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The Conference of Partners for Health in South-East Asia held in New Delhi from the 16-18 March 2011 was a resounding success. This was primarily due to the high-level participation and engagement of a wide array of partners representing governments, multilateral and regional intergovernmental organizations, nongovernmental organizations, foundations, the private sector, media as well as research and academic institutions.

In plenary and parallel thematic sessions, partners engaged in lively discussions on the health priorities for the Region, as well as the roles and responsibilities of each in advancing these priorities. Participants from all over the world shared invaluable insights on the challenges and opportunities for effective collaboration in health, elaborated best practices and lessons learnt and explored innovative ways of working together to accelerate the achievement of health development goals.

The Conference was held at a particularly important juncture for health development globally as well as in the South-East Asia Region. Underpinning the three-day discussions was the acknowledgement by a myriad of partners of the threat to health development in the South-East Asia Region as a result of the global food, fuel, economic and climate change crises.

Throughout the proceedings, particularly in their recommendations, partners were mindful that the 11 Member States of WHO’s South-East Asia Region hold more than one quarter of the world’s population and bear a disproportionate share of the global burden of disease. The unacceptably high rates of maternal and child mortality and morbidity were the subject of several interventions, as was the growing burden to health systems and society, of noncommunicable diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and conditions like mental illness, injuries and disabilities. The heavy burden of infectious diseases and neglected tropical diseases was similarly addressed in various sessions.

The meeting culminated in the “Delhi Call for Action on Partnerships for Health”, a commitment to, amongst other things, create, revitalize and sustain partnerships through aligned and integrated action in consonance with national development priorities. The participants also rededicated themselves to achieving better and equitable health for the people of the South-East Asia Region and accelerate efforts to achieve the Millennium Development Goals through community empowerment and revitalization of primary health care.

The principles embodied in the Delhi Call for Action and the deliberations summarized in this Report are representative of the combined efforts, resources, knowledge, commitment and passion which are vital to help prevent the unnecessary suffering, morbidity and mortality and thereby promote the health of the peoples of South-East Asia.

Samlee Plianbangchang
Regional Director
Acronyms and abbreviations

ADB  Asian Development Bank
ALMA  African Leaders Malaria Alliance
ASEAN  Association of Southeast Asian Nations
BGMEA  Bangladesh Garment Manufacturers and Exporters Association
BPL  below poverty line
BRAC  Bangladesh Rural Advancement Committee
BRICS  Brazil, Russia, India, China and South Africa
CDC  Centers for Disease Control and Prevention
CSO  civil society organization
CSR  corporate social responsibility
DFID  Department for International Development (UK)
DOTS  directly observed therapy – short course
GAVI  Global Alliance for Vaccines and Immunization
GDD  the Global Disease Detection (network)
GDP  gross domestic product
GIPA  greater and meaningful involvement of people living with HIV/AIDS
Global Fund  Global Fund to fight AIDS, Tuberculosis and Malaria
H4+ Agencies  UNAIDS, UNFPA, UNICEF, WHO and the World Bank
HPP  healthy public policy
HRH  human resources for health
IHP+  International Health Partnership Plus
IIM  Indian Institute of Management
ILO  International Labour Organization
IMR  infant mortality rate
MDGs  Millennium Development Goals
MMR  maternal mortality ratio
MOU  Memorandum of Understanding
<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>MoVE-IT</td>
<td>monitoring of vital events using information technology</td>
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<td>MSM</td>
<td>men who have sex with men</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NHC</td>
<td>National Health Commission (Thailand)</td>
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<td>NHCO</td>
<td>National Health Commission Office (Thailand)</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>NTP</td>
<td>National TB Control Programme</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<tr>
<td>PEN</td>
<td>Package of Essential NCD (interventions)</td>
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<td>PPM</td>
<td>public–private mix</td>
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<tr>
<td>R&amp;D</td>
<td>research and development</td>
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<td>RBM</td>
<td>Roll Back Malaria</td>
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<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
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<td>SBA</td>
<td>skilled birth attendant</td>
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<td>SEA</td>
<td>South-East Asia</td>
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<td>SEAPIN</td>
<td>South-East Asia Primary Health Care Innovations Network</td>
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<tr>
<td>SWAp</td>
<td>sector-wide approach</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<td>TFR</td>
<td>total fertility rate</td>
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<tr>
<td>TRP</td>
<td>target rating point</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNIC</td>
<td>United Nations Information Centre (UNIC)</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WONCA</td>
<td>World Organization of Family Doctors</td>
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The World Health Organization (WHO) conference, “Partners for Health in South-East Asia”, was held in New Delhi from 16 to 18 March 2011. It was organized with a view to strengthen regional collaboration for health, encourage effective and sustainable partnerships between stakeholders, share best practices and highlight partnerships in action. The objectives were to review progress in achieving health-related internationally agreed development goals, including the Millennium Development Goals (MDGs), in the South-East Asia Region, and discuss collaborative efforts to address challenges and bottlenecks; identify priorities for common action in the South-East Asia Region; identify roles and responsibilities of partners in addressing countries’ health priorities; and leverage partner commitment to foster better collaboration.

The conference had over 350 high-level participants from the 11 Member States of the Region, donor countries, multilateral and intergovernmental organizations, civil society, foundations, the private sector, media as well as research/academic institutions.

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region, welcomed the participants. Mr Kalyan Banerjee, President-Elect of the Rotary Foundation of Rotary International, USA, spoke about Rotary International’s many years of support for polio eradication efforts and said that the partnerships created for this would extend well beyond polio. The message of Mr Yohei Sasakawa, Chairman of the Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination highlighted the activities of the Nippon Foundation in utilizing partnerships to end leprosy. Ms Erin Soto, USAID Mission Director, India, identified five challenges facing the health sector. Dr Analjit Singh, Chairman, Max India Limited, raised the issue of challenging the “conventional wisdom” of demand creating surplus, and noted that an increase in supply can lead to an increase in demand. He expanded on the important role of the private sector in health, and the success of many Public-Private Partnerships in India. Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, pointed out that many noteworthy achievements in health are now under threat because of several global crises. Countries of this Region are still struggling with a large burden of communicable diseases as well as neglected tropical diseases, even as the problem of noncommunicable diseases (NCDs) becomes larger. His Excellency Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, India, pointed to the impressive gains made by the Government of India in improving the health status of the population, largely through health systems strengthening.

Mr Arun Maira, Member of Planning Commission of India and Former Chairman of the Boston Consulting Group, India delivered a special address on Partnerships in
Health. He stressed the importance of thinking out of the box, and listed localization, lateralization and learning as three key areas. While partnerships are already working, they can and must work better, to meet both old and emerging challenges.

The plenary sessions viewed partnerships in terms of specific issues. Progress towards the Millennium Development Goals (MDGs) has been slow and inequitable in the Region, especially MDG 5 (improving maternal health), although some innovative public–private partnerships have worked well such as the Chiranjeevi Yojana Gujarat, India. Such schemes could be adopted elsewhere in the Region to improve access to life-saving maternal and neonatal services. The reasons for the slow progress toward MDG 5 include poverty, inadequate funding of the health system and gender inequality.

WHO’s role in setting standards and norms was recognized as an important element in contributing to the joint efforts towards achieving MDG 5. Global and regional partnerships play a critical role in supporting national governments and advocating for commitments from all.

The Region currently faces a double burden of communicable diseases as well as NCDs. To combat NCDs, the social determinants of health need to be addressed. Various government interventions are also needed, such as micro- and macroeconomic interventions, urban development, and harnessing the help of the media. The Regional Framework for Prevention and Control of NCDs targets the main modifiable NCD risk factors and focuses on surveillance, health promotion and primary prevention. NCDs should be included in the agendas of Heads of State and Government. NCDs are preventable, and cost-effective solutions are available. Innovative approaches to their control are needed.

The session on “Building health system capacity” recognized that better health depends on equitable access to the health system. Among the challenges in the Region are fragmented systems, difficulty in reaching disadvantaged and marginalized populations, and a critical shortage of the health workforce in some countries of the Region. At a deeper level, there is a very basic knowledge gap that inhibits evidence-based decision-making due to inadequate and underutilized health information systems. In many cases, data, especially on civil registration, such as births and deaths, is simply not available to inform policy- and decision-making and planning. The Health Metrics Network attempts to remedy this situation and has innovative partnerships that are active in this area.

Countries below a certain threshold of health worker density are highly unlikely to achieve an acceptable level of service coverage. The South-East Asia Region has six countries that do not have the required health worker density, though attempts are under way to remedy the situation. The Global Code of Practice on International Recruitment of Health Personnel creates an unprecedented opportunity for countries to work within a common framework and collaborate in tackling challenges related to health workforce migration.

“Health partnerships and collaboration: the imperatives of collective responsibility to address the health of the poor and vulnerable” identified some innovative partnerships and
alliances that are working well. These include The Wellcome Trust, the Roll Back Malaria Partnership, the Global Alliance for Vaccines and Immunization (GAVI) and the World Bank. Many different approaches to reaching the poor and vulnerable were discussed, such as reducing taxes and tariffs, working in areas with the highest chances of success, and balancing innovation with cost reduction. An example of best practice was the control of the HIV epidemic in India through focusing on those most at risk.

Examples of successful partnerships at ground level were discussed in “Partnerships in action: reporting from the field”. It brought in perspectives from diverse groups such as the Centers for Disease Control and Prevention (CDC), the Bangladesh Garment Manufacturers and Exporters Association (BGMEA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Organization of Family Physicians (WONCA), Department for International Development (DFID) and the Salaam Baalak Trust. Each of these has different kinds of partnerships with different kinds of communities: the corporate sector to sex workers to the family doctor. Public health, particularly preventive health care, should be strengthened – this is especially important for developing countries.

Parallel break-out sessions discussed best practices in diverse areas. The session on “Addressing child and maternal mortality” recommended that different constituencies (government, UN agencies, private sector and academia) should work to reduce child and maternal mortality in the South-East Asia Region through a coordinated approach that addresses several areas of concern. “Ensuring universal access to health services” suggested that prevention of road traffic accidents and NCDs must be put on the national health agenda of countries. The problems of alcohol and tobacco need to be urgently attacked to reduce the burden of NCDs. Education of women should be targeted as a key factor for the improvement of health outcomes. “Revitalizing primary health care” emphasized that decentralization can address health inequities and is dependent upon achieving good governance, forming productive partnerships at all levels of the community, implementing a comprehensive approach to pro-poor growth, improving public services and coordination among stakeholders, and addressing the social determinants of health. Health should be viewed as an investment and not an expenditure. The South-East Asia Primary Health Care Innovations Network (SEAPIN) was established in August 2010 to strengthen health systems in the Region through the primary health care approach and helps countries to “bootstrap” themselves.

“Integrated approach to prevention and control of NCDs” concluded that prevention and control of NCDs should be “piggy-backed” onto existing systems and included in school health programmes, instead of creating parallel systems. The Package of Essential NCD (PEN) interventions has been implemented in Sri Lanka and could be duplicated in other countries. Innovative approaches to tobacco taxation (“sin” tax) can help in promoting health, as seen in Thailand. NCDs should also be included in the MDGs so that they are prioritized. The session on “Health for the urban poor” suggested that urban slum clusters be mapped and listed. Speakers from
Indonesia and India shared their experiences in the area. Active community partnerships and empowerment would go a long way in addressing the unique problems of the urban poor and help reduce health inequities.

Another break-out session addressed the issue of “Protecting health from climate change”. During extreme events of climate change, health is directly linked with food, water, sanitation and livelihood crises. Partnerships may be the solution to some of our present-day climate-engendered problems. More evidence needs to be created in the health sector for convincing ministries of finance and donors to allocate funds to combat climate change-related problems.

“Public–private partnerships in health” was discussed by a range of panelists representing global alliances, academia, the government and corporate sector. Innovative public–private partnerships are critical for service delivery of health, product development, fulfilling corporate social responsibilities and research with academia. They should aim at empowering and engaging communities. The community itself is a partner and is key to delivering interventions, such as spreading health messages, advocacy, and monitoring the progress of interventions.

“Financing for universal coverage” brought in discussions on the role of partnerships in financing, the options for South-East Asia and public financing. The Thai experience was highlighted as an example of best practice. To attain universal coverage, there needs to be political commitment, a legal framework, greater democracy and creation of a fiscal space. There is also a need to raise funds, reduce risk and improve efficiencies. However, all resources should not be used for financing universal coverage; some should be kept aside for emergencies.

“Opening new frontiers and innovative opportunities for collaboration in the health sector: South–South and beyond” highlighted examples of collaboration in the health sector in developing countries. South–South Cooperation is based on equal partnerships and the principles of solidarity, mutual benefit, capacity building and technological transfer, with a focus on equity in health within and between countries. However, partnerships should be sensitive to the global economic climate, even if they are not dependent on external funding. An operational framework is needed for implementing South–South Cooperation such as the New Partnership for Africa’s Development (NEPAD).

Several stakeholders discussed their perspectives on and roles in health development in the Region. Stakeholders included the private sector and foundations, NGOs and civil society, governments, UN/intergovernmental organizations and the media. Partnerships that are sustainable begin with sharing the most important resource, which is information. Information needs to be shared in order to properly intervene in communities – from conceptualization of initiatives to monitoring and evaluation. Current and emerging health challenges cannot be addressed by the State and private sectors alone. More recognition and responsibility should be given to credible organizations, and mechanisms created for better cooperation and collaboration. Building stronger aid partnerships based on aid effectiveness principles is the mutual responsibility of recipient and donor governments. The key aid effectiveness principles of
national ownership, alignment, harmonization, managing for results and accountability must be adhered to. Joint advocacy from UN agencies on health-related issues is important to enhance access to affordable and suitable medicines and health care.

The media roundtable chaired by Dr Shashi Tharoor, Member of Parliament, India, former UN Under-Secretary-General for Communications and Public Information, generated great interest. Though the media can convey public health messages effectively, there needs to be greater interaction between spokespersons and journalists to build mutual understanding and respect for each others’ needs and pressures. Public health messages can be of interest to the editor and reader – it is a matter of how they are packaged.

The key messages from the break-out sessions were encapsulated in a plenary on “Reflections on the roles of stakeholders in health development in the Region”.

The draft “Delhi Call for Action on partnerships for health” generated a lively discussion and the suggestions which achieved consensus were incorporated.

Dr Poonam Khetrapal Singh delivered the closing remarks on behalf of the Regional Director, WHO South-East Asia Region, Dr Samlee Plianbangchang. She emphasized that at the centre of all partnerships and initiatives are the people themselves, who should be tapped as partners. H.E. Lyonpo Zangley Dukpa, Minister of Health, Bhutan declared the conference closed.
Partnerships in health

- People on the frontline should be empowered.
- Localization is important for the success of programmes and capacity building must be done for this.
- Lateralization is also important but should not be forced; instead, it must be individualized for the best results.
- Learning should be much faster. One can learn from the various collaboration models already in existence, such as “South–South learning”.

Millennium Development Goals: the progress so far and opportunities ahead

- Global and regional partnerships, such as United Nations (UN) H4+ agencies (UNAIDS, UNFPA, UNICEF, WHO and the World Bank) and the Global Strategy for Women’s and Children’s Health, play a critical role in supporting national governments and advocating for commitments from all. Partnerships should continue with the South Asian Association for Regional Cooperation (SAARC), Association of Southeast Asian Nations (ASEAN), parliamentarians and the private sector, and also engage a broader spectrum of actors for increased resource allocation for reproductive health, focusing on equity and quality of services.

- The Chiranjeevi Yojana in Gujarat is a successful, innovative public–private partnership to improve access to life-saving maternal and neonatal services. These interventions could be adopted elsewhere in the Region with amendments to fit the local context.

The challenge of noncommunicable diseases

- NCDs are preventable, and cost-effective solutions are available. They should be addressed through surveillance, prevention and control.
- Innovative approaches should be used to control NCDs, and the social determinants of health addressed.
- Taxation on tobacco products (“sin” tax), alcohol and energy-dense foods should be increased.
- Government interventions should include microeconomic measures such as microfinancing and community health insurance, as well as health industry regulation; urban development; and spreading awareness through the media and marketing strategies.
- NCDs should be included in the agendas of Heads of State and Government, with multisectoral involvement and accountability, and by engaging the development sector to invest in NCDs.
**Building health system capacity**

- The knowledge base for reporting needs to be improved.
- For health systems to function well, good health data are needed.
- Attempts must be made to get policymakers to recognize the value of and accept the evidence that comes from research institutions.
- New opportunities such as the MoVE-IT initiative should be used to collect and compile data to ensure that all births are recorded and certified, and progress toward MDGs 4, 5 and 6 monitored.
- Promising practices such as scaling up skilled birth attendance by Bangladesh should be replicated in other countries.
- The Global Code of Practice on International Recruitment of Health Personnel creates an unprecedented opportunity for countries to work within a common framework and collaborate in tackling challenges related to health workforce migration.

**Health partnerships and collaboration: the imperatives of collective responsibility to address the health of the poor and vulnerable**

- Advocacy and funding are needed to strengthen immunization programmes and introduce new and underutilized vaccines.
- The nutritional status of children below two years must be improved to ensure that children reach their full potential and lead productive lives as adults.
- Reducing maternal mortality and high fertility rates will build the female workforce and improve the health of women and children.
- Health-care costs must be contained and catastrophic expenditure avoided.
- Best practices in the Region (such as the case of reduction in the HIV burden in India) should be replicated.
- Challenges such as control of malaria and new and emerging diseases must be tackled through partnerships with clear definition of the roles and responsibilities of partners.
- Monotherapy with artemether and substandard medicines for malaria must be avoided to prevent the emergence of drug-resistant strains of the malaria parasite.
- Accessibility to health care must be improved throughout the Region through the use of innovative practices such as barefoot doctors.
- Drugs should be made affordable through innovative means and measures enforced to control the production of spurious drugs.

**Partnerships in action: reporting from the field**

- Communities must be mobilized to demand better services and improve their outcomes.
- The corporate sector should be used as a partner in controlling tuberculosis (TB), HIV and other diseases.
- Public health, particularly preventive health care, should be strengthened, especially in developing countries.
• Laws and regulations that prevent most-at-risk populations from accessing services for HIV infection must be revised, and a supportive, non-stigmatizing environment provided.

• Harm reduction approaches have been shown to be successful at controlling drug use and reducing the spread of HIV. Best practices in the Region should be replicated for the prevention and control of HIV.

**Addressing child and maternal mortality**

• Different stakeholders such as government, community and religious organizations, UN agencies, private sector and academia) can play a significant role in reducing child and maternal mortality in the South-East Asia Region through a coordinated approach that addresses several areas of concern.

• Stakeholders can forge stronger partnerships that also need to be made sustainable.

• Best practices such as the Janani Suraksha Yojna in India (in which demand-side financing through conditional cash transfers has shown a significant increase in the use of services, and a decline in maternal mortality) could be replicated in the Region.

• Greater advocacy is needed for reproductive health, particularly with parliamentarians and the media.

• Role of the family and the community needs to be strengthened, to ensure effective interaction between the communities and the health system.

**Ensuring universal access to health services**

• Prevention of road traffic accidents and NCDs must be put on the national health agenda.

• Countries of the Region need to seriously attack the problems of alcohol and tobacco, which are responsible for a major share of the NCD burden.

• Educational and health initiatives go hand in hand; in particular, education for women should be targeted as a key factor for the improvement of health outcomes.

**Revitalizing primary health care – addressing health inequities**

• The success of decentralization is dependent upon achieving good governance, productive partnerships at all levels of the community, implementation of a comprehensive approach to pro-poor growth, improving public services, improving coordination among stakeholders, and addressing the social determinants of health.

• Health should be viewed as an investment and not an expenditure.

• The role of medical colleges is vital, as they are the “think tanks” and help in researching problems. Involving politicians is also important as they play a central role in health.

• Market mechanisms have to be considered in this era of globalization. Health should not be put in the marketplace as the ethics of health will suffer.
Integrated approach to prevention and control of noncommunicable diseases

- Expertise, experience and systems are in place. Instead of creating parallel systems, the control of NCDs should be “piggy-backed” onto existing systems.

- The Package of Essential NCD (PEN) interventions has been implemented in Sri Lanka and could be duplicated in other countries.

- Civil society has played a very important role in changing sexual and drug-use behaviour for the control of HIV/AIDS; similar measures should be applied for control of NCD risk factors.

- Prevention and control of NCDs should be integrated into existing health programmes such as school health programmes.

- The Framework Convention on Tobacco Control must be implemented more strongly.

- Innovative approaches to tobacco taxation can help in promoting health, as seen in Thailand.

- Member States should explore alternative financing for health promotion with a focus on prevention and control of NCDs.

- NCDs should be included in the MDGs.

Health for the urban poor – the way forward

- Spatial mapping should be done to include poverty clusters that are not listed.

- Urban slum guidelines should be created and bodies formed with responsibility to look after various areas.

- The community should be empowered to identify their needs and a budget provided to them.

- A public–private partnership approach can be used to address health needs in urban slums.

- The urban poor can act as active agents of change.

Protecting health from climate change

- Partnerships may be the solution to some of our present-day climate-engendered problems. People in need should be prioritized, with special attention to women and children.

- More evidence needs to be created in the health sector for convincing ministries of finance and donors to allocate funds for combating climate change-related problems.

- Renewable energy sources need to be piloted and scaled up.

Public–private partnerships in health

- Private sector enterprises should be encouraged to create supportive workplaces for HIV, TB and malaria prevention/treatment/care, preferably within broader occupational health measures for workers and their families.

- Innovative public–private partnerships are critical for service delivery of health, product development, fulfilling corporate social responsibilities and research with academia.
Public–private partnerships should also take an active role in preventive health care as this will improve performance of the workforce.

The government should encourage partnerships for health research in order to scale up discovery and development of new medical products.

Public–private partnerships in medical technology need to be formed in order to adopt/adapt technologies appropriate for countries of the Region.

**Financing for universal coverage**

Some resources should be kept aside for emergencies. All public health money should not be used for financing universal coverage.

WHO and the international community can advocate for public financing with governments and stimulate them to spend more on health.

Agreement on and understanding of universal coverage is limited. Data should be collected to fill the information gaps in order to facilitate public financing for universal coverage.

**Opening new frontiers and innovative opportunities for collaboration in the health sector: South–South and beyond**

South–South Cooperation is new and should be explored further.

Mechanisms such as South–South Cooperation and Triangular Cooperation can play a role in shaping and influencing the new world order according to the principles of mutuality, equity, transparency and sustainability.

Initiatives for cooperation in the health sector are modest. This is recognized as a nascent area of work where concerted action needs to be taken.

An operational framework is needed for implementing South–South Cooperation such as the New Partnership for Africa’s Development (NEPAD).

Partners in health should assist in mapping/documenting successful examples of South–South Cooperation across regions.

The South–South Cooperation in health should focus on ensuring equitable access to pharmaceuticals, building country capacity to produce low-cost quality drugs and vaccines, transfer of appropriate technologies among countries with similar contexts, health innovation, use of information technology especially for telemedicine, training of human resources, research and medical care.

All opportunities have to be seized to mainstream health in foreign policies.

