing national health surveys is a step in this direction.

The Protocol to Eliminate Illicit Trade in Tobacco Products, adopted by the Parties to the WHO FCTC in November 2012, was opened for signature by the Parties at WHO headquarters. The new international treaty is aimed at combating illegal trade in tobacco products through control of the supply chain and international cooperation. One Member State from the Region has signed the Protocol and other Member States are in the process of signing it.
We couldn’t have done it alone!

The Bloomberg initiative in the South-East Asia Region

Each year, tobacco kills almost 6 million people, including over 600,000 individuals exposed to secondhand smoke. It also causes hundreds of billions of dollars of economic losses worldwide every year. Unless urgent action is taken, tobacco-related deaths will increase to more than 8 million per year by 2030. More than 80% of those deaths will be in low- and middle-income countries.

In 2006, Michael Bloomberg, philanthropist and Mayor of New York City, launched a $125 million global initiative to reduce tobacco use in low- and middle-income countries, where the tobacco burden is the highest. Since then, total commitments have come to more than $600 million to date. The Bloomberg Initiative is the largest coordinated effort to reduce the harm caused by tobacco around the world, focusing on reducing the public health impact of tobacco use globally by implementing evidence-based tobacco control policies in low- and middle-income countries. Priority was given to the 15 countries with the largest number of smokers. Based on this criterion, four countries in the South-East Asia Region were chosen as Bloomberg Initiative focus countries: Bangladesh, India, Indonesia and Thailand.

WHO was chosen to be an implementing partner in this initiative and has the responsibility for serving as a coordination mechanism at country level, helping governments to develop national tobacco control plans, pass and enforce key laws, and implement effective policies and tobacco control measures. The other implementing organizations are: Campaign for Tobacco-Free Kids, Centers for Disease Control and Prevention (CDC) Foundation, International Union against Tuberculosis and Lung Disease, Johns Hopkins Bloomberg School of Public Health, and the World Lung Foundation.

Through this unique partnership, The Bloomberg Initiative in the South-East Asia Region has reinforced the tobacco control work of governments and key nongovernmental organizations, helped put tobacco control in the media spotlight and has strengthened the multisectoral approach to tobacco control. All Bloomberg countries have now implemented WHO’s MPOWER package, which is a set of evidence-based measures, each of which corresponds to at least one demand-reduction provision of the WHO Framework Convention on Tobacco Control (WHO FCTC). Since the start of the Bloomberg Initiative, each of the priority countries in the South-East Asia Region has passed comprehensive tobacco control legislation, which includes protection from secondhand smoke, bans on tobacco advertising and effective health warnings. A major achievement in this regard is that Bangladesh, India, Indonesia and Thailand now all have legislation requiring large pictorial health warnings on tobacco packages.

All countries have also put in place major mass media campaigns to warn against the dangers of tobacco. With leadership from WHO and CDC, tobacco surveillance has been heightened and all countries have now implemented the Global Adult Tobacco Survey (GATS), with several of the countries conducting the second round of surveys. These data have been used successfully in all of the priority countries to press for more effective tobacco control legislation. Partner organizations have also worked very effectively together on increasing taxes on tobacco products, which is one of the most important measures for reducing consumption and preventing initiation of tobacco use among youth. An array of training workshops was conducted for government and NGO participants. In addition, the Johns Hopkins Bloomberg School of Public Health runs the Global Tobacco Control Leadership Program, a two-week intensive training programme for individuals working in tobacco control from the government or NGO sector.
Millions of people worldwide are affected by mental, neurological and substance use disorders. According to WHO estimates, these disorders accounted for 13% of the global burden of disease in 2004. The good news, however, is that noncommunicable diseases, including mental, neurological and substance use disorders, can be controlled and treated by available health interventions through a primary health-care approach. Through these interventions and approaches, the underlying risk factors and determinants of these conditions can be addressed.

—DR SAMLEE PLIANBANGCHANG

Excerpt from a speech delivered at the Regional Meeting on Noncommunicable Diseases, including Mental Health and Neurological Disorders, 24–26 April 2012, Yangon, Myanmar

Key achievements in the past decade

- The five “A’s” strategy (Availability, Acceptability, Accessibility, Affordable medications and Assessment) has been shown to reduce the treatment gap for epilepsy in Bangladesh, Bhutan, Myanmar and Timor-Leste. Using this strategy at the national level will substantially reduce the treatment gap for epilepsy countrywide.
- The Mental Health and Substance Abuse Unit of the Regional Office has developed a step-wise validated screening instrument for the identification of generalized tonic–clonic seizures.
- A cross-cultural instrument for identification of depression and psychosis at the primary-care level has been developed, which will improve patient identification, treatment and management.
- Two Member States (Sri Lanka and Thailand) have developed and implemented alcohol control measures.

Mental health, neurological disorders and substance abuse

Mental health includes emotional, psychological and social well-being. Ensuring mental health is related to the promotion of well-being, prevention of mental disorders, and treatment and rehabilitation of people affected by mental disorders. WHO qualifies mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. While WHO has made significant progress in addressing mental illness in the past decades, more recently, it has also focused attention on the distinct need for promoting mental well-being, as it is a positive resource in promoting health.

Mental and neurological disorders are highly prevalent worldwide, affecting every community and age group across all incomes. One person in every four will be affected by a mental disorder at some stage of life. While mental and neurological disorders are responsible for about 1% of deaths, they account for almost 13% of disease burden the world over. Of these, 75% is in low-income countries. This huge burden of neuropsychiatric disorders is a challenge in the backdrop of limited resources, including funds, infrastructure and trained human resources.

People with mental disorders around the world are exposed to a wide range of human rights violations. The stigma and discrimination they face means that they are often ostracized and fail to receive the care they require.
Promotion of mental well-being

WHO is the foremost international agency working to promote mental well-being on a sustained basis. Promotion of mental well-being is a strategy to improve health, and should be considered as a continuum or spectrum, rather than a state that is either present or absent.

In the area of Mental Health and Substance Abuse, the Regional Office advocates a community-oriented approach to the promotion of mental well-being. A step-wise process for programme development in the area of mental health has been initiated. A broad process of consultation was initiated by the Mental Health and Substance Abuse Unit in 2008. At a meeting of experts in June 2009, it was decided to promote mental well-being as a public health strategy at individual, group and community levels, and assess the feasibility and means of incorporating mental well-being in national, state and local policies. A Regional Workshop on Promoting Mental Well-being in October 2009 recommended the need for identification of practical and effective measures for implementation.

Several broad approaches, such as health promotion, cultural and spiritual approaches, and programmes that address stigmatization and social exclusion, have proven to be successful in promoting mental well-being within Member States. Practical and effective measures that could be implemented in the Regional context have been identified, as well as strategies for the promotion of mental well-being in schools, workplaces, communities and other settings. The Regional Office has put forth the concept of primordial prevention, which implies that risk factors for mental illness, such as stress leading to depression, should not develop. Traditional practices such as yoga, meditation and vipassana, widely used for centuries in Member States (Bhutan, India, Myanmar, Nepal, Sri Lanka and Thailand), are also being promoted. Meditation and spirituality play an important role in improving mental health, as these approaches have a high level of acceptance in most parts of the Region.

MEASURING MENTAL WELL-BEING THROUGH GROSS NATIONAL HAPPINESS

Bhutan is the first country in the world to officially institute an index that measures happiness (Gross National Happiness Index – GNI), rather than economic expansion as the main indicator of progress in the country. The former Planning Commission of Bhutan has been renamed the Gross National Happiness (GNH) Commission, with the authority to allocate resources to different sectors of government. Thus, the concept of GNH is being operationalized at the highest level in the country. GNH surveys are carried out every two years to assess progress and sharpen policy interventions. In addition, a policy screening instrument has been developed to measure the impact of any proposed policy on GNH. This is used to select GNH-enhancing policies and projects, and reject those that adversely affect key indicators of GNH. It is also used as a tool to orient policy-makers and planners towards the GNH frame of thinking.

THAI MENTAL HAPPINESS INDEX

The Thai Health Promotion Foundation has funded a project to institute a Happiness Index in Thailand. This index is measured countrywide by the National Statistical Office and is analysed by the Mahidol University. This is a 15-item index through which determinants that affect mental well-being are measured. In addition to individual- and family-level factors, it also takes into account factors such as available infrastructure and economic issues. Surveys, carried out every two years, have already identified factors that hinder mental well-being at the provincial level. Interestingly, the surveys have found that individuals living in high-income provinces were less happy than those living in other provinces.

Mental and neurological disorders

Treatment of mental and neurological disorders is inexpensive, effective and available. However, despite this, a large proportion of people, particularly in rural and remote areas, are not getting appropriate treatment and care. Studies in the Region show that there is a huge treatment gap (defined as the percentage of patients in need of, but not getting, appropriate medical care), ranging from 87% to 95% for patients with epilepsy, and 25% to 98% for patients with psychosis.

Reducing the treatment gap

Experience in Member States of the Region shows that by strengthening the primary health-care system, mental and neurological disorders can be optimally treated and treatment can be made available to more persons in need. These programmes are sustainable as they are mainstreamed into existing national health-care delivery systems. The
Regional Office has been working with regional experts on a strategy to provide appropriate care for persons with mental and neurological disorders through the existing primary health-care systems by training village-based health workers to identify and manage the most common and most disabling mental and neurological disorders using a validated screening questionnaire. Once identified, patients are taken to the nearest primary health centre-based doctor who has been trained to provide appropriate treatment.

The strategy for community-based programmes is based on five “A’s”: Availability, Acceptability, Accessibility, Affordable medications and Assessment. The conditions being addressed in the first phase of the programme include epilepsy, psychosis and depression.

**Addressing epilepsy**

Pilot projects have shown that strengthening the primary health-care system through training and continuous supply of medications has successfully reduced the treatment gap for epilepsy in Bangladesh (from 87% to 5%), Bhutan (from 40% to 26%), Myanmar (from 84.6% to 5%) and Timor-Leste (from 70.7% to 53.7%). Thailand is also conducting such projects. The findings have helped to set trends in the health research agenda in these countries. Scaling up these projects at the national level will substantially reduce the treatment gap for epilepsy countrywide. Other Member States in the Region could adapt these projects to suit their needs.

The MHS Unit has also developed several technical materials on epilepsy for community-based health workers and physicians, including a step-wise validated screening instrument for the identification of generalized tonic-clonic seizures.

**Addressing depression and psychosis**

Depression is a major cause of disease burden. However, most people with depression are not identified or diagnosed and therefore not treated.

Among psychiatric disorders, psychosis is one of the most disabling conditions and contributes substantially to the social and economic burden related to mental illness. The disease burden can be significantly reduced with early diagnosis and treatment. The common, widely used scales for identification of depression have limited utility in a cross-cultural setting. To address these cultural variations, the MHS Unit is supporting the development of a cross-cultural depression and psychosis identification instrument, which will improve patient identification, treatment and management in the primary-care setting by trained health workers. These projects are expected to be completed by the end of 2013.

