Strengthening Public Health for Human Development

Reflections of

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Preface

The WHO South-East Asia Region has a vital role to play in achieving the global goals for health and development. After all, the vast majority of world’s population resides here. The Region also has a considerable proportion of people living in absolute poverty. On the other hand, we should not be swept away by generalizations. Within the Region, some countries’ health status compares favourably with other developing countries. The nations, importantly, have much in common – and running through is a quest for social justice and equity. The spiritual heritage of the Region professes health as one of the main pillars of human enlightenment. The South-East Asia Region is a veritable kaleidoscope, wherein the same elements combine to yield a multitude of patterns. Developing an appropriate, sustainable and people-centred health and development strategy for the Region is an enormous challenge.

Leading the health and development challenges of this extremely complex Region, which has such potential, is always a daunting task. Many countries in the South-East Asia Region are yet to effectively tackle the burden of communicable diseases and are already overwhelmed by the emerging problem of noncommunicable diseases. The gap between the “haves” and the “have nots” in the Region is telling.

Under the leadership of Dr Samlee Plianbangchang, the WHO Regional Office for South-East Asia has been able to substantially tackle these challenges in partnership with the governments. During his tenure, people-centred community-based health and development programmes have received enormous support and guidance. We have watched, with considerable admiration, his leadership in tackling the problems of avian influenza, severe acute respiratory syndrome (SARS) and the health impact of sudden large-scale natural disasters such as the Tsunami.

A major role of the Regional Office is to develop effective collaboration, based on evidence-based learning between the countries. The respect that Dr Samlee commands within the Region and his motivated leadership qualities, have ensured that this happens in full measure. He has gone beyond the boundaries not only to engage with the governments, but also with other potential partners from nongovernmental organizations, academic institutions as well as the “uncompromised” corporate sector. He has ensured that the concept of social determinants of health gets rooted within the governments of the Region. In technical areas, under his leadership, the Regional Office has played a stewardship role in the areas of innovation, intellectual property rights, promoting and shaping health products, and developing new diagnostics to treat diseases.

His conviction and commitment to take paths less travelled has ensured the breaking of new ground by WHO within the Region. His deep and heartfelt concern to address the problems of the unreached and excluded has been captured in all the programmes of the WHO Regional Office for South-East Asia.

This publication captures the essence of Dr Samlee Plianbangchang’s reflections and thoughts on various dimensions of health. His vast knowledge, long experience and genuine concern are reflected throughout this important document. It promises to be a great source of knowledge for present and future generations of health practitioners, leaders and decision-makers.

I am confident that the legacy that he is leaving behind will be further nurtured to meet our collective dream of having a healthy South-East Asia.

“Health is the best gift. Peace the best wealth. Trust is the best bond. Nirvana happiness.”

Dhammapada 204

Alok Mukhopadhyay
Chief Executive
Voluntary Health Association of India
Strengthening Public Health by Strengthening Health Systems

Public health plays a crucial role in our lives today especially as the world moves towards a new era where, paradoxically, on one hand there are critical improvements in health indicators and on the other, there are global health changes which confront the unguarded public. This unpreparedness is attributable to the huge complexity of the health challenges and to the neglected public health workforce, coupled by inadequate training programmes. The situation is further exacerbated as the resource stream is leaning towards biomedical research and there is very little effort to confront unhealthy behavioural patterns. WHO has recommended that for enhanced health equity, efforts need to be directed towards better management of health research and increased investment in health systems research. In addition, efforts need to be directed towards enhanced human resources and increased health financing that would facilitate better delivery of health services.

The bottom of the pyramid continues to bear the brunt of the incessant and persistent inequities in global health that pressurize the health systems of the developing world. For the remaining sections, the disease burden has reduced, quality of life has improved and life expectancy has increased. One fifth of the world’s population enjoys an average life expectancy approaching 80 years and a life comparatively free of disability, while two thirds of the world’s population – living in the least well-off countries of Africa, Asia and Latin America – suffer overwhelmingly from the world’s burden of illness and premature death. However, for this disparity to be addressed, what we need is reorientation. An understanding of what we have, and what needs to be done. A reformulation of the public health infrastructure that is appropriate for the global and national health challenges in this new era. The new system must echo the Alma-Ata model of primary health care and the public health of the 1980s. The work needs to address the schism that exists between research and health policy, and the focus should be on health reforms in clinical services that continue to
isolate the marginalized. Given that globalization has ensured we live in an interconnected, interlinked and interdependent world, the need to address health risks is imperative. The need of the hour is for institutions, such as universities and public health systems, to transcend national boundaries and make the health agenda conducive to current needs.

Perspectives on public health across the South-East Asia Region

Dr. Samlee’s views on health for the South-East Asia Region echo the global view. He advocates for political will together with an increased regional information-sharing as the path forward in addressing health concerns across the Region. Dr. Samlee believes a regional knowledge-sharing platform would further the public health capacity base in countries.

The role played by a country’s political set-up is of great significance to Dr. Samlee. He believes if the political will is in place, then the way forward is to continue, step up and accelerate the work. In ensuring this, the point to be noted is the lateral understanding of complex health challenges that would shape the health agenda ahead.

Dr. Samlee does not undermine the discovery of vaccines and the success of effective drugs over the past 50 years that have heralded the hope of conquering communicable diseases. However, he advocates for a perspective which takes into account that, even with this success, the brunt continues to be borne by children, women, the poor and marginalized sections of society. As per WHO estimates, nearly 90% of all deaths in the developing world are caused by infectious diseases such as acute respiratory infections, diarrhoea, measles, malaria, HIV/AIDS and tuberculosis. Efforts must be directed in a phased manner to ensure that benefits from such interventions reach the most vulnerable groups of the population. Dr. Samlee believes that will only be possible with a strong, efficient and well-equipped public health infrastructure, inclusive of effective surveillance systems and adequate laboratory back-up, and a functioning public health system that includes trained health staff.

Dr. Samlee is of the opinion that the current gaps in health systems could be addressed through improving the infrastructure by working on human resources and services. This view was echoed by the Calcutta Declaration on Public Health. The lack of human resources/manpower was suggested to be addressed through an increase of public health education in countries, which would ensure the availability of a critical mass of public health practitioners and professionals required for future health development. The education system could also be clubbed together with an interdisciplinary curriculum that would be country-specific, addressing the social, cultural, economic and political context. The focus would be on attracting people to work in the area of public health, which could be done through a cross-cutting approach that addressed the root cause of people’s unwillingness.

A promising career ladder would be an incentive provided by the governments and WHO. This would be an ideal strategy as it could work towards addressing the gap in staff and also ensure better implementation of programmes that presently suffer. This is an important strategy as we are faced with new health challenges, hence our approach needs to be novel and effective, calling for multisectoral actions and for “healthy sectoral policies and commitments”. He also suggested that the new health-care agenda must emphasize and promote vigorous efforts in disease prevention and health promotion.

Views on health systems strengthening

Dr. Samlee acknowledges and believes in the responsibility of health systems to provide care and services with dignity, which is a fundamental right of the consumer. He understands the various challenges in ensuring this, the primary one being the inaccessibility of the marginalized in the political agenda. Health systems will continue to play a critical role since health is an inseparable part of the lives of people across nations. The

**Public health strategy**

- Political will
- Social determinants of health
- Understanding the dynamic nature of health
- Inclusive and multisectoral
- Addressing the needs of the vulnerable
- Public health incentivized

"The public health infrastructure is as good as the people who operate it"
“haves” and “have nots” divide calls for integrated services, which must be organized at health facilities especially in communities and near people’s families. The current systems are unable to satisfy this requirement, and are thereby not addressing the needs of the population.

The current paradox in health-service delivery calls for more health facilities and staff at the village and community level (even though in many countries there is underutilization of facilities), which links to the responsiveness of health systems to the needs, demands and requirements of people. The reasons attributed to underutilization of services in the Region include the poor quality of care provided, large distances involved, high cost of services, bad attitude of staff, and a lack of social and cultural context. Health systems strengthening would need to relook at the health infrastructure, and must be viewed over the short and medium term. In addition, it requires working towards the long-term improvement of health by other sectors while keeping in mind an inclusive and multisectoral approach. The context of “healthy public policies” implies a “health concern” that needs to be incorporated in all development endeavours as represented in Figure 1 below.

Figure 1

The way forward on strengthening health systems and public health systems would require:

i) Re-examining the existing infrastructure for health (health policy, governance, human resources, finance, research and facilities) and public health (universities, human resources, finance, policy, International Health Regulations and framework)

ii) Working towards increased linkages, both multisectorally and intersectorally
The spectrum of health today calls for better equipped systems, which are dependent on factors such as the accessibility of financial and human resources and a favourable political framework. Health development as a concept must be utilized, which entails promoting optimal growth and development for everyone; maintaining good health for all, at all times; and promoting a healthy longevity of life, which is socially and economically productive. Providing affordable treatment to people is the key to facing the problem. Common concerns across all nations include the impact of aging populations, the provision of chronic care, and social security reforms. Similarly, the threat posed by new epidemics, such as avian or human pandemic influenza, requires a response from all countries, globally. The huge global spending on health systems still leaves the question of why health systems are not performing as well, unanswered. Therefore, the path forward must include understanding the health systems, evaluating their successes and challenges, and identifying more resources and ways of harnessing synergies towards health across different sectors.

"The best way to strengthen public health infrastructure and services is through strengthening the public health workforce"

Workshop on “Public Health Education in India: Issues, Challenges and the Way Forward”, New Delhi, India, 18 August 2005

Re-examining the existing infrastructure for health

The way forward would be an increased focus on health workforce health development. The established correlation between the performance of health workers and the critical health indicators must be acknowledged in the agenda. Countries in the South-East Asia Region continue to suffer from health workforce issues (shortage, quality of care, etc). There is a need for skilled health workers, particularly in ambulatory and community care, who have an insight given the status of public health now.

This correlates to the issue of public health education which, as Dr Samlee says, needs to be reformatory. The public health education system needs to relook at (i) settings (where and how to organize such a structure, to be nationally well placed given the changing nature of health disorders) (ii) restructurization of curricula and programmes for the education and training of public health professionals (content and quality) (iii) reorganization in the teaching/learning processes (motivating students and furthering their learning in terms of conceptual and practical skills). There is a need to think “outside the box” and perhaps create “leadership role models” in public health for younger generations. Dr Samlee explains that the basic principle of classic public health is still valid; however, rapid globalization and liberalization of international trade call for new public health strategies and approaches, which is where institutions, organizations and other sectors merge.

The strategic function of public health must be tapped to provide full support to comprehensive community-based health development.

The primary health care approach works towards ensuring health for all must be furthered. It is an established method of reducing disparities and is tailored towards strengthening health systems. The aim is to ensure that all people at the grass-roots level have access to primary health services. This also promotes the involvement of people, from all walks of life, in their own health development. Using this approach furthers efforts to reach the most vulnerable populations (rural and urban), and promotes local ownership, equity and social justice in health since it places the community at the centre of planning and implementation.

Regarding the current health system, there is consensus on the need for strengthening public health systems. The suggested method has been advocating for stronger public health education and research. Schools of public health must be tailored to contribute significantly to education and research in modern public health in the Region. The courses and curricula of schools need to be up to date and in sync with the new health
emergencies, so that they are able to cope with the dynamic nature of health. Short-term courses need to be initiated as well, to form the basis for courses at the higher level. In addition to this, the governing boards of schools must provide policy and strategic guidance to contribute to the strengthening of public health systems in the Region. The focus must be on educational content that helps tackle the health challenges of the entire population. The focus must be on:

- Reduction of disease burden
- Prolonging life by preventing death and disability through institutional care and services

These schools of public health need to serve national interests in the development and promotion of health for all, by promoting equity and social justice through a focus on community outreach. Public health needs to be linked to higher levels of care: primary, secondary and tertiary, through functional referral systems. The interventions should be developed and implemented within the context of local ecological, environmental and epidemiological factors. The context needs to be relevant to the needs of the people, as well as multidisciplinary and multisectoral, to pursue the ultimate purpose of public health – to reach the unreached.

Working towards increased linkages, both multisectorally and intersectorally

An effective network must ensure that governments have a significant role in the framing and implementation of health development policies, the scope of which has grown significantly over the years as the agenda works towards ensuring citizens to live longer and healthier lives. The policies need to be aimed towards reducing the burden of disease (communicable and non communicable), which could be achieved by shifting the emphasis from health care and services to promotive and preventive interventions. We need to focus on cost-effectiveness as it has a significant role in reaching out to the underserved and underprivileged. One of the ways to ensure increased regional coordination among countries has been the public health initiatives initiated in the South-East Asia Region in 2004. The purpose of engaging with forums like these is to help work towards an unwavering conviction and commitment to “good health for all people, through the implementation of the primary health care approach”. Such intercountry cooperation can lead to a better understanding of disease epidemiology and transmission patterns. This would facilitate a synchronous and effective response to pandemics.

Another body that should be worked closely with is the WHO Advisory Committee on Health Research (ACHR), which is an indispensable component of health development that aims to guide policies, strategies and programmes for health research. Health research should be an important priority for all countries as it enables the production of scientific evidence to further the development of better programmes. “Research for health” must be adopted, involving multidimensional research that has a bearing on health. It implies research efforts by
various disciplines and sectors required for improvement of the health of all people. Research for health expands the horizon of research needs for health development. The idea of research for health fits with today’s concept, as it aims to look at the scope of health far beyond the medical arena. The findings from health research must be directed to the stakeholders; for example, they must be properly utilized by policymakers, planners and managers. This could lead to quality research and produce reliable and relevant information. However, WHO has a role to play and must help Member States to gain self-reliance in such production, through promoting and facilitating technology transfer that could ensure sustainable development in the countries’ health care and services.

