Meeting Health Challenges

A 10-year journey across the South-East Asia Region

Dr Uton Muchtar Rafi
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Meeting health challenges: a 10-year journey across the South-East Asia Region
By Uton Muchtar Rafei

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ACKNOWLEDGEMENTS

During my tenure with the World Health Organization spanning over two decades, I have been most fortunate in receiving continuous and unstinted cooperation from my colleagues in the Regional Office, in the countries and from WHO Headquarters. This book is yet another example of such cooperation.

I wish to acknowledge the inputs provided by the Directors and other technical staff, and the assistance provided by Dr Saroj Jha and Mr Jitendra Tuli in documenting the highlights of my ten-year journey across South-East Asia.
FOREWORD

With over 1.5 billion people, the 11 Member Countries of WHO’s South-East Asia Region can be said to hold the key to the world’s health status. Over the past two decades I have closely observed the strong commitment and dedicated efforts of those responsible for health development in the Region striving to achieve their set targets.

With his long and varied public health background, Dr Uton Muchtar Rafei has provided mature and dynamic leadership as Regional Director to help steer this Region to better health. I have been impressed by Dr Uton’s insights and understanding of the health dynamics of the Region. This resulted in pragmatic approaches to address health issues of the Member States.

“Meeting Health Challenges” vividly recounts the formidable odds faced by the Region and the innovative efforts taken to deal with many of them. It captures the changing trends in public health as they keep pace with new priorities. Most of all, it reflects the author’s rare quality of combining idealism with reality. I especially appreciate Dr Uton’s genuine concern for the health and well being of the poor and the marginalized. I am sure the publication will find a prominent place in the annals of health development in South-East Asia.

Dr LEE Jong-wook
Director-General
PREFACE

Writing this preface, perhaps my last as Regional Director of WHO’s South-East Asia Region*, stirs strong emotions. I got to know the Region well during my association with it spanning over two decades. During this period, I had the privilege to share its vibrancy, its rich heritage, its joys and sorrows, and, above all, its unflinching faith and determination to create a happier and healthier future for its people.

I may be forgiven to sound nostalgic as I prepare to leave one of the world’s most outstanding Organizations. Working for the World Health Organization for over two decades provided me a truly remarkable opportunity to translate my vision for a healthier and more prosperous South-East Asia Region into something that was possible. It also gave me the humility to examine my weaknesses, the impetus to reinforce my strengths and the chance to dream of the future. A future where all men, women and children regardless of who they are, where they live and what they do, would have access to information, education, and health services that would help them to stay healthy and free from disease. If this sounds utopic, you must forgive me. I have, in the course of my public health career, seen far too much suffering, not to care. I have seen little children go hungry, women dying in childbirth, adolescents hooked to addictive drugs, young adults succumb to AIDS and TB, the elderly lonely and forlorn.

In my search for solutions, I have been extremely fortunate in finding some.

I would have been happier to have found more. This book highlights what was possible for me to do in collaboration

* The Region comprises Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste.
with our Member Countries. It also spells out what remains to be done. I am confident that my able successor will take the Region forward on a faster track to realize the goals that are yet to be achieved.

I am leaving for my successor something that I feel is very special. I am leaving behind some of the most dedicated staff I have ever worked with, men and women who have fought all odds to boldly meet the challenges of bringing health to all.

I am also leaving behind some very enlightened and committed health officials in the eleven Member Countries of the South-East Asia Region.

As I said at the 56th session of the Regional Committee for South-East Asia, which was my last as Regional Director, February 29, 2004 will mark the end of one phase of my journey in the South-East Asia Region, and the beginning of another.

This book is dedicated to all those who value health and are committed to promote health, especially of those who are in greatest need.

I am confident that the Region will scale even greater heights to reaffirm our belief in the indomitable spirit of humankind to overcome all odds to fight evil and bring peace to a growingly troubled world.

There can be no peace without good health.

Dr Uton Muchtar Rafei
Regional Director
Meeting Health Challenges

CHALLENGES, TRIUMPHS AND TRIBULATIONS

This journey began in March 1994. It wasn’t my first. I had traversed the Region in various capacities for many years on programmes related to primary health care. But in the last 10 years as Regional Director, my journey took me far beyond the confines of the traditional health care system. It made me deeply aware of the interrelatedness of health and development and the factors that determine health. It brought me face to face with the multiple issues that health sectors have to deal with – globalization, health sector financing, utilization of resources, partnerships, etc.

It took me to the highest political levels to advocate for health.

It took me to people and places to strategize for health.

It took me to the negotiating table to lobby for health.

It helped me get the whole picture.

The challenges were enormous. I knew they would be. To cater to the health needs of a vastly diverse Region with over 1.5 billion people, spread across 11 countries was not easy. Compounding the situation were other more challenging factors like the high levels of poverty, the widening gaps between the ‘haves’ and ‘have-nots’, low literacy rates, gender inequities and the inadequacies of health systems to ensure universal access to quality health care to its peoples.
Very soon I had built a team of competent technical and administrative staff who helped me steer a course to make the Region a healthier and more prosperous one. I am ever grateful to them for sharing their wisdom and experience, for their cooperation and, most of all, for the dedication and commitment they put into their work to realize many of our dreams. I also benefited greatly by having worked closely with my predecessor Dr U Ko Ko, gaining from him useful insights into the intricacies of health development in the Region.

The double burden of diseases posed serious challenges. On the one hand, infectious and parasitic diseases continued to take millions of lives. On the other hand, noncommunicable conditions like cardiovascular diseases, diabetes and malignancies became important causes of premature death and disabilities. The incidence of mental health disorders, especially anxieties, depressions, even suicides, rose significantly and accidents, especially road accidents, showed a steep rise. The tobacco epidemic defied all conventional methods of disease prevention. In a Region which has some of the world’s leading producers of tobacco with large commercial interests, I knew the battle would be a long drawn out one. A balance had to be struck. Both groups of diseases, communicable and noncommunicable had to be tackled. They demanded different strategies, different technologies and different resources.

This was not all. A variety of nutritional disorders added to the grim disease scenario. Unacceptable levels of infant, child and maternal mortalities stalked the Region. Between 1990-1993, the Region shouldered about 40% of the global maternal deaths and infant mortality rates were above 100 in some countries.

The Region’s population was growing beyond control, further eroding the already scarce resources. The unprecedented growth, particularly of urban populations brought in its
wake added health problems. The already overburdened municipalities and local governments were unable to meet the growing demands for basic amenities like safe drinking water, sanitation and housing.

Large-scale migration of populations from rural to urban areas and across countries were resulting in a variety of physical, mental and psychosocial illnesses. The joint family structure which provided a sound social support system was beginning to erode. Cultural and traditional values were getting diffused. The pressures of modern lifestyles and the resultant insecurities were driving many young people to substance abuse. Sexually transmitted infections, crime, prostitution and drug trafficking were on the increase. Violence emerged as yet another public health problem. In fact, suicides became the 5th, war the 10th and interpersonal violence the 12th leading causes of death in persons between 15 to 29 years of age.

HIV suddenly appeared to shake the Region out of a deep complacency based on the unfounded belief that ‘morally right’ Asian populations were immune to acquiring the infection.

The spread of the epidemic has been relentless. Nearly six million people live with HIV/AIDS contributing to 15% of the global burden. A major challenge now lies in achieving WHO’s global “3 by 5” target – putting three million people on antiretrovirals by the end of 2005.

There were other challenges. By the mid-1990s, the hazards of deforestation and environmental degradation were noted with even greater alarm. In rural areas, apart from the diseases caused by contaminated food and water, indoor air

The Region accounts for nearly one-fourth of the global population.
pollution, pesticide poisoning, and contamination of ground water with arsenic were serious life-threatening conditions.

Adding to these challenges were the natural disasters, and the emergencies that demanded instant action. Floods, cyclones and earthquakes rocked the Region, killing, crippling and displacing several thousands of people. Civil unrest that had erupted in some countries severely affected both the physical and the mental health of the people. In addition, certain disease outbreaks took the Region completely off guard. SARS in Asia, created a global crisis. It meant work round-the-clock to keep the epidemic at bay.

Launching, strengthening and intensifying programmes to prevent and control diseases was only one aspect of the challenges I faced. An equally serious concern was making these programmes accessible to the vast unprivileged masses that still remained outside the orbit of quality health care – men, women and children living under extremely deprived conditions.

The world was changing. With economic and trade liberalization, countries were increasingly getting enmeshed within a global economic framework. High speed communication had opened up a whole new world of opportunity. Many questioned, “opportunities for whom?” Economic growth and modernization which brought wealth to many also had its flip side. Unequipped to meet the skill demands of an increasingly sophisticated workplace, many among the youth, and especially women, found themselves robbed of their livelihoods or simply excluded.

There were other forces at work.

The financial turmoil during the mid and late nineties created economic instability in several countries particularly in Indonesia and Thailand. Health continued to be under-funded with most countries spending less than 5% of their GDP on
health. The effect of globalization on health became a debatable issue. The rapid liberalization of international trade affected health systems development, especially in countries with weak trade practices and legislations to protect health. The increasing tension developing between existing health care systems at national levels and the principal promoters of the global market-based economic systems like the World Trade Organization (WTO), World Bank, International Monetary Fund (IMF), and the multinational and transnational corporations had to be resolved. So also the implications of the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) on health.

As part of the global village, we found that we were no longer immune to the consequences of the actions of other people and nations. Nor could we find solutions to our problems in isolation. We had to accept the fact that the health sector had its limitations. Its inability to address all such issues was becoming evident. It could not work alone.

Merely providing medicines to treat the sick made little impact on the determinants of health which relied heavily on policy decisions, socio-economic reforms, legislation, ethics and a healthy and enabling environment. If the health sector had to make any impact on improving the health of people, then it had to enter into partnerships and alliances with various other sectors, institutions and groups working in the areas of human development with one goal in mind – to fulfill the promises we made 25 years ago at Alma Ata.

A new challenge now lay in convincing other sectors on the centrality of health in development and on the contributions they could make to build a healthy and prosperous nation.

This was not easy. Every sector had its own proprietary place and took pride in the ownership of its programmes. Sectors, in fact, competed with each other for money, status and
priority. In the pursuit of programme targets the wider visionary development goals were forgotten. But walls had to be broken, boundaries crossed and partnerships explored.

I am happy that more than just a beginning has been made to accomplish this. The fight against HIV/AIDS, TB and malaria, national immunization days to eradicate polio and implementing projects to establish healthy cities are some outstanding examples that are telling us that partnership indeed works.

Nearly all challenges have opportunities.

Facing up to these challenges was for me both an exciting as well as a fulfilling experience.

My frequent visits to countries brought me face to face with ground realities. It deepened my understanding of the health problems faced by countries and how they were being addressed. I couldn’t but admire their grit and determination to overcome formidable odds despite the paucity of resources. It also opened my eyes to the selfless contributions being made by peripheral health workers who silently and unobtrusively are, in fact, the true builders of health programmes.

During my visits, my discussions with health policy makers were focused on country priorities. These were wide ranging, and among others, covered, decentralization issues in Indonesia, cross-border control of infections in Thailand, humanitarian assistance in DPR Korea, human resource development in Bhutan and the health needs of people in the conflict affected areas in the North-Eastern Region of Sri Lanka.
I utilized the opportunities of country visits to strongly advocate with health and other related sectors on the need for strong partnerships that would be mutually beneficial in achieving development goals. My meetings with health officials, academicians and researchers, as well as my field visits to various health care facilities, covered a wide canvas, as for example, public health training, research and management in India, intensification of primary health care in Bangladesh, TB control in Myanmar, the Roll Back Malaria programme in Nepal, thalassaemia control in the Maldives and the development of health infrastructure in Timor-Leste.

The insights gathered during my country visits were shared with my colleagues in the Regional Office to help in formulating meaningful collaborative programmes with the countries of the Region. It was rewarding to get the opportunity to play a catalytic role in supporting countries to close the gaps and inequities in health. It was also gratifying to note how much the countries appreciated the technical role of WHO in strengthening health development.

Over the years, life expectancies have risen and infant mortality rates have declined. We developed new strategies to fight AIDS, TB and malaria, for the elimination and eradication of leprosy and polio, decreased goitre rates and other nutritional disorders, eradicated guinea worm disease and helped to build a global framework for the control of tobacco-related diseases.

Safe motherhood programmes received high priority. Among other initiatives, standards of midwifery practices were developed as well as a district model for the accelerated reduction of maternal mortality. Child and adolescent health were addressed through implementing the Integrated Management of Childhood Illness (IMCI) strategy and the Adolescent Freindly Health Services in several countries of the Region.
Deeply conscious of the fact that establishing effective health programmes rests largely on the availability of reliable epidemiological information, a regional strategy for an integrated disease surveillance system was drafted. This would help countries to develop their own multi-disease surveillance systems to ensure that continuous, accurate, complete and timely information was available to policy makers for planning relevant and realistic prevention and control programmes.

Times were changing. The interrelatedness of health and development was beginning to acquire a new equation. “Economic prosperity leads to good health” was being replaced by “good health leads to economic prosperity”. A global partnership to reduce the diseases of poverty attracted several international donors. In 2002, the global fund to fight three important diseases, AIDS, TB and malaria provided additional resources to countries to combat these economically crippling diseases. Approvals were based on proposals that were submitted by countries and strictly scrutinized for their soundness, feasibility and technical quality. Nine out of the eleven countries from this Region have already qualified for support from the Fund receiving allocations totalling US$ 709 million over five years. This level of resource mobilization is quite unprecedented. I have no doubt that it will contribute most significantly to combating the burden of disease which this Region so disproportionately suffers from.

High level advocacy, formulation of realistic and doable regional strategies, technical support to countries to carry out their health sector mandates, forging partnerships, mobilizing resources and contributing critical inputs into global strategies and programmes, all gave me some of the most enriching experiences any public health scientist could wish for.

However, many issues remain a cause of considerable tribulation to me.
Far too many women are still dying due to childbirth and its related causes. Neonatal, infant and child mortalities though declining are still at unacceptably high levels. Despite the increased coverage in health services through primary health care during the past two decades, 25% to 30% of the Region's population do not have access to standard quality health care. Uncontrolled urbanization and rapidly changing lifestyles are burdening the already over-stretched health systems of countries. With rising life expectancies, an increasingly ageing population is finding itself isolated and outside the focus of most health and welfare programmes.

