South-East Asia
Progress Towards Health For All
1977-2000

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“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

WHO Constitution

Foreword

*Over 22 years ago, the world set for itself a seemingly possible goal - **health for all** by the year 2000. Today, well into the first year of the 21st century, it may be pertinent to ask ourselves how far we have come, and how much further we have to go, to reach that goal.*

Undoubtedly, the past two decades have seen remarkable progress on several fronts. Man has conquered many frontiers. Technological advances have helped open up new vistas that, at best, seemed like science fiction not too long ago.

A quick look at selected health indicators for countries of the WHO South-East Asia Region clearly shows the gains made. Life expectancy has increased, crude death rates have declined, and infant mortality rates have improved considerably. Yet, despite these gains, the Region faces several daunting challenges. These include the burgeoning population, high maternal mortality rates, and the heavy burden of both communicable and noncommunicable diseases.

This Region accounts for nearly 7 million of the world's 17 million deaths caused each year by communicable diseases. Aggravating the situation is widespread poverty, which increases the risk for diseases caused by poor hygiene and inadequate nutrition. The Region also faces an increasing incidence of noncommunicable diseases. These are often related to increased life expectancy, unhealthy lifestyles including tobacco use, and environmental pollution.

*Since 1977, when the World Health Assembly called for **health for all** by the year 2000, the Region has seen an increased momentum in health development. With this has come the recognition that health is cen tral to development, and that it cannot be attained in isolation. This has led to multisectoral efforts and partnerships across a wide front.*

In its quest for better health, the Region has overcome formidable challenges. Yet many aspirations remain to be fulfilled. Above all, the targets set for health for all must be achieved. This goal is well within our reach, but only if justice and equity in health are ensured.

To all those concerned with health development in the South-East Asia Region, this publication will help trace the important landmarks on the road to better health. To those not familiar with this part of the world, it will provide interesting insights on a Region that holds the key to the world's health status.

Dr Uton Muchtar Rafei
Regional Director

Introduction

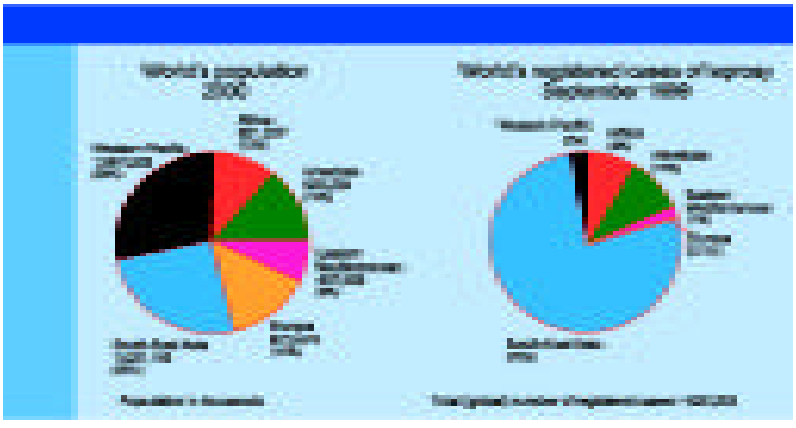
For those interested in health development, the South-East Asia Region of the World Health Organization has always held a special fascination. While the ten[1] countries of the Region present a vibrant and diverse socioeconomic and cultural picture, it is the health of the people of this Region that tilts the balance of world health - one way or the other.

With over 1.5 billion people, the Region accounts for 25% of the world's population. It is not surprising, therefore, that this Region also bears the largest portion of the global burden of many communicable diseases. These include tuberculosis, poliomyelitis, malaria and leprosy. Figure 1 provides a telling example, depicting the regional share of the global population compared to its leprosy burden.

Between 1975 and 2000, the population in the Region increased by 61%. It is estimated that the population will be over two billion by 2025 - an additional increase of nearly 31%. This is bound to affect population density in the Region - already among the highest in the world - with over 226 persons per square kilometre as compared to the world average of 45.

An interesting demographic change in the Region is the decline in the proportion of the population who are less than 15 years. From 41% in 1975, it declined to 33% in 2000, and is likely to drop to less than 23% by 2025. At the same time, the proportion of those aged 65 years and above increased from 3.7% in 1975 to 4.8% in 2000, and is expected to reach 8.4% by 2025. This will require more attention to health care of the elderly, including more specialized secondary and tertiary care, as well as substantial community and home based care. The increase in the number of

Figure 1: Distribution of the world's population and leprosy cases by WHO Region



Note: Percentages may not add up to 100 due to rounding.

Sources: 1. UN, World Population Prospects, The 1998 Revision, Volume 1: Comprehensive Tables.
2. WHO Geneva, Leprosy Status Report 1999 (Draft)

[1] Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand

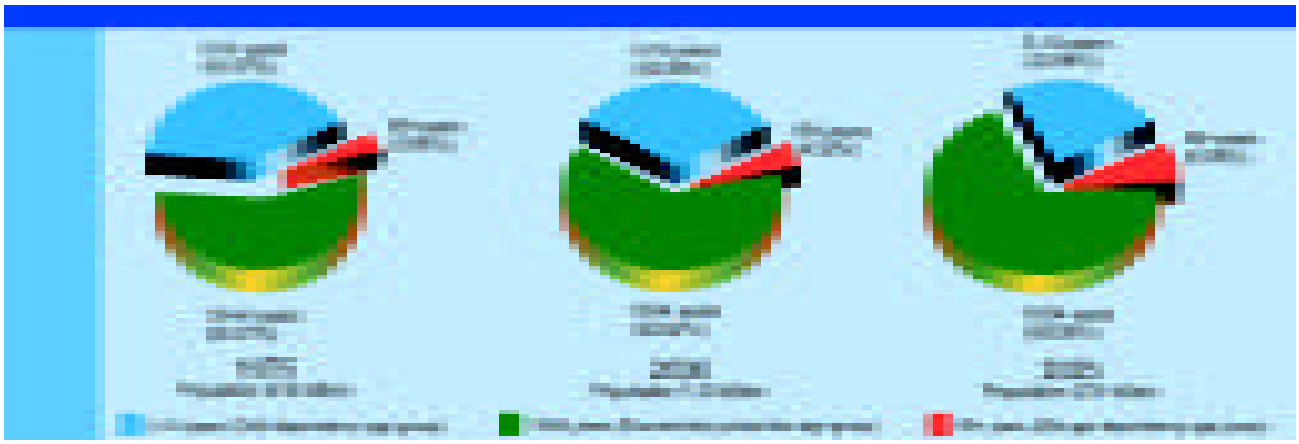
people in the 15-64 year age group will also require more resources, especially to cater to the reproductive health needs of this population subgroup.

Adding a new dimension to the already challenging health situation, is the rising trend in the prevalence of noncommunicable diseases, such as cardiovascular and cerebrovascular diseases, cancer and diabetes mellitus, as well as in the number of accidents and injuries. High maternal mortality ratios (40% of the world's maternal deaths occur in this Region) are also a cause for concern, as are the low literacy levels for women and girls. The latter is closely linked with the status of women, which has not improved significantly in a number of countries of the Region. This is surprising, considering the realization at the highest political level of the need to improve women's status, and the acceptance of the close relationship between women's literacy levels and infant and maternal health.

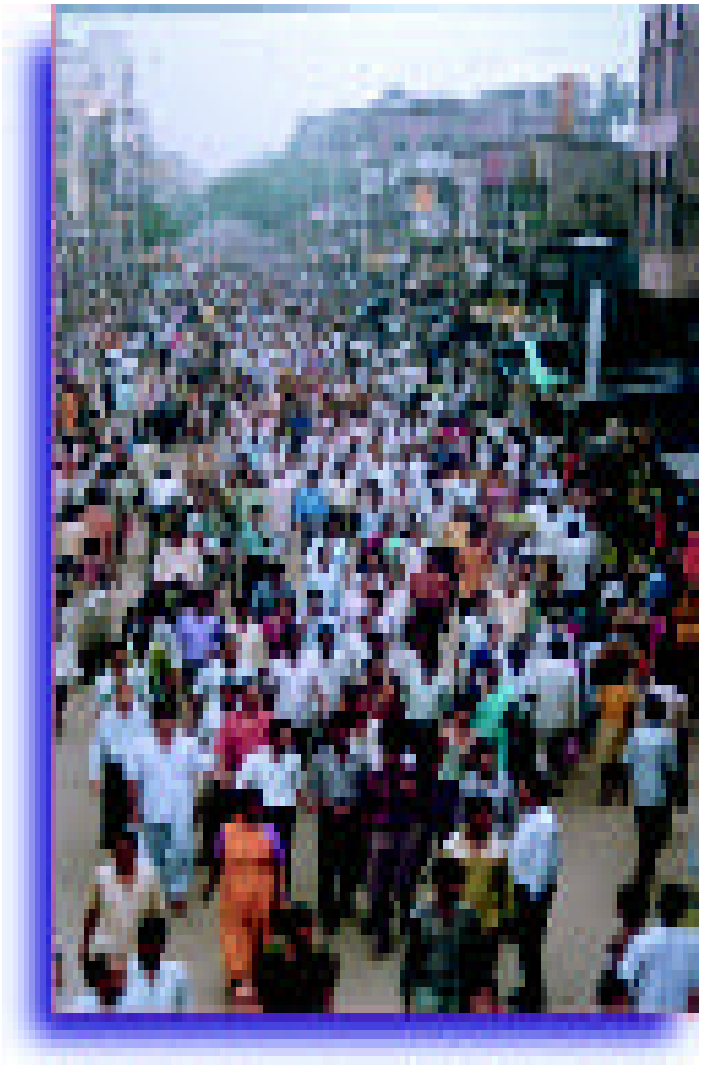
The widespread poverty in some countries of the Region poses a serious threat to health. Poor health aggravates poverty, just as poverty aggravates poor health. This is reflected in the high percentage of low-birth-weight infants and malnourished children. With its multidimensional characteristics, poverty is also a major contributor to disabilities and to shorter life expectancies. In a Region where millions live in poverty, the implications for health are obvious.