The multisectoral dimension of health must be understood and applied. There is a need to accept that health equity and social justice can be achieved only by multisectoral involvement and that the health sector alone is not enough to bring about effective changes. We need to realize that many solutions to health problems and health-related issues lie in sectors other than health, which is why it is important that different sectors take full responsibility. In addition, we need to have joint ownership that ensures synchronized work alongside increased regional ownership to help further the cause.

**Summary points**

Increased political will is a prerequisite while working on addressing the current challenges in health care. The need of the hour is to work on building capacities of the government and of the people.

The new approach needs to be multisectoral, where the focus is on reaching out to the most marginalized sections of society.

The multisectoral dimension of health must be applied and understood by all people, as it will be the base for sustained efforts for the future.

The way forward on strengthening the health system and the public health systems requires:

a) Revisiting the existing health infrastructure with an emphasis on an increased health workforce. This would be achieved through an enhanced public health education system.

b) Sustaining and conducting innovative efforts for strengthening primary health care.

c) Innovative and dynamic schools of public health which contribute significantly to research and learning and promote social equity.

d) Directing efforts towards increasing regional coordination among countries of the South-East Asia Region.

e) Focusing on health research as a critical component for engaging with other stakeholders.
WHO defines health as not merely the absence of disease or infirmity, but a state of complete physical, mental and social well-being. Health problems are the consequence of an interplay of factors, categorized into three main areas of disease, ignorance and poverty, all of which contribute to the root cause of ill health. These factors are perpetuated through a vicious cycle. Health is closely linked to development, which is why it is important to keep the benefit of the community at large in mind. Development practitioners must acknowledge emerging health concerns and ensure that the development activities agenda does not adversely affect people’s health. In fact, the focus should be on ensuring that development activities contribute positively and provide health benefits to people in the community. The responsibilities of various development sectors are part of “healthy sectoral policy”. Health development requires actions beyond those of the health sector and is considered to be an area that needs strong multisectoral coordination and cooperation. These are the policies under which respective sectors have to invest in order to ensure rational policy and strategy formulation leading to an enhanced sustainability.

Rapid urbanization in the Region is heavily taxing the available civic amenities and services, with associated problems of drug addiction, crime, violence, indoor and outdoor pollution, overcrowding, poor sanitation, and more. This calls for an urgent need to forge strong partnerships with all sectors and stakeholders, in order to create a viable and supportive environment to combat the problem at hand. The way forward must commence with the acceptance that the health sector alone is not enough to bring about effective changes to ensure health equity and social justice, and that the solutions to many health problems and health-related issues lie in other sectors. This understanding of the multisectoral nature of health needs to be universally recognized at all levels of development and not only at the top. The figure below helps explains the vitality of incorporating a multisectoral approach towards health.
Dr Samlee believes that creating a sense of ownership among stakeholders helps in taking determined actions to solve health problems. It is important as it helps realize an expanded concept of health that facilitates all sections of society to work in a synchronized manner towards the same health goal. He is of the opinion that the health of the public is affected by issues of trade, debt, technology transfer, capital flight, and brain drain among others, which is why health cannot be isolated. Globalization on one hand has contributed to a higher standard of health and on the other has increased health risks and inequalities. There is a wide gap between the “haves” and “have-nots” with regard to health, particularly in the South-East Asia Region. That is why we need to rethink the way forward on traditional medicine, which has been a core element used by people in the

Figure 2

Health and multisectoral action

Regional Conference of Parliamentarians on “Legislative and Policy Actions for Promoting Health”, Bali, Indonesia, 8-9 October 2007
Dr Samlee believes that we need to work towards providing good health to all citizens, regardless of their social and economic strata. This calls for equity and social justice in the provision of health care and services, and recognizes health as a fundamental human right. In providing health care services to the population, governments need to work towards ensuring universal coverage by reaching the unreached and most vulnerable. Work needs to be directed towards a social control of health technology – a technology that is affordable, socially and culturally appropriate, and acceptable to all people in the community. Such technology should also include information that enlightens the population to understand and recognize health risks. Primary prevention, which is achieved through public health interventions, targeting management of health risks and health determinants needs to be in place. The future of health is strongly linked with the results of primary health care initiatives from countries in the Region.

A balanced development in health care and services must be employed to ensure health for all people. It is balanced development through health promotion that prevents people from falling sick, by focusing on disease control and prevention. These are cost-effective interventions that help reduce the disease burden in the community and the entire population.

Health and disasters

Another example of why health must not be viewed in isolation is the Tsunami of 2004, which was one of the worst catastrophes of our times resulting in approximately 200,000 deaths in nine countries and displacing an estimated 1.2 million people. We were able to get over the loss only because of the prompt response of governments and international organizations. It was a landmark in global solidarity, unity and concerted effort by all stakeholders who came together to help the affected populations. The South-East Asia Region has experienced several catastrophes such as the earthquake in Gujarat, India in 2001; the chemical blast in Ryongchon, Democratic People’s Republic of Korea in 2004; bomb blasts in Bali, Indonesia in 2002 and in 2005; and monsoon floods in Bangladesh in 1998 and 2004. Events of this nature require an emergency response, including risk assessment, as well as the development of national multisectoral policies and strategies.

An understanding of the multisectoral aspect of health and its overlapping nature will enable countries to effectively plan and coordinate activities relating to emergency preparedness and response. In fact, Dr Samlee suggests the “4 Es” strategy for emergency response:
Effectiveness: How well did the strategies employed and the activities conducted reach the target population? What was the result? Should there be some tools to measure impact?

Efficiency: What was the cost incurred against the benefits provided to the affected population?

Empowerment: Did the actions get transferred to a larger objective and the wider community? Since the objective is emergency preparedness, it is important that the actions taken prepare communities for future disasters.

Engagement: Was the process of decision-making inclusive and collectively owned?

The health sector plays a pivotal role in providing technical access to other sectors to play their roles effectively. The private sector has already been involved in the provision of medical care services and could be further driven to provide the same to the most marginalized sections. Nongovernmental organizations continue to do a commendable job in improving access to health care. However, for a greater impact, increased political will is a must that requires intensive advocacy and promotion by the aforementioned stakeholders.

Health and environment

Recent findings indicate that a quarter of the global burden of disease is due to environmental degradation. Every year, an estimated 6.6 million deaths in Asia are attributable to health risks from the environment. In urban settings, where almost half of the world’s population live, civic amenities are unable to keep pace with the burgeoning population. In the Asia-Pacific region, more than 20% of the population does not have access to safe water and about 50% of this population have no access to sanitation facilities. Thousands of chemicals are circulating in the environment today. In addition, the extreme climatic changes and their adverse health impact are known to us. The complexity of relationships in health development among sectors, countries and agencies is clearly recognized. There is no formula for public and private mix. It depends on local specific situations and circumstances.

Dr Samlee, in agreement with the speech of His Excellency Mr Maumoon Abdul Gayoom, President of the Maldives at the World Health Assembly, echoes his view that global warming “threatens the very survival of the nation”, not only through economic impacts, but also through its health effects; increase in vector-borne diseases, reduced fish stocks, and salination of water supplies and agricultural land. In the case of Maldives, the solution is to work together across all sectors and national boundaries, both to reduce and adapt to climate change. The “links between the environment and health show that addressing the challenges in both areas calls for a global partnership, where everyone becomes a part of the solution and none of the problem...at the end of the day, prevention is still better than cure and we must work on making that our goal in promoting environmental health.”

Summary points

✱ Health cannot be viewed in isolation and its multisectoral nature has been proved on many occasions.

✱ The focus needs to be on a balanced development of health care, which includes multi-agency support and addressing gaps.

✱ The agenda must be tailored towards preventative care rather than curative measures, which will only be achieved if governments agree to provide people (especially the most marginalized) with a high quality of health care that would rationalizes high technology applications and works intersectorally to promote health.

✱ The current situation demands the joining of hands and partnering of multiple sectors, including the private sector and nongovernmental organizations, to work to empower people with a new sense of responsibility and participation in the pursuit of common goals for health.
Emerging Health Challenges

The South-East Asia Region is a hotspot for emerging infectious diseases, including those with pandemic potential. They take a heavy public health and economic toll on global economies. As per WHO estimates, infectious diseases are responsible for about 40% of the 14 million annual deaths in the Region. Their emergence is thought to be driven largely by socioeconomic, environmental and ecological factors. Severe acute respiratory syndrome rapidly decimated the Region’s tourist industry and avian influenza A (H5N1) had a profound effect on the poultry industry. The reasons why the Region is at risk are complex, since it is home to dynamic systems in which biological, social, ecological and technological processes are interconnected in ways that enable microbes to exploit new ecological niches. These processes include population growth and movement, urbanization, changes in food production, agriculture, water and sanitation, etc. together with generations of drug resistance.

The South-East Asia Region is still plagued by age-old foes of mankind such as tuberculosis and malaria that continue to take a toll on the population, the majority of whom reside in malaria-infected areas. Tuberculosis continues to kill more than 750,000 people every year. The situation is grim as more than 6 million people in the Region are already infected by HIV, and outbreaks of Japanese encephalitis, leptospirosis, hepatitis E and dengue are a regular feature. Therefore, the emergence of infectious diseases adds to the complexity of the situation in the Region. Researchers have struggled to calculate the present and the future costs related to the SARS outbreak, initially estimated at US$ 30 billion in the Far East alone. Microorganisms, particularly viruses, are highly unstable and possess remarkable genetic versatility, which allows them to alter their genetic make-up thus becoming a greater challenge. This is furthered by pathogens possessing the ability to become antibiotic resistant. There was an opinion floating around, of a day when infectious diseases would cease to be an area of public health importance; however, that has been proved wrong, as the arsenal
of antimicrobials have not kept pace with the genetic ingenuity of microbes.

The regional challenges to the control of emerging infectious diseases are formidable and range from influencing the factors that drive disease emergence, to making surveillance systems fit for purpose, and ensuring that regional governance mechanisms work effectively to improve control interventions. To ensure a sustainable impact, concerted efforts are required by all concerned across every level. Strong political commitments with adequate financial and other resources are essential prerequisites to develop the way forward.

Emerging infectious diseases – pandemic preparedness (SAARS and H1N1)

Outbreaks of avian influenza (H1N1) started in 2009, and spread rapidly to other parts of the world. In responding to the threat of these outbreaks, on 25 April 2009, Dr Margaret Chan, WHO Director-General, declared the world’s first ever “public health emergency of international concern”. This was done in accordance with the provisions of the International Health Regulations (IHR, 2005). As of 9 July 2009, there were 135 countries affected worldwide. A total of 94,574 confirmed cases were reported, with 429 deaths. The main concern with the H1N1 influenza was its “reassortment”. Dr Samlee explained pandemic preparedness through examples of pandemics in the South-East Asia Region such as avian influenza, which was a serious health threat worldwide affecting both animals and humans. It was one of the most formidable socioeconomic challenges, which had a huge impact on the national economies of the affected countries impacting tourism, travel and trade.

The South-East Asia Region witnessed SARS in 2003, the first in the category of diseases to cause a pandemic. It spread to more than 30 countries around the world with Asia being the epicentre that suffered both in terms of lives lost and economic disruption. The outbreak of the highly pathogenic avian influenza in poultry was historically unprecedented in scope and severity. According to the Food and Agriculture Organization (FAO), the pathogen was endemic and firmly entrenched in poultry in many parts of Asia. It is also believed that due to the close proximity between humans and poultry there are ample opportunities for the virus to be transmitted to man, which would in turn give rise to a mutant strain of the agent. The unpreparedness of South-East Asia means the Region is in a situation to be worst affected, especially at a time of a pandemic. The issue of quarantine needs to be addressed which carries with it social, economic and political implications.

Dr Samlee believes that we can curtail the huge social and economic impact of an epidemic by adequate preparedness. Pre-emptive vigilance ensures countries become equipped with resources, service deployment strategies and expert strategies to help minimize the impact of human morbidity and mortality and economic loss.

The path forward must direct efforts towards all Member States developing comprehensive, multisectoral plans along with political leadership and support. In this connection, the Asia Pacific Strategy for Emerging Diseases provides a framework to improve health protection of the populations through partnerships. The South-East Asia Region is in the Pandemic Alert Phase III, where countries have formulated national pandemic preparedness plans that are blueprints for further action and are being implemented by Member States. One of the main lessons learnt has been intersectoral collaboration, between agriculture and health, which is of paramount importance and if further ignored will have a catastrophic impact. Dr Samlee advocates

Avian influenza A (H5N1) virus caused 129 human cases in November 2005, out of which 65 died, overloading the health care systems.

Pandemic creates a stir and could bring life to a grinding stop; affecting workplaces, industries, schools, tourism and travel.

WHO must:
1. Investigate the outbreaks of human cases, when and where they occur
2. Provide support for strengthening countries’ capacities in disease surveillance and laboratory back-up
3. Procure and stockpile antiviral drugs and vaccines
4. Apply certain public health interventions in preparedness programmes
5. Inform and educate people
for coordination among all stakeholders, to look at weak links and strengthen the aspects of prevention and control. In addition to that, he promotes the technical role played by agencies such as WHO, FAO and the World Organisation for Animal Health, who must continue to support countries in preparing and refining their plans.

