Progress in Global Health

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This month, the World Health Organization (WHO) released a “Report Card” on the work of Dr Margaret Chan during her first 6-year term as Director General. It is an impressive 18-page summary of the work of WHO during this period and the achievement of her personal goals as director general. The highlights of this period have included major advances in the delivery of vaccinations, reductions in child mortality, progress against HIV, tuberculosis, and malaria, and support for the tobacco control convention. In the early years of this century, the number of child deaths, almost all preventable, hovered around 10 to 11 million deaths annually. In the past 6 years, the number has begun to decline again and may now be as low as 7.6 million. This represents a substantial advance toward achieving the UN Millennium Development Goals related to children.

Dr Chan was a key mover in launching the Decade of Vaccines in 2010. As a part of this initiative, a number of vaccine manufacturers and drug companies increased supplies and reduced the prices of vaccines for the developing world. This included a 95% price reduction for the new rotavirus vaccines, which led to its addition to the WHO-recommended vaccination schedule, a decision supported by a Cochrane Review.¹,² Rotavirus vaccination has reduced child admissions to hospital by at least 70% in developed countries where it is in use. Although it has great potential to reduce child mortality further, so far it has not been incorporated into the vaccination programs of most countries in our region.³ During 2010, estimated global coverage with the third dose of diphtheria–tetanus–pertussis vaccine (DTP3) reached the highest levels ever reported (85%). Coverage with the other routinely recommended childhood vaccines was 90% for BCG (Bacille Calmette-Guérin) vaccine, 86% for the third dose of poliovirus vaccine, 85% for measles vaccines, 75% for the third dose of hepatitis B vaccine, and 42% for the third dose of HIB (Haemophilus influenzae type B) vaccine.⁴ These are impressive figures and are due, at least in part, to Dr Chan’s strong advocacy. Fund raising for global health programs is always difficult and even more so in the current economic climate, but in 2011 donors pledged more than $4 billion to support the work of the Global Alliance for Vaccination, an amount that exceeded expectations.

Soon after her appointment, Dr Chan pledged her support for the WHO Framework Convention on Tobacco Control. But the fight against the multinational corporations that peddle the deadly scourge of tobacco is difficult and requires ongoing vigilance. Tobacco remains the number one modifiable risk factor for chronic disease, particularly in the Asia-Pacific region. WHO estimates that tobacco use, physical inactivity, unhealthy diets, and the harmful use of alcohol, are

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Public Health Strategies to Address Asian Men’s Health Needs

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Abstract
Men's health discourse has been around for more than 2 decades. The higher mortality rates and the shorter life expectancy in Asian men compared with their women counterparts show the disadvantaged status of men's health. Thus, discussions on men's health should address their health needs and not be confined to sex-specific male urology and reproductive health. In Asia, assessing men's health needs is challenging because of the vast differences in the socio-economic status and the diverse culture among its member countries. Although, the epidemiology of men's health provides the focus for what to address in improving men's health, having an optimal strategy requires the understanding of men's health-seeking behaviors and the social determinants surrounding them. Thus, public health approaches addressing health behaviors and health promotion in the society should be one of the keys in improving men's health status. Locally relevant information is needed to inform effective public health approaches.

Keywords
men's health, health-seeking behavior, health needs, Asia, masculinity

Introduction
Men have poorer health status compared with women in almost all countries in the world. Men’s health discourse started in the early 1990s in a few European countries, Australia, and the United States of America.¹,² However, as early as 1984, men were already noted to be disadvantaged in relation to mortality and morbidity patterns compared with women in the United States of America.³ More recent reviews have confirmed the same concern around the world.⁴⁻⁹ Men’s poorer health profiles compared with those of women are also reflected in almost all the vital statistics published by the World Health Organization (WHO), such as life expectancy at birth, mortality rates, disability-adjusted life years and non–sex-specific disease death rates.¹⁰⁻¹² On an average, men’s life expectancy at birth is 5 years shorter than that of women.¹¹

The diseases that contribute to men’s mortality are non–sex specific and amenable to early intervention. Although male-specific illnesses have been the emphasis in men’s health traditionally, cardiovascular disease is the most common cause of death in men. This is followed by

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The 2004 Tsunami in Penang, Malaysia: Early Mental Health Intervention

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Abstract
Disasters, natural or man-made, bring numerous health care challenges. In any crisis, mental health programs are a requirement during both the acute and postemergency phases. In the Asian tsunami on December 26, 2004, some of the northwestern coastal areas of Malaysia, particularly the island of Penang, were affected with devastating effects on the residents. Such disasters can predispose to mental health problems among the affected people. An early mental health intervention program was carried out in Balik Pulau, Penang, an area badly affected by the tsunami. The objective of the intervention program was to identify the victims, counsel them, make referrals if necessary, and provide help and resources to prevent the development of mental health problems. Penang residents identified as tsunami victims by the local health authorities were recruited. A group of health care workers, school teachers, village authorities, and volunteers were trained to carry out the crisis intervention program by health care workers experienced in crisis interventions. A total of 299 adults participated in the crisis intervention program, with follow-up assessments being made 4 to 6 weeks later. At the follow-up assessment, 1% of the victims had a problem and they were then referred for further medical assessment. This indicates that the intervention program in the first 2 weeks after the tsunami disaster with referrals to medical services may have helped stabilize the victims.

Keywords
asian Tsunami, disaster, mental health intervention, psychosocial intervention

Introduction
The Asian Tsunami occurred on December 26, 2004, following by an earthquake with an intensity of 9.0 on the Richter scale in the Indian Ocean, north of Sumatra Island, off the western coast of Sumatra Indonesia. The tsunami killed more than 230,000 people from 13 countries.

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