The health situation in the Region, however, is not entirely bleak. Over the past few decades, countries have made substantial efforts to reduce their population growth rates. The average annual population growth rate in the Region declined from 2.16% in 1975-1980 to an estimated 1.44% in 2000-2005. Life expectancies have risen and infant mortality rates have decreased. These improvements have been largely due to vigorously sustained immunization programmes. Efforts to control acute respiratory infections and diarrhoeal diseases have also contributed substantially. The Region is close to eliminating leprosy and to eradicating poliomyelitis. It was certified free of ***guineaworm disease*** in February 2000.

Figure 2: Changes in the age composition of the Region's population

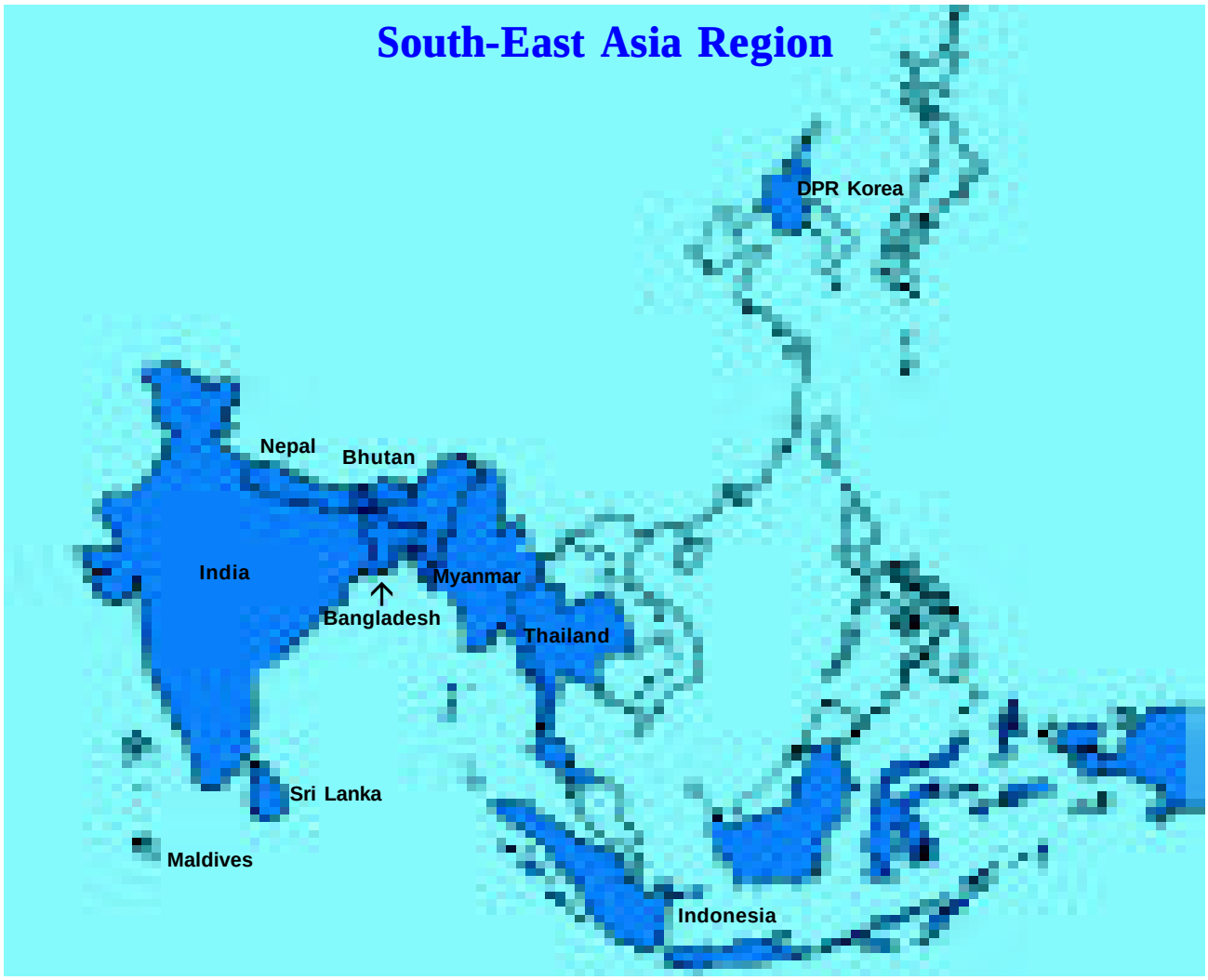


Source: Computed from UN, World Population Prospects, The 1998 Revision, Volume II: Sex and Age



Some countries have considerably strengthened their health services, establishing a network of facilities and making health care available close to where people live. What is being increasingly recognized is that functional access to health services is more important than physical access. In countries where noteworthy progress has been made, one of the contributing factors has been the social welfare-oriented state policies. These policies have, among other benefits, contributed to high literacy, particularly of women, and increased health awareness leading to improved health practices.

This publication provides glimpses of the health situation in the Region and highlights efforts of countries in their quest for better health since the mid-1970s. Trends in selected health and health-related indicators and specific topics like the health of women and children, environmental health, nutrition, control of communicable and noncommunicable diseases, and health systems development are discussed. Salient points from the *Declaration on Health Development in the South-East Asia Region in the 21st Century,* adopted by the Health Ministers of the Region in 1997, have been included to underscore the health challenges identified for the Region and the actions suggested to address them.



The boundaries shown on the map do not imply official endorsement or acceptance by the World Health Organization.

The Region accounts for 5% of the global land mass and 25% of the world's population

- 30% of the under-five deaths (1995-2000)
- 33% of the infant deaths (1995-2000)
- 33% of the blind persons (1997)
- 33% of the estimated cases of diabetes mellitus (2000)
- 38% of the estimated cases of tuberculosis (1997)
- 40% of the maternal deaths (1990)
- 41% of the deaths due to infectious diseases (1995)
- 67% of the estimated cases of hepatitis E (1995)
- 75% of the polio cases (1998)
- 78% of the reported cases of leprosy (1999)-

The Quest for Better Health

Providing adequate health care to their people has been the goal of all governments in the South-East Asia Region. A fresh momentum was provided in 1977 when the World Health Assembly adopted the historic resolution calling for *health for all* by the year 2000. The following year, at the International Conference on Primary Health Care held in Alma-Ata, the quest for *health for all* was set in motion.

Since then, the need for equity and social justice in health, and the fundamental right of every human being to health, have been increasingly recognized. This recognition culminated in the World Health Assembly's declaration in 1998 which underscored the interdependence of all nations, communities, families and individuals in working towards *health for all*. The Assembly also stressed that the community of nations must act together to meet common threats to health and to promote universal well-being. Thus, *health for all* has continued to be a principal health development goal and primary health care the main approach to attain it.

Strengthening health systems

Meeting the basic health needs of the people has always been one of the greatest challenges faced by countries of the Region. Yet, in competing for resources, the health sector often figures relatively low among national development priorities.

Currently, the proportion of the central government expenditure on health ranges from a low of 1% to a high of over 11% in countries of the Region. Compared with the situation in 1985, most countries have increased their budgets for health, a few have maintained the status quo, and one has reduced health expenditure by nearly 50%. Considering the high burden of diseases in the Region, the allocation of financial resources for health must be critically assessed, especially in terms of equitable distribution.

To bridge the gaps in financial resources, many countries are introducing alternative financing mechanisms, including health insurance schemes, to extend the coverage of health services. At the same time, national health policies are being revised in order to improve the provision of health care

and thereby improve the health status of the people. Health sector reforms are being initiated to ensure that, in the wake of increased privatization of health care, the poor are not exploited. The decentralization of health services is an important component of the reform process, aimed at, among others, bringing health services nearer to the people through community involvement.

Primary health care (PHC) is a practical approach going much beyond the provision of a basic package of health services. It aims at overall improvement in an individual's quality of life, encompassing the social and economic dimensions. Based on the principles of equity and social justice, the approach is aimed at integration, intersectoral collaboration, community participation, and the use of appropriate technologies, as essential ingredients to ensure successful implementation. Primary health care calls for an important sociopolitical process, including setting policies at the highest level of the government as an indication of its commitment. It also calls for some redistribution of resources, and the decentralization of action for health to the community and district levels.

As part of the global movement, countries developed health-for-all strategies and incorporated them within their national health development plans. In the early 1980s, health system infrastructures were further strengthened, in line with the primary health care approach. The attempt was to integrate clinical medicine into public health, and, at the same time, health within other sectors.

District health systems were strengthened to provide maximum coverage. Focused care for vulnerable population groups was promoted, as were many specific disease control campaigns. Health manpower systems were rationalized, and millions of health personnel and volunteers were trained for deployment to rural areas.

The number of physicians in countries of the Region, which ranged from 2 to 26 per 100,000 population in 1970, had increased to 4 to 48 and above per 100,000 by the 1990s. Over the same period, the number of nurses increased from 1 to 28 per 100,000 to 5 to 180 and above. In addition, by the mid-1990s, there were over 42,000 health centres of various categories in the Region. Over 746,000 outreach sites, managed by the community with support from health centre staff, had also been established.

Despite the increase in the number of health personnel, serious challenges persist in the management of human resources in many countries. For example, in addition to an imbalance in the geographical distribution of health personnel between urban and rural areas, there is a continuing shortage of nurses and midwives. There are also imbalances in their number and type in relation to other categories of health personnel, particularly physicians.

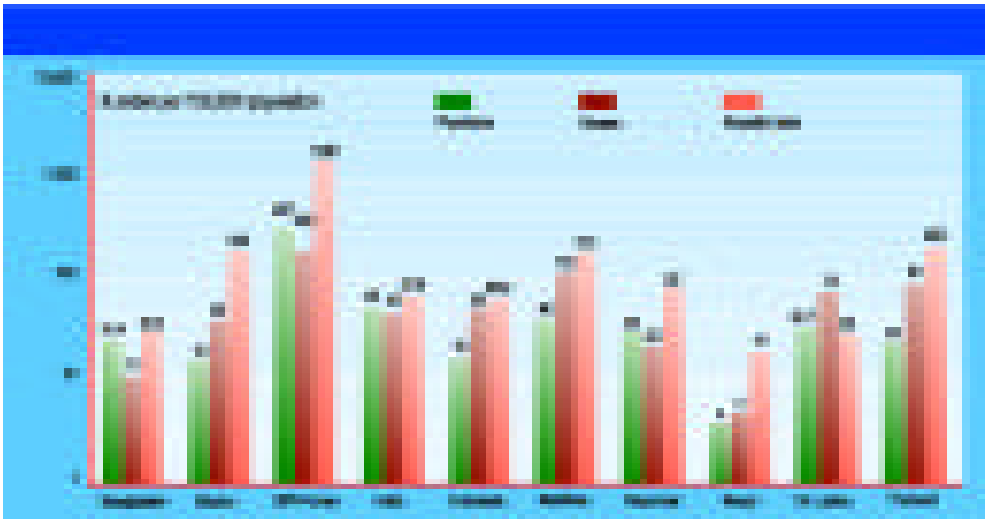
Over the past two decades, the steady development of health systems based on primary health care can be attributed to a number of factors:

- political, social and financial commitment,
- strong management capabilities for implementation,
- well trained and committed health personnel,
- decentralization to the district or local level,
- community involvement in local decisions,
- sustained financing, and
- widespread deployment of affordable and life-saving technologies.

