



Photo courtesy of Health Promotion Board, Singapore

Towards A Smoke-free ASEAN

Singapore's Health Minister Gan Kim Yong together with other ASEAN Health Ministers and Secretary-General of ASEAN, H.E. Dr. Surin Pitsuwan led the launch of "Towards A Smoke-free ASEAN," a campaign to initiate and encourage smoke-free living among ASEAN citizens during the opening ceremonies of the World Conference on Tobacco or Health in Singapore on March 20, 2012.

ASEAN health ministers, namely: Pehin Dato Hj Adanan - Brunei Darussalam), Dato' Sri Liow Tiong Lai - (Malaysia), Dr. Pe Thet Khin (Myanmar) and Dr. Eksavang Vongvichit (Lao PDR) also rallied behind the launch which was organized by the Health Promotion Board of Singapore, the Southeast Asia Tobacco Control Alliance (SEATCA) and the World Health Organization Western Pacific Region Office (WHO WPRO).

Dr. Surin said, "ASEAN, through the ASEAN Focal Points on Tobacco Control (AFPTC) works by protecting public health policies from being interfered by those

who want to campaign to increase the sales of their deadly products. We work with government agencies, we work between governments, institutions and we also work with civil society. We create a coalition, we create a network because civil society can do wonders, they have the reach, they have the commitment, they have built up expertise, they can do on the ground at the grassroots level more than just at the policy level."

Protection from exposure to tobacco smoke is one of the seven strategies set by the AFPTC to ensure that effective tobacco control measures and sustained responses are in place and in line with the ASEAN Social-Cultural Blueprint (2009-2015) and the WHO Framework Convention on Tobacco Control to curb tobacco-related diseases and deaths, reduce the prevalence of tobacco use, protect people from secondhand smoke, and improve the health and quality of life of the ASEAN population.

The AFPTC, which was organized in 2009, has been elevated as an official

ASEAN subsidiary body and this change will give a status of permanency of the group in the region.

Towards A Smoke-free ASEAN campaign serves as an opportunity to highlight regional efforts in advancing smokefree initiatives like the building a smokefree model in world heritage sites and cities. It is also a chance for ASEAN member states to share experiences and best practices to establish more smokefree environments.

Smoke-free ASEAN Secretariat

On May 2, 2012, the ASEAN has set a healthy example for the rest of the region, by declaring its own headquarters in Jakarta, Indonesia, officially smoke-free. Dr. Surin personally led the unveiling of the official "Smoke-free" signage at the lobby of the ASEAN headquarters and

said, "The ASEAN Secretariat (ASEC) as a Smoke-free Working Environment, calls on all staff and visitors to the headquarters to strictly observe and enforce the `no-smoking` policy in all rooms, toilets, lobby, and passageways, for the health, safety and welfare of everyone working in the ASEAN Secretariat Building."

Regional tobacco control advocates were quick in congratulating the ASEAN leadership for "a determined and progressive stance that unequivocally expresses where the region`s governments should stand with respect to curbing tobacco use." SEATCA Director Bungon Ritthiphakdee, on behalf of the alliance of tobacco control advocates from around the region said, "The ASEAN secretariat`s leadership by example isn`t merely symbolic. It follows through on a commitment and is concrete in action."

The ASEC Health and Communicable Diseases Division with the support of SEATCA and WHO, wants to strengthen the implementation of the ASEAN Secretary-General`s memorandum on Smoke-free Working Environments.

Dr. Surin had issued a memorandum for a smoke-free ASEAN Secretariat as early as 2009, but the ceremony in May was intended to build momentum and formally introduce the ASEAN Secretariat to the international community as a smoke-free building.



TOP: ASEAN Secretary General Dr. Surin Pitsuwan at the launch of the No Smoking sign at the ASEAN Secretariat. **BOTTOM:** Dr. Surin with Dr. Khanchit Limpakarnjanarat of the World Health Organization and Dr. Domilyn Villarreiz of Southeast Asia Tobacco Control Alliance (SEATCA). (Photos courtesy of SEATCA)

Smokefree ASEAN Events

Another smoke-free initiative endorsed at the 6th ASEAN Senior Official Meeting on Health Development in Nya Pyi Taw, Myanmar in July 2011 is the development of a policy to make all events sanctioned by the ASEAN Secretariat to be smoke-free. This means events shall only be

conducted in smoke-free places or venues and a sign stating "This is a Smoke-free Meeting (Function) with the No Smoking sign placed below it shall be placed at entrances of venues – function halls and meeting rooms.

Moreover, at the beginning of every event, all participants shall be informed that "This is a Smoke-free ASEAN

Event. Smoking is only allowed outside the building." The organizer of the event shall be responsible for the strict observance of this policy.

This policy has been developed to protect all participants to ASEAN functions or events from exposure to secondhand smoke as well as to promote a non-smoking norm in ASEAN member states.

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Note: The articles were contributed by the focal point from each of the ASEAN health subsidiary bodies.

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One Vision. One Identity. One Community.

Regional Launch of the First ASEAN Dengue Day in Indonesia

Dengue is generally found in tropical and sub-tropical areas. The World Health Organization (WHO) estimated that nearly 50 million dengue infections occur annually in the world. The number of dengue cases and death gave impact on socio-economic lost in countries. The economic lost is due to direct medical costs, direct nonmedical costs, and indirect costs such as days of productivity lost due to disease, both for the patient and to any other household member who had to care for the patient.

ASEAN Member States have in place programmes to prevent and control dengue infections; however, these need to be aligned with regional strategies and involve all relevant stakeholders. The ASEAN Health Ministers emphasized the need to comprehensively address dengue in the region. At the 10th ASEAN Health Ministers Meeting on July 22, 2010 in Singapore, the Ministers agreed on the proposed ASEAN Dengue Day as a way to increase public awareness on dengue. As the chairman of ASEAN in 2011, Indonesia hosted the launching of the ASEAN Dengue Day at



Winning logo from Indonesia chosen among the 10 ASEAN Member States finalists.

the regional level on June 15, 2011 at the National Museum.

The theme of the first ASEAN Dengue Day was, "Dengue is everybody's concern, causing socio-economic burden, but it's preventable." Several activities including the ASEAN Dengue Conference, regional dengue logo competition, and other national initiatives, helped increase public and government awareness about the disease as well as promote commitment from all health and non-health stakeholders.

The Jakarta Call for Action on the Control and Prevention of Dengue was also announced, and it specified that all

stakeholders are committed to addressing the problem and called for enhanced collaboration and cooperation from all sectors.

ASEAN Secretary-General Dr. Surin Pitsuwan said, "As we strengthen our community-building efforts, ASEAN Member States are committed to working together for the health security of the peoples of ASEAN, and dengue is one of our priority diseases for action."

Dr. Samlee Plianbangchang, WHO Regional Director for South-East Asia, said, "Tackling dengue is everyone's concern, delegates to the conference agreed. The disease cannot be fought by the health sector alone. All sectors need to collaborate."

And Dr. Shin Young-soo, WHO Regional Director for the Western Pacific, said, "Dengue respects no boundaries and our region needs to move from response-driven activities to long-term prevention and preparedness-driven approaches. A proactive approach will make better use of our resources and minimize negative health, social and economic impacts of dengue."

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ASEAN Assessment of National Multi-Sectoral Pandemic Preparedness and Response

The Association of Southeast Asian Nations (ASEAN) has been assisting ASEAN Member States (AMS) in monitoring their progress in strengthening national multi-sectoral pandemic preparedness to ensure the continuation of operations and businesses in the event of a severe pandemic threat. From 2008 until 2010, ASEAN had worked on developing the ASEAN non-health sector indicators for AMS, which led to the development of the tool for assessing national multi-sectoral pandemic preparedness and response (PPR)

capacities.