In general, Health Promotion as a response to the growing expectations for a new public health movement that would enable people to increase control over and improve their health is yet to appear more prominently on the agenda of most health planners and implementers.

In September 2000, the United Nations reaffirmed its commitment to work toward a world in which sustaining development and eliminating poverty would receive the highest priority. The Millennium Development Goals set out by world leaders include:

- reducing poverty, hunger, illiteracy, environmental degradation, gender inequalities and child mortality
- improving maternal health
- combating HIV/AIDS, malaria and other diseases
- building a global partnership for development.

The goals are ambitious and their targets more so.

However, I have full confidence that the Region will face up to the fresh challenges with its usual grit and determination under the leadership of my able and dynamic successor.

My journey across the Region may have ended. But my sentiments remain.
Looking back I can see that we have covered much ground and realized many of our collective dreams of making this Region a leader in health development. With the support of countries we have come a long way. But the road is long and we still have miles to go.

I have no doubt that the cohesiveness, the shared values and the common purpose we have pursued together, will get even stronger in the years ahead.

In the words of Dr LEE Jong-wook, Director-General, World Health Organization,

“We must do the right things.
We must do them in the right places.
And we must do them the right way”.

May the South-East Asia Region of WHO scale further heights to bring to all its citizens a level of health to enable them to live a long, healthy and productive life with dignity and in peace.
Poverty breeds ill health and ill health in turn breeds poverty. The nexus is well established. We do not need further research to tell us that. What is also known is that while poverty traps the poor into a vicious cycle of sickness and penury, when they are lifted out of their impoverished states through better health, they do not tend to slide back into poverty.

Of the 6.4 billion people in the world today, 1.3 billion live in absolute poverty. Of these, 522 million are in South Asia alone, living on less than one US dollar a day. It would indeed be a miracle if this could provide them with safe and sanitary homes, clean food and water, vaccines, medicines, maternal care and other essential requisites for good health.

Eighty percent of global mortality is due to diseases of poverty. Poverty also accentuates gender gaps. Poor women especially pay a high health price while they juggle with their roles as child bearers, home makers and wage earners.

Poverty-ridden populations are at high risk of acquiring communicable diseases. The South-East Asia Region demonstrates this in no uncertain terms. Home to about 40% of the world’s poor, the Region also bears a disproportionate global burden of disease, accounting for over 40% of the global mortality from communicable diseases. HIV/AIDS, tuberculosis and malaria are major poverty determined
diseases that accentuate poverty in already impoverished conditions, further marginalizing the poor and depriving them of the opportunities to attain good health. For example, research in Thailand has shown that poorer households are disproportionately affected by HIV/AIDS and in their ability to cope with the costs the disease entails. More than half of the households surveyed had reduced their consumption by more than 50% to care for a family member with HIV/AIDS, 60% had used all of their savings for medical costs, 19% had sold property such as land, animals or vehicles, 15% had pulled their children out of school to help at home and 11% had borrowed money to pay for medical costs and maintain household needs. Poor families became even poorer and lower middle-income households became poor ones.

Poverty is both a determinant of ill health and an obstacle to solving health problems. Poverty is destructive and requires more than medical technology to alleviate it. It requires intersectoral action that targets communities and households that are at greatest risk and helps to build the community’s capacity to help one another to overcome the development crisis brought on by poverty.

The Commission on Macroeconomics and Health in its report “Investing in Health for Economic Development” estimated that by 2010, around eight million lives per year could be saved – mainly in low income countries by essential interventions against infectious diseases, including AIDS, TB and malaria. Scaling up response to these diseases is an important way out of poverty.
Global Support for Tuberculosis, Malaria and AIDS

March 2000: Ministers of Health, Planning and Finance from 20 countries with the highest number of TB cases meet in Amsterdam and call for a massive support for action against diseases that cause poverty. They pledge to expand DOTS coverage to reach at least 70% of all infectious TB cases by 2005.

July 2000: Leaders of the G8 countries meet in Okinawa and endorse targets to reduce the number of young people infected by HIV by 25%, cut TB mortality and prevalence by 50% and bring down the burden of disease associated with malaria by 50%, by 2010.

October 2000: Leading advocacy and communications experts, largely from nongovernmental organizations and the private sector from all over the world agree in Winterthur, Switzerland, to mobilize global, national and community advocacy networks to hold governments accountable to agreed upon disease control targets and to increase the involvement of civil society in meeting the targets.

June 2001: The United Nations General Assembly Special Session on HIV/AIDS held in New York focuses on the need for international action to fight the spread of HIV/AIDS and to mobilize additional resources over and above those already pledged.

January 2002: Championed by the Secretary-General of the United Nations, the Global Fund to Fight AIDS, Tuberculosis and Malaria is established. The Fund is seen as an unique opportunity to build global public-private partnership to leverag additional financing mechanisms to effectively address the three diseases and achieve lasting reductions in the threat of these infections. To date, the Fund has allocated over US$ 709 million to countries of the South-East Asia Region, spread over five years, to fight these diseases.
If the “diseases of poverty” are not tackled urgently, countries of the South-East Asia Region will face, what world leaders believe “a reversal of decades of development, to rob an entire nation of hope for a better future”. Today there is unprecedented global support for AIDS, TB and malaria, diseases recognized as major health challenges in low income countries that keep people in poverty. Parliamentarians of the South-East Asia Region have responded overwhelmingly to the call for rapid, concerted and sustained action against these diseases.

**Rising to the Challenge of HIV/AIDS**

When Thailand reported the first case of HIV/AIDS in the Region in 1984, little did the countries expect that this heralded the spread of an epidemic, the likes of which was never before witnessed in the Region. In fact, many countries chose to ignore the warning, convinced that they would never have to face the problem. “Why should we be worried?” they asked. “We do not have gay communities, multipartner sex is rare, injecting drug use is practically unknown and, in general, the lifestyles of our people are based on strong, traditional family values immune to the risk of acquiring HIV”.

The myth was soon shattered. HIV prevalence rates soared. There are nearly six million people living with HIV/AIDS in the Region, currently contributing to 15% of the global burden of HIV which has now begun to spread from populations with high risk behaviours to the general population. The epidemic is highly dynamic with India, Myanmar and Thailand already at an advanced stage. India has the second highest estimated number of HIV infected people of any country, next only to South Africa. The situation in Indonesia and Nepal, particularly among intravenous drug users, is also causing concern.

The early years of almost complete denial and complacency during which HIV spread relentlessly, is fortunately, a
feature of the past. Asia’s vulnerability to the spread of HIV has become clearly evident. The epidemic has challenged traditional cultural boundaries. All countries today are deeply concerned and have pledged unflinching commitment to fight HIV/AIDS. National strategic plans have been developed involving a number of government sectors, the private sector and nongovernmental organizations.

Thailand’s response through a well coordinated multisectoral strategy has paid impressive dividends. The rate of HIV infection among all population groups has begun to decline. Among military conscripts, for example, HIV prevalence decreased from 3.6% in 1993 to 2.1% in 1996. Even more significantly, new cases of sexually transmitted infections treated at government clinics decreased by 90% between 1989 and 1996. As the result of an effective prevention and care programme, Thailand has succeeded in preventing an estimated 2-3 million people from being infected. The success of Thailand’s innovative 100% condom programme has encouraged other countries in the Region to apply the same model. Myanmar has initiated a 100% condom pilot project expected to cover 28 townships by the end of 2003. Similarly, Indonesia has also launched its 100% condom pilot project.

The experience of the past ten years in meeting the challenges presented by the epidemic has taught us some important lessons. In order to mount a timely and effective response, the public health infrastructure must be strengthened. This includes early diagnosis and treatment of sexually transmitted infections using the syndromic approach, blood transfusion safety, epidemiological surveillance and research and a continuum of HIV/AIDS care programmes linking health institutions, the community and home. In many countries, such activities are being undertaken with promising results.

Since risk behaviours and vulnerability which promote, facilitate and fuel HIV transmission exist in all countries, sentinel
surveillance is being strengthened to monitor risk behaviours among selected population groups. Bangladesh, India, Myanmar, Nepal and Thailand have already undertaken surveys to assess current risk behaviours.

Community-based responses to HIV/AIDS which are vital for successful intervention programmes are now increasingly visible in the Region. Intervention programmes are being expanded and community-based responses to the epidemic greatly strengthened through increasing NGO participation and involvement of the private corporate sector in activities covering the prevention and care aspects, particularly at the workplace.

Intravenous drug users marginalized in the past and one of the most difficult to reach groups are now being drawn into national control programmes. Indonesia and Myanmar have taken steps to integrate harm reduction into national AIDS policies, piloting harm reduction projects like needle/syringe and methadone maintenance programmes, in collaboration with various partners including UNODC, AuSAID and WHO.

Interventions like prevention of mother-to-child transmission (PMTCT) and voluntary counseling and testing (VCT) to decrease HIV transmission in the general population are now being implemented. There is nationwide implementation of VCT in Thailand and eight other countries in the Region are in the process of enhancing these services. The access to antiretroviral treatment (ART) is expanding. In May 2003, the World Health Assembly took note of the goal of providing three million people in developing countries with antiretroviral therapy by 2005. This “three by
five” goal presents both a technical and a political challenge. As only about 10 per cent of those infected actually know their HIV status, it is estimated that around 800,000 people in the Region are in need of antiretroviral treatment. Thailand, which provided ART to 6000 persons in 2002, is expanding its activities to support as many as 50,000 persons by the end of 2004.

While India is preparing for the first trials of an AIDS vaccine, the results of Thailand’s phase III vaccine trials have been disappointing showing that the Vaxgen vaccine has not been effective in preventing HIV infection.

Cross-border spread of HIV across the countries of the Region is a serious concern. More and more people, especially the young are on the move today seeking work opportunities. This has provided a new route for the spread of HIV. Research studies have suggested that there is significantly more risk behaviour in border areas which are remote from the usual legal and cultural restrictions imposed on communities living in those countries. Both in Thailand and Myanmar for example, HIV prevalence rates in border provinces with land crossings was found to be nearly twice as high compared to the rates found in provinces without border access. Myanmar’s sentinel surveillance carried out in 1995 showed similar results. Cross-border spread of HIV is thus gaining increased attention in the Region. Joint plans to prevent the spread of HIV across the Thai-Myanmar, India-Bangladesh, India-Bhutan and India-Nepal borders have been developed and pilot projects in various border districts are already at the early stages of implementation. Based on the experience gained, scaling up implementation to cover other border districts will be planned.

WHO’s technical support, I am happy to say, has been recognized by nationals as critical in taking countries forward in their HIV/AIDS prevention and care programmes. The Regional Office played a leading role in providing
support to the health sector, such as surveillance, targeted condom promotion, prevention and care of sexually transmitted infections and blood safety. It supported countries in scaling up programmes related to harm reduction among intravenous drug users, voluntary counseling and testing, prevention of mother-to-child transmission and care, including antiretroviral treatment for people living with HIV/AIDS. In the early 1990s, the importance of VCT services were only just beginning to be accepted in the Region. Access to antiretroviral treatment remained confined to a privileged few, harm reduction as a strategy to prevent HIV/AIDS among intravenous drug users was still being debated and children conceived by HIV positive mothers, were at a high risk of acquiring the infection. Today, the picture is different. VCT centres have developed in large numbers and antiretroviral therapy is much more accessible even to some of the poor. As future priority, a regional strategic plan is being finalized to guide countries in effective and efficient implementation of programmes to achieve the global target of providing three million people with antiretroviral treatment by 2005.

An unprecedented opportunity to mobilize additional funds for countries to scale up effective interventions against HIV/AIDS has come with the establishment in 2002, of the Global Fund to Fight AIDS, TB and Malaria (GFATM) an initiative of the Secretary-General of the United Nations to promote health in the world’s poorest countries. So far, six countries of the Region, Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand have had their proposals approved in the first three rounds of funding and together have received over US$ 395 million to strengthen their HIV/AIDS control programmes. The technical support provided by WHO/SEARO in the preparation of country proposals as well as reviewing each proposal before its submission to GFATM was greatly appreciated by the countries as well as by the Secretariat of the Fund.
Political commitment to fight HIV/AIDS has been expressed by many countries in many ways. One of the earliest and finest examples came from Thailand when the Prime Minister took over the chairmanship of the National Committee on AIDS and all ministries became actively involved. Funds allocated for the programme increased 17-fold and a national AIDS prevention plan was integrated into Thailand’s national five-year development plan. Other examples include resolutions passed by Parliamentarians of the Region and declarations adopted by health ministers calling for urgent measures to address the problem of HIV/AIDS.

An impressive show of political commitment was demonstrated more recently in India at the first national convention of the parliamentary forum on HIV/AIDS, organized in collaboration with the Ministry of Health and Family Welfare and the UNAIDS Secretariat. Nearly 1000 elected representatives from different political parties and from different levels of administration, including the Prime Minister and other prominent political leaders participated in the meeting that ended with a declaration of commitment towards ensuring leadership, enhancing advocacy and mobilizing resources, promoting gender equality, empowering women and intensifying multisectoral collaboration in the fight against AIDS.

Political will is not everything. What is also needed is for countries to grapple with the problem boldly and innovatively, shedding old inhibitions, learning from the many lessons of the past and developing the vision to formulate a realistic strategy and plan of action to fight AIDS. I am confident that the countries are now prepared to take up this daunting task.

During the last 10 years, I have been privileged to be part of this scene – to see the Region grow out of apathy and indifference to the problem of HIV/AIDS to a stage of awareness, enlightenment and action. It would, however,
be presumptuous to believe that the worst is over. Changing the course of the HIV/AIDS epidemic rests largely on changing people's behaviour. And this is not easy, especially in a Region where high illiteracy rates combine with taboos imposed by society on discussing matters related to sex and sexuality.

