Dr. NADARAJAH SIVARAJAH MEMORIAL LECTURE 2021

Some ethical tenets of public health policy

By
Dr. Palitha Abeykoon
WHO Director General's Special Envoy on COVID -19
for South East Asia

26th February 2022

Dr. Nadarajah Sivarajah Memorial Lecture 2021

Some ethical tenets of public health policy

Dr. Palitha Abeykoon
WHO Director General's Special Envoy on COVID -19
for South East Asia

26 February 2022

Dr. Nadarajah Sivarajah Memorial Lecture 2021

Vice Chancellor's Message

Late Dr. N. Sivarajah is one of the pioneers of Community Medicine at the Faculty of Medicine who contributed immensely to the development of Primary Health Care in the region. Dr. N. Sivarajah shouldered academic responsibilities of the faculty, health care services of the community and consultancy services to the WHO and UNFPA in the most difficult and unrestful period of the region with bravery and dedication. The Senate of the University of Jaffna commemorated the matchless service rendered to the university and the community by instituting this annual memorial lectures.

We are proud to have Dr. Palitha Abeykoon, World Health Organization Director General's Special Envoy for COVID -19 for South East Asia, and a Senior Advisor to the WHO Country Office and to the Regional Director of the WHO South East Asia Region, presently functioning as an Advisor to the Ministry of Health to deliver the Memorial Lecture 2021.

Dr. Palitha Abeykoon joined the WHO and served in Nepal and Indonesia before moving to the South East Asia Regional Office in New Delhi where he was the Director of Health Systems and Non Communicable Diseases. He was also the WHO Representative to India. We are fortunate to have Dr. Palitha Abeykoon because both Dr. Nadarajah Sivarajah and Dr. Palitha Abeykoon had a common interest in public health. Furthermore, the topic selected by Dr. Palitha Abeykoon is well suited to the interest of Dr. Nadarajah Sivarajah.

I thank Dr. Palitha Abeykoon for agreeing to deliver the Dr. Nadarajah Sivarajah Memorial Lecture 2021 on the title "Some ethical tenets of public health policy". I believe this is a suitable topic for those who are in the public health field to strengthen their engagement and expertise.

Prof. S.Srisatkunarajah
B.Sc (Hons) Jaffna, PGDE(Merit)OUSL Ph.D Heriot – Watt
Professor in Mathematics
Vice Chancellor
University of Jaffna.

Some ethical tenets of public health policy

Vice Chancellor, University of Jaffna, Prof. S. Srisatkunarajah, Dean, Faculty of Medicine, Dr. Surenthirakumaran, members of the family of Dr. Sivarajah, professors and all the academics of the Faculty of Medicine, Jaffna, distinguished invitees, ladies and gentlemen.

First, let me thank Dr. Surenthirakumaran, and the Faculty of the Jaffna Medical School for the very kind invitation to deliver the Dr. Nadarajah Sivarajah Memorial Lecture 2021. I feel exceedingly privileged and honored, and at the same time, humbled by your gesture. The opportunity to pay tribute to a revered medical educationist, an eminent public professional, a medical researcher of the highest caliber, a loving family man, and above all an exceptional human being, is indeed a matter of deep pride to me.

Dr. Nadarajah Sivarajah was born in Negombo on 12.04.1938. His father being a Government Servant had to relocate himself several times to different places. Dr. Sivarajah had a large part of his secondary educate in St. Mary's College, Negombo and later at Ananda College, Colombo. Unfortunately, he and his family were forced to move to Jaffna just two months before his high school examination due to serious unrest in 1958. Finally, after a short period of study at Jaffna Hindu College, he gained entrance to the Colombo Medical College and graduated in 1965. Consequently, he was a perfectly fluent trilingual scholar.

Dr. Nadarajah Sivarajah obtained his MD in Community Medicine and was conferred the Fellowship of the College of Community Medicine. He joined the Faculty in 1981 and worked continuously until 2003, and finally became Head of the Department of Community Medicine at University of Jaffna.

I know personally from my conversations with his students from here that he was role model of a teacher - well prepared, accessible, stimulating and challenging them to think. Naturally, he was held in high esteem by all his students.

To my mind arguably perhaps the most scientific public health expert I had met in Sri Lanka was Prof Sivagnanasundram who was my teacher at Peradeniya and later my colleague in the Faculty. I believe that Prof. Siva and Dr. Siva were a great duo who elevated the profile and narrative of public health in Jaffna.

