Strengthening the Foundations of Health in South-East Asia

Selected Speeches by
Dr Uton Muchtar Rafei
Regional Director, WHO South-East Asia Region

Volume III: 2001–2004
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Strengthening the Foundations of Health in South-East Asia
Preface

This third volume of selected speeches delivered by Dr Uton Muchtar Rafei, Regional Director, World Health Organization, South-East Asia Region, between 2001-2004, completes the “trilogy”. The present publication covers the period till 29 February 2004, when Dr Uton completed his second term as Regional Director.

The speeches, delivered at various important national, regional and global conferences and consultations cover a wide range of health development issues and challenges. The speeches also provide a glimpse of the health priorities of Member Countries and WHO’s collaborative role in the Region.

For ease of reference, the speeches have been broadly classified into four areas and are presented chronologically. The title and venue of the meeting/conference as well as the period are indicated in the footnotes.
Control of Kala-azar

I have known Dr Thakur for a long time, not only during his tenure as the Minister of Health, but also as an experienced and immensely gifted scientist in the medical field. A gold medallist in MBBS, Dr Thakur has carried his academic excellence throughout his career as medical practitioner, professor and researcher. He is closely associated with the World Health Organization in the area of control of kala-azar. His contribution towards health development activities in India, and in particular in revolutionizing the concept of treatment of kala-azar is quite well known. Being a recognized international authority in the field of kala-azar, Dr Thakur is still supervising research on the disease in Bihar.

Kala-azar continues to be a major public health problem in the South-East Asia Region, especially in parts of Bangladesh, Nepal and in some States in India. Some decades ago, we had witnessed a gradual decline in the incidence of this disease, even to the point of its near eradication. The blanket spraying of DDT for the control of malaria had proved to be also effective for kala-azar control. According to 2001 estimates, annually, Bihar, West Bengal and Uttar Pradesh together contributed over 20% of the world’s estimated half a million cases.

With regard to malaria control programmes, I note with satisfaction that countries of the Region have undertaken critical assessments based on the Revised Malaria Control Strategy. The Region reports about 2.5 million cases and 4000 deaths due to malaria every year. In 2001 the economic loss due to malaria in this Region was estimated at 2 billion US dollars. Member Countries of the South-East Asia Region supported the global Roll Back Malaria initiative launched in 1998. They took it as an opportunity to work in partnership with all stakeholders to strengthen malaria control efforts. If the maximum benefit is to be derived under the Revised Malaria Control Strategy and the Roll Back
Malaria Initiative, the focus should be on populations in areas sharing common international borders, migrant populations, ethnic minorities, refugees etc.

The control of malaria and kala-azar is of great importance for improving the health and well being of the people of the Region. The World Health Organization aims to reduce the negative consequences of these diseases through cost-effective, sustainable and technically sound control measures, and by mobilizing resources for these activities. The Government of India play a decisive role in the control of these two important public health problems. High political commitment and allocation of sufficient resources, coupled with strengthening of the health system are keys to success. Of particular importance is the Government of India’s role in leading all stakeholders in the control of malaria and kala-azar.

Viewed in this perspective, the present work of Dr C P Thakur would be an important milestone in the control of kala-azar and malaria. His current work is indeed a worthy addition to his more than 100 research papers in medical journals and 200 articles. I am sure that this book on “Strategies for Control of Kala-Azar and Malaria” will inspire Governments, nongovernmental organizations, students and researchers to scale up kala-azar and malaria control measures.
The worsening malaria situation during the 1980s led the World Health Organization to declare control of malaria as a global priority. The World Declaration on Malaria in Amsterdam in October 1992 committed the Member States to the intensification of the control of this disease worldwide. Accordingly, the Global Malaria Control Strategy was developed with emphasis on the following key elements: case management, disease prevention, capacity-building for control, containment of epidemics, and basic and applied research.

A study group on Vectors for Malaria and other Mosquito-borne Diseases met in Geneva in 1993 and recommended that selective use of vector control measures and capacity-building deserve special attention.

The WHO Expert Committee meeting held in December 1999, recommended that WHO should assist Member States by developing guidelines for the management of pesticides used in public health. The Intercountry Consultative Meeting of National Malaria Programme Managers of SEAR held in Indonesia in November 2001, recommended that the national insecticide policy and guidelines for public health should be established in the context of Roll Back Malaria in order to promote and implement the safe and judicious use of insecticides. The meeting of the Global Collaboration for Development of Pesticides for Public Health (GCDPP) held in WHO Headquarters in May 2002 discussed the above priority activities and identified critical issues in public health pesticide management that should be addressed to improve such practices by Member Countries.

One of the critical issues in this respect is quality control of pesticides. According to the WHO Expert Committee, it is estimated that around 30 percent of pesticides marketed in developing countries for agriculture and public health use do not meet

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Selective use of vector control measures and capacity-building deserve special attention.