Recognizing these challenges, countries in the Region have been making concerted efforts to make health care more accessible, particularly to vulnerable and marginalized groups. Within this context, there has been an added emphasis on ensuring the quality of services. Yet, with populations increasing rapidly, governments are hard pressed to meet even the basic health needs of their peoples. This, in turn, has led to a steady growth in the privatization of health care, which many can ill afford.

This predicament has millions in its grip, not only in developing, but also in developed countries. There is, however, a way out. And that is to recognize the role of the private sector in health care, and to realize that urgent policy directives are needed to ensure that health care is not provided to the 'haves' at the cost of the 'have-nots'.

Figure 3: **Physicians, nurses and hospital beds by country, 1995**



Notes: Data may not be comparable between countries due to likely variations in definitions.
Reference year for some data may vary between 1992 and 1997.

Sources: 1. WHO/SEARO, Report of the Third Evaluation of the Implementation of HFA strategies - South-East Asia Region, 1997
2. WHO/SEARO, Health Situation in the South-East Asia Region 1994-1997.

Governments must establish clear guidelines and norms within which the private sector can function, with full responsibility and accountability and the assurance that there will be no exploitation.

Compared to the meagre resources allocated to health care activities in the early 1970s, many countries have increased allocations, particularly for immunization, health promotion, maternal and child health, and communicable disease control, especially in rural areas. This is in sharp contrast to the time when, in several countries of the Region, only faith healers and practitioners of traditional medicine were available in most rural areas.

Nevertheless, seeing the crowds waiting to be attended at any government health facility, it is obvious that much more needs to be done. It is not merely *more* facilities that are needed, but facilities that are adequately equipped with human and material resources. With health personnel who are caring and efficient. With equipment that works. With drugs and vaccines that are effective.

What needs to be ensured is that district health systems and community health services become more functionally effective. Such aspects of ***health systems management*** can be improved considerably with attention being paid to some important issues:

- long-term perspective planning,
- efficiency in resource allocation,
- effective management of human resources,
- private sector participation,
- intersectoral coordination, and
- community involvement.

Only when health systems management is sufficiently strengthened can the current problems of poor integration of services, low quality of care, inadequate referral systems, imbalance in human resource development and deployment, and inequities in accessibility be resolved.

Health research has been a component of the health development process in all countries in the Region for several decades. The establishment of the WHO South-East Asia Advisory Committee on Medical Research in 1976 (redesignated as the Advisory Committee on Health Research in 1986) helped to strengthen this important component. In fact, several research programmes initiated in the Region were also taken up by the global research programme, for example health systems research and control of diarrhoeal diseases. Researchers in countries of the Region have worked

Successful health research projects in the Region include dengue vaccine production in Thailand, hepatitis B vaccine and anti-snake toxoid production in Myanmar, leprosy drug trials and community-based rehabilitation in India, testing drug resistance in malaria parasites in Thailand, and a multicentric study on low birth weight and its risk factors in India, Nepal and Sri Lanka.

closely with global programmes, particularly in the areas of human reproduction and tropical diseases.

There have been important achievements in the Region in the development of research manpower and in the strengthening of national capabilities in research management. Research efforts have also been enhanced by the recognition that research needs to be relevant to the needs of the people. Health research in some countries has been greatly stimulated by research on HIV/AIDS, which has helped to emphasize the social science and behavioural aspects of disease prevention. The increase in the number of WHO collaborating centres in the Region - from 21 in 1975 to over 90 in 1999 - has facilitated the expansion of collaborative efforts in training and research among WHO and its Member States.

Major constraints include the inadequacy of funds, of career opportunities, and of technology transfer. Weak coordination and collaboration among research scientists also hinder countries in attaining their full potential for managing and carrying out health research. Donor domination in international research collaboration can be a detriment in that it can drive research in non-priority areas. Yet, it can also have a positive impact in terms of strengthening national capacity.

Constraints to the early detection and control of infectious diseases in the South-East Asia Region

- Poorly developed epidemiological surveillance systems which fail to provide an early warning of impending disease outbreaks or epidemics. Many countries still lack trained epidemiologists or epidemiological health personnel to investigate and control outbreaks.
- Less effective vector control due to increased insecticide resistance, degradation of the environment which increases vector breeding, lack of awareness, and inadequate involvement of communities in vector control activities.
- An increasing trend in microbial resistance to commonly available antibiotics in all countries of the Region. This is a major obstacle for case management as well as for the reduction of transmission of infection from active cases. It also adds significantly to health care costs.
- Changes in socioeconomic, demographic and environmental patterns which favour the emergence and spread of infectious diseases. These changes include rapid population growth, increasing poverty, uncontrolled urbanization, environmental degradation, and rapid increase in travel within as well as between countries.

Combating communicable diseases

Communicable diseases figure prominently in the spectrum of illnesses in the Region, taking a toll of nearly seven million lives every year. Diseases like tuberculosis and malaria still dominate the disease pattern, with the added concern of drug resistance. In addition, kala-azar, once nearly eradicated, and plague, which was dormant for decades, have reappeared. HIV infection is assuming grave proportions, while cases of cholera, caused by a new strain, O139, need careful monitoring. Countries in the Region are formulating strategies to strengthen measures to control these new, emerging and re-emerging diseases of public health importance.

In a developing Region, striving to become economically strong, the burden of communicable diseases increases economic hardships and hampers development. Success in controlling them would, in fact, act as an impetus to improved health and national development. Yet, such successes are difficult to realize due to the many constraints faced by countries in combating these diseases.

Malaria eradication programmes launched in the mid-1960s led to remarkable reductions in cases. Yet by the early 1970s there were clear signs that malaria was making a comeback. In 1976, the Region reported over seven million cases. There were several reasons for this comeback, foremost among them being financial constraints and the development of resistance to DDT[2] in mosquitoes. Meanwhile, to compound the problem even further, the vector mosquitoes altered their biting and resting behaviour (by avoiding DDT-sprayed surfaces), and the malaria parasites developed resistance to anti-malarial drugs. During the 1980s, an alarming rise in the incidence of P. falciparum malaria occured, leading to increasing deaths. Malaria epidemics were reported in many countries, with an increase in urban as well as cross-border malaria.

An appraisal of the eradication programmes showed that the variety of epidemiological situations in different countries needed a flexible approach. The application of rigid and standardized measures of mosquito control was not enough, and malaria control strategies were therefore revised. At the Ministerial Conference on Malaria organized by WHO in 1992, a global strategy was endorsed. This strategy was intended to prevent mortality and reduce morbidity as well as social and economic loss. It called for, among other things, early diagnosis and prompt treatment, as well as planning and implementing selective and sustainable preventive measures, including vector control.

The South-East Asia Region, with 25% of the world's population, carries a disproportionate 39% of the world's burden of ***tuberculosis*** (TB). This disease kills more adults than any other infectious disease in the Region - over 750,000 deaths a year. That these are people in their most productive years only compounds the loss to their families, to their communities, and to their countries.

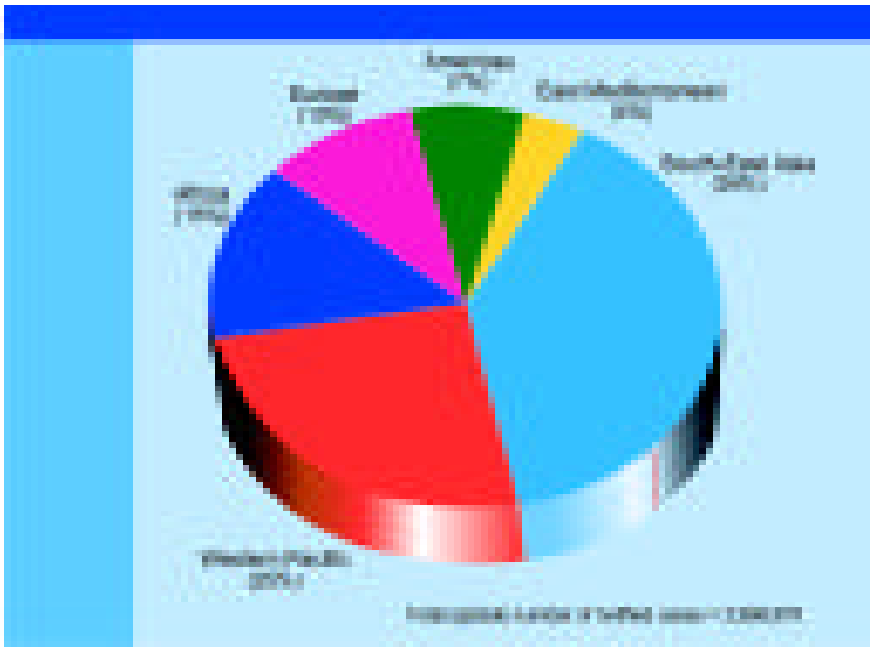
The emergence of HIV/AIDS[3] in the mid-1980s is of great concern in

Malaria control received added impetus through the *Roll Back Malaria* initiative launched by WHO, UNICEF, UNDP and the World Bank in 1998. This initiative seeks to:

- Strengthen health systems to ensure better delivery of health care, especially at district and community levels.
- Ensure the proper and expanded use of insecticide-treated mosquito nets.
- Ensure adequate access to basic health care and training of health care workers.
- Encourage the development of simpler and more effective means of administering medicines, such as training of village health workers and mothers on early and appropriate treatment of malaria, especially in children.
- Encourage the development of more effective and new anti-malaria drugs and vaccines.