After his retirement his role expanded and his wide range of involvements in NGOs covered the totality of public health and human and social development. He was actively involved in the Jaffna Medical Association, becoming its President in 1987. He was also an editor, writer and undertook multiple high profile roles. A truly versatile personality.

My close association with Dr. Sivarajah was during the period after 2003 until his passing. He had been invited by the WHO to be the Consultant Coordinator of the Jaffna Field Office - a role he continued until 2013.

During the Ceasefire period we travelled extensively in Jaffna and in the East; the Governor's office was in Trinco at the time. During these long travels and the working hours, we enjoyed wide ranging discussions on matters of health, education, culture and the multiple causes of the serious problems and turbulence that was seen in the North and East during this period.

He had a very sound reading on all these issues and not myself alone but many of our WHO colleagues were so impressed by his extensive and balanced knowledge. So, Siva became our "go to man", and our advisor for anything to do with Jaffna and the East. I am so happy to see Mrs. Sivarajah here. They - Siva and his dear wife- were generous hosts and we often talk of the excellent out-of-this-world meals that were lovingly prepared by Mrs. Sivarajah.

So, ladies and gentlemen, today we are honouring and celebrating the life of a doyen of public health and a true citizen of Sri Lanka, who contributed immeasurably to health development in our country in general and in the North and East in particular.

For today's talk I have chosen the topic of public health and will examine some of the main ethical issues and dilemmas of a public health worker in Sri Lanka. I will also touch on a few of the ethical dilemmas that we have observed during the COVID pandemic in the past 2 years, both in Sri Lanka and more widely.

Ethics in medicine and public health

First a word on the concept of Ethics in medicine and health. The Hippocratic ethical maxim is widely known in its Latin form as *"primum non nocere"*- **first do no harm**.

The goals of Western medicine grew out of Platonic individual and social obligations to one another in achieving the good life. The concept of an ethical doctor included a sense of the limits of medical knowledge, and what is referred to as the "art" of medicine. This balance is evident in the Socratic articulation of the aims of medicine: to cure sometimes, relieve often, and care always. A modern version of this Socratic dictum is the duty to promote health, cure disease, and prevent suffering....in other words **the essence of public health.**

The four principles of health care ethics developed by Beauchamp and Childress in the 1985 Principles of Biomedical Ethics provide basic values or principles to resolve ethical issues in complicated situations involving patients and community.

1. Autonomy: Patients basically have the right to determine their own healthcare.
2. Justice: Distributing the benefits and burdens of care across society.

3. Beneficence: Doing good for the patient.
4. Non-malfeasance: Making sure you are not harming the patient.

However, ethical values are not limited to just these four principles. There are other important values to consider, such as truth-telling, transparency, showing respect for patients and their families, and showing respect for the patients' own values.

The ethics for the conduct of research with human subjects evolved in the past century in response to reports about abuses, scandals, and atrocities, particularly the Nazi experimentation with human beings.

Why should we take medical ethics seriously?

All doctors want to be sure they have done the right thing. Being an ethical doctor or moral relief is considerably more important to most of us than, for example, merely being affluent. Patients too implicitly trust their doctors, and ethical conduct will sustain the respect of patients. Ethics will also help to maintain respectful relationships with colleagues.

Now to my choice of subject and the substantive part of my presentation.

I perused some of the erudite orations which addressed different ethical aspects of clinical medicine and medical research. I have chosen the less trendy, less addressed, but in my opinion equally important, area of public health and some of the relevant ethical tenets in public health policy and practice. Public health actions are often undertaken by governments and the principles and values which guide ethics in public health can differ from patient-oriented bioethics in research and in clinical medicine, although often the line is very thin between them.

What then is public health ethics?

Public health is often defined as "what we, **as a society,** do collectively to assure the conditions for people to be healthy". With its use of the phrase "we, as a society," the emphasis is the cooperative and mutually shared obligation. This idea is critical because most political leaders do not have a clear sense of public health nor its ethical dilemmas. The role of public health is to assure the conditions needed to promote and protect people's health. These conditions include various economic, social, and environmental factors and making adequate resource provision for these involves basic ethical issues.