**Scaling up care**

The pilot projects on reducing the treatment gap sponsored by the Regional Office have clearly shown that the strategy of strengthening the existing primary health-care system to address mental and neurological disorders directly reaches out to more people in need of care, including persons in rural and remote areas. Through this strategy, services are provided to the community at the doorstep with minimal extra investment in infrastructure, and draws upon the existing human resources based in the primary health-care setting. The only additional resources required are for training and empowering the existing primary health-care system. However, governments need to ensure a continuous supply of psychotropic medications.

The Regional Office advocates scaling up pilot projects in Member States where they have already been implemented to other sites across the country. Those Member States that have not tested this strategy could consider adapting and then adopting the programme. The technical tools to implement the strategy have already been developed and are available with the Regional Office.

**Reducing harm from alcohol use**

The Region has a low but increasing level of alcohol use. Alcohol use, even occasional use, leads to a diverse range of medical, social, psychological and economic harm. These affect not only the individual but also the family and community. Harm from alcohol use is increasingly being recognized as a matter of public health concern in the Region.

In order to successfully implement alcohol control strategies, the Regional Office has been active in conducting advocacy at the highest level of government, and developed a number of information and advocacy materials on alcohol use to create awareness in the community and among policy-makers. It has also held numerous intercountry workshops to discuss the actions that can be taken to reduce harm.

The Regional Office has completed a programme to acquire and synthesize information for developing and implementing interventions on the harms from alcohol use through community action in six Member States (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand). The data from these surveys have been instrumental in developing national policies and guidelines.

The Regional Office is providing technical assistance to Member States to adapt and implement components of the Global Strategy to reduce the harmful use of alcohol. Two Member States (Sri Lanka and Thailand) have developed and implemented alcohol control measures.
THE IMPACT OF HARM FROM ALCOHOL USE

Findings from a study of alcohol users in Bangalore, India:

- individuals spent more on alcohol than what they earned;
- most people took loans to support their habit;
- an average of 12.2 working days per year were lost;
- in one year, 18.1% lost their jobs;
- income from other family members was needed to support 59.4% of families;
- of those with children below 15 years, 9.7% sent their children to work to supplement family income.

Source: Benegal and Velayudan, 2000

COMBATING THE USE OF ALCOHOL: COUNTRY EXPERIENCES

In Nepal, a health tax fund established in 1997 from the sale of alcohol and tobacco products results in the collection of US$ 5 million per year, which is used for free treatment of noncommunicable diseases for the poor.

In Bhutan, alcohol is intimately embedded in the people’s way of life since ancient times. It is a leading cause of morbidity and mortality, domestic violence, divorce and road traffic accidents. Approximately 20% of food grains in the country are used to brew alcohol. A community-based programme implemented in six basic health unit areas of Bhutan showed a reduction in alcohol use by 70% and improvement in food security. At present, the cost of a funeral in Bhutan is around Nu 33 000 (US$ 549), which includes serving alcohol and meat at funerals. A rule implemented by the local monk and district administration forbids serving meat and alcohol during funerals. This brings down the cost of a funeral to Nu 3000. This policy alone, if implemented all over Bhutan, can save Nu 60 million (US$ 11 million) annually.

A community-based programme to reduce harm from alcohol use was carried out in a rural community of over 1000 families in Sri Lanka with help from the Regional Office. The factors that increase the attractiveness of alcohol use and availability of alcohol were addressed by the community. Serving alcohol at weddings has completely stopped. Two years later, an evaluation showed that the programme is being sustained by the community.

A programme targeted 116 households with alcohol users in two villages in Lop-Buri Province of Thailand. An innovative idea of saving money in a money-box was implemented, in which families were encouraged to put the cost of one bottle of alcohol into the money-box voluntarily. The family that saved the maximum amount of money in a month was given a reward by the head monk of the village. Evaluation showed that the villagers had increased their savings and reduced alcohol use and related harms.

Moving forward

Sustained advocacy with policy-makers, planners and programme managers will be needed to generate awareness among them of the urgent need for promoting mental and neurological health, reducing alcohol use, and allocating adequate human and financial resources in the area of mental health. Central to all activities is operationalizing the concept of mental well-being as a public health strategy.

Alcohol use is deeply ingrained in some societies in the Region. Evidence-based and culturally appropriate strategies need to be developed and successful models piloted, adapted and scaled up. This should be preceded by promoting increased awareness of the harms of alcohol use.

The World Health Assembly at its Sixty-fifth session in May 2012 adopted resolution WHA65.4 on “The Global Burden of Mental Disorders and the Need for a Comprehensive, Coordinated Response from Health and Social Sectors at the Country level”, calling on WHO to develop a comprehensive mental health action plan 2013–2020. The comprehensive Mental Health Action Plan 2013–2020 has been developed by WHO and approved by the Sixty-sixth session of the World Health Assembly in May 2013.
Towards utopia
Gender, equity and human rights

The Constitution of WHO was the first international instrument to enshrine the enjoyment of the highest attainable standard of health as a fundamental right of every human being (“the right to health”), and states, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Violations or lack of attention to human rights can have serious health consequences, while vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights.

In 1997, the United Nations adopted a policy of mainstreaming human rights into all work of the UN. Since then, WHO has placed increased emphasis on operationalizing human rights principles in all programmes that focus on health development as well as in humanitarian work.

The WHO South-East Asia Region recognizes gender-based violence as a public health problem. Governments of Member States of the Region are aware of the rising prevalence of violence of all types and have established structures and mechanisms to prevent violence and provide care for the victims. WHO, United Nations agencies and partners are supporting Member States’ efforts, particularly in the formulation of policies, strategies and interventions that effectively address health issues of women including violence against women, as well as in building country capacity and creating evidence. In its pursuit to achieve Millennium Development Goal 3 (Promote gender equality and empower women), WHO is also supporting multisectoral activities that raise public awareness and develop interventions related to human rights, gender and women’s health and empowerment.

—DR SAMLEE Plianbangchang


Key achievements in the past decade

- The Regional Office celebrated Human Rights Day on 10 December 2010 under the theme of “Speak Up... Stop Discrimination” and conducted a number of targeted activities aimed at increasing awareness.
- Gender issues have been integrated into the pre-service and postbasic medical education programmes on a pilot basis in Member States.
- Most countries now integrate gender concerns into normative programmes.
- Gender and reproductive issues have been appropriately integrated into the emergency preparedness plans of all countries.
- The Regional Office supported the Government of India to prepare a report to the Committee on the Rights of the Child, one of the United Nations human rights treaty bodies.
- In 2011, the Regional Office published a report on the Right to health in the WHO South-East Asia Region, which examined references to the “right to health” in the constitutions of the 11 Member States of the Region. All Member States’ constitutions refer to health as a right or as a constitutional obligation of the State.
- All Member States have ratified at least two international human rights treaties, and all have health-related human rights obligations in their domestic legislation.
Health and human rights

The Regional Office advocates with Member States to promote health-related human rights, facilitate understanding of a human rights-based approach, and promote understanding of the relevance of human rights to national health policies and programmes. A rights-based approach to health assesses and addresses the human rights implications of health policies and programmes, and integrates human rights in the design, implementation, monitoring and evaluation of health policies and programmes.

In July 2005, the Regional Director established a Coordinating Group on Health and Human Rights. This Group was charged with advocating and advancing the “right to health” concept in countries of the Region and mainstreaming the “right to health” approach into national health policy and action in Member States.

As part of its advocacy programme, the Regional Office celebrated Human Rights Day on 10 December 2010 under the theme of “Speak Up... Stop Discrimination” and conducted a number of targeted activities aimed at increasing awareness. It also developed several new information materials on health and human rights.

As a follow-up to advocacy, the Regional Office supports countries to build their capacities to design and implement health policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches. It builds capacity by facilitating orientation and training on health and human rights for ministries of health, national human rights commissions and other stakeholders; providing technical assistance for programming in human rights to health; developing human rights advocacy material; and commissioning research on topics related to health and human rights.

In 2011, two specially designed training programmes were organized on health and human rights in Dhaka, Bangladesh and Jakarta, Indonesia. As a result, both countries now apply a human rights-based approach to other technical areas of work as well, such as in the area of reproductive and sexual rights, and maternal and neonatal health in Indonesia, and adolescents’ sexual and reproductive health in Bangladesh.
Gender-based violence and women’s health

Gender-based violence is recognized as a public health problem in almost all Member States of the Region. Country fact sheets published in 2012 showed that women and girls are the victims of violence more often than men and boys, and that domestic violence is the most common type of violence. As many as one in five women between the ages of 15 and 24 years and one in six women between 40 and 49 years could be subjected to violence from their intimate partners/husbands.

In order to address the issues of gender-based violence and women’s health, the Regional Office focuses mainly on two areas: assisting Member States to document and prevent gender-based violence and addressing women’s low access to health-care services. The WHO country gender focal points along with stakeholders in each country address policy issues by promoting women’s education and empowerment, especially among poor and marginalized women, and the rights of women to voice their own health needs, the services they want and access to quality health care.

Gender issues have been integrated into the pre-service and postbasic medical education programmes on a pilot basis in Member States. The tsunami experience of December 2004 highlighted the need for mainstreaming gender concerns in emergency preparedness plans, and gender and reproductive issues have been appropriately integrated into the emergency preparedness plans of all countries. The strategy for integrating gender analysis and actions in WHO’s work adopted at the World Health Assembly in 2006 has expanded and institutionalized WHO’s capacity to analyse the role of gender and sex in health, and to monitor and address systematic and avoidable gender-based inequalities in health.

An international annual campaign against gender-based violence is the 16 Days of Activism Against Gender Violence, which starts on 25 November, International Day for the Elimination of Violence against Women, and ends on 10 December, Human Rights Day. The campaign hopes to raise awareness about gender-based violence as a human rights issue at the local, national, regional and international levels. In 2012, 16 questions related to gender-based violence, human rights and HIV/AIDS were posted on the intranet to educate staff and “end violence against women”.

In 2012, WHO identified the need for mainstreaming gender, equity and human rights as a priority in cross-cutting WHO programmes. To this end, the Regional Director appointed a Regional GER task force. The Regional Office’s effort at this stage is to build the capacity of WHO staff and support them to integrate GER in programmes. This will ensure that health services are designed to promote the right to health and enhance accessibility to quality services by all, regardless of sex and other determinants. The policy of mainstreaming gender, equity and human rights in WHO programmes will help to integrate all three issues in a systematic manner. With support from the Regional Office, most countries now integrate gender concerns into normative programmes.

In the area of women’s health, the focus now is on the health of women beyond reproductive health. In 2013, the Regional Office is working on country data on women’s health, services needed and services received to be able to design health systems that meet the needs of women and increase women’s utilization of health services.

Child, maternal and newborn health

In the area of child health, the Regional Office published The Convention on the Rights of the Child for health professionals. In India, it supported the Government to prepare a report to the Committee on the Rights of the Child, one of the United Nations human rights treaty bodies. The Regional Office is providing assistance for the development of a human rights-based tool for maternal and newborn health in Indonesia.

Health, human rights and the law

In 2011, the Regional Office published a report on the Right to health in the WHO South-East Asia Region, which examined references to the “right to health” in the constitutions of the 11 Member States of the Region. The document includes an overview of the status of the right to health in Member States, as well as a compilation of all right-to-health provisions in each Member State’s constitution.