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internationally accepted quality standards. These pesticides pose a serious threat to human health and the environment, as they frequently contain hazardous substances and impurities that have already been banned or severely restricted elsewhere. Moreover, such pesticides could also result in wastage of funds because of lack of efficacy. Such pesticides often contribute to the accumulation of obsolete pesticide stocks in developing countries.

The objective of this Consultation is to promote effective management of public health pesticides as well as to assist ministries of health in Member Countries to develop national policies and guidelines and legislative means for such activities.

Regulations for the control of pesticide use exist in most countries but their enforcement is frequently ineffective. In addition, post-registration monitoring of insecticide use or application is inadequate in most countries.

Finally, I should re-emphasize that insecticides still continue to be the cornerstone of the control strategy for disease vectors. Decisions on the use of insecticides must take into account different components of their effectiveness with minimum side-effects on humans as well as non-target organisms and the environment. Vector resistance management should also be considered as part of the plan.

I hope this Consultation will review the prevailing practices of pesticide management in the Member Countries and help develop guidelines on the management of pesticides used in public health. We would also need to follow up with Member Countries to develop plans of action for implementing the guidelines.
Today, malaria causes severe morbidity in more than 300 million people and at least a million deaths worldwide each year. In Africa, malaria kills one child every 30 seconds; more than 500,000 children develop cerebral malaria, leaving approximately 7% with permanent neurological damage. Many who survive an episode of severe malaria may suffer from learning impairment or brain damage. In this part of the world, malaria is estimated to cause as many as 10,000 maternal deaths each year. Malaria has been estimated to cause 8 to 14% of all low birth weight babies and 3 to 8% of all infant deaths in areas with stable malaria transmission.

All countries in the South-East Asia Region except Maldives have indigenous malaria transmission. DPR Korea reported, after a lapse of many years, *P. vivax* transmission in 1997. An estimated 1.3 billion people or 85% of the total population of the SEA Region are at risk of malaria. Malaria cases declined from 2.9 in 1998 to 2.7 million in 2000, but the percentage of *P. falciparum* cases increased from 44.1% to 43.3% during 1998-2000. The rising trend of *P. falciparum* in the Region is a cause for serious concern, as all malaria deaths are attributed to *P. falciparum* malaria. While the malaria situation in Bhutan, India, Myanmar, Sri Lanka and Thailand improved in 2000, it deteriorated in DPR Korea and Indonesia (Java). There has been no significant change in trend in respect of the malaria situation in Bangladesh and Nepal. In 2000, India contributed 75% of the malaria cases in the SEA Region.

In Asia, where some of the most devastating resurgences of malaria have occurred, the disease continues to pose a serious threat to public health. Much of the malaria in South-East Asia is transmitted by forest-dwelling vectors, making vector control extremely difficult and also leaving

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Impact of Malaria on Human Health

large infected populations beyond the reach of basic health infrastructure. In Asia, as in Latin America, the small island countries (including Malaysia, Singapore, the Maldives, and part of Indonesia) have generally fared better in malaria control than their continental neighbors (including Myanmar, Bangladesh, and India), although Sri Lanka is an important exception, reporting high risk of malaria.

In many of the regions where malaria is endemic, the situation is becoming increasingly difficult to control. Parasite strains resistant to chloroquine, the cheapest and most common anti-malaria drug, have spread throughout Asia, Africa, and parts of South America. In South-East Asia, multi-drug resistant strains are spreading, posing a threat to all means of effective case management. In addition, the spread of insecticide-resistant vectors poses a challenge to epidemiological control efforts. While the development of an effective vaccine is still several years away, many poor countries with endemic malaria will have to cope with the available means.

Today, WHO reports that of the approximately 100 countries in which malaria is endemic, “over 90% have designed control measures in line with the Global Malaria Control Strategy (which replaced the eradication programme).” Each of these countries has achieved varying degrees of success, but all strategies involve some combination of vector control, reduction of human-mosquito contact and drug treatment.

Any contemporary control strategy faces a variety of challenges. Vector control strategies are hindered by the rapid development of insecticide-resistance by the vector. In addition, anthropogenic changes in the environment have sometimes had unintended effects on vector populations, causing man-made malaria.

Drug treatment strategies are hampered by inadequate health care infrastructure, poor distribution of drugs, the explosion of drug-resistant parasite populations, and inadequate self-treatment education of the community. Reduction of human-mosquito contact is hindered by the presence of poorly constructed dwellings, exophagic vectors and community non-compliance in bed-net strategies.

Malaria and poverty are intimately connected. As Nobel Laureate in Medicine T H Weller noted, “It has long been recognized that a malarious community is an impoverished community”. Weller could have said the same for malarious countries. Malaria is most intractable in some African countries. India too has a serious malaria problem.