But even this is beginning to change. A colleague of mine recently narrated an interesting observation. The driver of the auto rickshaw in which she was traveling talked to her very openly and without embarrassment about his exploits with sex workers in Mumbai. “This would never have happened five years ago” she said. When she asked the driver if he was not afraid of getting AIDS, he replied “No. The sex worker gives me a condom”.

So, even if the worst is not over, I have every reason to believe that with continued advocacy, effective communications and strong technical support from WHO, the worst may soon be over.

**Controlling Tuberculosis**

No other infectious disease has brought so much suffering to so many people over so many centuries as tuberculosis. Killing nearly two million people every year, TB has remained one of the most elusive public health challenges of our times.

I vividly recall those years in the 1950s, when, as medical students, we saw at close quarters the devastation that TB caused among patients and their families. Streptomycin had just been introduced into the TB therapy regimen. It meant daily injections along with a whole package of other tablets to be taken with unfailing regularity. TB treatment extended for “years”. Not many had the patience nor the means to continue with it. Default rates were high, relapses were common and deaths from TB abounded. The spread of TB continued unabated, especially among the poor.
The nexus between TB and poverty is an undisputed one. TB incurs tremendous costs, both economic and social. Human lives are lost during their most productive years. Household incomes drop as much as 20% to 30%. The poor become poorer.

**The TB-poverty Connection**

- TB leads to a decline in worker productivity of the order of US$ 4 billion annually.
- Studies suggest that on an average, an affected employee loses 3-4 months of work resulting in potential losses of 20%-30% of annual household income.
- Fifteen years of household income is further lost as a consequence of the premature death of the person affected.

Controlling TB has not been easy. The most vulnerable to TB, the poor and marginalized groups, had for decades remained beyond the reach of most national TB programmes. Cure rates had been low and case detection rates even lower. The long history of stigma associated with the disease and especially discrimination against women suffering from TB had further thwarted the many attempts to get people to accept TB services.

The South-East Asia Region has borne the major load of the heavy burden of global tuberculosis, with 38% of the world’s TB cases. Nearly three-quarters of a million people in the Region die from TB every year. A new threat to TB control has now come in the form of a parallel HIV/AIDS epidemic. About 2.5 million people are currently estimated to be co-infected with both HIV and TB. The combination is deadly. HIV reduces the capacity of the body’s natural immune system to fight infections. TB thrives under such conditions.
conditions. In fact, TB is the most common life-threatening opportunistic infection among HIV-infected persons and accounts for 40% of AIDS deaths in Asia.

In 1993 WHO declared TB as a global emergency. The message was short and clear – “STOP TB”.

The Region lost no time in implementing DOTS – a strategy that revolutionized the existing approaches to TB control. Starting with a few pilot projects in 1993, DOTS rapidly expanded across all countries of the Region. Almost 80% of the Region’s population now have access to DOTS with overall treatment success rates nearly as high as 85%.

The Success of DOTS in the South-East Asia Region

- DOTS has more than doubled the accuracy of diagnosis of infectious cases.
- DOTS has tripled the treatment success rate to nearly 85% among cases registered for treatment under national TB programmes.
- DOTS has prolonged the survival of HIV-infected TB patients as seen in Myanmar and Thailand.
- DOTS has saved US$ 55 for every US$ 1 invested in TB control in Indonesia.

Intensive efforts to successfully implement DOTS in Member Countries included strengthening national capacity to ensure quality microscopic services, drug procurement and distribution, case management and supervision as well as monitoring.

Needless to say, all this required considerable resources, especially financial support. We succeeded in getting this support through global initiatives, from bilateral technical and financial donors and from other partners.

Funding additional resources was not the only challenge. How could the health sector alone cover vast areas of the Region with DOTS? Partnerships had to be explored.
Our efforts to convince other sectors on the critical role they could play to respond to the TB epidemic have not gone in vain. The private sector, medical schools, industry and NGOs are increasingly coming forward to collaborate with national programmes to implement DOTS.

Several other initiatives also hold promising outcomes. With increasing migration patterns noticed in the Region, joint plans of action for the control of TB, HIV, malaria and kala-azar in cross-border areas have been developed and support provided to pilot collaborative interventions in Bangladesh, India, Myanmar, Nepal and Thailand. An operationally integrated approach to strengthen collaboration between the TB and HIV programmes has also been initiated with the development of a regional framework for TB-HIV control.

Largely due to quality interventions under DOTS, the rate of multi-drug resistant TB (MDR-TB) is still low in the Region. However, considering the potential dangers, we cannot afford to ignore it. Plans, in fact, have been made to commence surveillance in MDR-TB in Indonesia, Myanmar, Sri Lanka and Bangladesh. Pilot DOTS-plus projects to treat MDR-TB are also being considered for India and Nepal.

To improve existing activities and introduce wider cost-effective interventions, operational research is being actively promoted in the areas of public-private partnerships to implement DOTS, introduction of DOTS in medical schools, urban DOTS projects, addressing issues of gender equity and access to DOTS in remote areas.

We have come a long way since those depressing early years of TB control when a diagnosis of TB spelt almost certain lifelong sickness and death. The past five years have brought new hope to the Region. TB control programmes are beginning to show some dramatic results. I see sustained commitment from governments, active collabora-
tion from various sectors both public and private and enhanced support from donors. The global targets of 85% treatment success and 70% case detection among all new sputum cases now appear well within our reach.

Tackling Malaria

Once, during one of my travels, through the vast expanse of India’s marshy lands, my thoughts went back to my first lesson on malaria in medical school. “Malaria kills”! My teacher had said this over and over again. Our class did not question. We had seen this ourselves in the neighbourhood we lived in, and in the hospital wards we attended. The rigor and the sweating of malaria patients had kept us awake several nights. Even children were not spared. In fact, they became the worst victims of the bite of the female anopheles mosquito.

Much later, I learnt other facts. Malaria does not only cause loss of lives; it also reduces agricultural productivity, blocks profitable investments and prevents the effective use of urban land and other natural resources. Malaria keeps poor people poor. In fact, it makes them poorer.

The long and protracted battle against malaria began.

I got involved in the battle long before I joined WHO and before the more modern antimalarial drugs had entered the market. In 1964, I was Director of the General Hospital and 15 health centres in Banjar, a malaria-endemic district in Indonesia. Insecticide spraying operations were unknown and except for quinine, no other medicines were available. There was only one thing we could do. And we did that well. We destroyed all the mosquito breeding sites that we could find with the help of a whole army of volunteers from women’s groups, from police departments and from youth organizations. We held fund raising shows to generate the resources to carry out these activities.
Being somewhat adept at hypnosis and telepathic communications, I joined the others to entertain large gatherings of rural audiences.

The experiment was a success – even if I did not succeed in hypnotizing the wily mosquito!

The success of the early malaria control programmes raised hopes of a malaria-free world. But the hope soon turned into despair. Malaria resurged. Eradication became a distant dream. In the countries of the South-East Asia Region, which bears a large proportion of the world’s poor, where populations are scattered far and wide beyond the reach of quality health services, malaria has continued to be a cause for public health concern. Large population movements, unhygienic conditions, climatic changes, increasing vector resistance to insecticides and multi-drug resistance among the malaria parasites in addition to uncontrolled development activities have continued to undermine the gains which countries had achieved in the past. About 1.3 billion people in the Region still live in malaria-prone areas.

Except for the Maldives, which records no indigenous transmission of malaria for the past 15 years, the disease is endemic in every other country of the Region. About 85% of the Region’s population is at risk, most of them in India, Myanmar and Thailand.

It is estimated that malaria affects over 21 million people every year claiming over 27,000 lives. Over the last 25 years, the more dangerous form of malaria, that caused by the p. falciparum parasite has in fact increased from 12.5% in 1976 to 44.9% in 2001. An additional concern is the
increasing resistance of the malarial parasite to the commonly used anti-malarial drugs. It is estimated that 400 million people are at risk of contracting drug-resistant malaria. However, there are clear indications that despite the continuing challenges, a decline in the number of cases and deaths is now discernible in the Region – from 3.3 million confirmed cases in 1997 to 2.6 million in 2001, and from 5800 deaths to 4400 in the same period.

To continue this trend, the need for a massive and sustained attack on malaria has been well recognized. The “Roll Back Malaria” (RBM) initiative launched by WHO in 1998, has provided the impetus to countries to strengthen their national malaria control programmes in collaboration with the general health services. This has helped countries to improve their epidemiological information system, pay special attention to vector control and intersectoral collaboration and secure adequate resources, both in terms of funds as well as skilled personnel.

RBM is a social movement aimed to halve the malaria burden by 2010, from what it had been in 2000, through community-based action, health sector development, integration and intersectoral collaboration as well as strong advocacy. The Region is an active partner in this movement. Insecticide treated nets (ITN) which may eventually prove to be the single most effective public health intervention to prevent malaria, have been introduced in all the malarious countries of the Region.

Over the past five years, several initiatives have been undertaken by us, both at regional and country levels, including the establishment of technical resource networks to cover priority areas like drug resistance and policy, reducing transmission risks, surveillance and epidemic response.

Networks related specifically to drug resistance have been established to prevent the spread of the more serious
multidrug resistant malaria in the Region. These networks operate in the Mekong Region and in Bangladesh, Bhutan, India, Nepal and Myanmar.

Operational tools for malaria control such as guidelines for implementing RBM at district levels, formulation of regional and country strategic plans for scaling up ITNs and guidelines on management of uncomplicated and severe malaria at different levels of health facilities including hospitals have also been developed and used. As malaria is an important problem in young children, collaboration with the Integrated Management of Childhood Illnesses (IMCI) programme has been initiated in the countries, focusing on community mobilization to facilitate various interventions in malaria control. Partnerships have also been built with various WHO collaborating centres, national centres of excellence and the WHO-supported Asian Collaborative Training (ACT) malaria network for capacity building. In addition, a regional insecticides policy as well as a monitoring and evaluation system are also being developed.

Besides these strategic developments, I have been happy to see certain very innovative attempts to control malaria in the countries. In Indonesia, practices aimed to enhance rice productivity and promote prawn and fish cultures have eliminated the breeding of certain malaria vectors. The reclamation of lands to increase rice fields have also resulted in substantial reduction of the disease.

In India, deforestation and construction of an irrigation dam in the foothills of the western ghats has removed forest litter and water seepage, thus eliminating breeding sites of vectors. Introduction of guppy and gambusia fish in many of the mosquito habitats have reduced malaria on a sustained basis. In certain areas, easy and rapid diagnosis of malaria is now possible with the use of ‘dipstick’ test kits.
Despite the various developments of the last few years, I am afraid that we may not see the end of malaria in the Region for a while yet. The complexities of malaria control will continue to challenge us. We must be prepared to face the ongoing challenge and continue to build on the RBM strategies we have initiated as well as utilize widely the tools we have developed. Control of malaria relies heavily on community participation. Roll Back Malaria in the Region must therefore become a truly dynamic social movement enabling communities to be vigilant and empowering them to take effective and sustainable action against the disease.
It was World Health Day 1977. At that time, I was stationed at Bandung as Director of Health and Director of Socio-Economic Planning of the Province. The district health office had invited me to be the chief guest at a function to mark the event. The theme was “Immunization”, with the slogan, “Immunize and Protect your Child”. I remember being deeply touched when a little girl with a bouquet of red roses in her tiny hands limped across to me and with the brightest smile on her face offered me the flowers as a token of appreciation for the efforts we were making to ensure that other children did not go through the lifelong disability that she faced.

Like everywhere in the world, polio in Indonesia was a disease to be feared. It had disabled thousands of young children in the country. Despite the availability of an effective vaccine the scourge continued.

This of course, was not just the case for Indonesia. In all countries of the Region, the polio virus continued to spread wildly and to disable and kill the young.

In 1977, the Expanded Programme on Immunization was at the forefront of a new systematic approach to control vaccine preventable diseases in children. There was no looking back. Over the next decade immunization coverage rates in the Region rose sharply. In the case of polio, the cover-
age increased from an estimated 3% to around 60%. This was the beginning of our belief and hope that polio would one day be eradicated.

In 1988, WHO endorsed that belief and hope. A global commitment for the eradication of polio was given at the World Health Assembly. The target was to begin National Immunization Days (NID) across the Region in 1994. The goal was ambitious: to immunize with polio vaccine all children under five years of age in a single day, followed by a second round a month later.

The results were spectacular: By December 1996, more children were immunized than ever before in the history of human health activity. This gave a tremendous boost to the polio-free movement.

Within a period of one week, National Immunization Days were held in nine countries of the Region. Our advocacy efforts and personal interventions with senior government leaders to motivate national health authorities to respond to the polio-free initiative had met with overwhelming response. However, additional resources were urgently needed. To galvanize this, we held interagency coordination committee meetings with UNICEF, bilateral and other donor agencies. Rotary International, a major NGO, who had been among those leading calls for the global eradication of polio, stepped forward and offered not merely financial support but also mobilized thousands of volunteers to help achieve the immunization targets that were set.

New partners joined in. In Bangladesh for example, an impressive 550,000 volunteers mobilized communities to
come forward to have their children immunized. Political and religious leaders, even private practitioners and pharmaceutical companies across the Region lent substantial weight to the campaign.

In 2003, over 228 million children in the Region will have been immunized, with the help of over 10 million vaccinators.

The outcome of these massive efforts is impressive
- In the 1990s, polio disabled or killed an estimated 150,000 children annually
- Today, there is a 99% reduction of the polio burden in the Region and ten of the eleven countries are polio free.

The focus of world attention is currently on India, the largest country in the Region, where the transmission of wild polio virus still continues.

The final assault on this last reservoir of polio in South-East Asia has begun. Intensive Sub-National Immunization Days are being conducted to maintain high immunization coverage especially in the high risk areas. Governments are being helped to expand and improve their surveillance systems and additional funds are being mobilized to achieve the eradication targets set by countries.

A polio-free South-East Asia Region is now well within sight.
The word “leper” still rings clearly as I recall my childhood days spent in Bandung in Indonesia where the very word spelt fear, dread and panic. We looked away from the painful, disfigured faces of those affected, afraid to speak to them, leave alone touch them. The compassionate among us, dropped coins in their begging bowls, but from a distance to make sure that we did not actually touch them. This is what society and even the law had taught us – to shun and isolate victims of what was at that time referred to as a “cursed” disease. It was not until I joined medical school that I learnt the following truths.