[2] Dichlorodiphenyltrichlorethane
[3] Human immunodeficiency virus/acquired immunodeficiency syndrome

Figure 4: Reported tuberculosis cases by WHO Region, 1997



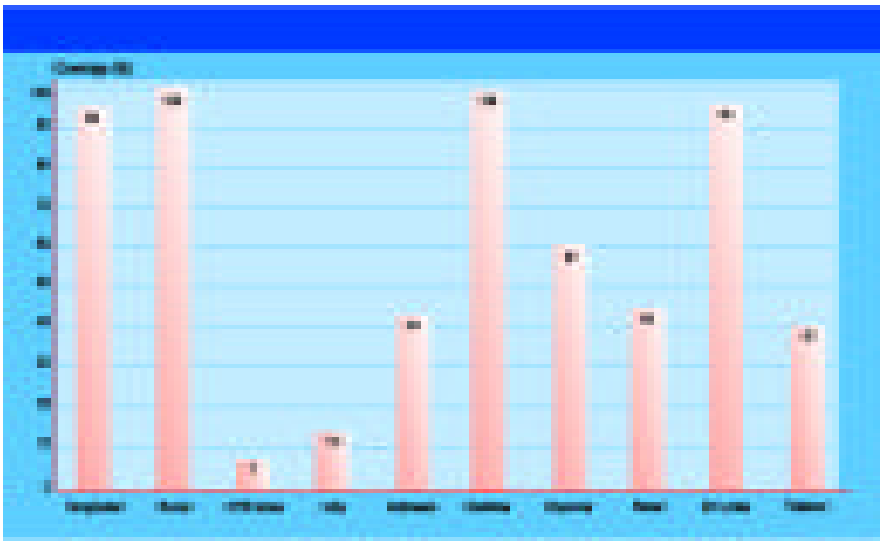
Source: WHO Geneva, Global Tuberculosis Control, WHO Report 1999

the context of tuberculosis, in view of the higher susceptibility of the HIV-infected individual to become ill with tuberculosis. Areas in the Region where HIV infection is high have already begun to report higher rates of tuberculosis.

Tuberculosis was declared a global emergency by WHO in 1993, and in 1994 a new control strategy was introduced - DOTS (directly observed treatment, short course). The strategy is based on the diagnosis of infectious cases by sputum microscopy and ensuring cure of these cases through directly supervised treatment lasting 6-8 months as compared to the previous 12-18 month regimens. DOTS aims to control tuberculosis by cutting transmission at the source - by curing the infectious case.

The strategy is showing good results in countries of the Region, all of which have accepted DOTS as a tuberculosis control strategy. Where implemented, treatment success is over 80% as compared to less than 30% earlier. In the absence of a highly effective vaccine, this is the best way of ensuring control. It is expected that the planned activities under the *Stop TB Initiative* launched in November 1998 will accelerate tuberculosis control efforts in the Region, so that targets will be met by or before 2005.

Figure 5: Proportion of population covered by DOTS, October 1999

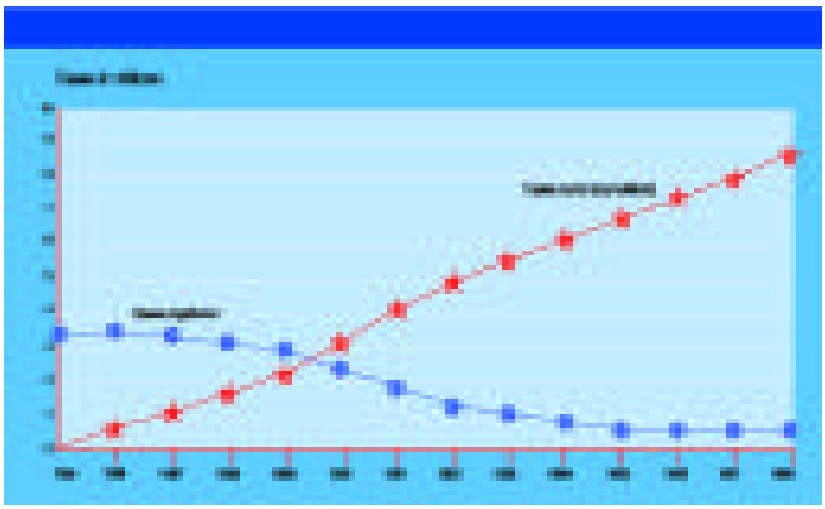


Source: WHO/SEARO.STD/AIDS and Tuberculosis Unit

South-East Asia has long accounted for a substantial proportion of the total ***leprosy*** cases in the world. Presently, four countries in the Region - Bangladesh, India, Indonesia and Myanmar - report approximately 76% of the global cases.

The introduction of multi-drug therapy (MDT) in the early 1980s led to a dramatic decline in the number of leprosy cases. Among the main reasons for this is the reduced duration of treatment - from two years or more to 12 months for severe forms of leprosy, and to as short as six months for milder cases. With the introduction of multi-drug therapy, the number of registered leprosy cases in the Region declined from around 3.5 million in 1985 to less than one million in 1998.

Figure 6: Trends in leprosy cases in the Region



Source: WHO/SEARO, Leprosy Unit

Spurred by these developments, the World Health Assembly declared its commitment in 1991 to eliminate[4] leprosy as a public health problem by the year 2000. In the South-East Asia Region, Bangladesh, Bhutan, Maldives, Sri Lanka and Thailand have already achieved this target, while Indonesia and Myanmar are well on the way. India and Nepal are expected to achieve the target shortly (2002). What needs to be kept in mind, however, is that treatment and rehabilitation facilities for persons with leprosy-related deformities still have to be provided, preferably close to where they reside.

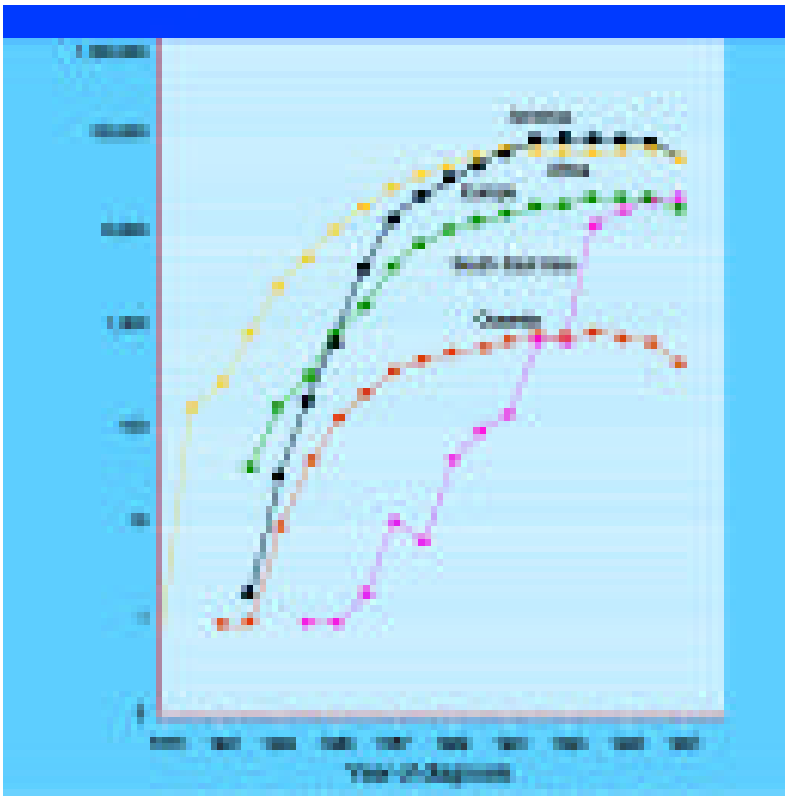
Dengue fever was first reported in the Region in epidemic form in Thailand in the 1950s. It later spread to other countries and is today endemic in Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. Nearly 1.3 billion people in endemic areas are at risk of the infection.

Since the late 1970s, there has been a steady increase in the incidence and geographical distribution of dengue fever and its more severe forms, ***dengue haemorrhagic fever*** (DHF) and ***dengue shock syndrome*** (DSS). In 1998, nearly 400,000 cases and 8,000 deaths were estimated to have occurred in the Region. Over the years, after diarrhoeal diseases and acute respiratory infections, dengue haemorrhagic fever has become a leading cause of hospitalization and death among children. Its mortality rate, however, can be substantially reduced with effective standard case management.

Considering the seriousness of the problem, WHO supported the development of a vaccine against dengue. For the first time in a developing country, after years of concerted effort, scientists from Mahidol University in Thailand successfully developed such a vaccine for human use. Clinical trials in adult volunteers have shown the vaccine to be safe and effective, and

[4] Leprosy elimination status is achieved when the leprosy prevalence rate is less than 1 case per 10,000 population.

Figure 7: Trends in reported AIDS cases by region

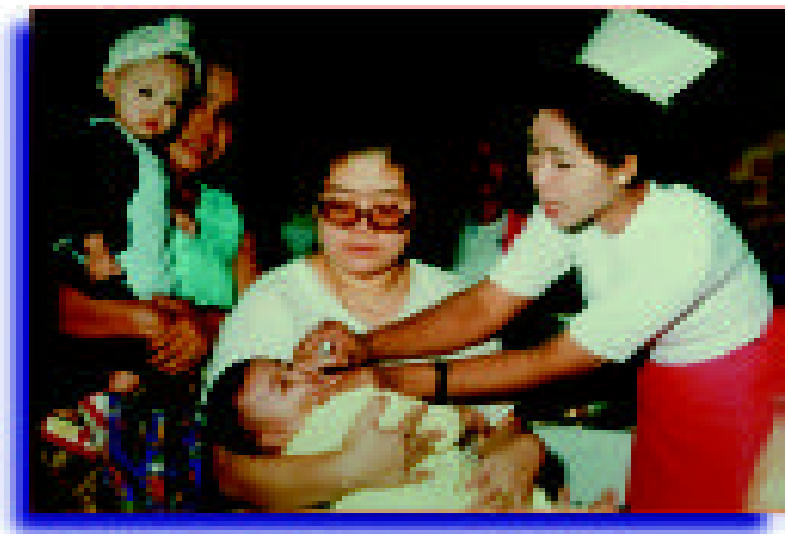


Source: WHO/SEARO, STD/AIDS and Tuberculosis Unit

commercial production of the vaccine has been undertaken by a French multinational company. Trials are currently being conducted in adults and children in Australia, Thailand and the United States.