All Member States’ constitutions refer to health as a right or as a constitutional obligation of the State. All Member States have ratified at least two international human rights treaties, and all have health-related human rights obligations in their domestic legislation.

The Indian Law Society (ILS) Law College is a WHO Collaborating Centre in Pune, India. The collaboration resulted in an International Diploma in Mental Health Law and Human Rights, offered at the ILS Law College. This is a key example of higher-level human rights education in the Region. In Indonesia, work is ongoing to introduce new tools developed by WHO which assess whether laws and policies uphold human rights.
Moving forward

As a specialized United Nations organization, WHO has several policy commitments to integrate human rights into public health work under various frameworks. However, despite a decade of advocacy and capacity-building efforts, a human rights-based approach has remained a somewhat unknown and underutilized concept within WHO. With ongoing efforts to mainstream gender, equity and human rights in its work, WHO should be able to better address and enhance gender equality, human rights protection and equity to achieve health for all.

Health as a human right is already expressed in national policies, constitutions and agendas of most Member States. However, implementation of human rights principles and a human rights-based approach to health needs to be strengthened further in medical schools and health-care facilities, and in health programmes and planning.

Key entry points need to be identified for human rights interventions in the South-East Asia Region. Particular efforts need to be geared towards enhancing WHO Country Office capacity to support countries in incorporating gender, equity and human rights within their national strategic health plans, other policies and activities on the ground, and monitoring efforts.

In the future, technical collaboration will need to be strengthened on health, human rights, gender and equity to provide a comprehensive analysis of the social determinants of health in selected areas of health and disease control and prevention. The Regional Office will support countries to develop a sex-disaggregated data collection system and gender analysis in health reports, and develop effective gender-responsive health strategies.
The number of people living in cities is rapidly increasing and it will be one of the most challenging global issues in the twenty-first century. One major reason for this rapid urbanization is rural-to-urban migration for better opportunities. But cities not only concentrate opportunities but also comprise risks and hazards for health. Rapid and unplanned growth of cities has major social, political, economic and environmental implications. Unplanned urbanization leads to inequities and crisis in urban health and the most vulnerable population is the urban poor.

—Dr Samlee Plianbangchang

Excerpt from message delivered at the Regional Workshop on Urban Health Equity Assessment and Intersectoral Responses, New Delhi, India, 27-29 November 2012

Key achievements in the past decade

- In collaboration with the WHO Kobe Centre, the Urban Health Equity and Response Tool (UrbanHEART) was developed in 2009. Two cities in the Region (Jakarta and Colombo) participated in the development of the tool, which provides technical guidance on how to identify health inequities in urban areas and how to process multisectoral actions to respond to the underlying causes.
- A number of Member States have taken action to address social disparities and health inequity through public policies, health programme interventions, health systems development, universal health coverage, governance and social participation.
- The Regional Office, along with other regional offices and WHO headquarters, developed a Global Plan of Action 2012-2017 to support Member States in implementing the Rio Political Declaration on Social Determinants of Health.

The social determinants of health: “causes of the causes”

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. They are complex elements that influence the health of the population, particularly in lower- and middle-income countries, and are the “causes of the causes” of health and illness. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. In the South-East Asia Region, gender imbalance, urbanization and rapid development are some of the factors that are threatening to further increase health inequities among the population.

Causes of inequities in the South-East Asia region

Sociodemographics and gender inequity

Countries in South-East Asia are undergoing a phase of sociodemographic transition, due to which the elderly population is increasing. Women tend to live longer than men, and for those women who have not been socially and economically active during their productive years, the quality of life is likely to deteriorate. The dependency of such women places them in a vulnerable situation with regard to economic and social security. Social welfare schemes and universal access to health are available in only a few countries of the Region.

Urbanization and health inequity: hidden cities

The Region is home to more than 1.8 billion people, 34% of whom live in urban areas. Of these, one fourth...
lives in poverty and difficult circumstances. It is estimated that, by 2050, about 42%–65% of the population will be living in urban areas. Urbanization is reshaping health problems, particularly among the urban poor, in the form of noncommunicable diseases, injuries, alcohol- and substance abuse, and impact from ecological disasters. Rapid urbanization has contributed to the weakening of social ties and changed the health-seeking behaviour of urban populations. Despite living near facilities and services, these poor and marginalized populations do not have access to or utilize existing facilities and services.

**Development and health inequity**

Rapid economic growth in South-East Asia brought development to several areas of livelihood, and provided more productivity and opportunity for populations. However, unplanned development has potential negative impacts on the health of populations due to environmental degradation, pollution, changing behavioural patterns and lifestyles because of modern working and living conditions. Global products and information technologies poured into communities, countries and regions without any boundary, which made it hard for governments to regulate distribution of unnecessary and harmful products, or provide equal accessibility to healthy quality goods.

Social disparities give rise to unfair living conditions for the poor and the disadvantaged. This, in turn, leads to different levels of health conditions among individuals and population groups across continents. The poorest of the poor, around the world, suffer the worst health. These people are generally marginalized and excluded. Being disadvantaged, they have been historically exploited through persistent inequity.

**Tackling health inequities**

WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce the persisting and widening disparities in equitable access to health care. During the past decade, countries in the South-East Asia Region have increasingly recognized the importance of the underlying social, cultural, economic, and political factors of health and disease. The Regional Consultation on the social determinants of health in 2005 shared the regional perspectives and recommendations of the CSDH. At this initial stage, focal points were set up on the social determinants of health in the Region under the umbrella of health systems development.

A Regional Consultation on the Social Determinants of Health held in 2009 was a collaboration between the Regional Office, WHO headquarters and the CSDH, and culminated in the “Colombo Call for Action”. This called for several concrete actions such as tackling health inequities in the Region through political commitment and “closing the gap in a generation”. Member States and intersectoral partners agreed to work on “health equity in all policies”, build intersectoral mechanisms, and empower vulnerable populations, among other recommendations.

To better understand what was needed in the Region, the Regional Office provided support for a series of research studies to analyse social disparities and health inequities in Member States. *Health inequities in the South-East Asia Region* was published in 2009, which highlighted five country case-studies. It provided evidence on the current determinants of health that affect maternal and child health outcomes, morbidity, mortality and access to health services.

In the area of urban health, the Urban Health Equity and Response Tool (UrbanHEART) was developed in 2009 in collaboration with the WHO Kobe Centre. This tool provides technical guidance on how to identify health inequities in urban areas and how to process multisectoral actions to respond to the underlying causes of these. Two cities in the Region (Jakarta and Colombo) participated

**SIRNet: SOCIAL INEQUITY REDUCTION NETWORK, THAILAND**

The Social Inequity Reduction Network (SIRNet), Thailand is a network of academics, policy-makers and civil society groups working together to address health issues of vulnerable groups such as people living with disability, elderly persons, farmers, labourers, women and others. The Network started with core technical individuals who foresee health as the broad responsibility of all sectors. They work together to produce evidence and advocate for policy change. The approach to health must be holistic and encompass physical, mental, social and spiritual well-being. A holistic health system includes health-care services, individual conditions, and the whole social, political, economic and natural environment.

The SIRNet is also a network of networks where research is conducted through networks with support from governmental organizations and partners in the country.
in the development of the tool. Evaluation of the UrbanHEART was conducted in these pilot cities in 2011, and further capacity was identified to strengthen healthy cities through an equity lens. The tool was then scaled up in India in 2012 and two more cities, Indore and Bally, were selected to implement the UrbanHEART in urban areas in 2013.

Longitudinal studies on morbidity and mortality of the urban population in selected cities were conducted in 2011 in order to link the social determinants of health and health-related information system. The exercise revealed the need for improving data quality and collection of disaggregated data for better analysis of health equity in several areas.

Making Health Facilities Accessible for Marginalized Populations

The Melghat region in the Amravati district of Maharashtra is mostly inhabited by the Korku tribe. The tribal region has several context-specific variables, such as wide geographical spread of the population of 300,000 in 4,500 sq. km, poor educational opportunities and literacy rate, livelihood challenges and overall socioeconomic backwardness, seasonality of undernutrition and child deaths. The region came into media focus in 1992-1993 and, since then, is almost synonymous with malnutrition and child deaths.

The region has a well-networked public health system. However, despite all the infrastructure and resources, the Korku community has remained poor and vulnerable. The poor uptake of services from public institutions is because of several social and cultural factors. One of the foremost hindrances responsible for the low uptake of services from the public health system has been the inaccessibility of these institutions to the people. Besides physical barriers in terms of poor connectivity between villages to facilities and the problem of absenteeism of staff in facilities, there is a cultural barrier in terms of inability of service providers at health institutions to be able to communicate with the Korku patients coming to health facilities. This has resulted in low patient turnout at public facilities, patient admissions and referrals to higher centres.

Taking note of the above situation, local civil society groups forged a partnership with the local administration of Amravati and started a pilot programme of placing one female counsellor during the day and a male counsellor at night in all the 14 health institutions in Melghat. The counsellors helped the patients to converse with the medical staff, looked after the hygiene and sanitation in hospitals, and also reported absenteeism and misconduct of service providers to the district administration. The programme started in September 2007 and ended in November 2007. The programme helped in increasing the outpatient and inpatient attendance, improving the quality of food served in hospitals, increasing the number of hospitalizations of severely malnourished children, and improving sanitary and lighting facilities.

Early positive results of the pilot programme led to the programme being reintroducted in Melghat hospitals in June 2008.

These activities highlighted the urgent need to address urbanization. A High-level Ministerial Meeting held in Bangkok in 2010 endorsed the Bangkok Declaration on Urbanization and Health. The Declaration called upon Member States to take actions to mitigate the determinants of health derived from pressures of unplanned urbanization and urban-rural migration. Health equity and a healthy cities approach were emphasized. Monitoring of the Bangkok Declaration is an ongoing process. A further step in this direction was provided by a Regional Consultation on Health of the urban Poor in 2010 to address the specific health consequences of urbanization and the health of vulnerable urban populations.

In 2011, a Regional Consultation on Intersectoral Actions for addressing the Social Determinants of Health highlighted the concrete actions taken in the Region to tackle health inequities and determinants of health in several areas. A number of Member States took action to address social disparities and health inequity through public policies, health programme interventions, health systems development, universal health coverage, governance and social participation.

With increasing recognition of the fact that the determinants of health were beyond individual and community factors, WHO generated better understanding of the structural determinants of health in which the whole health system, whole society, and global governance needed to play roles. In 2011, the first World Conference on Social Determinants of Health was held in Rio de Janeiro, Brazil. It aimed to reconfirm commitments from Member States and stakeholders to tackle the determinants of health. The Regional Office provided technical support and shared country experiences in the World Conference. The World Conference resulted in the Rio Political Declaration, which called upon WHO to support Member States to address the social determinants of health through a “whole health system” approach and
implement health in all policies. The Regional Office, along with other regional offices and WHO headquarters, developed a Global Plan of Action 2012–2017 to support Member States in implementing the Declaration.

