EMERGING HEALTH TRENDS IN SOUTH ASIA: GLOBAL AND NATIONAL RESPONSES FOR THE NEXT CENTURY

A ROUNDTABLE CONFERENCE
26-28 JUNE 1999,
DHULIKHEL, NEPAL

JOINTLY ORGANISED BY

South-South Solidarity, New Delhi, India
&
Resource Centre for Primary Health Care, Nepal

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Content:

PRELUDE

1. 1 Nepal was the venue of a 'South Asia health meet', jointly organised by South-South Solidarity and Resource Centre for Primary Health Care (RECPHEC), at Dhulikhel from 26th - 28th June 1999 several concerned NGOs and international agencies working in the health sector in South Asia participated. Realising the need to highlight the cross-boundary nature of critical public health and medical care issues, the initiative was taken by South-South together with concerned NGOs of the region, the theme of the roundtable conference was **"Emerging Health Trends in South Asia: Global and National Responses for the Next Century".**

1. 2 Apart from delegates from India, Nepal and Bangladesh, representatives from the World Bank, WHO, UNICEF and UNFPA participated. All of them shared the urgent need for coordinated and positive responses at the global, national, local and community levels to set right the ailing health system and to promote the will to successfully implement it in a sustained manner.

1. 3 During the deliberations, the conference (i) highlighted the emerging health trends in South Asia, (ii) conducted a critical review of present policies of national governments and international agencies and (iii) in that light, considered strategies for effective health action in the region - global, national, and community levels. It concluded with recommendations on the role of NGOs and other concerned groups, which could be adopted as Action Plan.

2. 0 Key Concern:

2. 1 The conference noted that health stands defined by WHO holistically as a *"state of complete physical, mental and social well-being and not merely the absence of diseases"*. To give meaning to this complex concept and having regard to the diversity of disadvantages faced by countries, a call was given two decades ago at Alma Ata for 'Health for All by 2000', through solidarity and self-reliance and the primary care approach.

2. 2 Clearly we have learnt from experience through these two decades of implementing HFA/PHC strategy that health is a socio-political question in its key dimensions. Eradication of poverty, greater commitment, funds for health care for the disadvantaged and spread of relevant medical knowledge and appropriate health systems will together prevent premature mortality, morbidity and disability in culturally acceptable terms.

2. 3 It is only through special focus on the poor and the disadvantaged that health for all can be achieved in the region. *"The attainment by all people of the highest possible level of health"*, will be a process will often be slow and often halting and meeting difficulties but must be persevered with. People of all ages and in all socio- economic classes must be able to achieve over a period of time their maximum potential, intellectually and physically through equitable access to health care and support by sensible health education and development of life healthy lifestyle; after all, at bottom, ensuring good health is also the individual's own responsibility.

2. 4 It is an irony that while global health status is uniquely based on interdependence, the world is broadly moving towards greater economic liberalisation in trade and investment; but at

the same time economic gap between the rich and the poor within and among countries is widening. Nowhere is this gap more prominent than in the South Asian region, giving rise to acute, and sometime unacceptable, inequity in the health sector. Ill health and disease is getting polarised both among and within countries through a period of economic growth.

2. 5 The growing population in the countries of South Asia and the low percentage expenditure of GNP spent on health especially with inequitable access to poor, has undermined the effectiveness of health care in this region. Moreover, the low social development status, especially illiteracy and ignorance among women has pushed down health as a lesser concern for the common people, leaving behind forgotten people and neglected areas in almost every country. It is often argued that since governments are faced with non-availability of basic health facilities and untrained (and unwilling) manpower in the health sector, private sector medical care can take over the responsibility to compensate for an underfunded public health infrastructure. This is also seen as a necessary consequence of market-oriented economic reforms in almost all countries in South Asia.

2. 6 This last year of the millennium has been dedicated by the United Nations to the older people. The growth in the number of older people in South Asia, over the last fifty years is a tribute to progress in medicine but it also means that more and more people will be at a higher risk of developing chronic and debilitating diseases at a stage, when their working life and earning capacity is ended; this presents new and serious challenges for national and international public health and issues of inter-regional equity in planning social development.

2. 7 There is a new reform pattern at work in medical care in the form of privatisation in the health sector. This has meant rolling back the role of State in health care, except for essential minimum curative care and selected public health programmes chosen on the sole criterion of cost effectiveness and disregarding traditional responsibilities of government's for broader welfare goals. One consequence would be the bulk of the curative care would to be entrusted to private practice of medicine in the market in health care. Throughout the region, such transfer of state responsibility to the private health sector has been urged keeping in mind the restricted resources of the governments to meet costs of infrastructure and trained manpower and technology development in diagnosis and treatment. Whatever may be the macro benefits of this approach, it leaves the key issue of treatment and care of the poor unresolved for they would to pay for such care in the market. Health care has become increasingly expensive and the majority of the people cannot afford it and are getting indebted as a result. Can privatisation alone be taken as a sensible and viable way out?

2. 8 Pursuit of hi-tech medicine, especially development of preventive vaccines has been responsible for global decline in death rate and gradual increase in life expectancy. But it is clear that by no means death-causing diseases have been eradicated fully or for all sections of the people. There has been some positive effort at controlling and preventing epidemics though governmental policies, supported by the intervention of international organisations, non-governmental agencies and voluntary organisations. Spectacular advances have occurred in the control and prevention of some diseases, development of vaccines and medication, and associated medical and scientific innovations have led to healthier longer life, though it is salutary to remember that the more protean diseases e.g. malaria, TB, STD and childhood

diarrhoea persists in good measures in all countries of South Asia not forgetting the specter of AIDS --- clear evidence of stalled epidemiological transition.

2. 9 As a result the war against ill-health in the 21st century will have to be fought in South Asia simultaneously, at different levels and different programmes among social classes and also on both fronts against both infectious diseases and chronic non-communicable diseases. This twin effort for the large population involves needs and coordinated national, international and community level efforts, special care for equitable provision and access to health care against persistent infectious communicable diseases and simultaneous efforts with a greater focus on prevention in dealing with heart diseases, cancer, diabetes, and other lifestyle diseases.