Poverty is also geographically specific. Almost all the rich countries are outside the bounds of malaria risk. Take the 150 countries which account for over 95% of the
Communicable Diseases

Forty-four of these countries, or 29%, have intensive malaria. Thirty-five of these 44 countries are in Africa. Ranking the 150 countries by income per capita, all but three of the 44 countries with intensive malaria are in the bottom half of the ranking. Of the 119 poorest countries, all but 12 have some incidence of malaria. The richest 31 countries are entirely free of malaria. Not only are malarious countries poor, but their economic growth over the past quarter century has been dismal.

Better health reduces production losses caused by workers’ ill health. Diseases and conditions prevalent among the lowest income groups seriously affect productivity. Even a single day off work can seriously affect the family income, particularly among the poor.

Better health increases school enrolment and educability of children and therefore increases human capital. Children who are sick, undernourished or disabled are much less likely to go to school or to benefit from schooling. Iron deficiency anaemia reduces children’s cognitive function; they tend to have lower scores in class than healthier children. Girls are more likely to suffer iron or iodine deficiencies than boys and more likely to miss school. Poor health also affects girls’ school attendance because they, more often than boys, have to stay at home and care for sick relatives. This better health translates into economic growth by enabling children to enroll and stay in school and gain more from their schooling.

Better health releases resources previously spent on treating illness for other uses. The cost of medical care is a heavy burden on any economy and the gains from avoiding ill-health are high, particularly where a disease is expensive to treat e.g. multidrug resistant malaria.

Better health increases national wealth by making available natural resources. People whose livelihood depends directly on the availability of natural resources, like farmers, are vulnerable to the effects of pathogens that prevent them from using those resources. Conversely, efforts to make that land usable can result in important gains to the economy.

Most of the observations suggest that the greatest beneficiaries of investment in health appear to be the lowest income groups because they are more likely to rely on their physical health and strength to earn their livelihood. Thus, investment in health is likely to benefit development. This is also true for investment in controlling malaria which affects poor farmers in the neglected rural areas.

Failure to implement and sustain other control measures may mean that the initial gains from reducing transmission may not be sustained even in the face of continuing interventions. Therefore, there is an urgent
need for effective and affordable drugs and for expansion of access to treatment and optimization of their delivery to where they are most needed.

Although during the assessment of the global burden of disease by WHO for the years 1999-2001, it was estimated that in the SEA Region, DALY loss due to malaria (4 million DALYs) was lower than that caused by HIV/AIDS (10 million DALYs), the chronic impact of malaria will no doubt adversely affect economic development, particularly the livelihood of the poor. Therefore, it is more than justified to continue our fight against malaria.
It is perhaps natural to become nostalgic as one recalls the close, sustained and fruitful guidance that WHO received from the late Prof Ramalingaswami at global, regional and national levels. This close relationship spanned several decades and included diverse health-related fields. It ranged from basic medical sciences to research development to health laboratories to public health. This symposium is indeed a most fitting tribute to the memory of the late doyen. He had strived life-long to generate and disseminate knowledge in various disciplines of medical sciences. The presence of a large number of international scientists, who were influenced, in one way or the other by the teaching, guidance, cooperation and encouragement of Prof Ramalingaswami truly makes this a special occasion. I am sure that this symposium will provide new direction in our collective efforts to mitigate mortality, morbidity and misery for the teeming millions who inhabit the developing countries of the world.

The attainment of the highest level of health by all has been the cherished goal of WHO and its Member Countries. Ever since its inception, WHO has strived to promote health, improve access to health services and support the initiatives of its Member Countries in strengthening their health systems. It also encourages research to augment the quality of care. WHO has always advocated the centrality of health to overall development – a fact which is now being recognized globally by all development agencies and governments. We strongly feel that health is a fundamental goal for development as well as a means for accelerating and sustaining it.

In line with the contemporary scenario, the corporate strategy of WHO aims at

- reducing excess burden of diseases;
- promoting healthy life styles and reducing risk factors;

The attainment of the highest level of health by all has been the cherished goal of WHO and its Member Countries.
Strengthening the Foundations of Health in South-East Asia

- developing health systems that equitably improve health outcomes, and
- developing an enabling policy and institutional environment.

Of the various areas encompassed by these strategies, I wish to discuss a few that are of immediate concern and relevance to this distinguished congregation. These include medical education, research and development in medicine and the role of laboratories in ensuring quality of care. It is most appropriate therefore that these issues are being discussed at the All India Institute of Medical Sciences which is globally recognized as a centre of excellence in these subjects.