Leprosy was not caused by the wrath of the gods as many seemed to believe in those days. Leprosy was like any other infectious disease caused by microorganisms and, in fact, was the least infectious among communicable diseases. I also learnt that leprosy was curable.

It took a very long time before the world could come to terms with this.

There were reasons for this. Sadly, many of them reflected the attitudes of the health professionals themselves.

I clearly recall asking my superiors one day, “Why are we keeping our leprosy patients confined in special leprosy hospitals, isolating them from everyone else? Isn’t this unethical? Are we not encouraging, even licensing the
discrimination and stigmatization shown to these unfortunate patients by our society?"

“Where else should we keep them?”, I was asked.

“In the wards of our general hospitals of course”, I answered. Much to my dismay, my suggestion was rejected.

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**Mahatma Gandhi and Leprosy**

It was sometime in the 1930s. Mahatma Gandhi was invited to inaugurate a leprosy hospital in India. He refused as he did not believe in leprosy patients being segregated and isolated. He fought against every form of stigmatization and discrimination against the disease. In his fervent hope to see the end of leprosy, he said he would instead be happy to be invited to close down a leprosy hospital when the disease had been eliminated.

The stigma against leprosy thwarted many of the efforts we made to detect cases and treat them. We had to fight it. The very term “leper” was offensive.

Despite the fact that this expression is thankfully no longer used and widespread public education programmes to dispel myths and misconceptions about leprosy have generally reduced the stigma associated with the disease, there are even today, instances where leprosy cases languish in restricted habitats abandoned by their families and friends, interacting only with those who are similarly afflicted.

Leprosy had always been widely prevalent in the South-East Asia Region. In the late 1940s, there were over a million cases in India, 80,000 in Indonesia, 110,000 in Myanmar, 100,000 in Thailand and 4000 in Sri Lanka. Despite national leprosy control programmes, these figures multiplied over the years. By 1985, the Region accounted for over 5 million cases, of which 4 million were in India.

WHO’s concern for leprosy dates back to as early as 1948, when, at the second World Health Assembly, countries of
the South-East Asia Region requested WHO to address the problem on a global scale. This was the beginning of a global movement to control leprosy.

Countries of the Region established national leprosy control programmes based on scientific methods to diagnose and treat the disease. However, it was not all smooth sailing. Increasing drug resistance to dapsone, the drug commonly used for leprosy, began to be reported. The issues of discrimination and stigmatization still needed to be addressed. There were other severe deficiencies in the programme.

In 1981, new hopes emerged that turned the tide of frustration and despair of leprosy workers everywhere. Based on scientific evidence collected from various clinical trials in many of the leprosy endemic countries, WHO recommended the Multidrug Therapy (MDT) regimen as the standard treatment for all leprosy patients. Countries of the Region responded to this new regimen and we began to see, for the first time, a reduction in leprosy cases. But treating cases was not everything. Leprosy had to be eliminated.

In 1991, the World Health Assembly adopted a resolution calling for “Elimination of Leprosy” as a public health problem which aimed to reduce the prevalence of leprosy cases to a level below one case per 10,000 population. This meant that, as important as treating every case, there was an urgent need to also detect every case of leprosy. In our Region, which has vast expanses of underserved, difficult to reach settlements and where myths and misconceptions about leprosy still prevail, the challenges remain formidable. However, the countdown has begun. The decline in leprosy cases in the Region over the past 10 years has been remarkable. A regional prevalence rate of 6.15 per 10,000 population in 1994 declined to 2.46 by March 2003.

Today, eight countries of the Region – Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Sri Lanka and
Thailand have achieved elimination targets at the national level and are maintaining them. India, which has always borne the heaviest load of leprosy cases in the Region, cured over 10 million cases. It still had in April 2003, about 345,000 registered patients with a prevalence rate of 3.23 per 10,000 population.

In all countries, efforts are being intensified to detect and treat cases through focused activities, targeted to areas that have not yet reached elimination levels. I am confident that by 2005, India, Nepal and Timor-Leste will join the other countries in achieving their national targets and that elimination at subnational levels will also soon be reached by many countries of the Region.

The elimination of leprosy as a public health problem will be a great achievement not only for health workers who have laboured hard to see the day but also for WHO. For me, it will also mean one of the greatest victories for all those who have struggled uncompromisingly against all odds to detect and cure cases, to care for the afflicted and to restore to them their human rights, self esteem and dignity.
A Success Story from Bhutan

The kingdom of Bhutan, with its high mountains, flowing streams and vast tracks of virgin forests has been likened to Shangri La – paradise on earth. Its breathtaking beauty, however, was marred by a conspicuous disfigurement, noticed among many of its people.

Forty years ago two English doctors found the cause of this. They reported that goitre was widely prevalent in the kingdom.

A nationwide study conducted in 1983 confirmed that goitre and iodine deficiency disorders (IDD) that cause goitre were a major public health problem in Bhutan. The extent of the deficiency was alarming, with the total goitre rate being as high as 64.5% and cretinism reported in all districts of the country. To tackle this deficiency, a year later, in 1984, the IDD Control Programme was established.

The programme was built on three main areas for action:

- Universal salt iodization;
- Information, Communication and Education on IDD;
- Monitoring the iodine content of salt.

The mainstay of the programme has been iodization of all salt distributed in the country.
In 1985, a salt iodization plant was established in Phuntscholing where salt imported into the country is iodized. To ensure that all salt consumed in the country has adequate levels of iodine, regular monitoring of the iodine content of salt is carried out. This is done at three levels. At the production site, monitoring is undertaken by the District Laboratory and the Public Health Laboratory. At retail outlet sites, this is carried out by the District Hospitals and at household levels, by health workers from the Basic Health Units.

The required standards for iodine vary from site to site – 60 parts per million (ppm) at the production site, 25 ppm at the retail levels and 15 ppm in households.

In 1991/92, a second national survey was undertaken to evaluate the outcome of the IDD programme. The results were most encouraging. The total goitre rate had dropped from 64.5% in 1983 to 25.45% in 1991-92 and 96% of all salt sold in the country was found to be iodized.

A third survey carried out in 1996 showed further improvement. The goitre rate had now dropped to 14%!

In addition to such surveys, an internal evaluation mechanism has been established which uses cyclic monitoring studies to measure the programme’s performance. This method enables identification of loopholes in the programme if any so that timely intervention can be taken before the larger nation-wide evaluations are done. The results of the cyclic monitoring studies showed that Bhutan was well on the way to eliminating iodine deficiency disorders. The total goitre rate had dropped to 5% in 2001.
The coverage of iodized salt in the country has also shown most impressive results, from no coverage in 1983 to 95% in 2001. For me, these results are specially exciting since my association with Bhutan dates back to the 1980s when I visited the country to see the primary health care programme in Mongar district.

I have watched the country’s health system grow from its most rudimentary networks to what it is today – a well established health care system that can take pride in its many achievements of bringing health to its people. The internationally recognized Mongar project, a model for primary health care was, in fact, one of the first success stories of this Region.

Bhutan has also other firsts to its credit:

- It was the first country in the Region to employ health telematics, an effective tool to extend equitable, basic health services to all people, and especially to those living in remote areas.
- It is the first country in the Region where every district, barring one, has been declared smoke-free.

None of this would have been possible without strong political commitment and hard work.

It is precisely this element that has also largely been responsible for the success of Bhutan’s iodine deficiency disorders elimination programme. The structure of the programme was meticulously planned right from its onset. It took the form of a well coordinated multisectoral programme, guided and reviewed by a high-level IDD Commission, having the Health Minister as its Chairman and an intersectoral task force to cover issues that are multisectoral in nature. Task force members were drawn from the departments of Trade, Food Corporation of Bhutan, Ministry of Education, Department of Roads, quality
control and regulatory services, the Bhutan Chamber of Commerce and Industries and the Royal Bhutan Armed Forces.

Capacity building of field health workers on IDD monitoring, laboratory testing, recording, etc. is a regular ongoing programme. Periodic national level assessments and an internal monitoring system has played an important role to provide the important feedback necessary for timely interventions.

In January 2003, an international mission comprising WHO and UNICEF with technical support of experts from the Iodine Deficiency Disorders Consortium and the Royal Government of Bhutan carried out an evaluation to assess the progress made towards the elimination of IDD from the country.

The results were spectacular.

In the span of 20 years, Bhutan had moved from severe iodine deficiency to adequate iodine nutrition status according to the criteria set by WHO, UNICEF and the International Council for Control of Iodine Deficiency Disorders.

This achievement was attributed to committed, high level leadership, and the guidance provided by His Majesty the King, respected Buddhist leaders, Cabinet Ministers, iodized salt producers, salt importers, and several others in the government and private sectors who mobilized many segments of society to ensure that only iodized salt is available and used throughout the country.

In September 2003, the Minister of Health was given a letter signed by the Regional Director of UNICEF’s South Asia Region and myself, congratulating the Royal Government of Bhutan for the successful efforts made so far to fight IDD and comply with the goal of IDD elimination,

The biggest challenge for Bhutan now is to sustain these achievements. Being closely involved with the programme all these years, I am confident that Bhutan will meet this challenge as efficiently and effectively as it has done in the past.
I had just joined WHO. It was in 1981 and as Regional Adviser in Primary Health Care I had to address a large gathering of health activists in Indonesia. I was asked to speak on WHO programmes in the South-East Asia Region. The first part of my presentation covered infectious diseases and nutritional disorders. This was well received. Approval for what WHO was doing in these areas was plainly visible from the nods I noticed in the audience.

The second part of my presentation covered noncommunicable diseases (NCDs). I talked about hypertension and cardiovascular diseases, diabetes and cancer and how these were some of the emerging health priorities of the Region. I did not see the audience nod this time. In fact, I was questioned, almost grilled.

“It is the rich and privileged who suffer from such diseases and they form just a minuscule of the population”, they argued. I tried to convince them that this was not true. NCDs were emerging as a major threat even among poor communities.

I was not wrong. Global projections now indicate that some NCDs will reach epidemic proportions in developing countries.

According to the World Health Report 2001, NCDs account for almost 60% of deaths and 46% of the global burden of
disease. As high as 75% of the total deaths due to NCDs occur in developing countries.

Paucity of reliable data had limited our understanding of the extent of the problem. We urgently needed more accurate and updated information on the NCDs, for advocacy and for developing relevant regional policies and strategies to control such diseases. It was in this context that we decided to carry out a study to develop a regional profile of priority NCDs – cardiovascular diseases, diabetes mellitus and cancers. The study was completed in 2000. Based on reported country information, the profile indicated that roughly one-third of all deaths in the Region were attributed to the selected NCDs that were covered in the study. Cardiovascular disease was the major killer causing from 12% to 25% of all deaths. Cancers claimed about half a million lives every year and based on available evidence there were 41 million cases of diabetes in the Region.

With people living longer and exposed to the numerous stresses that modernization has brought with it and with the profound lifestyle changes taking place, we find that NCDs are increasing even among the less privileged sections of the populations. A major epidemic of diabetes is, in fact, predicted. Harbouring 20% of the current global diabetic population, South-East Asia will soon become the world’s most challenged Region for the control of diabetes.

There is also growing evidence that malignancies will increase and that cardiovascular diseases now responsible for almost a third of all deaths in the Region will pose an even more serious health threat to the disadvantaged and the poor segments of the population.

But this is not all.

Anxiety disorders are also rising, becoming as frequent as those observed in the western countries. Accidents, violence
and suicides are emerging as important health issues in many countries.

It was time the Region faced up to the fact that non-communicable diseases were no longer a problem confined to the wealthy and the privileged. It had become a major public health challenge that had to be tackled most vigorously.

Lifestyles were changing. A faster pace of life to keep up with the rapid growth of technologies and competition in the employment sector, increasing consumerism as the result of extensive advertising, unhealthy food habits encouraged by the easy availability of processed foods, low physical activity with the advent of cable television and several other developments pushed the clock forward to catch up with the lifestyles of the West. Sadly, we have paid a high health price for this.

What could be done about it? That was a difficult question but it needed an urgent answer.

What we identified as a priority was the establishment of a sound surveillance system, not merely disease surveillance but also surveillance of the risk factors that were responsible for the diseases.

Five of the top ten global risk factors to health have been identified as tobacco, alcohol, high blood pressure, high cholesterol and obesity. While it is believed that all these factors are increasing in the Region, the exact role of each risk factor will now be studied in more detail.

A regional surveillance programme has been initiated in countries with WHO support, to quantify and track NCDs and their determinants. This will provide the scientifically sound data base needed for advocacy and for the launching of effective intervention programmes. I am particularly concerned about the large number of NCDs at community
levels that go unrecorded and unreported. I am happy, however, to find that Bangladesh, India and Indonesia have recently initiated demonstration projects on integrated community-based NCD prevention.

What has greatly encouraged me are the results of some community-based NCD prevention programmes implemented in developed countries which have clearly demonstrated that even modest risk factor reduction through adoption of healthy lifestyles can bring large public health benefits.

In recent years, World Health Day themes have focused on healthy lifestyles which have received support at the highest political levels. In 2002, the Prime Minister of Thailand led a group of nearly 50,000 people in aerobic exercises to highlight the World Health Day theme “Move For Health”.

Lifestyle changes, however, do not occur overnight. There is need for strong advocacy to formulate public health policy, even legislation, and cost-effective interventions supported by public education programmes.

Using the experience of other regions, we, at the Regional Office, are initiating a regional NCD prevention network and integrating it within the Global Forum for NCD Prevention and Control. Formation of national NCD prevention networks is also being encouraged.

The battle to control NCDs so far has been a long and difficult one. In all humility, I must admit that victory is still elusive. There are far too many powerful forces and vested interests involved that, in fact, encourage the lifestyles that are so detrimental to health. Multinational companies are finding the developing world attractive to market alcohol,
tobacco and processed foods. Media continues to glamourize the lifestyles of the rich and famous and information technologies are getting more and more young people hooked to their computers for relaxation. The effects are specially felt in the urban areas where high-rise offices and apartments have replaced play grounds and parks, where roads are paved for cars not pedestrians, where junk food abounds and where the pace of life outwits the body’s defences to ward off stress and anxiety.