In 1984, Thailand was the first country in the Region to report a case of ***AIDS.*** Initially restricted mainly to those practising high-risk behaviours, such as homosexuals, commercial sex workers and injecting drug users, HIV-infection rates have begun increasing in the general population as well. As of January 2000, over 135,000 cases of AIDS have been reported. More than 5 million people in the Region are estimated to be infected with HIV, an alarming 15% of the world's total.

India, Thailand and Myanmar report the majority of persons with HIV/AIDS in the Region. Considering the steady increase in the number of patients with AIDS, it is important to develop and strengthen the care of people living with HIV/AIDS at home and in the community. In the absence of a vaccine, preventive interventions aimed at various population groups, including those with high risk behaviour, and advocacy efforts focused on the general population as well as policy makers, need to be strengthened.



The successes achieved in different countries need to be shared among the Member States of the Region, with a view to their wider application. These successes include the high-level government commitment, the strong public health infrastructure, the 100% condom programme aimed at commercial sex workers, and education for youth in Thailand. The peer education of sex workers in Sonagachi, Calcutta in India, the harm reduction approach targeted at

injecting drug users in Nepal, and the community-based treatment and counselling activities in Myanmar are other examples.

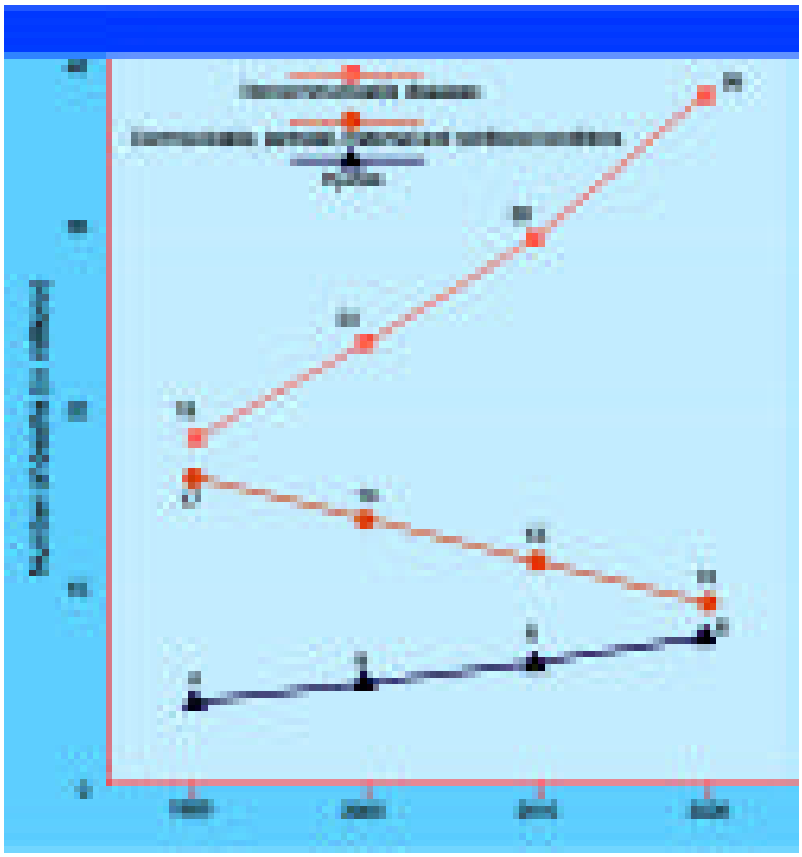
Since 1988, when the World Health Assembly adopted a resolution calling for the global eradication[5] of ***poliomyelitis***, significant progress has been made in the Region. From over 25,000 cases in 1988, the number dropped to less than 2000 in 1998. This was largely due to strengthened immunization networks and the organization of a series of national immunization days (NIDs) synchronized among neighbouring countries, during which record numbers of children were immunized. These NIDs represent a massive coordinated effort among governments, international agencies, NGOs and the community at large. As a result of such efforts, it is anticipated that the goal of polio eradication in the Region may be achieved by the end of the year 2000.

A new dimension, however, seems to have been added by some reports suggesting that the polio virus may persist longer in those infected with HIV. A few cases of poliomyelitis as an opportunistic infection in HIV/AIDS patients have been reported in some areas in the Region. Considering the large number of HIV-infected persons in the Region, this new development could have serious implications and needs to be watched closely.

In 1979, when India launched its ***guineaworm*** (dracunculiasis) eradication programme with the support of WHO, the disease was estimated to affect about 1.3 million people. By 1996, five years after the World Health Assembly had declared its commitment to eradicate guineaworm disease, dramatic progress had been made. The number of cases in India had dropped to nine, reported from just three villages of one district in the state of Rajasthan. Since then, no case has been reported. Following review by the International Commission for the Certification of Dracunculiasis Eradication in February 2000, India will join the other 109 countries already certified as free from guineaworm disease.

[5] Poliomyelitis eradication is the complete interruption of indigenous transmission of wild poliovirus.

Figure 8: Projected trends in the number of deaths by broad cause group in developing regions



Source: The Harvard School of Public Health, *Global Burden of Disease and Injury Series, Volume 1*, 1996

What helped in eradicating guineaworm disease was a combined strategy of stepwell conversion, provision of safe water sources, and massive social mobilization and education efforts. The end of this disease means much more than a significant health achievement. It has generated major social and economic gains which, though difficult to measure, are nonetheless easy to see on the happy faces of villagers who were once afflicted. They are now sure of the fact that nobody need ever suffer the pain and debility caused by this disease.

Confronting noncommunicable diseases

As countries of the Region continue their efforts to control communicable diseases, there are clear signs that noncommunicable diseases are assuming serious proportions. With increasing life expectancies and marked changes in lifestyles, the past two decades have seen a sharp increase in cardiovascular diseases, diabetes mellitus, hypertension, and cancers. For example, nearly 10-15% of the adult population are already affected by hypertension in countries such as India, Indonesia and Thailand. Violence, traffic and work-related accidents, and mental disorders, as well as problems related to substance abuse, are also increasing. Diseases and deaths attributable to tobacco use are a cause of serious concern.

By 2020, according to some estimates, noncommunicable diseases are expected to account for seven out of every ten deaths in developing regions, compared with less than half today - from 47% of the total mortality burden to almost 70%. Some countries have adopted an integrated approach for the control of major risk factors common to many noncommunicable diseases, such as the use of tobacco and alcohol, lack of physical exercise, and imbalanced diets.

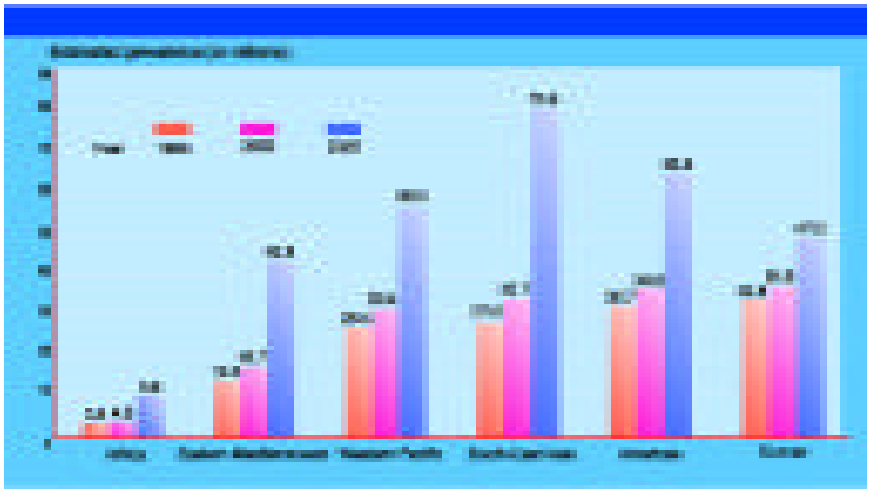
With the health services fully occupied with tackling communicable diseases, many countries in the Region are finding it difficult to cope with the added burden of noncommunicable diseases. With government-run health facilities already stretched to the limit, people have little option but to turn to the private sector.

In the late 1990s, the term "health expectancy" came into use within the context of higher life expectancy. This emphasis on health expectancy calls for not only adding years to life, but also enhancing the quality of life by preventing disability due to chronic conditions. For the Region, this is particularly relevant considering the steady growth in the elderly population and the increasing incidence of noncommunicable diseases.

During the last two decades, while mortality due to ***cardiovascular diseases*** has steadily declined in developed countries, the same has not happened in the developing world. In 1998, almost 17 million deaths globally were estimated to be due to cardiovascular diseases - 78% of them occurring in developing countries. The increase in these diseases is expected to continue in most countries of the Region. In fact, in countries where life expectancy is over 60 years, cardiovascular diseases are already a leading cause of mortality.

Of the estimated seven million new cases of ***cancer*** and five million deaths annually, developing and developed countries share the burden about equally. With improvements in life expect-ancy, however, the incidence of mortality from cancer is expected to increase substantially in the developing world. In fact, it is projected that by 2015 two-thirds of all cancer cases will occur in developing countries.

Figure 9: Trend in the estimated prevalence of diabetes mellitus by WHO Region



Source: WHO Geneva, *World Health Report 1997*

This trend can already be seen in the South-East Asia Region. In Thailand for example, the registered prevalence of cancers increased from 392 per 100,000 population in 1986 to 665 in 1996. The reported death rate for cancers more than quadrupled during the last three decades - from 12.6 per 100,000 population in 1967 to 51.7 in 1996. Neoplasms ranked fifth among the leading causes of deaths in hospitals in Sri Lanka in 1996, and around 4% of hospital inpatients in Indonesia suffered from cancer.

In India, at any given period of time, there are estimated to be about 2.5 million cases of cancer. Nearly 700,000 new cases are detected every year. Tobacco, which is widely used in India as well as in other countries of the Region, is a major cause of cancer. For example, a significant proportion of oral cancers in the Region are directly related to tobacco use.

What adds to the cancer burden, apart from the high cost of treatment, is the severe shortage of facilities for the screening and proper management of patients. With the help of NGOs, appropriate strategies are being developed, including public awareness campaigns, tobacco control mechanisms, and the application of self or assisted screening techniques for detection of oral, cervical and breast cancers. Within this context, the training of relevant health personnel about early detection of pre-cancerous conditions, the development of palliative care services, and the strengthening of referral facilities, have assumed added importance.