2. 10 As the 20th century ends, the prospects for countries in South Asia indeed seem grim. A large population lacks minimum health care facilities and the organic linkages between health and nutrition and environment cannot be de-linked from the prevailing socio-economic condition. Sadly, there's a deceleration in the tradition of planned economic development as a result of the currently dominant ideological preferences. Health is taken as a commodity in the market, which would decide on both production and distribution of health care as one among several goods and services. Privatisation, urbanisation and commercialisation of medical care and inappropriate medical technology will merely complicate the health inequalities even more, and slowly the focus is getting lost on how to use public resources for sensibly for promoting health and preventive diseases.

2. 11 We are also faced with re-appearance of once extinct diseases. This is largely due to the near collapse of basic environment and health infrastructure which has also led to the appearance of new diseases based on lifestyle changes, especially among the urban poor. To meet these challenges we need a new set of strategies and new linkages in solidarity - in the form of re-orientation of health services; decentralisation and community reforms for the health sector, composite and horizontal implementation of programmes; more funds from governments and international agencies for public sector efforts; stress on poverty reduction; education of women and girl child; training of manpower and planning services to deal specially with the elderly; revival of proved alternative systems and local medical practices like ayurveda, etc.; international cooperation and mutual learning to tackle cross-boundary health problems; and last but not the least -- establishment of a regulatory and monitoring governmental mechanism to keep watch over the relevance, reach, quality and affordability of multisectoral efforts to provide better health to its population.

2. 12 The Conference noted that various international organisations such as WHO, UNICEF, UNFPA, World Bank, etc. stand committed to provide critical and catalytic help for effective health care in South Asia. But these global partners in health, irrespective of the size of their budget allocation or their programme spectrum, do not always take into consideration the local socio-political factors and traditions and often work under stress from donor countries. Sometimes the rich countries from the north threaten to slash their contributions to agencies defending the cause of the poor in the countries covered and there are unresolved conflicts of interest within the national political debate and this spill over to affect international aids flow. Sometimes international oganisations are also constrained by their fear of criticising unacceptable local governmental policies. Trans-national corporations continue to exert indirect

pressure on UN agencies for adaptation of irrelevant and expensive technologies by lobbying with them and with national government officials. It cannot also be denied that World Bank, UNICEF, WHO, etc. are also a part of, and guided by, the dominant global power structure, their support to the poor is often disbelieved and questioned by local health activists; their functioning is sometimes hindered by the perception that they belong to, promote and serve the interests of the national elite and neglect basic issues affecting the quality of life - indeed survival - of the poor people worldwide.

PRESENTATIONS

3. 1 In his welcome address was given by **Professor Mathura Prasad Shrestha** highlighted the common problems faced by the region and the need to rethink on health priorities. This workshop could be an opportunity to discuss and exchange ideas on how to face such emerging challenges in the health sector through solidarity and mutual learning. Excessive privatisation of health care and globalisation of health issues has caused more damage to the actual health problems faced by the people, because they led to faulty and abrupt abandonment of governmental policies. In order to be effective, community participation was essential, as it was the people after all who are at the receiving end. A study published by JAMA, suggested that the determinants of overall global health problems largely related to human behaviour (48%), with rest accounted for by biomedical (11%), environmental (25%), genetic and hereditary (16%). To meet these health challenges, it was therefore necessary for each country to formulate a policy for appropriate management of needs and opportunities and for international donors to support them. All of us must own responsibility and develop the will to formulate an action plan and work together in solidarity.

3. 2 An introduction to RECPHEC was given by **Mr. Shanta Lall Mulmi**, who highlighted the functioning of this organisation in the health sector in South Asia. There was a lack of coherent system of information among the countries in the region and also inside each country. We need to stress on the 'right to information' to help face health challenges as a unit and create awareness on health issues at the grassroots level, through training, IEC material, etc. The participating NGOs should form a network and share information on health problem, health systems and seminars and scope for mutual learning, and to work together to solve cross boundary health problems.

3. 3 It was pointed out that South-South Solidarity was set up as an organisation in 1987 to bring about regional cooperation among the development groups in the countries of South. Through its various programmes, i.e. exchange of development practitioners, research on the macro and micro development issues, workshops/meetings and advocacy on the issues of popular concern and networking among the development groups, it has added to the process of strengthening equitable, people-centred, and sustainable development works, through NGOs and the networks of voluntary organisations in the south countries.

3. 4 A critical overview was needed on the emerging trends in health sector from which one can isolate key issues for analysis, advocacy and action for the next millenium at various national and international levels. South-South Solidarity as a regional networking organisation was ready to carry out responsibilities along with other concerned organisations in order to move ahead with any such Plan of Action formulated at the workshop.

3. 5 Mr. Alok Mukhopadhyay presented an overview on *"Health Concerns in South Asia"*. He laid emphasis on the state of misery in the health sector of this region and emphasised on the commonalties of South Asian countries that binds them together, and on how to enable sufficient transfer of technology and ensure preservation of indigenous knowledge bases in these countries. The workshop was a forum for challenging views and a base to reflect on and work towards the common goal for reducing inequity in health. This can only be possible only if we reflect upon past successes and failures in this sector in each country.

4. 0 Significant Features of the Regional Situation

4. 1 South Asian region is a global challenge as 40% of the world's population lives here and also bulk of the world's poor. South Asia faces a double burden of diseases i.e. the existence of old diseases and emerging new diseases at a time when poverty and inequality present unfinished challenges in socio/political development.

4. 2 The region has suffered from uneven planning and ineffective programme management in the past that prevented proper functioning and infrastructure growth in the health sector. Unfortunately, due to absence of genuine participation, mismanagement and decreasing accountability has increased in the public sector, with few effective checks and balances at various levels. This however does not diminish the need but argues for more informed and targeted public action.

4. 3 Absence of consumer laws and consumer rights organisation in health sector as in other sectors has tilted the balance away from the actual sufferers in the health market of free or mixed economies. Moreover, while the middle class has been mobilised into the civil society, especially during the freedom struggle after independence, most of them have shown little interest or inclinations to share programmes and institutions with poorer sections. On the other hand, an increasingly competitive society has widened the gap, and in this context, it is difficult to improve the quality and standards of public interest, largely meeting the needs of the people.

4. 4 Simultaneously, there has been an amazing growth of private sector in the recent past and private medical care accounts for 3/4 th of the medical care. Of course, formally trained private medical care may account for only a half or less, the rest being rendered by alternate and indigenous (cheaper) systems, partly trained medical personnel and quacks. Health technology is getting more and more sophisticated, and invariably makes health services more costly and therefore the problem of providing quality services at reasonable cost to the people at large has become daunting and it is not possible for governments to brush aside this respondents.