**Perspectives and roles of stakeholders in health development in the Region**

**Private sector/Foundations**

Technology for health needs to be brought to grass-roots users.

Best practices need to be documented and disseminated so that good work can be communicated and replicated.

Some models can be institutionalized and
mechanisms/working groups/follow-up workshops organized so that discussions are taken forward.

**NGOs and civil society**

- Current and emerging health challenges cannot be addressed by the State and private sector alone. Better recognition and responsibility should be given to credible organizations. Mechanisms should be created for better cooperation and collaboration (from policy level down to implementation).
- The voluntary sector should continue to improve their accountability and governance.
- To strengthen health services, it is necessary to encourage, enable and recognize the formation of associations, networks of membership-based organizations and NGOs.
- The role of civil society in policy and programme review of the health sector should be strengthened.

**Governments**

- Despite global commitment to the principles of the Paris Declaration on Aid Effectiveness, there are gaps in understanding and implementation at country level, particularly in terms of donor harmonization and alignment with national development priorities.
- Greater predictability of funds should be ensured.
- Technical assistance without adequate skills transfer can create dependency. There should be a clear road map for national capacity enhancement.

- Increased synergy with and involvement of civil society and non-State actors needs to be developed. Joint planning and monitoring and evaluation need to be conducted regularly.
- The gap between global political commitments and country-level realities in the area of aid effectiveness should be bridged. Funds should be pooled, flexible and not earmarked.
- Governments must be innovative in utilizing funds at the country level, for example, by scaling up interventions in NCDs with funding from the Global Fund to fight AIDS, TB and Malaria, by highlighting linkages between tobacco, cardiovascular diseases, diabetes and TB. Similarly, funding for malaria control can be used to prevent other vector-borne neglected tropical diseases.

**UN/Intergovernmental organizations**

- UN agencies can optimize resources by using each others’ auditing services, offices and have common initiatives to reduce costs and prevent duplication of efforts.
- Private practitioners should be asked to prescribe drugs using their non-proprietary names.
- In India, adolescent health, especially sexual and reproductive health, should receive more attention than at present. Advocacy is needed to stop early childbearing.
- Joint advocacy from UN agencies on health-related issues is important to enhance access to affordable and suitable medicines and health care. Joint programmes have an impact and need to be planned and executed collectively.
Media

- Development and health communication needs to be well packaged.
- The vernacular media should be engaged and involved to provide a wider reach for health messages.
- The media should be engaged as partners and sensitized to relevant issues.
- Public health officials should be trained to be better spokespersons and work with the media.

Reflections on the roles of stakeholders in health development in the Region

- Countries must allocate a larger share of the GDP to health. Investments in health and resources must be increased.
- While partnerships already exist, coordination, governance, regulation and stewardship need to be improved.
- Money spent on health is not expenditure but an investment in the lives of people.
- Political promises at the global and national levels must be followed through by providing resources, political space and services to the people.
- The incentives needed by the private sector for engagement should be considered by the public sector when entering into a partnership.
- Public–private partnerships should be looked for and promoted in various domains and at multiple levels.
- Civil society can educate the community about schemes by the government for their benefit. It can build the capacity of participatory committees to increase monitoring and accountability of such schemes. Community monitoring tools such as public dialogue should be developed and put into action.
- Disability issues must be taken on board as a part of health development concerns.
- Health is a political and cross-cutting issue, and is beyond the responsibility of only the Ministry of Health. Other ministries should also be involved.
- Politicians should be sensitized to health issues so that they are able to make adequate policy decisions, particularly with regard to the allocation of resources for health.
- Meetings such as this should be held at regular intervals (e.g. every two years) to check whether what was proposed has been achieved.
Introduction

The WHO conference “Partners for Health in South-East Asia”, was held in New Delhi from 16 to 18 March 2011. It was organized with a view to strengthen regional collaboration for health, and encourage effective and sustainable partnerships between stakeholders. With 26% of the world’s population and 40% of the disease burden, the Region faces multiple challenges in improving the health of its people. The conference aimed to provide a forum for the 11 Member States of the South-East Asia Region and their partners to identify and discuss health priorities for the Region, and the challenges and opportunities for advancing these priorities. It also provided an opportunity to share best practices, and highlight partnerships in action.

The conference had over 350 high-level representatives from governments in the Region, donor countries, multilateral and intergovernmental organizations, civil society, foundations, media, the private sector, as well as research/academic institutions.
Objectives

- Review progress in achieving health-related internationally agreed development goals, including the Millennium Development Goals (MDGs), in the South-East Asia Region, and discuss collaborative efforts to address challenges and bottlenecks;
- Identify challenges as well as opportunities and priorities for common action in the South-East Asia Region;
- Identify roles and responsibilities of partners in addressing countries' health priorities;
- Leverage partner commitment to foster better collaboration and explore new and innovative ways of working together to accelerate the achievement of health-related, internationally agreed development goals, including the MDGs.
Opening ceremony

Left to right: Dr Poonam Khetrapal Singh, Ms Erin Soto, Dr Analjit Singh, H.E. Mr Ghulam Nabi Azad, Dr Samlee Plianbangchang, Mr Kalyan Banerjee, Mr Keshav Desiraju

Welcome

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region

Addresses

Mr Kalyan Banerjee, President-Elect, the Rotary Foundation of Rotary International, USA

Ms Erin Soto, Minister Counselor for International Development and USAID Mission Director, India

Mr Yohei Sasakawa, Chairman, the Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination, Japan (read by Ms Chikako Awazu)

Dr Analjit Singh, Chairman and Managing Director, Max India Limited, India

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

H.E. Mr Ghulam Nabi Azad, Union Minister of Health & Family Welfare, India

Vote of thanks

Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, India

Master of ceremony

Ms Vismita Gupta-Smith, Public Information & Advocacy Officer, WHO South-East Asia Region

Session Coordinator:

Ms Nelly-Enwerem Bromson, Ag Strategic Alliances & Partnerships Officer, WHO South-East Asia Region
The conference started on a sombre note, with all participants expressing their deep sympathies and condolences with the people of Japan, who have been overwhelmed by a powerful earthquake and tsunami.

Dr Poonam Khetrapal Singh welcomed the Ministers of Health and Finance from Member States in the South-East Asia Region and the other distinguished participants to the first conference of Partners for Health in South-East Asia. She explained that the aim of the conference was to synergize and harmonize the efforts of all partners to improve health and reduce poverty in the Region. She thanked H.E. Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, India, and thanked him for his commitment to the health of the people of the South-East Asia Region and for sparing the time to inaugurate the conference. His presence would give an impetus to strengthening partnerships for health. She introduced the dignitaries on the dais - Ms Erin Soto, Minister Counselor for International Development, the United States Agency for International Development (USAID); Dr Analjit Singh, Chairman and Managing Director, Max India Ltd.; Mr Kalyan Banerjee, President-Elect, Rotary International, USA, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region and Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, India. She welcomed the print and electronic media and asked for coverage to advocate for partnerships in health. Mr Yohei Sasakawa, Chairman, the Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination could not attend due to the disaster in Japan.

The success of any meeting depends on the quality of the deliberations. The galaxy of eminent national and international experts, scientists, academia, NGOs, the media and decision-makers in health attending this meeting would ensure that the deliberations would be most fruitful.
Mr Kalyan Banerjee recounted the history of polio eradication in the world. Polio was eradicated 20 years ago in the Americas, 10 years ago in the Pacific region, and efforts are ongoing toward eradication in South-East Asia. Many countries around the world with similar challenges as in India have eradicated polio. In 1985, when Rotary started the immunization campaign, 350,000 children per year fell ill with polio. Today, the number is 1,000 children per year and 99% of polio has been eradicated. Initial efforts were aimed at immunizing all children, even in areas of conflict. We have stood at the threshold of a polio-free world for longer than we expected, but the goal is monumental. All but four of the world’s countries have been declared polio-free. The process has not gone as smoothly as might have been hoped, but the success of polio eradication, with the cooperation of all stakeholders, is an amazing achievement. The goal of polio eradication in India is a challenge, but polio is now at historically low levels. Much can be done by working together. Rotary’s success at working with other organizations in combating polio has provided a model for how we might work effectively to address the many other public health and development challenges we face as a global community. Rotary’s strength is in reaching out to people with different backgrounds in over 200 countries and establishing close links with them. The partnerships created would extend well beyond polio eradication.
Ms Erin Soto said that South-East Asia has made many improvements in health development and towards the MDGs. However, the trend is not uniform across and within countries, and hard-to-reach areas and populations are lagging behind. Equity in, access to, and use and quality of services are varied. These can slow the achievement of the MDGs. This forum provides an opportunity to discuss best practices and reforms among the public and private sectors. President Obama has launched the first-ever Presidential policy for health in September 2010. The US is committed to achieving sustainable development outcomes by making broad-based economic growth and democratic governance top priority. The US is investing US$ 63 billion over six years to help partner countries improve health systems.

Ms Soto identified five challenges facing the health sector: (i) shortage of skilled staff; (ii) limited investment in and utilization of information technology for development; (iii) need for mechanisms to ensure operational accountability; (iv) financial barriers to health care; and (v) the need to engage the private sector, especially in low- and middle-income countries. These challenges can best be addressed by strengthening health systems, which would lead to strengthened governance and better performance.
Since Mr Yohei Sasakawa could not be present due to the crisis in his country, Ms Chikako Awazu read out his message. She highlighted the activities of the Nippon Foundation in utilizing partnerships to end leprosy. The goal of freeing the world of leprosy might have seemed impossible at one time. However, the development of multidrug therapy in the 1980s offered a glimmer of hope. With partnerships between foundations, governments, nongovernmental organizations (NGOs) and other players, the Nippon Foundation supported free treatment through WHO from 1995 to 1999. From 2000, this role has been performed by the Novartis Foundation. Over 16 million people with leprosy have been cured since 1995 and leprosy will soon be eliminated. Partners have ensured that the drugs reach the people who need them.

Although drugs for leprosy are available even in remote places, those for common ailments such as fever, diarrhoea and respiratory illnesses are lacking. A system is needed which allows access to essential medicines by people when they need them. Home medicine kits with traditional medicines could be an answer. The Nippon Foundation launched such a programme in Mongolia, where the population is largely nomadic. Around 60 000 households use the system and it will soon be a part of the country’s health policy. Myanmar, Thailand and Cambodia have adapted the system to their needs. This is one approach to ensure primary health care to those in remote areas.

From elimination of endemic disease, ensuring primary health care in remote areas to recovery from a major disaster, the challenges the world faces today are too arduous for a single organization to tackle and partnerships are needed for this. It is possible to overcome challenges by working with all possible stakeholders.
Dr Analjit Singh raised the issue of challenging “conventional wisdom” of demand creating supply. He noted that an increase in supply can lead to an increase in demand, as higher capacity, new technologies and less lengthy hospital stays encourage people to seek medical care. The fear of surgical interventions has now been mitigated and people are coming forward to ask for these in cities of all types. This in turn improves health outcomes and the health status of the population. Earlier, it was believed that improvement in infrastructure, health care and education was an outcome of growth and development. But now it is commonly believed that improvement and investment in health care, education and infrastructure is a precursor for development.

He asked participants to question whether their countries’ health-care strategy was derived from the principle of sound logic and economic rationale, such as public and private investment and participation. In many countries, these strategies are not well founded. This raises the question of the compatibility of models—the “business logic” of the private sector and the strategies developed by the government. Ideally, there needs to be a partnership for concerted action. Public–private partnerships are very important, and governments should invite greater participation by the private sector. Private organizations need to realize that they have much to contribute, though they are accountable and work for profit.
Dr Samlee Plianbangchang pointed out that many noteworthy achievements are now under threat because of several global crises, not least the food crisis, the financial crisis, and the mounting problem of climate change. He highlighted the importance of finding new and innovative ways to tackle the prevailing gaps in under-funded health priorities including health systems’ strengthening. In addition, countries of this Region are still struggling with a large burden of communicable diseases as well as neglected tropical diseases, even as the problem of noncommunicable diseases (NCDs) becomes larger. Unplanned urbanization is a threat to health in a Region where a massive number of people live at close quarters and only 60% have access to proper sanitation. No single government, no single organization can successfully pursue these challenges alone. Global health is a multi-stakeholder process and sustainable partnerships will be key to facing and overcoming the related social, economic and environmental factors which contribute directly and indirectly to the disease burden in the Region and to helping prevent unnecessary suffering, morbidity and deaths.
His Excellency Mr Ghulam Nabi Azad pointed to the impressive gains made by the Government of India in improving the health status of the population; for example, efforts toward the achievement of MDG 6. The MDGs have influenced all bilateral and multilateral dialogue and the policies of many countries, including India. He noted that health systems’ strengthening has had a significant impact on reducing the infant mortality rate (IMR) and maternal mortality ratio (MMR). In the area of Safe Motherhood, the Janani Suraksha Yojna has reached women across the country, and was cited by the Lancet as a most promising health initiative.

India has the largest diabetic population in the world. A three-pronged strategy has been put in place to tackle the problem of NCDs under the aegis of the new national programme for the prevention and control of cancer, cardiovascular diseases, diabetes and stroke. However, all initiatives would be unproductive without health systems strengthening. To this end, the federal government has committed US$ 3.5 billion annually to help the states to improve their infrastructure through the National Rural Health Mission. In spite of having more than 730 000 doctors and 930 000 nursing personnel, these are concentrated in urban areas, leaving a huge gap in rural areas. He outlined impressive plans in the areas of medical education and other fields, particularly aimed at strengthening the system in backward and underserved areas. He urged Member countries to join hands and make the Region free of want and disease.
Mr Keshav Desiraju thanked all the speakers for their insightful interventions which brought to light very important issues which he hoped would be further developed during the course of the meeting. He reminded participants that while health care is the primary responsibility of national governments, partnerships are needed to ensure the necessary human, financial and physical resources for health. He concluded by thanking the Regional Director for South-East Asia of the World Health Organization for his leadership in organizing the Conference and bringing together such high-level participants, which he was confident would take forward and strengthen partnerships in health in the Region.
Special address - Partnerships in Health

Mr Arun Maira, Member of the Planning Commission of India and Former Chairman of the Boston Consulting Group, India

Session Coordinator:
Dr Nata Menabde, WHO Representative, India
Mr Arun Maira stressed that India faces many challenges. One of these is providing acceptable, accessible and affordable health care to its citizens. There is a long way to go in the area of health but one cannot afford to take too long in getting there. The requirement for health is ongoing and does not wait for one to find solutions. The time for action is now, and the question is how can partners work together to produce the desired outcomes? Mr Maira quoted parts of a famous poem by Nobel Laureate Rabindranath Tagore, Where the mind is without fear and the head is held high,

Where the world has not been broken into fragments by narrow domestic walls…

What are the fragments in which we live and the walls which divide us?

In India, five-year plans are made, which should be developed for, by and of the people, but this has not been done well, which perhaps explains why the outcomes of the plans have not been good. Another possible reason is the existence of walls and silos within the government. Recognizing this, in the development of the 12th Five-Year Plan we were guided by the philosophy of Gandhiji’s Antodaya movement “think of the poorest first”. The government through NGOs and civil society groups therefore asked those who were the poorest and neediest what they needed most, and their suggestions on how these needs could best be met. Twelve questions were given, which represented the 12 challenges faced by India. The government asked these NGOs and civil society groups to provide consolidated and clear recommendations as to what needs to be done. The groups took up the challenge and recommended to the government what it should do. The process was not without problems. For example, NGOs which the government had not even thought of, emerged in representation of marginalized communities such transgender people and others, and were subsequently involved. Citizens throughout the country were reached directly through social media such as Facebook and the internet, and their suggestions solicited.

The greatest challenge identified was implementation, due largely to inefficiency and corruption. Business groups, civil society organizations, the government, academicians, experts and others formed conclaves to decide what should be done as interaction between various groups could provide new and mutually beneficial solutions to common problems. The results were surprisingly clear and, at present, stakeholders are being involved. At one of the meetings, a participant was surprised to
find how alike the thoughts of these various organizations were, contrary to what was expected. Thus, the stereotypes that we create also lead to walls being built up.

*Where the clear stream of reason has not lost its way in the dreary desert sand of dead habit…*

There is a need to step out of silos and to think innovatively and with open minds, not with preconceived ideas. Referring to the Conference logo “inspire, innovate, involve”, Mr Maira urged participants to be inspired, to get out of their heads and into their hearts, and to think about what they really cared for. He stressed that innovation stems from involving people one does not usually learn from or listen to. How can we act together to produce effective change? He listed localization, lateralization and learning as three key areas. It is very important for the development and success of partnerships to expand what is understood by learning beyond an academic model, to include listening to diverse viewpoints, working with those outside our usual spheres of knowledge and work, and creating a new “learning architecture”. He suggested that each one at the meeting should step back and allow others to speak, and listen to them to gain new learning.

He concluded by saying that this meeting was a forum for learning from each other and finding a way forward.

**Discussion points**

- A participant wanted to know how India could think outside silos since health was a state subject. What is the government doing to get the states to prioritize and implement relevant programmes? Mr Maira answered that as the states are huge, health is delivered at the local level. Thus, engagement with those for whom health care is being delivered is needed. Localization is important, as well as capacity building to empower the 1.2 billion on the frontline. Lateralization is also crucial. People should learn to cooperate, look for things that can be done similarly and those that can be done differently. There is also a need to learn much faster and better, creating a learning architecture for effective change.

**Conclusions and recommendations**

- Gauge the people for whom results are to be produced instead of telling them what they have to do.

- Empower people on the frontline. Until they want to do something, it will not be done.

- The architecture of implementation has to be changed.
• Localization is important for the success of programmes and capacity building must be done for this.

• Lateralization is also important but should not be forced; instead, it must be individualized for the best results.

• Learning should be much faster. One can learn from the various collaboration models already in existence, such as “South–South learning”.
Plenary I

**Millennium Development Goals: the progress so far and opportunities ahead**

*Chair:*
H.E. Lyonpo Zangley Dukpa, Minister of Health, Bhutan

*Speakers:*
Ms Nobuko Horibe, Regional Director, United Nations Population Fund (UNFPA), Thailand

Millennium Development Goals: the UNFPA perspective

**Innovations in maternal health care: a case study from Gujarat**

*Dr Amarjit Singh*, Joint Secretary, Ministry of Human Resource Development, India

*Session Coordinator:*
Dr Quazi Monirul Islam

*Rapporteur:*
Dr Akjemal Magtymova
Ms Nobuko Horibe provided UNFPA perspectives on improving women’s and reproductive health. She described the progress on maternal and reproductive health in the Region as “slow and inequitable” with inequities among and within countries, population groups and socioeconomic quintiles. While the maternal mortality ratio (MMR) has decreased in almost all regions of the world, it remains high in South Asia, and reaching MDG 5 does not seem possible, though some countries such as Sri Lanka, Thailand and the Maldives are doing well. Reaching MDG 5 is pivotal to reaching the other MDGs. The lifetime risk of maternal mortality in South-East Asia is the third highest in the world, and health systems are thus failing to meet the needs of women. The key determinants of the slow progress toward MDG 5 are a lack of availability of family planning services, lack of skilled care at every birth, and lack of emergency obstetric services. Adolescent pregnancy has enormous consequences, and signifies an unmet need for contraception.

Health financing in the Region is very poor. The South-East Asia Region spends less on health than Africa, and out-of-pocket expenditure is very high. In emergencies, deaths are common because of this. Some governments hope to overcome this problem through cash incentives and vouchers.

It has also been observed that in countries with a high MMR, gender inequality is deeply entrenched. Promoting gender equity will need concerted efforts and engaging men as agents of change. The three main causes of increased maternal mortality are delay in recognizing danger, delay in reaching facilities and delay in receiving treatment. Such weaknesses must be addressed through partnerships with intergovernmental agencies to improve the health of women. Despite successes, there is no time for complacency. All partners must unite and take action to finance and improve services, so that MDGs 4 and 5 can be reached.
Dr Amarjit Singh described the success of the Chiranjeevi Yojana in the state of Gujarat, which helped to increase institutional deliveries and bring down the IMR. He highlighted the importance of skilled birth attendance during pregnancy, childbirth and post partum to substantially reduce maternal mortality and early neonatal deaths.

In 2005 in Gujarat, there were only seven obstetricians in rural areas to handle the complications of delivery, and only 30% of health centres had trained auxiliary nurse midwives. The Chiranjeevi Yojana was launched to address this problem. At that time, Gujarat had 1800 private practitioners and it was decided to involve them through a consultative process with NGOs, the Federation of Obstetricians and Gynaecologists Society of India (FOGSI), and the government. The State Government would take full responsibility in case of death. A package with payment for services was prepared by the Indian Institute of Management (IIM) Ahmedabad. A memorandum of understanding (MOU) was signed and all payments were promptly made, which showed the commitment of the government.

The Chiranjeevi Yojana promoted institutional deliveries in Gujarat and emphasized (1) midwifery education; (2) designing a service package; and (3) ensuring distribution, retention and motivation of skilled staff, including obstetricians/gynaecologists and paediatricians, for improving access to skilled care and emergency obstetric services by those in need. In addition, a transport system was organized in August 2007 to take pregnant women, especially those below the poverty line, to hospitals during emergencies. This helped to save the lives of many women.

By December 2010, the rate of institutional deliveries had gone up to 91.3% from 57% in 2004–05, accompanied by a steep decline in the IMR and MMR. The scheme has been extended and 266 paediatricians have now been enrolled in the Bal Sakha scheme for the care of newborns and children. The Chiranjeevi Yojana could be replicated in other Indian states, but this has not been done so far.
Discussion points

• The Chair, H.E. the Minister of Health, Bhutan proposed that Gross National Happiness be included as the ninth MDG.

• Maternal mortality data are often politicized as the figures may range widely, depending on the sources and methodologies. The methodologies require constant refinements. The UNFPA, along with the United Nations Development Programme (UNDP) and United Nations Children’s Fund (UNICEF), contribute to the improvement of statistical capacity for the use of data and development of evidence-based strategies. UN estimates by WHO/UNFPA/UNICEF/the World Bank are used to make data more comparable. Disaggregated data have the capacity to provide vital information on the vulnerable groups that need to be targeted with additional programme efforts.

• Within the Chiranjeevi scheme, monitoring of the health-care facilities was based on a grading system and incentives were tailored specifically to the gaps.

Conclusions and recommendations

• WHO’s role in setting standards and norms was underlined and recognized as an important element for contributing to the joint efforts for achieving MDG 5 on improving maternal health.

• Global and regional partnerships, such as United Nations (UN) H4+ and the Global Strategy for Women’s and Children’s Health, play a critical role in supporting national governments and advocating for commitments from all. Partnerships should continue with the South Asian Association for Regional Cooperation (SAARC), Association of Southeast Asian Nations (ASEAN), parliamentarians and the private sector, and also engage a broader spectrum of actors for increased resource allocation for reproductive health, focusing on equity and quality of services.