Until a few decades ago, it was generally thought that ***diabetes mellitus*** was a problem primarily in developed countries. With changing lifestyles and dietary habits, diabetes mellitus has emerged as an important public health problem in the Region, affecting an estimated 32.7 million people. Even more disconcerting

is the projection that, by 2025, there will be an almost 70% increase in the number of cases of diabetes in developing countries. The increase in developed countries over the same time period is projected to be about 42%. In the South-East Asia Region, it is estimated that there will be almost 80 million diabetics in 2025, the highest among all six of the WHO Regions.

The estimated prevalence of diabetes mellitus in adults in countries of the Region ranges from 2% to 4%. Contrary to trends in developed countries, where the majority of diabetics are 65 years or older, most diabetics in the South-East Asia Region are between 45 and 64 years of age - the more economically productive age group.

While efforts are being made to create public awareness about preventive measures, the real dimensions of the problem are not known to the majority of people. As a result, there is inadequate awareness about existing interventions for preventing diabetes and about the management of complications.

Diabetes mellitus in children is also a serious problem in some countries of the Region. Because of the lack of adequate medical care including the availability of insulin, nearly 45% of the world's deaths among diabetic children aged 0 to 14 years in 1990 occurred in India alone. A major challenge in the control of diabetes is to involve people in self care. This has to be done on a sustained basis, using all available media to stress the importance of healthy lifestyles, including appropriate diet and exercise.

Disability and rehabilitation

Reliable data on the magnitude of the disability burden in countries of the Region are not available. However, various surveys indicate the prevalence to be between 3% and 10%. The prevalence of severe mental disorders has been estimated to be five per 1000 population in some countries. The increasing number of disabilities due to road traffic accidents, occupational injuries and degenerative diseases poses new challenges to rehabilitation services.

To meet the situation, countries are emphasizing the prevention of disabilities and the integration of rehabilitation services within the general health care infrastructure. Many countries of the Region are also promoting the use of available rehabilitation technologies to enable the disabled to lead meaningful lives. Considerable efforts have been made by countries to create public awareness about disability issues, including the rights of the disabled, and to promote community-based rehabilitation through intersectoral efforts.

In the mid-1970s, there were an estimated seven million ***blind*** persons in the Region. According to the latest available figures, the Region accounts for nearly 15 million blind people, or one-third of the global total. Cataract, trachoma, xerophthalmia and glaucoma are the leading causes of blindness in the Region.

Childhood blindness is also a cause for concern in the Region. It is estimated that 1 in 1000 children under 16 years of age in Asia suffers from childhood blindness. There are thus nearly 700,000 blind children in the Region - nearly half of the world's total. This means that every day about 220 children in countries of the Region lose their sight, and are relegated to darkness forever.

The major constraint in the provision of eye care services is the lack of adequate

health care infrastructure, appropriate human resources, and funds. The services that are available, are mostly confined to urban areas. Even though NGOs are playing very active roles in blindness prevention programmes, they are only able to cater to a small percentage of those in need.

In a Region with the numbers of elderly growing rapidly, the problem of cataract is bound to increase. Already, there is a heavy backlog of cataract patients awaiting surgery. To deal with all these cases would require 4000 operations per million population per year - presently, only 1800 operations are being performed. The gap between what is needed and what is available is evident.

In 1995 it was estimated that there were 120 million hearing-impaired people globally. A substantial proportion of these people live in the countries of this Region. However, data on ***deafness*** continue to be scanty and outdated. Some studies carried out in Bangladesh in 1986 revealed hearing impairments of 6.92% and 5.1% in rural and urban areas respectively. Otitis media was a major contributing factor to these hearing impairments. In India, a 1983 study revealed a prevalence of deafness of 6.9% in males and 6.7% in females in urban areas, and 11.2% in males and 10.2% in females in rural areas.

Among the reasons cited for the slow progress in the area of ear health is the acute shortage of trained personnel. For example, there were only 98 ear, nose and throat (ENT) surgeons for a population of 119.4 million in Bangladesh in 1995, while India had only 4,500 for a population of over 960 million in 1997.

The last decade has seen a significant increase in ***tobacco-related diseases*** and deaths globally. Tobacco kills about four million people every year, or one person every eight seconds. Of these deaths, nearly 600,000 occur in the South-East Asia Region. By the third decade of this century, smoking is expected to kill 10 million people annually worldwide - more than the total deaths from malaria, maternal and major childhood conditions, and tuberculosis combined.

In eight of the ten countries of the Region, tobacco is produced in commercial quantities. In fact, India and Indonesia rank third and seventh respectively among the 25 major tobacco producers of the world. Over 70% of the total tobacco production in the Region is consumed locally in various forms.

According to available data, it is estimated that the overall prevalence of tobacco consumption in countries of the Region ranges between 55% and 80% among adult men and between 3% and 71% among adult women. Over the past 20 years, the Region has seen the second highest growth rate (2-8%) in per capita cigarette consumption among the six WHO Regions. Among 40 countries surveyed by WHO in 1989, three countries of the Region - Nepal, Bangladesh and Thailand - were among the ten countries having the highest adult female smoking rates, at 58%, 20% and 13% respectively. The last few years have also seen a sharp increase in tobacco consumption among youth and adolescents, with some starting to smoke as young as 10 years.

Governments have undertaken several measures to counter the promotional activities launched by tobacco manufacturers through extensive advertising campaigns and sponsorship of sports and cultural events. These include intensive public awareness campaigns using the *World No Tobacco Day* as a focal event. Advocacy for healthy public policies has included the development of national strategic plans, bans on tobacco advertisements on government media, reducing access to minors, special taxes on cigarettes, and crop substitution efforts. As a result of such initiatives, many countries have banned smoking in public places, on public transport, in government institutions, and on domestic and international flights. Sales of tobacco products to minors and sales in close proximity to schools have also been prohibited in many countries.

With the launch of the *Tobacco Free Initiative* by WHO in 1998, efforts for a tobacco-free world received a welcome boost. In January 2000, the WHO Director-General, Dr Gro Harlem Brundtland, along with the Regional Director for South-East Asia, Dr Uton Muchtar Rafei, launched a regionwide advocacy campaign by lighting the South-East Asia Anti-Tobacco (SEAAT) flame. The flame will travel to all countries of the Region, returning to New Delhi in May 2001.

Promoting health

Health education has come a long way from its “victim-blaming” days. It had previously been associated mainly with the production of posters and pamphlets, and with telling people how they, themselves, were to blame for their ill health. With the Alma-Ata Declaration identifying primary health care (PHC) as the key approach to achieve *health for all*, and with health education receiving a prominent place among the eight essential elements of PHC, this discipline came into its own.

Health education has now become an essential part of most health development programmes in all countries of the Region. Gradually, it has also become an integral component of health promotion activities. These in turn received a boost with the adoption of the Ottawa Charter at the first international conference on health promotion in 1986. The charter called for a new public health policy by reaffirming social justice and equity as prerequisites for health, and advocacy, enablement and mediation as the strategies for their achievement.

Of the 4.4 billion people in developing countries:

- *nearly three-fifths lack basic sanitation*
- *one-third have no access to clean water*
- *one-quarter lack adequate housing*
- *one-fifth have no access to modern health services*

The spirit of the Ottawa Conference was carried forward at the second international conference in Adelaide in 1988 and the third in Sundsvall in 1991. At these conferences, *healthy public policy* was characterized as an essential tool for creating a *supportive environment* to enable people to lead healthy lives. At the Sundsvall conference, the term "environment" was considered in its broadest sense, including social, political, economic, cultural as well as physical dimensions. Since these conferences, health promotion efforts have gathered considerable momentum. There has been an increasing recognition of the direct link between certain psychosocial and environmental factors, personal behaviours and ill health.

Over the past decade, countries of the Region have intensified their efforts to address critical health problems and social issues. Activities related to maternal and child health and the control and prevention of communicable and noncommunicable diseases have received intensified health promotion inputs. Countries have also successfully implemented programmes to promote health in different settings, such as schools, communities, workplaces and hospitals. Partnerships with the private sector, particularly in the areas of health promoting workplaces, have been strengthened. Alliances with NGOs and bilateral agencies have paved the way for increased investment in health development, and improved the access of communities to health information and services.

In 1997 at the fourth international conference on

health promotion in Jakarta, directions and strategies to meet future health challenges were defined. The Jakarta Declaration, *Leading Health Promotion into the 21st Century*, included the following priorities: promoting social responsibility for health, increasing investments for health development, consolidating and expanding partnerships for health, increasing community capacity and empowering the individual, and securing an infrastructure for health promotion. The spirit of this declaration is reflected in the 1999 World Health Assembly resolution which sets out the mechanisms for realizing the vision of health promotion in the 21st century.

Sustaining a healthy environment

The past two decades can appropriately be described as the "browning" of the Region. This has largely been due to uncontrolled urbanization and industrialization, and wanton deforestation in most countries. Much of the degradation is visible in large cities, with their congested roads, choked sewers, and polluted air. The once-green vegetation has gradually taken on a mottled grey hue as a result of unchecked vehicular emissions.

Countries have, however, in keeping with various global initiatives, made concerted efforts to address these issues. One of their principal aims has been to extend the provision of safe drinking water and sanitation facilities to the maximum number of people. This is particularly important, considering the substantial proportion of diseases in the Region that are water-borne.

While drinking water is now available to more people in both rural and urban areas, its safety is not always assured. For many millions in the Region, drinking water remains scarce and has to be carried over long distances. Surface and groundwater resources are being increasingly polluted due to municipal, industrial and agricultural wastes, including pesticides.

In certain parts of India and Bangladesh, arsenic contamination of the ground-water has assumed serious dimensions. Measures to urgently address the problem are being devised with support from WHO and other agencies. Similarly, some countries are also tackling problems arising from high contents of fluoride in groundwater used as sources of drinking water.

With the involvement of environmental activists, there is a growing awareness of the direct links between the environment and health. An added momentum was provided to national efforts when WHO selected environmental health as the theme for the 1990 *World Health Day*. The slogan, *Our Planet, Our Health: Think Globally, Act Locally*, underscored the need to preserve the environment and thereby protect human health.