Dr Samlee believes that the focus should be on equipping people with information in a manner so that they are equipped to do everything possible to protect their own health. The community must be sensitized on how to protect themselves through improved hygiene, sanitation, food safety, nutrition and physical exercise. Communication tools must be utilized and disseminated which are tailored to the needs of the community in a local language. This would instil confidence in people, helping them to prepare and face pandemics, and also have an important impact on the prevention of other communicable diseases.

Dr Samlee feels that the course of an epidemic could be modified if all agencies continued to do their work diligently. Since past experience has shown that the initial situation of influenza pandemics could change and, historically, it is believed that influenza pandemics encircle the globe twice or thrice in two to three years. The deadly influenza pandemic which occurred in 1918 was in a mild form at first, before turning into a far more deadly one. The 1957 influenza pandemic began with a mild phase, and then was followed by a second wave of a higher fatality; and the influenza pandemic in 1968 remained mild in both its first and second waves. Indeed, the influenza virus is unpredictable and given the ambiguity and in the midst of this scientific uncertainty, he recommends it is incumbent upon us to:

- be well prepared
- be prudent in providing advice to the public
- be vigilant with the monitoring system.

Non-communicable diseases

Chronic noncommunicable diseases (NCDs) have become a public health challenge in this part of the world. Combating them requires wisdom and unwavering efforts, as they are the leading cause of death and disability affecting all social and economic strata. In WHO’s South-East Asia Region alone, NCDs account for 51% of all deaths, and 44% of the overall disease burden. Major NCDs targeted for integrated prevention and control include cardiovascular disease, cancer, chronic pulmonary disease and diabetes. Ischaemic and hypertensive heart disease, stroke, and rheumatic heart disease account for 27% of all deaths and 10% of disease burden in this Region. Almost half of these deaths occur prematurely. NCDs impose an enormous burden on health which can be countered by making the available know-how of the disease accessible and available to all. The application of simple, population-based interventions such
as reducing blood pressure levels by limiting salt intake can save thousands of lives, curtailing the cost of hospitalization and rehabilitation. When applied in an integrated manner at every level of the community, the available interventions can prevent at least 80% of all heart diseases and strokes.

Dr Samlee suggests that interventions that are integrated, comprehensive, population-based and risk factor-centred can ensure an effective reduction of the occurrence of heart diseases. WHO’s programme on the prevention and control of chronic NCDs is particularly targeted at the major risk factors. These include tobacco use, alcohol consumption, physical inactivity, imbalanced diet, obesity and high blood pressure. Prevention and control are pursued through risk factor surveillance and integrated community-based interventions. This approach is based on the recognition that risk factors, particularly those that are behavioural in nature, operate throughout a lifetime. They are interlinked and cumulative and must be addressed with a set of coordinated interventions. To strengthen the evidence base for action, WHO has been devoting its efforts to support the review and development of national NCD surveillance in countries. It has a well-defined approach that works across NCD information bases that are being developed, monitored and updated.

Tobacco is responsible for a quarter of the five million deaths annually in the South-East Asia Region. In addition, the Region is the largest producer and the largest consumer of tobacco products. Illicit trade in tobacco products has contributed significantly to the global problem of tobacco use and is emerging as one of the biggest obstacles to the control of tobacco use in developing countries. It is important that work is directed towards increased collaboration among partners at all levels for a successful tobacco control programme worldwide. WHO has been a partner in the Bloomberg Global Initiative to Reduce Tobacco Use and work must continue to engage closely with other stakeholders, nationally and internationally. Dr Samlee is of the view that WHO must continue striving towards setting international standards on tobacco control.

Diabetes continues to affect the lives of many people. According to 2007 estimates, there were 54 million people affected by diabetes in the South-East Asia Region. This number is anticipated to increase by 71% by 2025. India, due to its very large population, has the highest number of people with diabetes in the world at nearly 41 million. The prevalence rate of diabetes in adults in countries of the Region ranges from 2% to 8%. High rates between 7% and 8% are reported from India, Maldives, Sri Lanka and Thailand. Dr Samlee recommends “primary prevention” of diabetes, which requires greater attention at all levels. The Region, with its high incidence of risk factors (including imbalanced diet, physical inactivity, obesity, tobacco use and harmful consumption of alcohol) continues to suffer. There is also a remarkable variation in the prevalence of individual risk factors, which reflects the complexity of the situation. Hence, there is a need for targeted public health interventions to suit specific national, subnational and local settings.

Emergencies and disasters

The South-East Asia Region is known to be disaster prone, a situation that is aggravated by the onset of climate change impacting on all countries in the Region. During 1999 to 2008, about 62% of the total global deaths from natural disasters occurred in the Region. As an example, the devastating Tsunami of 26 December 2004 left an estimated 230,000 dead or missing, and contributed to losses estimated at several billion US dollars. In 2007, cyclone Sidr hit Bangladesh, resulting in an estimated 3000 deaths and losses totalling about 1.7 billion US dollars. In 2008, cyclone Nargis struck Myanmar, and resulted in about 134,000 deaths or “missing persons” and losses of about 10 billion US dollars. In these crises, the existing “inequities” in both social and economic terms have been amplified with new social and public health problems emerging. The prevailing health problems have been aggravated. However, the sad part is that the hardest hit are

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**NCDs in the South-East Asia Region account for:**

- At least 1.4 million deaths due to sustained high blood pressure
- 1.1 million deaths due to tobacco use and high cholesterol levels
- 1.3 million deaths due to sedentary lifestyles

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the most vulnerable, including women and children, the disabled and the elderly. This is an important humanitarian issue. Protecting health, livelihoods and assets during the response phase of an emergency and addressing the root causes of crisis in the recovery phase provide a better chance for sustainable impact from emergency management efforts. With limited external help during the first week of the crisis, a coordinated response from the community and local government determines the positive outcome of the efforts.

The Tsunami provided WHO with an excellent opportunity to reflect on their own work and understand how their strength of delivering services efficiently helped cope with the emergency at hand, which could have been furthered by increased intercountry and interregional networks.

Dr Samlee feels that WHO as the technical agency in health has a strong comparative advantage, but the work of the people must underline the technical competence and credibility of the agency, and its ability to move fast logistically and managerially. However, he understands that this needs, among other things, well-coordinated and integrated efforts within the Organization. Emergencies that require quick actions, such as immediate deployment of staff to affected area and medical supplies, among others, also need an immediate response from national authorities. The focus must be on working as a team, in synergy with the efforts of the Member States and various partners. He feels that disasters have the potential to strengthen the capability and capacity of the nation, which can be done if simultaneous efforts are made to empower communities and people to respond more efficiently and effectively to the emergency situation on the ground.

Policy interventions and provisions always help ensure that national governments can steer and guide the health sector in the desired direction. There is also a need to preserve policy space, which is particularly relevant when countries are acceding to the World Trade Organization; yet, at this particular time, officials from both the trade and the health sectors may be unfamiliar with the effects that trade policies and agreements can and do have on health. Often, there is inadequate communication between the health and the trade sector, which affects coordination and policy adherence.

Dr Samlee believes in an enhanced reinforcement of communities and people, who have always come together and coped with disasters. Taking an overview of the disaster in Indonesia, when a devastating earthquake in Yogyakarta killed more than 6000 people and injured over...
Dr Samlee recommends preparedness and joint coordination as the solution for an emergency. Joint preparations by the government and all concerned sectors with regard to the eruption of Mount Merapi helped to put in place important resources that were then easily mobilized for the response to the earthquake. Operational guidelines which were developed during the time of Tsunami provided strong support.

A factor which helped Indonesia cope was the provincial health system, which was well resourced with health facilities and health professionals. In addition to the assistance that was mobilized from neighbouring provinces, international support helped to augment what was already on the ground. Bottlenecks have been the inefficient and nonexistent disaster management system in some places which have delayed responses, as well as lack of financial resources and trained staff.

Emergency preparedness is an element that must be included in national development strategies and plans. The World Health Assembly has underlined the need to strengthen the capacity of Member States in emergency preparedness and response. The WHO Regional Committee for South-East Asia has also provided direction on several key issues so that Member States can move forward rapidly in strengthening their national capacities for emergencies. The health of affected people during crises depends on the capacities of health systems to effectively address emergency health needs. One of the recommendations is using the primary health care approach which ensures “equitable access”. The Tsunami in 2004 is an example of commendable results achieved where effective and urgent interventions were made during the first hours of the emergency by trained health volunteers in Thailand and Indonesia; and during Cyclone Sidr in Bangladesh where community-based actions took place in response to “early warning” and evacuation. This approach, along with the efforts of various sectors, promotes synchronized actions on the ground multiplying community capacities through better preparedness and response.

**Climate change**

Climate change contributes to the frequency and severity of natural disasters. The reality of global warming due to climate change is now universally accepted. It is the result of human actions and activities. According to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change, there has been a remarkable increase in global atmospheric concentrations of greenhouse gases. Global warming due to these greenhouse gases is undisputed. The sad part is that global warming will continue even if the concentrations of greenhouse gases are stabilized. Some effects of global warming are already being felt: more frequent and intense heat waves and cyclones, unusual patterns of rain and floods, and unpredictable droughts in certain places.

In the South-East Asia Region, about 82,000 deaths in 2002 were attributed to malnutrition and diarrhoea. These deaths could be attributed to climate change. The rising global temperature, if not properly addressed now, will jeopardize achievements in the field of health-related Millennium Development Goals (MDGs).

Developing countries contribute the least to climate change; however, they are disproportionately affected by it. Energy policies, for example, need to be guided by an assessment of the impact of climate change on vulnerable populations. There needs to be a check on carbon emissions, which must be reduced to avoid the worst outcome. Developing countries need rapid economic growth so that no country is too poor to successfully pursue adaptation to the impact of climate change.

The principle of contraction and convergence needs to be implemented. In order to reduce global carbon emissions by industrialized nations and simultaneously ensure accelerated economic development of underdeveloped countries, the health sector needs to send positive messages on health gains from well-conceived adaptation and mitigation policies.
Dr Samlee views climate change as a fundamental threat to human health that requires urgent attention and action. Efforts need to be directed towards:

“Bangladesh provides a good example of a successful adaptation programme against natural disasters.”

South-East Asia High Level Preparatory Meeting for COP16, Dhaka, Bangladesh, 19–21 October 2010

- Strengthening public health programmes to control diseases of poverty such as malnutrition, diarrhoea and malaria; this is essential to protect the most vulnerable populations.
- Cutting greenhouse gas emissions; this represents a mutually reinforcing opportunity to reduce climate change and improve human health.

Summary points

- The way forward must include strengthening of surveillance systems; application of epidemiological, molecular, biological and behavioural approaches and establishing linkages amongst all stakeholders.
- Applied research will help in understanding the epidemiology and pathogenesis of the diseases, as well as in developing effective measures to counter the destructive attack of these organisms.
- Public–private partnerships focusing on early detection of emerging infectious diseases must be adopted as they assure health security.
- Intercountry cooperation, exchange of information and risk communication must be incorporated as they help prevent panic and hysteria during an epidemic.
- Work must be directed in close coordination with the IHR (2005) to prevent spread of diseases.
Social Determinants of Health

Health can increase the impact it has on the well-being of a person by leveraging the “social determinants of health” – i.e. the social, economic, and physical conditions that underlie and shape health. Determinants of health are factors that contribute to a person’s current state of health. These factors may be biological, socioeconomic, psychosocial, behavioural, or social in nature. Addressing the social determinants of health is a primary approach towards achieving health equity. Health equity is “when everyone has the opportunity to ‘attain their full health potential’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance.” Health equity has also been defined as “the absence of systematic disparities in health between and within social groups that have different levels of underlying social advantages or disadvantages – that is, different positions in a social hierarchy”. Social determinants of health such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying contributing factors of health inequities. International agencies and donors are committed to achieving improvements in people’s lives by reducing health inequities. Health organizations, institutions and education programmes are encouraged to look beyond behavioural factors and address the underlying factors related to social determinants of health.

The social determinants of health are crucial elements in understanding the world today, especially since the gap in health between the haves and have-nots is ever widening. There is a crisis in access to basic health services, particularly among the poor and vulnerable populations. The South-East Asia Region, which is home to a quarter of the global population, carries 30% of the global disease burden and accommodates about 40% of the world’s poor. In spite of the increased coverage in health services through primary health care, 25% to 30% of the population does not have access to essential health protection.
Therefore, tackling health inequities among countries and within individual countries is a formidable challenge. Inequity is enhanced through rapid urbanization and globalization which lead to unhealthy lifestyles, low levels of education and gender imbalances. The impact of epidemiological and demographic transition, along with constant social change, has a huge impact on the overall health of the population.

Urbanization in South-East Asia heavily taxes the available civic amenities and services, particularly in areas of high population density, and is associated with problems of drug addiction, crime, violence, indoor and outdoor pollution, overcrowding, poor sanitation and more. Dr Samlee believes that to tackle these problems effectively, we need to:

**Design and implement future campaigns which emphasize and tackle the root cause of poverty**

This could be achieved through:

1) Forging partnerships with all sectors and stakeholders that will help create a viable environment.
2) Accepting that the health sector alone is not enough to bring about effective changes to ensure health equity and social justice.
3) Understanding the determinants of health and directing work towards closing the gaps and inequities in health in our societies, by catering to the needs of the marginalized sections.