Thus whereas clinical ethics focuses on treatment of disease and injury, individual benefit and harm avoidance, the doctor - patient relationship, and the doctor's professional duty to place the interests of the patient first, in public health ethics the focus is on prevention of disease and injury, a range of interventions by various professionals, autonomy of interdependent NOT independent persons (this is crucial to remember), and authority based on law, which is a principal tool of public health policy. Public health Ethics covers both personal and community health. (Utilitarianism, equity and social justice are the key terms to bear in mind).

Both public health practice and policy formulation raise diverse ethical considerations. An important set of issues concerns the relationship between the liberty of the individual and broader societal concerns. Other important issues include equity and fairness, social justice and trust. Underlying all approaches to public health ethics is a strong commitment to collective action to protect the public from harm.

Whose responsibility is public health?

What is the role the government should play in public health or is it mainly a matter of individual choice?

The main arguments in public health ethics get polarized. On one side the curbing of our personal freedom to do as we please is seen as being infringements by a "nanny state". On the other side there are cries that "someone should do something" to tackle public health problems such as communicable diseases, for example we see this with COVID - 19 right now, or dengue or excessive drinking or smoking or substance abuse or the epidemic of chronic diseases.

The central ethical dilemma in public health, therefore, is to balance respect for individual freedom with the responsibility of governments to limit that freedom to provide citizens with health protection.

Public health ethics are also important at international level. For example, the activities of tobacco companies in developing countries and their concept of corporate social responsibility (CSR). It had been well established that tobacco is a highly harmful product. In many developed countries, but not in the developing countries, companies voluntarily adopted harm reduction strategies, such as bans on advertising and restricting the availability of tobacco to children. But in developing countries, these became universal policies only after the WHO Framework Convention on Tobacco Control was passed as International law amidst tremendous resistance. So too with the marketing of formula milk.

Law and public health ethics?

As became clear during the current COVID pandemic, public health practice and ethics are intimately related to public health law, and as Callahan and Jennings have noted, "public health is one of the few professions that has legal power-in particular, the police power of the state-behind it and has an obligation both to government, and toward the public that it serves." However, **something can be legal and yet conflict with ethical standards.**

For instance, there are no laws prohibiting countries from investing vast public resources in the development of medical interventions of minor public health significance, as an extreme example, a cure for male pattern baldness. Ethically speaking, should not countries instead devote their resources to reducing the burden of life threatening disease?

The 10 greatest public health achievements of the twentieth century, were realized, in a significant part, **through legal reforms and regulations:** vaccinations, safer workplaces, safer and healthier foods, motor vehicle safety, control of infectious diseases, the decline in deaths from coronary heart disease and stroke, family planning, tobacco control, healthier mothers and babies, and fluoridation of drinking water.

Ethics of specific areas of public health policy and practice

I shall briefly touch on some of the specific areas in public health policy formulation and practice where ethical dilemmas can emerge.

Social determinants, equity and vulnerable populations

Primary Health Care (PHC) adopted by the WHO and UNICEF at Alma Ata in 1978 emphasized Social Justice and Equity as the core ethical values of public health. Social justice demands more than merely a fair distribution of resources. Several groups within our population such as the rural and urban poor, the elderly, children, those living with mental or physical disabilities, and the terminally ill are vulnerable to health care problems, have different experiences in the health system and are at heightened risk.

Prof. Michael Marmot who chaired the World Health Organization Commission on the Social Determinants of Health showed that people with higher socioeconomic position in society have a greater array of life opportunities to lead a flourishing life. They also clearly have better health.

The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health should not be a footnote to the 'real' concerns with health - it should become the main focus.

Consider one measure of social position in Sri Lanka and elsewhere: education. People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with a degree, there would be a reduction of a large number of premature deaths each year.

Just last week I had a friend with serious pain along his spine, and who consulted a surgeon and was told that he needed rather urgent surgery. He was also told that he could come and register at the National Hospital clinic and it could take around 2 years for his turn. Alternatively, in the private sector he could get it done the next day. Not an unusual story. Not being a very wealthy person, but with the help of friends and relations he got the surgery done the same week and has recovered well. You count and recount such examples of social determinants of health and access to health care.

Marmot stresses that health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad' behaviour, or difficulties in access, important as these are.

Therefore, a major task for us is to assemble the evidence and develop a health inequalities strategy for Sri Lanka.