The importance of and need for intersectoral action to address environmental issues has been widely accepted. In several countries this has resulted in *healthy city*, *village* or *island* programmes, undertaken with the active participation of communities. This approach was initiated by WHO in the late 1980s. Programmes launched under this initiative have been recognized as effective means for improving urban health and environment, particularly for low-income populations. The underlying concepts of such programmes are intersectoral collaboration, supportive environments for carrying out activities, and participation from development sectors, local authorities, the private sector, NGOs and communities themselves.

Ensuring women's health

Although girls and women comprise about 50% of the population, it is only recently that women's issues are being given priority attention by health planners and policy makers. The focus on women's health and its multiple determinants has led to a gender approach to health and development being advocated and understood on a wider scale. This approach has, in turn, led to greater attention on the gender-based inequalities that adversely affect women's health as well as that of their children and families.

Girls up to nine years of age form over 23% of the total female population of the Region. Due to prevailing sociocultural and economic conditions, many of these girls have limited access to food, education and health care. Many also suffer from malnutrition, anaemia and worm infestations. All of these factors profoundly affect their health in their reproductive years, when, in addition to the pangs of growing up, they face early marriage, early pregnancy and life threatening health risks.

Reproductive health has been defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Over one-third of all healthy life lost in adult women in the developing world is due to reproductive health problems, as compared to only 12% in men. In the past, reproductive health strategies in the Region primarily focused on maternal health.

However, although there have been marked decreases in infant and child mortality in all countries of the Region, the same is not true for maternal

mortality. Complications of pregnancy and childbirth still contribute to high maternal mortality in most countries, and the proportion of deliveries attended by skilled personnel is less than 20% in some. The lifetime risk[6] of maternal death ranges from *1 in 9* to *1 in 500*. These indicator values reflect the varying social status of women as well as their access to essential obstetric care.

Within this context, an important development has been the formulation of a regional reproductive health strategy. The strategy defines an essential reproductive health care package to address problems related to sexual and reproductive health throughout the life cycle. It focuses on high priority problems within the reproductive age group. Based on the regional framework, countries have developed and are implementing national strategies.

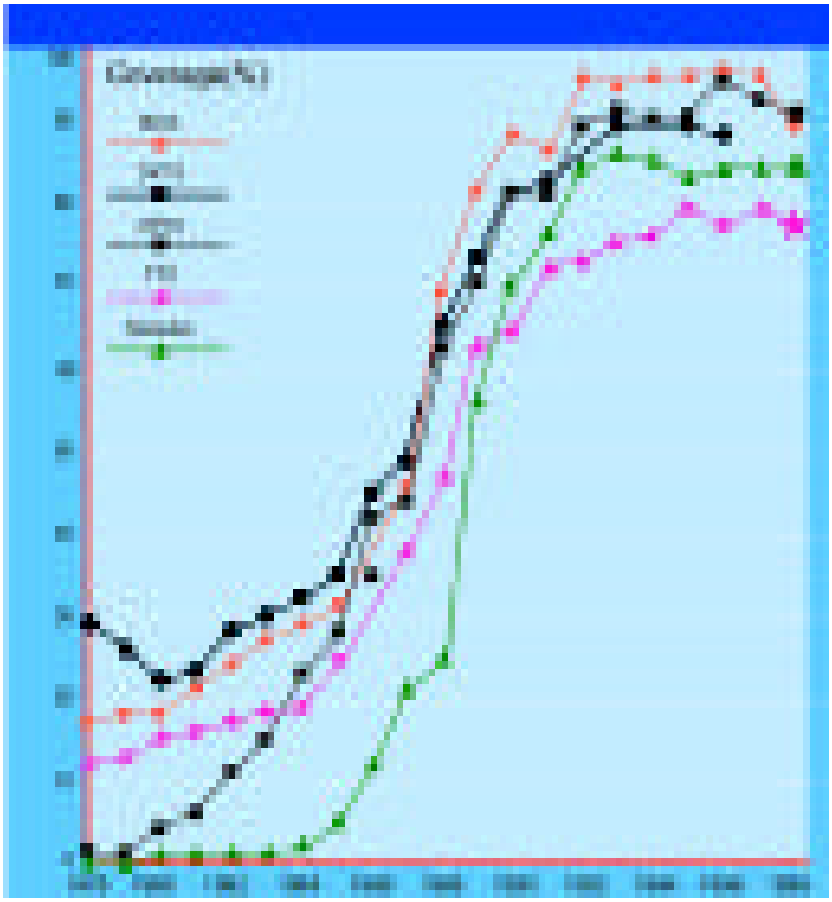
In close collaboration with countries, *Standards of Midwifery Practice for Safe Motherhood* have been developed to improve the quality of maternal and newborn care. Field tests have revealed that using the standards has helped to enhance the competence of midwifery trained personnel and to increase client satisfaction in the Region. It has also facilitated improvement in the quality of midwifery services.

Reproductive problems are not the only health risks women face. Malaria, tuberculosis, sexually transmitted infections including HIV and diseases such as diabetes and cancer also take a heavy toll. Women in developing countries are known to be more malnourished than men. This results in their giving birth to low birth weight babies. In 1990-94, for example, the proportion of newborns weighing less than 2500 grams ranged from 13% to 50% in countries of the Region. Of the more than 600 million people in the Region affected by iron deficiency anaemia, adolescent girls, women of reproductive age and young children form the largest group.

[6] The lifetime risk of a woman dying from pregnancy-related causes

Since the Fourth World Conference on Women, held in Beijing in 1995, women's health issues are increasingly being included in development agendas. In the South-East Asia Region, women's health programmes promote the integration of a gender perspective in both WHO and national health programmes. They also promote the development of health policies, programmes and research to address priority issues. To further strengthen these activities, a technical unit for women's health was established in the Regional Office in 1997.

Figure 10: Trends in immunization coverage in the Region



DPT3 Diphtheria, pertussis (whooping cough) and tetanus (third dose)
OPV3 Oral polio vaccine (third dose)
BCG Bacillus Calmette-Guerin (anti-tuberculosis vaccine)
TT2 Tetanus toxoid (second dose)

Source: WHO/SEARO, EPI unit

The *Declaration on Health Development in the South-East Asia Region in the 21st Century*, while identifying the health challenges in the Region, stated that gender inequities, generally due to political, economic and societal forces, hinder development. In some countries of the Region, this has at times led to serious deprivation of girls and women. Recognizing that women's health throughout the life span is far from satisfactory, the declaration reaffirmed the Health Ministers' commitment "to the ethical concepts of equity and social justice, and in particular to ensuring gender equity, as fundamental to the sustainable pursuit of health for all".

Protecting children's health

Accounting for nearly one-third of the population, the health of children below 15 years has always received the priority attention of health professionals in the Region. Within this age group, children under five years are the most vulnerable to disease and death. About 70% of all childhood deaths are due to diarrhoea, pneumonia, measles, malaria and malnutrition. During the 1980s, efforts in child health were intensified. During this period, further reductions in infant and child mortality were achieved through high immunization coverage and increased access to oral rehydration salts.

Since 1977, when activities under the expanded programme on immunization (EPI) were initiated in all countries of the Region, significant progress has been achieved in vaccination coverage. As a result of concerted efforts by Member States, routine immunization coverage against measles, tuberculosis, neonatal tetanus, poliomyelitis, diphtheria and pertussis has remained at high levels since the late 1980s (Figure 10). The organization of synchronized national immunization days by neighbouring countries and other related national activities are bringing the eradication of poliomyelitis within reach.

The programme for the control of diarrhoeal diseases was launched by WHO in 1978. The South-East Asia Region soon became a pioneer in promoting oral rehydration therapy (ORT) and standard case management of diarrhoea. During this period, several studies were initiated in the Region to help refine diarrhoea control strategies. For example, it was shown that children with acute diarrhoea who receive nearly all of their normal dietary requirements from the first day of rehydration therapy have a better clinical and nutritional outcome than those fed more cautiously. Simultaneously, WHO identified exclusive breast-feeding during an infant's first 4-6 months as an important factor in reducing both diarrhoea incidence and mortality.

It is estimated that acute respiratory infections (ARIs) are responsible for a substantial proportion of child mortality, for 30% to 50% of child morbidity, and for about 40% of consultations with physicians or other health care providers. Programmes initiated during the past several decades to control acute respiratory infections have helped to reduce the number of infant and child deaths. The emphasis has been on managing cases effectively, educating mothers and other caretakers on preventive measures, and on reducing the inappropriate use of antibiotics and other drugs.

Experience in the Region has shown that sick children often have symptoms related to more than one condition. This makes it difficult to arrive at a diagnosis and to prescribe treatment that would effectively address the overlapping conditions. These could be related to undernutrition, low birth weight, anaemia and worm infestations. Recognition of this situation led to the integrated management of childhood illnesses (IMCI).

Targeted at sick children from one week to five years of age, IMCI is proving to be highly cost-effective. This approach helps to provide effective treatment and facilitate the promotion of child health.

Imagine a world without immunization

- Nearly four out of every 100 school-aged children would be disabled by poliomyelitis.
- Almost all children would contract measles.
- Measles would kill two children out of every 100 cases in the developing world.
- Measles would kill 10 or more children out of every 100 cases in malnourished populations.

Through IMCI, mothers are actively involved in efforts aimed primarily at preventing deaths due to pneumonia, measles, diarrhoea, malaria and malnutrition. The focus is on early recognition and prompt treatment or referral, and on counselling caretakers on feeding, immunization and follow-up care. The emphasis on improving the skills of health workers, strengthening health systems, and involving family and community members in promoting child health as well as in the care and treatment of sick children has contributed substantially to the success of this approach.

Improving nutrition

Malnutrition has been a serious concern in the Region for several decades. Though improvements have been noted in some countries, the Region still accounts for a significant percentage of the world's malnourished children. Protein-energy malnutrition and micronutrient deficiencies constitute the major forms of nutritional disorders.

Iron deficiency is the most common cause for anaemia in the Region, with over 600 million people affected. Predominant among those affected are young children, adolescent girls, and women of reproductive age.

The South-East Asia Region accounts for a large proportion of the world's cases of iodine deficiency disorders. More people are affected with higher levels of severity compared to any other WHO Region. It is estimated that almost 600 million persons live in iodine-deficient areas and are at risk, and about 172 million of them are likely to suffer from goitre.