To help achieve these aims, the Commission on Social Determinants of Health, a global network of policy-makers, researchers and civil society organizations, was established by WHO in 2005. The Commission delivered its final report to WHO in 2008 and subsequently ceased its functions. The purpose of the Commission was to tackle social causes of avoidable health inequalities. It used the following principles to guide its work in eliminating health inequities for local communities, nations and the world:

- improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;
- tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally;
- measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

This conceptual framework, figure 4 describes the relationships among individuals and structural variables. It also represents relationships among variables that are based on scientific studies or substantive evidence. The framework provides a point from which researchers work towards targeted interventions on social determinants of health.

"All sectors and all sections of society must work in a synchronized manner towards the same health goal, if the goal of health for all people is to be realized."

Regional Consultation on Social Determinants of Health, New Delhi, India, 15–16 September 2005
Dr Samlee feels that the Commission was the best platform to address the health challenges in a technically sound and effective manner. It would go a long way towards ensuring health equity and social justice by focusing on the root causes of ill health and on the factors contributing to good health in the development process, thereby setting a high benchmark. The approach was wholesome and would ultimately lead to better sustainability of health gains from the investment in health and health-related sectors. This global exercise would greatly contribute to a more rational policy and strategy formulation, thereby directing efforts towards sustainable development in health. The Commission would also provide guidance on the direction, tools and mechanisms that must be employed for addressing social determinants in various ongoing and new WHO collaborative programmes at regional and country levels. Dr Samlee believes the Commission helped provide an opportunity to chart out concrete steps to reduce health inequalities, ensure social justice and accelerate the development of health for all.

The community-based health workforce is the cornerstone of primary health, consisting of community health workers and community health volunteers who have contributed considerably towards equity in health care at the grass-roots level and play a significant role in ensuring health for all.

Figure 5

Community health workers and community health volunteers help achieve health targets due to their unstinted commitment, which makes them an integral part of the community as they become accepted “change agents”. Figure 5 explains their significance and their approach of facilitating ownership in the community by involving people from all walks of life through their in-depth understanding of the community and the people. People in rural areas rely greatly on community health workers and community health volunteers and who continue to play a crucial role in prevention interventions and disease control. They are important segments in the social determinants of health approach. However, to optimize their strength it is necessary to have (i) a strong
referral system for sending sick people from the community to higher levels of care; primary, secondary and tertiary (ii) institutional support for the education and training of the community workers throughout their careers in order to sustain their competence and skills (iii) professional backstopping in planning, implementing and monitoring the activities of the community workers to ensure the efficiency and effectiveness of their work (iv) operational back-up and policy support for effective development and deployment of community workers.

Dr Samlee believes that public health programmes must serve the entire population, and address health risks and health determinants. The social determinants of health approach would require the insight to ensure that programmes are ecologically and environmentally sound in their development and implementation, and that they are developed within the socioeconomic, cultural and political context of the country. It would also be implemented through a multidisciplinary and multisectoral approach that ensures health for all, paying special attention to the vulnerable populations. All of this will be possible if we realize that the community-based health workforce constitutes the backbone of efforts to attain health for all.

An example of the importance of community participation can be seen in the grave situation of maternal, newborn and child health, which is particularly serious in Asia and the Pacific. Every year, more than half a million women in the world die due to pregnancy-related conditions and more than 9 million children die before their fifth birthday. However, it is believed that most of these deaths could have been prevented if the currently available technological interventions were appropriately applied, within the sociocultural context of family and community.

Another reason why it is important for successes to be sustained while addressing the present trend of maternal and newborn mortality is due to its linkage with the MDGs, which are unlikely to be achieved by many low-income countries in Asia and the Pacific. The MDG targets are the markers not only for health development, but also for economic and other aspects of social development. These indicators reflect cultural practices, as far as rural health is concerned. Dr Samlee, during a bi-regional consultation, highlighted the importance of the sociocultural and economic dimensions of maternal, newborn and child health and focused his attention on the way that these dimensions are incorporated in the programming process to benefit the health of the mother, newborn and child.

The recommendations of the global Commission on Macroeconomics and Health and the Commission on Social Determinants of Health provide us with adequate policy guidance. However, the guidance needs to be tailored to suit the situations and needs in the individual countries in their attempts to improve their health indicators.

Community health actions require the combined force of both health workers in government systems and the community members themselves.

We need to also remember that community health action needs capacity-building; capacity-building through interactive learning processes, with in-built research and development.

As stated earlier, a major challenge facing the Region is inequity in health. In spite of the increased coverage in health services through primary health care during the past two decades, 25% to 30% of the population continues to not have access to standard quality health care. The market-oriented approach and privatization of health care without effective regulatory systems has had a negative impact on people’s health. In a private health care market, access to health care is dictated by the consumer’s purchasing power. In a region where the majority of the people are poor and have neither sufficient information nor the buying capacity, a profit-oriented market system cannot serve the health interests of the poor. There is also a supplier-induced demand, leading to technical inefficiency as a result of the unnecessary use of highly sophisticated health services. Hence, countries in the South-East Asia Region face a major challenge related to increasing health care costs. Accessibility to health services is an important issue that Member States need to address, since health care
The recommendations of the Commission on Macroeconomics and Health emphasize the importance of investing in health as a means of improving economic development and highlight the need for intersectoral and community action for health as the way forward. Dr Samlee feels that learning from the past experiences of countries which have launched schemes to further community ownership and partnerships are important aspects of the social determinants of health approach. Examples include the “Community Health Worker” scheme in India, “Lampang Health Project” in Thailand and the “Village Community Health Development” programme in Bangladesh, which were all commenced with the objective to increase community participation and ownership.

Dr Samlee advocates for a more community-centred approach to health care, addressing the main issues of equity and access to health care by all. The purpose must be focused on shortening hospital stays and pushing for cost-effective interventions. The way forward must extend health services beyond the hospital walls, particularly to those in the greatest need. Health care services must be redesigned to meet local health needs as identified by the community. Activities and tasks should ideally be the responsibility of the person or institution best suited to perform them.

Dr Samlee believes that as a way forward to tackle the problems effectively, we need to design and implement campaigns which emphasize and address the root causes of poverty. This could be done using the guidelines from the Commission on Social Determinants of Health to help chart out concrete steps to reduce health inequalities, ensure social justice and accelerate the development of health for all.

“All services should place patients/diets at the centre of care and contribute to the development of a good relationship between the service providers and dients, based on mutual trust.”

Annual Academic Sessions of the Kandy Society of Medicine “Healthcare Beyond the Large Hospitals”, Plant Genetic Research Auditorium, Peradeniya, Sri Lanka, 10 February, 2005.

Summary points

✱ Dr Samlee believes that as a way forward to tackle the problems effectively, we need to design and implement campaigns which emphasize and address the root causes of poverty. This could be done using the guidelines from the Commission on Social Determinants of Health to help chart out concrete steps to reduce health inequalities, ensure social justice and accelerate the development of health for all.

✱ There is a need to revisit the community-based health workforce.

✱ The point to be kept in mind is that community health actions require the combined force of both health workers in government systems and the community members themselves.

✱ The social determinants of health approach would work towards developing public health programmes which are community-based and serve the entire population, addressing health risks and health determinants.
The concern that countries in the South-East Asia Region need to address is identifying ways of improving access to health care for the unreached. This is very significant in view of the current challenges we are facing in our efforts to ensure health services for all. The three substantive areas that have a significant role to play in health access are: health care financing; health care delivery; and the nongovernmental sector in primary health care. If we can, we must find appropriate approaches to integrate them as they would help us reach a long way in targeting the unreached. At this juncture, all countries in the world are trying to ensure that health services cover the population including urban and rural, rich and poor. Even with our systems that have been developed over the years, there are still more than 800 million people worldwide who do not have access to necessary health care and services.

Dr Samlee feels that we must direct our attention not just to infrastructure development but also to identifying ways of bringing health services to each and every community. He feels that institutional care caters only to the urban population who can afford the services and to those who are really sick. He goes on to explain how the vast majority of people, even though they are ill, do not come to receive such institutional care. There are various reasons for such underutilization of institutional care, ranging from lack of physical accessibility and financial ability, to psychosocial distance between care providers and receivers. The universally accepted solution is primary health care, the development and implementation of which must be rooted in the community itself, whereby the process is implemented by the people and for the people. Dr Samlee feels the way forward must be in health systems strengthening,

### WHO’s vision for health care access

- **1950s–1960s** Advocated for development of systems for delivering basic health services to all population groups.
- **1970s–1990s** Advocated for the primary health care approach as the key to the attainment of the goal of universal health coverage.
- **2000s** Advocating for innovation in the primary health care approach; “continued relevance” of health systems; increased focus on the marginalized populations and multisectoral involvement.
on the basis of the primary health care principle that reaffirms the goal of “good health for all people” in countries and the world.

The focus needs to be on ensuring that primary health care is readily available to all people who are in need, everywhere, especially the poor and marginalized. The responsibility lies at both the individual and collective level, and at all stages of development, i.e. planning, implementation, and monitoring and evaluation. We must work towards fulfilling the objective of “health for all” and “all for health”, which will be achieved only if we can involve people from all walks of life to participate in the process of development for their own health. To ensure these objectives, particular efforts need to be directed towards educating and empowering people to be able to take responsibility. People, governments and WHO have to participate in the process of education and empowerment. Dr Samlee believes that effective advocacy would further political will in the development of health care systems. We need a public health infrastructure and workforce that ensures delivery of health services and reaches out to every corner of a country, in a manner which focuses on the community needs.

The overarching principles of primary health care:
- Equity
- Universal coverage
- Social justice

Primary health care is an integral part of a country’s health system, of which it is the nucleus. It forms an important part of the overall social and economic development of the community.

Primary health care is:
- essential health care made universal
- accessible to all individuals and families in the community
- care that is socially acceptable and economically affordable to the people in the community through their full participation and involvement

A landmark event in the history of the primary health care movement came during the Thirtieth World Health Assembly in 1977. Mutual agreement was made on the social target of governments and WHO: the attainment, by all the citizens of the world by the year 2000, of a level of health that will permit them to lead socially and economically productive lives. This was also known as “Health for all by the year 2000”. At this time, however, the overriding consideration underlying the decision was the increasing magnitude and severity of the world’s health problems, and the global concern with the unjust and unbalanced distribution of health resources throughout the world. Health for all through the primary health care approach requires “unconditional access” to health care by all people everywhere. It is universally accepted that primary health care has significantly contributed to improvements in the health of all people around the world. This contribution has mainly been through overall social and economic development in countries, in addition to direct contributions from health programmes. Developing countries have had greater health benefits from the implementation of the primary health care principle.

Dr Samlee believes that even though health for all could not be attained by the year 2000 as envisaged, it still exists as an aspirational goal, towards which all countries should strive in their health development efforts. Primary health care is still considered as the key to reaching the social goal of health for all. Since its inception, the principles and concepts of primary health care have been adapted and applied by all countries in the past three decades. The application of these principles and concepts has been carried out in a manner suited to the local sociocultural, economic and political contexts of the countries concerned.

We have proof enough to understand that the proper application of primary health care concepts has far-reaching consequences that penetrate not only the health sector, but also impact other aspects of social and economic development, particularly at the community level. Primary health care contributes to health systems development and management, as well as making a positive impact on the health of people around the world. Today, due to global changes in all spheres – social, economic, political and technological, there are environmental, ecological, demographic and epidemiological transitions that come with formidable health challenges affecting the way we plan and manage health programmes for health development today.

Globalization ensures that the world’s people increasingly live in a global village, where they share almost all things including health and disease.
Dr Samlee suggests that if we are to achieve health for all, we need strategies and technological tools that can help us tackle today’s health problems in a much more efficient and effective manner. These strategies and tools need to be suitable for implementation through primary health care. He advocates for a revisit of the primary health care approach, its principles and operational modalities. This is with the aim of ensuring continued relevance in the application, utilization, improvement and innovation of these principles and modalities of primary health care. Health is not just restricted to one sector and needs to partner closely with other sectors to ensure collective responsibility for the development of health for all people. It requires multisectoral actions, where sectors work in coordination, since they play an important role in ensuring better access to health services. However, the health sector must continue to provide the technical know-how to other sectors and all work must be targeted towards providing medical services to the poor and vulnerable.

Technological advancement has a role to play, particularly in information and communication, which can contribute positively and negatively to health. This is the reason why it is important for all sectors to be cognizant of health concerns when formulating and implementing their respective development programmes. The focus is on developing “healthy public policies”, whereby concerned sectors act individually to protect and promote the health of the population. Health development is the key strategy for human resource development, for the development of human potential and power. In order to achieve this, community participation is employed whereby individuals and families assume responsibility for their community and own individual health and welfare needs.

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“We need to understand that a healthy population can contribute optimally to the national goal of social and economic development.”

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**Efforts must be directed towards:**

- Mobilizing governments to ensure the development of efficiently functioning health care referral systems
- Supporting community health workers, by providing support from professionally skilled people for guidance, education, training and other technical back-up
- Ensuring that services through primary health care have the security of logistic and financial backstopping
- Exploring innovative approaches to “health care financing”
- Advocating for a correction of the “imbalance” in current health resource allocation
- Including the social determinants of health in the new agenda for primary health care
- Using academics and research institutions to further innovations in primary health care development

“We need to understand that a healthy population can contribute optimally to the national goal of social and economic development.”
The focus should be on ensuring that the implementation of primary health care leads to long-term sustainable development and self-reliance in the health of the community. Primary health care is delivered by community health workers, or other workers in community-based organizations. These workers and volunteers might have varying levels of skill, but the important point is that they understand the health needs and on-the-ground reality of the community they serve. This would help to ensure that the services they provide are socially acceptable and economically affordable.