Resource allocation and Universal Health Coverage

Universal health coverage (UHC) is a global aspirational health goal. We need to frame UHC not only in economic (financing) terms but to place it within a rigorous ethics framework, as we set priorities to move towards UHC.

Sri Lanka has developed an Essential Services Package for UHC and the implementation of this package will involve many ethical dilemmas as to what services to prioritize and what population to serve. Otherwise, the poor can lose out. According to Bill Hsiao of Harvard, the ethical foundation should be a crucial determinant when allocating health funds: "There are limited resources, and these are not spread evenly across society".

Dr. Julio Frenk in Mexico had to prove to the Finance Minister that Universal Health Coverage saved money in the longer term. In Thailand, the people's momentum for the right to health propelled the country towards UHC. Cuba is often noted as an exception to the rule that a country has to be wealthy to achieve Universal Health Coverage. What makes Cuba different? It is community participation in priority setting that makes the system viable even under political and economic stress (Richard Levins).

Therefore, tension between doing what is best for the community and a JUST allocation of scarce resources is at the heart of the ethics of health care. Whereas physicians are traditionally guided by principles of autonomy and beneficence in patient care, Ministries of Health are guided by notions of efficiency, cost reduction and optimal resource allocation (Perkel 1996). The challenge is to find an equitable way to allocate health care resources without unduly conflicting with ethical principles. The importance of this is obvious today in Sri Lanka.

What should be the ethics regarding allocation of resources for lifestyle diseases? Should they be based on the outcomes of the treatment and the economic evaluation of the cost and benefit?

Should all patients be treated equally regardless of their lifestyle? Let me ask you a simple question: should an alcoholic cirrhotic be transplanted a scarce donor liver even without any likelihood that he would give up alcohol? Opinion will be divided. Is it ethical to deny?

So too with smoking and heart surgery. Should the outcome be considered as a condition? The question therefore is: if we want a right to the resources of society do we also have a duty to respect them and be prepared to have these resources denied if we do not observe our duties?

Look at another topical issue. The CKDU issue that has enveloped the country for some time. There are so many who require dialysis and many who would also need kidney transplants. Obviously, it is well-nigh impossible to provide transplants to all those who need them, no country has that kind of capacity and resources. What would be an ethical way to select? What criteria? Not an easy issue at all. Different countries have tried different formulae but all of them are compromises and the ethical dilemmas are not totally resolved.

The problem of limited access to health care in countries like ours has been exacerbated by a "brain drain". Health professionals trained in developing countries are commonly recruited to work in wealthier countries, resulting in a severe shortage of health care workers in the former. This raises questions about the ethicality of such recruitment and the incentives that might be used to discourage emigration. This is another case of a moral conflict between the individual freedom to relocate and the need to provide health care to the most vulnerable people.

Health managers in most countries, including Sri Lanka are working on the "infinity model of medical progress," which derives from "the idea that life can and should be extended indefinitely using technology, even to the exclusion of other goods". This in itself holds an ethical dilemma.

In the clinical context, this generates what is called the "technological imperative," that because technological interventions are available, they should be used.

The result is "a powerful bias towards cure, rather than care; acute, rather than chronic disease; length of life rather than quality of life; individual benefit rather than population benefit, subspecialty medicine, rather than primary and family care; and increased medicalization of life and social problems".

Vaccination issues

Second only to the development of clean water and sewage systems, vaccines have been the major factor in reducing infectious diseases worldwide. Sri Lanka is showcased as a country that has eliminated smallpox, polio and neonatal tetanus and reached near elimination of measles and reduced a number of serious diseases. However, many ethical issues surround the development and use of vaccines. These include: requiring vaccination by law, development and testing of vaccines, informed consent about the benefits and risks of vaccination and the equitable distribution of vaccines. In developed countries, some parents do not allow vaccination to children even though the consequences to the children and the community can even be tragic.

I will mention two current cases with ethical relevance to vaccines -very relevant to the Covid 19 vaccines - one global and the other in Sri Lanka.

Before that a word on a historical anecdote....There was a vaccine that was being field tested in the Philippines. Dengvaxia is the name.

That story begins on a stage in Manila in 2016.

A young girl, about age 8, bit her lip as the Health Secretary of the Philippines, gave her a shot in the arm. That shot launched a massive vaccination campaign to inoculate nearly 1 million school children with Dengvaxia.