An initial assessment (pilot) was conducted in Indonesia in early June 2009, from which lessons learned led to a new approach to the assessment methodology that has been incorporated in the final assessment tool. Broadly, the national assessments were expected to identify oversight and operational gaps within national and sub-national structures and within the relevant civil society and public-private sector linkages, so that AMS can more easily develop strategic plans to

address the needs and to fill the gaps, which could otherwise lead to a breakdown in societal functions.

This assessment provided a descriptive overview of multi-sectoral pandemic preparedness and response but did not venture into a quantitative comparative assessment (or scoring) of countries' efforts. With the findings of this assessment, future assessments could attempt to measure the progress of countries with their continuity of essential services/operations readiness.

Findings

The findings show that countries have established central national and sub-national multi-sectoral/inter-ministerial coordinating bodies within an all-hazard framework, with high-level leaderships and fund appropriations. However, national budget appropriations may need to be augmented to sustain the planning efforts that have been initiated. External support from international government organizations that have assisted some countries in initiating their Business Continuity Planning (BCPs) should continue to be encouraged. With the proper central coordination framework in place, command and control processes are easily defined and are expected to function during a severe pandemic. Generally countries need to further define their command and control structures in regard to a whole-of-society approach to PPR that include clear linkages with civil society organizations (CSOs) and private sector groups.

Most countries are advancing with their BCPs, considering that they have already identified their essential service sectors and have formulated some policies and guidelines, and broad sectoral BCPs. Countries are expected to pursue the development of detailed continuity of operations plans and operational procedures within individual essential service organization and for entire sectoral systems.

Generally, countries are expected to direct further efforts toward the following: expanding sectoral involvement in BCP, information and communication strategies, addressing the needs of vulnerable groups, defining clearer linkages with CSOs, international non-governmental organizations (INGOs) and various businesses, and defining the potential roles of such groups in relation to BCP. Some countries may need to review and update their coordinating structure and mechanism to ensure interoperability of agencies' responses.

Figure 1: Sustainable Operational Systems (SOS) – Institutional Oversight Stages

PROGRESSIVE PANDEMIC EMERGENCY RESPONSE CONTINUUM		
Stage 1: Primarily through the health organization	Stage 2: Through the disaster coordination and response organization	Stage 3: Through the national security organization
Response: <ul style="list-style-type: none"> • Outbreak investigation and response • Containment • Control 	Response: Continuity of essential operations management (<i>sustaining the coping mechanism in a severe pandemic</i>)	Response: Continuity of essential operations emergency management (<i>maximum coping ability – complete activation of the whole-of-society emergency system involving communities</i>)
Trigger: Disease outbreak and spread / WHO declaration	Trigger: 40% absenteeism	Trigger: Breakdown in services/impact on functions of society

In comparison to the preliminary desk-study of existing contingency plans among the non-health sectors carried out in 2009, the situation today shows that sector-wide coverage is no longer sketchy and that there has been significant progress in broad BCP within ASEAN. However, non-health sectors' awareness and sector-wide coverage still need to be expanded.

Recommendations

In case of a severe pandemic event, ensuring continuity of essential operations requires a whole-of-society response. A whole-of-society response, on the other hand, must be founded on a sustainable operational system (SOS) that conforms to the following global principle: "The integration of pandemic preparedness into disaster management and emergency/national security response systems."

As a pandemic is a progressive condition, then each stage or form it presents (i.e. mild to severe) requires a set of mitigating actions. In this regard, the components of the operational system must be interoperable to sustain the actions within a response continuum. The response continuum could be towards a spectrum of issues ranging from socio-humanitarian to political security. It appears to have three institutional oversight stages (*see Figure 1*).

The response transition from

one stage to the other should be clearly defined, such as from Stage 2 to 3, where in Stage 2 continuity of essential operations requires standard disaster management systems, and in Stage 3, continuity of essential operations requires the complete activation of whole-of-society emergency management systems encompassing communities to achieve maximum coping ability. It is therefore important that AMS recognize that a pandemic is a potential national/regional security threat.

In addition to country-level preparedness, ASEAN should seriously consider collectively addressing serious pandemic threats or impacts of disasters resulting from pandemic, through formulation of institutional and operational frameworks and plans on regional multi-sectoral pandemic response coordination.

Five key institutional drivers/enablers to SOS for pandemics, namely: 1) an encompassing highest level inter-ministerial Central Body for all-hazard-security-emergency coordination; 2) legislation/clear mandate for the Central body; 3) budget/resources allocation or mobilization; 4) Comprehensive Continuity of Operations Plans are in place at all levels (vertical and horizontal) - country level and regional. Develop appropriate capacities down to community levels; and 5) tests and simulation exercises conducted lead to development.

ASEAN Risk Communication Resource Centre in Malaysia

In line with the ASEAN Socio-Cultural Community (ASCC) work plan and the risk communication key strategic area of Asia-Pacific Strategy for Emerging Diseases (APSED), the ASEAN Member States made a recommendation to establish the ASEAN Risk Communication Resource Centre (RCRC) during the Planning Meeting of the ASEAN Plus Three (ASEAN+3) Emerging Infectious Diseases (EID) Programme held in July 2009 in Bali, Indonesia. The Senior Officials Meeting on Health Development (SOMHD) held on December 7-9, 2009 in Kuala Lumpur, Malaysia, has requested Malaysia, as a proponent of this initiative in the ASEAN+3 EID Programme Phase 2, to prepare and submit a proposal on the proposed ASEAN RCRC.

The proposed ASEAN RCRC was endorsed in July 2010 at the ASEAN Health Ministers Meeting held in Singapore. The Centre is located at the Institute for Health and Behaviour Research (IHBR) of the Ministry of Health in Malaysia. Identifying and appointing staffing requirements for the Centre are based on the existing staff of IHBR that could be immediately utilized to initiate the activities of the centre. The capacity building activities are based on the needs of the Member States, and the rich experiences of the countries on risk communication which are systematically shared among countries. The ASEAN RCRC focuses on risk communication training for Ministry of Health and relevant sectors of the ASEAN Member states, knowledge management to share best practices as well as publishing case studies and research reports on risk communication which can be used as inputs to various training programmes.

The objective of the ASEAN RCRC is to strengthen the risk communication mechanism among the ASEAN Member States through a regional centre that focuses

on training, research and consultation. Malaysia has been tasked to lead this project. It is anticipated to be a ground-breaking initiative, being the first centre of its kind, to be established in the region. It will also ensure that capacity building efforts be

based on the identified and unique needs of the Member States. In addition, the diverse country experiences on risk communication will be systematically shared, as part of the research and training programme aspect of the Centre.

Regional Training Model on Field Epidemiology in Singapore

Enhanced global connectivity and urban development have endowed emerging infectious diseases with the ability to rapidly trigger a pandemic. As an intrepid observer surveys ASEAN's bustling landscapes, so too do novel pathogens probe its systemic transformations. These threats are compounded by extreme weather events in recent years.

In the process of grooming officers in the Singapore Field Epidemiology Training Programme (S-FETP), a dearth of regional training materials tailored to such contexts was recognized. This prompted the S-FETP to organize its first regional training workshop focused on the development of case studies on infectious disease outbreaks. The event

was hosted at the Furama Riverfront Hotel, Singapore, on December 14-16, 2011.

