

# ***Opening Remarks by***

***Dr Samlee Plianbangchang  
Regional Director, WHO South-East Asia***

***At the***

***Regional Meeting on Primary Health Care Approach in  
Emergencies***

***28-30 September 2010,  
Dhaka, Bangladesh***

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Prof. Dr Syed Modasser Ali, Health Adviser to the Prime Minister, Dr Capt. (Retd.) Mozibur Rahman Fakir, State Minister for Health and Family Welfare, Mr Humayun Kabir, Secretary, Health and Family Welfare, Prof. Shah Monir Hossain, Director-General, Health Services, distinguished participants, representatives of international agencies, honourable guests, ladies and gentlemen,

On behalf of the World Health Organization, I am pleased to welcome you all to the “Regional Meeting on Primary Health Care Approach in Emergencies”. At the outset, I would like to gratefully thank the Government of Bangladesh for kindly accepting to host the meeting.

It is timely to discuss this topic in view of our efforts to revitalize primary health care (PHC) in the South-East Asia (SEA) Region and in view of the increasing “frequency” and “severity” of emergencies due to disasters.

A number of regional meetings in the area of PHC have been organized during the past two years, and “innovations” in the PHC approach have been developed in several countries.

In Bangladesh, the government's scheme on "community health clinics", aiming at universal access to health services, especially in rural areas, has been a "laudable development". At this gathering, we will capitalize on what has come out from our experiences in revitalizing PHC. We will also see how the PHC approach can help protect the "affected population" when disasters strike and how it can help ensure availability of necessary health services; before, during, and after any emergency. Not only do they cause death, disasters also threaten lives by increasing the risk for disease; decreasing food security; diminishing access to basic services; and endangering water safety.

We all know that the SEA Region is prone to disasters and we know that climate change is increasing the possibility of disasters. All countries in the Region are affected by climate change. During 1999 to 2008, about 62% of the total global deaths from natural disasters took place in the SEA Region.

During the same period, the number of disasters in Asia represented around 44% of the reported events worldwide. Some examples in the recent past show that several major disasters in the SEA Region impacted country development.

For example, the devastating Tsunami of 26 December 2004 contributed to an estimated 230000 deaths and "missings", and contributed to losses, estimated at several billion US dollars.

In 2007, cyclone Sidr hit Bangladesh, resulted in an estimated 3000 deaths and losses totaling about 1.7 billion US dollars.

In 2008, cyclone Nargis struck Myanmar, and resulted in about 134000 deaths or “missings” and losses of about 10 billion US dollars. In these crises, the existing “inequities” in both social and economic terms were amplified. New social and public health problems emerged. The already prevailing health problems were aggravated. Sadly, the people who are hit the hardest are the vulnerable; including the poor, women, children, handicapped and the elderly. This is an important humanitarian issue.

“Universal coverage” in “humanitarian health action” during crises is needed. This action includes the provision of a package of necessary services that are extended to “all affected areas” in an “equitable manner”. Adopting the “Primary Health Care approach” means putting people at the core of humanitarian action – action that can ensure effective health protection through promotion of community participation and intersectoral collaboration; “community-enhanced resilience” during emergencies; and the ability of people in the community to make appropriate choices of action.

Protecting health, livelihoods and assets during the “response phase” of emergency and addressing the root causes of crisis in “recovery phase” provide a better chance for “sustainable impact” from emergency management efforts. With limited outside help during the first week of the crisis, coordinated response from community and local government determines the positive outcome of the efforts.

Health of “affected people” during crises relies on the capacities of health systems to effectively address emergency health needs. Applying the PHC principle has proven to be the best strategy, and cost-effective investment in health in “any situation”. This is not only to ensure “equitable access” of population to essential “quality health care” but also to reduce “vulnerabilities”, and enhance “resilience” of communities.

Additionally, the PHC principle will eventually promote and ensure “self determination” and “self-reliance” of people in community and as a consequence, it will reduce “dependence on external assistance”. Humanitarian health action is not just meeting the basic needs in the “short term” but rather a means to promote “social justice in health”, and to fulfil the “fundamental right to health” in the “long term”.

The success of humanitarian health action depends on strong implementation of the PHC approach. Preventive measures through primary health care with well planned preparedness are more cost-effective than action in response to the damage that is already done.

The cost generated by the increasingly frequent natural disasters is one of the most important lessons that warrant more investments in PHC as it emphasizes prevention while maintaining a good balance with treatment.

Several examples of commendable results from implementation of the PHC approach during an emergency have been demonstrated and witnessed; in the 2004 Tsunami – effective and urgent interventions during the first hours of emergency by

trained health volunteers in Thailand and Indonesia; and in Cyclone Sidr in Bangladesh where community-based actions took place in response to “early warning” and “evacuation”.

In these events we saw the strength of combined efforts of various sectors with civil society, NGOs and private sector; the coordinated and synchronized actions on the ground multiply “community capacities” in preparedness and response. Although these sound simple, the challenges are immense, and take time to turn such thoughts into practice at the ground.

There are several fundamental constraints like inappropriate policy that focus es mainly on “response” rather than “preparedness”; change that drives focus away from community involvement and actions; unavailability of “community-based workers” or “volunteers”; lack of capacity in community to respond effectively to an emergency situation; inadequacy of information systems relating to “early warning” and “surveillance”; and inefficient coordination at both national and subnational (field) levels.

These are some of the main challenges that are faced in adopting the PHC approach in emergencies. However, it is important also to look at the “positive aspects ” for our future endeavours. The disasters that occurred during the recent past have actually brought about “greater awareness” at various levels; awareness of how “community resilience” can be improved through strengthening of “health systems based on the PHC approach”, through empowering people in the affected community to

be able to mobilize the local resources, especially human resources, for helping themselves during the first 24 hours of an emergency.

In several countries in the Region, individual sectors take emergency action during crises according to their respective responsibilities. “Disaster risk reduction” and “emergency health preparedness” are considered integral parts of “health systems”. “Health systems based on PHC” are used to build community resilience and resistance to devastation and “Health Systems based on Primary Health Care” are providing concrete “foundation” for effective “emergency preparedness” and “response”.

Planning for health in “disaster management” needs to aim at “inclusive and participatory” involvement; and key “preparedness strategy” also includes “development” of “self care”; especially at individual, family and community levels. Preparedness strategy includes the important component of improvement of “knowledge” and “communication skills” of “community-based health workforce”.

The issue of equity is fundamental to the development of disaster preparedness and response plans. With this perspective in view, we can see that there are numerous opportunities to achieve our aim in this challenging area.

Through sharing of our experiences, we will be able to help each other find effective means and ways to move forward. This meeting is a platform for exchange of information and learning together so that the “best practices” can be applied and adapted within our own countries’ social, cultural and governance systems.

Let us also work tirelessly in empowering our people through the PHC approach, for them to be able to help themselves effectively during the first hours of crisis.

With these words, ladies and gentlemen, I wish you all “fruitful deliberations” during the course of this important meeting.

Thank you.