Out of 1 million kids, the vaccine would cause about 1,000 to be hospitalized, sometimes with severe disease, but would prevent over 15000 hospitalizations over five years, Sanofi estimated. But in the world of vaccination this is not an acceptable risk. A year and half later, that campaign came to a screeching halt. No dengue vaccine resulted.

The Sri Lankan case is less controversial but yet illustrative. Could there be better use of these funds? The ethical issue is whether a known preventive measure be denied to children, especially the poor, when it is already available in private markets for those who can afford it.

Ethics in health promotion

Health promotion invariably raises ethical issues because health promotion aims to influence people's views and lifestyles, and are often initiated and funded by government agencies. In the prevention and control of communicable diseases, in most countries, public health measures that prevent their spread are addressed by regulations and legislation. Public health practitioners have the legal mandate, for example, to inspect food preparation areas in restaurants and, if necessary, to close them to protect the public. Under certain circumstances, public health officers can quarantine individuals who put the health of the community at risk, as we see regularly with COVID - 19.

Public health practitioners must balance the need to promote the common welfare against the rights of individuals such as freedom of movement or freedom to pursue a business.

Today the role of industry and its influence has become omnipresent. The tobacco and alcohol industries, the pharma industry and the food industry all raise a number of public health ethical concerns. Their undue pressure on the government and politicians is well documented.

We also had the experience quite recently, of the tobacco and alcohol industries getting some of the policies of the Ministry of Health reversed, mainly with regard to pricing and licenses. We also face periodic serious ethical concerns regarding collaboration between health promoters and industry, particularly with regard to sponsorships for events.

Common ethical concerns in COVID - 19

I will end my presentation by referring to some of the ethical concerns in relation to the current pandemic of Covid 19.

Some of the main areas of ethical concern in COVID - 19 include the following:

- Testing and quarantine of exposed
- Case management including ICU management
- End of life support
- Disposal of the dead
- Research issues
- Media and ethics

People known to have been exposed or infected

- Normally testing, tracing and monitoring and reporting might be considered in violation of the legally enshrined duty of medical professional secrecy.
- Conflict between the clinical ethical framework (emphasizing medical secrecy and the patient-physician relationship) and the public health ethical framework (where the provision of sensitive medical information could be acceptable to the goal of minimizing either infection, hospitalization or death).

- In the short term, dilemma between the issue of data protection and privacy.
- Obtaining relevant information could be justified from a public health ethical approach to chart how many have been exposed to the virus.
- For the infected, testing equity and confidentiality can be issues

What about the decision to hospitalize or manage at home

- How are decisions to manage at home made? Fairness ensured?
- How is the level of care assured at the ICCs and hospitals?
- How are decisions to transfer to a hospital made? Are all able to get a bed? Equity?
- Can we give equitable care when the system is overburdened?
- What about the case of health workers getting ill and their burnout?
- What about delayed services to those without COVID-19?

COVID -19 vaccination ethics - some questions?

- Who should get (have got) the vaccine first? If vaccine freely available?
- What to do with people jeopardizing immunization by refusing to take it? Is getting vaccinated a basic moral obligation?

- If individuals fail to fulfil this moral obligation, do governments have the moral responsibility to enforce vaccination to achieve certain public health and social goals? No law.
- Are coercive state interventions acceptable? Is it a straightforward ethical issue –do people have a duty to get vaccinated?
- Can we justify by the ethical concept when applied on a large scale, namely, to reach herd immunity?
- Protecting vulnerable people through herd immunity is a collective enterprise. This effort raises tensions between collective and individual responsibility?
- Is it morally right that some wealthy countries and groups in society monopolize immunizations before others who also need them?
- Should there be 3rd and 4th dose boosters when some countries have not even reached 10% population coverage?

Privacy and Confidentiality Protection

Public health requires robust data on diseases and health threats within a population. Such data allows priorities to be set and resources to be allocated. How should the need for accurate surveillance data be balanced against the principle of individual autonomy? For example, in the mid-1980s, blood samples were stripped of identifying information and tested for HIV, to estimate the population prevalence of HIV infection. It was considered ethical as the results provided important information about the prevalence of HIV in the community at a time no treatment was available. Now, however, treating HIV is possible, and the argument has shifted.

Today, anonymous testing of blood samples for HIV would probably not be approved by many ethics committees, as it would be considered ethically inappropriate to identify HIV positive individuals without being able to follow up with treatment. This shows how ethical policy making is a dynamic process that must adapt to the evolving situation.