• The Chiranjeevi scheme in Gujarat is a successful, innovative public–private partnership to improve access to life-saving maternal and neonatal services. These interventions could be adopted elsewhere in the Region with amendments to fit the local context.
The challenge of noncommunicable diseases

Chair:
**Dr Lalit M Nath**, Former Director, All India Institute of Medical Sciences, India

Speaker:
**Dr Bela Shah**, Senior Deputy Director-General NCD, Indian Council of Medical Research, India

Session Coordinator:
Dr Renu Garg

Rapporteur:
Dr Dhirendra Narain Sinha

Noncommunicable diseases: challenges
Dr Bela Shah in her address said that NCDs account for 60% of deaths globally and 80% of deaths in low- and middle-income countries. They affect all income groups and all regions of the world, and are a threat to development. Their chronic nature leads to long-term disability. NCDs are a more expensive global risk than the global financial crisis, with a potential cost estimated between $250 billion and $1 trillion dollars. WHO projects that over the next 10 years, deaths from diabetes, cardiovascular disease, cancer and respiratory disease will increase in all regions of the world. NCDs have tremendous economic consequences and may slow the economic growth of a nation.

NCDs have socioeconomic, cultural, political and environmental determinants. Some common modifiable risk factors include an unhealthy diet, physical inactivity, and alcohol and tobacco use, while non-modifiable risk factors include age and heredity.
The South-East Asia Region is going through various health transitions. These include an epidemiological transition, with a large burden of communicable diseases and a significant increase in NCDs. At the same time, the Region also is home to several neglected tropical diseases. A demographic transition is evident in the fact that nearly a third of NCD deaths are among those below the age of 60 years. The periurban population has an increased prevalence of NCDs. A nutritional transition is also taking place, due to substitution of coarse grains with polished cereals, low intake of fruit and vegetables, and higher intake of fats and sugars. Health-damaging behaviours like smoking, drinking, consuming unhealthy diets, which are driven by urbanization, technological change, market integration and foreign direct investment, account for the behavioural transition that is simultaneously taking place.

Weak health-care systems worsen the impact of the epidemic of NCDs. People aged 30–59 years in developing countries die from NCDs at twice the rate of their counterparts in high-income countries. Low-income countries have a 30% greater morbidity from NCDs, possibly due to weak health systems, which also account for high and sometimes catastrophic out-of-pocket expenditure on health.

The way forward to meet the challenge of NCDs lies in addressing the social determinants of health. Most importantly, strengthening health systems focusing on the primary health care approach is crucial.

The road map for the control of NCDs is enshrined in the Regional Framework for Prevention and Control of NCDs, which was endorsed by the Regional Committee in 2007. The strategy targets the main modifiable NCD risk factors and focuses on surveillance, health promotion and primary prevention. Subsequently, the Regional Action Plan (2008–2013) for implementing the Framework was formulated.
Conclusions and recommendations

- NCDs are the single biggest cause of deaths, of which a large proportion is premature.
- They have strong social determinants that must be addressed.
- Preventable and cost-effective solutions are available.
- NCDs can be addressed by surveillance, prevention and control.
- Health systems in developing countries are overwhelmed by the increasing magnitude of NCDs and policy-makers are increasingly asking for technical support, which remains largely unanswered. This is a serious health and development problem.
- Innovative approaches should be used to control NCDs.
- Taxation on tobacco products (“sin” tax), alcohol and energy-dense foods should be increased.
- Government interventions should include microeconomic measures such as microfinancing and community health insurance, as well as health industry regulation; urban development; and spreading awareness through the media and marketing strategies.
- NCDs should be included in the agendas of Heads of State and Government, with multisectoral involvement and accountability, and by engaging the development sector to invest in NCDs.
Building health system capacity

Chairs:
Dr T. Ravindra C. Ruberu, Secretary, Ministry of Health, Sri Lanka
Dr Jai P. Narain, Director, Department of Sustainable Development and Healthy Environments, WHO South-East Asia Region

Speakers:
Dr Ugrid Milintangkul, Deputy Secretary-General, National Health Commission, Thailand

Healthy public policies: moving towards an integrated and intersectoral approach to health – Thailand’s experience

Dr Carla AbouZahr, Team Leader, Monitoring Vital Events (MoVE-IT), Health Metrics Network, Switzerland

The need for civil registration and vital statistics

Dr Mubashar Riaz Sheikh, Executive Director, Global Health Workforce Alliance, Switzerland (read by Mr Sunil Nandraj, WHO Country Office, India)

Reflections on the health workforce crisis in South-East Asia

Session Coordinator:
Dr Thushara Fernando

Rapporteur:
Dr Prakin Suchaxaya
The Chair, Dr Ravindra Ruberu highlighted that health outcomes are not satisfactory in our Region. There is inequity among different populations within and between countries. Thus, health delivery is not uniform. We run into obstacles when we try and deliver services. Therefore, health systems are important, especially in reaching the MDGs. The six building blocks of health systems have been defined by WHO, but must be tailored to each country’s needs.

Dr Ugrid Milintangkul reported that the process of building healthy public policies in Thailand started in 1980 through numerous Acts. In 1986, Thailand shifted its health development strategy to emphasize health promotion in accordance with the Ottawa Charter. Thailand began to see health beyond health care.

A paradigm shift in health took place in 1997 when the Constitution was adopted. It emphasized the importance of public participation and reaffirmed many rights of the people, especially their right to health.

The National Health System Report in 2000 declared that in fact Thai people still suffered from preventable illnesses. The health-care services were focused on curative services, which caused a high expenditure on health care, but gave low returns on health. The National Health System Reform Commission was established in 2000 with the responsibility of drafting the National Health Act as a new tool to reform the health system. The National Health Act, 2007 envisages health as having four components: physical, mental, social and spiritual.
In Thailand, many organizations and networks at the national and local levels work hand in hand with the Ministry of Public Health. Thus, this Ministry is not solely in charge of everything on health. Health organizations also work closely with the National Economic and Social Development Board. There is good networking from top down.

The National Health Commission (NHC) is a cross-sectoral mechanism to support policy coherence. It is chaired by the Prime Minister and comprises three sectors – government, academic and civil society. The NHC is managed by the National Health Commission Office (NHCO), an autonomous body that plays a synergizing role to facilitate the development of participatory healthy public policies (HPP).

The tools and processes for participation on HPP under the National Health Act, 2007 include the Health Statute, Health Impact Assessment and Health Assembly. The Health Statute developed in 2009 serves as a framework for all sectors to apply their policies, strategies and action plans, and is revised every five years.

Health Impact Assessment complements the 2007 Constitution and the National Health Act. The right to health of the people is reaffirmed in this Act. The three key elements of the Health Assembly are public participation (government, academia and the community), knowledge-based information and consensus.

A controversial issue is the medical hub policy, one of the resolutions from the 2010 National Health Assembly, to boost medical tourism. While this would promote economic growth, it would create inequity in health care between urban and rural areas. Other problems that may result with this policy are brain drain and shortage of health professionals in rural areas. The government has been asked to reconsider this.

Despite the considerable progress made, some challenges remain. Meaningful and inclusive participation requires time and patience. Knowledge generation and management are required throughout the process. Policy to action can only be achieved if there is a sense of ownership among all stakeholders along the process of HPP.
Dr Carla Abou Zahr informed that the Health Metrics Network, started in 2005, is a global partnership of producers and users of health information. The goal was to enhance the availability and use of timely and reliable health information. It is hosted by WHO with funding largely from the Bill and Melinda Gates Foundation, and brings together representatives of health and statistical constituencies.

Most current measurements are estimates, which have a weak empirical base. There is heavy reliance on household surveys for monitoring mortality, but these have limitations. They are conducted occasionally, give retrospective estimates, have wide margins of uncertainty, and limited usefulness for cause-of-death data. In addition, they are not suitable for local- or district-level monitoring, where action needs to be taken. They are also externally funded.

For public health decision-making at both the national and local levels, data should provide a reliable reflection of the patterns of mortality among different groups and across regions. They should also be continuous and complete.

At present, 85 countries with 66% of the world’s population do not have reliable cause-of-death data. Each year, 40 million births and 40 million deaths go unregistered. This is because the data are inaccessible, lost or not compiled in a user-friendly fashion. Civil registration, if functioning well, generates continuous data for the whole population, is nationally owned and implemented, and benefits both national and individual users and policymakers. It requires the partnership of the community, those who register, statisticians, legal authorities and public health stakeholders. It is a national endeavour which involves multiple stakeholders. In the South-East Asia Region, Sri Lanka and Thailand have good civil registration systems.

The MoVE-IT initiative aims to move away from a paper-based system. It uses information technology (IT) to collect and compile data to ensure that all births are recorded and certified, and helps to better monitor progress toward MDGs 4, 5 and 6. It also serves as a platform for tracking NCDs, causes of death and health system performance.

MoVE-IT has a three-pronged approach: it contributes to regional and country policy processes; provides standards and tools for assessment and quality control; and generates evidence of what works. In Asia,
Dr Mubashar Riaz Sheikh’s presentation was given by Mr Sunil Nandraj, who stressed that the health workforce is the main building block of health systems, and there is a direct relationship between availability of health workers and coverage of essential health services. Countries below a certain threshold of health worker density are highly unlikely to achieve an acceptable level of service coverage. There is a similar correlation between health worker availability and health outcomes, pointing to the fact that without sufficient health workers, countries are unlikely to achieve the health MDGs and other health development objectives.

In 2006, WHO estimated that 57 countries fell below the minimum required threshold of health workers. Of these countries, six are in the South-East Asia Region (Bangladesh, Bhutan, India, Indonesia, Myanmar and Nepal). In addition, there is urban–rural maldistribution due to poor management of the workforce. Some of the human resource issues are: most countries do not have a costed workforce plan; there is non-availability of national data on human resources for health (HRH); difficulty in retaining the workforce in rural areas; and migration of the workforce from developing to developed countries.

At the First Global Forum on Human Resources for Health held at Kampala, Uganda in 2008, the Kampala Declaration and Agenda for Global Action was adopted as an overarching framework to address the global health workforce crisis. This framework comprises six interconnected themes of the meeting can be applied to civil registration.

Inspire: Civil registration is a prerequisite for development.
Innovate: Use IT to improve strategies.
Involve: Involve all sectors.

several partners are working together to generate and use data.

It was suggested that the Delhi Call for Action should include the statement from the Prince Mahidol Award Conference in 2010 in relation to 90% completeness of birth and death registration and improved cause-of-death data by 2020.
strategies to bolster the health workforce: strengthening leadership, better use of evidence, scaling up training, improving retention in rural areas, managing international migration and increasing investments for health workers.

In the lead-up to the Second Global Forum, held in Bangkok, Thailand in 2011, the Global Health Workforce Alliance conducted a survey to review progress in each of these six areas in the 57 priority countries affected by severe health worker shortages. With regard to leadership and stewardship for health workforce development, while most priority countries in the South-East Asia Region (five out of six) have an HRH plan or strategy, only two of these were actually being implemented, and only one had an associated budget or cost estimate.

Less than half of the countries reported having an institutional mechanism, such as a health workforce observatory, to serve as a platform for sharing information and evidence with policy-makers. Only one country (Bhutan) in the South-East Asia Region reported the existence of such a mechanism. All the six priority South-East Asia Region countries reported having implemented strategies such as increased salaries, allowances or benefits to attract and retain workers in underserved areas. While data on international migration are not consistently available, several countries in the Region, such as Indonesia, are severely affected, exporting large numbers of health workers to other countries in the Region and globally. Other countries, such as India, are also large net exporters of health workers.

Countries have been working to improve their workforce situation. Bangladesh has scaled up the number of skilled birth attendants (SBAs) to 17 000; India under the National Rural Health Mission (NRHM) has increased the number of posts in public health facilities, offered incentives, locality-specific recruitment, recruited a new cadre, and added more than 80 000 health workers. Nepal used community health workers to reduce pneumonia among children below the age of five years, and the country is on track to achieve MDG 4.

A few opportunities have recently opened up at the global level: a Global Code of Practice on International Recruitment of Health Personnel was approved at the World Health Assembly in 2010. This creates an unprecedented opportunity for countries to work within a common framework and collaborate in tackling challenges related to health workforce migration.
Discussion points

- There is substantial underreporting in the civil registration system even in developed countries. Though systems are in place in many countries, these have not been used effectively. However, reporting can be improved in a short span of time as shown by Sri Lanka and South Africa. Sometimes, data are either underreported or missing, especially those on maternal mortality. This may be related to the difficulty in identifying the cause of death. Civil registration is about recording births and deaths, not disease notification.

- Healthy public policies should be based on evidence, not opinion. Civil registration can play a part in this process. However, it is hard to get policy-makers and the community to recognize evidence that comes from research institutions. Underscoring the importance of health data will lead to better health outcomes. Endorsement of the Health Information Charter available on the web should be encouraged.

Conclusions and recommendations

- The knowledge base for reporting needs to be improved.

- For health systems to function well, good health data are needed.

- Attempts must be made to get policy-makers to recognize the value of and accept the evidence that comes from research institutions.

- New opportunities such as the MoVE-IT initiative should be taken to collect and compile data to ensure that all births are recorded and certified, and monitor progress toward MDGs 4, 5 and 6.

- Promising practices such as scaling up skilled birth attendance by Bangladesh should be replicated in other countries.

- The Global Code of Practice on International Recruitment of Health Personnel creates an unprecedented opportunity for countries to work within a common framework and collaborate in tackling challenges related to health workforce migration.
Health partnerships and collaboration: the imperatives of collective responsibility to address the health of the poor and vulnerable

Chairs:
H.E. Dr Farooq Abdullah, Union Minister for New and Renewable Energy, India
Mr Hussain Niyaaaz, Additional Secretary, Ministry of Foreign Affairs, Maldives

Panelists:
Dr Bina Rawal, Head of Medical Affairs, The Wellcome Trust, UK
Dr Thomas Teuscher, Deputy Executive Director, Roll Back Malaria Partnership, Switzerland

Mr Paul Kelly, Director, Country Programmes, Global Alliance for Vaccines and Immunization (GAVI), Switzerland
Dr Mariam Claeson, Programme Coordinator, HIV/AIDS, Human Development, South Asia Region, The World Bank, India

Session Coordinator:
Ms Nelly Enwerem-Bromson

Rapporteur:
Dr Kathleen Holloway
The Chair, H.E. Dr Farooq Abdullah spoke about issues close to his heart. He emphasized the need to reach out to the vulnerable and marginalized, particularly the poorest of the poor. Referring to development, he stressed that growth should not merely be measured in terms of GDP but by the health status of the people. He requested the participants to think creatively about the challenges to health including governance, drug resistance, safe drugs and emerging and re-emerging diseases.

Dr Bina Rawal said that Henry Wellcome left all his fortune including his pharmaceutical company to the Wellcome Trust. This amounts to GBP 6–7 hundred million per year. It supports researchers to develop their ideas, and supports people to implement them. The strategic plan for 2010–2020 has three focus areas: it supports outstanding researchers; accelerates the application of research; and explores the historical and cultural contexts of medicine. It faces five challenges: maximizing the health benefits of genetics and genomics; understanding the brain; combating infectious diseases; investigating development, ageing and chronic disease; and connecting the environment, nutrition and health.

The Trust has major overseas programmes and funds seven projects in India. It has three divisions and funds a range of technologies in six areas. It funds early-stage research and development, and plugs funding gaps for projects that benefit the public. Since July 2010, it has partnered
Dr Thomas Teuscher explained that a global effort to tackle the problem of malaria led to the Roll Back Malaria (RBM) initiative in 1998. RBM harmonizes action in support of the fight against malaria. RBM was launched because (1) the Director-General of WHO heard that it was a common disease clogging up beds, (2) malaria had been identified as a major determinant of slow socioeconomic development, and (3) donor efforts to control malaria were not harmonized and were duplicative. It aimed to reduce poverty and enhance development.

Many lessons were learnt from the global effort at eradication in the 1950s. An intervention rolled out globally could work; people are passive recipients but could be more active; and public–private partnerships could be used to deliver care particularly to remote and hard to reach populations.

Thus, RBM was launched with WHO, the World Bank and other partners and includes in its Partnership Board: South Asia and Asia Pacific malaria endemic countries represented by India and China, respectively, bilateral donors, foundations, NGOs, the private sector, other United Nations organizations, the research and development (R&D) industry, academia and the capacity-building sector. Some new players involved in RBM are the Global Fund and UNITAID.

The African Leaders Malaria Alliance (ALMA) was launched in 2009. It is close to the Office of the UN Secretary-General’s
Mr Paul Kelly informed that the Global Alliance for Vaccines and Immunization (GAVI), established in 2000, is a creative and effective partnership with UN agencies, governments, the vaccine industry, the Bill and Melinda Gates Foundation and other philanthropic organizations. Within the past year, 8.9 million children died of vaccine-preventable diseases before their fifth birthday, accounting for over 90% of all child deaths. One quarter of these deaths could have been prevented by available vaccines.

Immunization is one of the most cost-effective ways to improve health in the long term and reduce the burden on already stretched health systems. Expanding and maintaining immunization coverage in developing countries depends on strong partnerships between the private and public sectors. GAVI has a business model to develop innovative ways to increase immunization in developing countries, contributing to reduced child mortality, and helping to achieve MDGs 4 and 5. It has committed US$ 6 billion and has prevented five million deaths by increasing access to immunization in poor countries.

GAVI has four strategic objectives in which the various partners play lead roles:

1. To accelerate the use of underused and new vaccines: WHO and UNICEF help with this by ensuring the availability and use of programmatic and epidemiological data. They also stimulate the demand for vaccines in countries.

2. To strengthen the capacity of integrated health systems to deliver immunization by resolving health system constraints:
Consistent with the Paris Declaration for Aid Effectiveness, the Alliance works with the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank and WHO through countries.

(3) To increase the predictability of global financing and improve the sustainability of national financing for immunization: This includes raising public and private financing, and developing innovative options to access new and predictable funding sources. For example, the pneumococcal vaccine has been available for a long time, but is not affordable by developing countries. An initiative is available which further develops vaccines to make them affordable by developing countries. For the pneumococcal vaccine, which is priced at US$ 70 per dose, the cost per dose in developing countries will be US$ 3.50. This initiative makes vaccines available 15–20 years earlier than otherwise at a price that countries can afford. GAVI also encourages countries to co-finance vaccines, and include budgets for vaccines in their national plans so that in time they can do without GAVI support.

(4) To shape vaccines markets: GAVI works with partners to reduce vaccine prices. It works with governments and UNICEF to develop demand forecasts and engage industry to promote competition and ensure an adequate supply of vaccines. GAVI also works with civil society to strengthen their capacity to organize and deliver sustainable health immunization services.

Partnerships are at the centre of the GAVI Alliance Board, which includes representation of all partners. The opportunity to achieve MDGs 4 and 5 from GAVI’s standpoint is real. The demand from countries is also high, and they realize the importance of vaccines in reducing child deaths and contributing to economic development. The reality is that more financial resources are needed.
Dr Mariam Claeson clarified that the key mandate of the World Bank is poverty reduction and economic development. The World Bank engages in the health sector because of its economic and development perspective. Only by building health systems can one have sustainable health development. What are the imperatives for making a difference to the poor and vulnerable?

First, do not let a large number of pregnant women and children die. Although some countries may meet the MDGs, there are substantial differences within countries. Some countries may meet this goal without actually decreasing poverty. It also involves reduction in high fertility because this affects per capita income, reduces the female workforce and reduces the health of women and children in the home.

Second, improve the nutritional status of children less than two years of age because it irreversibly impacts on their learning capacity and future productivity. Water, sanitation, education, social protection and agriculture impact on nutrition. The private sector and partnerships can play a role in improving nutrition. At the present rate, none of the countries is likely to achieve MDG 4.

Third, continually identify and respond to leading public health concerns through stronger public health systems and sustained efforts.

Fourth, contain health-care costs and ensure that spending gets value for money. The focus should be on NCDs (which have an increasing health burden), out-of-pocket expenditure, equity, implications of ageing, changing disease patterns and reduced household income due to disability and early mortality. One of the best practices in the Region is in Tamil Nadu, where there is cervical cancer screening, hypertension clinics, and community-based risk factor awareness. This shows that even a poor state can manage such initiatives.

Fifth, find ways to pay for health care without catastrophic spending, including risk sharing and pooling, and payment of incentives to providers, employers and health-care workers. This too can be achieved through partnerships.

The case of HIV control in India is an example of best practice. India has managed to curb the epidemic because of the focus on those most at risk, and by investing in prevention among vulnerable populations. This needed strong government leadership, wide partnership, investment in the most vulnerable sector of
society where there is much stigma, and a strong civil society.

Partnerships are a means to an end; proven successes in global health include successful partnerships, with clarity on the roles and responsibilities.

**Discussion points**

- A participant noted the Minister’s concern with access to health care. The problem is whether to focus on the determinants of health or health-care delivery as a way to improve access to health care. How does one find a balance for this in the context of basic health care?

- Basic health care means the ability to provide clean drinking water. This would prevent many diseases. Easy accessibility to health care is important, i.e. travel short distances to get care. Barefoot doctors/teachers should be given training in basic health care so that when a child goes to school s/he could be educated on the treatment of simple ailments and could then educate her/his parents. This would result in avoidance of the current practice of bypassing primary care facilities to go to tertiary hospitals. If this training could be done by the World Bank and Asian Development Bank, it would reduce the load on bigger hospitals.

- Drugs should be made cheaper. Fortunately, drugs are cheap in India but we have to control spurious drugs, which can kill. As an example, many young women in a hospital in India died recently due to contaminated IV fluids.

**Conclusions and recommendations**

- One quarter of childhood deaths can be prevented by the use of available vaccines.

- Advocacy and funding are needed to strengthen immunization programmes and introduce new and underutilized vaccines.

- Monotherapy with artemether and substandard medicines for malaria must be avoided to prevent the emergence of drug-resistant strains of the malaria parasite.

- The nutritional status of children below two years must be improved to ensure that children reach their full potential and lead productive lives as adults.

- Reducing maternal mortality and high fertility rates will build the female workforce and improve the health of women and children.

- Health-care costs must be contained and catastrophic expenditure avoided.
<table>
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<tr>
<th>• Best practices in the Region (such as the case of reduction in the HIV burden in India) should be replicated.</th>
<th>• Accessibility to health care must be improved throughout the Region through the use of innovative practices such as barefoot doctors.</th>
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<tr>
<td>• Challenges such as control of malaria and new and emerging diseases must be tackled through partnerships with clear definition of the roles and responsibilities of partners.</td>
<td>• Drugs should be made affordable through innovative means and measures enforced to control the production of spurious drugs.</td>
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Partnerships in action: reporting from the field

Chairs:
H.E. Professor Dr Syed Modasser Ali, Health Adviser to the Prime Minister, Bangladesh
Ms Tine Staermose, Director, International Labour Organization (ILO), India

Speakers:
Mr Ken Earhart, Director, Global Disease Detection Program, U.S. Centers for Disease Control and Prevention (CDC), India
Dr Md. Shafiullah Talukder, Project Coordinator, TB Control Programme, Bangladesh Garment Manufacturers and Exporters Association (BGMEA), Bangladesh
Mr Steven J Kraus, Director, Regional Support Team for Asia and the Pacific, UNAIDS, Thailand
Dr Preethi Wijegoonewardene, Regional President, World Organization of Family Physicians (WONCA) – South Asia, Sri Lanka
Mr William Stewart, Senior Health Adviser, Department for International Development (DFID), India
Mr Sanjoy Roy, Managing Trustee, Salaam Baalak Trust, India

Session Coordinator:
Ms Nelly Enwerem-Bromson

Rapporteur:
Dr Supriya Bezbaruah
In his introductory remarks, the Chair H.E. Professor Dr Syed Modasser Ali said that partnerships in the Region constitute those who have plenty as well as those who have very little. All five fingers are not of the same size, but they work as a team.