The World Health Organization has had a long and sustained interest in medical education. It has received an added thrust following the global initiative of “Health for All”. WHO considers human capital as the primary resource for health development since all the technology has to be delivered by people. It also makes good sense to ensure that human resources are fully developed as they consume nearly 60 to 70% of the health budget. As in other spheres of science, technology has assumed the driving seat in health care. It has, unfortunately, increased the cost of health services thereby pushing some of the vital services beyond the reach of millions. It is, therefore, essential to focus increasing attention on the responsiveness of medical education to societal needs and strategies for linking health services to medical schools as well as ensuring quality of care, especially to the deprived sections of society.

The research undertaken in various leading institutions should also become a tool in improving the overall health of the population. This will be possible only if research is undertaken in realistic field situations drawn from an understanding of the needs and demands of the community. In this context, the WHO South-East Asia Advisory Committee on Health Research (SEA-ACHR) has been guiding an agenda for comprehensive research in all countries of our Region to increase national capabilities for solving priority health problems and for promoting scientific approaches to primary health care. Prof. Ramalingaswami was one of the chairpersons of the ACHR. He was instrumental in providing new impetus to this Committee. During his chairmanship, as well as since then, the ACHR has played a critical role in orienting scientists towards the research needs that are most appropriate for our Region.

Health laboratories play a pivotal role in curative services and in the control of communicable diseases. They also contribute significantly in bringing to light some of the factors responsible for some noncommunicable diseases. There has been a growing awareness about their utility. I am confident that in the near future health laboratories will play a greater role in all spheres of health care. However, as you will agree, laboratory results need to be timely,
Quality assurance in laboratory testing is, therefore, of fundamental importance. In most developing countries the emphasis has been on improving quantitative infrastructure. The shift and emphasis on quality needs to be implemented urgently. Standards for various laboratory procedures have been established either at the national or at international levels by agencies including WHO and the International Standards Organization. National institutes and professional bodies can play a critical role in strengthening advocacy for quality. “Quality costs, but poor quality costs more” – that is the message we need to convey to national policy planners, health administrators as well as laboratory professionals.

Coming back to the theme of this symposium, what does the future hold for us? We now stand at the threshold of a new era. We need to address the assaults of disease-producing microbes. We should also recognize that many of the causes of our ill health are increasingly related to our lifestyles, habits and man-made changes in our environment. The ongoing epidemiological transition in the developing world warrants a heightened state of preparedness to fight many of the “old” diseases. We should be alert about the emergence of “new” diseases for which borders and geographical distances are increasingly irrelevant. We should develop effective mechanisms to counteract the onslaught of noncommunicable diseases.

Today, there is enough reliable data to show that nine of the 10 leading causes of death in the developed world are non-infectious in nature. Estimates made by WHO show that by 2020, cardiovascular diseases, depression and road traffic accidents will be the leading causes of death replacing pneumonia, diarrhoeal diseases and perinatal conditions. We have, therefore, to tailor our medical education, technological advances and research and development efforts to meet these changes and challenges. We also need to orient accordingly, our vast pool of skilled human resource.

I am sure this congregation of experts will ponder over these issues and develop the means and mechanisms to make sure that quality care is accessible to all sections of society. We all need to be active partners in the overall development of humanity. This indeed, would be a fitting tribute to the memory of Professor Ramalingaswami.
The Global Leprosy Elimination Programme is one of the recent success stories in the area of communicable disease control. During the short span of 15 years from 1985 to 2000, the global leprosy case load decreased from 10 million to less than one million. The prevalence of leprosy has decreased from 10 per ten thousand to less than 1 per ten thousand population. In addition, 107 out of 122 leprosy endemic countries achieved the leprosy elimination goal at the national level by the target date of December 2000. This was made possible due to the availability of an excellent tool – Multi-drug Therapy (MDT), and its effective implementation. WHO was able to provide free supply of MDT to over 70 countries, thanks to the donation of drugs from The Nippon Foundation from 1995-1999 and from the Novartis Fund for Sustainable Development, which has pledged the drugs from 2000-2005.

Due to various factors, the South-East Asia Region accounts for the largest share of global leprosy cases. The Region contributed 66% of the registered and 78% of the newly detected cases in 2001. These figures should not mask the achievements and efforts towards leprosy elimination in the Region. Seven countries have attained the elimination goal. Over 9.3 million cases have been cured. The number of deformed cases as well as multi-bacillary cases has drastically declined. As of December 2002, 14 countries are yet to achieve the elimination goal, of whom – India, Myanmar and Nepal – are from our Region. We are making all efforts to ensure that these countries will achieve elimination by 2005.

The achievement of the leprosy elimination goal in seven countries of the Region and the massive ongoing efforts in India, Myanmar and Nepal are a commendable example of collaboration between the Governments, WHO, several bilateral and multilateral agencies, international and national NGOs, service organizations and
community groups. Such collaboration need to be further strengthened in order to progress towards a leprosy-free world. In this context, the formation of the Global Alliance was a significant milestone.