Stigma and discrimination in public health

Stigma is when someone views you in a negative way because you have a characteristic or personal trait that is thought to be, or is, a disadvantage. Unfortunately, negative attitudes and beliefs toward people then can lead to discrimination. Fear of discrimination will drive individuals to hide information about themselves because they have an attribute, or marker of disease that is stigmatized in society. Some other harmful effects of stigma include reluctance to seek help or treatment, get tested, disclose their status, lack of understanding by the family, friends, co-workers, and few opportunities for employment, schooling for children or even finding housing. In Sri Lanka, we still see instances of such discrimination, even on mere suspicion and wild rumor.

Public health paternalism and conflict of interest

Paternalism is the interference with a person's freedom of action with the intent exclusively - or primarily -to protect his or her own health and well-being. Supporters of paternalism point out that personal behavior cannot simply be a matter of free will - and that state regulation is clearly warranted. Regulation of behavior that poses a risk to oneself includes mandatory motorcycle helmet and seat belt laws, criminalization of so-called recreational drugs, restrictions on tobacco and alcohol, fast food, and sugary drinks and advertising for children.

Opponents of paternalism, in Sri Lanka, the tobacco and alcohol industries and the food industry mainly, profess freedom of choice, arguing that individuals should be allowed to decide for themselves, even if they make "unhealthy" or "unsafe" choices and cry foul that the government is invoking a public health "nanny state." We should not worry about this.

Half a century ago, when societal norms and educational standards were changing in the West, the medical profession shifted from paternalism (the doctor knows best) to individual autonomy (patients must be consulted). However, changes have been slow and often we find that overall, our own medical practice still shows paternalistic features. Especially in the state sector. Would you not agree? May be culturally even our patients expect this and are happy with it, would you say?

Now a word about conflict of interest of doctors that affects public health policy. A recent JAMA editorial talks of expert physicians who play an oversized role in cancer medicine. They write the editorials in major medical journals that can influence other physicians' prescribing practices, influence governments to buy particular brands of medicines, they give educational sessions at meetings, and they decide what evidence is good enough for off-label use. The fundamental problem here is that, as a profession, we do not address conflict of interest well. The pharmaceutical industry is run by intelligent people who choose to reward doctors in many ways. It is hard to believe they have not calculated that this increases their bottom lines. In this area Dr. Sivarajah was a role model and he had the pharma industry as we say, at arm's length. I am reliably told that even now the wall calendars in his old Department of Community Medicine are from hardware companies!

Ladies and gentlemen let me conclude with a few summary statements and possible roles for the Jaffna Medical School to help to sort out ethical dilemmas in public health in Sri Lanka.

1. Public health is ultimately an ethical or moral construct and thus public health policy and practice must be grounded on ethics and moral values. We as public health professionals must respect this and create a fair and just public health system that provides universal health coverage primarily as a moral issue.
2. Public health ethics has three core functions, 1) identifying and clarifying ethical dilemmas in policy and practice, 2) identifying alternative courses of action and their consequences, and 3) resolving the dilemmas by showing the path that best balances the principles and values.
3. Health policy decisions can be ethically challenging because of differing health system goals (health promotion vs health care), competing stake-holder interests (funders vs health providers), conflicting values (equity vs utility), or incomplete information, for which there is no "rationally" correct policy answer.
4. The Faculty could play a valuable role to improve the quality of ethical decisions in public health by educating your students appropriately and by bringing your professional experience and expertise to the table.

Let me end with a quote from Michael Marmot. He says, I quote, "All of us are gung ho on human rights – my feeling is that with regard to public health we should be more worried about human wrongs…." End of Quote.

Dr. Sivarajah would have expected no less.

Dr. Surenthirukumaran was organizing this oration to coincide with Dr. Sivarajah's birthday last year but the Delta intervened. This time we thought of holding this somehow although there is an Omicron surge in the country right now.

Thank you very much.

Dr. Palitha Abeykoon
WHO Director General's Special Envoy
on COVID -19 for South East Asia

Bibliography

1. Association of Schools of Public Health. Ethics and Public Health: Model Curriculum 2003. Available at http://www.asph.org/document.cfm?page=782.