Dr Samlee applauds the role of health workers as phenomenal. They become change agents, who effectively contribute to changes in people’s health knowledge, attitudes, behaviours and practices. Such changes can help ensure the effective involvement of all people in solving their own individual health problems and the health problems of the entire community. They are the link in achieving the “health for all” vision. We could learn from Thailand, who started training public health nurses to contribute significantly to health development. Dr Samlee suggests that we must assess the role of public health nurses, who might need reorientation in the light of the changing scenario in the health field.

We need to understand that primary health care cannot function in isolation. It needs support from other levels in the health system, including secondary and tertiary care for the referral of sick people, when needed. This is necessary to ensure that people in the community have the opportunity to enjoy the benefits of valid and useful technical know-how; benefits in the advancement of health sciences and technology; and benefits from technologies which are too complex, or too costly, to be applied through primary health care in the community, especially in rural areas.

Dr Samlee recommends that efforts be directed towards intergovernmental coordination as well, which would entail governments devoting resources for developing and implementing health programmes in the areas of their concern. As examples, he highlights the usefulness of the ministry of education in running a programme on health education, the ministry of agriculture in the area of food, food safety and nutrition, or the public works department on water supply and sanitation. In order to reemphasize the significance of health in a country’s development, we must work towards reducing poverty in the community through public health interventions. Primary health care ensures a healthy population and a healthy workforce, which in turn means economic development. Health is reflected in the political agenda and is becoming more prominent in the national development agenda. Furthermore, an attempt has also been made to pursue health activities as a bridge for peace, through humanitarian health actions.

Members States of the South-East Asia Region must continue their untrilling efforts to advocate for greater political will, and for decisive political commitments to the development of national public health systems based on primary health care. Especially since health issues over the next three decades will largely be an extension of the health challenges of today, which are posed mainly by demographic, environmental, ecological and behavioural changes. The dual burden of chronic non communicable and communicable diseases will continue to cause illness and death. The situation is further complicated by advancements in medical science, whereby people will live longer due to the availability of better technological tools, which may lead to more disability and dependency requiring preventive strategy in the years to come. Recommendations include fighting illnesses and disabilities through curative and rehabilitative care, alongside an increased investment in primary prevention with a focus on health promotion and disease prevention.

To ensure the smooth operation of primary health care, we need to work towards developing a multidisciplinary public health workforce that helps carry out public health programmes and can extend services to wherever there is a need. We must critically analyse the types of health problems that can be effectively taken care of by other categories of health staff, particularly community health workers, and then train and educate them accordingly. This would be an efficient means of management. Understaffing is a possible eventuality, hence we need to work towards educating and empowering people to take care of their own health, at the primary level. This would equip people and the community
with the appropriate information, education and guidance in order to take effective actions for themselves. Doctors are trained mainly for personal and institutional care; we should try to keep them that way. The skills and expertise of nongovernmental organizations need to be tapped in order to improve access to health care and advocacy.

Primary health care plays an important role in creating a functional literacy in people with regard to their own health. It directs efforts to enhance people’s ability to make appropriate decisions on the use of medicines and enhances self-care practices. The backbone of primary health care is the community-based health workforce, who are the key actors in ensuring health for all, and who cannot function in a vacuum but need support in order to be fully effective.

The issue that requires reiteration is governments focusing on primary prevention and maintenance of good health for all, as the key strategy in health development. Since public health aims to support comprehensive community-based health development, it needs to be pursued through primary health care, whereby community health workers of various categories and community health volunteers play a key role.

Dr Samlee explains that effective community-based health care is based on the primary health care principle that advocates for policy change at a national level. He is a supporter of national health policies which, among other things, ensure a well-balanced allocation of health resources between preventive and curative care, adequate referral, and other institutional support to community-based health-care systems. He congratulates the primary health care movement in the South-East Asia Region, and highlights the following pilot projects that have been successful:

✱ “Basic minimum needs” in Thailand
✱ “Integrated Health Posts” (Posayandu) in Indonesia
✱ “Ayadaw Health Development Initiative” in Myanmar
✱ “Mongar Health Services Development Project” in Bhutan

In addition, Dr Samlee feels we must learn from the “Strategic Road Map” in Thailand, the “Network of Community Health Clinics” in Bangladesh, and the “Integrated Community Health Services” (SISCa) in Timor-Leste. He believes that all of these are examples of how primary health care has reinvented and reoriented itself. The focus needs to be on “demystifying” health knowledge, which needs to be understood by all according to their needs. Health technology must be “appropriately developed” so that it can be used by people at different levels. With advancements in information and communication technology, health messages to people have become increasingly complex. This complexity is in both the content and the process. It is therefore the duty of health professionals to help people choose and select the right information.

Tapping of local or indigenous technologies could also be employed. In addition, we must work on the “thrust areas” that will effectively contribute to revitalizing primary health care in the countries. For this, we need to ensure that the people themselves are educated and empowered, which is dependent on the community-based health workforce.

Summary points

✱ The focus needs to be on ensuring that primary health care is readily available to all people, who are in need, everywhere, especially the poor and marginalized. The responsibility must be at both individual and collective levels, and at all stages of development, i.e. planning, implementation, monitoring and evaluation.
✱ Primary health care is the way forward; modalities of it have existed before, and we need to learn from countries which have shown success.
✱ Healthy public policies must be envisaged and implemented, which will happen only if individual sectors are also cognizant of health concerns when formulating and implementing their respective development programmes.
Community Education and Empowerment for Promoting Health Through Life-course Approach

Employing the life-course approach through an epidemiological perspective involves studying an individual’s life throughout gestation, childhood, adolescence, young adulthood and midlife, since all of these phases have an impact on risk and health outcomes in later life. It also helps in understanding the biological, behavioural and psychosocial processes that operate across the lifespan of an individual, thereby providing a holistic framework.

Research suggests that there are critical periods of growth and development, not just in utero and early infancy but also during childhood and adolescence. This period is responsible for influencing life-course trajectories and has implications for health in later life. The life-course approach is significant because of its ability to view a disease not just through conventional risk factors and individual risk, but through the striking social and geographical inequalities in the distribution of chronic diseases. It helps disentangle the influence of early life factors relative to genetic and later life factors on adult health and ageing: explanations may be cohort- and disease-specific, factors may be additive or interact synergistically.

In the South-East Asia Region, there are groups of populations disproportionately affected by several communicable and noncommunicable diseases. However, the way forward through a life-course approach would be holistic, that would utilize the fruits of available scientific information to benefit the group. The need is to conduct studies that understand the unique barriers faced by the poor and vulnerable in getting access to health services, including disease control services. The research must also understand how these
barriers could be overcome since the purpose is to view a disease as a multifactorial phenomenon with an epidemiological and ecological perspective that focuses on the host and the environment.

**Nutrition**

Most countries in the South-East Asia Region suffered from nutritional problems during the mid-twentieth century, with famine and chronic macro- and micronutrient deficiencies being the most common illnesses. Countries moved forward by adopting multisectoral and multipronged strategies, and invested in programmes that also aimed at improving the economic status of their citizens. The interventions focused on prevention, detection and management of nutrition and health problems. In the present day, countries in the Region are suffering from rapid transition in terms of socioeconomic, demographic, nutrition and health dimensions of the population. The situation is complex, since the rapid improvement in per capita income and reduction in poverty are welcome; however, the concurrent steep increase in overnutrition-associated health hazards is a matter of concern.

To combat the dual issues of malnutrition and disease burden we need to be well-prepared. Food and nutrition are the most basic requirements of life, which contribute to our physical and mental growth and longevity. To effectively harness these advantages from food and nutrition, however, we need knowledge derived from research conducted in premier institutes. Research, which is also an effective tool for policy advocacy, helps to ensure the availability and consumption of appropriate food.

An important fact that should be kept in mind is that, while we yearn for more knowledge and research, the synthesis and synopsis of existing databases do not help the general population (especially the most vulnerable sections of society) and continues to benefit the upper strata of the population. The focus should be on identifying the compounded barriers that manifest themselves in community behaviours and which are predicated by socio cultural factors. Child health policies and strategies need to devise mechanisms to promote practices that improve maternal, newborn and child health. This can be achieved by placing special emphasis on demand creation, coupled with attention to health system issues to provide effective and efficient services.

The challenge of closing the gap between knowledge and practice with regard to food, diet and nutrition remains. There is a minimal
nutritional requirement standard that has been set for the last three decades. Achieving this remains difficult for low-income groups, even after subsidized food grains are provided. Their diet is monotonous and does not contain sufficient pulses and vegetables, leading to undernutrition and micronutrient deficiency. There is a vicious cycle of ill health, which must be countered by the available research that indicates linking good maternal nutrition and weight gain to positive perinatal outcomes, including reduced incidence of low-birth-weight and very-low-birth-weight infants.

Dr Samlee recommends employing the Integrated Management of Childhood Illness (IMCI) strategy, to help improve the skills of health workers for integrated management of common childhood diseases. Evidence suggests that IMCI training for health workers managing children at first-level health facilities can lead to rapid and even sustained improvements in their performance. In addition, we must focus on building capacity for immediate triage, assessment and management of severely sick children as that will contribute to efforts towards helping countries to achieve the child health-related MDGs.

To counter nutritional deficiencies as a major public health problem, countries need to:

✱ improve access to a variety of foods, in order to achieve dietary diversification, for sustainable improvement in micronutrient intake;
✱ increase coverage under the national anaemia, vitamin A and universal access to iodized salt programmes;
✱ ensure research institutions can provide concrete evidence and help with planning to ensure the effectiveness of the above-mentioned interventions.

New research must be incorporated and the way forward needs to be dynamic, and must include the latest evidence on undernutrition-overnutrition linkages. It is believed that this predisposition could be genetic or environmental; it could manifest itself at birth, in childhood, during adolescence and in adulthood. Therefore, prevention of intrauterine growth retardation through antenatal care, early detection, and correction of undernutrition during childhood can go a long way, not only in reducing low birth weight and undernutrition, but also in contributing to a reduction in non communicable diseases in adult life.

One factor is common across the area of nutritional deficiency: that it is never too early to start practicing a healthy lifestyle and dietary habits. Even though countries in the South-East Asia Region are yet to overcome poverty, undernutrition and communicable diseases, they are increasingly facing problems related to the rising incidence of overnutrition and associated non communicable diseases. Nutrition also plays a significant role in the prevention and control of tuberculosis and HIV/AIDS.

With the commendable successes in this field, the recommendations for future programmes are to develop and tackle food and nutritional problems within an environmental and ecological context.

Maternal and child health

Globally, we have made significant progress in several areas of social and economic development; however, every year almost 200,000 women still die during pregnancy and childbirth. The well-being of mothers and children is essential for the development of every nation as it has broad social and economic dimensions. The progress has been a bit skewed, with countries of the Region accounting for about one third of global maternal and child mortality. The majority of these deaths are due to preventable or treatable conditions, such as diarrhoea and pneumonia. We know that most maternal and newborn deaths can be prevented if skilled care is available during pregnancy, childbirth and the post-delivery period. Simple cost-effective interventions such as promotion of exclusive breastfeeding, oral rehydration therapy and community-based management of pneumonia work well as prevention measures.
Overall, there have been some improvements. During 1980–2000s, the under-five mortality rate in the Region declined by a third; and from 1990–2000s, the maternal mortality ratio in Asia decreased by 15%. The way to accelerate progress would be ensuring that every mother and child has access to effective health interventions, when needed. Employing a life-course approach requires the development and consistent implementation of more effective strategies to ensure skilled care for every birth, through improved community-based health care. There is a need to establish a continuum of care between maternal, newborn and child health care. In addition, child health policies need to promote the establishment of mechanisms that span the home, the community, first-level health facilities and referral centres.

The survival and well-being of mothers and children has broader social, economic and developmental dimensions. Poor health has been recognized as an important factor in families becoming poor. When a mother is sick or dies, not only is her contribution to the family, workforce and society lost, but the survival, education and development of her children are also jeopardized. Frequent illness and malnutrition have an adverse effect on the cognitive development, body size and strength of children.

The adolescent group within a population must also be targeted, as they play a significant role in the overall maternal mortality rate for the Region.

Dr Samlee feels an area that could be better tapped is the effectiveness of media as an advocacy tool. It could be utilized to mobilize opinion, which in turn could influence both the demand for and the supply of good-quality health care.

He believes that specifically for India, the challenge in the field of obstetrics and gynaecology is to ensure that evidence-based guidelines are adapted in everyday clinical practices across all levels of care in the country.

**Women and gender equity**

Women’s health plays a critical role in a country’s overall development indicators. However, for optimum health to be achieved, the foremost thing is for women to enjoy a proper social status, while being able to access the options available to them, which include living a healthy life and pursuing an education as represented in figure 6. These factors are closely interlinked and are part and parcel of gender equity, which envisages a society where women are able to participate more effectively in social and economic development.
WHO has been exerting special efforts to promote the same, with some success. It is important to note that women’s development cannot be carried out as an independent programme, separate from other areas of work. It has to be pursued within the context of gender equity, which encompasses several social and economic dimensions, and it needs to be multidisciplinary. Work in the area of gender equity has led to an improvement in the health of women, but work is still pending. For example, about 60% of women in South-Asia are anaemic and suffer from chronic energy deficiency. There is discrepancy between the nutritional status of men and women, and we need to enhance our efforts in the areas of nutrition and maternal health by organizing services for women. Dr Samlee believes that school lunch programmes for children and a nutrition package for pregnant women will help to significantly improve women’s health.