**Moving forward**

Human rights and health have been advocated throughout the South-East Asia Region. However, they need to be built into health policies and implemented within the health sector. In order to do this, evidence and information on broader factors related to health inequities need to be generated. Quality and reliable disaggregated data are crucial for the accurate analysis of health inequity at the national and subnational levels. Regular monitoring and assessment of social and economic indicators and health outcomes is necessary to provide evidence for priority-setting in countries where resources are limited.

Despite efforts to provide universal health coverage and pro-poor health policies, health equity remains a challenge. Most countries do not yet have plans of action to address health inequity and reduce poverty and social gaps. In addition, the linkage between social and economic development, health and human rights needs to be integrated into national health policies.

National health equity surveys would help to identify inequities within countries. For this, the Regional Office needs to conduct advocacy with governments and encourage them to undertake such surveys. The Regional Office also needs to build the capacity of programme managers and focal points so that they can comprehensively understand the social determinants of health and factors that cause inequity at each level – individual, family and the community.

Most Member States need coordination mechanisms to respond to and report on the health of the urban population, with evidence from health systems and other sectors beyond health. Intersectoral actions are needed to tackle the social determinants of health, which is a challenge in the absence of coordination and joint planning. Existing tools such as UrbanHEART, and Health Impact Assessment would increase the capacity of the health sector to address the issue and provide linkages between health and development.

**COUNTRY EFFORTS AT ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH**

India used an integrated approach to human development to address the social determinants of health, such as the joint package of Bharat Nirman and the National Rural Health Mission to address Millennium Development Goals 4 and 5, along with involvement of people’s organizations at the grass-roots level. A larger number of institutional deliveries resulted from this partnership, which considerably brought down the maternal mortality rate.

Thailand is one of the countries in South-East Asia that addresses health equity through a whole health systems approach and has undertaken major health reforms since 2002. During this period, Thailand has significantly reduced socioeconomic and geographical gaps in antenatal care, improved skilled birth attendance and family planning, and reached coverage of nearly 90%. This became possible because of extensive investment in the health system, particularly at the district and subdistrict levels.

The “Lighthouse project” in Sri Lanka was jointly implemented by the WHO Country Office, Sri Lanka, the Regional Office and WHO headquarters between 2011 and 2012. This project aimed to bring out important intersectoral actions that would address challenging areas of the social determinants of health, such as gender-based violence and health, as well as the determinants of selected communicable and noncommunicable diseases. Social determinants and causes of disparities such as education, income, gender and social exclusion were analysed. Analysis of the project was used to design pathways of interventions to address the determinants of health that would lead to health in all policies through a primary health-care model to reduce and mitigate the inequalities caused by social determinants. “Social capital” was found to be the major factor in safeguarding family health and in supporting livelihood activities of poor women. It also contributed to determining disease patterns and health-care utilization practices among families living in poor settlements.
Building a safer world
Emergencies and disasters: applying lessons from the past; reducing risks for the future

The South-East Asia Region is highly vulnerable to the forces of nature. Typhoons, earthquakes, volcanic eruptions, landslides, tsunamis – the 11 countries of WHO’s South-East Asia Region have experienced them all. The diversity and magnitude of disasters and their effects have a considerable impact on health and life in the Region.

The date 26 December 2004 will be forever etched in the minds of people in the Region. A massive earthquake measuring 8.9 on the Richter scale occurred under the sea off the western coast of North Sumatra, triggering powerful tsunamis about 10 metres in height, which moved through the Indian Ocean at astounding speeds of over 500 km an hour, wrecking coastal areas in India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. For WHO, the event was a unique learning experience. Never in its history had it responded to a natural disaster of such scale and geographical spread. The challenge was to ensure timely assistance to the affected countries while maintaining standards, norms and procedures, and ensuring accountability. The event defined WHO’s operational role in response and as a coordinating body for humanitarian health actors. It was a challenge as much as it was an opportunity – it was a turning point for WHO and countries in the Region to strengthen their capacities for emergency risk management in health.

Building emergency preparedness and response

Since 2004, efforts are under way to plan, develop and build systems to reduce the burden of disasters and create a society that is well prepared to stand strong during an emergency. The Emergency and Humanitarian Action (EHA) programme works towards reducing the health consequences of emergencies, disasters, crises and conflicts, and minimizing their social and economic impacts. The Regional Office and Member States of the Region are working towards a comprehensive

Key achievements in the past decade

- In November 2005, 12 benchmarks on emergency preparedness and response were formulated by all Member States by involving several other sectors such as home affairs, foreign affairs and education, and integrating multisectoral concerns at the community, subnational and national levels. The framework provided by the benchmarks is a strong tool for planning programmes and activities in the area of emergency preparedness.
- The South-East Asia Disaster Health Information Network (SEADHIN) was created as a repository of “good practices” in different countries. Information is shared between scientists, practitioners, technical institutions and end-users through the existing medical and public health library networks.
- A two-volume book entitled Tsunami 2004: a comprehensive analysis was published based as a repository of public health-related information collected in the aftermath of the tsunami of 2004. The information is relevant for future events and contributes to better public health practice in emergencies.
- The South-East Asia Regional Health Emergency Fund (SEARHEF), established in 2007, is designed to meet immediate financial needs after an emergency.
- The Regional Office manages a stockpile of emergency medicines and supplies in warehouses in Delhi and Bangkok. These are mobilized for response in emergencies.
- A roster of experts on disaster management in the Region is maintained and used for emergencies.
- The Kathmandu Declaration on Protecting Health Facilities from Disasters was signed by the health ministers of the Region in September 2009.
disaster risk management mission in the health sector.

In the past decade and especially after the tsunami of 2004, much has been done to ensure comprehensive preparedness and response by countries in the face of disasters. The many achievements in this area can be grouped under four areas. The first is providing information for action, which can be done through activities such as measuring performance, setting priorities and addressing gaps. The second area is the preparedness and response of countries and strengthening their capacity to deal with sudden disasters. The third area focuses on reducing risks and providing safer health facilities. The fourth area deals with building the capacity of countries through a comprehensive approach.

Information for action: measuring performance, setting priorities and addressing gaps

South-East Asia Region Benchmarks for Emergency Preparedness and Response

Shortly after the 2004 tsunami, countries thought of addressing the issue of risk management systematically. They started by trying to answer some questions: What are the necessary elements for the health sector to prepare for an emergency? How is preparedness measured? How prepared is prepared?

To answer these questions, the Regional Office and its partners decided to apply the process of setting benchmarks as a novel approach to increasing performance in emergency preparedness and response. In November 2005, twelve benchmarks on emergency preparedness and response were formulated by all Member States by involving several other sectors such as home affairs, foreign affairs and education, and integrating multisectoral concerns at the community, subnational and national levels.

Investing in risk management is investing in future development

The Region has learnt from past experiences and continues to better manage risks. On 11 April 2012, an earthquake of the magnitude of 8.7 on the Richter scale hit the coast of Aceh for over 4 minutes with tremors being felt in neighbouring countries. It seemed like a repeat of the 2004 earthquake and tsunami. Thankfully, it was not.

But some of our actions on that day clearly demonstrated that we have moved on with better preparedness and response. There was more organized evacuation of people to higher grounds by all coastal communities, not only in Indonesia, but also in Sri Lanka, India (Chennai), Maldives and parts of Thailand. The clear link of communication between tsunami warning systems and the community was seen in many coastal areas. There were only eight deaths, and all those injured were promptly treated and accounted for.

Although some health posts were damaged, the city’s infrastructure did not suffer major destruction. Hospitals in Banda Aceh evacuated their patients in an orderly manner, which is a reflection of their preparedness plans and drills. In Sri Lanka, the tourism sector was well organized and moved guests to higher grounds.

The 11 April event has proved that in Indonesia, Thailand, Sri Lanka, Maldives and India the major catastrophe in 2004 was taken as a turning point to integrate lessons into action. This shows how disaster risk management can be improved with proper investments, both technical and financial. Political will and a disaster prevention perspective can bring changes to populations to better live with risks.

With this concrete display of commitment of countries, the Region is well poised to provide inputs to, and adapt and adopt the new global framework and guidance for emergency risk management for health that WHO is developing.

Paraphrased from a speech by Dr Samlee Plianbangchang on the occasion of the Regional Meeting on Disaster Risk Management in the Health Sector, 6–8 June 2012, Bangkok, Thailand.
The 12 benchmarks are grouped into four areas: Policy and legislation, Community capacity, Capacity-building, and Health surveillance and early warning, and contribute to systematic capacity development. The framework provided by the benchmarks is a strong tool for planning programmes and activities in the area of emergency preparedness. Standards related to each benchmark further define the technical quality of all its components. Indicators for the non-health sector have been included for each standard, which have a crucial impact on the overall preparedness levels of the country. A checklist is included to help guide analysis of the existing situation and establish a baseline, while a simple scoring system provides a numerical value.

All these are packaged in a tool that has been applied in countries of the Region. At present, seven countries have completed the exercise. The methodology used is that of engaging stakeholders from various sectors in the country and rating the benchmarks together. In the process, they gain consensus on the level of achievement, gaps and priorities against the benchmarks, and corresponding standards and indicators. In most countries, a university or academic institution is involved in the process.

In countries that have completed assessment, action has been taken based on the results. Bangladesh identified that one of its priorities is the development of a national comprehensive health sector emergency preparedness and response plan focusing on all hazards faced in the biennium. In Nepal, the assessment triggered the formation of a Disaster Risk Management working group using the results of the assessments as a guide for their actions. In Indonesia, it contributed to strengthening the ongoing activities in the Disaster Risk Reduction programme of the Ministry of Health. The tool will be adapted to assess the nine regional and two sub-regional crisis centres in Indonesia. At a later stage, operational research using the adapted tool is planned to be conducted at the subnational level.

### Building a repository of information on emergencies

There is an enormous need for an information management system that stores all types of information on disasters and emergencies. Organizing such information allows for analysis and drawing lessons from several events, and uses the memory of past disasters for future benefits. Information that is stored systematically acts as an evidence base for review, adaptation and revision of guidelines. In November 2009, the South-East Asia Disaster Health Information Network (SEADHIN) was created as a repository of “good practices” in different countries. Information is shared between scientists, practitioners, technical institutions and end-users through the existing medical and public health library networks. SEADHIN is at different levels of implementation in countries of the Region.
**Documenting and analysing the tsunami of 2004**

Most recently, the Regional Office embarked on an extensive documentation of the tsunami of 2004 using a structured methodology and process. As is seen in any emergency or disaster, one of the weaknesses identified in every “lessons learnt” exercise is information and knowledge management. The tsunami of 26 December 2004 in the Indian Ocean was no exception. The lessons learnt during the post-tsunami emergency operations and later during the post-tsunami recovery and development phases have been covered in a number of publications prepared by the Regional Office.

The Regional Office realized the need to publish a scientific document based on the repository of public health-related information collected in the aftermath of the tsunami of 2004. This endeavour culminated in a two-volume book entitled *Tsunami 2004: a comprehensive analysis*.

**Preparedness and response: strengthening surge capacity in the Region**

**South-East Asia Regional Health Emergency Fund (SEARHEF)**

Speedy assistance matters the most in an emergency, as it can make all the difference to the affected population. Yet most emergency support, primarily the funding, arrives a few days or even weeks after the disaster. The South-East Asia Regional Health Emergency Fund (SEARHEF) was conceived to bridge this gap. The Fund, officially established during the Sixtieth session of the WHO Regional Committee for South-East Asia held in 2007, is designed to meet immediate financial needs after an emergency according to the rules governing the Fund.