4. 5 The contribution of NGOs and voluntary organisations to health care is still inadequate in all countries especially in rural areas which are more vulnerable, remote poverty-stricken and politically neglected. In any case voluntary work can never be a substitute for well run coordinated public and private systems.

4. 6 There is a substantial flow of funds from foreign agencies though not always too relevant priorities. This inevitably has led also to globalisation of health policies extinguishing the sensitivity to local issues and solutions in which people can participate. We need a balance between the

funding for vertical and horizontal programmes in so that the interlined health problems of the people can be identified and services provided for fair and equitable access to care.

4. 7 The increasing cost of health care, specially arising from the new technologies and medicines, is posing difficulties as most of the poor cannot allow such treatment. There are no incentives to providers in the system to seek to provide affordable care. An alternative cost-effective system needs to be developed with the key aim of helping medical care of those who cannot pay.

4. 8 The traditional systems continue to play an important role in health care. The question of sensible incorporation into the national system of health care remaining unresolved, essentially due to the low esteem of such systems both in the eye of governments and donors, even though a substantial part of the population has recourse to no other care. While we must check the growth of quacks who thrive on the non-availability of medical facilities in remote areas, the indigenous system needs more and more informed promotion on various fronts without condescension.

4. 9 In some areas there is clearly a greater need for regional cooperation for instance in Reproductive health care, malaria control, preservation and developments of local knowledge bases etc. Regional offices of foreign aid agencies should ensure that in all vertical implementation of programmes there should be a component to strengthen horizontal implementation facilities and infrastructure, For preparing a plan of action without duplication of work, case studies from various countries could be useful for the whole region.

5. 0 Regional Thrust Areas

5. 1 NGOs play a demonstrative role to lobby with the government to adopt successful and proven changes in policies and programme implementation taking care to provide synergy by integrating innovative changes with broader governmental structures. NGOs must continuously highlight the grievances of the population and remind the government of their plight, apart from reaching out to the people for service. NGOs can never become a substitute for well-designed public policies and their implementation.

5. 2 In Nepal health services have suffered from politicians ignoring and obstructing the role of medical professionals. This was true of other countries as well, where politicians tend to forget the health issues of importance till the next elections. Corruption at all levels has given rise to major loopholes when it comes to proper implementation.

5. 3 The youth needs to be guided towards a value oriented growth to realise their future potential in promoting health. Educating the young population to lead a healthy life would reduce the health burden, in a long run. Youth can also be motivated to play the role of initiators, implementers and regulators in various aspects of the health sector, especially in the rural areas.

5. 4 Health Care system should be built on what already exists as part of on going systems and must develop traditional medicinal practice making it complementary and integral to existing national health policies based on western medicine. Neglecting ancient medicinal practices, especially in South Asia with its rich indigenous traditions, will prove detrimental as the population continue to have faith in such systems for solutions to chronic or undefined diseases. One associated

question was how to relate the ethno- traditional systems of such alternative medicine to scientifically valid testing, and they in time should be faced without lack of self-esteem or the danger of condescension.

5. 5 Developmental issues should not get to be donor driven but the aim should also be to make best use of resources available. Policies should not be based on the whims of the donor agencies but must be put to test against actual needs of the people, attempting a holistic approach to health. Patenting of essential drugs has become in fact a way of imprisoning knowledge and Nepal's 'no' to joining WTO could be seen as an example against the deep-seated misgiving of the developing world.

5. 6 Malnutrition and health of women and child continues to be wide spread in South Asia and there is a need to shift focus to preventive care and persist with well tested maternal and child care devices to combat malnutrition at infancy.

5. 7 It is salutary to remember that we are dealing with a large-scale problem in all countries, and because population is large, only governments can deliver effectively. And it was the government through its concern for equity that must ensure due access to care overcoming resource constraints, apathy of the middle classes to the conditions of the poor and dangers of misdirection of efforts flowing out of donor priorities. In short, it is the government's responsibility to devise public policies and public action to remove the increasing gap in health status and that clearly is a political issue.

5. 8 Privatisation of the health sector could be always justified as being complementary to government policies and action and private sector medicine has always coexisted. But excessive privatisation has led to the exclusion of all public roles for governments, a dangerous development that would ignore and exclude the majority of the population from facilities, thereby, furthering socio-economic inequity and undermining the concept of 'health for all'.

5. 9 The question of health care of an increasingly older population was a point of concern. Not many health professionals are yet aware of special needs of the old age and there exists a gap in relevant and judicious treatment of the aged. There is a scope for the government to consider the older population as a special area of attention and provide special training in geriatric diseases as a branch of medical sciences.

6. 0 Country Overview

Dr. Morshed Chowdhury on Bangladesh, Prof. Mathura P. Shrestha on Nepal and Dr. Almas Ali on India presented country overviews.

BANGLADESH

6. 1 Among the initiatives to improve health care services in Bangladesh mention was made of constructions of health centres as the union and thana level. Inspite of these only 30% people have access to organised primary health care. Children remain the worst sufferers with ill health and poor growth resulting from deficiency of nutrients such as Vitamin A and Iodine. There is the emergence

of old and new diseases with malaria and kala azar, HIV/AIDS, Hepatitis on the rise. Rapid population growth and slow growth of the heath care sector has given rise to problems.

6. 2 Increasing disparity among priority services, resource allocation, and its relation with other sectors have complicated the functioning of the health sector completely. Less allocation of funds and low utilisation of resources in the public sector have an effect on health of the population. About 30% people have access to PHC services. Health professionals who are posted in various health posts have doubtful competencies, because their training doesn't always address the needs for service delivery in rural areas.

Clearly there is a need to consider how to:

- Reorganise health according to the needs of the people, which is economical, accessible, and sustainable.
- Ensure quality care in the existing circumstances and to organise a proper referral system at the district level.
- Launch literacy and health education programmes with particular emphasis on women and children.
- Prepare for meeting epidemic and natural disaster, which affects morbidity of the population, specially women and children.

NEPAL

6. 3 Nepal's burden of diseases is due to selected risk factors such as poverty, malnutrition, poor quality water and sanitation, pollution, tobacco, etc. There is a risk of emerging and re emerging diseases. Multi drug resistant infections are on the rise, especially malaria and tuberculosis. There exists a higher risk of tobacco related diseases, and Nepal has the highest percentage of female smokers in the world. Lower social status and inequalities poses higher risk of diseases and death in the population. Social inequality, including relative poverty, deprivation and health inequality increases death rates and morbidity.