The Co-Chair Ms Tine Staermose emphasized that for the International Labour Organization (ILO), developing new partnerships is most important.

ILO brings health to the workplace. Many work in the informal sector where working hours are longer and working conditions worse than in the formal sector. Promoting healthy workplaces that do not harm the physical and mental health and fundamental rights of workers is extremely important. A healthy workforce is a productive workforce.

ILO works with the public and private sectors, private organizations, enterprises, and with governments and research institutions in areas such as HIV/AIDS, occupational safety and health, micro health insurance and factory improvement programmes. The Factory Improvement Programme combines workshop training with in-factory consultation in Sri Lanka, India and Viet Nam, and will soon be expanded. This helps to improve quality, boosts productivity and improves work
practices, thereby creating a collaborative workplace culture. Tailored advice is provided to participating enterprises so that practical improvement can be made to increase overall competitiveness. One example is that of a factory in Viet Nam with 420 staff, which makes electrical motors. It had many safety hazards, due to the use of paint, inflammable material, workers wearing thin cotton masks during painting, and inadequate personal protective equipment. The ILO team made recommendations and prepared a detailed health and safety checklist that was available to a health and safety committee consisting of workers and managers. They put these procedures on every work floor. They looked at the costs of these improvements and the required financial resources were made available. Finally, the company reduced working hours, and therefore exposure to toxic materials, without reducing productivity and salaries. The challenge is to introduce such changes in the vast informal sector.

Mr Ken Earhart explained that the mandate of the Centers for Disease Control and Prevention (CDC) is healthier, safer and more productive lives through prevention.

CDC works by forming technical partnerships with public health agencies. CDC has a Global Disease Detection Program since 2004 whose mission is to build a network through collaboration with ministries of health, multilaterals, and US agencies; establish and connect regional centres; integrate activities such as surveillance, training, pathogen discovery and outbreak response; and strengthen global public health systems. There are currently eight centres and the most mature are in Thailand and Kenya. The most recent are in Bangladesh and India.

The value of global disease detection is health protection for the entire global community. The Global Disease Detection (GDD) network rapidly detects, accurately identifies and promptly contains emerging infectious diseases and bioterrorist threats internationally. The focus is on laboratory strengthening and surveillance of emerging diseases. Usually this is done through strengthening existing surveillance and the public health system within the country. About 40 new pathogens have been discovered. Training in epidemiology and
Dr Md Shafiullah Talukder informed that the National TB Control Programme (NTP) of Bangladesh is a good example of partnerships for health. The NTP follows a public–private mix (PPM) approach, with a memorandum of understanding (MOU) used to formalize these partnerships. The partners collaborating in TB control include the government, municipalities, NGOs, medical colleges and universities, government and private hospitals, the corporate sector. Individual health-care providers include specialist medical practitioners, graduate private practitioners, non-graduate private practitioners, village doctors and community health workers.

Diagnostics helps to ensure a more timely and accurate response to threats and enhanced compliance with the International Health Regulations. The future of global health security lies with individual countries and the capacity within each country. Though CDC has many partners such as NGOs and academic organizations, at the core is the relationship with countries and WHO. It bears thinking about whether NCDs could also be incorporated into the global health platform.

The Bangladesh Garment Manufacturers and Exporters Association (BGMEA) is also a partner in TB control. Youngone, a South Korea-based group, was the first company to provide directly observed treatment, short-course (DOTS) since 2002, as well as diagnosis and management of patients. The NTP provides guidelines, logistics, drugs and training. Youngone provides the manpower. In 2009, an MOU was signed by the BGMEA with the NTP. Individual garment industries provide management support and employees’ time. The Bangladesh Rural Advancement Committee (BRAC) provides technical support.

The BMGEA workforce employs 3.6 million workers, comprising 80% women, who are being empowered and involved in decision-making. As a result, the total fertility rate and MMR are decreasing and female literacy is increasing. Twelve health centres have been established, where medicines are provided free of cost. The BMGEA is now poised to establish two 150-bedded hospitals in which all treatment will be free for garment workers. BMGEA has invited international organizations (UNFPA) to partner with it, and welcomes more partnerships.
Mr Steven J Kraus reminded the audience that 2011 marks 30 years of the AIDS epidemic. The work at UNAIDS will be guided by the new UNAIDS strategy 2011–2015, which aims to advance global progress in achieving country-set targets for universal access to HIV prevention, treatment, care and support, and to halt and reverse the spread of HIV and contribute to the achievement of the MDGs by 2015. UNAIDS has ten co-sponsors from the UN system. It works with governments and civil society organizations, key bilaterals (PEPFAR and the US government), which brings validity, legitimacy, accountability, reality and credibility to the response. Partnership in the AIDS response and the principle of greater and meaningful involvement of people living with HIV/AIDS (GIPA) underpin the philosophy and approach of UNAIDS.

UNAIDS is working in three areas:

1. *Revolutionizing HIV prevention:* There has been a 20% reduction in new infections in Asia in the past 10 years. However, there is an urgent need to revolutionize HIV prevention as for every person treated, two get new infection. At this rate, one can never win. There is evidence in the Region that three key populations contribute to HIV; these are men who have sex with men (MSM), sex workers and drug addicts. These have to be involved in the partnership. India, Nepal and Thailand have reduced HIV infections by 50% by focusing on these populations. In Asia, 75 million men buy sex from 10 million women. These 75 million men are also in intimate relationships with 50 million women. These 50 million women must be protected. Thus, these groups have to be addressed. This can be done either in a legal or illegal environment. In 20 countries of Asia, it is illegal for men to have sex with men. Thirty-nine countries regard commercial sex as illegal. Eight countries have the death penalty for people who use drugs. Asia has some of the best examples of harm reduction, needle–syringe exchange and opioid substitution therapy. Civil society can be of great help. “Nothing about us, without us”; if programmes are designed for at-risk populations but not with them, they fail.

2. *Catalysing the next phase of treatment, care and support:* Ten years ago, the cost of treatment for AIDS was $10 000 per year. Today, it costs $116 per year...
(99% reduction in price). This has been achieved by governments and key civil society partners. However, this can be undone by free trade agreements and loss of generics, which are being bought by big pharmaceuticals. At present, 15 million people need access to treatment. The challenge is to energize the next round of treatment.

3. **Advancing human rights and gender equality for the HIV response:** There is a need to improve sexual and reproductive health and access to treatment. Various surveys in many countries have shown that the most common source of stigma against populations most at risk for HIV comes from the health-care sector. State-sponsored discrimination is greatest for sex workers. Therefore, clear, compassionate and genuine partnerships with civil society are needed.

Dr Preethi Wijegoonewardene stated that the World Organization of Family Doctors (WONCA) brings the family doctors of the world together (>250 000 doctors in 116 nations). It advocates and supports, through its member organizations, the highest standards of clinical care, education, training and research, and represents general practice/family medicine at WHO. WONCA advocates for improvements that make a difference to people's lives at a regional and global level.

In 2009, at the World Health Assembly, adopted a resolution urging countries to invigorate the primary healthcare system. The resolution puts the primary health care workforce, including family doctors, at the centre of every health system. As examples of partnerships that have been working, the South Asia primary care research network trains general practitioners in South Asia to conduct research in primary care. The Member of the Royal College of General Practitioners (MRCGP) international degree is provided to South Asian countries through collaboration between the Royal College of General Practitioners (RCPG), UK and South Asian countries. Yet another partnership is that between the Post Graduate Institute of Medicine, Sri Lanka and the Indian Medical Association. These partnerships will elevate the quality of family medicine.
Mr William Stewart highlighted three exciting partnerships in which the Department for International Development, UK (DFID) is involved in “to improve the health and nutritional status of the poorest and excluded in DFID partner states”. It works with state governments in India to improve health, nutrition, and water and sanitation services, thereby reducing maternal and child deaths, undernutrition and unwanted pregnancies. This is the first time DFID has put water and sanitation into its health programme. The second Partnership, which will deliver this platform, is built around community engagement; empowering communities and working with community organizations to better hold public sector services to account.

The third partnership that is not yet fully functional is the one around the evidence for these approaches and the need to continue to build upon an evidence base on how comprehensive community-based approaches can improve health outcomes. Traditionally, programmes in DFID have been in vertical streams. At present, these are more from the perspective of the life cycle, especially of young women and girls, to deliver comprehensive services.

In the area of sanitation, DFID does not supply the hardware, e.g. building toilets. Its work involves meeting community demands and supporting communities to understand the linkages between poor sanitation and diarrhoeal and other diseases. Supporting communities not tolerate open defecation and other practices which impact on their health. India has the largest nutrition programme in the world, but the delivery is poor, and the biggest gap is a nutrition strategy for those below the age of two years, and teaching better infant- and child-feeding practices to women.

In India, public health-care services are of poor quality so people go to private physicians, driving up the cost of health care. There is little accountability of these services to the community. DFID therefore works with self-help groups, women’s groups and other community organizations to ensure an increase in the quantity and quality of supply and demand for essential services, through increased use of essential health, nutrition, and water and sanitation services.

Evidence in India and globally shows how community approaches can improve maternal and newborn health. Communities must be mobilized to demand better services and improve their outcomes. DFID is building partnerships to further that.
Mr Sanjoy Roy explained that the Salaam Baalak Trust started working with street children 22 years ago. It was a bitter cold winter so blankets were distributed to children at the railway station. The children said they did not need these because if they used the blankets, someone would molest them. They would rather stuff newspapers down their chests. The next day, they were given sweaters. They said they had no place to wash or store a second set of clothes. The Trust then realized that what was needed was not just education but a whole array of facilities – nutrition, health and mental health. Apart from selling things at the railway station, these children made money primarily by selling themselves to international tourists. The Trust then met each hotel owner in the area, telling them to ask questions if a tourist came in with a child, and if the child was molested in that hotel, the police would be called in. It worked; hotel owners cooperated and a partnership was formed.

Next, an HIV testing unit was set up in Safdarjung hospital for these children as they were at high risk for HIV infection. To bring about any kind of change, it was necessary to bring about psychological change in the child. Therefore, a child psychiatrist from Newcastle was called to look at the mental health of the children, and now there is a full-scale mental health scheme. Over the past three years, about 9000 children have been examined and treated. Fifty-three children were diagnosed with TB, of whom six have died. Several have been treated for scabies, STIs, malnutrition, a few for HIV and many other ailments.

The NGO sector is very guarded, and should be more transparent, while governments tend to get lost in the bureaucracy. United Nations and bilateral organizations need to leverage their goodwill to bring about dialogue and change. People should be empowered to demand good health. Empowerment is the key to success.
Discussion points

- This session discussed different kinds of partnerships with different kinds of communities: from the corporate sector to sex workers to the role of family doctors.

Conclusions and recommendations

- Communities must be mobilized to demand better services and improve their outcomes.

- The corporate sector can be a useful partner in controlling tuberculosis, HIV and other diseases.

- Public health, particularly preventive health care, should be strengthened, especially in developing countries.

- Nutrition strategies should be formulated for children less than two years of age.

- Laws and regulations that prevent most-at-risk populations from accessing services for HIV infection must be revised, and a supportive, non-stigmatizing environment provided.

- Harm reduction approaches have been shown to be successful at controlling drug use and reducing the spread of HIV. Best practices in the Region should be replicated for the prevention and control of HIV.
Best practices: parallel session I

**Addressing child and maternal mortality**

**Moderator:**

Dr Quazi Monirul Islam, Director, Family Health and Research, WHO South-East Asia Region

**Speaker:**

Dr Vinod Paul, Vice-Chair, Partnership for Maternal, Newborn and Child health, and Head, Department of Paediatrics, All India Institute of Medical Sciences, India

**Best practices for addressing child and maternal mortality: the hype, the reality and the hope**

**Panelists:**

H.E. Ms Madalena F.M. Hanjam C. Soares, Vice-Minister of Health, Timor-Leste

Ms Nobuko Horibe, Regional Director, United Nations Population Fund (UNFPA), Thailand

Dr Harshalal R. Seneviratne, Dean and Senior Professor, Faculty of Medicine, University of Colombo, Sri Lanka

Mr Ashok Alexander, Director, Bill and Melinda Gates Foundation, India

**Session Coordinator:**

Dr Neena Raina

**Rapporteurs:**

Dr Narimah Awin/Dr Rajesh Mehta
Discussion points

- Countries, as exemplified by Timor-Leste, expect a coordinated approach to external aid and technical support from agencies and donors. In Timor-Leste, the contribution of the private sector is less than 1%, so the government plays a major role in coordination.

- Governments and policy-makers need to further engage scientists in their programmes, who can provide technical advice as well as introduction/use of tools.

- Delays in deciding to seek care can be reduced by improving women’s status and empowering them, so that they can make informed decisions.

- The common perception is that the private sector needs to practise corporate social responsibility (CSR); however, partnerships would be more effective if the needs and aspirations of both sides are considered.

- For partnerships to be sustained, there is a need to look at a systematic approach. This means obtaining a “win–win” formula; each partner needs to know the components that are to be delivered/adhered to by the other partner, and trust among partners must be built.

- Need for the application of “business principles” in efforts to scale up interventions.

Conclusions and recommendations

- Different stakeholders such as government, community and religious organizations, UN agencies, private sector and academia can play a significant role in reducing child and maternal mortality in the South-East Asia Region through a coordinated approach that addresses several areas of concern.

- Stakeholders can forge stronger partnerships that also need to be made sustainable.

- Best practices such as the Janani Suraksha Yojna in India (in which demand-side financing through conditional cash transfers has shown a significant increase in the use of services, and a decline in maternal mortality) could be replicated in the Region.

- Greater advocacy is needed for reproductive health, particularly with parliamentarians and the media.

- Role of the family and the community needs to be strengthened, to ensure effective interaction between the communities and the health system.
Best practices: parallel session II

Ensuring universal access to health services

Chairs:
H.E. Mr Rui Manuel Hanjam, Vice-Minister of Finance, Timor-Leste
Dr Ascobat Gani, Health Economist and Former Dean, School of Public Health, University of Indonesia, Indonesia

Speakers:
Dr T. Ravindra C. Ruberu, Secretary, Ministry of Health, Sri Lanka
Dr Soe Aung, Programme Adviser/ Director, Myanmar Medical Association, Myanmar

Dr Dirgh Singh Bam, President, Dirgh-Jeevan Clinic, Nepal

Community based TB control: lessons learnt from Nepal

Dr Viroj Tangcharoensathien, Director, International Health Policy Programme, Ministry of Public Health, Thailand

Reaching universal coverage in Thailand: what strategic approaches?

Session Coordinators:
Dr Ilsa Nelwan and Dr Iyanthi Abeyewickreme

Rapporteur:
Dr Leonard Ortega
**Discussion points**

- Health-care financing is key to universal coverage. Even where universal coverage has been achieved, there may be a shortage of services. Out-of-pocket payments remain high. Broadening the tax base and reducing indirect taxation are important.

- There is a need for greater efficiency, development of master plans, increased accountability and transparency, and modernization of the health services.

- Vertical programmes with a horizontal approach to implementation help improve the coverage of interventions.

- To sustain universal coverage, curative spending has to be stabilized and should be balanced with public health interventions. This is more cost effective for improving population health, particularly in view of ageing populations and the burden of NCDs.

**Conclusions and recommendations**

- A balance needs to be achieved between government-pooled funds and private insurance schemes.

- A shift toward community-based rather than institution-based human resources for health would include recruiting a health workforce from among teachers, members of religious groups and organizations, and other community stakeholder groups.

- Operational research as well as laboratory coverage needs to be strengthened.

- Prevention of road traffic accidents and NCDs must be put on the national health agenda.

- Countries of the Region need to seriously address the problems of alcohol and tobacco, which are responsible for a major share of the NCD burden.

- Educational and health initiatives go hand in hand; in particular, education for women should be targeted as a key factor for the improvement of health outcomes.

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1 Universal access to health services implies how much of a population can reach health services. Universal coverage is the output related to utilization and acceptability.
Revitalizing primary health care – addressing health inequities

Chairs:
Dr Gado Tshering, Secretary, Ministry of Health, Bhutan
Dr Amorn Nondasuta, Chairman, The Foundation for Quality of Life, Thailand

Speakers:
Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Ministry of Health, Indonesia

Decentralization of health care: can it address health inequities?

Mr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India, India

Community empowerment: means for reducing equity gaps

Dr Dharma S. Manandhar, President, Mother and Infant Research Activities (MIRA) and Head, Department of Paediatrics, Kathmandu Medical College, Nepal

Community mobilization and community-based health workforce can make a difference

Session Coordinator:
Dr Sudhansh Malhotra

Rapporteur:
Dr Boosaba Sanguanprasit
**Discussion points**

- Decentralization of health care can address health inequities. It is a desirable process for improving health systems, and should be an integral part of broader health reforms to achieve improved equity, efficiency, quality and financial soundness.
- The essence of decentralization is distribution of authority and resources.
- To revitalize PHC, the key is the community itself.
- Countries should “bootstrap” health programmes to a higher level of effectiveness by analysing existing programmes, and upgrading and reorienting them.
- The South-East Asia Primary Health Care Innovations Network (SEAPIN) was established in August 2010 to strengthen health systems in the Region through the PHC approach. Innovative approaches are already in existence; they only need to be identified.
- Implementation of demand-side policies and community mobilization can help in reaching vulnerable and hard-to-reach populations, as has been shown in Nepal.

**Conclusions and recommendations**

- The success of decentralization is dependent upon achieving good governance, productive partnerships at all levels of the community, implementation of a comprehensive approach to pro-poor growth, improving public services, improving coordination among stakeholders, and addressing the social determinants of health.
- Health should be viewed as an investment and not an expenditure.
- The role of medical colleges is vital, as they are the “think tanks” and help in researching problems. Involving politicians is also important as they play a central role in health.
- Market mechanisms have to be considered in this era of globalization. Health should not be put in the marketplace as the ethics of health will suffer.
Integrated approach to prevention and control of noncommunicable diseases

Chairs:
Dr Sudha Sharma, Secretary, Ministry of Health and Population, Nepal
Professor Tint Swe Latt, Rector, University of Medicine (2), Myanmar

Speakers:
Dr Mahesh K. Maskey, Chair, Nepal Public Health Foundation, Nepal

Status of Noncommunicable Diseases in South-East Asia and the role of civil society in its prevention and control, Nepal

Dr Neelamani Rajapaksa Hewageegana, Provincial Director of Health Services, UVA, Sri Lanka

Package of Essential Noncommunicable (PEN) Disease interventions for primary health care in low-resource settings, Sri Lanka

Dr Prakit Vathesatogkit, Executive Secretary, Action on Smoking and Health Foundation, Thailand

Using innovation in tobacco taxation in promoting health, Thailand

Session Coordinator:
Dr Renu Garg

Rapporteur:
Dr Nyo Nyo Kyaing
Discussion points

- It is important to work with industry to further the principle of healthy public policies. The tobacco and alcohol industry should not be involved as health partners.
- The media are experts in communicating with the public, and should be involved in spreading health messages.
- Civil society’s intervention in containing the NCD epidemic is vital to effectively tackle the twin challenges of NCD prevention and control – changing human behaviour and creating the right physical and social environment.
- NCDs need to be demystified. Awareness of the risk factors for NCDs should be raised among the community.
- The exclusion of NCDs from the MDGs is a strong reason for the weak political commitment and deficiency in funding.
- The Regional Framework on Prevention and Control of NCDs should be translated into local languages and widely utilized. Civil society can play an important role in each step of the Regional Framework.

Conclusions and recommendations

- Expertise, experience and systems are in place. Instead of creating parallel systems, the control of NCDs should be “piggy-backed” onto existing systems.
- The Package of Essential NCD (PEN) interventions has been implemented in Sri Lanka and could be duplicated in other countries.
- Civil society has played a very important role in changing sexual and drug-use behaviour for the control of HIV/AIDS; similar measures should be applied for NCD risk factors.
- Prevention and control of NCDs should be integrated into existing health programmes such as school health programmes.
- Incentives may need to be given to health workers in remote and difficult areas.
- The Framework Convention on Tobacco Control must be implemented more strongly.
- Innovative approaches to tobacco taxation can help in promoting health, as seen in Thailand.
- Member States should explore alternative financing for health promotion with a focus on prevention and control of NCDs.
- NCDs should be included in the MDGs.
Health for the urban poor –
the way forward

Chairs:
Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, India
Dr Genevieve Begkoyian, Regional Health Advisor, Young Child Survival, United Nations Children’s Fund (UNICEF), Nepal

Speakers:
Dr Abdul Sattar Yoosuf, Assistant Regional Director, WHO South-East Asia Region

Dr M.H. Basyir Ahmad Syawie, Mayor of Pekalongan, Indonesia
City without slums through community-based poverty eradication programme

Dr Siddharth Agarwal, Executive Director, Urban Health Resource Centre, India
Improving health of the urban poor: experiences from the field and lessons learned

Session Coordinator:
Dr Sudhansh Malhotra

Rapporteur:
Dr Suvajee Good
**Discussion points**

- The urban poor constitute the most rapidly developing segment of the population in developing countries and face demographic, environmental and health challenges.

- To engage people to move out of slums, the main challenge is funding and empowerment.

- To eradicate slums, institutionalization is required at various levels, such as the city, subdistrict and hamlet levels.

- Urban health is not only about health services but also improvement of infrastructure.

- Active partnerships with the community and empowerment can help in identifying those communities which are most in need.

- Opportunities include democratic systems, decentralization, availability of expertise, information technology and funding.

- Many urban poverty clusters are not listed; health vulnerability in these areas is greater than in listed clusters. This inhibits their ability to be active, productive and prosperous members of society.

**Conclusions and recommendations**

- Spatial mapping should be done to include poverty clusters that are not listed.

- Urban slum guidelines should be created and bodies formed with the responsibility to look after various areas.

- The community should be empowered to identify their needs and a budget provided to them.

- A public–private partnership approach can be used to address health needs in urban slums.

- Urban poor communities can act as active agents of change.
Protecting health from climate change

Chair:
Mr Young Woo Park, Regional Director and Representative for Asia and the Pacific, United Nations Environment Programme (UNEP), Thailand

Panelists:
Dr Iqbal Kabir, Coordinator, Climate Change & Health Promotion Unit, Ministry of Health and Family Welfare, Bangladesh

Experiences and initiatives to protect human health from climate change in Bangladesh

Ms Mabel Rebello, Member of Parliament and Member of Standing Committee of Indian Association of Parliamentarians on Population and Development (IAPPD), India

Community-level initiatives to protect human health from climate change

Dr Sharad Ointa, Professor, Department of Community Medicine and Family Health, Tribhuvan University, Nepal

Climate change, vulnerability assessment: experiences from Nepal

Mr Yeshey Penjor, Climate Change Policy Specialist, United Nations Development Programme (UNDP), Bhutan

Climate change and human health: adaptation in Bhutan

Dr Bindeshwar Pathak, Founder, Sulabh International Social Service Organisation, India

Impact of climate change on sanitation and health and how Sulabh International has contributed in addressing the issue, India

Session Coordinator:
Ms Payden

Rapporteur:
Dr Zakir Hussain
Discussion points

- Basic necessities such as food, drinking water, sanitation and shelter are the first services that are hit by extreme weather events caused by climate change, and these have a direct impact on health.