To understand and eradicate the root cause of gender inequity and ill health, we need to understand that women have difficulty in accessing health services due to several cultural beliefs and practices. We need to understand they have special health needs that require insight to tackle them effectively.

There must be a global understanding to take measures to ensure the equal rights of women to basic health services. In the Region, the status of women in various domains has been irregular, so while literacy and political participation among women is rising, their education enrolment level is still low. The focus needs to be on building consensus among the general population that educating a woman can contribute to the education of an entire family. Their role as change agents for health needs to be reiterated. We must remember that countries that have high female literacy have low infant mortality and, in general, women carry a higher family burden than men.

Investment in both maternal health and child survival is critical and essential. The World Bank estimates that for every dollar invested in child health, seven dollars are returned to society through reduced spending on social welfare and increased productivity of young people and adults.

Women have a significant role to play in contributing to the achievement of the MDGs, and we need to realize that female education is the best strategy to lead to gender equity. It was found, by a United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) study, that barriers to employment of women cost the Asia-Pacific region US$ 42–47 million annually. A number of measures have to be in place to monitor the effective contribution of women to economic development. Efforts need to be directed towards reducing discrimination against women and harassment of women at work, along with campaigns for fairness in wages and promotions. These would benefit both the country and the women themselves.

“The projected estimate of disease burden from neuropsychiatric conditions, measured using DALYs method, shows an increase from 9% in 1990 to 14% in 2020.”

Intercountry Workshop on Developing Country-Specific, Community-Based Strategies for Reduction of Treatment Gap in Common Neuropsychiatric Conditions, WHO/SEARO, New Delhi, India, 18–20 November 2004

Healthy and educated women have a better opportunity to contribute effectively in the political arena.

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1. Female enrolment in primary schools is still 26% lower than that of males.
2. 80% of women in most parts of the world have decision-making responsibilities for health care in the family.
Gender-sensitive policies and gender-responsive actions have been promoted, especially in the development and implementation of national health programmes. WHO must continue their approach of pushing for a multisectoral agenda and work closely with other stakeholders at the political level in advocating for gender equity and women’s health.

**Mental health**

The World Health Report 2001 pointed out that mental and neurological conditions cause a significant amount of morbidity and disability all over the world. It is estimated that about 450 million people are affected by mental, neurological and substance use disorders. A large proportion of these people live in developing countries, including South-East Asia Region countries. This is important, since many people suffering with mental health issues who reside in developing countries are known to not get appropriate treatment. It is believed that the treatment gap in developing countries could be as high as 80–90% of the affected population. Traditionally, neurological and psychiatric services have been concentrated in tertiary care hospitals, thereby depriving the large segment of the population living in rural and remote areas of such services. This is despite the fact that both neurological and psychiatric conditions are common in all communities.

WHO has been concentrating on community-based activities and making efforts to develop programmes that deliver at least the basic minimum level of services to everyone who is suffering from neuropsychiatric conditions, everywhere.

The life-course approach must continue to focus on providing an integrated programme with basic health care services within the community, which would also benefit community members who need to travel long distances for tertiary care.

The care must be affordable and appropriate and should be dovetailed using the primary health care approach. We need to ensure that our work addresses psychosocial issues, such as stigma and rehabilitation, as well. Lastly, we must direct our efforts towards ensuring quality care, which would require training people to identify and manage these conditions effectively.

The WHO Regional Office for South-East Asia, together with experts from the Region, has developed community-based strategies. However, we need to remember that for these strategies to be really useful for implementation in countries, we need to take into account the local, sociocultural situations.

The community-based mental health programme in Thailand is an inspiration; here, the Buddhist monks play a leading role in organizing mental health promotion activities in the community. The programme involves the entire community voluntarily, including community leaders, the police, businessmen and families of those affected. Such grassroots activities are normally supported by the mental health hospital in the area. These community-based actions very effectively help in closing the treatment gap; such successful initiatives provide valuable lessons for other countries to learn from.
Community-based health care: promoting self-care

Community-based health care is incomplete without the support of public health nurses who recognize and help implement the MDGs. “Public health nurses” are called “community health nurses” in some countries. They form a part and parcel of the community-based health workforce; the workforce that is the backbone of the health for all/primary health care movement. This workforce contributes significantly to equity and social justice in health. In health care, it is well known that “prevention” is better than “cure”, and prevention is cheaper than cure. The governments of our countries underline “preventive care” in their national health policies. Preventive interventions, to ensure the protection of people’s health, are carried out by public health nurses as their main functions. We need more effective preventive interventions; and therefore, among other things, we need more public health nurses. Community-based health workers, including public health nurses, help overcome obstacles; in particular, the sociocultural and psychosocial barriers.

Ensuring better healthcare in the region, health systems strengthening has been an important area requiring urgent attention. The increasing numbers of people with chronic ill-health conditions mean there is a greater need for ambulatory care within the community, thereby increasing the demand for the services of public health nurses. Public health nurses play a key role in community health care. One of the recommendations for strengthening the quality of community-based care has been engaging with national professional bodies, such as the Nursing and Midwifery Council, that could help set standards of practice. Associations of nurses and midwives should work towards incentivizing community health care by promoting an enabling work environment with appropriate incentives and career advancements.

Efforts need to be directed towards strengthening the community based health workforce, which would relieve the pressure on the secondary and tertiary levels of healthy and also ensure greater outreach of services and programmes. The role of the health worker as change agents need to be understood and incorporated while developing programme strategies. This has been discussed in detailed in the chapter of Primary Health Care.

Besides focusing on community health care, we need to direct our efforts and work towards promoting self-care. It is imperative that people be educated and empowered by the community health workforce who help the community members to take informed health decisions. We need to ensure that the community health workforce equips the community for “self-care”.

The community health workers need to be equipped adequately to face today’s community health challenges in the most efficient and effective manner. They need to be provided with information so that they can pass it on to the community members. These workers are change agents in the community and among the people.
agents who help promote behavioural change among members of the community.

On the other hand, we must also explore innovative approaches to “health care financing” to ensure people do not fall into the poverty trap due to the high cost of health care. We need to advocate for correction of the “imbalance” in health resource allocation at the national level to ensure a fair share of national health resources for promotive and preventive care. In the end, knowledge management and behaviour change are very important and challenging issues that we are facing in our efforts to improve the quality of services and client satisfaction. These have a significant impact on health and development. Promotion of evidence-based practices and guidelines is one of the first, but most important, steps in this process. Only utilization of, and adherence to, evidence-based best practices will ultimately help to improve the quality of services and client satisfaction.

**Summary points**

✱ An understanding of a life-course approach must be deployed in all aspects of health care. This would enable better health care and also address current gaps, if any.

✱ Dr Samlee believes that it is very important for people to have correct information, as that helps them make the right decision as far as their own health is concerned.

✱ Efforts need to be directed towards promoting education and communication skills among community-based health workers, which are indispensable elements for effective promotion of self-care.

✱ Dr Samlee believes that for an overall improvement in health, self-care has to be seen as an integral part of promotive, preventive, curative and rehabilitative care.

✱ Demystification of health information would help people at the grass-roots level to integrate health research findings into aspects of people’s lives.

✱ A life-course approach in health care must work towards closing/reducing the gap between knowledge and practice. Knowledge management and behavioural change are very important and challenging issues that must be addressed while discussing issues pertaining to health care.
Elimination of Diseases: Successes and Challenges

The South-East Asia Region has come a long way in the area of health and development where people now live longer, have higher literacy rates and an improved quality of education. This has also led to better vaccines, higher employment and higher incomes. There has been tremendous growth over the years to conquer communicable diseases, in which India has witnessed considerable successes such as eradication of small pox and dracunculiasis (guinea-worm disease), and the infant mortality rate has been halved. These successes can be attributed to an increased budget allocation, which is furthered by a vibrant pharmaceutical industry that has revolutionized the care and treatment of people living with HIV/AIDS. However, success across the Region is not uniform and 40% of the 14 million deaths annually are still attributed to communicable diseases alone. It is very unfortunate that much of the brunt is borne by children, women, the poor and marginalized sections of society.

Achievements tend to make us optimistic about the future, but we need to continue and accelerate efforts to strive towards controlling communicable diseases for various reasons. One of them is the huge impact the communicable diseases have on developing countries where nearly child mortality continues to be aggravated by cases of respiratory infection and diarrhoea. Malaria, for which there have been effective treatments since the 1960s, continues to take the life of many children around in the South-East Asia Region annually.

The Region is struggling with communicable diseases as they never

We must work towards countering communicable diseases since:

✱ they are preventable and treatable
✱ there are cost-effective public health interventions available that help tackle the problem at the country level
✱ the scale of vulnerable people affected is huge, and includes those most in need of access to life-saving interventions
cease to give us unpleasant surprises. Over the past three decades, 30 new infectious pathogens have been detected most of which have originated in animals. SARS and avian influenza remain unpredictable and versatile, as they have a high propensity to spread across countries to infect new areas. This calls for strengthening of veterinary public health services, and a close cooperation between animal and human health agencies. The challenge is enormous, where on one side there are significant achievements and on the other we have limited choices. Much needs to be done to combat these scourges and we need to work towards continuous vigilance and continued preparedness with enhanced capacity at the local, national and international levels.

The way forward

Dr Samlee suggests that the battle against communicable diseases needs to be intensified on several fronts. Keeping resource limitations in mind, efforts need to be focused on the intensification of interventions efforts. We need to make every effort to scale-up the available cost-effective interventions against communicable diseases. This needs to be achieved in terms of both coverage and quality. A systematic approach to planning for scaling-up and measuring progress is needed which must be mapped in a phased manner. He reiterates the importance of the benefits from such interventions reaching the most vulnerable groups of population.

Dr Samlee also emphasizes the need for a functioning public health system, which is the key for responding to the challenge of communicable diseases. He advocates for a system which consists of people who are adequately trained and work in the field of public health. There needs to be a complete physical infrastructure that includes effective surveillance and an early warning system with adequate laboratory back-up. Dr Samlee aims for effective networking among various institutions, especially in the case of India which is home to several internationally acclaimed public health institutions. He acknowledges the role of financial initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provide an excellent opportunity to build public health infrastructure and capacity. He feels that such initiatives help to ensure the long-term sustainability of public health programmes in countries. Another area of great relevance is the International Health Regulations (2005) that provide an opportunity to build core capacities.

Incorporating a multisectoral approach in control measures is another important prerequisite for Dr Samlee regarding the control of communicable diseases. Since communicable diseases are caused by the interplay of diverse factors, it is important to recognize the demographic, social, cultural and economic attributes of the diseases. Several key partners have important roles to play and the national authorities should keep all partners on board right from policy formulation through to the implementation process. Partners must include private enterprises, academic institutions, the mass media, civil society and various international agencies, among others.

Dr Samlee views intercountry cooperation as a very important segment that must not be ignored, since microbes know no boundaries; he feels it is of fundamental importance in dealing with cross-border spread of diseases. Learning from SARS and avian influenza is important as both are examples of how information sharing leads to better understanding of disease epidemiology, transmission pattern and natural history. Thereby helping countries plan joint interventions to respond to a pandemic in a synchronous, timely and effective manner.

Community involvement and partnerships are significant aspects that help public health interventions generate the desired results while implementing the control strategies. Public health machinery needs to be operational in communities through productive partnerships with the mass media and nongovernmental organizations, both of which work towards helping secure public confidence and support and ensure operational efficiency. Dr Samlee advocates for thoughtful risk communication as he believes it assists in preventing ineffective, fear-driven, and potentially damaging public responses while also fostering the trust and confidence of the population that are vital in any emergency situation.
Successes and challenges: malaria

Malaria continues to be a serious public health problem in the Region, with Maldives being the only country which is free from malaria. Currently, the Region reports about 2.5 million confirmed cases annually, with nearly 5,000 deaths. These figures are gross underestimates due to the huge underreporting of malaria cases and deaths, which is indicative of weak surveillance systems in countries. These numbers are a reflection of the poor state of national malaria control programmes. We do not know the actual disease burden; hence, it is very difficult to accurately assess the socioeconomic loss attributable to malaria.

Challenges in malaria control

The proportion of the severe form of malaria (*Plasmodium falciparum*) is on the increase, to the extent that half of all malaria cases are now caused by this strain. There is the added problem of vector-resistance to insecticides, and behavioural changes among vector populations. The frequent ecological imbalances created by human activities are a cause for concern furthered by environmental changes, including natural disasters such as the Tsunami, super cyclones and other repercussions of global warming. Under such situations, a uniform method of control, as practised during the “Eradication Era”, is no longer applicable. The way forward is rational planning that formulates specific malaria control strategies for each problem, precisely stratified. This calls for a clear understanding of the disease epidemiology and entomology for both stratification and intervention planning.

Malaria poses specific characteristics for urban and rural settings which warrant different strategies. Industrialization and urbanization have furthered many large, medium and small-scale development projects which have been done without proper planning, leading to the occurrence of mosquito-breeding places. In addition, the migration of labour from endemic areas into those which are malaria-free, or to cities and towns, also contributes to new foci of malaria. The same is true of irrigation projects, which often create mosquitogenic conditions. The areas along international borders are highly vulnerable to malaria infestation due to a lack of public health measures, hence malaria control today requires new and locally-specific solutions. There needs to be special attention given to the vulnerable groups of population, particularly children and women, especially pregnant women.
Opportunities in malaria control

One of the foremost requirements for countering malaria is increased investment, which would help to accurately assess the burden of malaria throughout Asia. There is a need for a sensitive surveillance system that can provide an early warning of an outbreak; a system that can help rational planning and prompt a response that contains an outbreak and prevents further spread. It would also help promote basic and laboratory studies and investigations, operational or action-cum-research. The priority area for research must include the development of new antimalarial drugs and various combination therapies. A vaccine against malaria is not yet available, in spite of the tremendous efforts over several decades. However, there are several innovative tools available, which are the products of the tireless attempts of researchers. Newer tools such as rapid diagnostic tests, long-lasting insecticide-treated nets, geographical information systems and remote sensing technologies should be fully utilized for malaria control.