I must confess that with the onslaught of infectious diseases we had, to an extent, neglected the noncommunicable health problems that beset the Region. The experience of the last couple of years however, has brought hope that this will change. Reducing risks and promoting a healthy life has now become an integral part of the regional health strategy.
I was a hardened non smoker until I was 30. My friends smoked, my colleagues smoked and many of my family did. I eventually succumbed to their pressures. No one talked of the health risks involved. Cigarettes became an integral part of our social scene. We also fooled ourselves into believing that they were the greatest stress relievers of all times.

Wisdom dawned several years later. Millions of people all over the world were dying from tobacco-related causes. The clear scientific evidence on the tobacco-cancer link, the tobacco-heart disease connection and the several other health risks associated with tobacco made many of us think. Giving up smoking was not easy but where there is a will, there is a way!

In the South-East Asia Region confronting tobacco is a major challenge. Tobacco use has reached epidemic proportions with varying prevalence rates in individual countries. Overall, between 25.7% and 59.6% of adult men and between 1.75% and 28.7% of adult women smoke, estimated to lead to over 500,000 tobacco-related deaths every year. The youth and the poor are specially vulnerable. Smoking rates among women are rising according to reports received from Thailand, Indonesia and Bangladesh. The everyday sights of very young children at street corners, railway stations and other places, puffing away at discarded butts of half-smoked cigarettes produce shudders even among the most
permissive. A Global Youth Tobacco Survey undertaken in 17 sites in four countries – India, Indonesia, Nepal and Sri Lanka during 1999-2001 showed a high median rate of current use of tobacco products of 50% among children between 13-15 years of age. Exposure to second-hand smoke was also high as one-third to two-thirds of their parents smoked.

The challenge has other dimensions. Most countries in the Region grow tobacco in commercial quantities. India, for example, rates among the top five tobacco producing countries in the world. Indonesia is the largest producer of cigarettes in the Region. Bidi products have more than doubled in Nepal, Bangladesh and India between 1990-1999. The tar contents of cigarettes and bidis produced in the Region is also higher than in most other countries.

A study on the economics of tobacco conducted in eight countries of the Region reveals some interesting findings:

- the poor spend relatively more on tobacco than the rich.
- raising taxes on tobacco leads to a decrease in demand.

Considering the large numbers of the poor and young in the Region, the risks are great and without effective regulatory policies, countries of the Region face a major health crisis.

Countries had, in fact, been warned by WHO of the impending tobacco epidemic for over a decade. Thailand, Bhutan, Indonesia and Sri Lanka established comprehensive tobacco policies in 2002. In other countries, various legislations and regulations to create smoke-free places, ban cigarette advertisements, print health warnings on cigarette packs, levy tobacco taxes, etc., met with varying degrees of success. However, Bhutan, Myanmar, Maldives and Thailand have stood out in their continuing high-level commitment to tobacco control. All districts in Bhutan, except Thimphu,
have now been declared smoke-free. Two islands in the Maldives are also smoke-free. Ministries of Health, I am happy to say, have been the driving force for carrying forward WHO’s Tobacco Free Initiative. Nongovernmental organizations have responded equally well to the call. In fact, in many countries of the Region, NGOs spearhead the movement through extensive youth and school education programmes and other innovative interventions. I was pleased to know that a number of them have been selected for support by the UN Foundation to carry out activities under projects titled “Channeling the Outrage” and “Protecting the Youth from Tobacco”.

In some countries a number of private citizens also have mounted public interest litigations with significant success. These have all been most laudable examples of what concerned groups have been able to achieve through community participation.

However, I am convinced that it will only be through comprehensive policies that tobacco use can eventually be reduced. The per capita consumption of cigarettes in Thailand for example has decreased, thanks to its comprehensive tobacco control policy. On the other hand, countries that do not have such a policy show increasing trends in tobacco use.

In view of the greater impact and the need to adopt a multisectoral approach to tobacco control, a review of existing and potential multi-sectoral mechanisms for comprehensive national tobacco control in eight countries of the Region has been initiated. A regional situation analysis is also being carried out to assess the impact of tobacco use on women.
The battle continues. Confronting the tobacco epidemic will mean confronting highly placed and influential forces in society – the corporate giants, the revenue and labour departments of governments and world trade practices.

The good news is that we now have an international legal instrument to control the global spread of tobacco and tobacco products – the Framework Convention on Tobacco Control (FCTC), adopted by the World Health Assembly in May 2003. This is the first time in its history that WHO has used its treaty-making rights to support its Member States in developing a legally binding instrument in the cause of public health. The Convention provides a framework for parties at national, regional and international levels to implement measures that will reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke. It requires countries to impose restrictions on tobacco advertising, sponsorship and promotion, establish new norms for labeling and clamp down on tobacco smuggling.

WHO support to Member Countries in Adopting and Implementing FCTC

- Strengthening national capacity, particularly in the areas of programme management, surveillance, monitoring and evaluation of national tobacco control programmes.

- Providing guidelines and support for regional, sub-regional and country preparedness workshops related to signing, ratification and implementation of FCTC.

- Mobilizing funds to develop a surveillance system and a regional database on tobacco control which will help countries in monitoring and implementing FCTC.

I am happy that we were able to facilitate the active participation of countries of the Region in framing the
Convention during the four years of discussions and negotiations prior to the adoption of the FCTC. Four of our countries, Bangladesh, DPR Korea, India and Thailand have already signed the treaty and I am confident that others will soon follow suit. As a beginning, focal points have been identified and intra-ministerial cells on tobacco control have been established in all countries of the Region.

Commitment and dedication to the cause is now markedly visible compared to the earlier years of impassiveness and complacency. The ground work has been done. I am confident that the countries will take this further by not only signing the Convention but ratifying it as well to create a tobacco-free South-East Asia Region.
GLIMPSES OF A
TEN-YEAR JOURNEY
The term “health” has strong positive connotations. WHO defines health as “a state of physical, mental and social wellbeing – not merely the absence of disease.” Yet, when most people talk about health, it is really about disease, disability and death. The concept that health can be actively promoted is rarely applied at levels that will truly enable people to increase control over, and to improve their health. This has been extremely disappointing. While talking to various health officials in countries of the Region, I get the impression that lip service is being paid to health promotion. Many also believe that health education and health promotion are synonymous.

They are not.

Health promotion goes far beyond health education. It is not enough to merely educate communities on prevailing health problems and the methods of controlling and preventing them. It is equally critical to develop and promote healthy public policies and provide supportive environments that would empower individuals and communities to critically examine the determinants of health and mediate between different interests in society to overcome the challenges they present, expeditiously and effectively. The environment in which people live is one such determinant.

Environmental issues have always been a matter of concern for as long as I can remember. By the mid-1990s, the
burgeoning population and certain unrestrained developmental activities in the countries of the Region had exposed the population to several environmental hazards. Uncontrolled urbanization had overstrained the capacity of local governments and municipalities to provide basic amenities like safe water, sanitation, housing and clean air.

In rural areas, provision of safe drinking water and adequate waste disposal facilities became our priority concerns. We also had to address indoor pollution caused by poorly designed cooking stoves which led to acute respiratory infections affecting millions of women and young children. Pesticides and herbicides used in agriculture were additional sources of worry. We also discovered that the water from 10 million tube-wells servicing nearly 50 million of the Region’s population contained arsenic, in excess of levels recommended by WHO.

The problems were gigantic and the programmes and activities planned to address them, diverse and multifaceted. Our goal was ambitious – to provide to people “a healthy environment that will protect them from the risks associated with chemical pollution, environmental degradation and disasters, and where all will have access to safe and sufficient food and water, adequate sanitation and safe working environments”.

In each of these components, strategies are now being implemented to assess the extent and risks of such exposures, and to mitigate them.

The settings approach to health promotion is gaining ground. This approach focuses on promoting health in the key social settings of everyday life – in places where people live, work, learn and play – the home, the school, the workplace and the community. Such settings attract a host of opportunities, through intersectoral and community partnerships, to create health in cities, workplaces, schools, hospitals, even islands, villages and markets.
Safe Drinking Water Eradicates Guinea-Worm Disease
A Success Story from India

For thousands of years, people have lived with guinea-worm disease, a painful affliction caused by a parasitic worm and transmitted through infected cyclops found in water sources like step wells, ponds and water tanks. In the 1980s, India reported about 40,000 cases of guinea-worm annually, with an estimated five million people at risk. By the 1990s, no sporadic cases were reported from the other countries of the Region where the disease was also prevalent. Only India remained endemic.

The disease posed several challenges. There was no vaccine that could provide protection against the disease. There were no drugs that could cure the disease and sources of clean and safe water that could prevent the disease were scarce.

A solution to the problem was eventually found. The technology applied was simple, cheap and appropriate. Since the source of infection was cyclops that held guinea-worm larvae in the various water sources from which people collected water, people were advised to filter their drinking water through a piece of cotton cloth. It was as easy as that.

A community-based surveillance system was also established and widespread information and education activities were launched to convince people that this would work.

There is no looking back—thanks to the untiring efforts of health, rural water supply and rural development departments and the thousands of people from all walks of life, from village-level health workers to top-level health planners and administrators who participated most actively in eradicating the disease.

*Guinea-worm disease is finally wiped out. The first disease after smallpox to be eradicated from the Region!*
The 1980s saw the inception of the Healthy Cities Movement in Europe and North America. By 1994, the movement had spread to the South-East Asia Region, initially with six cities, Chittagong, Cox’s Bazaar, Bangkok, Badulla, Kathmandu and Delhi launching healthy city projects. Today, there are more than 40 such projects in the Region, implementing strategies that focus on the environmental, social and economic determinants of health. A project like this is unique in the sense that it aims to work intersectorally – to place health issues firmly on the agenda of urban policy makers and work through partnerships with the public and private sectors, with NGOs and with the community.

The need to assess such an unconventional approach was met through a commissioned study carried out in 12 cities of five countries of the Region. The study findings confirmed many of our own views. Successful implementation rests on commitment of decision makers, particularly the local politicians; on a strong planning and management team with a high degree of stakeholders’ involvement and institutionalization of the programme through the establishment of separate Healthy City offices.

An important milestone in getting countries of the Region committed to the “Settings Approach”, at least from the policy point of view, was the resolution adopted by ESCAP in 1996 and by our Regional Committee in 2000.

The healthy settings approach has also been applied in creating health promoting schools and healthy districts.

A health promoting school is a setting where education and health programmes combine to foster health as an essential component of life, using strategies that include health education as part of the school curriculum, creating supportive environments for health in schools, and involving parents and the community as supportive partners.
The health promoting school initiative is making good progress in Indonesia, Maldives and Thailand. About 84% of all schools in Thailand are currently health promoting. Of these, 23% have met the evaluation criteria developed by the country for assessing their performance.

In good time a regional network of health promoting schools will be established that will demonstrate how effectively schools present an extraordinary setting to promote a healthy, prosperous and more harmonious world.

The healthy settings structure has, in addition, proved to be very useful for locating other health programmes requiring intersectoral collaboration.

For example, a new global alliance called the Healthy Environments for Children Alliance (HECA), born out of the cooperative commitment led by WHO, UNICEF, UNEP and several other global health agencies, can well be located within such a setting.

Even if we cannot begin a new programme, I have suggested to my staff as well as to the countries that by piggybacking into already existing community development efforts, the healthy settings concept can well be applied and partnerships enhanced.

Apart from healthy settings, there have been other successful environment-related initiatives in the Region, as for example, the management of health care wastes to prevent commonly encountered unsafe injection practices and needle re-use. Single-use syringes are now used for immunization throughout the Region. There are also plans to introduce auto disable syringes and projects to install locally built, small-scale double chamber incinerators. Particular attention is being paid to the management of infected sharps at primary health facilities.

These and other examples of health initiatives in the Region clearly demonstrate the potential of health promotion in improving the environment on which people depend. The challenge lies in unlocking this potential.
Promoting Health: Creating a Healthy Environment
Frequent natural and man-made disasters have crippled national economies, not to speak of the untold human cost due to loss of life and home. The South-East Asia Region bears testimony to this!

Estimates indicated that 38% of the persons affected and 57% of the persons killed by natural disasters during the last decade were from the South-East Asia Region. This warranted urgent review and action.

In 1996, I set up an Emergency and Humanitarian Action Unit which is now headed by a Regional Adviser, to assist countries of the Region in managing the health consequences of natural and man-made disasters, in reducing vulnerabilities, in emergency preparedness and in building capacities in health professionals and emergency workers to deal with disaster situations. The terrain was vast. Floods in Bangladesh, India, Indonesia and Sri Lanka; cyclones in Bangladesh and India; earthquakes in India and Indonesia; civil strife in Indonesia, Sri Lanka and Timor-Leste; earthquake preparedness in Nepal; refugee health coordination in the Thailand-Myanmar borders and biological, chemical and radionuclear preparedness in a number of countries.

The emphasis soon shifted from emergency response to emergency preparedness.
New partnerships were forged to reduce the health impacts in populations affected by the humanitarian crisis. Jointly with WHO’s Western Pacific Regional Office and the Asian Disaster Preparedness Centre in Bangkok, we signed a memorandum of understanding to conduct training programmes on Public Health and Emergency Management with courses offered at international levels for senior staff. Meanwhile, we have continued offering our services to countries in need. Some of them are now equipped with national disaster preparedness plans and have gained experience in managing disasters.

The Super-cyclone in Orissa

In October 1999, a super-cyclone hit Orissa in India leaving 10,000 people dead, 10-15 million people directly affected and five coastal districts totally devastated. The threat of impending epidemics loomed large. They had to be prevented. We went into action to coordinate a multidisease surveillance system in collaboration with various stakeholders – the government, World Bank, DFID and NICD. Existing infrastructures and systems were used to develop an early warning system to detect disease outbreaks and staff were trained to use the system. This did not end as a mere fire-fighting exercise. The disease surveillance programme has now been extended from the cyclone-affected districts to cover the entire state of Orissa.