**Stockpile of health emergency medicines and supplies**

The Regional Office manages a stockpile of emergency medicines and supplies in warehouses in Delhi and Bangkok. These are mobilized for response in emergencies. The stockpile contains items such as the interagency emergency health kits, surgical and trauma kits, as well as diarrhoeal disease kits. Basic emergency supplies and medicines are pre-positioned and sent to countries prior to the monsoon season. The stockpile has also served several emergencies in the Region such as Cyclone Giri in Myanmar, the cloudburst in Leh, India, earthquake in Myanmar, and floods in the Democratic People’s Republic of Korea, Nepal and Sri Lanka.

**Health cluster lead**

Coordination is vital in emergencies. Good coordination means fewer gaps and overlaps in humanitarian organizations’ work, and ensures a coherent and complementary approach for better collective results. The United Nations Humanitarian Reform in 2005 defined WHO as the global health cluster lead with responsibility for ensuring that health needs are addressed in any emergency. Clusters are groups of humanitarian organizations (UN and non-UN) working in the main sectors of humanitarian action.

The cluster approach was put to the test during the emergency in Aceh, Indonesia in 2006 due to the tsunami, where there were around 250 nongovernmental organizations working in health at the peak of the response. Since then, the cluster approach has been rolled out in many emergencies – Cyclone Sidr in Bangladesh (November 2007) and Cyclone Nargis in Myanmar (May 2008), the earthquake in Sumatra (September 2009) and, most recently, in Myanmar for the Rakhine conflict (2013). All had different levels of implementation and demands from WHO. A training programme for health cluster coordinators in the Region was conducted in 2010 so that all partners and key stakeholders are capable of managing health clusters in

**SEARHEF TO THE RESCUE: MT MERAPI ERUPTION OF 2010**

Mount Merapi in Indonesia erupted on 26 October 2010. It caused many fatalities and disrupted the health systems in the affected areas of Central Java and Yogyakarta province. About 3.5 million people were affected. A safe zone was demarcated at a 20 km radius from the volcano where the displaced were relocated in camps managed by national and subnational authorities.

The influx of patients was beyond the capacity of the hospitals, and the medical supplies necessary to manage such cases were exhausted. At the request of the Ministry of Health, supported by the WHO Representative to Indonesia, US$ 175,000 was allocated for the emergency from SEARHEF to procure the necessary medical supplies and equipment to provide health-care support to the victims. SEARHEF was swiftly mobilized not only to help provide urgently needed interventions but also to strengthen the capacity of Dr Sardjito Hospital to meet any similar emergency in the future. Essential drugs and supplies were speedily procured and distributed to ensure speedy recovery and prevent disease outbreaks.
GLIMPSES OF CYCLONE NARGIS IN MYANMAR THROUGH THE EYES OF WHO STAFF

“After the confusion of the first few days we managed to set up a structure in the office, including a core team for the emergency and a functional operations room. We purchased some of the medicines locally with funds provided by SEARHEF, and started sending our cars to deliver them. After a meeting of the United Nations Interagency Standing Committee, the focus shifted to funding and a cluster approach. We began by trying to map who was working in which areas prior to the cyclone and who could do what in order to have an idea of what resources (financial and technical) were available to NGOs and how best to use them.

“...Everyone we met had a story of suffering to tell. We saw one brick health centre that had been completely flattened. A flag had been placed in honour of the midwife who had died. In the same village, the three pillars of the village community – the health worker, school head-teacher and the monk – died, leaving villagers feeling orphaned. In another village, a woman told us that she had lost 20 members of her family. I saw so much suffering but was also impressed by the dissemination of the people and how quickly they started rebuilding their lives. The resilience of the people is impressive and inspiring.

“...We developed a joint plan of action for dengue and malaria prevention and control in cyclone-affected areas. Because of excellent microplans, in two days, 89 130 households were covered with preventive measures.

“...As a human being, I feel this disaster was in some ways worse than the tsunami. My thoughts also kept going back to my home province, which is near the sea – something like this could easily happen there too. Yet life must go on.”

Reducing risks: safer health facilities

Risk reduction is an integral part of emergency and disaster risk management and covers mitigation and prevention. In the health sector, a focus on safer health facilities was the priority. In the Region, this was taken up through a regional technical consultation in 2008 and subsequently with high-level advocacy through the Kathmandu Declaration on Protecting Health Facilities from Disasters, adopted by the health ministers of the Region in September 2009. Since then, Member States have used these as their main tools for advocacy and interventions.

Policy changes

In India and Indonesia, new policies and regulations are being put in place on the design and structure of health facilities according to the hazards in the areas where they are located. In Bhutan, national preparedness and contingency planning with an all-hazards approach was completed in 2011 and a comprehensive safe hospitals programme is being conceptualized for implementation.

Advocacy

Besides the Kathmandu Declaration as an advocacy tool, in order to engage the public on the issue, a regional web-based/social media campaign is being carried out to spread the message to a wider audience regarding safer health facilities. It is linked to other global campaign efforts of the International Strategy for Disaster Risk Reduction to further spread the word and work on the essentials for safe health facilities.

Partnerships and multisectoral collaboration

In 2008, the United Nations International Strategy for Disaster Risk Reduction (UNISDR) for Asia and the Pacific together with WHO in the Western Pacific and South-East Asia...
Regions convened partners that would work together for safe hospitals. The group reconvened once more in 2009 to assess progress after the global campaign. This informal group communicates regularly and exchanges information.

Countries have made commendable progress in making health facilities safer. In May 2009, the Government of Nepal launched the comprehensive Nepal Disaster Risk Reduction Consortium, which is developing a long-term disaster risk reduction action plan building on the National Strategy for Disaster Risk Management. In Timor-Leste, consultative workshops are conducted to discuss the topic with various stakeholders. In India, discussions with the Confederation of Indian Industry have taken place to look at advocacy with private health-care providers.

**Structural and non-structural assessments**

An assessment for disaster resilience was conducted in four selected hospitals in Bangladesh and more detailed assessments and interventions are under way. In India, for existing health facilities, the Ministry of Health is working on several assessments, both structural and non-structural. In Indonesia, continuing assessments are being conducted of more health facilities in the areas affected by the most recent earthquake in Sumatra with appropriate interventions. In the Maldives, a hospital vulnerability assessment was conducted and a more comprehensive assessment is planned. In Nepal, further structural and non-structural assessments are being conducted in existing health facilities and interventions are being implemented from the results of these appraisals. New tools for prioritization were developed for various hospital groups/managers/owners to agree on a method for priority-setting.

**BHUTAN: EFFORTS AT MAKING HEALTH FACILITIES SAFER**

In 2012, Bhutan, in collaboration with Geohazards International, conducted a detailed assessment of the Jigme Dorji Wangchuk National Referral Hospital, the only hospital in the capital of Bhutan. The hospital has begun working on improving the facility’s performance. Retrofitting activities after the assessment revealed that the hospital is vulnerable to large earthquakes. Two additional district hospitals will conduct structural, non-structural and functional assessments, including training for engineers and health staff supported by the Ministry of Health, Disaster Preparedness ECHO and WHO. Smaller health centres are in the process of safety assessments supported by the United Nations Development Programme. These efforts are all part of a comprehensive national safe hospitals plan, which the Ministry of Health together with partners has drafted and is implementing.
Emergency and Humanitarian Action in

Severe monsoon flooding in Bangladesh

Earthquakes and tsunami of 26 December 2004 affecting India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand – 220,000 people dead

Nias Island, Sumatra, Indonesia earthquake

Yogyakarta earthquake, Indonesia

Severe monsoon floods – Bangladesh and India

Cyclone Nargis, Myanmar – 130,000 dead

Flash floods in Sri Lanka

Kosi river floods, Nepal – around 30,000 displaced

WHO country offices and SEARO support health responses and interventions for tsunami-affected countries

Post for Technical Officer-EHA established in SEARO as part of institutional capacity building for WHO in emergencies

Regional Committee resolution on emergency health preparedness passed

Globally, the beginning of humanitarian reform initiative of the UN

Development of SEAR benchmarks for emergency preparedness and response

Release of several documents on the tsunami response

Development of SEAR benchmarks for emergency preparedness and response

Health cluster approach first implemented in South-East Asia Region

The South-East Asia Regional Health Emergency Fund (SEARHEF) established – rapid response fund provided within 24 hours upon request

Formation of Regional Technical Advisory Group for Emergency and Humanitarian Action with external partners

Regional stockpile of emergency supplies set up in Bangkok and New Delhi

Regional Public Health Pre-Deployment Course conducted for country teams

Regional consultation on Keeping Health Facilities Safe from Disasters

Emergencies supported by SEARHEF
Emergency and Humanitarian Action in the South-East Asia Region

Global Campaign for Safe Hospitals: Save lives keep hospitals safe from disasters
Social media campaign launched: www.facebook.com/clickabrick
Kathmandu Declaration by Health Ministers on Protecting health facilities from disasters
South East Asia Disaster Health Information Network (SEADHIN) established www.seadhin.org

2009

- Sri Lanka conflict ends – approximately 300,000 displaced
- Fire in Dhaka – 100 dead, over 200 with burn injuries
- Mt Merapi eruption in Indonesia – 3.5 million affected

2010

- Scaling up of WHO country office operational readiness capacities
- Health cluster coordinators training – Jakarta, Indonesia
- Regional meeting on primary health care approach in emergencies

2011

- WHO country officers lead response and Regional Office provides back-up financial, technical and operational support
- Assessments using SEAR benchmarks completed in SEAR countries
- Regional Meeting on Disaster Risk Management in the health sector to define strategic directions
- SEARHEF working group meeting to scale up mobilization of resources
- Consultation on Guidelines for Safer Health facilities in water related disasters

2012

- Maldives: floods
- Bangladesh: floods and landslides
- Nepal Kaski: floods
- Myanmar fire explosion
- Update of curriculum and materials for Inter-Regional Public Health Emergency Management in Asia and the Pacific (PHEMAP) programme
- Completion of capacity assessments using the SEAR Benchmarks
- Support application of WHO Emergency Response Framework – through continuing WHO Country Office Operational Readiness Workshops
- Support development of a global framework for emergency risk management for the health sector

2013

- Jakarta, Indonesia: floods
- Bangladesh: factory collapse
- Sri Lanka, India, Bangladesh, Myanmar: Cyclone Mahasen
- Uttarakhand, India: floods and landslides
- Indonesia: forest fire – smoke and haze
- Aceh, Indonesia: earthquake
- Myanmar Rakhine State: Communal conflict

The South-East Asia Region
Building capacity: a comprehensive approach

Emergency preparedness and response is integral to the public health function of the health workforce. A training programme called Public Health and Emergency Management in Asia and the Pacific (PHEMAP) organized by the Asian Disaster Preparedness Center (ADPC) is a way forward to address certain gaps in skills enhancement of personnel taking a lead in helping people during emergencies. The course has been ongoing for the past 10 years and has trained 122 graduates from various Member States. The Regional Office has supported national PHEMAP courses and assisted in adapting the courses in partnership with academic and national institutes.