Malaria needs to be brought onto national and international agendas where the concerns need to be articulated. This would increase resource allocation and also help further MDG agendas. Malaria needs to be viewed as a disease requiring a broad multisectoral and multidisciplinary approach. Since it not only a medical and public health problem, sectors such as agriculture, environment, forestry, education, and finance must fully share their respective responsibilities for malaria control.

The malaria control programme should shift its emphasis from a mainly treatment-oriented approach to a well balanced combination of prevention and treatment. This is to ensure that we have more ways and means to reduce or stop the transmission of the malaria parasite. What might be suitable in other continents may not necessarily be appropriate in Asia. Devices and tools need to be properly adapted, or even invented to suit our specific needs and requirements. Asia suffers from high morbidity but low mortality due to malaria which means we have succeeded in reducing the case fatality rates through early diagnosis and prompt treatment, but have not been equally successful in reducing malaria incidence.

Social mobilization and community involvement are important aspects that will ensure a greater programme impact and must be a part of the entire process right from the planning, implementation, monitoring and evaluation stages of the programme. They help create a better acceptance of preventive measures, such as reducing mosquito breeding places and the use of personal protection materials in communities. They also increase utilization of treatment services.

Dr Samlee concludes by saying that to ensure an effective campaign against malaria, we need to work together where governments, international organizations, the public and private sectors, and the people are equal partners in health development, which includes malaria control.

Successes and challenges: leprosy

The South-East Asia Region has almost achieved the goal of leprosy elimination. This is a remarkable achievement, considering that the Region carries the heaviest load of global leprosy cases. India carries the biggest burden of the disease in the world, but is moving steadily towards leprosy elimination.

Globally, the leprosy elimination goal has already been achieved by over 100 countries, which is a commendable gain in international public health work that has been achieved through the combined efforts of concerned national governments and their partners, including international agencies and nongovernmental organizations.

“Nippon Foundation, Novartis Foundation and Sasakawa Memorial Health Foundation have helped ensure that the leprosy programme does not suffer from resource constraints.”

International Conference on Malaria (Commemorating 125 Years of Malaria Research) Theme: Laveran to Genomics, National Agriculture Science Complex, Pusa Institute, New Delhi, India, 4–6 November 2005
Opportunities in leprosy control

Public health workers must look towards focusing their attention on leprosy elimination. The top priority must be leprosy elimination, together with focused work directed towards subnational elimination in the individual countries to further reduce the disease burden of leprosy. As the number of new cases continues to decline, this situation poses its own challenges.

Efforts need to be intensified in order to ensure sustained political commitment and adequate resources, which will help maintain the gains achieved and the quality of services. Enhancing the knowledge and skills of general health service staff and ensuring persons with deformity continue to receive proper treatment and care should be the mandate from here on.

Successes and challenges: tuberculosis

Tuberculosis is a threat to the public which is aggravated by poverty, urbanization and HIV/AIDS, all of which expose people thereby increasing risk and making them susceptible to the disease. Tuberculosis is grounded in social and economic factors, hence it is imperative that a holistic approach is taken while developing and implementing a tuberculosis programme, especially since it cannot be tackled through a medical approach alone.

WHO is working towards increasing the profile of tuberculosis control programmes as a priority health intervention in the Member States, with particular attention to alliance building. WHO gives special attention to developing and strengthening national tuberculosis control programmes, underlining the importance of surveillance, monitoring and evaluation. Reinforcing institutional capacity and investing in human resource development are key elements that are supported by WHO.

Opportunities in tuberculosis control

Among the avenues for tuberculosis control, the most significant is increased commitment both at national and international levels. There is immense global support that has increased remarkably through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Drug Facility. Various partnerships have been developed to support the programme in a multidisciplinary and multisectoral manner. In addition, WHO has been providing full support to countries to develop sound policies, strategies and plans, and have used their comparative advantage to mobilize resources.

Furthering the use of the DOTS strategy, which is a package combining various key components of tuberculosis control, has been very effective in the Region. It is one of the most cost-effective public health interventions available against tuberculosis today. DOTS also helps in achieving the MDG targets which may seem ambitious, but to ensure effective management of a tuberculosis control programme we need to ensure that the data and information from surveillance systems also reflects the related social and economic domains of the problem.

Dr Samlee believes that a well-conceived and well-run tuberculosis programme has the most potential to cure patients, medically and socially; interrupt transmission of the infection; reverse the trend of the epidemic; and control tuberculosis until it is no longer a problem of public health importance. Efforts should be also directed towards adjusting our policies, strategies and plans as per country situations.

Successes and challenges: sexually transmitted infections

Sexually transmitted infections are among the most common causes of illness in the world and...
have far-reaching health, social, and economic consequences. They are a major public health problem in developing countries, worldwide and in South-East Asia. More than 300 million new cases of curable sexually transmitted infections occur each year, with a global distribution that closely mirrors that of HIV. Worldwide, nearly one million new cases are detected daily. The Asia-Pacific region accounts for more than 50% of the global burden, because of the high prevalence of sexually transmitted infections among high-risk groups such as sex workers, migrant populations and other bridging population groups.

Challenges in sexually transmitted infection control

One of the main issues in countering sexually transmitted infections is the serious complications they can cause, including fetal loss, stillbirths, infertility, ectopic pregnancy and severe congenital infections. Syphilis alone, when present during pregnancy, results in fetal loss in one third of cases, and half the surviving infants suffer congenital disability.

Another aspect of concern is reaching the people who are most frequently exposed to the infection, who pose a high risk of passing on the infection to others. The cofactor effect of sexually transmitted infections on HIV transmission is huge; there is believed to be an eightfold increase in the risk of HIV infection in the presence of sexually transmitted infections. The risk is particularly high in the case of genital ulcers, where the data indicates a 10- to 50-fold increase in the probability for male-to-female HIV transmission per sexual act, and a 50- to 300-fold increase for female-to-male transmission. A strategy to address this involves developing large-scale programmes strongly focused on sexually transmitted infection prevention and treatment.

Opportunities in sexually transmitted infection control

At the population level, sexually transmitted infections seem to be one of the key factors that drive the HIV pandemic in developing countries; at the same time, there is evidence that suggests that the treatment of sexually transmitted infections, particularly in patients presenting with genital ulcers, reduces HIV transmission.

There are many large-scale interventions that demonstrate the potential impact of sexually transmitted infection control on HIV transmission. For example, Thailand reduced the incidence of curable sexually transmitted infections by more than 80% in less than five years through a comprehensive effort that included both improved sexually transmitted infection treatment and targeted promotion of condom use in commercial sex establishments. During this period, HIV prevalence, which had been increasing rapidly, began to fall. Through sustained application of these interventions, Thailand stabilized HIV transmission early and averted a far more extensive epidemic.
Learning from Thailand, other countries such as Cambodia and Myanmar have started similar programmes. The Sonagachi Project in Kolkata, India, is a good example of a successful peer education programme among sex workers. It also includes the provision of health care and social marketing of condoms. HIV prevalence among sex workers in the project area continues to be low and the prevalence of sexually transmitted infections is declining.

An area that needs to be tapped is sexually transmitted infection trends, which can offer important insights into where the HIV epidemic may grow, making sexually transmitted infection surveillance data helpful in forecasting the movement of the HIV epidemic. Efforts needs to be directed towards improved linkages between HIV and sexually transmitted infection surveillance nationwide, in order to better monitor the trend of the epidemic and the impact of programme interventions. WHO advocates for an integration of sexually transmitted infection services with reproductive health and family planning as well as AIDS programmes, and promotes reaching high-risk groups such as sex workers and their clients.

Efforts need to be directed towards scaling-up anti-retroviral treatment as a major managerial and logistic effort, similar to DOTS expansion in tuberculosis control. Political commitment towards implementation of national strategic plans is essential. We need to continue to promote the implementation of national strategic plans for scaling-up quality sexually transmitted infection services in the public and private sectors.

Summary points

✱ Efforts need to be directed towards countering communicable diseases, whereby we intensify our efforts by ensuring continuous vigilance and continued preparedness with enhanced capacity at the local, national and international levels.

✱ The way forward is ensuring an effective public health system that includes a complete physical infrastructure, along with effective surveillance and an early warning system with adequate laboratory back-up.

✱ The multisectoral approach cannot be ignored, together with community participation. We need to work with governments, international organizations, the public and private sectors, and the people at large, to ensure effective campaigns against diseases. All stakeholders need to be equal partners in health development.
The World Health Assembly adopted the International Health Regulations (IHR) on 23 May 2005. They came into force on 15 June 2007, following an extensive revision process. They represent a historic development for international law and public health that placed a number of obligations on both signatory member states and WHO. The United Nations Secretary General, Kofi Annan, identified the IHR revision as a priority for moving humanity toward “larger freedom.” States Parties were given until mid-June 2012 to ensure they had built and/or maintained “core capacities” to conduct disease surveillance and respond to public health emergencies of international concern.

IHR as a concept embodies an “all risks” approach, which is an important conceptual shift concerning the role of public health in IHR. The IHR are the primary legislative instrument that helps to prevent the spread of infectious diseases, and minimize disruptions to international traffic and trade. Without robust disease surveillance systems, new and resurgent diseases have the potential to spread unchecked, causing human suffering and death as well as economic damage. It is therefore critical that every Member State fully implements the revised IHR. The significance of this was witnessed during H1N1 and SARS.

The IHR become significant in the South-East Asia Region due to the specific features of countries and how they affect one another. There are significant diversities both within and between countries in the Region, especially in terms of demography, climate, culture and socioeconomic status. The diverse nature of the continent also determines disease patterns
in the countries. This is the reason why there needs to be different approaches in planning and delivery of health services and its approach.

The IHR bind 194 countries across the globe to prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide. Based on a self-monitoring process in late 2011, implementation of core capacities in the member countries in the Region was on average 60%. However, overall levels of IHR implementation varied considerably between countries and were uneven across technical areas. The South-East Asia Region is prone to public health emergencies due to natural disasters such as floods, cyclones and earthquakes in particular, as well as radiological and chemical accidents.

The Region is also vulnerable to outbreaks of certain communicable diseases, such as avian influenza and the disease caused by the Nipah virus. These are public health emergencies of international concern, as they threaten the health security of populations, both regionally and globally. WHO recommends that priority be given to strengthening some specific areas including public health legislations, points of entry, and chemical and radionuclear safety. Summary data from the annual self-assessment questionnaire also help WHO to identify gaps and prioritize the support it provides.

Views on the prerequisites for effective implementation of IHR

Dr Samlee believes that in order to ensure smooth implementation of the IHR, we need to have an agreed upon mechanism to rapidly share information on incidents of “international public health importance”. There needs to be an effective process that helps to mount an “international response” to a global health threat through well coordinated efforts. All of this would be possible if there was core capacity in the Member States to facilitate “intersectoral coordination”, as well as appropriate legislation to ensure effective enforcement of necessary measures. These requirements must be in place in all countries without exception in order to achieve the successful containment of disease outbreaks and other international public health emergencies.

There are several aspects to the core capacity required by countries, legislation being one of them. Dr Samlee believes that since the context and procedures concerning national legislations are specific to each country, it is important that each State Party takes full ownership of processes that could include legal, health organization and political systems. WHO has been working closely on providing technical support to countries for the assessment and strengthening of national laws to support IHR implementation. Workshops have also been arranged...
Challenges and solutions in IHR implementation

Dr Samlee believes that the foremost challenges faced by countries during IHR implementation include moving from vertical structures to integration, limited capacities and the shortage of resources. Other challenges at the country level include competing interests of major stakeholders, adjustment of domestic legislative and administrative arrangements, and developing appropriate standard operating procedures for port health, quarantine, isolation, and social distancing for affected populations.

He believes that the crux of the problem with regard to implementation is the lack of a clear definition of the core capacities required. The lack of a coherent definition makes it difficult to assess the situation objectively at the country level unless the national IHR focal points and the WHO contact points clearly understand the process of assessing these IHR core capacities. In order to address this issue, WHO has developed a training module which helps familiarize the national focal points with the assessment process. A further recommendation is the bringing together of IHR focal points and WHO contact points from national, regional and global levels in a regional forum to conduct interactive, face-to-face assessment of IHR core capacities which will support the objective evaluation of the status of the implantation and facilitate sharing of best practices.

Assessments of existing core capacities of IHR in the South-East Asia Region highlighted that that all Member States had:

- designated IHR national focal points and coordination mechanisms;
- distinct places and relevant rules for communicable disease prevention, including for quarantine, vector control, vaccination and prevention, and health emergency response;
- established national communicable disease surveillance systems that generated weekly epidemiological data on priority diseases, which are in some countries incorporated to epidemiological bulletins;
- rapid response teams trained by designated a national institution or department for coordination of national response.

Suggested approach to implementation of IHR as discussed in the First Regional Workshop, Male, Republic of Maldives, 23–25 April 2007

- **Policy and coordination**
  a. Designate and provide all required support for IHR national focal points.
  b. Review existing rules and laws for any constraints for implementation of IHR (2005), and amend where required.