2. Annual performance report. Ministry of health, nutrition and indigenous medicine, Colombo. Sri Lanka, 2017

3. Centers for Disease Control and Prevention Public Health Ethics Resources http://www.cdc.gov/od/science/phethics/resources.htm.

4. American College of Obstetricians and Gynecologists. Health care for women, health care for all: a reform agenda. Washington, DC: ACOG; 2008. Available at: HCFWHCFA-ReformPrinciples.pdf.

5. World Health Organization (WHO). Making Fair Choices on the Path to Universal Health Coverage. Final Report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: WHO; 2014.

6. World Health Organization. Achieving universal health coverage: developing the health financing system. Technical Briefs for Policy Makers No. 1. Geneva: WHO; 2005. Available at: http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf.

7. World Health Organization. Sustainable health financing, universal coverage, and social health insurance. Resolution WHA58.33. Geneva: WHO; 2005. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf.

8. Institute of Medicine (US). Insuring America's health: principles and recommendations. Washington, DC: National Academies Press; 2004.

9. Ethical issues in health care system reform. The provision of adequate health care. Council on Ethical and Judicial Affairs, American Medical Association. JAMA 1994;272:1056–62.

10. The President's Council on Bioethics. Session 3: Health-care—who is responsible? The individual? Society? Both? Washington, DC: PCBE; 2007. Available at: http://www.bioethics.gov/transcripts/june07/session3.html.

11. Beauchamp TL, Childress JF. Principles of biomedical ethics. 6th ed. New York (NY): Oxford University Press; 2009.

12. Aiken HD. The levels of moral discourse. Ethics 1952; 62: 235–48.

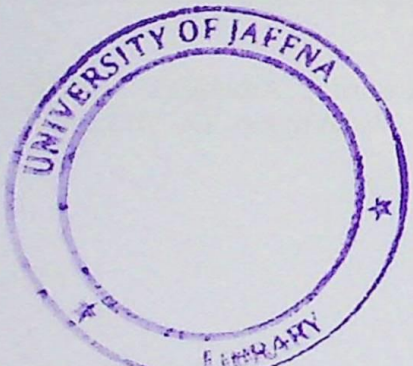
13. United Nations. The universal declaration of human rights. New York (NY): UN; 1948. Available at: http://www.un.org/en/documents/udhr/index.shtml.

14. Marmot MG, Smith GD, Stansfeld S, Patel C, North F, Head J, et al. Health inequalities among British civil servants: the Whitehall II study. Lancet 1991; 337:1387–93.

15. Daniels N. Justice, fair procedures, and the goals of medicine. Hastings Cent Rep 1996; 26:10–2.

16. May WF. The physician's covenant: images of the healer in medical ethics. 2nd ed. Louisville (KY): Westminster John Knox Press; 2000.

17. Norheim OF. Ethical perspective: five unacceptable trade-offs on the path to universal health coverage. International journal of health policy and management. 2015 Nov; 4(11):711.



Dr. Palitha Abeykoon

WHO Director General's Special Envoy on COVID -19 for South East Asia

Dr. Palitha Abeykoon is currently the World Health Organization Director General's Special Envoy for COVID -19 for South East Asia and a Senior Advisor to the WHO Country Office and to the Regional Director of the WHO South East Asia Region. He is also an Advisor to the Ministry of Health.

He is a Graduate of the Faculty of Medicine, Peradeniya, and had his post graduate education in the University of Southern California in Los Angeles and the School of Public Health of the Harvard University in Boston.

Dr. Abeykoon was Director of the Department of Medical Education at the Faculty of Medicine in Peradeniya. He joined the WHO and served in Nepal and Indonesia before moving to the South East Asia Regional Office in New Delhi where was the Director of Health Systems and Non Communicable Diseases. He was also the WHO Representative to India.

He was President, Sri Lanka Medical Association, chaired the National Authority on Tobacco and Alcohol, and received the WHO Director General's Award for Tobacco Control. He also received the Dr. Fred Katz Award of the Australian and New Zealand Association of Medical Education, the Dr.Taro Takemi Award of the Harvard School of Public Health and the Prof. McLaren Leadership Award of the Asia Pacific Academic Consortium for Public Health.

Dr. Abeykoon holds Fellowships from the Colleges of Community Physicians, Medical Educationists, General Practitioners and the Medical Administrators of Sri Lanka. He has many publications to his credit.

Guru Printers - Thirunelvelly. 021 221 4777