In the Region, Bhutan and Sri Lanka are developing a national PHEMAP course and other countries are reviewing the course and will adapt and implement it through identified institutes. National PHEMAP brings skills to subnational levels, which contribute a great deal to the resilience of communities to all types of disasters.

Moving forward

In 2004, the concept of disaster management was new. Since then, Member States have come a long way. However, most of the activities that have been initiated over the past decade need further intensification. National technical capacity for disaster risk management in the health sector needs to be strengthened further. To generate better research and evidence for action, procedures for collection, analysis and reporting of disaster risk management-related data need to be strengthened. This would help to improve national and regional databases and knowledge on the public health aspects of disaster risk management. Post-disaster development could be included as an essential part of disaster risk management.

New areas that pose new risks include climate change and urbanization. To effectively manage disasters arising from these areas, evidence and good practices need to be promoted and shared through information networks, platforms and technology.

As the health sector cannot manage disasters on its own, the capacity of other sectors involved in disaster risk reduction and mitigation needs to be strengthened and the roles of each defined and coordinated. In addition, including communities in disaster risk reduction plans and activities, assigning defined roles to them and improving their capacity for resilience after a disaster through training would go a long way in mitigating the aftereffects of disasters.

As training needs and competencies are evolving, they need to be designed according to the systems of countries. Newer ways of upgrading skills and systems should be thought of and put in place. WHO in the Region together with other partners will be looking at various ways of capacity development in the coming years.

Currently, WHO globally is developing a comprehensive framework for emergency risk management in health. The Regional Office, through its EHA unit, along with representatives from some Member States, is leading and participating in the discussions to put together this agenda. The Region has turned its most devastating crises into opportunities for better health and development – a lesson the rest of the world can learn from.

HOW THE PHEMAP PROGRAMME IMPACTED RESPONSE

In December 2004, the tsunami killed 12 500 people in the Ampara district of Sri Lanka. Ampara General Hospital was the tertiary care institution that managed the largest number of tsunami victims.

Based on the concepts introduced during the “Public Health and Emergency Management in Asia and Pacific” (PHEMAP) course conducted by the WHO Regional Office for South-East Asia together with the WHO Regional Office for the Western Pacific and the Asian Disaster Preparedness Center, a graduate of this course held three workshops in Ampara General Hospital for medical consultants, medical officers, nurses, paramedics and other employees. The course increased the participants’ understanding of natural and human-induced disasters, disaster management and its cycle, community participation, triage, pre-hospital casualty management and accident/emergency care.

The course led to conducting internal and external triage for disaster management, opening of a disaster management command centre and a new accident and emergency treatment unit. In addition, the community was trained to deal with disasters.

As a result of these preparedness measures, when the tsunami struck on 26 December 2004, the Ampara General Hospital staff was well aware of what their duties were. A total of 1015 patients were admitted to the hospital immediately after the tsunami. More than 4000 patients received treatment from the outpatient department. Of these, only 17 died in the aftermath of the tsunami.
Injury prevention, disability and rehabilitation

The South-East Asia Region has the highest proportion and rate of injury-related deaths (116.6/100 000 population) in the world. According to the 2004 Global Burden of Disease study, the leading causes of injury-related mortality in the Region are road traffic injuries, self-inflicted injuries, fire and burns, falls, interpersonal violence, drowning and poisoning. In the area of disability, the Global Burden of Disease study in 2004 estimated that the South-East Asia Region has the second-highest prevalence of moderate disability and the third-highest of severe disability.

Injuries constitute one of the priority public health problems in the South-East Asia Region and require urgent action. Thousands of children in the Region, though successfully protected from infectious and nutritional diseases, are killed or crippled by injury, demonstrating that injury is also a major public health challenge. Road traffic injury is the biggest offender in most countries, the total regional share in the global burden of road traffic injury being 34% in 2000. Drowning and burns are other major causes of injury.

—DR SAMLEE PLIANBANGCHANG

Excerpt from a message in Health in South-East Asia, September 2010

Key achievements in the past decade

- Five Member States have established injury prevention units in the ministry of health to implement injury prevention policies and plans, and coordinate with multisectoral organizations.
- Nine Member States have national plans drafted by multisectoral stakeholders. Bhutan and Myanmar are in the planning stage.
- All Member States have national focal points for prevention of injury and violence.
- In 2012, five Member States had incorporated trauma-care services for victims of injuries or violence, using WHO trauma-care guidelines, into their health-care systems. Others are in the process of doing so.
- By 2012, national injury surveillance and information systems were operating in Myanmar and Thailand. Seven countries have either subnational injury surveillance systems (Bangladesh, India and Maldives) or are piloting schemes (Indonesia, Nepal, Sri Lanka) or have integrated the injury surveillance system into the health management information system (Bhutan).
- A sustainable model of community-based rehabilitation has been integrated into the primary health-care systems of many countries.
- The Regional Office is the first WHO office that has conducted an accessibility audit to improve infrastructure for disabled persons, in compliance with the United Nations Convention on Rights of Persons with Disability.
- Ten Member States have national plans and all countries have national committees for the prevention of blindness.
SAFE LAMPS IN SRI LANKA

In Sri Lanka, burns from makeshift kerosene lamps have been occurring for over a century. These lamps are tall, narrow and light; as the wick holders are not of the “screw-on” type, the flammable kerosene can leak out, causing fire and extensive burns to those who try to extinguish the fire. A campaign was launched by Dr Wijaya Godakumbura to make a lamp that was both safe and effective. The result of his efforts was “Sudeepa”. Sudeepa is squat and heavy, and so does not tip over easily. It has a near-globular shape and is made of thick glass, so it does not crack if it falls. With two flat sides, it does not roll even if it does tip over. It has a screw-on metal lid to prevent oil spills. In addition, the lamp costs little and lasts for a long time.

The Sudeepa lamp has won four prestigious international awards, and has been featured in several magazines and journals.

Injury prevention

The high burden of injuries and their prevention have received concerted attention during the past decade. Before 2005, only one country in the Region (Thailand) had a national injury surveillance system and an injury unit in the Ministry of Public Health. Since 2005, the Regional Office has been supporting intensive injury prevention work in Member States.

Ensuring political commitment through advocacy

To garner political commitment and raise awareness of the need for injury prevention and control, the Regional Office conducts advocacy with the governments of Member States. It also supports activities in this direction, such as road safety week campaigns conducted in collaboration with United Nations Regional Commissions and international nongovernmental organizations. WHO acts as a coordinator on road safety issues within the United Nations system.

To ensure that injury prevention is mainstreamed into other health promotion activities, the Regional Office advocates for institutionalization of injury prevention in the ministry of health. Five Member States (India, Indonesia, Maldives, Sri Lanka and Thailand) have established injury prevention units in the ministry of health. Nine Member States have national plans drafted by multisectoral stakeholders. Bhutan and Myanmar are in the process of developing a plan. All Member States have national focal points for prevention of injury and violence.

Guidance and capacity-building

The core framework for activities in the Region in this area stems from the adoption of a resolution on “Injury Prevention and Safety Promotion” by the Sixty-third session of Regional Committee in 2010. As a result, several important injury prevention policies, programmes, plans, interventions and systems have been established or strengthened in the Region. To guide Member States in setting up systems and policies, the Regional Office provides normative guidance through the publication of several Region-specific documents, guiding principles and fact sheets. It also published a handbook for policy-makers in the health sector on implementing the United Nations Convention on Rights of Persons with Disability.

In the area of capacity-building, the Regional Office provides technical support to countries in all areas of injury prevention and control, from establishing systems to reporting information. Several training courses on injury epidemiology, prevention and care have been organized in collaboration with the WHO Collaborating Centre on Injury Prevention and Safety Promotion (Khon Kaen Trauma Center), using a comprehensive global modular curriculum on injury prevention and control called TEACH-VIP (Training Education and Advancing Collaboration in Health on Violence and Injury Prevention). Technical support has also been provided for setting up and strengthening emergency trauma-care systems to manage victims of injuries. In 2012, five countries (Bhutan, India, Indonesia, Sri Lanka and Thailand) had incorporated trauma-care services for victims of injuries or violence, using WHO trauma-care guidelines, into their health-care systems. Others are in the process of doing so.

In order to sensitize and educate health professionals, injury prevention and control has been included in the curricula of undergraduate medical and nursing education in Thailand, and the Regional Office is supporting other Member States to do so. A draft curriculum on injury prevention and care for emergency room chief nurses of tertiary-care hospitals in the South-East Asia Region has been developed for review. Training will be conducted in 2014.

Assessing the burden

In order to assess the burden of disability due to injuries and formulate policies and programmes, collection and reporting of accurate data is paramount. In 2012, four countries (Bhutan, India, Maldives and Thailand) had published national data on the prevalence and incidence of disabilities. By 2012, national injury surveillance and information systems were operating in Myanmar and Thailand, with regular publication and dissemination.
of reports. Countries have either subnational injury surveillance systems (Bangladesh, India and Maldives) or are piloting schemes (Indonesia, Nepal, Sri Lanka) or have integrated the injury surveillance system into the health management information system (Bhutan). Regional data on the 10 leading causes of death and hospital admissions due to injury and violence will be available for almost all countries in 2014.

Road safety is crucial for the prevention of road traffic injuries. To improve road safety, in 2011, the Regional Office supported the launch of the Global Decade of Action Plan on Road Safety in Member States. In the Region, three countries have a national action plan for the Decade of Action for Road Safety (Bhutan, Indonesia and Thailand). WHO and Bloomberg Philanthropies are supporting India to address the burden of road traffic injuries. All countries have submitted assessments of their national road traffic injury prevention status to WHO. Bloomberg Philanthropies supported WHO financially to publish the first Regional report on road safety status in 2009 and the Factsheet on road safety status in 2013.

Ensuring rehabilitation and a rights-based approach

WHO strongly advocates for the removal of health and social barriers against people with disabilities, and promotes their rehabilitation. Community-based rehabilitation provides persons with disabilities an opportunity to get access to rehabilitative care and services in their own communities, and ensures equal opportunity and social inclusion of such people. A sustainable model of community-based rehabilitation has been integrated into the primary health-care systems of many countries since 2004, and a Regional strategic framework developed on community-based rehabilitation.

The human rights aspects of the initiatives taken by governments cannot be overlooked. Simple but important measures, such as improving access to services by disabled persons, are vital. The Regional Office is the first WHO office that has conducted an accessibility audit to improve infrastructure for disabled persons, in compliance with the United Nations Convention on the Rights of Persons with Disability. At present, there is greater awareness of the burden of disability and increased national investment for ensuring the rights of persons with disability. Actions have been implemented to increase accessibility by persons with disability to various health premises, employment and information.

Injuries among children

The high rate of injuries among children in the Region is a particular tragedy that needs attention. In 2004, the South-East Asia Region had the second-highest rate of unintentional child injuries (49/100 000 children per year) globally. Bangladesh, Myanmar, India, Sri Lanka and Thailand have a large burden of injury-related child deaths. Road traffic injuries, drowning, accidental falls and burns are the major causes of injury in children in most Member States. Among road traffic injuries, motorcycle accidents are a common cause, especially in Thailand. Although estimates of the violence affecting children are not available, studies by the WHO Kobe Centre showed that violence is a major cause of injury-related mortality and morbidity among children in Nepal, Sri Lanka and Thailand.