Vitamin A deficiency is a public health problem in many countries of the Region. It is estimated that 125 million children under five years are currently at risk, and 1.3 million are reported to be vitamin A deficient. They are therefore at 20 times greater risk of death from severe infections like measles, diarrhoea and pneumonia. The countries are taking various public health measures, including health education, to encourage the intake of carotene rich foods, particularly green, leafy and yellow vegetables.

Over the years, WHO has supported countries in their efforts to strengthen national nutrition programmes. Ensuring the safety of food and water, through multisectoral action and community involvement, is key to the success of these programmes. The result of the countries' sustained efforts are now being seen. The incidence of iodine deficiency disorders, for example, the most important and preventable cause of mental retardation, has shown a remarkable decline in some countries of the Region. This has been possible by, among other measures, making iodized salt readily available to the people.

Nutritional status and health are, in fact, closely linked. Studies suggest that as much as 30% of the estimated per capita economic growth rate in the UK between 1870 and 1979 might be associated with improvements in health and nutritional status. Studies in the Region also support this close linkage. In Indonesia, for example, it was reported that anaemic men were 20% less productive than non-anaemic men.

Another nutritional aspect that merits attention is obesity. With new urban-based lifestyles, "fast food" diets, and low levels of physical activity, a higher occurrence of obesity is seen, as well as of related chronic disorders including coronary heart diseases, diabetes mellitus and hypertension. According to recent reports, 9-19% of children aged 19 years or less in Thailand were obese, and 20-30% of adults had a body mass index[7] (BMI) of more than 25 - indicative of overweight. Surveys in India recently showed that 6.6% of adult women were overweight.

[7] Body mass index is a measure of body mass relative to height, calculated as weight in kilograms divided by the square of height in metres.

The Future : Moving into the 21st Century

In gauging the future health situation in the Region, clues can be taken from the past as well as from the present. Some predictions can also be based on the achievements made so far, and the foundations that have been laid.

Ideally, in the years ahead, people will be living in a healthy environment, with access to basic health services, education, safe water and sanitation, adequate and safe food, as well as appropriate housing. The South-East Asia Region, presently a major contributor to the global disease burden, should emerge among the healthier Regions in the world.

In keeping with the historic resolution adopted by the World Health Assembly in 1977, calling for *health for all* by the year 2000, it is expected that at least the basic targets set will soon be achieved. Most importantly, it is hoped that the twin principles of equity and social justice will guide policy makers when they formulate and implement policy directives to achieve better health for all.

Urgently needed is a political and social climate which facilitates good governance in health. Access to health care must be guaranteed. At the same time, it should be ensured that essential public health services of the highest quality are available to all people. This would mean an opportunity *for all* to be healthy, with a clear recognition that respect for the dignity of individuals and communities, as well as sensitive and appropriate responses to their needs, are central to human development.

The *Declaration on Health Development in the South-East Asia Region in the 21st Century* has clearly spelt out the foremost challenges to the Region's health. These include closing the gaps in accessibility to health care by ensuring basic health services to all, especially the poor, women and other vulnerable groups, creating conditions that promote health and self-reliance, upholding and enforcing health ethics, and placing health at the centre of development.

When adopting the declaration, the Ministers of Health of the Region recognized the vital role of WHO as the lead international agency for

health. They urged WHO to continue to work towards an understanding of the interactions between health and development, of the factors which lead to inequities in health, and of the directions to be taken in response to these challenges.

The most crucial challenge facing health professionals will be to find effective ways to reduce the gap between the health infrastructure and the demand for health care - both quantitatively and qualitatively. Related to this will be the challenge of financing health services - defining who will pay for what. Considering that private sector participation in health care will increase, it will be essential to ensure some balance between the cost of services and their affordability and accessibility, especially to the poor. The growth of the not-for-profit sector will be necessary, especially in the form of small scale, community owned and driven enterprises.

Declaration on Health Development in the South-East Asia Region in the 21st Century

This declaration was adopted by the Health Ministers of countries of the Region in September 1997, and endorsed by the Regional Committee at its 50th session. The declaration calls for actions on various fronts to effectively achieve its objectives. These are to:

- Accord the highest priority to alleviate the burden of disease, disability, premature death and suffering afflicting the people, especially the poor.
- Ensure universal access to quality health care.
- Invest in women's health and development to eliminate gender discrimination and disparities.
- Mobilize financial resources for health and promote their effective use.
- Involve communities as active partners in health development.
- Propagate and preserve medicinal plants and promote traditional medicine.
- Ensure quality health programmes for children and families.
- Strengthen existing partnerships and forge new ones for health development.
- Prevent health hazards that may result from development efforts.
- Ensure adequate nutrition.
- Advocate intensively for health.
- Uphold and enforce health ethics.
- Ensure the quality and social relevance of education and training for health personnel.
- Strengthen epidemiological surveillance and health information.

It is in this context that the need to foster and strengthen partnerships in health assumes a new meaning. Partnerships can be used as springboards for effective health action. They can also enable people to recognize the powerful contributions that health can make to development efforts, and in fact, to improving the quality of life.

Lakshmi's Story

Lakshmi can be called a *health for all* baby. She was born in 1977 - the year the World Health Assembly adopted the resolution on health for all by the year 2000.

When barely three years old, Lakshmi contracted polio. To her parents, this was a cruel blow indeed. But, as many others in similar situations, they accepted it as their destiny.

Lakshmi's mother recalls that her daughter wasn't the only child in their slum who had polio - there were several others. When Lakshmi's younger brothers and sister were born, her mother made it a point to have them immunized. Today, they are healthy young adults, studying and learning a vocation.

Lakshmi, now a confident young woman, recounts how her life took a dramatic turn when her mother, through a friend, took her to an NGO working for the rehabilitation of the disabled in Delhi, India. "I literally crawled on all fours when I first came to Amar Jyoti as a four-year old", says Lakshmi. Soon, she was fitted with braces, given crutches and provided gait training. She also underwent regular physiotherapy. Within weeks of this meticulous attention, Lakshmi became independently mobile. For her family and the neighbourhood, this was a miracle. Other, bigger miracles were to follow.

From a shy, withdrawn and feeble child, Lakshmi gradually blossomed into a bright, confident girl, lovingly supported by the staff and students at Amar Jyoti's integrated school. Upon completion of the eighth grade, she decided to undergo the training in watch repairing offered at the institution. After six months' training, Lakshmi became a watch repairer. Meanwhile, she enrolled as a student in the National Open School and completed 12th grade.

Today, Lakshmi happily commutes from her home to work on a motorized tricycle obtained from the institution through a donation. On her way, she readily gives lifts, "but only to girls and women", says Lakshmi. Lakshmi's transformation from a person who was only seen as disabled, to a confident, independent young woman, earning more than many in her neighbourhood, has changed the entire concept of disability in her community.

Recently, Lakshmi was sponsored for a short course in hairdressing and beauty culture run by one of Delhi's leading professionals. Her dream is to start a parlour of her own and provide free training to disabled girls. "I would also like to do something for others. After all, I have received so much", she says gratefully.

Like any other young person of her age, Lakshmi too is thinking of a family of her own, of setting up a home. Has she found someone suitable? The deep blush on her face and her shy smile are answer enough.

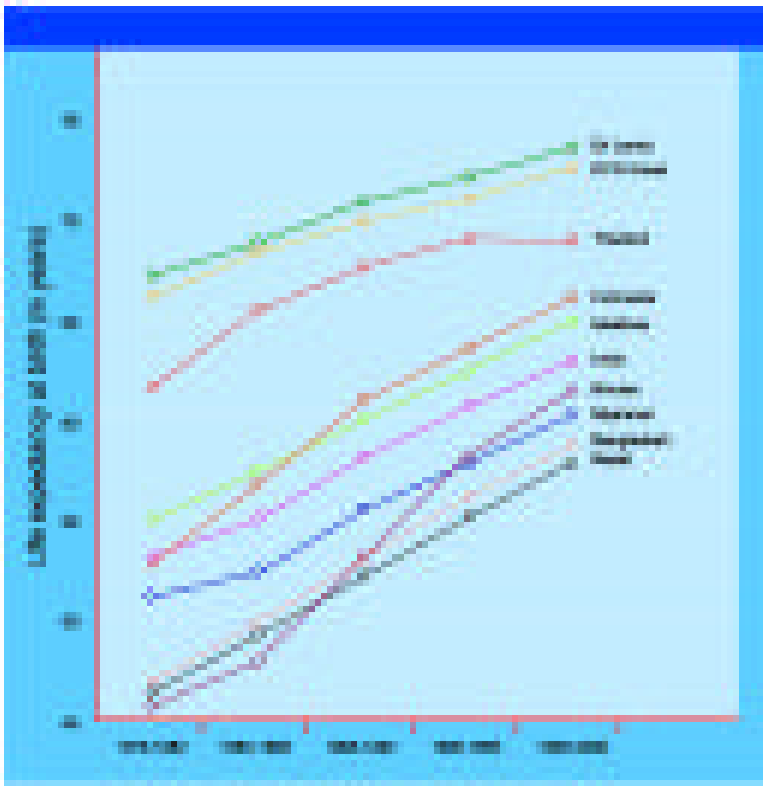
As enumerated in the Regional Health Declaration, the rich heritage of indigenous systems of medicine in the Region need to be integrated into the mainstream of health care. Traditional systems that provide relief, that are scientifically proven to be safe, and that are easily available, accessible and affordable, must be promoted. This would also help to ease the burden on health services and provide a boost to systems that have been tried and tested over centuries.

It is clear that, after over two decades on the road to *health for all*, countries of the South-East Asia Region have overcome tremendous odds and achieved remarkable results. Their achievements are vividly depicted by the increase in life expectancy in every country.

New heights were scaled, breakthroughs were made. Many declarations were adopted, summits held, problems identified, and solutions suggested.

Yet, when reviewing the balance sheet on health, it can be seen that, on the one hand, the *haves* seem to have gained substantially from their better socioeconomic conditions. They can now avail of the most sophisticated medical facilities at home, without having to travel abroad.

***Figure 11*:** Trends in life expectancy at birth by country



Source: UN, World Population Prospects, The 1998 Revision, Volume I: Comprehensive Tables

On the other hand, many millions can still only dream about the day they will get safe water at home, send their children to school, obtain medical help close to their homes, and not see their loved ones die prematurely from preventable causes. Only when these dreams become reality, can the quest for better health in the Region forge ahead.

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