- **Assess structures and system**
  a. Assess existing capacity and structure in each Member State; the process should involve national partners to ensure that the findings and recommendations are owned.
  b. Include laboratory capacity, ports and airports health services.

- **Develop plan based on assessment findings**
  a. Develop/harmonize time-bound implementation plan. This should include activities to further strengthen coordination, surveillance, laboratory, response, case management and infection control, communication, and capacities at ports of entry
  b. Develop contingency plans to respond to risk and public health emergencies of international concern. These need to be developed along with plans to strengthen core capacities at various levels.
  c. Include resource mobilization and advocacy into the plan. Set specific targets as benchmarks

- **Prioritize implementation**
  a. Implementation could follow a phased approach, depending on the current capacity and resources in each country. For example, the first phase can focus on strengthening capacity for early detection, reporting, verification, notification, response and containment of risks or potential public health emergencies of international concern.
  b. Mobilize resources required for implementation of IHR (2005), including advocacy for national, regional and global partners.

- **Monitor and document**
  a. Based on benchmarks included in the plan, to track progress of implementation and document progress
  b. Review experiences and lessons learnt on a regular basis, and adjust implementation of activities as required.
The way forward

Dr Samlee believes that we have useful benchmarks that must be tapped and utilized. He reiterates that the IHR monitoring process involves the assessment of implementation of eight core capacities and the development of capacities at points of entry and for IHR-related hazards, notably biological (zoonotic, food safety and other infectious hazards), and chemical and radionuclear.

He advocates for looking at the Asia-Pacific Strategy on Emerging Diseases (APSED) which is a useful framework that can serve as a roadmap for building core competencies. The document identifies five main strategic areas for capacity development, namely surveillance and response, laboratory, emerging zoonoses, infection control and risk communication. He also supports the International Programme on Chemical Safety (IPCS) which functions to rapidly detect, verify, assess and respond to chemical events of international public health concern as part of the revised IHR. He advocates for the programme as it provides guidance for strengthening the role of public health in chemical incidents and emergencies. It is especially useful for countries in our Region which have economies in transition.

Dr Samlee recommends increased coordination and stronger networks among the Member States. WHO is working closely with the Atomic Energy Agency (IAEA), the principal coordinating agency, and we all need to work towards establishing functional links to ensure continuous communication and regular activation of the plan of action. WHO and IAEA work closely together to prepare for and respond to nuclear accidents and radionuclear emergencies; principally to provide, coordinate and consult on medical assistance to victims of severe radiation exposure. Emergency medical support for radiation-exposed individuals is provided through WHO’s Radiation Emergency Medical Preparedness and Assistance Network (REMPAN).

The way forward must include working with partners, including WHO, who must double their efforts in supporting Member States. A fresh review and assessment of the “required country core capacities” needs to be urgently pursued in order to identify current “strengths”, “weaknesses”, “bottlenecks” and “constraints”. Sharing of best practices and other practical experiences through “intercountry collaboration” is important in promoting and supporting country core capacity strengthening. In order to ensure effective containment of disease outbreaks across international borders, it is critically important for neighbours to work together to harmonize disease control efforts at border areas.

Dr Samlee believes that strengthening national capacities in “public health laboratory”, “port health” and “hospital infection control” will require substantial financial investment, and sometimes involve the establishment of physical infrastructure. The implementation of this plan would require generous back-up and must be supported by concerned partners who have a significant role to play, especially since implementation of the IHR (2005) is an issue of international health security. He is also a supporter of information-sharing among countries, especially information on best practices in improving “intersectoral collaboration”, and sharing of information on issues and challenges faced by countries in their efforts to implement the IHR. Dr Samlee advocates for Member States of the South-East Asia Region to assess together how much time is still required for completing country core capacity strengthening, since that discussion would play a significant role in the development of new or renewed national implementation plans. He urges the global community to join hands to engineer a global community in ensuring that globalization and trade liberalization are much more health-friendly.

Summary points

✱ The MDGs represent a global commitment that has been working as a catalyst and has ensured joint global action towards specific outcomes with a limited time frame.

✱ According to Dr Samlee, progress towards the MDGs has been uneven among countries, but can now be accelerated since we have access to effective technical interventions. He calls for innovative strategies and effective approaches in the implementation of these interventions.

✱ Dr Samlee advocates for joint action in four main areas: 1) health systems strengthening 2) increased resource allocation 3) stronger multisectoral collaboration and 4) enhanced understanding of health inequity.
The Millennium Summit in 2000 adopted the Millennium Development Goals (MDGs), which recognized the crucial role that health plays in overall development. These goals were based on the central principle of a healthier world making way for development. They reiterated health as both a goal and an objective.

Time is now critical, as the clock is ticking, and we need to maximize progress while ensuring that the goals achieved are sustained. The current situation, with the huge variations among countries, is an area that needs to be examined closely. There are disparities that need to be closed, as they can work against the progress achieved so far. The general consensus among stakeholders ranges from ensuring completion of these goals, to sustainability and ensuring the new agenda is updated, time-bound, measurable and practically ambitious. The two threads of the MDG paradigm shift include expanding the MDG agenda, which calls for global consensus and universal ownership, and working towards identifying visionary goals and targets. The MDGs were concrete and at the global level are achievable, and as a result governments feel accountable for achieving them. The MDGs represent a global commitment that has been working as a catalyst to ensure joint global action towards specific outcomes within a limited time frame. The way forward, as emerging through consultations and discussions, is towards “universal health coverage”, which is broad and visionary. However, the debate – as emerging from the experience of the current MDG process – has revealed that the new goals and targets are and should be the focus of this process, and that targets must be customized at the national level.
by each country. The new paradigm must work towards benefitting the most marginalized and excluded, since reaching them has been a challenge in many countries. However, we cannot deny the impact the MDGs have made in terms of providing a clear guiding framework for donors and developing country governments by agreeing on unanimous outcomes. Focusing on the health sector alone, we have stories of millions of healthier children and families and these are the vital indicators of their success.

It was a landmark agreement when the global community vowed to combat tuberculosis as one of the identified goals. We were to halt and reverse the trend of this devastating disease; as of 2010, we have been able to bring about a reduction in its prevalence and mortality by 50%. That is a crucial milestone; however, we do have a long way to go in reaching the fulfillment of the MDG targets. The MDGs are a medium which have had a positive impact on poverty alleviation and on the overall economic development of our countries, especially since they bring major diseases such as HIV, tuberculosis and malaria under one bracket. It is important to note that six of the eight MDGs relate to health, covering the very fundamentals such as survival of mothers, newborns and young children. They also address the major communicable diseases that predominantly affect the poor. HIV/AIDS, tuberculosis and malaria are not just the leading killers, but an economic deathblow for poor families. Thus, health-related MDGs are closely linked to the most important outcomes to be achieved for overall development. These include: fewer women dying in childbirth; more children surviving the early years of life; successfully dealing with the catastrophe of HIV/AIDS; ensuring access to life-saving drugs; and better health in all its forms for contributing to poverty reduction.

Dr Samlee believes the consultations held to discuss the impact and success of the MDGs have provided a fertile environment to refocus on the social conditions and determinants of health. Especially since the consultations and forums have underlined the crucial importance of strengthening health systems capacity, promoting multisectoral actions, securing resources, and ensuring equity in access to quality health services. It is imperative we learn from these lessons. Some countries in Asia and the Pacific have already achieved certain health-related MDGs. However, we need to redouble our efforts in strengthening and accelerating the required partnerships and collaboration. The current global development agenda, and the MDGs, present an excellent opportunity in this regard.

The MDGs identify a set of interrelated targets for addressing extreme…
poverty and its many related dimensions, with health being placed at the centre. Although progress towards the MDGs in the Region is still uneven among countries, it can be accelerated since effective technical interventions exist. We only need innovative strategies and more effective approaches in the implementation of these interventions. The MDGs are a call for closing disparities in health, and highlight the urgent need to ensure that health development contributes maximally to poverty reduction. Dr Samlee believes real progress in health depends on stronger health systems based on primary health care. Without effective health systems that respond to the complexity of current health challenges, there will only be limited advances towards the MDGs and other health priorities.

The way forward

Taking as an example the outbreaks of the highly pathogenic avian influenza A (H5N1) in poultry, which started in 2003, Dr Samlee understands the unprecedented damage it caused in terms of its scope and severity. He explains how these outbreaks cause a huge economic loss to the affected countries in the Region, and seem difficult to contain. It is believed that if outbreaks of avian influenza cannot be checked, these may lead to a future global influenza pandemic that could start in Asia. It is predicted that should this ever happen, it would be the worst influenza pandemic with the most serious consequences, in terms of both human life and the economy of countries. Therefore, while reviewing our strategies to attain the MDGs, the prevention and control of emerging infectious diseases must be kept in mind.

Dr Samlee advocates for joint action in four main areas. Firstly, a clear and practical strategy should be developed to strengthen health systems, with special emphasis on the public health infrastructure. The need is to develop a strong public health workforce that can successfully expand and implement public health programmes, such as disease control and prevention, immunization, maternal and child health, water and sanitation, environmental health, and nutrition. Dr Samlee explains that the need of the hour is to have public health services that reach out effectively into the community and the entire population. We need to reorient our interventions in order to effectively reach the unreach. He breaks it down further into the need for effective stewardship, adequate health facilities and staff, especially at the peripheral level, to ensure universal coverage of health services. Regarding the issue of drugs being easily available in urban settings but not in rural areas where people need them most, Dr Samlee believes that the problem lies in many places. Trained health workers are not available to provide essential care and to carry out health promotion and disease prevention activities, which are prerequisites for sound public health interventions. When health systems are weak, it is usually the poor who suffer the most. A strong public health infrastructure will guarantee sustainable development in health.

The second action point is the need for additional funding for health care and public health services. There is a need for more investment in health, since health is often woefully underfunded. It is important to understand that significant progress in health development will not be achieved without adequate financing. Dr Samlee advocates for rationalizing the use of available funds by reducing unproductive spending, which would thereby release the resources required for priority health needs. Currently, the bulk of funding usually goes to urban areas – often for costly curative services – at the expense of essential health interventions in rural areas. He believes that in order to reduce the high proportion of out-of-pocket health expenditure, various mechanisms of risk sharing need to be introduced. There is also a need to expand various social safety net programmes. This will enhance financial protection for the poor, who constitute the vast majority of the population in the Region. He acknowledges the key role that international partners have to play in providing more funds for health; however, he campaigns for better coordination and alignment of external aid to ensure relevance to countries’ health priorities and needs.

The third action point that Dr Samlee recommends is stronger multisectoral collaboration and action as a medium to ensure effective health promotion and disease prevention. He believes that partnerships among stakeholders and empowerment of people are the foundations
for successful multisectoral and multidisciplinary actions in health
development. Recent evidence suggests a significant reduction in child
mortality, improved access to drinking water, and increased years of
schooling among women through several diverse actions. He believes
that the responsibility for and commitment to the development of
health for all people has to go beyond the health sector. Other sectors
have to share these responsibilities and commitments, as the health
sector alone will not be able to achieve the total health development
goal.

Lastly, Dr Samlee advocates for the need to seriously address the issue
of inequity in health, which includes unequal access to quality health
services and positive health outcomes. We have seen how disparities in
access to health care can occur due to various factors, such as income,
location, ethnicity and gender. It is important to note that these factors
are actually overlapping; hence, we need to develop programmes with
special focus on the underserved and vulnerable population groups.
The equity issue must be taken into consideration throughout the
development process from policy formulation and resource allocation,
to programme planning and implementation. For effective policy
development and programme planning to ensure equity in health,
there is a need for better evidence and better disaggregated data and
information.

**Summary points**

✱ The MDGs represent a global commitment that has been working as a catalyst and has
ensured joint global action towards specific outcomes with a limited time frame.

✱ According to Dr Samlee, progress towards the MDGs has been uneven among coun-
tries, but can now be accelerated since we have access to effective technical interven-
tions. He calls for innovative strategies and effective approaches in the implementa-
tion of these interventions.

✱ Dr Samlee advocates for joint action in four main areas: 1) health systems strengthen-
ing 2) increased resource allocation 3) stronger multisectoral collaboration and 4) enhanced understanding of health inequity.
This publication is a collaborative effort of WHO-SEARO and VHAI. It is a contemplation of Dr. Samlee Plianbangchang’s work as a recognized public health professional, an outstanding health expert and an administrator. It is an endeavor to highlight his leadership and contribution in furthering the health of the people of the region. Dr. Samlee since 2004 campaigned for an increased collaboration among member countries through horizontal collaborations. He believes it imperative for each country to take into account the prevailing demographic, social and economic situation that looks at issues of availability and accessibility. He is a firm believer of the need to close the gaps and inequities in health by promoting conditions that promote health and self-reliance among all groups especially women and other vulnerable groups. He also believes in promoting health systems based on primary health care and a thorough understanding of social determinants of health. WHO-SEARO under the leadership of Dr. Samlee has played a pro-active role as a coordinating international authority, striving to establish and maintain effective collaboration with the United Nations and other agencies.

This collection of his reflections provides his perspectives drawn from select speeches on various health concerns and is an invaluable resource to understand the principles and policies of WHO-SEARO’s work. It attempts to chart a roadmap for future, placing emphasis on a comprehensive and holistic strategy towards health, through vigorous human resource development and trained public health personnel who would be socially responsible for taking aggressive steps to ensure health for all.