Convening the regional training workshop represented a logical offshoot from the local training provided in S-FETP. In tandem with the growth of FETPs worldwide, regional countries faced common challenges in capacity building for public health emergencies. Yet, the need to strengthen global health security has never been greater. Pandemics such as SARS in 2003 and A/H1N1 influenza in 2009 showed how novel pathogens readily lay siege on immunologically-naïve, heterogeneous, and highly mobile populations. Hence, health security requires regional responses to the enemy in a coordinated and targeted



Participants developing field epidemiology case studies through cross-cultural collaboration and learning from fellow regional colleagues.

manner. This regional training workshop provided a first step towards such a goal through the exchange of ideas and local experiences.

The trainers for the workshop were Dr Alden Henderson (US CDC, Thailand), Dr Fadzilah Kamaluddin (EIP, Malaysia) and Dr Pengiran Hishamuddin (S-FETP, Singapore). The original participants comprised 20 medical and public health officers undergoing field epidemiology training in the Ministries of Health of Malaysia and Singapore. Initially planned as a bilateral event, this workshop quickly garnered interest from the World Health Organization through its Western Pacific and Southeast Asian regional offices, and eventually expanded to involve

six participants from Cambodia, Laos, Mongolia, Myanmar, Thailand and Vietnam. In addition, two high-level observers from the Mekong Basin Disease Surveillance Network and WHO were present.

Throughout the intensive three-day workshop, participants exercised their knowledge and ability to work in teams, and contributed to group discussions on disease prevention and control. Workshop deliberations were highly insightful, and produced three complete case studies involving outbreaks of adenovirus infection, dengue, and salmonellosis. Participants were all smiles by the end of the workshop, and the successful outcome was clearly evident from positive feedbacks.

As a result of the workshop, participants emerged better equipped with the knowledge and skills to manage regional outbreaks and develop case studies for use in training. The event enabled participants to benchmark their strengths and weaknesses, and provided a form of professional update on core competencies central to field epidemiology. Its valuable lessons can serve as a model to guide future regional training workshops. Moving forward, we hope to develop joint workshops as a cost-effective learning activity in ASEAN's field epidemiology training network. This will help to further enhance capacity-building across borders, and nurture camaraderie in the next generation of field epidemiologists.

Workshop on Rational Use of Drugs in Brunei Darussalam

The Department of Pharmaceutical Services of the Ministry of Health in Brunei Darussalam, together with the World Health Organization (WHO), held a training workshop on the "Rational Use of Antimicrobials and the Containment of Antimicrobial Resistance (AMR)" for ASEAN Member States. This is one of the various activities of the ASEAN Working Group in Pharmaceutical Development (AWGPD), where Brunei and Singapore lead programmes to promote the rational use of drug.

The workshop was held in Bandar Seri Begawan, Brunei Darussalam on December 5-9, 2011 aimed at discussing the concept of rational/quality use of medicines, with specific emphasis on antimicrobials, highlighting the implications of irrational use or poor quality use of antimicrobial agents, and focusing on strategies to overcome or mitigate the irrational use of antimicrobial agents. It was also an opportunity to learn about antibiotic stewardship and to share experiences and best practices from various countries.

The workshop was attended

by 48 local participants and 9 ASEAN participants from Indonesia (3), Lao PDR (2), Malaysia (2), and the Philippines (2). The participants consisted of pertinent stakeholders, i.e. medical doctors, pharmacists, nurses, laboratory specialists and clinical microbiologists from either the national and institutional levels (both hospitals and health centres) as well as from various disciplines related to the rational use of antimicrobials, infection control, surveillance and containment of AMR.

Three experts from the WHO were involved as facilitators, namely: Dr Budiono Santoso (WHO, Western Pacific Regional Office in Manila Philippines), Dr Anuj Sharma (WHO, India Country Office, New Delhi, India) and Professor Kumut Kumar Kafle (International Networks for Rational Use of Drug, Kathmandu, Nepal).

Among the topics included in the workshop were the WHO six policy package on containing antimicrobial resistance, infection control for containment antimicrobial resistance, and the innovative approach in introducing essential medicines concept and selection

of antimicrobials, particularly "The Wise List – A Comprehensive Concept to Select, Communicate and Adhere to Recommendations of Essential Drugs in Ambulatory Care in Stockholm".

The topics also included: national policies in promoting rational use of antimicrobials and containment of antimicrobials resistance, antibiotic policies, guidelines and formularies – development and implementation; the roles of medicines therapeutics committee in promoting rational use of medicines and antimicrobials; monitoring training and planning (MTP) approach in promoting rational use of medicines and antimicrobials; and small group interactive learning for self-medication.

Field visits to the Rimba Health Centre and RIPAS Hospital (a tertiary teaching hospital) were also undertaken to learn the delivery of medicines services and microbiology laboratory services. The participants collected data on medicines use and any microbiological related data, and they were encouraged to devise and present their follow up plan at the end of

the workshop.

The recommendations of the 5-day workshop are:

- National networking shall be started in order to coordinate between different institutions and relevant parties; to lead a consolidated national strategy to promote rational use of antimicrobial agents and containment of antimicrobial resistance.

- National consultation process shall be undertaken to coordinate the actions and define roles and responsibilities of each pertinent stakeholder, which shall include policy makers, managers, academics and civil society organizations to promote rational use of antimicrobial and containment of antimicrobial resistance.

- Inter-country networking, communication and collaboration mechanism

shall be developed in promoting rational use of antimicrobials and containment of antimicrobial resistance. Regular inter-country meeting need to be organized to monitor progress.

The participants pledged to take action in their institution to promote the rational use of antimicrobials and the containment of resistance.

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Traditional Medicine in Cambodia

In improving the health status of the Cambodian people, the Ministry of Health has developed the Health Sector Strategic Plan for 2008-2015. This policy direction has 14 elements to strengthen institutions at all levels of the health system, but unfortunately, traditional medicine (TM) was not included.

The few regulations on TM practice and products in Cambodia are not sufficient to protect, commercialize and preserve of, as well as to enhance creativity and innovation in, this medical field. However, the Ministry of Health has recently promulgated the Traditional Medicine Policy and developed the Traditional Medicine Strategy to integrate TM into the National Health Care System. A Traditional Medicine Task Force was established in May 2011 to facilitate the implementation of the policy.

An important area of this policy is on education and training. Since 2009, the National Center of Traditional Medicine (NCTM) has collaborated with Cambodia Traditional Medicine Organization (CaTMO) and supported by the Nippon Foundation in conducting several short course training programs targeting the TM healers (Kru Khmer) from Phnom Penh and the provinces. The training curriculum covers 65% of TM subjects and 35% of the basic concepts of Western Medicine.

Aside from the short

courses, the NCTM, with the support from World Health Organization Western Pacific Regional Office, has already developed and awaiting approval by the Ministry of Health of the TM curricula for the 3-year Associated Degree of Traditional Khmer Medicine (ADTKM) and the 5-year Bachelor Degree of Traditional Khmer Medicine (BDTKM).

Another important area of the policy focuses on raw materials and products. The NCTM maintains three (3) simple botanical gardens and cultivates around 2,025 herbal plants from 520 species collected from different places of the country. The objectives of these botanical gardens are to: 1) conserve rare and endangered species of herbal plants; 2) educate people in appreciating the value and significant of these herbal plants, and; 3) teach students and Traditional Medicine healers in gaining more knowledge about

herbal plants.