- Community participation is important for addressing the effects of climate change.

- The Asian Development Bank (ADB) has undertaken a project to address the impacts on health in other sector activities such as water, sanitation and agriculture. It tries to convince governments to allocate funds for health through a cost–benefit analysis.

- Several factors other than climate change have an impact on health, such as country policies and health systems. These should be considered while carrying out research to understand the impacts of climate change on human health.

- WHO is preparing a health vulnerability assessment guidance document. Nepal has used the guidelines to assess the vulnerability of the health sector to climate change.

- Sulabh International has provided toilet services and has also developed five new technologies that are water efficient and environment friendly. It aims to collaborate with the Government of India to provide toilets to all by 2015.

Conclusions and recommendations

- Partnership was identified as one of the solutions to some of our present-day climate-engendered problems. People in need should be prioritized, with special attention to women and children.

- More evidence needs to be created in the health sector for convincing ministries of finance and donors to allocate funds to combat climate change-related problems.

- Co-benefits need to be gauged through working with other sectors.

- Renewable energy sources need to be piloted and scaled up.
Public–private partnerships in health

Chairs:
Mr Prasanna Kumar Pradhan, Special Secretary, Ministry of Health and Family Welfare, India
Dr Narottam Puri, Advisor, Health Services Committee at The Federation of Indian Chambers of Commerce and Industry, India and President – Medical Strategy & Quality at Fortis Healthcare Limited, India

Speaker:
Mr Anil Swarup, Director General for Labour Welfare and Joint Secretary, Ministry of Labour and Employment, India

......a journey called Rashtriya Swasthya Bima Yojana

Panelists:
Dr Akram Ali Eltom, Director, Partnerships Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland

Country-level opportunities and challenges in public–private partnerships for health

Mrs Penny Grewal Daumerie, Director, Global Access, Medicines for Malaria Venture (MMV), Switzerland

The power of partnerships: accelerating the development and delivery of much-needed medicines

Dr Harinder S. Sikka, Director, Corporate Affairs, Piramal Healthcare Limited, India

Discussion on public–private partnerships in health

Professor S.P. Thyagarajan, Pro-Chancellor (Research), Sri Ramachandra University, India

Research partnerships in health

Session Coordinator:
Dr Manisha Shridhar

Rapporteur:
Mr Gautam Basu
### Discussion points

- **Public–private partnerships** can be used to cover below poverty line (BPL) families with health insurance (though smart cards/electronic systems). Families can make a choice from select private hospitals in the health insurance scheme of Rashtriya Swasthya Bima Yojana by the Ministry of Labour, Government of India.

- **Private sector involvement** needs to be in place for the Emergency Management Research Institute (EMRI) and Health Management and Research Institute (HMRI).

- **Effective communication** with the private sector is needed on the advantages of investing in the health of the workforce. A healthy, robust workforce would contribute to a profitable private sector and productive individuals; hence, public–private partnerships for health should be a priority for the private sector.

- **Reducing out-of-pocket expenses** through risk pooling can be done by offering direct private insurance or participating in joint government/employer national insurance and/or community-based insurance schemes for individuals/communities affected by HIV, tuberculosis and malaria.

- **There is a need for accelerating the development and delivery of much-needed medicines** through the power of partnerships.

- **Ethical challenges in public–private partnerships** must be addressed.

### Conclusions and recommendations

- **A quality check** of the health insurance scheme of the Rashtriya Swasthya Bima Yojana run by the Ministry of Labour, Government of India needs to be enforced. The manner of ensuring such quality checks is under development by the Ministry of Labour.

- **Private sector enterprises** should be encouraged to create supportive workplaces for HIV, TB and malaria prevention/treatment/care, preferably within broader occupational health measures for workers and their families.

- **Innovative public–private partnerships** are critical for service delivery of health, product development, fulfilling corporate social responsibilities and research with academia.

- **Public–private partnerships** should also take an active role in preventive health care as this will improve performance of the workforce.

- **The government should encourage partnerships for health research** in order to scale up discovery and development of new medical products.

- **Public–private partnerships in medical technology** need to be formed in order to adopt/adapt technologies appropriate for countries of the Region.
Financing for universal coverage

Chairs:
H.E. Mr Ahmed Asad, State Minister of Finance and Treasury, Maldives
Dr David Evans, Director, Health Systems Financing, WHO Headquarters, Switzerland

The global situation: health systems financing: the path to universal coverage

Speakers:
Professor Indrani Gupta, Professor and Head of Health Policy Research Unit, Institute of Economic Growth, India
Universal health coverage: options for South-East Asia Region

Dr Hasbullah Thabrany, President South-East Asia Public Health Education Institutes Network (SEAPHEIN) & Former Dean, School of Public Health, University of Indonesia, Indonesia

Public financing – private delivery to strengthen health systems

Dr Phusit Prakongsai, Director, International Health Policy Program, Ministry of Public Health, Thailand

Financing for universal coverage: experiences from Thailand

Session Coordinator:
Dr Sunil Senanayake

Rapporteur:
Dr Kathleen Holloway
Discussion points

• To attain universal coverage, there is a need to raise funds, reduce risk and improve efficiencies. Low-income countries may find this difficult. The global community and international agencies can be of help.

• For universal coverage to be attained, there needs to be political commitment, a legal framework, greater democracy and creation of a fiscal space.

• The private sector can play a role as there is a shortage of skills. However, the private sector should be regulated and the public sector involved more than the private sector.

• Financing mechanisms should be mixed and the poor should be targeted.

• Chronic diseases and ageing are a major challenge. It will take time to reach universal coverage of NCDs. There are three dimensions – the percentage of the population covered, what services are covered, and the percentage of costs covered. Financing these is a challenge. A mix of services is needed; preventive actions as well as treatment.

• Unfortunately, the focus is always on curative services and not on preventive services, and insurance does not cover these. There is a need to include prevention and promotion, which may need a different financing mechanism from insurance. However, even private insurance is now giving risk reduction premiums for people who do some preventive activities. This can also cover screening tests/activities under insurance for older age groups.

• Social insurance protects from social disasters, not natural ones. Catastrophic and out-of-pocket expenditure need to be monitored.

Conclusions and recommendations

• Some resources should be kept aside for emergencies. All public health money should not be used for financing universal coverage.

• WHO and the international community can advocate for public financing with governments and stimulate them to spend more on health.

• Agreement on and understanding of universal coverage is limited. Data should be collected to fill the information gaps in order to facilitate public financing for universal coverage.
Opening new frontiers and innovative opportunities for collaboration in the health sector: South–South and beyond

Chairs:
Dr Marie-Andree Romisch-Diouf, Director, Country Cooperation, WHO Headquarters, Switzerland
Dr Nata Menabde, WHO Representative, India

Speakers:
Dr Biswajit Dhar, Director-General, Research and Information System for Developing Countries (RIS), Ministry of External Affairs, India
Dr K.M. Gopa Kumar, Legal Advisor, Third World Network, India

Dr Alvaro Matida, Adviser, FIOCRUZ Center for Global Health, The Oswaldo Cruz Foundation, Brazil
Dr Mmathari Kelebabgile Mastau, Deputy Director-General, Strategic Health Programme, Department of Health, Government of South Africa
Dr Antonio Duran, Coordinator, International Health Policy, Andalusian School of Public Health, Spain

Session Coordinators:
Dr Nata Menabde and Mr Sunil Nandraj

Rapporteur:
Ms Anagha Khot
Discussion points

• South–South Cooperation is an innovative mechanism based on equal partnerships and the principles of solidarity, mutual benefit, capacity building and technological transfer, with a focus on equity in health within and between countries.

• South–South Cooperation does not adopt the traditional “assistance mode” but is based on developing effective partnerships that are evaluated from the recipient’s point of view, applying the principles of the Paris Declaration and the Accra Agenda For Action.

• Several successful initiatives are under way under the South–South Cooperation and Triangular Cooperation, and several of these involve the BRICS (Brazil, Russia, India, China and South Africa), other emerging economies as well as other developing countries in Latin America, Africa and South-East Asia.

• South–South Cooperation is primarily concerned with international negotiations in the area of trade and health but is not adequately translated into action.

• Partnerships are required because they transform the imbalance in collaboration between the North and South and aim for social equity.

• Partnerships help in technology transfer, vaccine development, e-health initiatives, training for human resources, research and medical care, and strengthening health systems.

• In forming partnerships, there is a need for a perfect fit, so that both parties benefit from each other. There should be a give and take between all those forming a partnership. The delicate balance between synergy and individualism should be maintained.

• Multisectoral collaboration should not promote health at the cost of other sectors.

• Partnerships should be sensitive to the global economic climate, even if they are not dependent on external funding.

• Countries such as India have established pharmaceutical manufacturing plants in some African countries as joint ventures. To move to the next step, new products and technologies in health should be introduced.

Conclusions and recommendations

• South–South Cooperation is new and should be explored further. There is huge scope for learning from each other.
• The role of South–South Cooperation and BRICS is acknowledged, especially in the changing landscape of global governance and rapid economic growth in several developing countries.

• Mechanisms such as South–South Cooperation and Triangular Cooperation can play a role in shaping and influencing the new world order according to the principles of mutuality, equity, transparency and sustainability.

• Initiatives for cooperation in the health sector are modest. This is recognized as a nascent area of work where concerted action needs to be taken.

• There is need for a renewed focus on implementation, based on learning from good practices and success stories.

• While there has been unprecedented economic growth in several developing countries, the challenge is to ensure that this growth is harnessed to address the existing health sector challenges and translates into better health for the people.

• An operational framework is needed for implementing South–South Cooperation such as the New Partnership for Africa's Development (NEPAD).

• Partners in health should assist in mapping/documenting successful examples of South–South Cooperation across regions.

• The South–South Cooperation in health should focus on ensuring equitable access to pharmaceuticals, building country capacity to produce low-cost quality drugs and vaccines, transferring appropriate technologies among countries with similar contexts, health innovation, use of information technology especially for telemedicine, training of human resources, research and medical care.

• All opportunities have to be seized to mainstream health in foreign policies.
**Perspectives and roles of stakeholders in health development in the Region**

1. **Private sector/Foundations**

   **Chairs:**
   - Dr Ranjit Roy Chaudhury, Chairman, Task Force for Research, Apollo Hospitals Educational and Research Foundation, India
   - Mr Sushanta Sen, Principal Advisor to the Confederation of Indian Industry (CII), India

   **Panelists:**
   - Ms Sinta Kaniawati Munir, General Manager, Unilever Indonesia Foundation, Indonesia
   - Dr Jingjai Hanchanlash, Advisor to Executive Board & Former Board Member and Co-Chairman, The Thai-EU Business Council, Thailand
   - Dr Vikram Sheel Kumar, Co-Founder and Chief Medical Officer, Dimagi Inc., India

   **Corporate social responsibility: empowering the community through public health education program**

   **Overview of mobile applications (for health)**

   - Ms Indrani Kar, Senior Director & Head – Development Initiatives, Confederation of Indian Industry (CII), India

   **Role of private sector and partnerships**

   **Session Coordinator:**
   - Dr Roderico Ofrin

   **Rapporteur:**
   - Dr Sara Varughese
## Discussion points

- Public–private partnerships should aim at empowering and engaging communities. The community is a partner in delivering interventions such as spreading health messages and monitoring the progress of interventions. A service provision model should not be applied.

- Education and behaviour change remains the best intervention to prevent disease and, in communities, this can be done successfully only if they are involved. These initiatives should be in synergy with those of the government.

- There is a need to think beyond the usual ways of working with the private sector in partnerships for health, especially in the following: governance of public health; building the capacity of civil society; innovative schemes for managing health and social insurance; and maintaining standards of quality of the health services.

- Corporate social responsibility programmes are not about donations to hospitals; these schemes should be well thought out as per the priorities and needs of populations/communities, keeping sustainability in mind.

- Partnerships that are sustainable begin with sharing the most important resource, which is information. The private and public health sectors need to share information in order to properly intervene in communities – from conceptualization of initiatives to monitoring and evaluation.

- Technology can provide solutions but these should be well thought out. It is important not to automate idealized systems – actual intervention in the field is what is more relevant.

- There are innovative ways for the private sector/industry to be involved in public health: – Advocacy and awareness in the workplace and the community in areas such as HIV and TB – Capacity development of workers, civil society and health service providers – Taking interventions beyond awareness and the workplace – Private–private partnerships to support health and health-related needs in villages – Knowledge creation and dissemination of good practices – Involvement of the private sector in national health commissions, health authorities or legislation/policy development.

- Mutual benefits or co-benefits should be identified/described together by the private and public sectors so that partnerships can be sustained.

- There is a need to massively scale up these private sector models and interventions to make a meaningful
difference, and this can be done by working together. Clear roles and responsibilities are necessary so that every sector can maximize their comparative advantage.

**Conclusions and recommendations**

- Technology for health needs to be brought to users at the grass-roots.

- Best practices need to be documented and disseminated so that good work can be communicated and replicated.

- Some models can be institutionalized and mechanisms/working groups/ follow-up workshops can be organized so that these discussions are taken forward.
Perspectives and roles of stakeholders in health development in the Region

2. NGOs and civil society

Chair: Mr Azmat Ulla, Head of Regional Office, International Federation of Red Cross and Red Crescent Societies, India

Speakers:

Dr Md Akramul Islam, Programme Head, Health Programme, Bangladesh Rural Advancement Committee (BRAC), Bangladesh (read by Dr Khurshid Alam Hyder, WHO SEARO)

Role of NGOs in health: experience in tuberculosis control in Bangladesh

Dr Vinya S. Ariyaratne, General Secretary, Sarvodaya Shramadana Movement, Sri Lanka

Building sustainable civil society partnerships for health: challenges and responses

Dr Mirai Chatterjee, Programme Coordinator, SEWA Social Security, India

Health action through membership-based organizations (MBOs) of women: some experiences of the Self-Employed Women’s Association (SEWA), India

Session Coordinator:

Dr AP Dash

Rapporteur:

Dr Khurshid Alam Hyder
Discussion points

• Focusing primarily on disadvantaged groups often inadequately addressed by the government, civil society organizations have, over the years, played an important role in addressing the health needs of the poorer segments of the population in the Region.

• While some NGOs in the Region have been and continue to provide “services” in the health sector, others such as the Sarvodaya Shramadana Movement in Sri Lanka have been working on the “determinants” of ill-health. It believes in an integrated approach to health. At various stages of its evolution, Sarvodaya has established partnerships with community organizations, government agencies, the private sector, UN agencies and international development organizations.

• Effective partnership-building requires sharing a common vision, mutual understanding between partners, respect for organizational mandates, and recognizing each others’ strengths and limitations.

• Bureaucratic attitudes, procedural constraints, conflicting interests on issues such as procurement, payments for services, etc. often result in serious problems that inhibit partnerships. Organizations that work on the determinants of health to address inequities are faced with more structural issues in building partnerships, particularly with the State sector.

• Membership-based organizations for self-employed women’s associations are key to enhancing bargaining power and strength. Partnership alliances are needed for the poor to improve the social determinants of health across the life cycle in the Region.

• Bangladesh is a unique example of government–NGO partnership in implementing TB control and working on other health-related issues. The key areas are participatory planning and joint review, resource mobilization, health systems strengthening and capacity building, and advocacy, communication and social mobilization.

• Partnerships enhance performance and capacity for rational use of resources, provide a platform for civil society, coordination and oversight strengthened by joint meetings and field visits, and conflict resolution and trust building through regular communication.

Conclusions and recommendations

• Current and emerging health challenges cannot be addressed by the State and private sectors alone. Better recognition and responsibility should be given to credible organizations. Mechanisms should be created for better cooperation and collaboration (from policy level down to implementation).

• The voluntary sector should continue to improve their accountability and governance.

• To strengthen health services, it is necessary to encourage, enable and recognize the formation of associations, networks of membership-based organizations and NGOs.

• The role of civil society in policy and programme review of the health sector should be strengthened.
Perspectives and roles of stakeholders in health development in the Region

3. Governments

Chair:
H.E. Dr Aminath Jameel, Minister of Health and Family Welfare, Maldives

Panelists:
Mr Gopal Krishna Menon, Country Manager, Australian Agency for International Development (AusAID), India

Role of donor governments

Dr P.B. Jayasundera, Secretary, Ministries of Finance and Planning and Economic Development, Sri Lanka

Role of recipient governments

Dr Sudha Sharma, Secretary, Ministry of Health and Population, Nepal

Health development in Nepal: Government of Nepal’s perspectives

Session Coordinator:
Dr Jigmi Singay

Rapporteur:
Ms Nelly Enwerem-Bromson
### Discussion points

- It is important to strengthen consultative forums between recipient governments and development partners, as well as reinforce multisectoral partnerships at country level to address the social needs of the population.
- Aid effectiveness should be assessed in the attainment of health development outcomes, and ownership of development policies and plans by recipient countries.
- Building stronger aid partnerships based on aid effectiveness principles is the mutual responsibility of recipient and donor governments.
- Key aid effectiveness principles include national ownership, alignment, harmonization, management of results and accountability.
- Recipient countries should set clear national development priorities and have robust health policies and plans for partners to align with.
- Accountability seems to be imposed on recipient governments, but not always followed by donor governments. The principle of mutual accountability should be kept in mind.
- The sectorwide approach (SWAp) and the example of Nepal’s International Health Partnership (IHP+) were highlighted as models of aid effectiveness, resulting in improved health outcomes, such as a reduction in the MMR.

### Conclusions and recommendations

- Despite global commitment to the principles of the Paris Declaration on Aid Effectiveness, there are gaps in understanding and implementation at country level, particularly in terms of donor harmonization and alignment with national development priorities.
- Greater predictability of funds should be ensured.
- Technical assistance without adequate skills transfer can create dependency. There should be a clear road map for national capacity enhancement.
- Increased synergy with and involvement of civil society and non-State actors needs to be developed. Joint planning and monitoring and evaluation need to be conducted regularly.
- The gap between global political commitments and country-level realities in the area of aid effectiveness should be bridged. Funds should be pooled, flexible and not earmarked.
- Governments must be innovative in utilizing funds at the country level, for example, by scaling up interventions in NCDs with funding from the Global Fund to fight AIDS, TB and Malaria, by highlighting linkages between tobacco, cardiovascular diseases, diabetes and TB. Similarly, funding for malaria control can be used to prevent other vector-borne neglected tropical diseases.
Perspectives and roles of stakeholders in health development in the Region

4. UN/Intergovernmental organizations

Chair:
Ms Caitlin Weisen, Country Director, United Nations Development Programme (UNDP), India

Panelists:
Dr Nata Menabde, WHO Representative, India

Mr Marc G.L. Derveeuw, Representative a.i, United Nations Population Fund (UNFPA), India

Professor Charles Franklin Gilks, Country Coordinator, Joint United Nations Programme on HIV/AIDS (UNAIDS), India

Dr Asheena Khalakdina, Health Specialist, United Nations Children’s Fund (UNICEF), Thailand

Ms Tine Staermose, Director, International Labour Organization (ILO), India

Dr Ram Boojh, Programme Specialist, Ecological & Earth Sciences, United Nations Educational, Scientific and Cultural Organization (UNESCO), India

Session Coordinator:
Dr Narimah Awin

Rapporteur:
Dr Prakin Suchaxaya
Discussion points

- UN agencies and international organizations, having a “bird’s eye view” of the situation in countries, are in an opportune position to assist Member States by focusing on major issues and challenges such as poor geographical, social and financial access to services; extreme disparities within countries; weak health systems; poor scaling up of interventions; high catastrophic expenditure on health with poor social security; no health and safety net for workers; environmental pollution from using cow dung for cooking; and several unfinished agendas such as deaths from pneumonia and diarrhoea.

- Partners also have to use opportunities such as strong political commitment (e.g. the Janani Suraksha Yojna in India), robust national plans for the NHRM and the huge pharmaceutical industry in India, the role of IT in health, and the various models for integration and decentralization of services.

- However, many opportunities can pose challenges and sometimes do not lead to solutions; for example, the huge pharmaceutical industry in India and the IT revolution have not led to equity, and have played no role in reducing hunger and malnutrition; the high intellectual capital has not been able to harness public leadership to allow universal access to safe water and sanitation.

- There is a need to balance the social determinants of health with the strengths and potential of the health system.

- Adhering to international standards can be a win-win situation for both enterprises and workers. Workers get a healthy workplace, could get higher wages, face fewer hazards while enterprises get a healthier workforce and higher profits.

- Global agencies provide support to countries with bad indicators. Support should also be given to countries that are doing well.

- In the past four years, UN organizations in India are much better coordinated, for example, in HIV work or census and gender mainstreaming. However, there are areas that need improvement.

- Support to the government to achieve the MDGs will require collaborative efforts among UN agencies. Both vertical and lateral approaches are required. Maternal and child health and nutrition are key issues.

- Progress in health is mainly focused on inputs and not much on outputs or outcomes. UN agencies are accountable to assist governments in improving on this. With the information technology that India has, health information, monitoring and reporting systems can be improved.
Conclusions and recommendations

- UN agencies can optimize resources by using each others’ auditing services, offices and have common initiatives to reduce costs and prevent duplication of efforts.

- Private practitioners should be asked to prescribe drugs using their non-proprietary names.

- In India, adolescent health, especially sexual and reproductive health, should receive more attention than at present. Advocacy is needed to stop early childbearing.

- Joint advocacy from UN agencies on health-related issues is important to enhance access to affordable and suitable medicines and health care. Joint programmes have an impact and need to be planned and executed collectively.
Perspectives and roles of stakeholders in health development in the Region

5. Media roundtable

Chairs:
Dr Shashi Tharoor, Member of Parliament, India, Former UN Under-Secretary-General for Communications and Public Information
Dr Bindeshwar Pathak, Founder, Sulabh International Social Service Organisation, India

Panelists:
Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region
Ms Damayanti Datta, Deputy Editor, India Today, India
Mr Siddhartha Swaroop, Deputy Country Director, The BBC Trust, India
Ms Patraleka Chatterjee, Columnist, The Lancet, India
Mr Shankar Raghuraman, Associate Editor, The Times of India, India
Ms Arti Dhar, Special Correspondent, The Hindu, India
Dr Iqbal Kabir, Coordinator, Climate Change & Health Promotion Unit,
Ministry of Health and Family Welfare & Health Editor, Prothim Alo, Bangladesh
Ms Kiran Mehra-Kerpelmen, Director, United Nations Information Centre (UNIC), India
Ms Paula Alvarado, Regional Communications Manager, International Federation of Red Cross and Red Crescent Societies, India
Mr Rajat Ray, Information Focal Point, UNFPA, India
Ms Sonia Sarkar, Communications Officer, UNICEF, India
Ms Usha Bhasin, Deputy Director-General, Delhi Doordarshan, India
Ms Abha Bahadur, Senior Vice-President, Sulabh International Social Service Organisation, India
Mr Paresh Tewary, Director, Federation of Indian Chambers of Commerce and Industry (FICCI), India
Ms Vandana Mehra, Communications and Information Officer, the World Bank, India

Moderator and Session Coordinator:
Ms Vismita Gupta-Smith

Rapporteur:
Dr Supriya Bezbaruah
Discussion points

• The stage was set with the question – what would it take for the media to be different and give more space/coverage to social issues? Followed by what role the media can play in public health.