6. 4 Share of health budget is mere 4% of total governmental budget; share of GDP spent on health is further less. Only 8% of funds are allocated for 93% of the population. Although there has been some improvement in PHC programmes, but it is not effective due to poor infrastructure and organisational development. poor decentralisation, and poor management.

There is definitely a need to:

- Widen the frontiers of knowledge and encourage enlightened research to reach evidence-based decision.
- Put the people first in all matters of health, remove health inequalities.
- Develop transparent and accountable health care system.
- Foster transparency, encourage participation and make the process accountable in developing legislation from drafting to inaction to evaluation.
- Develop health care with the participation of all sectors concerned.
- Improved the efficiency of the health sector. Improvement is desirable in both allocative and technical efficiency.

INDIA

6. 5 The HDI ranks India at 139, and as per GDI India ranks 128th. HDI measures on three basic dimensions - longevity, education and standard of living. As per health indicators (1997), Birth rate is 27.2, Death Rate is 8.9, IMR is 71, Life expectancy at birth is 62 and MMR is 453(approximately).

6. 6 Health problems that needs to be tackled are nutrition related diseases, water borne diseases, communicable and non communicable diseases, AIDS, mental ill health, addiction and substance abuse, pollution related diseases, geriatric diseases, and accidents. Health problems in India will show a complex epidemiology and we will continue to have problems related to poverty, hygiene, nutrition, sanitation, and poor environment.

It is essential to consider:

- A strategy to ensure sufficient food and nutrition to all the sections of the population.
- Provision for safe drinking water and proper sanitation, especially in the rural and backward areas.
- Effective utilisation of health services.
- Revival of traditional medicinal system.
- Formulation of a rational drug policy and ensuring of adequate supply of drugs
- Strengthening of the referral system at the district and the sub divisional levels.

6. 7 ***All these country overviews led to a detailed discussion where the following points were highlighted –***

1. Double burden of diseases faced by this region was a serious challenge to be met at the regional level, learning from each other's experience and helping each other through information exchange initiatives.

2. There was a clear need to protect the vulnerable women and children population facing grave challenges, and NGOs must extensively take up public information education through IEC.

3. Lower expenditure on health by the government has led either to disbanding of health programmes or halting a programme mid way. In either of the circumstances it is the population who suffer. Therefore, lobbying with the government to increase public funding and focus it on effective goals must to be undertaken seriously.

4. In all these countries inequity in health and the ill effects of increasing privatisation will remain an area of primary importance. We must strengthen the role of government to check this widening health status gaps in different sections of the population and to regulate the arbitrary growth of the private sector in health.

5. There is undoubted weakness in health management at the district/block level, which must be tackled; there is an urgent need to develop a proper referral system.

HMG'S RESPONSE ON NEPAL'S HEALTH SYSTEMS AND SERVICES

6. 8 Dr. Chhatra Amatya representing the Ministry of Health in HMG, Royal Kingdom of Nepal highlighted on the structure of governance prevalent in the country. She made special mention regarding the development of grass root level infrastructure in Nepal, for e.g. the presence of over 3000 sub health posts and effective use of health volunteers at the lowest level.

6. 9 The main reasons for the low health standards of the people are the lack of public awareness of health matters. Therefore, health education will be provided in an effective manner from center to rural level. For this, political workers, teachers, students, social organisations, women and volunteers will be mobilised extensively upward level. Target to be met by 2000 is to decrease IMR to 50%, CMR to 70%, TFR to 4%, MMR to 4, and Life expectancy to increase to 60 years (from 53 years).

6. 10 Programme Objectives of the Ministry of Health can be summed up as:

a. To develop positive attitudes towards health through effective IEC interventions.
b. To promote participation of people in health programmes by increasing access to information.
c. To ensure adequate supply of IEC materials to service outlets.
d. To mobilise participation of local cultural groups, mass media and NGOs for promoting public awareness on health.
e. To build institutional capabilities in the field of IEC at various level of service outlets.
f. To develop audiovisual media in support of imparting specific information to the target audience.

6. 11 The strategies to be followed for implementing the objectives were: promotion and focus of IEC activities in target audience through organised efforts; minimising impairment of rumors and health taboos; dissemination of messages through NGOs, INGOs and private sectors; strengthening IEC programmes based on the results of the evaluation, research and monitoring; better institutional framework and IEC efforts; clear and appropriate IEC information flow from center to the people; and enhance the demand for health services through vigorous IEC campaign.

6. 12 Health Programmes in the government pipelines are: expanded programme on immunisation, Nutrition, Control of diarrhoeal disease, Control of acute respiratory infection, Family planning, Safe motherhood, Malaria control, Kalazar control, Tuberculosis control, Leprosy control, STDs, HIV/AIDS control. At the level of strengthening the infrastructure the government is putting in for FCHV, TBA, PHC Outreach, Health Institute and Manpower Development, Training, Health Education, Logistic, Community Drugs and Laboratory facilities, and Regular IEC Interventions

6. 13 Innovative programmes undertaken in the wake of educating the people regarding health are: drama serial for general public, distance education radio programme for health workers, RH/FP, FM, Radio programme for adolescent, FCHV radio education radio programme for FCHV, HELLIS Network activities, Celebration of National Immunisation Days, and satisfied client group discussion in the communities. The Various Target Groups aimed at by HM's government are: the basic influential groups, health personnel, general public, patient and their relatives, community

leaders, teachers children in or out of school, parents, priority risk groups, volunteers, married couples, men-women-adolescents, elderly women and others. The Communication Channels employed are Interpersonal Networks, Radio and television, print materials, Indigenous and ethnicity, Street drama and cultural events and Hoarding boards.

6. 14 In the light of her presentations discussion revolved around the fact that in order to meet the increasing cost of medicines there is a need for a community drug sharing scheme in which the seed money is provided by the government and community shares the later cost.

7. 0 International Responses

WORLD BANK

7. 1 Dr. Tirtha Rana representing the World Bank, Nepal presented some comprehensive data on Health, stressing the case for cost effective delivery of essential health services with special allocation to the poor and under-served population. She drew particular attention to the following issues:

7. 2 Critical factors that influence health and nutritional conditions among the regional countries are income levels and poverty; status of women; development opportunities and access to labour market; education of women and girl child; better access to food, clean water, sanitation; level of participation; traditional culture and behaviour, political situation, leadership and level of commitment.