Since Cambodia does not have a clear Good Manufacturing Practices (GMP) standards for herbal medicines, the TM practitioners produce products based on their own methods and these unregistered products are made available and marketed to villages because of the demand from low-income earners in these areas. Meanwhile, the Department of Drugs, Food and Cosmetics does not pay much attention to the registration of TM products and for more than two decades has only registered two locally-manufactured products, namely Yang Chun box of six capsules and Yang Chun box of two capsules.

In strengthening the capacity of TM healers on the treatment of diseases, the NCTM has published and disseminated four volumes of the "Cambodia Medicinal Plants," and has produced last year the



Photo courtesy of the Ministry of Health, Cambodia

“600 Formulas of TM drugs for Treatment” collected from experiences of TM healers around the country, and from the “Treatment of Diseases by Traditional Medicine Translated from Palm Leaves.”

Current Issues, Future Plans

Cambodia is facing many difficulties and may not yet be ready to integrate TM into the National Health Care System. Among the many issues facing the country include the lack of laws and regulations on TM and the technical and financial support both from government and other relevant stakeholders. There is also the lack of competent human resources,

equipment and tools to implement TM.

There are also no clinical studies on TM to further improve evidence-based knowledge. Learning institutions or universities offering courses as well as hospitals offering services on TM are non-existent. What Cambodia has are private clinics operated by TM healers who developed their skills mostly through apprenticeships, family traditions and learnings from community elders. Thus, GMP standards are not practiced. Moreover, international cooperations on TM research between and among ASEAN member states and other developed countries have not made significant progress. And a national program on TM in Cambodia has yet to exist.

But the future is not that bleak for TM in Cambodia. There are already moves to develop rules and regulations to strengthen and implement of TM. Attention is now focused on capacity building of human resources and in providing scholarships to students who will work on medicinal plant research. Also in the drawing board is the establishment of the Traditional Medicine Institute and the National Botanical Garden as well as steps in looking into the possibility of setting up clinical researches on medicinal plants and setting up GMP standards in producing herbal medicines. And finally, local and international cooperation on TM are currently being strengthened.

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Investigating Antiplasmodial Activity of 8 Plants Used to Treat Malaria in Cambodia

Malaria is one of the main causes of death in the world with more than one million dead people every year. According to the Ministry of Health of Cambodia, almost one million Cambodian people are infected each year. The serious problem is that most patients are poor and not capable of receiving modern medicine treatment. Thus, the use of traditional medicine for treating malaria and its associated symptoms is popular because it is affordable and accessible.

Medicinal plants in Cambodia have been used for healthcare since pre-Angkor era and remained common particularly among the poor in rural regions. During the Khmer Rouge era, only medicinal plants were used in the whole country for the treatment of diseases such as fever and malaria. As indicated by Leng (1983), *Azadirachta indica* was well-known as remedy to treat and control malaria and fever.

A study by Aun Chea, Riad Elias, Sunna Pen, Punley Hieng and Guy Balansard was conducted a study to investigate eight (8) medicinal plants for the commonly used in the treatment of fever or/and malaria as

indicated by local healers and in reference documents, as well as to test their in vitro antiplasmodial activity.

The search for medicinal plant species was based on four reference documents, namely: Menaut 1930, Petelot 1952, Petelot 1953, Petelot 1954, Leng 1983 and Dy Phon 2000. This was done to obtain the accurate and specific ethnobotanical and ethnopharmacological information.

The ethnobotanical survey was carried out in four regions of Cambodia – Stung Treng, Siem Reap, Kandal, Kampong Thom – between July and September 2004. The local traditional healers in the regions were contacted for information about the medicinal plants used in the treatment of malaria and/or fever. The freshly picked parts of the plants were air-dried at room temperature for two weeks, with no direct sunlight. The voucher specimens were deposited in the herbarium of National Center of Traditional Medicine.

Aqueous, methanol and dichloromethane extracts were prepared according to the methods described in a recent study by Chea in 2006. Similarly, an in vitro

antiplasmodial activity was performed as previously reported by Chea.

Of the 50 plant species reported in a survey to have been used for the treatment of fever or/and malaria, only eight (8) plant species have been cited in all the reference documents. Thus, this encourages the researchers to further investigate the in vitro antiplasmodial activity of the eight plants. The result showed that three extracts were active against the multidrug-resistant *Plasmodium falciparum* W2 strain. These three extracts were derived from two plants, namely: *Azadirachta indica* and *Phyllanthus urinaria*. Interestingly, the aqueous extract which would be the preferred method in preparing the plants when used in traditional medicine displayed the strongest antiplasmodial activity.

This study provides a better understanding of medicinal plants and a compelling evidence for rational exploration of indigenous plants as a source of antiplasmodial agents. Otherwise, further investigation for other plants and other activities including its cultivation and preservation are needed.



Dengue Risk Perceptions in Myanmar

Two fifths of the world population are now at risk for dengue. In Myanmar, in Yangon Region, there were 3,604 cases and 31 deaths in 2008 and 3,333 cases and 37 deaths reported in 2009.

Effective risk communication strategies are essential for making decisions and changes in preventive behaviors especially before and in times of outbreaks of infectious diseases such as dengue. Risk perceptions are important for precautionary actions for effective risk management of epidemic infectious diseases without any specific treatment or possible vaccination.

A cross-sectional comparative study focused on 150 mothers/caretakers for children with confirmed dengue (Group 1) and equal number attending children without dengue (Group 2) was conducted at the Yangon Children Hospital between June to September 2010 to find out the relationship between dengue experience and their knowledge, attitudes and risk perceptions. Group 1 was more likely to attain high knowledge scores than Group 2

especially for general knowledge, dengue vectors and symptoms and treatment. Both groups accepted dengue as life-threatening. Group 1 was also more likely than Group 2 to perceive the risk of dengue infection at home when within the vicinity of 10 houses got dengue, re-infection in the child who suffered from dengue and the severity of the disease when re-infected and whether they were able to carry out effective vector control at home and in schools. In both groups, high knowledge scores provoked high risk perception scores.

Both groups preferred health personnel as the risk communicator to consult for comprehensive information. However, the study pointed out that knowledge of risk, modes of transmission and vector still needed much improvement. Majority expressed misconceptions on specific medications available for dengue which may lead to false security. Dengue as a preventable disease is widely known (>90%) in both groups. Whether their children had experienced dengue infection or not, the preventive measures focused

mainly on the control of adult mosquitoes than adequate container management (<25%) and environmental measures (<40%). Although some experienced both previous and current dengue infections in their children, the risk perception of mothers/caretakers towards the chances of re-infection was not high. This may mean that they are not paying full attention on the preventive measures.

This small scale study highlighted the importance of bridging the knowledge and risk perception gaps with exposure to risk communication. It is necessary to improve risk perceptions and to carry out preventive measures effectively in households and organized community activities. Challenges or bottlenecks in effective risk communication can be overcome by tapping the fully-informed, well-trained health personnel to advocate for prevention and control measures especially during outbreaks. Future research is also required for replication in other endemic regions.

ASEAN Dengue Day in the Philippines

On June 15, 2012, the Philippines Department of Health commemorated the ASEAN Dengue Day as nationwide dengue cases from January to 2 June 2012 now reached 32,193. This figure is 3.89% higher compared to the same period last year (30,989).

This year marks the second year since June 15 was declared ASEAN Dengue Day during the 10th ASEAN Health Ministers Meeting held in Singapore on July 22, 2010. The said ASEAN Dengue Day is supported by a community of experts which demonstrates a shift from reactionary strategies to forward planning and long-term prevention strategies.



Philippines Health Secretary Enrique T. Ona emphasizes community action against dengue.