• It was commented that one’s own health is always of interest to people. Once the media believes that, getting public health messages out will be easier.

• It was acknowledged that health and development issues get less coverage in the media. While the private media is driven by Target Rating Points (TRPs), health and development programming often lacks the professional packaging. It is often perceived as ‘boring’ and not at par with commercial programmes.

• The UN and partner agency communications experts also expressed that health and development issues need to have a human interest angle to make them news worthy. Timely dissemination of public health information to meet media’s deadlines is also often a challenge. Partners for health need to simplify technical messages and make statistics more relatable to the common person.

• It was felt that public broadcasters often partner better with the UN and partners for health by giving more airtime to these issues. The private news agencies often do not see in-depth health and development stories as priorities.

• Editors and members of the media strongly recommended “field trips” organized by agencies to facilitate reporting with human interest stories from the ground.

Conclusions and recommendations:

• Development and health communication needs to be well packaged.

• The vernacular media should be engaged and involved to provide a wider reach for health messages.

• The media should be engaged as partners and sensitized to relevant issues.

• Public health officials should be trained to be better spokespersons and work with the media.
Reflections on the roles of stakeholders in health development in the Region

Chair:
Mr K Chandramouli, Secretary, Ministry of Health and Family Welfare, India

Panelists:
Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Indonesia
Mr Siddhartha Swaroop, Deputy Country Director, The BBC Trust, India
Mr Steven J Kraus, Director, Regional Support Team for Asia and the Pacific, UNAIDS, Thailand
Dr Akram Ali Eltom, Director, Partnerships Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland
Ms Anuradha Singh, Programme Coordinator, SEWA Social Security, India
Dr Budihardja Singgih recalled the Alma-Ata Declaration, wherein governments were urged to increase financing for public health focusing on primary health care, community empowerment and universal coverage. However, in 2000, most countries did not get even 5% of the gross domestic product (GDP) for the health budget. Thus, selective interventions but with the highest level of care are needed for health development. Even as we move to tackle the challenge of NCDs, health inequities still exist, along with disasters, trauma, mental health, leprosy, maternal and child health and nutrition, among other problems. Climate change and the food and energy crisis also confront the world. The answer is to move ahead in partnership, as no single problem has a single cause. The governments of all countries must take the lead. While partnerships already exist, coordination, governance, regulation and stewardship need to be improved.

Mr Siddhartha Swaroop summarized the media roundtable held the day before. Why do health issues fail to capture the attention of the media and the public? Can health find its place in a market driven by target rating points (TRPs)? Do facts and figures interest the public? News and facts on health should be made interesting and relevant for readers. In India, there is less content and more advertising in the newspapers. Partnerships should be formed with media owners to bring them on board and sensitize them to health issues. Corporate social responsibility within media houses can help in getting free air space for health issues. The vernacular media should be helped to build capacity and be engaged, for example, by taking them on field visits, as they have a wider reach than the English media. Public health experts need regular training to become better spokespersons and simplify technical issues. Journalists also need training on health issues.
Mr Steven J. Kraus strongly appreciated the good work done by the WHO Regional Office for South-East Asia Region in organizing the meeting, where great ideas were discussed in an environment of openness and trust, and the Government of India for its leadership. Time should be taken to reflect on our successes as well as our failures and challenges, and think about what can be done to improve health globally. He reminded us of the impressive number of people, many present at the meeting who are actively working together to make a difference. Improving health requires more than accepting the status quo. Deliberate, creative acts are needed to change and improve health outcomes.

Over the past few days, there have been many examples of people who are doing just this.

Money spent on health is not an expenditure but an investment in the lives of people. Such investment and political commitment will help in reaching all the MDGs. The systems that are built today are the best investment that can be made for the health of our children and for the future.

Political promises at the global and national levels must be followed through by providing resources, political space and services to the people. Governments should be made accountable for their promises. Democratization of the healthcare process and a people-centred approach are imperative. If people are mobilized, they can make changes to improve their health. One should look to the future and decide how our objectives can be achieved. We must “be the change we want to see”.
Dr Akram Ali Eltom spoke about partnerships such as the Global Fund, STOP TB, RBM, GAVI and others which benefit from the full potential of public–private partnerships. The South-East Asia Region has significant potential for providing the leadership for public-private partnerships. The Region can become the incubator for such partnerships. Important values and assets from the Region can be harnessed, and concerns shared. Public–private partnerships should be looked for and promoted in various domains and at multiple levels, and is not just a corporate affair. It is imperative that we better understand, learn from the positive practices and reduce the challenges of public-private partnerships. The private sector should be regarded as an ally for improving health, and has been beneficially engaged in areas such as water and sanitation and Information technology.

One of the challenges to public–private partnerships is managing a balance between altruism and profits. The incentives needed by the private sector for optimal engagement should be considered by the public sector when entering into a partnership.

Ms Anuradha Singh described the role of civil society as an agent of change. Though there are various schemes, these do not have reach and awareness is lacking at the ground level. Civil society can educate the community so that it can benefit from these. It can build the capacity of participatory committees to increase monitoring and accountability of such schemes. Community monitoring tools such as public dialogue should be developed and put into action.
Mr Chandramouli summed up the session by describing the roles of stakeholders in health development. The Alma-Ata Declaration is one of the best articulations on health, which subsumes resources and other aspects. However, the Region still faces many challenges such as a high IMR, MMR and total fertility rate among others. It is a challenge to increase financial investment and commitment to health, and improve health indicators. Tackling communicable diseases was a priority in the Region, but now the growing incidence of NCDs has been added to the disease burden. In addition, mental health, neurological disorders and tobacco are other important issues. At the end of the day, health can never be lost sight of as a national priority, as health issues are interlocked with poverty, especially in the South-East Asia Region. These challenges continue to confront governments, communities and individuals. Political will and an adequate share of the GDP allocated to health is needed to tackle health problems in the Region. Activities need to be expanded to achieve universal access to health. Communities need to be empowered to take care of their own health. The media is an important ally in ensuring that health messages are disseminated at the grass-roots.
Discussion points

- Health professionals, health workers and the community must work together. In times of economic turmoil, health must be the last to be affected. The health workforce, including hospitals, must be secure and protected. Health professionals must be united and work as one.

- We should learn from the agriculture sector, where the farmer takes care of the agriculture. In the case of health, it is largely health professionals and the family. Communities can take care of their own health and should be engaged innovatively as partners.

- Many participants felt that this was one of the best and most productive meetings they had ever attended. They proposed that meetings such as this should be held every two years on a regular basis to see whether what is committed today has been put into action.

- Health is a political and cross-cutting issue, and is beyond the responsibility of only the Ministry of Health. Other ministries should also be involved. Involving the Ministry of Finance in this meeting is an important step. Politicians should be increasingly involved in such meetings so that they are sensitized to health issues. This will enable them to make better policy decisions, particularly in terms of allocation of resources for health. Lessons should be learnt from other countries but filtered to each specific country’s situation. Mathematical models and cost–benefit and cost-effectiveness analyses are needed to make health attractive to politicians and donors.

- Inequitable development causes many problems, such as malnutrition, among others. “Marketization” of health should be controlled to make health accessible and affordable.

- Health should be looked at in an integrated manner, and should include social justice, water, sanitation, empowerment etc. Why do people lose health? What happens to those with poor health? They lose many opportunities. Twenty per cent of the world’s poor are disabled. The issue of disability must be confronted, as it causes poverty and poor health. Persons with disability should also be brought into the mainstream.

- Twenty per cent of the population is beyond the reach of health services. A way to reach them should be found. For this, large financial resources are not needed; instead, communication, and education on health and rights are needed.

Conclusions and recommendations

- Countries must allocate a larger share of the GDP to health. Investments in health and resources must be increased.
• While partnerships already exist, coordination, governance, regulation and stewardship need to be improved.

• Money spent on health is not expenditure but an investment in the lives of people.

• Political promises at the global and national levels must be followed through by providing resources, political space and services to the people.

• The incentives needed by the private sector for engagement should be considered by the public sector when entering into a partnership.

• Public–private partnerships should be looked for and promoted in various domains and at multiple levels.

• Civil society can educate the community about schemes by the government for their benefit. It can build the capacity of participatory committees to increase monitoring and accountability of such schemes. Community monitoring tools such as public dialogue should be developed and put into action.

• Disability issues must be taken on board as a part of health development concerns.

• Health is a political and cross-cutting issue, and is beyond the responsibility of only the Ministry of Health. Other ministries should also be involved.

• Politicians should be sensitized to health issues so that they are able to make adequate policy decisions, particularly with regard to the allocation of resources for health.

• Meetings such as this should be held at regular intervals (e.g. every two years) to check whether what was proposed has been achieved.
Plenary VII

Delhi Call for Action on Partnerships for Health

Chair:
H.E. Lyonpo Zangley Dukpa, Minister of Health, Bhutan

Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Ministry of Health, Indonesia and Chair, Drafting Committee for Delhi Call for Action

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region
Adoption of the Delhi Call for Action on Partnerships for Health

Discussion points

- The drafting committee had prepared a draft of the Delhi Call for Action, which was read out by the Chairperson of the drafting committee, Dr Budihardjah Singgih. After a lively discussion, those suggestions that attained consensus were incorporated and the Delhi Call for Action was unanimously adopted by the participants.
Delhi Call for Action on Partnerships for Health

We, the participants in the conference of Partners for Health in South-East Asia,

Recognize that the eleven countries of the WHO South-East Asia Region hold more than a quarter of the world’s population and bear a disproportionate share of the global disease burden, including a heavy burden of maternal and child mortality and morbidity, infectious diseases such as malaria, tuberculosis, HIV and neglected tropical diseases, as well as emergent threats like SARS and pandemic influenza;

Are concerned that noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and conditions like mental illness, injuries and disabilities, which affect the poor as much as those better off, are placing a further burden on health systems and society, and also aware that NCDs account for more than half of annual deaths in the Region;

Recognize that both natural and human factors contribute to the Region’s vulnerability, including its susceptibility to natural disasters, rapid demographic and epidemiological transition, limited and inconsistent political support and uneven implementation of health-promoting laws and policies, a rapidly growing and inadequately regulated private sector, occupational health issues, rapid and often unplanned urbanization, the increasing numbers of the elderly, unhealthy lifestyles, and the health consequences of climate change;

Are concerned that despite years of action by a range of partners, health inequity remains, a significant proportion of the population lacks access to quality health care, and the Region has the highest out-of-pocket expenditure on health care in the world, which contributes to and exacerbates poverty;

Consider that rapid economic growth in South-East Asia does not effectively translate into investment for better health for all people;

Acknowledge that strong health systems based on the primary health care (PHC) approach are the cornerstone of achieving better health outcomes and addressing emerging public health priorities, but that health systems in the Region often remain ineffective, too focused on curative care, underfunded and fragmented, and are further challenged by difficulties in training and retaining health workforce;

Believe that health challenges with social, political and economic determinants can only be addressed by a spectrum of partners acting decisively and in concert.
In cognizance of the foregoing, we the representatives of national governments, parliamentarians, academia, civil society and patients rights groups, NGOs, the private sector, professional organizations, bilateral and multilateral donors, global health partnerships, development partners, media and UN organizations:

Rededicate ourselves to achieving better and equitable health for all people of the South-East Asia Region, regardless of socioeconomic status, geography, culture, beliefs, gender, sexual orientation, age or disability;

Resolve to accelerate our efforts towards achieving key goals and targets outlined in the Millennium Development Goals (MDGs) in consonance with national development priorities and through revitalization of primary health care;

Commit ourselves to capitalize on the momentum generated at global, regional and national levels for galvanizing action toward prevention, care and control of NCDs, as well as the health effects of climate change;

Pledge ourselves to create, revitalize and sustain partnerships between governments, health and other sectors, parliamentarians, civil society, nongovernmental organizations, intergovernmental organizations, the private sector, the media, donors, patients rights and other advocacy groups, academia, global health partnerships, development partners, and organizations of the United Nations system;

Resolve to foster South–South cooperation as an innovative mechanism for effective cooperation between equal partners, based on the principles of solidarity, mutual benefit and equity;

Resolve to collaborate more closely in order to align and integrate action, as well as to avoid duplication of effort and to fill gaps, thereby making more efficient and effective use of limited resources in an austere global financial climate;

Dedicate ourselves to mobilizing resources in a collaborative and coordinated manner to support the development and strengthening of all policies that promote health, including national and subnational health policies, and research and evidence for policy-making;

Commit ourselves to working collectively to empower our communities so that they can take an active part in health and development;

Agree to work together in a spirit of shared effort, responsibility and accountability to meet the existing and emerging health challenges in the South-East Asia Region;

Call upon Member States and partners to jointly develop collaborative, coordinated and time-bound action plans to address the commitments embodied in this Delhi Call for Action.
Closing remarks

Dr Poonam Khetrapal Singh delivered the closing remarks on behalf of the Regional Director, WHO South-East Asia Region, Dr Samlee Plianbangchang. She thanked the participants for their sustained interest in the meeting.

The meeting provided a unique opportunity to bring together partners from various sectors – government, civil society, international NGOs, donors, UN agencies, global health partners, the media and the private sector. A number of key themes emerged in terms of challenges and successful strategies and solutions in the area of health. Partnerships are vital, as no single sector can address health problems by itself. The meeting discussed how collaboration could be improved. Pressing health issues were examined, such as enhancing efforts to reach the MDGs, reducing maternal and child mortality, the rising burden of NCDs, health of the urban poor, climate change and reaching the unreached. What emerged was the interrelatedness of these health challenges. Numerous participants traced the complex relationships between health issues and social and economic determinants of health. Often, improvement in health must come through non-health initiatives. NCDs, for example, can be traced to the use of alcohol and tobacco, unhealthy diets and sedentary lifestyles.

The challenges are immense and complex but not unsolvable, as can be seen from the innovative interventions presented such as using the “sin” tax to finance health-promoting initiatives and legislations that enable individuals to make better choices for health.

Revitalization of PHC and universal access are key strategies for improving health in the Region. These raise issues of access, affordability, public–private sector cooperation, among others. Designing schemes for sustainable funding for universal access to health services remains a key concern. In some countries, the delivery of health care is largely a State concern, while other countries have a large private sector capacity. No one size fits all. Not all the gaps identified relate to lack of funding. Some have to do with the way partners are engaged, sometimes with the most vulnerable groups such as sex workers and drug users. Greater flexibility and openness are needed.

As partnerships are developed, there must be openness to sectors, organizations and
individuals with different perspectives and experiences. The media can be a powerful tool for advocacy for health promotion. The private sector plays an important role in health delivery but operates with a business logic that needs to be understood for successful collaboration. Knowledge, information and technology are key areas for future development and collaboration. The need to develop health information systems and improve data and evidence for decision- and policy-making was focused on by several participants.

At the centre of it all are the people themselves. Those who are vulnerable and at risk are also people who can be tapped as partners. The development of the Delhi Call for Action is itself a good example of partnership and must be carried forward through follow-up and continued efforts to inspire, innovate and involve.
Annexes

Annex 1: Programme

Annex 2: List of participants

Annex 3: Delhi Call for Action - Drafting Committee

Annex 4: Regional Director’s address

Annex 5: Millennium Development Goals

Annex 6: Fact Sheet – Child and maternal mortality in South-East Asia

Annex 7: Fact Sheet – Millennium Development Goal 6: Fighting HIV/AIDS, Malaria and Tuberculosis in South-East Asia Region

Annex 8: Fact Sheet – Health Systems Strengthening

Annex 9: Fact Sheet – The growing crisis of noncommunicable diseases in the South-East Asia Region
Programme

Wednesday, 16 March 2011

0800 – 0900 1. Registration

0915 – 1015 2. Opening Ceremony

Welcome by Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region

Address by Mr Kalyan Banerjee, President - Elect, The Rotary Foundation of Rotary International, USA

Address by Ms Erin Soto, Minister Counselor for International Development and USAID Mission Director, India

Address by Mr Yohei Sasakawa, Chairman, The Nippon Foundation and WHO Goodwill Ambassador for Leprosy Elimination, Japan (read by Ms Chikako Awazu)

Address by Dr Analjit Singh, Chairman and Managing Director, Max India Limited, India

Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

Address by H.E. Mr Ghulam Nabi Azad, Union Minister of Health & Family Welfare, India

Vote of Thanks by Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, India

Master of Ceremony: Ms Vismita Gupta-Smith, Public Information & Advocacy Officer, WHO South-East Asia Region

Session Coordinator: Ms Nelly Enwerem-Bromson

1015 – 1045 Tea/Coffee

1045 – 1145 3. Special Address

Mr Arun Maira, Member of Planning Commission of India and Former Chairman of the Boston Consulting Group, India

Partnerships in Health

Session Coordinator: Dr Nata Menabde, WHO Representative, India
1145 – 1230  4. **Plenary**

*Millennium Development Goals – The Progress so far and Opportunities ahead*

Chair: H.E. Lyonpo Zangley Dukpa, Minister of Health, Bhutan

Speakers: Ms Nobuko Horibe, Regional Director, United Nations Population Fund (UNFPA), Thailand

*Progress Towards Millennium Development Goal 5*

Dr Amarjit Singh, Joint Secretary, Ministry of Human Resource Development, India

*Innovations in Maternal Healthcare: A Case Study from Gujarat*

Session Coordinator: Dr Quazi Monirul Islam

Rapporteur: Dr Akjemal Magtymova

1315 – 1400  Lunch

1400 – 1500  5. **Parallel Break-out Sessions: Best Practices**

5.1 *Addressing Child and Maternal Mortality*

Moderator: Dr Quazi Monirul Islam, Director, Family Health & Research, WHO South-East Asia Region

Speaker: Dr Vinod Paul, Vice Chair, Partnership for Maternal, Newborn and Child Health and Head, Department of Paediatrics, All India Institute of Medical Sciences, India

*Best Practices for Addressing Child and Maternal Mortality – the hype, the reality and the hope*

Panelists: H.E. Ms. Madalena F.M. Hanjam C. Soares, Vice Minister of Health, Timor-Leste

Ms Nobuko Horibe, Regional Director, United Nations Population Fund (UNFPA), Thailand

Dr Harshalal R. Seneviratne, Dean and Senior Professor, Faculty of Medicine, University of Colombo, Sri Lanka

Mr Ashok Alexander, Director, Bill and Melinda Gates Foundation, India

Session Coordinator: Dr Neena Raina

Rapporteurs: Dr Narimah Awin/ Dr Rajesh Mehta
5.2 Ensuring Universal Access to Health Services

Chairs: H.E. Mr Rui Manuel Hanjam, Vice-Minister of Finance, Timor-Leste
Dr Ascobat Gani, Health Economist and Former Dean, School of Public Health, University of Indonesia, Indonesia

Speakers: Dr T. Ravindra C. Ruberu, Secretary, Ministry of Health, Sri Lanka

*Achieving Universal Coverage in a Free Health Environment – The Sri Lankan Scenario*

Dr Soe Aung, Programme Adviser/ Director, Myanmar Medical Association, Myanmar
*Community participation in scaling up malaria control*

Dr Dirgh Singh Bam, President, Dirgh-Jeevan Clinic, Nepal
*Community based TB control. Lessons learnt from Nepal*

Dr Viroj Tangcharoensathien, Director, International Health Policy Programme, Ministry of Public Health, Thailand
*Reaching Universal Coverage in Thailand: what strategic approaches?*

Session Coordinators: Dr Ilsa Nelwan and Dr Iyanthi Abeyewickreme

Rapporteur: Dr Leonard Ortega

5.3 Revitalizing Primary Health Care – Addressing Health Inequities

Chairs: Dr Gado Tshering, Secretary, Ministry of Health, Bhutan
Dr Amorn Nondasuta, Chairman, The Foundation for Quality of Life, Thailand
*PHC Innovation*

Speakers: Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Ministry of Health, Indonesia
*Decentralization of Health Care – Can it Address Health Inequities?*

Mr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India, India
*Community Empowerment – Means for Reducing Equity Gaps*

Dr Dharma S.Manandhar, President, Mother and Infant Research Activities (MIRA) and Head, Department of Pediatrics, Kathmandu Medical College, Nepal
*Community Mobilization and Community-based Health Work Force can make a Difference*

Session Coordinator: Dr Sudhansh Malhotra

Rapporteur: Dr Boosaba Sanguanprasit

1500 – 1530 Tea/Coffee
1530 – 1615 6. Plenary

*The Challenge of Noncommunicable Diseases*

**Chair:** Dr Lalit M Nath, Former Director, All India Institute of Medical Sciences, India

**Speaker:** Dr Bela Shah, Senior Deputy Director General and Head, Division of NCD, Indian Council of Medical Research, India

*Noncommunicable Diseases Challenges*

**Session Coordinator:** Dr Renu Garg

**Rapporteur:** Dr Dhirendra Narain Sinha


7.1 *Integrated Approach to Prevention and Control of Noncommunicable Diseases*

**Chairs:** Dr Sudha Sharma, Secretary, Ministry of Health and Population, Nepal  
Prof. Tint Swe Latt, Rector, University of Medicine (2), Myanmar

**Speakers:** Dr Mahesh K. Maskey, Chair, Nepal Public Health Foundation, Nepal  
*Status of Noncommunicable Diseases in South-East Asia and the Role of Civil Society in its Prevention and Control, Nepal*

Dr Neelamani Rajapaksa Hewageegana, Provincial Director of Health Services, UVA, Sri Lanka  
*Package of Essential Noncommunicable (PEN) Disease interventions for Primary Health Care in Low Resource Settings, Sri Lanka*

Professor Prakit Vathesatogkit, Executive Secretary, Action on Smoking and Health Foundation, Thailand  
*Using Innovation in Tobacco Taxation in Promoting Health, Thailand*

**Session Coordinator:** Dr Renu Garg

**Rapporteur:** Dr Nyo Nyo Kyaing
7.2 *Health for the Urban Poor – The Way Forward*

**Chairs:**  Mr Keshav Desiraju, Additional Secretary, Ministry of Health and Family Welfare, India  
**Dr Genevieve Begkoyian,** Regional Health Advisor, Young Child Survival, United Nations Children’s Fund (UNICEF), Nepal