7. 3 Some diseases are not so fatal but many times disabling, adding burden physically, economically, socially and mentally to the individual and to the family, society and the country itself. As similar to the Indian case, this dual burden of communicable and non-communicable diseases is likely to result in an "epidemiological polarization" in which section of the Nepalese would successfully complete a demographic and epidemiological transition while others remain in the pre-transition phase. Overall increase in the population will demand at least a corresponding magnitude of increase in health care and also of elderly population (65 and above). There are implications of additional resource needs from more rapid population growth, faster fertility and mortality decline, and better quality care.

7. 4 Tuberculosis is a leading cause of death - especially among the productive young adults; and pneumonia is a major killer among the elderly. There could be some level of under-estimation on malnutrition at it appears plausible with deaths reported for the category of nutritional disorders. Children between 0-4 years of age contributed to approximately one half of the total burden of disease attributed to perinatal conditions, ARI, diarrhoea, vaccine preventable diseases and nutritional disorders, followed by those in the 15-44 age.

7. 5 The higher burden of disease among females, especially in younger age groups suggests gender bias against female children while the higher burden among females in 15-44 age group was essentially due to high maternal morbidity and mortality. The burden attributed to diseases influenced by life styles (smoking, drinking etc.) such as ischaemic heart disease, cirrhosis and alcohol dependency were greater among males than females. Injuries and accidents were

estimated to contribute 9% of the total burden of disease.

According to her suggestions:

- There is strong need for specific focus on interventions aimed at child survival; the need to ensure improved domestic environment and better access to safe drinking water and sanitary disposal of excreta; an effective safe motherhood programs, especially in the rural and remote areas, and interventions aimed at improving the status of women in society are needed to address the neglect of female children.
- With regards to preventable communicable diseases like TB, kala azar and HIV, operational/technical efficiency of on-going intervention programs which must be improved through enhanced community awareness especially aimed at modifying life styles such as smoking, drinking etc. need to be considered.
- We also need more reliable vital statistics and epidemiological data should be development and implemented.

7. 6 In response, it was felt that there should be greater a focus on data indicators and urge the development partners must be urged to make it a starting point especially regarding health trends. The World Bank must take a holistic view of its investment and ensure only that productive areas are covered with transparency in programme. It was pointed out that World Bank is a coherent and holistic donor, and its investment depends on the government's needs.

WORLD HEALTH ORGANISATION

7. 7 Dr. Harry Fierman representing WHO listed out the priority areas of Ministry of Health and WHO. Major area of concern as understood by WHO is basically that of education and training of health personnel, epidemiological surveillance, health care for the elderly and development of regional self-reliance. In particular he laid emphasis on the following issues:

7. 8 The foremost challenge facing South Asia in the health sector today can be better dealt with by closing the gaps and inequities in the health sector in our societies. Differential needs and gender equity should also be taken into account.

7. 9 Patients should be given the autonomous right to determine what will happen to him/her. Informed consent should also be practiced. Furthermore, placing health at the centre of development will foster better formulation and implementation of health policies. To ensure universal access to quality health care, the government has to take up a new role in relation to health. The government should further strengthen the infrastructure, provide equitable or alternative financing, encourage de-centralised decision-making and governance and lastly, promote NGOs and private sector participation. The government should take special initiative and invest in women's health and development to eliminate gender discrimination and disparities.

7. 10 Application of scientific knowledge and technology should be encourage and to ensure that the generation and application are relevant and appropriate to the needs of the community. Medicinal plants should be preserved and their medicinal qualities should be propagated. Traditional medicine should be promoted and consequently integrated into the mainstream health care. Traditional systems that are scientifically proven to be effective and safe, and are easily

available, accessible and affordable should be promoted.

7. 11 Financial resources for health should be mobilised and their effective and efficient use should be promoted. Communities should be involved as active partners in health development, specially in planning, implementation and monitoring policies and programmes.

Some specific recommendations were put forward:

- Health promotion should be undertaken to empower people with knowledge and skills to improve their own health and in effective countering of unhealthy lifestyles. Quality health programmes for children and family should be ensured.
- Existing partnerships should be strengthened and new ones for health development at all levels should be fostered. Interaction between health planning policies and actions with other sectors (e.g. education, environment, agriculture, etc.) should be fostered and these sectors could be urged to include health concerns in their agendas.
- A public policy on fair price distribution of quality food should also be ensured.
- Health should be advocated intensively, noting that it is central to development. Health should be placed high on the political agenda of government and on the social agenda of people. Health ethics should be upheld and enforced.
- Quality and social relevance of education and training of health personnel should be stressed.
- Strengthening of epidemiological surveillance and health information to be ready to face a further change in the health trend in this region. Development of regional self reliance to meet the health challenges effectively
- Strengthening of health care facilities for the elderly, where geriatric diseases can be effectively dealt with at various levels.

7. 12 In the course of discussions on WHO's role, it was felt that WHO should play the role of a forum for discussions and debates, and WHO should be open to receive young professionals, and the question of funds inflow into a particular country depends on the national policy. It was generally felt that South-South cooperation is crucial for effective dissemination of materials on health in this region. South-South study tours, tropical research, higher education prospects within South Asia, etc. should be encouraged.

7. 13 WHO programmes are country specific and region specific too. There exists a memo of understanding for providing training in Sri Lanka and in the field of traditional medicine in Sri Lanka and Nepal. WHO hires quality consultants and provides funds for technical assistance in various countries. There exists a good relationship with the governments and work in health is carried out in partnership. There is a devaluation of WHO for the mere fact that it is involved more in technical affair than in health policies, and it is because of the lack of understanding that health is altogether a different issue and health policy is a totally different thing.

UNITED NATIONS POPULATION FUND

7. 14 Dr. Godfrey Walker representing UNFPA, Nepal pointed out that his organisation was guided by three challenges - improving reproductive health, young people and their healthy life and healthy ageing.

7. 15 South Asia today faces a triple challenge of the unfinished agenda of improving the reproductive health of the population, the young people preparing for life and healthy ageing by adding years to life and life to later year. The alarming rise in the fertility level, the percentage of maternal mortality, sexually transmitted diseases, perinatal and neonatal morbidity and mortality gives rise to a precarious health scenario in this region.