This year's theme, "ASEAN Unity for Dengue-Free Community", aims to increase public awareness of dengue that would help reduce the risk of transmission and strengthen regional collaboration and

responsibilities for dengue control. The DOH adapted the theme and emphasized community action against dengue by tapping information technology to implement 'specific targeting' of dengue cases in communities in an effort to significantly reduce cases and deaths. This process would allow real-time reporting of dengue cases from rural health units and hospitals.

Under the system, rural health units or hospitals can report suspected dengue cases to the dengue coordinator, who would forward the message to the Philippine Information Agency (PIA) and to the *barangay*- or community-based health

team. The PIA will then conduct a mobile phone 'text blast' in the affected area about dengue prevention while the health teams will conduct investigation.

Moreover, the patient's name and address will be given to the community health team which will visit the patient on

the same day and identify other possible patients in the neighborhood and will advise them to seek medical consultation. Searching and destroying mosquito breeding places is still the main message among community members.

For the first half of this year, most

dengue cases in the country came from Metro Manila. Ages of cases ranged from less than a month to 90 years old. Majority (53%) of the cases were male. There were 195 deaths recorded this year from January to June 2. Last year's number of deaths for the same period reached 201.

Emergency Obstetric Care in Myanmar

Death and disability of women of reproductive age due to complications arising during pregnancy or child birth was first focused in 1987 during the International Conference on Safe Motherhood. The maternal mortality ratio (MMR) became a Millennium Development Goal (MDG) indicator and a measure of the quality of the health care system.

In Myanmar, MMR remains high with a national average of 94 and 136 deaths per 100,000 live births in urban and rural areas respectively. The Myanmar Health Statistics (2010) indicated that 68.2 percent of pregnant women registered for antenatal care service while only 43 percent had delivery assisted by professional attendants. According to the National Health Plan (NHP), the maternal mortality ratio is to be reduced by identifying risk pregnancies and giving specialized care in delivery to those who need it.

Maternal and child health care services have already been established at all levels of health delivery in Myanmar. The health center staff at these levels must provide good quality antenatal and delivery services to all pregnant women according to management guidelines set by Ministry of Health and based on World Health Organization guidelines. On the other hand, another important intervention is to improve the accessibility, utilization and quality of services for the management of safe delivery and complications

during child birth.

At least 15% of pregnant women develop serious complications that are often unpredictable and require life-saving access to quality obstetric services. A list of essential signal functions mainly based on care, called Emergency Obstetric Care (EmOC), has been identified to combat obstetric complications which cause most of maternal death (i.e. hemorrhage, prolonged/obstructed labor, postpartum sepsis, complications of abortion, preeclampsia/eclampsia, ectopic pregnancy and uterine rupture). EmOC refers to the functions necessary to save the lives of women with obstetric complications.

The essential signal functions that need to evaluate EmOC are: 1) use of parenteral antibiotics, 2) use of parenteral oxytocic drugs, 3) use of parenteral anticonvulsants, 4) performing manual removal of placenta, 5) performing removal of retained products, 6) performing assisted vaginal delivery, 7) performing surgery, and 8) performing blood transfusion.

In 2009, a national level assessment was conducted using the standard guideline methodology for EmOC. A random sample of 101 obstetric facilities was made in four states and three divisions in Myanmar that systematically observed facilities and reviewed records and registries for 2008. Two-thirds of the observed facilities were not fully functioning for emergency care services mainly due to the lack of a medical doctor, less motivation of the posted medical doctors, and less demand on services. It was also found out that there was a lack of performance of Lower Segment Caesarean Section (LSCS) and a lack of ability to perform blood transfusion as other major causes for being non-EmOC status. Moreover, many basic EmOC facilities were lacking services for manual removal of retained placenta and non-use of anticonvulsants.

The overall amount of EmOC facilities were found sufficient over the country. All areas under the study had good utilization of EmOC services (i.e. proportion of all births in the type of EmOC facilities, 33.5%) which is more than minimum level of 15%. However, 60% "met need for EmOC" (i.e. proportion of all women with complications who are treated in EmOC facilities) did not reach acceptable level or 100% in all areas. The national level Caesarean section rate (11.5%) was between the acceptable minimum and maximum levels. Nationwide case fatality



Photo courtesy of Department of Health, Philippines

rate (CFR), i.e. 1% of complicated cases at facilities, was about the acceptable level. However some areas were in relatively higher CFR than the acceptable level.

The overall situation could be assumed that there was unmet need of EmOC in the country. Not fully functioning EmOC facilities, less utilization of EmOC service by complicated cases and regionally high CFRs meant the need for EmOC is not

being met in most areas of the country and clearly indicated the need for improving existing activities.

Motivation and skill of providers and demand of service by the community played major roles in the quality and coverage of services. The reasons for underutilization should be explored and the program must make efforts to increase utilization. Strategies to correct the 40%

unmet need of EmOC services should be addressed in order to reduce maternal morbidity and mortality. Shortening the duration of referral by the first birth attendant could reduce CFR. However, clear understanding on the high CFR is necessary. The findings also highlighted the program areas that need to be focused and the regions that need to be provided with intensive care on EmOC services.

Cervical Cancer in Myanmar

Cervical cancer is the third most common cancer in women and the seventh overall with an estimated 530,000 new cases worldwide in 2008. More than 85% of the global burden occurs in developing countries, where it accounts for 13% of all female cancers. The World Health Organization South-East Asia Regional Office (WHO SEARO) reported that cervical cancer incidence and mortality is an estimated at 188,000 new cases and 102,000 deaths in 2008. This is due to the fact that the majority of women in the world do not have access to cervical screening, which can prevent up to 75% of cervical cancer cases.

In Myanmar, over the past 30 years (1976-2006), from a total of 56,097 most common female cancers, cervical cancer accounted for 13,181 cases making it ranked either on the top or second in the list of the female cancers. The estimated cervical cancer incidence in 2008 was 26.4% (6,434 cases per 100,000).

Human Papillomavirus (HPV)-16 and -18, the two vaccine-preventable types, contribute to over 70% of all cervical cancer cases in the world, between 41% and 67% of high-grade squamous intraepithelial lesion (HSIL) and 16-32% of low-grade squamous intraepithelial lesions (LSIL). In South-East Asia, the prevalence of HPV-16 and HPV-18 by cytology was 72.6% in cervical cancer, 33.3% HSIL, 14.2% LSIL and 3.2% normal cytology.

HPV-DNA testing and genotype identification is important for the estimation of the impact of HPV-based cervical cancer

screening and HPV vaccination. A study, entitled "HPV- DNA testing and genotyping in women with cervical cytological abnormalities in Myanmar" conducted by the Department of Medical Research (DMR Lower Myanmar) aimed at determining the proportion of high-risk HPV infection and genotypes in women with abnormal cervical cytology. This study was conducted by Mu Mu Shwe, Hlaing Myat Thu, Mo Mo Win, Khin Saw Aye, Khin Khin Oo, Ko Ko Zaw, Aye Aye Win, Nan Cho Nwe Mon and Yin Lin Myint.

A cross-sectional descriptive study was carried out in women attending the cervical cancer screening clinic in the DMR (Lower Myanmar) in 2010-2011. Cervical swabs were collected from 116 women diagnosed with 62 inflammatory smear, 34 cervical cytological abnormalities and 20 normal cytology; age ranging from 18-69 years. High-risk HPV-DNA testing was performed by polymerase chain reaction (PCR) using consensus primers which detect HPV genotypes (-16, -18, -31, -33, -52b, -58).