**Speakers:**  Dr Abdul Sattar Yoosuf, Assistant Regional Director, WHO South-East Asia Region  
*Health for the Urban Poor in the 21st Century: Challenges and Opportunities*  
Dr M.H. Basyir Ahmad Syawie, Mayor of Pekalongan, Indonesia  
Dr Siddharth Agarwal, Executive Director, Urban Health Resource Centre, India  
*Improving Health of the Urban Poor: Experiences from the field and Lessons Learned*  
Session Coordinator: Dr Sudhansh Malhotra  
Rapporteur: Dr Suvajee Good

7.3 *Protecting Health from Climate Change*

**Chair:**  Mr Young-Woo Park, Regional Director and Representative for Asia & the Pacific Office, United Nations Environment Programme (UNEP), Thailand

**Panelists:**  Dr Iqbal Kabir, Coordinator, Climate Change & Health Promotion Unit, Ministry of Health and Family Welfare, Bangladesh  
*Experiences and Initiatives to Protect Human Health from Climate Change in Bangladesh*  
Ms Mabel Rebello, Member of Parliament and Member of Standing Committee of Indian Association of Parliamentarians on Population and Development (IAPPD), India  
*Community level initiatives to protect human health from climate change*  
Dr Sharad Onta, Professor, Department of Community Medicine and Family Health, Tribhuvan University, Nepal  
*Climate Change, Vulnerability Assessment – Experiences from Nepal*
**Mr Yeshey Penjor**, Climate Change Policy Specialist, United Nations Development Programme (UNDP), Bhutan  
*Climate Change and Human Health - Adaptation in Bhutan*

**Dr Bindeshwar Pathak**, Founder, Sulabh International Social Service Organisation, India  
*Impact of climate change on sanitation and health and how Sulabh International has contributed in addressing the issue, India*

**Session Coordinator**: Ms Payden  
**Rapporteur**: Dr Zakir Hussain

1800  
Regional Director’s Welcome Reception, Hotel Le Meridien

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**Thursday, 17 March 2011**

0800 – 0845  
8. *Registration*

0845 – 0900  
9. *Recap of Day 1*

**Dr Sangay Thinley**, Director, Department of Communicable Diseases, WHO South-East Asia Region

0900 – 1000  
10. *Plenary*

**Building Health System Capacity**

**Chairs**: Dr T. Ravindra C. Ruberu, Secretary, Ministry of Health, Sri Lanka  
Dr Jai P Narain, Director, Department of Sustainable Development and Healthy Environments, WHO South-East Asia Region

**Speakers**: Dr Ugrid Milintangkul, Deputy Secretary General, National Health Commission, Thailand  
*Healthy Public Policies: Moving towards an integrated and intersectoral approach to Health - Thailand’s Experience*

Dr Carla AbouZahr, Team Leader, Monitoring Vital Events (MoVE-IT), Health Metrics Network, Switzerland  
*The need for Civil Registration and Vital Statistics*

Dr Mubashar Riaz Sheikh, Executive Director, Global Health Workforce Alliance, Switzerland (read by Mr Sunil Nandraj, WHO Country Office, India)  
*Reflections on the health workforce crisis in South-East Asia*

**Session Coordinator**: Dr Thushara Fernando  
**Rapporteur**: Dr Prakin Suchaxaya

1000 – 1030  
Tea/Coffee
1030 – 1200  11. **Parallel Break-out Sessions: Best Practices**

### 11.1 Public-Private Partnerships in Health

**Chairs:** Mr Prasanna Kumar Pradhan, Special Secretary, Ministry of Health and Family Welfare, India  
Dr Narottam Puri, Advisor, Health Services Committee at The Federation of Indian Chambers of Commerce and Industry (FICCI) and President – Medical Strategy & Quality at Fortis Healthcare Limited, India  

**Speaker:** Mr Anil Swarup, Director General for Labour Welfare and Joint Secretary, Ministry of Labour and Employment, India  
*…. A Journey called Rashtriya Swasthya Bima Yojana*

**Panelists:** Dr Akram Ali Eltom, Director, Partnerships Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland  
Mrs Penny Grewal Daumerie, Director, Global Access, Medicines for Malaria Venture (MMV), Switzerland  
*The Power of Partnerships: Accelerating the development and delivery of much-needed medicines*

Dr Harinder S. Sikka, Director, Corporate Affairs, Piramal Healthcare Limited, India  
*Discussion on Public-Private Partnerships in Health*

Professor S.P. Thyagarajan, Pro-Chancellor (Research), Sri Ramachandra University, India  
*Research Partnerships in Health*

**Session Coordinator:** Dr Manisha Shridhar  
**Rapporteur:** Mr Gautam Basu

### 11.2 Financing for Universal Coverage

**Chairs:** H.E. Mr Ahmed Asad, State Minister of Finance & Treasury, Maldives  
Dr David Evans, Director, Health Systems Financing, WHO Headquarters, Switzerland  
*The Global Situation – Health Systems Financing: The Path to Universal Coverage*

**Speakers:** Prof. Indrani Gupta, Professor and Head of Health Policy Research Unit, Institute of Economic Growth, India  
*Universal Health Coverage – Options for South East Asia Region*
Dr Hasbullah Thabrany, President South-East Asia Public Health Education Institutes Network (SEAPHEIN) & Former Dean, School of Public Health, University of Indonesia, Indonesia
*Public Financing – Private Delivery to Strengthen Health Systems*

Dr Phusit Prakongsai, Director, International Health Policy Programme, Ministry of Public Health, Thailand
*Financing for Universal Coverage – Experiences from Thailand*

**Session Coordinator:** Dr Sunil Senanayake

**Rapporteur:** Dr Kathleen Holloway

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### 11.3 Opening New Frontiers & Innovative Opportunities for Collaboration in the Health Sector: South – South & Beyond

**Chairs:**
- Dr Marie-Andree Romisch-Diouf, Director, Country Cooperation, WHO Headquarters, Switzerland
- Dr Nata Menabde, WHO Representative, India

*South-South Cooperation and Beyond. Some Reflections.*

**Panelists:**
- Dr Biswajit Dhar, Director General, Research and Information System for Developing Countries, (RIS), Ministry of External Affairs, India
- Dr K.M. Gopa Kumar, Legal Advisor, Third World Network, India
- Dr Alvaro Matida, Adviser, FIOCRUZ Center for Global Health, The Oswaldo Cruz Foundation, Brazil

*South-South Cooperation*

Dr Mmathari Kelebogile Mastau, Deputy Director-General, Strategic Health Programme, Department of Health, Government of South Africa

Dr Antonio Duran, Coordinator, International Health Policy, Andalusian School of Public Health, Spain

**Session Coordinators:** Dr Nata Menabde and Mr Sunil Nandraj

**Rapporteur:** Ms Anagha Khot
1200 – 1300  Lunch

1300 – 1400  12. Plenary

*Health Partnerships and Collaboration: The imperatives of collective responsibility to address the health of the poor and vulnerable*

**Chairs:**
- H.E. Dr Farooq Abdullah, Union Minister for New and Renewable Energy, India
- Mr Hussain Niyaaaz, Additional Secretary, Ministry of Foreign Affairs, Maldives

**Panelists:**
- Dr Bina Rawal, Head of Medical Affairs, The Wellcome Trust, United Kingdom
- The Wellcome Trust
- Dr Thomas Teuscher, Deputy Executive Director, Roll Back Malaria Partnership, Switzerland
- The Roll Back Malaria Partnership
- Mr Paul Kelly, Director, Country Programmes, Global Alliance for Vaccines and Immunization (GAVI), Switzerland
- Dr Mariam Claeson, Programme Coordinator, HIV/AIDS, Human Development, South Asia Region, The World Bank, India

**Session Coordinator:** Ms Nelly Enwerem-Bromson

**Rapporteur:** Dr Kathleen Holloway

1405 – 1515  13. Plenary

*Partnerships in Action: Reporting from the Field*

**Chairs:**
- H.E. Professor Dr Syed Modasser Ali, Health Adviser to the Prime Minister, Bangladesh
- Ms Tine Staermose, Director, International Labour Organization (ILO), India

**Panelists:**
- Mr Ken Earhart, Director, Global Disease Detection Program, U.S. Centers for Disease Control and Prevention (CDC), India
- Global Disease Detection Program
- Dr Md Shafiullah Talukder, Project Coordinator, TB Control Programme, Bangladesh Garment Manufacturers and Exporters Association (BGMEA), Bangladesh
- Reporting from Bangladesh Corporate Sector
- Mr Steven J Kraus, Director, Regional Support Team for Asia and the Pacific, UNAIDS, Thailand
- UNAIDS: Partnership in action
Dr Preethi Wijegoonewardene, Regional President, World Organization of Family Physicians (WONCA) - South Asia, Sri Lanka

**Partnerships in Action: WONCA**

Mr William Stewart, Senior Health Adviser, Department for International Development (DFID), India

**Strengthening multi-sectoral action for health and nutrition**

Mr Sanjoy Roy, Managing Trustee, Salaam Baalak Trust, India

Salaam Baalak Trust

**Session Coordinator:** Ms Nelly Enwerem-Bromson

**Rapporteur:** Dr Supriya Bezbaruah

1515 – 1545  Tea/Coffee


**Perspectives and Roles of Stakeholders in Health Development in the Region**

14.1  **Private Sector/Foundations**

**Chairs:** Dr Ranjit Roy Chaudhury, Chairman, Task Force for Research, Apollo Hospitals Educational and Research Foundation, India

Mr Sushanta Sen - Principal Advisor to Confederation of Indian Industry (CII), India

**Panelists:** Ms Sinta Kaniawati Munir, General Manager, Unilever Indonesia Foundation, Indonesia

**Corporate Social Responsibility: Empowering the Community through Public Health Education Program**

Dr Jingjai Hanchanlash - Advisor to Executive Board & Former Board Member and Co-Chairman, The Thai-EU Business Council, Thailand

**Perspectives and Roles of Private Stakeholders in Health Development in the Region**

Dr Vikram Sheel Kumar, Co-Founder and Chief Medical Officer, Dimagi Inc., India

**Overview of Mobile Applications (For Health)**

Ms Indrani Kar, Senior Director & Head – Development Initiatives, Confederation of Indian Industry (CII), India

**Role of Private Sector and Partnerships**

**Session Coordinator:** Dr Roderico Ofrin

**Rapporteur:** Dr Sara Varughese
14.2 **NGOs and Civil Society**

**Chair:** Mr Azmat Ulla, Head of Regional Office, International Federation of Red Cross and Red Crescent Societies, India

**Speakers:**
- **Dr Md. Akramul Islam,** Programme Head, Health Programme, Bangladesh Rural Advancement Committee (BRAC), Bangladesh
  *Role of NGOs in Health: Experience in Tuberculosis Control in Bangladesh* (read by Dr Khurshid Alam Hyder, WHO SEARO)

- **Dr Vinya S Ariyaratne,** General Secretary, Sarvodaya Shramadana Movement, Sri Lanka
  *Building sustainable civil society partnerships for health: Challenges and responses*

- **Dr Mirai Chatterjee,** Programme Coordinator, SEWA Social Security, India
  *Health Action through Membership-Based Organisations (MBOs) of Women – some experiences of the Self-Employed Women’s Association (SEWA), India*

**Session Coordinator:** Dr A.P. Dash

**Rapporteur:** Dr Khurshid Alam Hyder

14.3 **Governments**

**Chair:** H. E. Dr Aminath Jameel, Minister of Health and Family Welfare, Maldives

**Panelists:**
- **Mr Gopal Krishna Menon,** Country Manager, Australian Agency for International Development (AusAID), India
  *Role of Donor Governments*

- **Dr P.B. Jayasundera,** Secretary, Ministry of Finance & Planning and Secretary, Ministry of Economic Development, Sri Lanka
  *Role of Recipient Governments*

- **Dr Sudha Sharma,** Secretary, Ministry of Health and Population, Nepal
  *Health Development in Nepal: Government of Nepal’s Perspectives*

**Session Coordinator:** Dr Jigmi Singay

**Rapporteur:** Ms Nelly Enwerem-Bromson
14.4 UN/Intergovernmental Organizations

Chair: Ms Caitlin Weisen, Country Director, United Nations Development Programme (UNDP), India

Panelists: Dr Nata Menabde, WHO Representative, India

Dr Marc G.L. Derveeuv, Representative a.i, United Nations Population Fund (UNFPA), India

Prof. Charles Franklin Gilks, Country Coordinator, Joint United Nations Programme on HIV/AIDS (UNAIDS), India

Dr Asheena Khalakdina, Health Specialist, United Nations Children's Fund (UNICEF), Thailand

Ms Tine Staermose, Director, International Labour Organization (ILO), India

Dr Ram Boojh, Programme Specialist, Ecological & Earth Sciences, United Nations Educational, Scientific and Cultural Organization (UNESCO), India

Session Coordinator: Dr Narimah Awin

Rapporteur: Dr Prakin Suchaxaya

14.5 Media Roundtable

Chairs: Dr. Shashi Tharoor, Member of Parliament, India, Former-UN Under-Secretary-General for Communications and Public Information

Dr Bindeshwar Pathak, Founder, Sulabh International Social Service Organisation, India

Panelists: Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO South-East Asia Region

Ms Damayanti Datta, Deputy Editor, India Today, India

Mr Siddhartha Swaroop, Deputy Country Director, The BBC Trust, India

Ms Patrlekha Chatterjee, Columnist, The Lancet, India

Mr Shankar Raghuraman, Associate Editor, The Times of India, India

Ms Arti Dhar, Special Correspondent, The Hindu, India

Dr Iqbal Kabir, Health Editor, Prothom Alo, Bangladesh

Ms Kiran Mehra-Kerpelman, Director, United Nations Information Centre, India
Ms Paula Alvarado, Regional Communications Manager, International Federation of Red Cross and Red Crescent Societies, India

Mr Rajat Ray, Information Focal Point, United Nations Population Fund, India

Moderator & Session Coordinator: Ms Vismita Gupta-Smith

Rapporteur: Dr Supriya Bezbaruah

1930  Reception – Government of India, Hotel Ashok

Friday, 18 March 2011

1000 – 1015  15. Recap of Day 2

Speaker: Dr Athula Kahandaliyanage, Director, Department of Health Systems Development, WHO South-East Asia Region

1015 – 1115  16. Plenary

Reflections on the Roles of Stakeholders in Health Development in the Region

Chair: Mr K. Chandramouli, Secretary, Ministry of Health and Family Welfare, India

Panelists: Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Ministry of Health, Indonesia

Mr Siddhartha Swaroop, Deputy Country Director, The BBC Trust, India

Mr Steven J Kraus, Director, Regional Support Team for Asia and the Pacific, UNAIDS, Thailand

Dr Akram Ali Eltom, Director, Partnerships Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland

Ms Anuradha Singh, Programme Coordinator, SEWA Social Security, India

1115 – 1145  Tea/Coffee
1145 – 1230  17. Plenary

*Delhi Call for Action on Partnerships for Health*

**Chair:** H.E. Lyonpo Zangley Dukpa, Minister of Health, Bhutan

Dr Budihardja Singgih, Directorate General for Nutrition and Maternal and Child Health, Ministry of Health, Indonesia and Chair, Drafting Committee for Delhi Call for Action

*Adoption of the Delhi Call for Action on Partnerships for Health*

**Closing Remarks by Dr Poonam Khetrapal Singh,** Deputy Regional Director, WHO South-East Asia Region

**Lunch**

**Bilateral Meetings**
List of Participants

**SEAR MEMBER STATES**

**Bangladesh**

H.E. Professor Dr Syed Modasser Ali  
Health Advisor to the Prime Minister  

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Mr Hyon IL Kim  
First Secretary  
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Union Minister for New and Renewable Energy  

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Mr Keshav Desiraju  
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OTHER GOVERNMENTS

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Mr Stephen Solat  
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ACADEMIA

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Dr Vinod Paul  
Vice-Chair, Partnership for Maternal Newborn and Child Health and Head, Department of Pediatrics  
India

Dr Chandrakant S. Pandav  
Professor and Head of Centre for Community Medicine  
India

Dr Shakti Kumar Gupta  
Head - Dept. of Hospital Administration & Medical Superintendent  
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Mr Jitendar Kumar Sharma  
Project Officer  
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And former Member of Public Enterprises
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PhD Scholar
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Associate Professor
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Distinguished Biotechnology Fellow & Adviser
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Vice Chancellor
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Royal Institute of Health Sciences
Dr Chencho Dorjee
Director
Bhutan

SEA Regional Association of Medical Education
Professor Anan Srikiatkhachorn
Deputy Dean
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Pro Chancellor (Research),
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**Sulabh International Academy of Environmental Sanitation and Public Health**
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Chairperson
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**The George Institute for Global Health**
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Head, Research & Development
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Sri Lanka

Professor Rohini de A Seneviratne
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Department of Community Medicine
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Professor Bambang Wispriyono
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Faculty of Public Health
Indonesia

Dr Ascobat Gani
Health Economist and Former Dean
Faculty of Public Health
Indonesia

Professor Hasbullah Thabrany
President South-East Asia Public Health Education Institutes Network (SEAPHEIN) & Former Dean
Faculty of Public Health
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**FOUNDATIONS**

**Action on Smoking and Health Foundation**
Professor Prakit Vathesatogkit
Executive Secretary
Thailand

**Apollo Hospitals Educational and Research Foundation**
Professor Ranjit Roy Chaudhury
Chairman, Task Force for Research
India

**Chronical Care Foundation**
Dr Sita Ratna Devi
Chief Executive Officer
India

**Clinton Health Access Initiative**
Ms Amita Chebbi
Country Director
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Dr Fabian Toegel
Senior Technical Advisor
India

**Bill and Melinda Gates Foundation**
Mr Ashok Alexander
Director
India

Dr Devendra Khandait
Program Officer
India

**John D. and Catherine T. MacArthur Foundation**
Ms Dipa Nag Chowdhury
Acting Director
India

**Lanka Alzheimer’s Foundation**
Dr Hearath B. Tamitegama
President
Sri Lanka
<table>
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<tr>
<th><strong>MI International Foundation</strong></th>
<th><strong>The Oswaldo Cruz Foundation</strong></th>
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<tr>
<td>Dr Vivek Gupta</td>
<td>Dr Alvaro Matida</td>
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<td>Senior Consultant</td>
<td>Adviser</td>
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<td>India</td>
<td>FIOCRUZ Center for Global Health</td>
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<th><strong>Nepal Public Health Foundation</strong></th>
<th><strong>The Rotary Foundation of Rotary International</strong></th>
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<td>Dr Mahesh K. Maskey</td>
<td>Mr Kalyan Banerjee</td>
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<tr>
<td>Chair</td>
<td>President-Elect</td>
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<td>Nepal</td>
<td>USA</td>
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<th><strong>The Nippon Foundation</strong></th>
<th><strong>The Wellcome Trust</strong></th>
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<td>Ms Chikako Awazu</td>
<td>Dr Bina Rawal</td>
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<tr>
<td>International Program Department</td>
<td>Head of Medical Affairs</td>
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<td>Japan</td>
<td>UK</td>
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<th><strong>Pakistan Polio Plus Committee</strong></th>
<th><strong>Global Health Partnerships</strong></th>
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<tr>
<td>Mr Aziz Memon</td>
<td>Global Alliance for Vaccines and Immunization (GAVI)</td>
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<tr>
<td>National Chairman</td>
<td>Mr Paul Kelly</td>
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<td>Pakistan</td>
<td>Director Country Programmes</td>
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<th><strong>Public Health Foundation of India</strong></th>
<th><strong>Dr. Subhadra Menon</strong></th>
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<tr>
<td>Dr Hanimi Reddy Modugu</td>
<td>Head, Health Communication and Advocacy</td>
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<tr>
<td>Senior Social Scientist</td>
<td>India</td>
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<tr>
<th><strong>Dr Monika Arora</strong></th>
<th><strong>Mr Anil Kapur</strong></th>
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<tr>
<td>Head-Health Promotion Tobacco Control Adjunct Assistant Professor</td>
<td>Managing Director</td>
</tr>
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<td>India</td>
<td>Denmark</td>
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<th><strong>The Foundation for Quality of Life</strong></th>
<th><strong>Mr Farouk Shamas Jiwa</strong></th>
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<tr>
<td>Dr Amorn Nondasuta</td>
<td>Programme Officer, Advocacy and Public Policy, External Relations</td>
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<tr>
<td>Chairman</td>
<td>Switzerland</td>
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<td>Thailand</td>
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</table>
Global Fund to Fight AIDS, Tuberculosis and Malaria
Dr Akram Ali Eltom
Director, Partnerships Unit
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**Medical Women's International Association**
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Kathmandu Medical College
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**Operation ASHA**
Dr Shelly Batra
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Ms Anne Andrews
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# Delhi Call For Action on Partnerships for Health Drafting Committee

**17 March 2011**

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Annex 4

Address by
Dr Samlee Plianbangchang
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Excellency, Mr Ghulam Nabi Azad, Union Minister of Health & Family Welfare, the Government of India, Excellency, honourable guests and partners, ladies and gentlemen, With great pleasure and privilege, I warmly welcome you all to the WHO’s Regional Conference of Partners for Health in South-East Asia.

Ladies and gentlemen,

Global health is a multi-stakeholder process. The organizations, both governmental and nongovernmental, which you represent here today, have an important role to play in global health governance. This meeting is being held at an important juncture in health development worldwide and in the South-East Asia Region.

Many of the noteworthy achievements in health attained during the past century are now under threat. This is especially so in the developing countries like many in the South-East Asia Region. The threat from the combined effects of global crises started at the beginning of this century, in particular food, fuel, economy and climate change.

As the world strives to address these global challenges, development budgets for health – particularly in developing countries - are being placed under tremendous pressure. New and innovative ways must be found to effectively tackle the prevailing gaps in under-funded health priorities, including:

- health systems strengthening; and
- control of chronic noncommunicable diseases.

Although significant progress has been achieved towards improving health of the people in South-East Asia, we simply must do much more. The South-East Asia Region bears a staggering 40% of the world’s disease burden for 26% of the world’s population, rendering the health challenges facing the Region vast, in both number and magnitude. South-East Asia still struggles with a list of communicable diseases that are now virtually unheard of in many countries of the world.

Neglected tropical diseases, such as kala-azar, lymphatic filariasis, and yaws still thrive in some countries in this part of the world. The rapid increase of people living in cities with improperly planned urbanization represents a major threat to health where roughly 40% of the urban population lives in slums or shanty towns, exposing itself to many basic health problems.
Ladies and gentlemen,

Disadvantage and ill health are closely linked. So, the urban poor suffer disproportionately from a wide range of health problems. With a massive number of people living at close quarters and only 60% of all people in South-East Asia having access to proper sanitation, the struggle to fight communicable diseases lingers on.

Diseases such as malaria, tuberculosis, diarrhoea, vector-borne diseases and HIV/AIDS will continue to subsist under these conditions. Progress made thus far in malaria and tuberculosis control is also now being compromised by the emergence and spread of drug resistant pathogens. This burden of communicable diseases is compounded by the growing challenge of NCDs. The Region has about 240 million smokers, a large percentage of adults who do not have adequate physical activity, and at least 80% of the population does not eat sufficient quantities of vegetables and fruits.

The biggest killers in South-East Asia are cardiovascular diseases, diabetes and cancer. Indeed, the Region is facing the double burden of communicable and non-communicable diseases.