The Earthquake in Gujarat

It was India’s Republic Day – 26 January 2001. The celebrations had begun when a strong earthquake measuring 6.9 on the Richter scale, shook the Kutch district of Gujarat, killing 20,000 people, injuring 166,000 and leaving one million homeless. We moved in swiftly – on the very first day, to quickly respond to the threat of epidemics. Rapid response surveillance teams were set up. Coordinated multidisease surveillance and an early warning system was also put into action. The results were dramatic. There were no epidemics or outbreaks of diseases reported following the massive calamity.
In partnership with UN agencies, the government and NGOs, we assisted the health system in the north-east province of Sri Lanka to meet the short-term needs of conflict-affected communities, leading to strategies that would help health systems to recover and reconstruct, if necessary.

In DPR Korea, WHO helped to channellize humanitarian assistance to provide essential drugs and strengthen the health system. Since November 2001, UN appeals for funds have been launched for community health services, tuberculosis, essential drugs, control of communicable diseases and improvement of health and nutrition. Donors have also supported strengthening of blood transfusion services and monitoring and management of malaria control.

**Civil Unrest in Timor-Leste**

Months of civil unrest in Timor-Leste displacing 75% of the population led to extensive destruction of property and health care infrastructure. Public health services needed urgent coordination. Since communicable diseases were held to be responsible for 60% of deaths, we established coordinated multidisease surveillance and early warning systems as quickly as we could and timely response was mounted to avert further disease outbreaks.

Responding to emergencies and disaster situations, however, required broader partnerships with organizations and institutions that included in their work a more holistic approach to soften the impact of the disaster through provision of timely aid and rehabilitation measures. This was realized in September 2003, through a Memorandum of Understanding signed between us and the International Federation of Red Cross and Red Crescent Societies for:

- enhancing collaboration in preparing for and responding to emergencies and disaster situations;
- preventing and controlling communicable diseases, including HIV/AIDS in the most affected countries of the South-East Asia Region;
- promoting voluntary non-remunerated blood donation in order to contribute to a safe blood supply and
- exploring collaboration in other areas such as water and sanitation, pre-hospital care, and mental health in emergency and post-disaster situations.

I am certain that this partnership will greatly strengthen our own efforts as well as that of our partners in mitigating the sufferings of millions of men, women and children affected by both man-made and natural disasters across the Region.

SARS – the “Mystery” Disease that Shook the World

No one had heard of SARS. When the first case was reported from China to WHO on 11 February 2003, it was called “atypical pneumonia”. Already 305 persons had been infected and five had died from the disease.

Severe Acute Respiratory Syndrome (SARS) came to our Region on 11 March 2003 when an infected WHO staff member traveled from Vietnam to Thailand. Following a global alert issued by WHO on 15 March 2003, I appointed a Task Force on SARS and by 18 March 2003 issued policy guidelines on SARS prevention control to all the WHO Representatives (WRs) of the Region. This was followed by a teleconference with the WRs when further guidelines were provided on measures that needed to be taken to prevent SARS getting a foothold in the Region. Media had to be specially briefed to avoid panic and confusion.

The sense of urgency that prevailed in the Regional Office was distinctly palpable. Countries needed support and guidance on how to deal with the epidemic and we made sure
that this was provided to them most expeditiously. Experts in laboratory diagnosis and infection control were promptly recruited and sent to countries on request. A workshop on ‘infection control’ and an intercountry consultation on ‘how to improve a country’s preparedness to respond to SARS’, were held. Various other initiatives that we took included designation of laboratories in India and Thailand for the diagnosis of SARS, development of guidelines on good infection control and stocking of supplies and equipment for future SARS epidemics.

Close collaboration and technical support to WHO country offices was maintained throughout the outbreak.

A website was created with links to other sites such as that of WHO headquarters, CDC Atlanta, and WHO’s Western Pacific Region.

Strong collaboration with WHO’s Western Pacific Region was developed. Collaboration was also forged with the Asian Development Bank for financial assistance to countries of both the Regions.

SARS was brought on the agenda of the meeting of Health Ministers of the countries of the Region held in September 2003. The need to have a strong and effective surveillance system that would detect outbreaks in the early stages as well as the need for a mechanism to rapidly respond to such outbreaks were clearly and strongly expressed.

On 5 July 2003, transmission of SARS had been successfully interrupted. So far, there has been no local transmission reported in any of our Member Countries.

But we are not complacent. Our vigilance continues with even greater vigour to ensure that SARS does not make a re-entry into the Region.
I see the 1990s as the start of a new age for WHO – the Reform Age. The world was changing. Political change brought greater freedom and democracy to many parts of the world. Economic and trade liberalization led to increased growth and improved standards of living for many. The rapid spread of communication opened up a whole new world of opportunity making information available on tap. Modernization and increasing wealth meant changes in lifestyles and an increase in demand for services and leisure pursuits.

The most dramatic breakthroughs were in the field of biological sciences and technologies. People were living longer.

There was a bleak side too. ‘Modernity’ was destroying old cultural values and family supports were diminishing. The population was exploding. The world was getting more polluted and new diseases were emerging. War, ethnic conflicts, terrorism and violence of all sorts led to destruction and devastation on a scale never witnessed before.

In this scenario, it became increasingly obvious that health was central to national development; a healthy nation meant a prosperous nation.

Reforms were urgently needed. In the field of health it could never be business as usual. Changing needs meant
that revised strategies and fresh approaches had to be initiated to implement new programmes and improve existing ones.

There was need for strengthening advocacy at the highest levels to convince policy makers of the importance of healthy public policies and the provision of supporting environments to sustain health. There were several other issues that demanded fresh approaches.

We recognized that a centrally planned and managed health system had tremendous limitations in effectively catering to the needs of the entire country. Decentralization was needed to foster greater ownership for programmes at local levels and to mobilize increased community participation in making them work.

The need for partnerships in health was never greater. Education, social welfare, women’s empowerment, gainful employment— all had an impact on health. However there was a lot the health sector could never undertake on its own. It had to enter into alliances with other sectors, institutions and groups in the true spirit of sharing and sustainable partnerships.

The commonalities between the various regions of WHO and cross-border movements across regions, carried the spirit of collaboration further to provide added impetus to health development.

Extrabudgetary resources were mobilized and the country offices of the WHO representatives strengthened to more effectively empower the representatives to respond to the needs of countries. The last decade also saw an increasing focus on women’s health and gender issues.
Advocacy at the Highest Levels

The past ten years had given me some remarkable opportunities to carry out advocacy on a wide range of issues which were of regional concern. In fact, if I were asked to single out just one role which I found the most challenging and also the most fulfilling was the advocacy role that I played as Regional Director. It also brought back old memories of the various tactics we had employed in the districts to convince our bosses for the need to provide additional resources for controlling diseases like cholera, polio and tuberculosis. I must confess, we hadn’t heard of the term, “health advocacy”, at that time. Our methods were not sophisticated. But, ultimately, we got what we wanted – in most cases!

I do not believe that there is a government in our Region which does not want to see people improve the quality of their lives. This conscience needs further awakening through dialogue, discussion and conviction. It calls for strong advocacy to motivate national ministries of health to introspect, to identify its thrusts based on country priorities and to act.

During the past ten years, high level advocacy meetings have succeeded in sensitizing policy makers to the new and emerging health problems of the Region, orienting them to strategies that can be used to address the problem and motivating them to mobilize additional resources to meet the fiscal needs of such initiatives.

Various structures and mechanisms that would provide an official and regular forum for advocacy were established. Three such structures took the form of annual meetings with Health Ministers, Health Secretaries and Parliamentarians.
Advocating for Polio: Prompted by an Impulse

The first round of polio immunization had just been completed. “Are all the arrangements ready for the second round?” I asked Indonesia’s Minister of Health. He looked away. “There will be no second round”, he said. “We do not have the funds”. 

The same evening I approached friends in Rotary and some other international donors for their support. They seemed willing to help, provided it was seen as a priority by the President of the country. The timing was perfect as the Director-General of WHO was visiting Indonesia at the same time and we were to call on the President.

During the meeting, entirely on an impulse, I took the liberty to directly ask the President for more resources to protect thousands of the country’s children from polio. He reiterated that it had not been budgeted for, but at the same time also acknowledged how important it was to meet the eradication target. It was a priority, he said, and would welcome WHO’s help in mobilizing the needed resources.

At this point I informed him of the meeting I held with Rotary and other donors who assured full support to meet a priority set by the President.

*My mission was fulfilled. The funds flowed in and the second round of polio immunization was successfully completed!*

A historic event that took place in Bangkok in 1997 was the adoption by the Ministers of Health of all the countries of the Region of a “Declaration on Health Development in the South-East Asia Region in the 21\textsuperscript{st} Century”.

The Declaration embodies the cardinal principles of the Health for All strategy and commits itself to ensure universal access to quality health care to develop regional self-reliance, to advocate intensively for healthy public policy and to ensure that health is placed high on the political agenda of governments and on the social agenda of people.
I am gratified to note that the Declaration did not remain as some declarations do, as just another document, just another piece of paper that would pass into oblivion. In September 2003, the Regional Committee reviewed the progress made in achieving the targets set out by the Declaration and expressed satisfaction in its implementation, despite various constraints and challenges encountered.

Advocacy for health was further strengthened with the findings of the Commission on Macroeconomics and Health clearly showing that investments in health lead to economic growth and poverty reduction.

As this narration of my ten-year journey indicates, the countries of the Region have responded as best as they could to make significant strides in securing for people their rights to health.
Renewed Strategies and Fresh Approaches

But we have miles and miles to go. New challenges will emerge. New strategies will be called for. New partners will join the advocacy trail. When communities themselves become the most effective advocates for health, we can consider our job to be done.

**Decentralization to District Levels**

I am an ardent believer in decentralization. Centralized, top-heavy administration and management systems have never appealed to me. I have seen how they have failed, especially in large countries, where policies and programmes planned at the top seemed far removed from the realities at ground levels.

In the countries of the South-East Asia Region, like in many other developing nations of the world, health management
Renewed Strategies and Fresh Approaches

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has been, by and large, heavily centralized. This has deprived many programmes of public ownership and commitment at local levels.

The District, on the other hand, which is the most peripheral organized unit of local government and administration, offers unique opportunities for “bottom-up” planning and organization and “top-down” planning and support. It is at the district level that national priorities and local needs come together and where relevant and realistic health programmes to address the needs of the population can be planned and implemented.

Keeping this in mind, I initiated measures in the Regional Office to promote decentralization in order to make health programmes more accessible and relevant to the needs of people in provinces and districts, far away from the central corridors of power. I was part of the decision-making process even before I assumed office as Regional Director, examining closely the pros and cons of such an approach. To lift countries out of their traditional hierarchal modes of working into more democratic ways of getting the same job done was no mean challenge. Advocacy at high levels finally succeeded in changing deeply entrenched practices and mind sets.

Today, all countries of the Region are practicing some form of decentralization. However, their extent, strategies and efforts vary.

In Sri Lanka, the Central Ministry of Health now deals only with policy setting, human resource development and procurement of supplies for health services. In India, health

All Member Countries in the Region are decentralizing their health systems.
has always been a state subject. In some states, the responsibility of providing primary health care and specialized care are being transferred to the private sector, including NGOs. In Thailand, the Ministry of Public Health now only looks after policy formulation, setting and monitoring standards and providing technical support to the health sector as a whole. In Indonesia, two new laws have been introduced that will bring fundamental changes in the authoritative roles and responsibilities of the central, provincial and district governments, including in matters related to health.

I have learnt some important lessons on this whole issue of decentralization. One has been that decentralization in the health sector being a new concept in many countries, appropriate mechanisms for data collection, planning, implementation and monitoring are absent. Higher costs are incurred and, in some cases, there has even been a decline in the quality of programmes in the decentralized units.

There were other lessons too. Decentralization processes are likely to get stalled or derailed due to a weak institutional base at concerned levels, including the central level. Then there is the issue of power sharing. Used to wielding absolute power, central authorities are unwilling to hand this over to lower levels. To add to this, there is lack of clearly defined new roles and responsibilities expected from officials at the decentralized levels.

I have also been acutely aware of the shortcomings of decentralization, especially when carried out hastily without systematic planning and capacity building for implementing and managing programmes.

One of the biggest constraints to successful decentralization has been the paucity of funds. Although the Constitutions of several Member Countries provide for decentralization in some form, in effect, financial authority is still centralized.
Renewed Strategies and Fresh Approaches

Meeting Health Challenges

to a large extent with no discretionary funds available at local levels.

Reflecting on the many aspects of decentralization and the lessons it has taught us, I have come to believe that decentralizing health indeed carries tremendous benefits. Its successful implementation, however, requires several conditions. Additional funds must be made available to recruit field-level staff and organize training. Active involvement of the community must be sought to initiate and sustain community-based health programmes and a sound information and management system must be in place to monitor the programmes and ensure that they reach the most needy.

District health systems – how they work, how they should work and what additional responsibilities they need to take on to become viable decentralized units, will remain issues for extensive discussion in the coming years.

I have urged decision makers in the health sector to learn from the experiences of other decentralized sectors within their own countries as well as from other countries if they are truly convinced of the vast benefits of decentralization and are serious about implementing it.

Health Care Financing Reforms

Good quality health care comes at a price. It needs substantial investments to build infrastructures that meet the health needs of people, however far and distant they may be from the hub of development activities. In a Region where 40% of the world’s poor live, a substantial proportion of the population incurs very high out-of-pocket expenses to pay for health. State or public patronage is thus essential, not merely to meet humanitarian compulsions but also to boost the economies of countries. It was becoming increasingly evident that investments in health were concrete inputs for
socioeconomic development. In fact, improving people's health was considered as one of the most important determinants for rapid development in low income countries like many of those in the South-East Asia Region.

However, this realization is not translated into action as it should be. Total government expenditure on health as a percentage of the GDP was, and still is, dismally low. Only four countries in the Region – Bhutan, India, Maldives and Thailand, spend more than 5% of their GDP on health. It became imperative that reform measures in financing health care as part of the overall health reform are instituted to provide affordable essential health care for all people, especially those living below the poverty line. This became one of my first concerns after assuming office.