In the past, many countries operated “vertical” control programmes for diseases like leprosy. However, in this era of declining leprosy and low-endemic situations in several areas, it is vital that leprosy services are fully integrated into the general health services. All countries in our Region have taken measures towards integration. India, Myanmar and Nepal will be implementing special activities to detect the remaining cases and progress towards elimination at the national level by 2005. Consistently high new case detection rates in some countries raise the question whether operational factors such as over-diagnosis, recycling of cases are responsible for this. Selected studies in India point to this possibility. Therefore it is important to develop a system to improve the quality and accuracy of diagnosis.

The countries which have achieved elimination at the national level have another goal to achieve – sub-national or district level elimination. This may prove to be more difficult and challenging. I would therefore urge GAEL and other partners to provide critical support to these countries, in order to progress towards sub-national elimination.

Even though much progress has been made in our efforts to eliminate leprosy, there are several challenges that need to be addressed. These are:

- Sustaining political commitment and mobilization of resources;
- Strengthening the capacity of general health services to provide quality leprosy services;
- Extending MDT to under-served communities and hard-to-reach areas;
- Adopting innovative approaches to effectively tackle leprosy in urban areas and metros;
- Further increasing community awareness;
- Establishing effective supervision, monitoring and evaluation systems;
- Devising a system to ensure the quality of diagnosis, and
- Providing the necessary care and rehabilitative services to those disabled or displaced by leprosy.

Finally, I would like to underline the fact that WHO sincerely appreciates and gratefully acknowledges the support of the GAEL partners, bilateral and multilateral agencies, national and international NGOs. Most importantly, we acknowledge the efforts of the officials, health workers and the community groups working relentlessly for leprosy elimination.
One of the cardinal features of hospital care is that it should do no harm to the patient. However, the fact is that many patients acquire infections while in hospital. There are many reasons for this. The invasive procedures on patients are being undertaken in greater numbers and with a higher degree of aggressiveness. This makes the targeted organs prone to invasion by micro-organisms.

The number of patients with immunocompromised status is increasing. The environment of the hospital gets worsened by an accumulation of a variety of micro-organisms which act as a source of infection. The micro-organisms endemic in hospitals are also resistant to most of the antibiotics since extensive use of these agents destroys the sensitive organisms thus permitting selection of resistant ones to perpetuate prolifically in the hospitals.

Hospital-Associated Infections (HAI) have been the bane of hospitals since the inception of hospitals as an institution for the healing of the sick. Despite rapid advances in therapeutics, diagnostics and a better understanding of the disease process, the problem of HAI persists throughout the world. Greater hospital-based care of immunocompromised patients and extensive use of invasive techniques have accentuated this problem.

It is well known that patients with burns, on ventilators and catheters usually contract serious infections while they are in hospital. The incidence of post-operative sepsis is also very high in the countries of this region. Even outbreaks due to resistant organisms have been frequently reported from various hospitals causing considerable morbidity, mortality and economic loss.

The incidence, type and magnitude of HAI vary from hospital to hospital, but it is estimated to be around 10% of all hospital admissions. HAI not only increase morbidity and mortality in patients but also...
cause considerable economic loss and an extra burden on health care facilities. For example, it is estimated that HAI account for a loss of more than US$ 40 million every year in Thailand alone. Given the prevailing conditions in hospitals in the developing countries, this figure is likely to increase. Hence, there is an urgent need to set up systematic control measures.

WHO has been striving to improve the quality of patient care at all levels. This was reflected in one of the resolutions adopted by the World Health Assembly in May 2002. Prevention of infection in hospital patients is one of the important components of patient care and safety.

Of late, there has been growing realization of the problem of HAI all over the world. As a result, many hospitals are constituting hospital infection control committees. Attempts are being made to institute surveillance mechanisms. However, not much has been accomplished. We realized that one of the reasons was nonavailability of practical guidelines to implement an efficient program for the prevention and control of these infections. Accordingly, WHO has developed practical and simple guidelines to assist Member countries in instituting efficient hospital infection control programmes. These guidelines encompass all steps to be taken in prevention, surveillance and management of hospital-associated infections.

I am sure these guidelines shall not only serve as a technical resource for hospital administrators, but will also be used as an advocacy tool to institute appropriate mechanisms to prevent and contain hospital-associated infections in the Member Countries of our Region.