To protect children from injury, the Regional Office supported evaluation of the “Project motorcycle helmet for kids, with love and care” in Thailand in 2005, which was an educational campaign on the risks of and protection for children on motorcycles, along with distribution of standard child helmets as educational tools. Evaluation and experience of the project were shared with other countries in 2006. The standardized child motorcycle helmets were manufactured in Indonesia within one year of sharing the experience. At the first National Road Safety Week in 2007, the President of Indonesia distributed 1000 child helmets to raise awareness and promote child safety. Since then, more than 10 000 child helmets have been distributed. At present, the standardized child motorcycle helmets are exported by Indonesia and Thailand to other developing countries. Efforts towards this have also been initiated in India, in coordination with the Urban Development Ministry and the Transport Research and Training in Safety Technology Department of the Centre for Biomedical Engineering, Indian Institute of Technology, Delhi, which is a WHO collaborating centre.

In 2012, the Regional Office conducted a multisectoral expert group meeting on prevention of motorcycle injuries in children. This was the first such meeting in the world. The recommendations were widely shared and follow-up activities are being conducted.
Blindness and deafness

The South-East Asia Region is home to 12 million of the 15 million blind persons in the world. Although the number has dropped from 12.5 million in 2002, the prevalence of preventable blindness remains high, and varies from 0.31% to 1.47%. Disabling hearing loss affects 5.3% of the world’s population, with one third of persons over 65 affected. The prevalence of disabling hearing loss in low income regions is nearly double that of high income regions.

The Regional Office provides normative guidance on blindness and deafness through several publications. It has drafted guiding principles for screening of hearing loss in infants, prepared a model outline of a national programme for the prevention of deafness to facilitate the development of national programmes by Member States, and conducted regional and national meetings and workshops to build capacity. In India and Indonesia, a model has been developed to integrate prevention of blindness and deafness into the health system. In 2012, India documented the burden of hearing and visual impairment and four countries (Bangladesh, Maldives, Myanmar and Nepal) are now in the process of doing so.

In the area of deafness, the Society for Sound Hearing has worked closely with the Regional Office and achieved several milestones, such as the formation of national committees for ear and hearing health care in Bangladesh, India and Indonesia. Nepal will soon establish a national committee. The Society worked in partnership with WHO to promote the prevention of deafness and its management, including rehabilitation for hearing loss. The first international course on Epidemiology of Hearing Loss and community ear and hearing care, the first of its kind in Asia, was organized in 2011.

Moving forward

To consolidate the gains of the past decade, more political and financial commitment from Member States is needed for preventing injury and violence, and providing trauma care. Emphasis needs to be placed on strengthening the existing data system and establishing a sentinel trauma-cum-injury surveillance registry to provide information.

More lead agencies have to be established and programmes implemented with multisectoral actors. For this, effective partnerships need to be established with the ministries of health, other concerned sectors, and United Nations and international agencies. Working with other sectors and integrating injury prevention with primary health care will be the main strategies for disability prevention and rehabilitation in future.

Evidence from research helps to inform policies and programmes. Capacity for conducting research and carrying out interventions needs to be strengthened at the national level to create a critical mass of people to work efficiently and effectively.

Implementing the United Nations Convention on the Rights of People with Disabilities and community-based rehabilitation will also need more political and financial commitment.

In the area of prevention of blindness and deafness, national committees need to be strengthened further and adequate budgets allocated for regular assessment of the situation at the national level. More efforts should be made to integrate prevention of blindness and deafness into the existing health system and strengthen community-based rehabilitation of those affected.
Occupational health and chemical safety

Workers’ health, safety and well-being are of paramount importance to the productivity, competitiveness and sustainability of enterprises, communities, and national and regional economies. As many people spend a large part of their waking hours at the workplace, a healthy workplace environment is crucial for their health and well-being. It also offers an ideal setting and infrastructure to promote the health of a large population.

South-East Asia is home to a workforce of 560 million persons, many of whom work in the informal sector. Informal sector workers are those who are not part of traditional employment contracts and occupational health and safety measures, and include those working in small businesses, domestic settings and agriculture. Informal workers can include women, children and migrant workers, who are often among the most vulnerable with limited access to health services.

The magnitude of work-related illness and injury is staggering. Worldwide, an estimated 2 million people die each year as a result of occupational accidents and work-related illnesses or injuries. Each year, there are 268 million non-fatal workplace accidents, as well as 160 million new cases of work-related illness. Globally, about 125 million people are exposed to asbestos at the workplace. According to WHO estimates, worldwide, more than 107,000 people die each year from asbestos-related lung cancer, mesothelioma and asbestosis resulting from occupational exposure. One in every three deaths from occupational cancer is estimated to be caused by asbestos. In addition, it is estimated that several thousands of deaths can be attributed annually to exposure to asbestos in the general living environment.

The focus of occupational health is on the prevention of all work-related ill-health, disease and fatalities, whether caused by physical or mechanical factors, including falls and other accidental injury, noise, heat, biological and chemical hazards including infectious agents, toxic chemicals including carcinogens and highly hazardous pesticides, ionizing and non-ionizing radiation, and psychological and social issues.

Workers need to be healthy in all aspects, physical, mental and social. Health issues and problems faced by workers have to be realistically and practically addressed through multidisciplinary and multisectoral efforts whereby multistakeholder involvement is necessary.

—DR SAMLEE PLIANBANGCHANG

Excerpt of speech delivered at the International Consultation on Healthy Workplaces, 16–18 March 2011, New Delhi
Managing chemicals

The sound management of chemicals can be achieved only by adopting a life-cycle approach to the manufacture, production, use, recycling and disposal of chemicals. Such an approach is needed in all workplaces, including healthcare facilities.

The import and production of chemicals in most developing countries and countries with economies in transition outstrips that in developed countries. Rapid industrialization with increasing production of chemicals, growing urbanization and modernization, and increasing import and use of agricultural chemicals and pesticides comes at a time when the awareness of the risks of chemical exposures, and technical and legislation capacity remains weak.

Many sectors must work together to ensure the sound management of chemicals.

Key achievements in the past decade

- A Regional Strategy on Occupational Health and Safety in South-East Asia Region countries was first published in 2005. National action plans in a number of countries have been developed to implement the strategy.
- A situation analysis report on occupational health for the Region was prepared in 2008. Detailed country-specific reports have since been prepared in a number of countries, including Bhutan, India, Maldives and Thailand.
- Training in the provision of basic occupational health services and of specific occupational groups, such as occupational nurses, has been stimulated by implementation of the Regional Strategy and the Workers’ Health Global Plan of Action, assisted by the efforts of a new WHO collaborating centre based in India.
- The Regional Office prepared a situation analysis on the current and projected use of asbestos and the burden of asbestos-related diseases.
- The Asian Asbestos Initiative established in 2006 is a bi-regional initiative with the Regional Office for the Western Pacific and has provided Member States with a platform for sharing experiences and information on efforts to eliminate asbestos-related disease.
- In 2008, the Regional Office and Chulabhorn Research Institute initiated the development of an Internet-based help desk for fielding questions on chemical safety (ChemHelpDesk).
- A new poisons centre in Chennai, India, was developed with support from WHO in 2006. National guidelines for poison management in hospitals were developed in 2009, as well as training in the use of a harmonized case reporting and information exchange system (INTOX) with the centres in the Region.
- The Regional Office published revised guidelines on the management of snakebite in 2010.
Ministries of health have much to achieve by working with sectors responsible for legislat- ing and controlling hazardous exposure to chemicals. The large and increasing number of multisectoral, multistakeholder and legally binding processes and conventions to which countries are party serves to emphasize the significant impact that chemicals may pose beyond national borders, particularly if not managed in a sound and sustainable way.

Strengthening and integrating efforts in occupational health

A Regional Strategy on Occupational Health and Safety in SEAR countries was first published in 2005, based on an analysis of the status of occupational health in the Region and consultation with Member States. The strategy consists of three goals: establishing a regional occupational health network, promoting the use of a health-risk paradigm and capacity-building. National action plans in a number of countries have been developed to implement the strategy, new WHO Collaborating Centres have been designated and engagement with the WHO Western Pacific Region and the International Labour Organization (ILO) has been stimulated, including through joint workshops on the formulation of national policies and plans of action and activities focused on the elimination of asbestos-related diseases.

In May 2007, the Sixtieth World Health Assembly passed a resolution called “Workers’ health: global plan of action” to protect and promote the health of workers in all economic sectors, including the informal sector. It includes the primary prevention of occupational hazards, protection and promotion of health at work, employment conditions and a better response from health systems to protect workers’ health. The Global Plan of Action is underpinned by a number of common principles; that all workers should be included, the workplace should not be detrimental to health, workers’ health should be integrated within health systems and that the workplace can also serve as a setting for delivery of other essential public health interventions.

To assess the readiness of Member States for implementing the recommendations of the Global Plan of Action on workers’ health, a baseline study was completed among Member States of the Region and a situation analysis report on occupational health for the Region prepared in 2008. This showed that nine countries have an occupational health policy framework, nine countries have a national occupational health profile, and eight countries have a national plan of action for occupational health. Four countries have special programmes on asbestos-related problems. Three countries have programmes to integrate occupational health services with the existing primary health-care system. The Regional Office is assisting other countries to develop their occupational health policies in line with the global recommendations. Detailed country-specific reports have since been prepared in a number of countries including Bhutan, India, Maldives and Thailand. Implementation of the Global Plan of Action is monitored periodically and reported to the World Health Assembly.

To build capacity in the area of occupational health, the Regional Office has provided fellowships to train officials from Bangladesh, Maldives, Myanmar and Sri Lanka at WHO collaborating centres.

In 2009, the Regional Office supported the Government of India to formulate a national policy on safety, health and environment at the workplace, which recognizes that a safe and healthy work environment is a fundamental human right. The ministries of labour and health, Bangladesh, with support from WHO and ILO, jointly prepared a draft national policy on occupational health in 2011, in line with the World Health Assembly resolution on workers’ health.

To further improve the health of workers, the Regional Office is carrying out research in identified priority areas through WHO collaborating centres in India, Thailand and Sri Lanka. These priority areas include delivery of basic occupational health services in rural areas, risk evaluation and management, effects of climate change on workers’ health, studies
on lead toxicity, development of communication skills in occupational health, estimation of the burden of work-related diseases, and use of an occupational risk management toolkit for small and medium industries. The toolkit, developed by a group of international experts including from ILO and WHO, is useful in recognizing and controlling workplace hazards in small and medium enterprises.

Training in the provision of basic occupational health services and training of specific occupational groups such as occupational nurses has also been stimulated by implementation of the Regional Strategy and the Workers’ health: Global Plan of Action, assisted by the efforts of a new WHO Collaborating Centre based in India.

A Regional Strategy to provide basic occupational health services through the existing primary health-care system was modelled by WHO collaborating centres in India and Thailand, and subsequently implemented in a district in Sri Lanka in 2009. To train health workers, the Regional Office developed a training manual.