7. 16 There will be a steady increase in population in the countries of South Asia. As can be seen with the increase in population there is also a steady increase in the elderly population over 65 years of age. There will be a rise in the % of elderly population as seen for year 2020, drastically in India and Sri Lanka. There will be a decline in the % of young people in year 2020 as compared to year 2000, except in the case of Pakistan, which will note a tremendous growth and slight growth in noticed in Nepal also. In 2020 there will be an increase in non-communicable diseases and injuries, whereas a decline will be seen in case of communicable diseases. Such will follow due to the change in lifestyle.

7. 17 A trend has emerged where the age for first sexual encounter is declining. A large proportion of young people are engaged in unprotected pre-marital sex. In Bangladesh, 60% of boys above 16 years have had sexual experiences. Which further gives rise to the number of abortion cases, specially involving unmarried adolescents. It is worth noting that about 6% of abortions in Nepal were by adolescents under the age of 20 years. Many married and unmarried adolescents suffer from reproductive tract infections (RTIs) and sexually transmitted diseases (STDs). In Sri Lanka about 6.5% STD cases are among adolescents between 15-19 years. Knowledge about HIV/AIDS is equally poor. Even if people are aware of it, they are not sure how to prevent it.

7. 18 UNFPA was setup to "extend assistance to developing countries and countries in transition to help them address reproductive health and population issues."
The main areas of work involve:

i. To help ensure universal access to reproductive health including family planning and sexual health to all couples and individuals by 2015 AD;
ii. To support population and development strategies;
iii. To advocate for mobilisation of resources and political will to accomplish its area of work.
iv. In new programmes, UNFPA aims at including the issue of advocacy and extending specific support for strengthening national capacity in critical areas.

Keeping in mind the role of UNFPA, some recommendations that emerged are that:

- There is a need for a viable population policy aimed at controlling the alarming rise in population. It should provide the people with family planning education and provide incentives for a smaller family.
- Importance needs to be attached to the education of women and girl child regarding their reproductive rights and precautions to be taken to avoid unwanted pregnancies. Education regarding sexual interaction and its repercussions i.e. pregnancy and sexually transmitted diseases needs to be given at the school level.

7. 19 During the course of discussions few points that emerged are that an international health programme at the right time will benefit the people of the world at large. UNFPA through its worldwide programme on safe motherhood takes care of childhood disabilities. There exists a

distinction between specialised agencies and direct agencies. Due to difference in organisational philosophy and through coordination overlapping of work can be avoided to a greater extent. Voluntary sector should also come forward and lend a helping hand.

8. 0 Emerging Health Concerns and Priorities

8. 1 In his presentation Mr. Srinivasan listed out the major health concerns highlighted during floor discussions, priorities to be set to arrive at solutions for these health problems and finally sought responses to these concerns on the part of aid agencies, voluntary organisation and government agencies.

8. 2 The changing epidemiology in South Asia - double burden of diseases, malnutrition, and growing percentage of older population. Inequalities occurred in two dimensions - firstly in terms of access which might be physical, financial or cultural, secondly in terms of provision of facilities and services. Poverty and social inequity are inter-related giving rise to massive health complications.

8. 3 Gender injustice and neglect of the girl child is a visible trend in all of South Asia. Where the birth of girl child is looked down and women enjoy a low status in the society not much attention is paid to their health needs. Literacy level among women is very low and as such they are totally unaware of their health needs and rights. Education and economic empowerment can lead to better health of the women.

8. 4 Unsafe water and improper sanitation adds to complications in health. Unhygienic social condition is a major factor for rural health problems persisting in spite of attention for several decades.

8. 5 A proper identification of the needs of the people and resource mobilisation thereof can alone benefit the people and make the programme relevant. Resources should compliment need and not just chalked out arbitrarily. Vertical implementation of programmes should be disbanded in favour of composite programmes, and if that is not feasible, each vertical programme must have a component to strengthen common infrastructure.

8. 6 Proper utilisation of the medical technology is necessary, but only if there is more understanding among doctors of illness and poverty and deprivation as symbiotic issues affecting health systems. The more sophisticated the technology, costlier is the use of it, and less relevant to the poorer sections. The question is therefore of how to provide the best to the people without putting financial pressure on them. We must stress that the government to increase its budget allocation to meet increasing health needs of the people. Better management and creation of better infrastructure is only possible by governmental initiatives, because government alone can address the people's need in a credible way.

8. 7 Traditional system of medicine should be evolved as complementary to the dominant western system of medicine, because it is not only reliable and perceived to be free of adverse effects but also cost effective. Due emphasis should be given to preserve, promote and popularise herbs, etc. used in traditional medicine, but this is not possible with greater self esteem among alternative systems.

8. 8 In the light of the emerging priorities, it is necessary that the responses of regional aid agencies and national-international agencies be re-formulated into a coherent framework:

(a) The role of government remains primary as the principle provider for health care through more resources and better management.

(b) Community concerns for quality in health services, minimum standards and accountability in the private sector, availability of services in the remote areas, affordable cost of health care, responsiveness to patient's rights are key issues that can be handled effectively, only through greater community participation, and decentralised (manageable) delivery systems.

(c) There is a need to ensure and direct the role of private sector into carefully defined clinical and public health services. A drive to improve the competency, relevance and fair practice among the professionals is a must, to be undertaken seriously and effectively to bring better health care facilities to the people. All major developmental initiatives should incorporate a focus on good health and its promotion.

(d) Health reforms should be accepted inevitably as flowing from structural reforms but only along directions that do not hurt the poor and the vulnerable and do not involve abrupt changes in support systems. Focus should be more on preventive health than on curative health, cutting cost on health incurred by the patient drastically by preventing diseases and treating illness at early stages. It is necessary to note the inherent contradiction between the 'trickle down' approach to economic growth and the grave vulnerability imposed by illness during poverty.

8. 9 Initially, any coherent framework of responses must keep in mind that ---- health is a political issue; the challenge lies in making the realisation come alive in the country context. South Asia must look inside for solutions based on earlier experiments/experiences, and derive from existing capabilities. Moreover, only that development process can last that is based on justice and meets essential needs of the people. Better implementation through decentralisation, resource mobilisation, effective community management and professional accountability are essential ingredients for successful implementation of programmes. Foreign assistance is best used when directed towards purposes determined by country priorities and is adapted to regional/local needs. Training of peripheral functionaries must ensure greater confidence and more transfer and demystification of knowledge, which will prove due motivation for implementation. An appropriate and practical state-market role in the health sector can not be born out of any abstract model based on experience of developed countries alone but must emerge out of national political consensus on the extent to which compensatory transfer payments should support the disadvantaged.