Distinguished participants,

Despite a high level of government commitment, the South-East Asia Region contributes to one third of maternal deaths world wide. Child mortality shows a declining trend; but it is still unacceptably high in several countries. The challenges in meeting the desired targets for maternal and child mortality reduction are linked to low financing for maternal, newborn, and child health; low coverage of comprehensively evidence-based interventions; and weak health systems infrastructures.

The infrastructures of our health care services are fragmented and suffer from huge deficits in human resources and facilities. Catastrophic expenditures on health-care are recognized as a major cause of impoverishment and poor health. These are only some of the issues and challenges facing SEAR. Through inclusive partnerships, we must collectively address the related social, economic and environmental factors in the most comprehensive manner, the factors that contribute, directly and indirectly, to the double disease burden in South-East Asia.

It is our common responsibility to take full advantage of the momentum gained from our past experiences and use it as an impetus to invest more, in both technical and financial terms, in saving lives, and ensuring better health for all people. No single government, no single organization, no matter how resourceful or powerful can successfully pursue such a formidable challenge alone.

Health is indeed a cross-cutting area, which must be addressed in the true spirit of partnerships. By bringing together our combined wisdom and efforts, we can make a difference and we can help prevent unnecessary suffering, unnecessary morbidity and unnecessary deaths.

Let us join hands and work together to meet the formidable health challenges that lie ahead. The efforts made today to promote and protect the health of all people in SEA will reverberate throughout the Region – and throughout the world – far into the future.

With these words, ladies and gentlemen, I wish you all a very successful meeting.

Thank you.
Annex 5

Millennium Development Goals

Adopted by world leaders in the year 2000 and set to be achieved by 2015, the Millennium Development Goals (MDGs) provide concrete, numerical benchmarks for tackling extreme poverty in its many dimensions.

The MDGs also provide a framework for the entire international community to work together towards a common end – making sure that human development reaches everyone, everywhere. If these goals are achieved, world poverty will be cut by half, tens of millions of lives will be saved, and billions more people will have the opportunity to benefit from the global economy.

The eight MDGs break down into 21 quantifiable targets that are measured by 60 indicators.

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a Global Partnership for Development

Available at: http://www.undp.org/mdg/basics.shtml
Annex 6

Child And Maternal Mortality In South-East Asia

What is the problem?

- Child, newborn and maternal mortality are declining in SEAR countries. There are many success stories in the Region to share with others. However, this decline has been uneven. Overall the Region needs to accelerate progress to achieve MDG 4 and MDG 5.

- Member States of the WHO SEA Region account for 27% of the world’s population but contribute to a third of global burden of child and maternal deaths.

- MDG5 (reducing maternal mortality) is the MDG that has made least progress globally; the average MMR for the SEA Region for 2008 was 240 per 100 000 live births. Five countries account for 80% of these deaths – Bangladesh, India, Indonesia, Myanmar and Nepal.

- The incidence of low birth weight (LBW) is still high (30%) in the SEA Region; the prevalence of underweight and stunting in children also remains high.

- The major causes of maternal deaths are haemorrhage, eclampsia, sepsis, unsafe abortion and underlying medical conditions.

- The major causes of under-five child mortality are acute respiratory infections and diarrhoeal diseases. Above 50% of

<table>
<thead>
<tr>
<th>Country</th>
<th>Under-5 mortality rate (per 1,000)</th>
<th>Maternal mortality ratio (per 100 000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>54 – on track</td>
<td>340 – making progress</td>
</tr>
<tr>
<td>Bhutan</td>
<td>81 – slow</td>
<td>200 – on track</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>55 – no progress</td>
<td>250 – insufficient progress</td>
</tr>
<tr>
<td>India</td>
<td>69 – insufficient progress</td>
<td>230 – making progress</td>
</tr>
<tr>
<td>Indonesia</td>
<td>41 – on track</td>
<td>240 – making progress</td>
</tr>
<tr>
<td>Maldives</td>
<td>28 – early achiever</td>
<td>37 – on track</td>
</tr>
<tr>
<td>Myanmar</td>
<td>122 – insufficient progress</td>
<td>240 – making progress</td>
</tr>
<tr>
<td>Nepal</td>
<td>51 – on track</td>
<td>380 – making progress</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>17 – slow</td>
<td>39 – achieved</td>
</tr>
<tr>
<td>Thailand</td>
<td>14 – early achiever</td>
<td>48 – achieved</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>93 – slow</td>
<td>370 – making progress</td>
</tr>
</tbody>
</table>
Why is it important and urgent to address this problem?

- A large proportion of maternal and child mortality is preventable.
- Additionally, the high mortality among children and women and low national averages of coverage of life saving interventions are associated with a remarkable difference among different population groups.
- This inequity of health and survival exists because of economic status and social factors like gender, location (rural vs. urban) status of education etc. Addressing health inequity would help ensure the basic rights of gender and social equality in the member countries.

Inequity in MNCH

Use of the basic maternal and child health services by lowest and highest economic quintiles, 50+ countries

Reprinted, with permission of the publisher, from Gwatkin, Wagstaff and Yazbeck (2005).
• Evidence-based and affordable technologies and interventions are available that are applicable across the continuum of care and during specific stages of the life course.

### Global consensus MNCH interventions & packages

<table>
<thead>
<tr>
<th>Clinical</th>
<th>REPRODUCTIVE HEALTH CARE</th>
<th>CHILD BIRTH CARE</th>
<th>EMERGENCY NEWBORN AND CHILD CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post-abortion care, safe abortion where legal</td>
<td>Emergency obstetric care (including External cephalic version, AMTSL, Partogram use, antenatal steroids, antibiotics as indicated)</td>
<td>Hospital care of newborn and childhood illness including HIV care</td>
</tr>
<tr>
<td></td>
<td>STI case management</td>
<td>Skilled obstetric care and immediate newborn care (hygiene, warmth, breastfeeding) and resuscitation, infection prevention</td>
<td>Extra care of preterm babies including kangaroo mother care</td>
</tr>
<tr>
<td>Outreach/outpatient</td>
<td>Family planning</td>
<td>4-visit focused package</td>
<td>Hospital care of newborn and childhood illness including HIV care</td>
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<tr>
<td></td>
<td>Prevention and management of STIs and HIV including ART</td>
<td>IPTp and bednets for malaria</td>
<td>Extra care of LBW babies</td>
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<tr>
<td></td>
<td>Peri-conceptual folic acid</td>
<td>PMTCT/ART for HIV</td>
<td>PMTCT</td>
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</tbody>
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<tr>
<th>FAMILY AND COMMUNITY</th>
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<tbody>
<tr>
<td>Adolescents and pre-pregnancy nutrition</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Prevention of STIs and HIV</td>
</tr>
<tr>
<td>Counselling and preparation for new born care, breastfeeding, birth and emergency preparedness</td>
</tr>
<tr>
<td>Where skilled care is not available, consider clean delivery and immediate newborn care including hygiene, warmth and early initiation of breastfeeding</td>
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<tr>
<td>Healthy home care including:</td>
</tr>
<tr>
<td>Newborn care (hygiene, warmth)</td>
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<tr>
<td>Nutrition including exclusive breastfeeding and appropriate complementary feeding</td>
</tr>
<tr>
<td>Seeking appropriate preventive care</td>
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<tr>
<td>Danger sign recognition and care-seeking for illness</td>
</tr>
<tr>
<td>Oral rehydration salts for prevention of dehydration</td>
</tr>
<tr>
<td>Where referral is not available, consider case management for pneumonia, malaria, neonatal sepsis</td>
</tr>
</tbody>
</table>

| INTERSECTORAL | Improved living and working conditions-Housing, water and sanitation, and nutrition education and empowerment |

![Pre-pregnancy Pre-pregnancy Pregnancy Birth Newborn/postnatal Childhood](image-url)
• However, the coverage of interventions that can save the lives of women and children has been low in the countries in the Region.
What contributes to this problem

- Weaknesses in the health system, especially shortage of human resources, and access to quality care 24 hours and 7 days a week, are often a determinant of poor maternal and child health survival.

- Beyond the health system, maternal and child health has multifactorial determinants such as poverty and several socio-cultural factors like status of women, education, employment, transport, etc.

- Adolescent (10-19 years age group) pregnancy, because of social practice of early marriage in some countries in the Region, is associated with higher
What is being done to alleviate this problem? has there been progress?

- Member States have put in place policies, strategies and programmes to improve maternal and child health. While the current maternal and child mortality rates are still unacceptably high in several countries, some are making good progress and a few are on track to achieve MDG 4 and MDG 5. As with the global trend, there has been significant reduction of maternal and child deaths in the SEA Region from 1990 to 2008.

- WHO and international development partners have worked together with Member States in these efforts.

- This underscores the importance of multisectoral collaboration and partnerships with all relevant stakeholders.

- The survival of mothers, newborns and children is significantly affected by the quantum of national health expenditure, especially from public funds.
There is a high level of political commitment as reflected by the Governments in the UN Secretary-General’s initiative for the health of women and children.

**What else is to be done?**

Member States, in partnership with development partners, civil society and other stakeholders must continue to:

- Accord high political commitment and visibility to maternal and child health; and this commitment must be manifested in terms of increased resources for maternal and child health.

- Eliminate inequities in health between the rich and the poor, men and women, urban and rural areas by increasing access to health services at community level so that the ‘unreached’ can be reached with life saving interventions.

- Ensure adequate financing and investment for maternal and child health, and increase public spending on health, to reach about 5% of GDP to prevent catastrophic out-of-pocket expenditure.

- Strengthen the health systems and address the shortage of human resources for health to increase the coverage of life-saving interventions and ensure access to quality care in order to improve maternal and child health and survival.

- Further enhance intersectoral collaboration to address the socio-cultural determinants of maternal and child health and survival and decrease barrier of access to quality care.

- Strengthen governance and stewardship and develop a mechanism for accountability.
Millennium Development Goal 6: Fighting HIV/AIDS, Malaria and Tuberculosis in the South-East Asia Region

Millennium Development Goal 6
- This goal focuses on combating HIV/AIDS, malaria and other diseases.
- It has three main targets:
  - Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
  - Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.
  - Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases such as tuberculosis.

Why HIV, TB and Malaria are important
- Though HIV, TB and malaria are preventable and TB and malaria are curable, more than 10 million people in the Region suffer from these three diseases with a significant health, social and economic impact.
- More than 70% of the population of the South-East Asia Region lives in areas where malaria is transmitted.
- One in every three patients with TB lives in the WHO South-East Asia Region, where half a million deaths due to the disease occur every year. Bangladesh, India, Indonesia, Myanmar and Thailand are among the 22 countries with the highest burden of TB, accounting for 80% of all TB cases globally.
- Globally, an estimated 33.3 million people live with HIV/AIDS, and 2.6 million were newly infected in 2009. In the South-East Asia Region, 3.5 million people are living with HIV/AIDS, largely in India, Indonesia, Myanmar, Nepal and Thailand. In 2009, there were an estimated 220 000 new HIV infections, and 230 000 deaths due to AIDS-related illnesses in the Region.

Estimated HIV Burden in South-East Asia Region, 2009
The people who are most vulnerable

- Pregnant women and under-five children are biologically high-risk groups for malaria. Migrant workers in rural areas, those residing in forested areas or forest fringes, and ethnic communities are among the high-risk groups.

- Sex workers, men who have sex with men, transgenders and injecting drug users are more vulnerable to HIV/AIDS.

- Those who are immuno-suppressed, such as people living with HIV, are also more vulnerable to TB. Over 25% of TB is attributable to poor nutrition and another 25% to HIV infection. Those living in crowded and poorly ventilated conditions are more likely to get TB. TB is also linked to smoking, alcohol use and diabetes.

- The South-East Asia Region accounts for nearly 15% of the global burden of new HIV-positive tuberculosis cases.

- HIV prevalence among new TB patients is 5.7% but varies widely among countries.

MDG 6 and poverty: A “Catch-22” situation

- The association between poverty, malnutrition and communicable diseases, including HIV, malaria and TB, are well established. The poor are malnourished, leading to greater susceptibility to infection.

- In children, this combination of malnourishment and disease could have long-term repercussions in terms of mental development as well as life expectancy.

- In adults, absenteeism due to ill health, and the cost of care, leads to further erosion of earning capacity, and so the family sinks deeper into poverty.

- The poor also have the least access to proper treatment.
**Preventing HIV/AIDS, malaria and tuberculosis**

- Simple measures can go a long way towards preventing these diseases. The most important is awareness. For example, the vast majority of people living with HIV/AIDS remain unaware of their infection status.
- Use of insecticide-treated bednets and use of mosquito repellents can substantially reduce the risk of malaria.
- Awareness of TB and the fact that it is curable leads to prevention.

**Key challenges**

- Universal access to care is crucial for fighting the three diseases.
- Newer, better and more cost-effective drugs and diagnostics are urgently needed.
- Stigma and discrimination continue to be challenges.
- The underlying social and economic factors that lead to greater vulnerability to the disease also need to be tackled.

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**Malaria Intervention Status in SEA Region, 2004-2009**

**Bednet Coverage**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Bednets Distributed (cumulative)</th>
<th>Percentage pop (high+mod) covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>12,268</td>
<td>0.3%</td>
</tr>
<tr>
<td>2006</td>
<td>16,318</td>
<td>4.7%</td>
</tr>
<tr>
<td>2007</td>
<td>26,020</td>
<td>11.4%</td>
</tr>
<tr>
<td>2008</td>
<td>27,657</td>
<td>14.6%</td>
</tr>
<tr>
<td>2009</td>
<td>33,012</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

Bednet coverage (including untreated) increased from 0.3% in 2004 to 23.8% in 2009.
WHO’s role

- WHO plays a key role in providing technical support to Member States. In the case of HIV/AIDS, for example, WHO has recently produced guidelines on the use of antiretroviral drugs for treating pregnant women; and preventing HIV infection in infants could substantially reduce pediatric HIV and improve maternal and child survival rates.

- WHO also plays a strong advocacy role, especially with governments. WHO is advocating for action to reduce stigma and discrimination in health-care settings and communities so that vulnerable and high-risk populations can access health-care services without prejudice and fear.

- Through the Global Drug Facility, an arm of the Stop TB Partnership housed by WHO, 95 countries have access to quality assured first- and second-line anti-TB drugs. Uninterrupted supply of these vital drugs at the service delivery points and strengthening of procurement and supply management chain are the focus of attention at all levels and targets for the programmes.

Why partnerships are needed

- The three diseases targeted by MDG 6 are too deeply entrenched in society to be easily effaced.

- They are no longer health issues alone but also social issues. They cannot, therefore, be fought by the health sector alone.

- Partnerships are therefore needed from every part of society to successfully fight these diseases.
Health Systems Strengthening

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.

Why is health systems strengthening important?

The Alma-Ata Declaration on Primary Health Care (PHC) in 1978 advocated a comprehensive and integrated approach in implementing essential health programmes through health systems. It is also known as comprehensive PHC. The declaration also promoted the goal of Health for All (HFA) by the year 2000. HFA is a social goal, aiming at attainment for all people of the world of the highest health status that will permit them to lead a socially and economically productive life.

Primary health care requires a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services that are public health in nature.

Some have considered PHC too idealistic and expensive, and many donors preferred a selectively focused, disease-centred model. Thus, they took a shortcut by adopting the so-called vertical approach, or selective PHC, to deal with health conditions responsible for a high disease burden that need quick results.

This approach continues to be used for eradication or elimination of certain diseases, such as polio, measles and communicable diseases having significant public health implications, e.g. AIDS, tuberculosis and malaria. Immunization, as the most-cost effective intervention for preventing various childhood diseases, takes similar path.

Despite many benefits that have accrued from the vertical approach, it has been realized that there are disadvantages. The sustainability of vertical programmes is compromised due to fragmentation of already weak health systems. The approach further weakens the already overstretched health systems. Donors under the Global Health Initiatives realize that harmonization and alignment of funds are mandatory to enhance the efficiency and effectiveness of their assistance (Paris Declaration and Accra Agenda for Action, 2006). In line with these principles, GAVI, the Global Fund (GF) and the World Bank have agreed on strengthening the health system through provision of specially earmarked funds.

Key challenges for health systems

High disease burden: WHO’s South-East Asia Region contains 27% of the global population, accounts over 28% of global disease burden.

Emergencies and disasters: The Region continues to be vulnerable to emergencies and disasters caused by various hazards but primarily by natural ones. For the decade 1998-2008, 61.16% of global deaths due to disasters caused by natural hazards were in these 11 countries.
**Low budget**: In the Region, health expenditure depends on private expenditure (66.4%). Total expenditure as a percentage of GDP is only 3.4% and per capita government expenditure on health was only US$29 in 2006, much lower than the *World Health Report 2010* recommendation of 60 international dollars for essential interventions comprising HIV/AIDS/TB/ malaria, childhood infectious diseases, maternal and prenatal conditions, micronutrient deficiencies and tobacco-related illnesses.

**Health workforce**: In most countries too much focus is placed on medical care and less on public health, resulting in low priority being accorded to community-based health workers and community health volunteers compared to doctors.

The conceptual framework for strengthening health systems to accelerate the achievement of the health-related Millenium Development Goals is outlined below:

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### Health systems strengthening conceptual framework

**Challenges:**
- High disease burden: Communicable disease and non-communicable disease
- Emergencies: Epidemics & natural disasters
- Low health budget
- Health workforce

**National Health Policies Strategies and Plans**

- Increase funding
- Align and harmonize donor funding

**Health system strengthening based on PHC:**
- Equitable access
- Focus on primary care with referral back-up
- Affordable
- Public health balance with medical care
- People-centred care
- Use of appropriate technology
- Good intersectoral collaboration

**Improved health** (including MDGs)
- Improved health equity
- Social inclusion (including MDG3)
- Trust and confidence

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*The World Health Report 2010* theme is “Health Systems Financing for Universal Coverage”. It must be remembered that achieving universal coverage does not automatically mean improvement of the health of the population in a significant manner due to the following:

- Many associate Universal Coverage with coverage of health insurance or social
security schemes that mainly deal with medical care.

- Most public health interventions are provided free by the government or enjoy high government subsidy.

- Unlike medical care that is a *private good*, public health is a *public good*. The private sector is not interested in producing this good and the government has to provide it free.

- Few public health specialists that are multidisciplinary and multisectoral in nature to reduce dependency on medical doctors that is expensive to produce.

The report identifies ways for countries to *improve efficiency*:

Reducing unnecessary expenditure on medicines and using them more appropriately, and improving quality control, could save countries up to 5% of their health expenditure. Solutions for the other problems can be grouped under the following headings:

- Get the most out of technologies and health services
- Motivate health workers
- Improve hospital efficiency
- Get care right the first time by reducing medical errors
- Eliminate waste and corruption
- Critically assess what services are needed
Noncommunicable diseases: 
Why are they important?

• Four types of noncommunicable diseases (NCDs)—cardiovascular diseases, cancers, diabetes and chronic respiratory diseases — contribute to the majority of global mortality.

• Four modifiable health-risk behaviours — lack of physical activity, unhealthy diet, tobacco use and excessive alcohol consumption — are responsible for much of the illnesses and early deaths related to NCDs.

• These diseases are largely preventable through effective interventions that tackle common risk factors, and are frequently manageable through early detection, improved diet, exercise and treatment.

NCDs are the top killers in the Region

• 22% of the global NCD deaths occur in the South-East Asia Region.

8 million people die of NCDs each year in the Region.

54% of all deaths in the Region are due to NCDs — far in excess of deaths from communicable diseases, maternal, perinatal and nutritional causes put together (see chart).

A 21% increase in NCD deaths is projected in the Region over the next 10 years.

NCDs affect younger age groups in the Region

30% of NCD deaths in the Region occur among adults below 60 years of age.

A sharp rise in NCD deaths is noted after the age of 40 years.

Middle-aged adults (40–60 years) show disproportionately higher death rates due to NCDs compared with their counterparts in more developed countries.

NCDs affect the poor and further exacerbate poverty

• The poor are extensively exposed to the health-harming impacts of the environment and have less freedom and power to make healthy choices.

• Loss of household income among the poor occurs from unhealthy behaviours (such as tobacco and alcohol use), loss of productivity (due to disease, disability and premature death) and high
out-of-pocket health-care expenditure (on treatment), thus exacerbating poverty.

- 40% of household expenditures for treating NCDs in India are financed through household borrowing and sale of assets.

**Major risk factors for NCDs are prevalent in the Region**

- 8%–26% of all adults do not meet the recommendations for aerobic physical activity based on global guidelines.
- Nearly 250 million people smoke in the Region.
- 80% of the population does not eat sufficient quantities of fruits and vegetables.
- Childhood and adult obesity, key determinants of NCDs, are on the rise in the Region.

**NCDs are increasing health-care demands**

- NCDs are dominating health-care needs in most countries in the Region as a result of the epidemiological and demographic transition.
- Health systems are currently ill equipped to tackle NCDs.
- Lack of access to affordable medicines and health-care services are also major causes of premature deaths due to NCDs.

**NCDs can be prevented**

- NCDs can be prevented, delayed or alleviated through simple lifestyle changes.

- 80% of heart diseases and stroke, 80% of Type 2 diabetes and 40% of cancers can be prevented by eliminating common risk factors, namely poor diet, physical inactivity and smoking.

- Estimates suggest that a 2% annual reduction in NCD deaths over a decade would save over 8 million lives, the majority under the age of 70 years.

- 150 minutes of moderate physical activity a week or its equivalent is estimated to reduce the risk of ischaemic heart disease by 30%, the risk of diabetes by 27% and the risk of breast and colon cancer by 21%–25%.

**Key challenges in the prevention and control of NCDs**

- NCD prevention and control programmes remain largely neglected and underfunded at all levels.

- Globalization and economic development are fuelling the risk factors for NCDs through the availability of processed/high-energy foods and lack of opportunities for physical exercise.

- NCD prevention and control programmes are currently not included in the Millennium Development Goals, making them a low priority for national and international developmental partners.

**WHO’s role in NCD control**

- Raising the priority of NCDs in health, development plans and initiatives is one of the key priorities of WHO’s work. The Global Strategy for the Prevention and Control of
Noncommunicable Diseases (2000) and the Global Action Plan (2008–2013) guide the work of WHO at the global level. The work of WHO SEARO in the area of NCDs in the Region is guided by the Regional NCD Framework, endorsed by the WHO Regional Committee in 2007. Key strategies include:

- Advocacy and raising awareness.
- Surveillance to map risk factors for NCDs.
- Primary prevention focusing on health promotion and legislation.
- Early disease detection and early treatment at the primary health care level.
- Evidence building through research.

**Partnerships are key**

- Many determinants of NCDs lie outside the health sector. Addressing these risk factors requires the commitment and active involvement of the non-health sector, including planning, agriculture, industry, trade, finance and education. Action is also required by the private sector and civil society.
- Prevention and control of NCDs should be on everybody’s agenda.

- NCDs are a serious threat to ALL Member States in the South-East Asia Region.
- Effective NCD control is cheaper than treatment for both governments and families. Prevention is key.
- Urgent actions are needed by all partners to prevent and control NCDs.