High-risk HPV was identified in 73.5% (25/34) cervical cytological abnormalities, 35.5% (22/62) of inflammatory smear and 5% (1/20) normal cytology. Among cervical cytological abnormalities cases, High-risk HPV was detected in 60% (6/10) atypical squamous cells of undetermined significance, 86.7% (13/15) LSIL, 50% (3/6) HSIL and 100% (3/3) squamous cell carcinoma cases.

In PCR positive cases, HPV

genotyping were analyzed by cleaved amplification polymorphism method. The most prevalent HPV genotypes in Myanmar were HPV-16 (60.4%) followed by HPV-31 (14.6%), HPV-18 (12.5%) and HPV-58 (12.5%). The women with abnormal cervical cytology were 15 times more likely to be high-risk HPV positive than those with normal cytology ($P = 0.0001$). Among cervical cancer cases, 66.7% was HPV-16 and 33.3% was HPV-18. Most patients infected with HPV-16 and HPV-18 were age between 40-49 years followed by 30-39 years in Myanmar.

HPV infections occur with a high-attack rate soon after sexual initiation. Follow up studies of virgins from different countries after sexual debut have shown up to 70% of women becoming HPV-DNA positive at least once within 48 months. The cumulative life time exposure to HPV has been estimated to be close to 80% and for HPV-16 or -18 is 20%. Thus primary prevention with HPV vaccines should focus on the years before sexual initiation, in the adolescent and pre-adolescent age groups.

If no intervention is implemented in the near future, a dramatic increase in the number of cervical cancer cases is predicted. HPV vaccines offer an efficient way to prevent HPV related cervical cancers. This study suggests that the implementation of routine vaccination programme against HPV in pre-adolescent and adolescent age groups should consider and it will greatly reduce the burden of HPV associated cervical cancer in Myanmar.

Universal Health Coverage in Thailand

An Achievable Goal by Countries at All Income Levels

Universal Health Coverage (UHC) means the universal access to essential health services without financial, geographical or other barriers. Based on several decades of experience in achieving UHC in Thailand from 1975 to 2011, a few key policy messages emerged for regional and global policy development.

UHC as an essential measure to reduce poverty can be started at a low income level. Thailand started to cover the poor in 1975 when the gross national income (GNI) per capita was merely USD 400 and achieved UHC in 2002 with the GNI of less than USD 2,000 per capita. Achieving UHC is not “a one shot” decision but a gradual extension of social and financial risk protection.

UHC is a concrete measure to reduce impoverishment from health care costs in addition to equitable access to healthcare. In the past decade, since 2002, the Thai UHC has prevented almost 100,000 households impoverished from illness-driven poverty. There is a need to create “fiscal space” of a country for additional health investment. Since 1985, due to rapid export-driven economic growth and domestic political peace, around 20-30 percent of fiscal space has been created from reduction of proportion of national budget to debt services and security.

The key success factors for achieving UHC in Thailand are: 1) *Strong political commitments at the top-level.* The Thai government, since early 1980s, decided to shift investment from secondary and tertiary care to primary health care. This decision had extensively increased geographical access to essential health services. Furthermore, several top level decisions were made to gradually increase the health insurance coverage, and the new elected government in 2001 decided to increase from 70% to 100% coverage of essential health insurance, which greatly

reduced the financial barrier to health care.

2) *Adequate institutional capacity.* Thailand has built up adequate capacity in generating health policy and systems knowledge, and evidence to support the decision-making and management of the pre-paid health care financing systems. 3) *Good systems design.* In countries with a huge size of informal economy like Thailand, general tax revenue is the most pragmatic sources of finance for UHC. A fixed and close-ended budget with flexible provider payment approaches is essential to control costs as well as providing incentives.

4) *Separation of responsibility.* A contracting model with much less overlapping role and responsibility between financial supporters (purchasers) and health care providers is applied. 5) *A comprehensive benefit package.* This covers breadth, depth, and width of the health insurance functions.

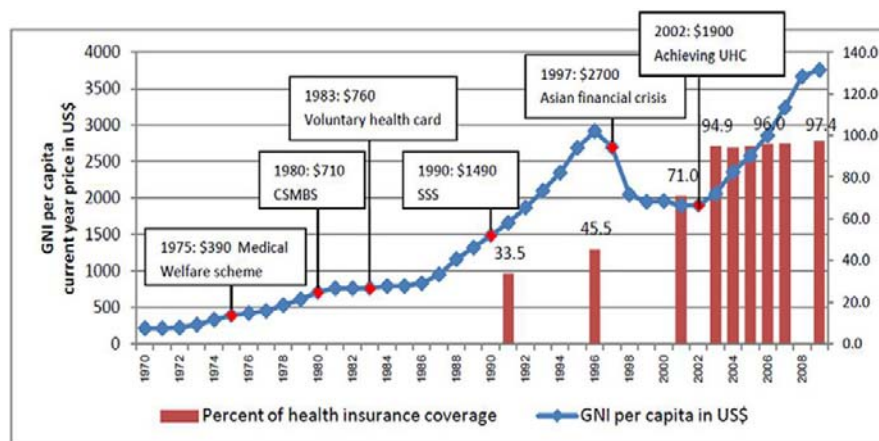
Good system designs determine significant achievements. The UHC has improved health equity of the entire population on various dimensions: equity in financial contribution, equity in access to health care and health service use, and equity in government subsidies on health.

Improving access to health services from UHC result in a low level of unmet-need. The 2010 panel household survey found that among those who were asked on necessary use of health services

during the last 12 months, 1.44% and 0.4% had unmet-need for outpatient and inpatient services, respectively. This low level is at par with high performing Organization for Economic Cooperation and Development (OECD) countries

Remaining challenges and solutions. The roles between the National Health Security Office (NHSO) as the main financial supporter/purchaser and the main public and private health care providers should be clarified. The three public health insurance schemes (UC, CSMBs, SSS) should be harmonised through standardization of benefit packages, provider payment methods, level of government subsidies, and dataset used for scheme administration. Funds and delivery systems should be managed by focusing more on disease prevention and health promotion services, the effective primary care gate-keeping system, and developing community and home-based long term care.

There is also a need to move towards more geographical equity in delivering essential services, especially on more equitable distribution of human resource for health. And finally, the UHC governing bodies should be strengthened further by making them more representative, transparent, and socially accountable; and by managing and preventing conflict of interest among governing body members.



Thailand's pathway towards universal health coverage against GNI per capita, 1970-2010

Tapping on People Power to Inspire Health in Singapore

The World Health Organization emphasises strengthening community action as a key action area in the Ottawa Charter for Health Promotion. Indeed, the success of community participation as a strategy to influence behavioural changes is well-documented in literature.

The California Tobacco Control Program (CTCP) is one such example. It has successfully harnessed the influence of the community to bring down smoking rates, helping to save over one million lives in California. Likewise in Singapore, the Health Promotion Board (HPB) recognises that tapping on people power and building on the cohesive strength of the community are critical in successfully achieving its goal of “A nation of healthy people.”

In trying to ensure better health for all Singaporeans, HPB faces the challenges of trying to change behaviour and sustaining these changes. Recognising this, HPB uses the strategy of creating the groundswell for healthy living through a ground-up movement. This is coupled with a supportive environment to enable Singaporeans to make the healthier choice so as to achieve the goal for every Singaporean to stay healthy together in schools, workplaces, the community and at home.