The implementation of the guidelines requires extensive training of staff at different levels in hospitals. This demands development of a core group of trainers in all the Member Countries of the SEA Region. They can act as focal points for this emerging problem and also play a pivotal role in widely disseminating these guidelines, as well as providing technical support in their effective implementation. This workshop aims at training the trainers in implementing these guidelines. I am sure you will all benefit from the collective wisdom of this group and imbibe the training for effective utilization of these guidelines, thus helping to reduce the incidence of HAI.
Over the last 15 years, the South-East Asia Region has made remarkable progress towards leprosy elimination. This is reflected by the following achievement:

- Over 10 million of the 11 million people affected by leprosy have been cured using Multi-drug Therapy (MDT).
- Six countries of the Region – Bangladesh, Bhutan, Indonesia, Maldives, Nepal and Thailand – were able to achieve the leprosy elimination goal by the target date of December 2000. The remaining three endemic countries – India, Myanmar and Nepal – are expected to attain the goal by 2005.
- The prevalence of leprosy has declined by nearly 90% and the deformity rate among new cases has also steadily declined, particularly in India from 10% to 2%.

These achievements were made possible mainly due to effective implementation of MDT, through drugs donated to WHO by The Nippon Foundation and the Sasakawa Memorial Health Foundation from 1995 to 2000. We are fortunate that starting from 2000 and till 2005, Novartis has committed to donate MDT drugs to WHO for uninterrupted and free supply to every endemic country.

In our Region, leprosy elimination is yet to be achieved in India, Nepal and Myanmar. Our Region contributes 75% of the global leprosy case load. India alone contributes 66% of the global burden of cases. As of March 2002, there were nearly 460,000 patients under MDT in India and another one million new cases can be expected to be detected in the next three years. Against this backdrop, achieving the leprosy elimination goal by 2005, is a formidable task. The main challenges are:

The Region contributes 75% of the global leprosy case load. India alone contributes 66% of the global burden of cases.
To detect all the remaining cases of leprosy, within the next two years

To provide MDT to all detected cases

To achieve cure rates of more than 95%

To improve specificity of diagnosis

WHO is supporting Member Countries to tackle these challenges through well-developed strategies. These include:

1. Improving the accessibility of MDT by integrating leprosy services into the general health services. We should aim at making MDT drugs available at every primary health care centre and sub-centres. If necessary, we should enlarge the number of MDT centres by using private hospitals, and NGO clinics etc.

2. Increasing community awareness with the aim of promoting self-reporting of new cases, to mobilise family and community support to ensure treatment compliance and to ensure that cured leprosy patients are fully integrated and accepted in the community.

3. Establishing partnerships and alliances to mobilise and utilise all available resources within and outside the country. It is accepted that the Government alone cannot do everything. I recognize that one of the strengths of the National Leprosy Programme in India is the partnership among the Government, WHO and a large number of international and national NGOs who are assisting and supplementing Government efforts. The existing partnerships should be further strengthened and new partners invited to join our efforts.

It is most important to sustain an intensive partnership in order to mobilise additional resources for priority interventions including adequate MDT services, early case-detection and prevention of deformities. Our objective is the timely detection and treatment of leprosy patients leading to cure without deformities/disabilities. This means that trained doctors and other health staff at the primary health care centre should be able to diagnose and treat leprosy cases. Vertical leprosy staff should be absorbed in the general, health care system and retained for monitoring the progress of elimination at district and block levels and to provide technical guidance.

The WHO South-East Asia Regional Office has provided and will continue to provide the following support to NLEP-India:

- Uninterrupted and free supply of MDT drugs. Support to planning, management, capacity-building and monitoring of leprosy elimination through:
  (i) recruitment of Field Project Directors and State/Zonal Coordinators in twelve endemic States; (ii) Capacity-building of Chief Medical Officers,

- Support to Data Collection and Information System including Geographic Information System (GIS) through recruitment of Field Data Entry operators and supply of computers and equipment in every State/Union Territory.

- Support to Leprosy Elimination Campaigns in endemic states in order to promote case detection and enhance public awareness.

- Support to IEC activities through supply of the publication “Guidelines to eliminate leprosy”, in 13 Indian languages throughout the country and supply of posters and leaflets, and

- Support to holding of periodical review meetings of leprosy elimination activities in endemic states.

Our Regional Office will continue to support NLEP in these activities until India achieves the elimination goal by 2005. The thrust of future WHO support to India will be mainly focused on:

- The process of integration of leprosy services into the general health care system so that all suspected leprosy cases are diagnosed at health facilities close to the people, and

- Advocacy at all levels to enhance political and administrative commitment support.

I would like to take this opportunity to thank Mr. Yohei Sasakawa, Special Ambassador for the Global Alliance for Elimination of Leprosy, for arranging this very important meeting. I would like to assure you that the World Health Organization will continue to support the global, regional and national efforts in combating the problem of leprosy and to work towards a “leprosy free” world in the foreseeable future.
More than one billion people in 80 countries are at risk of lymphatic filariasis, with 120 million already infected. The South-East Asia Region bears more than 60 per cent of the global burden, with eight countries having been affected by the disease. Among these eight countries, India is the most endemic in the world, with 70 per cent of the regional burden.