**Promoting healthy workplaces**

Enterprises can have many impacts, both positive and negative, on the health and well-being of the community in which they operate. WHO has been working to support the establishment of mechanisms by enterprises to manage risks to health and promote community health and safety as part of their activities and mission.

WHO has also been facilitating the identification and sharing of good practices and the development of tools to manage health risks, and promote health within the workplace.

The WHO healthy workplace model is a comprehensive way of thinking and acting. It addresses work-related physical and psychosocial risks, promotion and support of healthy behaviours, and broader social and environmental determinants. The framework encompasses five main criteria which are outlined in the document *Five keys to healthy workplaces: no business wealth without workers’ health*.

**Eliminating asbestos-related disease**

Asbestos is the name given to group of naturally occurring fibrous minerals, with commercial usefulness due to their tensile strength, poor heat conduction and relative resistance to chemical attack. Evidence that all forms of asbestos are carcinogenic to humans and recognition that exposure to asbestos in the workplace is entirely preventable led WHO to adopt a global policy to eliminate asbestos-related disease in 2005.

Recognition of the continued increase in use of asbestos by countries of the Region at a time when use has largely been eliminated in developed countries led to a number of specific actions in South-East Asia, including the provision of policy guidelines to Member States. The Regional Office organized a number of advocacy workshops and supported conferences in the Region aimed at elimination of asbestos-related diseases. It also prepared a situation analysis on the current and projected use of asbestos and the burden of asbestos-related diseases. Country profiles on the detailed inventory of asbestos use, reported cases, and existing and proposed mechanisms to meet the challenges have been prepared for Bhutan, India, Indonesia, Sri Lanka and Thailand.

To strengthen their capacity for managing industrial carcinogens, particularly asbestos, Bhutan, Indonesia, Sri Lanka and Thailand successfully applied for funding from the Strategic Approach to International Chemicals Management (SAICM), an international policy framework to promote the sound management of chemicals. WHO headquarters and the Regional Office provided technical support for preparing the project proposals and for implementing the projects following their approval.

The Asian Asbestos Initiative established in 2006 is a bi-regional initiative with the Regional Office for the Western Pacific, which has provided Member States with a platform for sharing experiences and information on efforts to eliminate asbestos-related disease. The development of national profiles and plans of action that describe the uses of asbestos, systems of surveillance of asbestos-related diseases, and legislation and other instruments to control exposure is a part of the work under this initiative.

Silicosis, another disease caused by occupational exposure, has been targeted by WHO through a global programme for elimination of silicosis. The Regional Office has helped to implement this programme in India and Thailand.

**Integrated vector management**

India and Sri Lanka have led efforts within the Region to implement an integrated approach to vector management, which aims to reduce the burden from vector-borne diseases by integration of chemical and environmental management, thereby reducing reliance on pesticides such as DDT. The development of a regional strategy for community-based
integrated vector management has been an important outcome of this work.

**Regional helpdesk for chemical safety**

In 2008, the Regional Office and Chulabhorn Research Institute initiated the development of an internet-based help desk for fielding questions on chemical safety (ChemHelpDesk). The ChemHelpDesk provides registered users cost-free access to experts in the field of chemical safety as well as access to a web-blog of information on international and regional events and developments. In 2012, this service became fully operational and was introduced to representatives of health and environment ministries at an International Workshop to Strengthen Capacities for Sound Chemicals Management, held at the International Centre for Environmental Health and Toxicology, Chulabhorn Research Institute, Bangkok.

**Improved management of poisoning**

Poisons centres are a central part of the health system with the specialist capacity to advise on the recognition and management of the toxic effects of chemicals. A number of activities to strengthen the recognition and management of poisoning have been undertaken, including the establishment of a new poisons centre in Chennai, India, with support from WHO in 2006, development of national guidelines for poison management in hospitals in 2009, and training in the use of harmonized case reporting and information exchange system (INTOX) with the centres in the Region.

Snakebite is a common type of poisoning incident in many countries of the Region. To keep pace with the advances in science and on the basis of global experience, the Regional Office published revised guidelines on the management of snakebite in 2010. These guidelines will help Member States to improve their management of snakebite and help in saving human lives.

**Mercury-free health-care facilities**

In response to a WHO policy paper on mercury-free health care, several large hospitals in India, Indonesia and Thailand have voluntarily opted to support the WHO policy. With the new international Convention on the Elimination of Mercury expected to come into effect soon, a greater emphasis on national policies and action plans to eliminate mercury from the health-care system is expected.

**Moving forward**

With over 70% of workers engaged in the informal sector, improving occupational health in this population will be a priority. Opportunities for improvements in the context of ensuring universal health coverage will be pursued, as well as implementation of WHO policies and guidelines to promote healthy workplaces.

WHO has also been facilitating the identification and sharing of good practices and the development of tools to manage health risks, and promote health within the workplace. Continued and greater emphasis on information and advocacy, and technical support for the elimination of asbestos-related diseases and silicosis will be needed as long as countries continue to import and use asbestos.

At present, monitoring and surveillance systems for occupational disease and chemical exposure in the Region are less than optimal and much remains to be done to ensure their operability. Building upon the work to establish and strengthen poisons centres, efforts will be needed to continue to develop these networks of centres and to build awareness of the prevention of poisoning and improve surveillance of poisoning. Systems for preparedness and response to chemical and radiological incidents and events of potential public health importance, particularly in the context of the International Health Regulations, 2005 remain to be completed but, like other areas of occupational health, much of this work needs to be carried out in coordination with other sectors. Possibilities exist for taking advantage of work under way to implement other internationally binding conventions and agreements that support the protection of human health and the environment, and should be pursued.

Only with increased availability of evidence for the effectiveness of preventive interventions can more be done to garner the necessary political will to prepare and implement national policies and action plans for the sound management of chemicals.

The Regional Office will continue to provide advocacy and support for articulating policy options and action plans through regional consultations, and help in building the research agenda and capacity to develop expertise through fellowships. It stands ready to support Member States in building core capacity for the sound management of chemicals.
Globally, events that occurred in the past decade have redefined the world as we know it. Major wars have reshaped global politics. Moving from a booming economic growth to a slowdown and even severe recession in major countries, unmatched in recent history, has had an impact on resources, and on the lives of people everywhere. Technology has changed the way we live and function – 10 years ago, social media/social networking sites such as Facebook and Twitter did not exist. Today, they have more than a billion users, and have become so powerful that they have even been attributed a role in bringing about revolutions and bringing down governments or indeed as tools for epidemiology.

Public health is an intrinsic part of the intricate global socioeconomic-political patterns that define our lives, and cannot be dissociated from them. As these events shape public health, so too does public health influence social and economic outcomes.

The importance of health as an essential driver of human development is often underestimated. Some of the greatest achievements in public health in the past decade reflect how positive health outcomes are linked to developmental outcomes. For example, 10 years ago, HIV/AIDS was considered one of the greatest threats to human kind. Today, the epidemic is largely considered to be within control. Similarly, concerted efforts in malaria control have brought down the levels of the disease. In South-East Asia, we have eliminated leprosy at the national level. We are at the cusp of eradicating polio. All these achievements have led to people leading better lives. No less significant is the improvement in the health of mothers and children, reflected in the declining mortality figures. The South-East Asia Region is estimated to have lost 3 million children under the age of five years in 2000 mainly due to preventable conditions. In 2010, the number of child deaths reduced to just over 2 million. From 2000 to 2010 the maternal mortality ratio in the Region was brought down from 370 to 200 per 100 000 live births.
Yet, some of the greatest threats to human lives too have been experienced in the past decade – the tsunami of 2004, which claimed over 200,000 lives in South-East Asia, and the influenza A (H1N1) pandemic, the first pandemic of the twenty-first century, are examples. Much has been learnt from these experiences, and WHO has attempted to integrate these lessons into prevention and response systems. Through the International Health Regulations, 2005, capacity to prevent as well as respond to public health emergencies has been significantly strengthened in the Region.

The period of transformation that the world is undergoing can therefore be viewed as an opportunity to push forward the public health agenda. Investment in health is crucial – healthy human capital is the basis for all progress, both social and economic. However, investment in health in the past decade has not been consummate with need, and has been skewed towards curative care at the expense of more cost-effective health promotion and disease prevention initiatives. This needs to be corrected as the Region progresses towards universal health care.

People are at the core of the enterprise of public health, and the success of health systems depends ultimately on the people who provide such services. Therefore, in order to achieve universal health care, health systems based on a primary health-care approach have to be strong and robust, and people who are a part of such systems have to be sufficiently empowered to effectively reach the most marginalized persons. We will need to redouble our efforts to further strengthen the public health workforce. At the same time, a greater emphasis on building an evidence base is needed for policy formulation.

Across the Region, community-based models of public health services have achieved significant success. These need to be integrated into the broader public health system. Simultaneously with building an evidence base and integrating models into the larger system, we need greater innovation – to find more effective delivery mechanisms, more effective drugs, and more effective ways to remain healthy, at the lowest possible cost, monetary and otherwise.

This cannot be achieved by governments alone. The private sector also has a key role to play in public health, a role that needs to be further strengthened and optimized. Indeed, most innovations in health, particularly in the area of drugs and vaccines, have originated in the private sector. However, the motivations of the private and public sectors vary widely, and finding ways to work harmoniously together, for the greater common good, remains a challenge.

Innovation goes hand in hand with technology. Rapid technological advances need to be harnessed for significant and rapid advances in public health. Utilized imaginatively and wisely, technology alone has the power to reach the unreached, to minimize cost and time of delivery, and lead to greater empowerment and informed decision-making in health.

There is wide acceptance of the fact that social determinants have a profound effect on health. We can no longer ignore the imperative of building a movement towards integrated approaches wherein multiple stakeholders across the various sectors of the economy adopt policies and strategies that contribute to human health. This assumes greater importance in view of the impending epidemic of noncommunicable diseases. The time has arrived to work towards making “health in all policies” or healthy public policies a reality.

The information technology revolution affords us a unique opportunity to strengthen community education and empowerment for health. We need to continue our quest to make individuals, families and communities self-reliant for informed decision-making on health.

The road ahead therefore leads from the foundations laid in the past decade, and builds on the following:

- greater public health capacity, particularly for response to emergencies;
- greater space for innovation;
- greater harnessing of appropriate technology for health;
- formulation of evidence-based policy.

"Health for All" may be considered to many a utopian goal, but the South-East Asia Region will continue to pursue it as an aspirational goal of health development.
THE TWENTY-FIRST CENTURY dawned with remarkable economic, political and technological potential for the over 1.83 billion people in the 11 countries of the World Health Organization’s South-East Asia Region. Along with the opportunity, the Region faced several public health challenges, including epidemiological transition characterized by a high burden of communicable diseases and a rising incidence of noncommunicable diseases, the unfinished agenda of high maternal and child mortality, and demographic transition. Added burdens included the threat of pandemics with new and emerging pathogens, the ageing population, lifestyle changes, rapid urbanization, high burden of injuries, effects of globalization and climate change, and the global economic crisis. This document showcases our efforts at meeting these challenges and moving towards “Health for All”.