The Health Ambassador Network

The vision for community-driven movement encompasses two distinct aspects: the “hardware” and the “software”. The “hardware” refers to creating health-promoting infrastructures such as shopping malls, hawker centres, and establishing such ecosystems across the island. These are everyday, common touchpoints through which HPB can reach many Singaporeans. The “software” is no less important. It entails tapping on the personal networks



Singapore's health workers demonstrating the proper technique for effective hand-sanitising

of people from all walks of life to spread the “live and stay healthy” message more effectively across Singapore. This is why HPB started the Health Ambassador Network (HAN) in October 2011.

HPB recruits volunteers for HAN through its events and website, and via community networks, professional and voluntary organisations as well as schools. Anyone is eligible to become a Health Ambassador (HA) as long as he lives healthily and has the passion to inspire those around him to do the same. The HAs are role models from within the community who inspire their family, friends, colleagues and neighbours to embrace healthy behaviours. They share health information and experiences as well as mentor their social contacts in adopting healthy lifestyle habits. To date, there are around 2,000 HAs. The aim is to expand the network to 10,000 HAs by 2015.

Co-creating and Co-implementing Solutions with the Community

Coming from the local community, the HAs are familiar with the ground and as such, solutions developed to promote health are localised to the context of the

community concerned. Often, such joint solutions are well embraced by the local community. For example, HAs, together with HPB, co-plan exercise sessions and cooking demonstrations which are attended by the community.

Through such co-creation and co-implementation with the HAs as well as other local community leaders, HPB instils in them a sense of ownership over these health promoting solutions and strengthens the people-driven health movement. A local community club was transformed into a health promoting centre, with the help of the HAs. Besides interactive exhibits that reminded residents to adopt a healthy lifestyle, HAs also encouraged residents to participate in health-promoting activities organised by the club. Successful programmes championed by the HAs include HPB’s “I Quit” smoking cessation programme where many smokers have quit through the support of the ambassadors.

Recognising Health Ambassadors' Efforts

More importantly, HPB acknowledges that the HAs play a significant part in getting all Singaporeans

to lead healthier lifestyles. Initial successes of projects undertaken by the HAs are celebrated. This creates the impetus to drive the movement on to even greater heights. Human interest stories of the HAs are regularly featured in the media and community newsletters. Annual appreciation dinners and awards ceremonies are also held to recognize the HAs' contributions.

HPB equips the HAs with the necessary skills and knowledge in basic health promotion. To do so, HPB, through its Health Promotion Academy, collaborates with the National University of Singapore's Saw Swee Hock School of Public Health to develop training programmes for the HAs. The training is tiered in its content and the HAs are awarded certificates upon completion of the training. Recognising

that HAs can have diverse interests, "Communities of Practice" ranging from active aging to weight management have also been created to continuously engage them and hone their health advocacy skills. HPB's health-promoting approach centres on people – for the people and by the people. By focusing on people and tapping on people power, HPB aims to help Singapore become "A nation of healthy people".

NCD Prevention and Control in Malaysia

Malaysia has embarked on various programs for the prevention and control of non-communicable diseases (NCD) since the 1990s, like the Healthy Lifestyle Campaign which was initiated in 1991 and has now focused on five elements in addressing modifiable NCD risk factors – healthy eating, exercise and physical activity, smoking cessation, handling stress and alcohol abstinence. However, upon realisation of the increasing prevalence and burden of NCDs and their risk factors, the Ministry of Health (MOH) has strengthened its program in Malaysia by producing the National Strategic Plan for Non-Communicable Diseases (NSP-NCD) 2011–2015.

NSP-NCD was developed in line with the mandates of the World Health Organization, particularly with reference to the Action Plan for the Global Strategy for the Prevention and Control of NCDs (2008–2013) and the Western Pacific Regional Action Plan for NCDs. The programs and activities contained in NSP-NCD use obesity and diabetes as the entry points. It contains seven strategies, namely: 1) prevention and promotion; 2) clinical management; 3) increasing patient compliance; 4) action with non-government organizations (NGOs), professional bodies and other stakeholders; 5) monitoring, research and surveillance; 6) capacity building; and 7) policy and regulatory interventions.

Malaysia acknowledges that national policies in sectors other than health have a major bearing on the risk factors for NCD because the broad determinants largely

fall outside of the health domain. Adopting the whole-of-government approach, this document was presented and approved by the Malaysian Cabinet on December 17, 2010. The Prime Minister also consented to the formation of a Cabinet Committee for a Health Promoting Environment, chaired by the Deputy Prime Minister with membership consisting of 10 Ministries.

Under Strategy One: Prevention and Promotion, the MOH intensified further its media campaign on healthy lifestyle by using the traditional media (newspaper, television and radio). It also engaged magazine feature writers and bloggers to contribute to the campaign. In December 2011, the MOH started expanding the focus of its existing Communication for Behavioural Impact (COMBI) program for dengue as to include NCDs. With this new focus, the MOH, on December 15, 2011, appointed three 1Malaysia Health Ambassadors to encourage Malaysians to adopt healthy lifestyles.

Moreover, the MOH introduced the NCD Prevention 1Malaysia program or NCDP-1M. It is an NCD risk factor intervention program conducted in three different settings, i.e. community, workplace and schools, and uses weight management as the entry point. The main objective of this program is to empower Malaysians to be pro-active in screening for NCD risk factors and to initiate intervention among those found to be at risk, outside of the clinical setting. Currently, a total of 220 programs (126 community-based, 52

workplace-based, and 42 school-based) throughout Malaysia has been conducted with approximately 8,000 participants. For 2011, about 22% of participants have managed to lose weight, and 69% have improved their blood cholesterol levels.

Under Strategy Two: Clinical Management, the MOH continues to improve quality of care for patients with NCD particularly at the primary care level. There are over 190 Family Medicine Specialists currently working in MOH health clinics throughout Malaysia. The MOH has trained nurses and assistant medical officers with the necessary skills to screen patients for diabetes- and hypertension-related complications, as well as in delivering health education and counseling on changing lifestyle. At present, there are 250 NCD resource centres available – 200 health clinics and 50 hospitals – all over Malaysia. These resource centres serve as a focal point for NCD patients and their family members in receiving health counseling to further improve the control of their diseases.

This also comes under Strategy Three: Increasing Patient Compliance. The MOH inculcated opportunistic NCD risk factor screening in all health care facilities, not just for patients, but also for family members, using the self-service equipment made available in the waiting areas. The MOH has also set a key performance index (KPI) of 5% of total clinic attendance to be screened daily.

Under Strategy Four: Action with NGOs, Professional Bodies and Other

Stakeholders, the MOH conducted a National NSP-NCD Advocacy Seminar which was held in Putrajaya International Convention Centre on March 22, 2011, officiated by the Health Minister. This seminar was attended by over 70 representatives from NGOs, professional, media and sports associations. Last year, the Malaysian Health Promotion Board (HPB) placed special emphasis on programs and activities related to NCD. As of August 2011, the HPB has disbursed funds of RM8.7 million to 181 NGOs for such programs and activities, and in December 2011, the HPB published several training modules on obesity prevention, healthy eating, active living and smoking cessation to increase the skills and capacities of NGOs in conducting their activities.

Under Strategy Five: Monitoring, Research and Surveillance, the National Health and Morbidity Survey (NHMS) for NCD risk factors was started in 2011 and will be made every four years. Previously, this survey is only done every 10 years. Several

NCD indicators have also been incorporated into the KPI of the MOH and the Director General of Health.

Under Strategy Six: Capacity Building, the MOH, on November 29, 2011, organized a seminar entitled "Role of Media in Improving the Nutrition Status of Malaysians" to increase the involvement of media players in promoting healthy eating among Malaysians. Moreover, training programs on NCD risk factor screening and intervention are conducted on a continuous basis for the public, involving health care personnel, volunteers from the community, workplaces and schools.