The World Health Assembly, in 1997, urged Member States to strengthen activities for elimination of lymphatic filariasis as a public health problem. The Global Alliance for Lymphatic Filariasis Elimination was established as a free and non-restrictive partnership forum, and WHO serves as the Secretariat for the partnership. The first meeting of the Global Alliance was held in 2000 in Spain, where the Health Secretary from India was elected Chairperson. The meeting emphasized the need for closer collaboration between the partners in the elimination of the disease.

I am confident that this meeting will strengthen the commitment and ownership of affected countries to the goal of elimination, and garner continuous and increased donor support.

As you are also aware, two important strategies have been established for achieving the goal of elimination of lymphatic filariasis by the year 2020. The first is the interruption of transmission by mass drug administration (MDA). Diethylcarbamazine (DEC) and albendazole or ivermectin, are to be given annually, in all endemic areas, to the entire at-risk population. Alternatively, DEC-fortified common salt should be regularly used. The second strategy is the alleviation and prevention of disability caused by lymphatic filariasis.

WHO facilitated the free supply of albendazole from GlaxoSmithKline (GSK) and ivermectin from Merck & Company, for mass drug administration in endemic countries. As part of technical support,

Second Meeting of the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF), New Delhi, India, 2-3 May 2002.
training workshops were organized for programme managers on mapping of LF distribution and morbidity management. In 2001, the WHO South-East Asia Regional Office assisted in conducting mass drug administration (MDA) covering a population of about 18 million in Bangladesh, India, Myanmar and Sri Lanka. In 2002, all endemic countries of this Region have planned to scale up MDA covering a wider population of about 46 million.

In the light of recent experience, while many technical problems associated with the elimination of lymphatic filariasis have been solved, the commitment of the countries as well as partners is essential to achieve the goal of elimination. I am confident that this forum will sensitize local and national authorities, the Alliance and the international community to accord high priority to this disease.

WHO appreciates the commitment of the countries of South-East Asia especially India, where the disease burden is the highest. We are happy to note that the Government of India has included elimination of lymphatic filariasis in its National Health Policy.
We are meeting at a most critical period since the launch of the polio eradication initiative in 1988. In the next few months, the results of our efforts in northern India will determine the course of the initiative, not only in the Region but the entire world.

Over the years, as we are all aware, the Region has made tremendous progress. Reported polio cases declined more than 90% from about 35,000 in India alone in 1988 to 268 virus-positive cases in 2001. In 2001, our Region accounted for 57% of the global polio burden, down from 75% in 1988. Within the WHO South-East Asia Region, all of these cases occurred in India. Although the case count in 2001 was more than in 2000, indigenous poliovirus transmission has been successfully restricted to three endemic foci in the Northern States of Uttar Pradesh and Bihar.

Of the ten Member Countries in our region, Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand have been polio-free for more than four years in the context of good quality AFP surveillance. Bangladesh, Nepal and Myanmar have been polio-free for more than one year.

Most encouraging of all is the fact that the wild poliovirus type 2 was last isolated in October 1999 in Uttar Pradesh. Since then, through good AFP surveillance, we believe that this virus has probably been eradicated from our Region.

All Member Countries are continuing to implement the recommended strategies for polio eradication. India is moving into a very aggressive strategy of conducting high-risk response immunization in the three endemic foci between 4 March and end-April 2002, in order to break transmission. This activity will be supplemented by mop-ups, Supplementary Immunization Days and National Immunization Days, in addition to strengthening routine immunization.
AFP surveillance in the Region continues to improve. Sixteen of the 17 laboratories in the SEAR polio laboratory network are accredited by WHO. The polio laboratory network in the Region is second to none. It can provide results to the programme within 45 days of onset of paralysis, thus permitting timely immunization response.

It is against this background that the fifth meeting of the International Certification Committee for Polio Eradication (ICCPE) is being convened. Its objectives are:

- To review country documentation on polio eradication from Bhutan, Bangladesh, DPR Korea, Indonesia, Maldives, Myanmar and Nepal, and
- To review the ICCPE Plan of Action in SEAR and timetable for certification.

Your deliberations and discussions with the Chairpersons of the National Certification Committees from the countries represented here will provide clear guidance for polio-free countries and others on the information required by the ICCPE and the plan for achieving certification by the end of 2005, or shortly thereafter. The time is now ripe for ICCPE to play a proactive role and provide guidance to the programmes in these countries.
Less than six months ago, I inaugurated the 8th Technical Advisory Group on EPI here in Delhi. The theme of that meeting was how countries in this Region could improve access to and strengthen EPI through building on the polio eradication programme. The TCG signalled a new emphasis on vaccine preventable diseases and set the framework for the next five years.