In 1995, for the first time, the topic of alternate health care financing was brought on the agenda of the technical discussions of the Regional Committee and debated extensively. Countries of the Region were urged to explore various alternative financing options and introduce appropriate reform measures to make optimal use of all available resources, as well as to mobilize additional resources for achieving the ‘health for all’ goals. It was reiterated that such reforms should aim to ensure quality, accessibility and affordability and to introduce measures to protect the poor and the underprivileged. A follow-on regional consultation held in October of the same year, reviewed the Region’s experience in health care financing reforms, including the development of social health insurance.

The consultation pointed to the need for a careful study on various policy options before they were adopted.

Since then countries of the Region have implemented health care financing reforms within the context of their socioeconomic and political situations.

The economic crisis of the late 1990s once again forced policy makers of the Region to review their reform policies.
We convened a regional consultation in March 1998 to discuss the health implications of the economic crisis. At this meeting, strong emphasis was placed on the urgent need to focus on the poor, to protect them from both the financial and health risks that they may face during this time of financial and social turmoil. Since the involvement of political leaders was crucial to success, we called a meeting of Parliamentarians the same year. I was gratified to find that the Parliamentarians of the Region gave their full support to adopt necessary policies that would be guided by the principles of social justice and equity in health care.

Health care financing continued to demand attention from policy makers and others to meet the needs of the poor and underserved populations of the Region. At the 52nd World Health Assembly in 1999, the Health Ministers of the Region agreed on the need to assess the consequences of their health care financing reforms through an update of their national health accounts.

In 2000, the Health Secretaries of the Region met to review and share their experiences on health care financing reforms. They noted that different countries had instituted reforms differently, based on their specific socioeconomic, political and health systems. There were a lot of lessons to learn from each other which needed to be documented and shared.

Over the years, the most visible of the changes made in health care financing in the countries of the Region has been not the higher investments made for health but the various methods that were applied for resource collection, such as "sin" taxes and fee-for-service payments, in order to relieve the burden of public expenditure on hospitals and health centres. Many countries also promoted privatization of the health sector and reassigned government responsibilities to cover policy issues, coordination and regulation of the services provided.
Social Health Insurance, another effective means to provide protection for financial risks, is being implemented in some countries on a national level. A need to study and explore social health insurance as one of the alternatives for health care financing, especially for those countries which have not
yet adopted it on national scale, was expressed through a resolution adopted by the Regional Committee in September 2003.

I was glad to see that many innovative ways were also attempted to raise revenue for health. Thailand and Nepal for example introduced “sin taxes” on tobacco and alcohol respectively, by earmarking a certain proportion of the revenue collected from indirect taxation, for health promotion and disease prevention. Bhutan established a Health Trust Fund to secure the necessary resources for essential drugs and vaccines for its needy population.

I feel extremely encouraged to find that some countries in the Region have started to apply other innovations in health care financing. A mix of measures like increasing the public share of health expenditure, improving the coverage of social insurance, enhancing community-based financing and formulating appropriate policies for promoting private health insurance have been initiated. This will go a long way in addressing the health equity issues that face the Region.

Resource Mobilization

In a Region comprising several least developed countries beset with a high burden of disease, the paucity of resources has always posed a major challenge to health development. In 1998, this situation became even more critical when the World Health Assembly adopted a resolution leading to a reallocation of regular budget resources to regions, and gradual reductions for the South-East Asia Region.

This had serious implications for us as it meant a reduction of over six million US dollars spread over 3 bienniums (2000-2005).

Considering the seriousness of the situation, I initiated a series of consultations with senior policy makers in countries of the Region to enable us to take a unified stand to press for a more realistic allocation that would at least spare the least developed countries of our Region. This joint
endeavour was successful in more than one way. Not only did it soften the impact of the resolution on the least developed countries but it also highlighted the spirit of unity and solidarity among countries of the Region, which was extremely heartening for me to see.

Despite budget cuts, activities were increasing – old programmes were being scaled up and new programmes initiated to combat the major diseases. The fiscal gaps had to be met if the Region was serious in implementing the priorities set out by it. New ways had to be found to tap into additional resources.

We were lucky. We got support from some innovative global funding mechanisms that had been established to support priority health problems of developing countries. These included the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); the Global Alliance for Vaccines and Immunization (GAVI) and the establishment of the new Global Health Research Fund (GHRF), to support basic, biomedical and applied sciences research on the health problems of the poor and on health policies and systems required to address them.

In 1996-97, extrabudgetary funds for the Region stood at a mere US$ 53.4 million. Today, this amount has doubled to US$ 120 million. These funds have made significant contributions to immunization programmes including polio eradication, tuberculosis and HIV-AIDS control programmes and to the emergency and humanitarian action programme.

The World Bank has led the list of multilateral donors supporting the Region, providing funds ranging from US$ 10 million to US$ 300 million for over a dozen ongoing projects.

In some countries, additional resources became available through bilateral donors, international entrepreneurs and multinational corporations like the Nippon Foundation, the United Nations Foundation and the Bill and Melinda Gates Foundation.
Other major donors in the Region are AuSAID, DANIDA, CIDA, DFID, Finland, Japan, Germany, Italy, Norway and USAID.

We are now seeing a changing pattern among donors towards supporting country focused initiatives based on the disease burdens carried by the respective countries, rather than on which Region they belong to. I see this change in focus greatly benefiting the countries of our Region, many of which bear a disproportionately high burden of disease. With the judicious use of such resources, I foresee great opportunities for countries in the Region to make significant strides in achieving their goals to improve the health and wellbeing of their peoples.

Forging Partnerships

Health is a social goal. While responsibility for it rests largely with the ministries of health, there is today an increasing recognition of the critical roles other sectors, both governmental and nongovernmental, can play to contribute to the health and wellbeing of populations.

The evidence is glaring. The correlation between high infant mortality and low educational status of women is well known. The crucial role the education sector can play in changing people’s behaviours as seen in the HIV/AIDS epidemic is also well recognized. Women’s health is another case in point. The conferences and meetings held during and following the International Decade of Women highlighted the need to empower women. Health is part of that empowerment, along with education, employment and social reform. It became clear that the benefits of any attempts to improve the health status of women will be limited without a simultaneous effort to raise their social status.

Acute respiratory infections (ARI) is another example where a multisectoral approach is not just advantageous but essential. Preventing ARI, one of the biggest killers of children,
and the range of respiratory diseases caused by environmental pollution, overcrowding and substandard housing cannot be achieved by the health sector alone as the underlying causes are environmental issues which the health sector has no control over. Similarly, with the resurgence of malaria in some areas where developmental projects are being undertaken, no amount of insecticide spraying alone will effectively cover the ever-increasing spread of new mosquito breeding sites.

There are other examples. Preventing diarrhoea, a leading cause of death among children is possible only with close collaboration with the water and sanitation sector. Efforts to control malnutrition involve the food and agriculture sector as well as the country’s economic policies and culture. There must be food available to buy. People must have the purchasing power to buy it. There must be no discrimination shown with regard to distribution of food among family members.

Controlling accidents requires close alliances with the road and traffic sectors, with the agricultural and industrial sectors, with construction companies and with education authorities.

Over the past few years, a movement for greater partnerships in health has been growing globally. We seized this opportunity to initiate action on collaborative activities in the Region. The Healthy Cities Project for example provided a good opportunity to get this done at local administration levels. We derived further encouragement from the outcome of the World Summit on Sustainable Development held in 2002, to strengthen our resolve in creating partnerships for health development at local levels. Efforts are now on to work with various agencies towards achieving the Millennium Development Goals and pursuing the health of children through the Healthy Environments for Children Alliance.
These few examples demonstrate the multisectoral dimension inherent in practically every health intervention. Opportunities for partnership span all development sectors and all aspects of their work. A proactive approach is needed to recognize these opportunities, to seize them and mobilize the support necessary to enter into effective and sustainable partnerships.

Partnerships have been built at various levels – at the global and regional levels for setting a broad framework for collaboration and for intercountry cooperation; at the national level for translating the framework into policies, services, training, research and advocacy, and at the local level, where partnerships have taken the form of action-oriented programmes.

**Partnerships for Primary Health Care**

**A Model from Bhutan**

The Mongar Health Services Development Project showed how one district in the mountainous kingdom of Bhutan could succeed in extending primary health care throughout the district through partnerships. Mongar’s project was implemented through several partners, both within and outside the health sector. Every member of the isolated district was targeted, with special focus on mothers and children and on community participation.

With guidance from district health and block development committees, outreach clinics were set up, health awareness and hygiene promoted, latrines constructed, referral systems developed and health care extended with the help of local volunteers.

The results were impressive. Immunization coverage reached 94%. Two-thirds of households were able to access safe water and 90% to sanitary latrines. Over two-thirds of all pregnant women received antenatal care and 85% obtained two doses of tetanus toxoid. The project is replicable, for extending primary health care to the entire country to achieve health for all.
The South-East Asia Region has a long history of successful health partnerships, many of which became models for primary health care attracting international attention.

In the 1980s, the Ayadaw Township in Myanmar demonstrated how good planning and management, effective intersectoral as well as community action and collective leadership could dramatically improve health conditions through safe water and sanitation programmes, immunization and maternal and child health care. Partnering the health sector in this pioneering effort were other sectors such as education, agriculture and livestock, transport and communication. Nongovernmental organizations also joined in as equal partners to achieve common goals.

In Indonesia, the community-based PKK movement created history with its country-wide activities in the areas of family planning, mother and child care and nutrition provided through ‘posyandus’ the community integrated service posts. The movement involves the active participation of several partners – the agricultural sector, the national family planning programme, the non-formal education sector, and religious organizations.

“The Prevention and Control of Blindness Programme” in Nepal is yet another example of an unique Government-NGO-Academia partnership.

I was closely associated with the initiative from its very early stages, mobilizing resources from various government and non-government sectors to help establish the programme. Subsequently, I was pleased to watch it grow from two capital based centres to a nationwide network of eye care
facilities in over 50 centres, making services accessible to even those living in far flung areas. Several international NGOs, like Christoffel Blinden Mission, SEVA Foundation, Swiss Red Cross and others joined hands with the government to make this possible. Many of the centres are now self-reliant. Among its other achievements, the programme has not only been able to develop a cadre of nationally trained ophthalmologists and mid-level eye care personnel but has generously provided training opportunities to other Member Countries. The Programme has undertaken pioneering research on the role of Vitamin A in improving

An NGO-Government Partnership
A Win-Win Situation

Not all of the 2000 coral islands of the Maldives are inhabited. Spread across the ocean, even those that are, pose a special challenge to health care delivery.

The challenge was met by an NGO, Society for Health Education (SHE), which through innovative partnerships with the government health sector and with far-flung community groups, has established health posts and community centres across the islands of the archipelago.

SHE is playing a pioneering role in the prevention of thalassemia, one of Maldives’ major health problems, through its screening and genetic counselling services.

Through its multi-purpose health teams, SHE also organizes and provides services in family planning, medical consultations and school health education.

It is a win-win situation in which the government gains by reaching out its health services to remote population groups and SHE, in its turn, is able to fulfil its humanitarian ideals.
child survival and has contributed significantly to developing a model for prevention of corneal ulcers following agricultural injuries. Nepal today manufactures its own intraocular lenses and supplies it to the global market at very competitive prices, again through a partnership initiative. The prevalence of blindness is now declining in Nepal and what is most reassuring is that concerted efforts continue to sustain this trend.

Public-private partnerships

To what extent can governments continue to bear the costs of meeting the growing health needs of its people? This is a question that has been pondered by the public sector for a long time. A solution that found ready acceptance in most countries was for governments to enter into partnerships with the private sector that would relieve them of the service provisions while maintaining regulatory powers. Bangladesh is now piloting a large urban-based project to test the benefits of such partnerships. In Indonesia, Sri Lanka and Nepal, public sector hospitals provide private beds to patients who can pay. Cooperative medical services in Myanmar owned by cooperative societies operate as private clinics. In Thailand, a revolving drug fund, contributed by members of a drug cooperative scheme provides drugs at low cost and has expanded to cover nearly one-third of all villages. A hill drug scheme in Nepal runs along similar lines.

It may be too early to assess whether such public-private partnerships are working well and whether the most deprived populations are benefiting from such linkages. On the face of it, such partnerships appear apt to address health issues more promptly and effectively. On the other hand, what I fear, but hope will never happen, is that with the spread of market-oriented technologies that are unaffordable to the poor, equity issues will remain unsolved. In this regard, I have been strongly advocating for the public sector to function as a regulatory body, constantly monitoring for equity, effectiveness and quality.
Six years ago I wrote a book titled “Partnerships: A New Health Vision” in which I expressed my strong and growing conviction that as we enter the 21st century, partnerships for health could well become a turning point for health development in the South-East Asia Region.

Today, I am even more convinced that if we are serious about meeting the health challenges of our Region, we cannot rely solely on our own efforts. Health determinants are complex requiring multisectoral efforts. The boundaries of the health sector must be stretched persuasively to foster and sustain new relationships to effectively address the issues and ethics involved in protecting the individual’s fundamental right to health. The benefits are mutual. Through such linkages, our partners, I am certain, will gain as much as we do.

**Focus on Country Initiatives and Strengthening the Offices of WHO’s Country Representatives**

The impact of WHO’s policies, directions and guidance, must show at country levels. It does not matter how strong the Regional Office is. What matters is how well WHO is able to cater to the needs of the countries.

This is what I believed in, even before I assumed office as Regional Director. For me, country interests came first, whenever new strategies were envisaged, new programmes drawn up and additional resources mobilized.

As Regional Director, I was able to carry my conviction even further. I saw to it that substantial budget allocations to countries were made, comprising 75% of the regular budget allotted to us. I am proud to say that this is probably the highest proportion allotted to countries by any regional office of WHO. I was also happy to know that donors too preferred to make their long-term investments on country focused initiatives.
Increasing the capacities of countries to reform their health systems and deliver quality health care had always received high priority in our Region. This was reflected in the large number of training programmes conducted to upgrade the skills of national programme managers and others at various levels to more effectively plan, formulate strategies and implement a wide range of health programmes. There were very few days when WHO training was not being carried out, somewhere in some country in the Region. It is very satisfying to see the progress of human resource development in the countries. It has been a real pleasure for me to meet, during my visits to countries, many of those trained by WHO, now at the most senior levels of health management, research and training, equipped to plan, build and sustain a network of primary health care.