8. 10 The consensus that emerged from discussions on the framework alone can be stated as below. Health should not be a responsibility limited to Ministry of Health specialists as it is an all encompassing issue, and responsibility must be distributed within all sections of government and of the Civil Society. This shift of responsibility must seek to establish a definition for quality and standards of care that meet three parameters --- doctor's accountability as a provider; rights of citizens as a consumers, and obligations of State as a moderator to ensure equity and fairness.

8. 11 Some issues like poverty, water and sanitation, it was argued, though related to health are beyond the preview of WHO and Ministry of Health. To compensate for the decreased role of government, encouragement for community participation in health sector was needed; the successful example of EPI & FP in Bangladesh was quoted. The role continues for government as coordinator and quality regulator.

8. 12 There is need for decentralisation of governance, district level planning and dispersion of responsibility in health sector for proper implementation of health programmes. And that NGOs, private organisation and all agencies should move ahead on health issues in an integrated and collaborated manner.

8. 13 Strong regulatory action, including promotion of self-regulatory bodies, is needed for maintaining reasonable standards, especially after introduction of technology. Enforcement of standards is a real challenge to government and the NGOs, voluntary organisations and related institutions could help the government. There should be an increased effort at developing intermediate technologies using rich traditions and practices in South Asia.

8. 14 Integration and coordination of health services with other sectors and among countries should be looked into but advocacy of prescriptive concerns by donors from western experience should be avoided, as the issues are country specific.

8. 15 Doctors should not be treated like rest of the civil servants for purposes of remuneration and rewards. They have a special status among professionals in the society and should be provided with special incentives to encourage proper motivation, and optimum output, displaying a combination of skill and compassion, often under stressful circumstances.

8. 16 Drawbacks of selective vertical programmes of and growing organisations on sectors like AIDS, Malaria, etc is well known. This occurs because governments do not seek out new or radical programmes but just accept what donors dictate. Also the sequencing of aid by agencies might be necessary so that a certain percentage of each programme could be put aside for infrastructure development.

9. 0 Vision to Action

9. 1 The sense of the floor at the end of two days discussion was that there are still serious problems existing in the health sector and even though some initiatives have been taken by the State, Civil Societies and the Multilateral Agencies, the gravity of emerging needs should not be underestimated. There are old unresolved issues like effective primary health care services, health care to the vulnerable group and to the people in remote areas, health care at affordable costs to the poor and often issues related to poverty. Besides there has been a significant epidemiological shift, (described broadly as double burden of disease) and malnutrition and growing percentage of older population.

9. 2 In response to these emerging needs it was agreed that the following actions at various levels was required:

1. Government programmes must be readjusted to reflect these concerns.

2. More resources i.e. up to 15 % of GNP must be allocated for total social sector requirements, i.e. with at least 5% each for health, education and welfare. Out of the total revenue budget at least 15% needs to be spent on health programmes to sustain public provision.

3. There is a need to involve the private sectors in a meaningful way to meet the increasing health needs of the people. Incentives should be given to the Private Sector provided they agree to be considered as a part of the national health set up. In that light, the role, the responsibility, accountability and affordability of the private sector must be made clear as part of national health policy. There is a need to regulate the quality, standard and cost of medical care so that even the poor section of society can afford it.

4. The ethical pursuing medical practice in all systems is a major cause for worry and proper systems are needed to watch over and analyse ethical issues in health care. Quality of care and social relevance of medical education and training of health personnel needs to be stressed.

9.3 The Role of the State:

The forum arrived at the conclusion that in the absence of medical care and good preventive measures primarily in the rural area there will be an increase in the poor quality of life among the vulnerable section of the society. The unequal health entitlements of vulnerable sections of society must be constantly monitored and the issue of an equitable health care system must be part of political debate.

Therefore the responses to the emerging trends in health sector must aim at:

1. Strengthening the existing PHC system that provides health care to the people, by developing and strengthening preventive health care system for the poor and people living in the remote areas.

2. Involving private sector into the health care system to meet the increasing demand on health services. There is an increasing problem of unaffordable cost of health care, which has influenced the effectiveness of the system. As the health sector is facing scarcity of resources, it is forced to think about the involvement of private sector in providing services, needs to be backed by rules and regulations to protect the rights of common people. There is a need to move towards an appropriate and practical state-market role in the health sector.

3. Even after the involvement of the private sector, the State has to play a larger role in ensuring an affordable health care to its people. In this regard there is a need to:

a. Find out new alternatives to meet the scarcity of resources and to ensure efficiency in service.
b. Sensitise the medical community to address the concern of the people.
c. Look into the need for public-private balance in the health sector, which may be different in different countries. The need may arise from economic condition of a country, strength of public health infrastructure and access of medical care.
d. Create a competent authority involving experts, activists and responsible member of the societies to review the activities undertaken by the state, private sectors and civil societies.

9. 4 The Role of Global Agencies

The group strongly felt that the Global organisations mainly WHO, UNICEF, UNFPA must support the evolution of integrated Public-Private health policy in each country and their policies must have properly balanced vertical and horizontal programme. These global agencies must help create an affordable medical care infrastructure in the rural and remote areas, which can only be possible, if they are more sensitive to multiple health care system practised by the people in South Asian Countries.

The multi-lateral agencies should understand the traditional health care system prevalent in South Asia. There is a need to incorporate in and promote it through their policies as a specialty of South Asia. These agencies need to pay attention to the population burden in South Asia. While specific thrust is important, it is also important to consider population, nutrition and health together.

9. 5 The Role of Private Sector

Private sector should be more sensitive to the concern of common people and they should come forward to the areas where government services have not reached. Clinical and PHC services provided by private sector should be complementary to that of government services. Government can make arrangement and reach contracts with private sector for providing their services in remote areas.

High technology in Tertiary Care should be introduced according to the guidelines provided by the government, so as to involve themselves in research with an objective to provide health care in an affordable cost to the poor.

9. 6 The Role of Civil Society

The Civil Society must take up demonstrative projects for health care in the remote areas and for the vulnerable section of the society. It must undertake massive public information campaign on health issues and involve the people's group and government agencies through IEC materials i.e. leaflets, books, etc.