Under Strategy Seven: Policy and Regulatory Interventions, the Ministry of Education has agreed to implement the new healthy eating guidelines in schools, consisting of three components –1) measurement of students BMI twice a year and reporting the results to parents. Students found to be obese in two consecutive readings will be referred to a

healthcare professional; 2) healthy menu in school canteens; and 3) depiction of calorie contents of food sold in school canteens. The MOH is also in the final stages of discussions with the Department of Local Authorities to standardize the by-laws on the prohibition of sale of unhealthy food and drink outside of school perimeters.

Finally, following the National Food Safety and Nutrition Council Meeting which was held on December 8, 2011, the MOH will develop a guideline to control marketing of food and non-alcoholic beverages to children in Malaysia by 2012. This was reiterated by the Health Minister during a dialogue with food and drinks industries on December 16, 2011 in Putrajaya. During this meeting, the food and drink industries have made several commitments to increase the production and promotion of healthy food choices, and adopt an active role in multisectoral partnerships with the MOH.

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ASEAN on NCDs

(Continued from back page)

We appeal to our international partners to fund and align the prevention and control of NCDs with their other development programmes such as those of the MDGs and Climate Change. We urge our development partners to fund researches on the unique public health problems of our region. We call upon the international community to help us ensure that essential pharmaceutical products and medical devices are available to the region. This will help avert the devastating socioeconomic impact of NCDs on our societies. In short, the partnership among countries is a must. Among developed and developing countries. At the global, regional and bilateral levels.

Last but not least, we are ensuring the involvement of all stakeholders.

To effectively respond to the challenges posed by NCDs, we must enlist the participation of all stakeholders. ASEAN is therefore committed to implementing a whole-of-government people-centered approach involving civil society, the private sector and community organizations. By taking these steps, we in ASEAN are confident that we will be able to contribute significantly to the global reduction of NCD death rate in this decade.

Mr. President, at the national level, Indonesia is grappling with the double threat of communicable and non-communicable diseases. The impact of NCDs is not only affecting the urban populations but also rural poor. This is compounding the basic problem of poverty.

Mr. President, to address this challenge, we established in 2006 a special unit in the Ministry of Health and tasked it with strengthening the legal framework for and to advocate NCDs control. We have also given priority

to minimizing the common risk factors: tobacco use, alcohol abuse, unhealthy diet and physical inactivity. We are now simplifying and increasing taxes on tobacco to control the consumption of this deadly commodity.

Indonesia also is committed to implementing the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. To support global efforts at addressing NCDs, Indonesia hosted a Regional Meeting on Health and Development Challenges of NCDs in Jakarta in March 2011. The Meeting produced significant recommendations that have been offered as inputs for the outcome document of this meeting.

Mr. President, the scale and virulence of non-communicable diseases require unprecedented political commitment at the highest political levels to address this global issue. That commitment must therefore be incorporated into global agenda of the international community. That is why we are holding this high-level meeting.

Let us not waste this opportunity. Let us seize this moment to secure global commitment for a coordinated response to this challenge. This means mobilization of resources. The building of a genuine global partnership. These should be clearly stated in the Political Declaration that will be adopted in this meeting. Then we will have to work hard as a family of nations to carry out what we have declared—including an extensive review of the progress we shall have made by 2014.

Finally, we call on the international community to include progress in the fight against NCDs as component of the MDGs plus beyond 2015.

I thank you.

ASEAN on NCDs

by H.E. DR. R. M. MARTY M. NATALEGAWA, Minister for Foreign Affairs, Republic of Indonesia
at the plenary of the High-level Meeting on Non-Communicable Diseases Prevention and Control,
United Nations General Assembly in New York, USA on 19 September 2011

First of all, on behalf of ASEAN, let me present our regional perspective on the matter at hand. For ASEAN Member States, non-communicable diseases are a major challenge that compounds the deadly impact of communicable diseases.

A 2010 WHO Report showed that non-communicable diseases caused some 36.1 million deaths in 2008. Eighty percent of these deaths are caused by four main non-communicable diseases. And low to middle income families suffered 80 percent of these deaths. According to the WHO, NCDs-related deaths will increase by 17 percent over the next decade. And among ASEAN communities, deaths due to NCDs can increase from its current 2.6 million to 4.2 million people.

At the global level, NCDs are affecting mostly working-age adults – thereby eroding the most productive generation in the world today. And thus reducing the gross domestic product of low to middle-income countries by as much as five percent. This is one reason why poverty is so wide-spread. And why many countries suffered in backwardness. Hence, we in ASEAN are working hard and in concert to address this grave challenge.

In our view, prevention is the key to resolving it. Prevention is and will always be our priority. We are therefore carrying out four major prevention strategies.

First and foremost, we in ASEAN are strengthening our health systems and infrastructures.

This includes mainstreaming NCD prevention and control alongside infectious disease prevention and control in national development

programmes, and enhancing operations in health facilities from the lowest to the highest levels. It includes raising the capabilities of human resources for medical care and developing effective referral systems. We are also improving our surveillance systems on the diseases and the modifiable risk factors.

We are working toward universal health coverage and providing service packages that cater to the needs of people with chronic NCDs. In brief, we must have a comprehensive health system and infrastructure for addressing NCDs. This is not an option. It is an imperative.

Second, we are strengthening our national health policies and accelerating programmes for tobacco control.

We will not be content only with passing laws that heavily tax cigarettes. We will also consider using the revenues derived from sin taxes to support NCDs prevention. We will continue to promote a smoke-free environment in order to protect our people from secondary smoke. We are aligning national policies on agriculture, trade, industry and transport to improve diets, encourage physical exercise and reduce harmful alcohol use. We are implementing community based intervention for early detection of factors of major NCDs.

Third, we are strengthening partnerships for health.

The need for international cooperation for public health cannot be overemphasized. Although the Millennium Development Goals do not include targets for the reduction of NCDs, individual efforts by ASEAN Member States warrant complementary coordinated support from our partners.

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ASEAN Health Events

July - December 2012

2-3 July 2012

- Preparatory Senior Officials Meeting (PrepSOM) -
11th ASEAN Health Ministers Meeting (AHMM)
- PrepSOM-5th ASEAN Plus Three Health Ministers Meeting (APTHMM)
- PrepSOM-4th ASEAN-China Health Ministers Meeting (ACHMM)
Phuket, Thailand

5 July 2012

11th ASEAN Health Ministers Meeting
Phuket, Thailand

6 July 2012

- 5th ASEAN Plus Three Health Ministers Meeting
- 4th ASEAN-China Health Ministers Meeting
Phuket, Thailand

August 2012

9th Meeting of the ASEAN Expert Group on Food Safety (AEGFS)
Viet Nam (tentative)

26-27 September 2012

29th Meeting of ASEAN Task Force on AIDS (ATFOA)
Luang Prabang, Lao PDR

October 2012

7th Meeting of the ASEAN Expert Group on Communicable Diseases (AEGCD)
Philippines (tentative)

26-28 November 2012

4th Conference on Traditional Medicine in ASEAN Countries
Kuala Lumpur, Malaysia

29 November 2012

3rd Meeting of the ASEAN Task Force on Traditional Medicine (ATFTM)
Kuala Lumpur, Malaysia

4-6 December 2012

28th Meeting of the ASEAN Working Group on Pharmaceutical Development (AWGPD)
Bandar Seri Begawan, Brunei Darussalam

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