The role of the WHO representatives (WRs) in the countries has always been critical. WRs are called upon to provide flexible responses to the needs of countries in ways that optimize the health of all people, especially the poor, the marginalized and those facing specific health issues. WRs are also increasingly involved in providing guidance to Member States on WHO’s policies, actions and collaboration with other development partners. Their role also involves building local relationships and networks of experts and policy makers to implement agreed health actions.

In our efforts to collaborate meaningfully and effectively with Member Countries and to enhance national capacity, we have constantly taken initiatives to strengthen the WHO Country Offices. For example, the posts of national officers were created in almost all WR offices to provide necessary technical support to countries in priority areas. As a result, I am glad to say, that not only the rate of programme implementation but also its quality has improved.
In the case of DPR Korea, which joined WHO on 19 May 1973 and where collaborative activities were being organized through UNDP, we were able to establish a full-fledged WHO Representative’s Office in January 2003. This has helped to focus more sharply on the country’s needs and to provide timely response.

Similarly, WHO had been extending support to Timor-Leste even before it officially joined WHO and the South-East Asia Region in May 2003. We were able to pool funds from various sources to provide this essential support. Approximately US$ 1 million was provided to Timor-Leste in 2003, the youngest member of our family.

In 2000, the Director-General of WHO introduced a renewed country focused initiative to make WHO’s role even more meaningful. The South-East Asia Regional Office has contributed significantly to this initiative as aptly reflected in the programme budget for 2004-2005. WRs are now granted greater powers and flexibility to effectively address country issues, given to them by a gradually increased delegation of authority from the Regional Office to the country offices.

In one of his first statements after assuming office as WHO Director-General, Dr LEE Jong-wook also emphasized the need to focus on country needs to make WHO’s work more effective.

The call for a stronger WHO presence in countries has now become an Organization-wide priority which will govern WHO’s strategic agenda in the foreseeable future.

**Strengthening Collaboration with other Regions**

“WHO is one”, was the message that went out from WHO headquarters to all its regional offices in 1998, the year Dr Gro Harlem Brundtland took over as Director-General.
This, for us, made very good sense particularly since health issues were getting more and more globalized and there was much to learn from countries of other regions on their experiences in dealing with them. Increasing cross-border migrations and the health problems associated with it provided even greater justification for such an approach.

Not that inter-regional collaboration had not existed. It had, but it needed to be expanded and strengthened.

During the past 4 years, we have collaborated with our neighbour, the Western Pacific Region on a number of important issues, such as the cross-border challenges of malaria control. Six Mekong countries, Myanmar, Thailand, Cambodia, PDR Laos, Viet Nam and China have committed to work together to halve the global malaria burden by 2010. Various other regional collaborations have also been initiated through ESCAP in Bangkok.

“WHO is one” has meant that there is now even closer collaboration between the WHO country offices, regional offices and headquarters. This is now being reflected in the collaborative process of preparing WHO’s programme budget. It has also led to the need to reform the working methods of WHO’s governing bodies.

As a strong proponent of collaboration, I am particularly happy to note that the reforms proposed were endorsed by WHO’s Executive Board in January 2003.

Collaboration between the regions and WHO headquarters was also strengthened. A global cabinet at headquarters level, comprising the Director-General and the six Regional Directors met at regular intervals to share and exchange information.
Renewed Strategies and Fresh Approaches

Meeting Health Challenges

concerning the regions, to learn from the experiences of other regions and to interact on global issues. In addition, mechanisms have been strengthened to enable more formal links between the work of Regional Committees, WHO’s Executive Board and the World Health Assembly.

While WHO has always maintained its status as the lead agency in world health, I am convinced that the WHO I will leave behind will become even more effective, vibrant and responsive to a changing world.

Addressing Gender Issues

Gender issues had always confronted the Region but most of these had been swept under the carpet within the culture of silence that prevailed in matters related to the unequal power relationships between men and women. For a long time, gender issues were considered mainly in the context of maternal health and family planning. Establishing safe motherhood programmes seemed an answer to the growing demands of thousands of women in the Region for a gender perspective in health programmes. It was around the mid-nineties, that an enhanced vision to view women’s health issues not merely through a reproductive health perspective but through a wider life-span approach was projected. Gender took centre stage. About the same time, the gender-related development indices (GDI) developed by UNDP were being published. We found, not surprisingly, that GDI was lower than the human development index (HDI) in all countries of the Region.

Several studies had highlighted gender discrimination resulting in women being denied equal opportunities and equal access to health resources that were essential for survival. There was an urgent need for gender mainstreaming in all our health programmes. This is now carried out in collaboration with various technical units in the Regional Office.

Health profiles of women, prepared in collaboration with multi-sectoral and multi-disciplinary advisory and research
teams in individual countries of the Region analysed women’s health issues and their determinants. The profiles provide compelling evidence for the need to accelerate investments on women’s health.

In the countries, gender issues are now receiving greater attention. Bangladesh has developed a gender strategy for its Health and Population Sector Programme. Bhutan has conducted a gender study to collect and analyse gender disaggregated information on health, in addition to other relevant data.

Nongovernmental organizations concerned with gender issues are also increasingly visible in the Region. Many of them collaborate with their governments in establishing women’s empowerment programmes and in providing gender training.

With stronger political commitment, greater intersectoral collaboration and enhanced partnerships among all concerned, I see no reason why gender inequities in health cannot be eliminated in the decades to come.

At the Regional Office, a glaring gender imbalance reflected through inadequate representation of women in professional grades had to be corrected. I was acutely aware of the dynamic role women were playing in the work of the Organization and made special efforts to constantly remind my senior staff to encourage qualified women candidates to apply for professional posts. In addition, a women’s panel to effectively represent and protect the interests of women candidates was appointed. I am happy that in the past decade the proportion of women professional staff has increased from 13% in 1992 to 33% in 2003. Hopefully, one day this would further increase to meet the target of 50% set by the World Health Assembly in 1997.
I am not a seer. I cannot predict the future. I can but dream that the South-East Asia Region, in fact, the world, will one day become a healthier, happier and a more peaceful place to live in.

When will that day come? I do not know, nor can I hazard a guess.

Going by events over the past decade or two, we must be prepared for some rude shocks as well as for some pleasant surprises.

Unexpected political developments over the past few years led to unification of some countries after years of separation and to fragmentation of some others. New alliances were built to fight terrorism. Globalization connected nations, businesses and people across the globe through increased economic integration and communication exchange, cultural diffusion and travel. The bio-medical sciences uncovered their bag of surprises too. No one could imagine even a few decades ago that one day practically all organs of the human body could be replaced, when humans could be cloned and genetic structures manipulated. It seemed like anything could happen – sometimes to brighten our lives, sometimes to threaten it.

Many of these developments have been clouded in controversies.
In the health field people questioned the virtues of globalization to address issues related to equity. That diseased organs could now be replaced with healthy transplants was exciting, but when human organs were being traded, the picture turned ugly. The availability of more effective drugs to treat tuberculosis and malaria gladdened the hearts of millions until the appearance of drug resistant strains of disease-causing organisms threatened to destroy that hope. Newer reproductive technologies brought hope to women who were unable to conceive the natural way, but, at the same time, it eroded in some ways, the sanctity of marriage and reproductive practices upheld by certain communities. Genetic engineering held promise for eliminating several congenital abnormalities, but its manipulative possibilities to produce “monsters” that could destroy the world is frightening. And now, human cloning has thrown the world into yet another ethical debate.

There are no full stops. Scientific research will continue to dazzle us with exciting possibilities for a better world. It could also hold some disastrous implications.

Lifestyles that carry high risks for disease will become a major cause for concern; so also violence, substance abuse and unsafe sex. Health promotion practices have yet to make an impact. Strong advocacy will be needed to place health promotion high in the list of priorities for health development. That health promotion and health education are not synonymous must be made known to all those who frame health promotion policies and programmes. Health education alone will not change lifestyles. Health promotion will, comprising as it does, a much more comprehensive approach to improve people’s health and the quality of their lives.

As a public health protagonist committed to primary health care and health for all, my glimpses into the future will revolve primarily around one issue closest to my heart and that is, “will health equity be achieved? Or will it remain a
mirage, a desired but unattainable goal, merely providing a platform for rhetorics and profound declarations?

Much as I would like to be an idealist, I must be a realist too. In my glimpses into the future, there is both optimism and pessimism.

I am optimistic that many of the communicable diseases that have stalked the Region for centuries and especially affected the poor will either decline or get eliminated. Leprosy, poliomyelitis and other vaccine preventable diseases will lead in the list of such diseases. Neonatal tetanus and deaths due to diarrhoeal diseases will also decrease. Much of this trend will be the result of technological advances made to control and eliminate the microorganisms that cause disease.

But technology alone is not everything. If health systems do not change, if corrupt practices overrule, technologies in fact can be exploitative. Social advances that empower the poor to access their right to health information and services must take place simultaneously. This is where I see a glaring gap.

Nevertheless, there are some encouraging signs that the gaps now seen will narrow, as evident in the increasing participation of civil society in matters related to their health and wellbeing. In this, the contribution of other sectors, other than health will be most significant. Literacy rates will rise, gender issues will take centre stage and prevailing inequities will demand that health and social security measures be put in place.

In a Region which harbours large sections of people who have limited capacities to pay for health services, and where national budgets are low, paucity of funds to strengthen the health infrastructure and provide services to people and places most in need, has always been one of the biggest obstacles in the delivery of primary health care. In my 10-year journey across the Region, I have passed through
many a dark tunnel in search of resources to scale up our programmes to enable all the people of the Region to access basic quality health care.

I am delighted that after a long time I can see a light at the end of the tunnel.

One of the very positive developments that is taking place today is the enhanced interest of donors in funding health programmes. Apart from the humanitarian concerns, I see this as recognition by financial institutions, philanthropists and others that health is central to development. I have good reason to believe that this trend will grow in the years to come.

But considerable efforts will be needed in producing reliable evidence-based data to convince planners and others engaged in development of the importance of health to the social development process and of the irrefutable fact that there can be no sustainable social and economic growth without a healthy and active population. And, when the resources come, equally hard work will need to be undertaken to ensure that they are managed well and used effectively for the purposes they are meant for.

A burning issue currently being discussed at various national and international levels is the issue of globalization and free trade. Globalization has come to stay but for many of us in public health, the debate will continue.

Personally, I am a passionate believer in globalization if it means narrowing the scale of international inequities and the unjust burden of disease borne by the world’s poor.

What we are witnessing is that while globalization has several potential health benefits like, for example, diffusion of new knowledge and technology that can aid in disease surveillance, treatment and prevention, it also can have some serious negative health effects. This includes the increased adoption of unhealthy lifestyles and worsening of some epidemic diseases in developing countries due to environmental degradation caused by deforestation and large-scale irrigation schemes.
For us in the South-East Asia Region, it will also be necessary to ensure that the new health technologies do not benefit only the rich.

Increasing privatization of health care is another related issue that will have to be seriously debated. Private health care and private investments in health services have already expanded in the South-East Asia Region. While it has helped to support under-funded government health services, it is also known to disproportionately benefit the wealthy who can pay for them.

The public-private mix must strike a balance to ensure that the health of the poor is protected.

I am happy to see that WTO members have agreed to provide countries who have little or insufficient capacity for pharmaceutical production, with access to affordable medicines. This will greatly help our Member Countries in their programmes on AIDS, TB and malaria. At the same time, it will be pertinent to watch whether trade liberalization will, in fact, increase health inequities and poverty as some critics predict.

In my vision of the future, I see health programmes being largely influenced and even controlled by the political and economic systems of countries. If political developments tilt towards upholding democratic principles in matters of governance and when economic policies are framed to favour the poor, then ethics will prevail to ensure health as a fundamental right of every citizen regardless of social or economic status. Literacy levels will improve. Enlightenment will grow. Communication highways will increasingly expose the elitist agendas of special interest groups, both internationally and nationally. This would spur civil society to address equity issues, such as unequal access to health care, gender biases which discriminate against women, resource allocations which favour urban against rural populations and technologies which serve only the privileged few.
In fact, as levels of knowledge increase, more and more people will begin to understand the determinants of health and how these can be controlled. They will become more vocal in expressing their needs and thus intensify efforts to raise political interest in health and to put to work policies to ensure health security and accountability.

In my vision of the future, I also see that with the growing realization of the importance of health for long term gains, planners and policy makers will begin to see the wisdom of placing health high on the political agenda. Development sectors will increasingly appreciate the relationship between health and development and the centrality of health to development.

Seven years ago I expounded this vision in my book “Partnerships: A New Health Vision”. The vision remains.

I also see the Region becoming more homogenous with respect to its standards of health and development. The wide disparities in health indicators between countries of the Region that we see today will be narrowed. Greater intercountry collaboration and cooperation have already helped the least developed countries and those in greatest need to move closer to their goals of health for all. With the rapid spread of diseases across borders, I envisage that this will be further strengthened for the planning and implementation of cross-border interventions. But there is still a sizeable, unfinished agenda. The tempo must accelerate. I have good reason to believe it will, with the health sector reforms now taking place in countries and extrabudgetary sources of funds becoming available.

I also have dreams.

I dream about a Region with health systems that people trust in, that are accountable, that provide a sense of health security, specially to those who have been marginalized and left outside the reach of primary health care.
I dream about a Region that sheds the burden of its past and no longer carries the largest share of the global burden of disease.

I dream about a Region nurtured in the hallowed traditions of care and compassion, pooling its resources and sharing its wisdom to bring all countries on par in their levels of health development.

I dream about a Region where people will be empowered to fight the formidable enemies of health, through health promotion strategies and practices that will advocate for healthy public policies and the creation of enabling environments to support good health practices.

It is said that a dream is a wish your heart makes. As I end my journey with these wishes, I have one more to make.

I wish those interested and involved in health development all success in their efforts to ensure that the principles of equity and social justice guide them to realize their cherished dream of a healthier and happier Region.