The NGOs must take initiatives to strengthen the existing PHC center and their staff to meet the health needs of the local people and protect their health rights through filing of public interest litigation. Acting as pressure groups, the Civil Societies can ask the government authority to create an early warning system at grassroots level which would work as weather station for diseases. They must act as supervisors/regulators and pick up of issues with government where management has failed.

10. 0 Plan of Action

10. 1 Keeping in view the health scenario in the region, the various responses, and the role of different agencies in providing health care at an affordable cost to the people in the region, it was unanimously agreed that --- to begin with NGOs can involve themselves in reviewing the following

issues by forming a **Task Force** on each issue apart from some specific action at the community level:

1. Primary Health Care System,
2. Involvement of Private sector into Health Care,
3. Education and Training to the Medical/Health professionals.

10. 2 The group discussed the various key principles to be kept in mind as a consensus in the mode of operations and activities that will range at many levels --- from Community to National/Regional level:

1. Planning and implementation of health programmes should be done at the district level.
2. Information campaign by NGOs and people's group in collaboration with government.
3. Existing PHC structure and staff should be motivated and mobilised to draw optimum results.
4. Review of previous health plans and formulation of alternate citizen's report.
5. There is a need to strengthen the participatory process at local and district council level.
6. Public health task especially municipal functions like management and logistics should be addressed.
7. Decentralisation of resources, power and autonomy in the health sector is essential.
8. Qualitative review of the medical Training/Education for the health professionals.
9. Medical education with ethics and service in rural areas for a period should be made compulsory.
10. Integration of various developments sectors that finally affect health of the people.
11. Cross-purpose working should be avoided by national health governments.
12. Vertical implementation and overlapping of work should be checked.

10. 3 Keeping in view the discussions and conclusions arrived upon through the various phases of the meeting, the NGOs adopted a Specific Plan of Action at the following levels:

At the Community Level

A three-phase programme was unanimously agreed upon to strengthen the PHCs at the District/Block/Thana level. It was further agreed that RECPHEC, Nepal, VHSS and GK in Bangladesh and VHAI in India would take up needed action in collaboration with NGOs, Civil Societies, and Government Agencies in their respective countries.

Phase I - Massive public information campaign on health issues by NGOs and people's group in collaboration with government. Identification of areas and resources available and the collection of basic information for the implementation of pilot projects. The participating NGOs will adopt 2 blocs and put into effect the priorities discussed at the community level.

Phase II - Training and capacity building process for the members of civil society, government departments at the grassroots level to achieve the optimum result.

Phase III - Adopting the planned strategy to the local needs of the people.

Stress must be laid on massive information campaign at the community level to educate the people about essential health care. NGOs must collaborate to avoid duplicity and benefit from each other's expertise and experiences. IEC material must be explored at local level and must build upon the existing resources for the benefit of the community to cut unnecessary expenses.

At the District Level

A consensus was reached on to study and document success stories with special emphasis on district level planning in health. The Indian State of Kerala, Bhatshala in Bangladesh and Sankhua Sabha in Nepal were identified as crucial areas to study and for documentation of district level planning in health. The responsibility for overall study of these areas would lie with the participating NGOs, who would formulate strategy through discussions with members/people associated with district level planning.

At the National Level

A comprehensive alternate citizen's health report must be prepared by VHSS/GK for Bangladesh, RECPHEC for Nepal and VHAI for India taking initiatives in their own countries. An exposure of senior government policy makers to the areas where health planning at the district level has been successfully undertaken must be considered. A network of NGOs must be created at the national level to act as a pressure group and involve in constant advocacy to bring about a health policy, which will benefit the people at the level of government, bilateral agencies and multi-lateral agencies.

At the Regional Level

The forum laid further stress on pressurising governments, multilateral aid agencies, etc. to make a balance between the vertical and horizontal implementation of programmes. There must be a strengthening of dialogue with governments and International and Regional Bodies of WHO, UNICEF, UNFPA etc. apart from other support agencies. It was agreed by the members participating in the roundtable to create a Task Force with following members who are interested to take the responsibility of reviewing the various concerned issues and suggest accordingly.

i. **Training to Health / Medical Professionals**
   Convenor - Dr. Morshed Chowdhury, Bangladesh
   Members - Prof. Mathura P. Shrestha, Nepal
   Mr. G.P. Dutta, India

ii. **Private sector in Health Care**
   Convenor - Mr. R. Srinivasan, India
   Members - Dr. Nasiruddin, Bangladesh
   Mr. Mahesh Sharma, Nepal

iii. **Traditional systems of medicine in South Asia**
   Convenor - Prof. Darshan Shankar, India
   Members - Prof. L.M. Singh, Nepal
   One member to be identified from Bangladesh

A common action programme in terms of communication + NHS + IEC + TRG strategy among the major players of the sub-continent will be stressed upon. Through common consultations, meetings at specific intervals a relevant strategy must be arrived upon from time to time.

South Asia Health Alliance (SAHA) was formed, and it is expected that South-South Solidarity will work as a Secretariat for networking among organisations and to help in implementation of the action plan.

As per the floor decisions following follow-up meetings to review the activities were decided -

Follow-up Meetings	Place	Date	Organised by
SAHA Meeting to Review of activities undertaken by NGOs in Nepal, India and Bangladesh	New Delhi	October 99	VHAI & SSS
Review of actions decided in earlier meeting	Dhaka	March 2000	VHSS & GK
Follow-up of various activities decided in the SAHA meetings	Kathmandu	September 2000	RECPHEC

Future challenges, therefore, must be met through re-organisation of existing resources; creating opportunities for community participation; development of infrastructure, decentralisation, accountability; poverty reduction; integration of health services with developmental activities; further strengthening the role of NGOs; the unanimous consent to derive a workable 'action plan' for the region as a whole.

Therefore, it was agreed that a list of the areas of health concern of the participating countries must be formulated, so that the documents could be shared. Similarly, SEARO office and civil society must be able to interact with each other. INGOs must keep the National Policy under constant vigil and its aberration and violation and Aid agencies should be checked. The Civil Society must further act as a (weather) health station to report disturbing trends in the areas e.g. HIV/AIDS etc. A steady documentation and build up of pressure groups to ask aid organisations like World Bank, WHO, etc. is a must to provide key documents to South-South, which can then be circulated to other NGOs.

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