The purpose of this meeting is to take the next step and develop or expand specific plans that will address critical health problems of our Region. As you know, polio eradication remains a major priority until the global polio-free status is certified. This, by itself, is a major challenge, particularly due to limited resources and competing priorities. However, as the TCG meeting noted, “The strategies and lessons learned from polio eradication can equally add value to the control of other EPI diseases, particularly in the areas of disease surveillance, service delivery, vaccine management and injection safety, data for decision-making, and improved communication.” The challenge for all of us is to build on the lessons learned and apply them to EPI, specifically to eliminating neonatal tetanus and controlling measles.

Since 1989, when the World Health Assembly called for the elimination of neonatal tetanus, 104 of 161 developing countries have achieved elimination. However, none of us can afford to be complacent. How can we, when more than 200,000 infants are still dying each year from neonatal tetanus? In South and South-East Asia, all 12 countries have made progress towards Maternal and Neonatal Tetanus elimination, but seven countries in the region continue to report Neonatal Tetanus - NT deaths above the elimination goal. Reducing deaths from NT is one of the simplest and most cost-effective means to reduce the neonatal mortality rate. However, because most of the deaths occur at home, neonatal tetanus is often called the invisible killer.

Countries that have not yet eliminated this killer must re-double their efforts so that we can all achieve the target of world-wide elimination by 2005. Countries that have already reached the target must maintain elimination status and share their successful strategies with their neighbours.

The second target for this meeting is measles. As you know, measles is a major killer of children in developing countries. It accounts for about 875,000 deaths a year. In 2000, an estimated 225,000 of those deaths occurred in countries represented here today. This makes measles the leading cause of vaccine-preventable deaths in childhood in these regions.

Failure to deliver at least one dose of measles vaccine to all infants remains the primary reason for high measles mortality and morbidity. Poor management, logistical problems, and missed opportunities for immunization are among the main reasons for the under-utilization of services and high dropout rates. I hope all these issues will be addressed during this workshop. For countries that do provide adequate primary coverage, the challenge is to provide a second opportunity for measles vaccination. Hence, this workshop will also focus on developing appropriate strategies to meet this goal.

Efforts to combat these two major vaccine preventable diseases must be addressed in the context of improving routine immunization programmes. A decade ago, Universal Child Immunization (UCI) was achieved with the help of massive social mobilization. The challenge before us is to rekindle the spirit of UCI through developing clear and concise strategic plans of action at both the regional and country levels. By mobilizing parents, partners, and health workers around identifiable targets of measles and Maternal and Neonatal Tetanus, we can serve to revitalize EPI and meet the targets originated by Universal Child Immunization.
The Regional Task Force was formed upon the recommendation of the Regional Ministers of Health after extensive deliberations on the present and possible future impact of the HIV pandemic, when they met in Maldives from 20 to 22 August 2001.

More than 5 million persons are living with HIV/AIDS in the South-East Asia Region of WHO, making it the second most HIV-affected Region in the world after Sub-Saharan Africa. The HIV pandemic is spreading at an alarming pace in the Region which is home to one-fourth of the world’s population. The pandemic can have grave social and economic consequences for the Region, unless timely action is taken to fight it. Hence, there is an urgent need to combat the disease with effective prevention and care programmes in the countries. However, there is still a window of opportunity for curtailing the spread of the pandemic and all efforts must be made to seize this opportunity.

Experience in the countries of this Region has shown that a number of prevention and care interventions can and do work successfully. Examples of successful interventions include ensuring blood safety, prevention of sexual transmission of HIV through condom promotion and use among targeted population sub-groups and effective management of sexually transmitted infections. All experiences, whether successful or not, should be shared among the countries of the Region and this will be one of the functions of the Regional Task Force.

Many of the successful interventions are being implemented on a limited scale — limited in geographical coverage or in population subgroups. They need to be scaled up and extended to cover entire countries, particularly to all vulnerable populations. However, that will require additional resources and lack of resources...
is a severe constraint in the implementation of national AIDS programmes.

The United Nations Secretary-General, Mr Kofi Annan, has established the Global Fund to fight AIDS, TB and Malaria to counter the lack of resources to combat these major communicable diseases. The Global Fund will provide additional resources to developing countries and is not meant to replace the existing resources. Although it was estimated that 7 to 10 billion US dollars will be required annually, only US$ 700 million will be available this year. The Transitional Working Group has met three times to deliberate on the functions of the Global Fund and has made recommendations on its title, scope, functions and governance. The Governing Board of the Global Fund is meeting next week to decide on these recommendations. The Regional Office has been sharing this information with the members of the Regional Task Force and will continue to do so in future.

The next important step is to develop sound country proposals for submission to the Global Fund. It is essential to prepare proposals on the basis of evidence collected from HIV and behavioural surveillance and experiences from interventions already implemented based on national priorities. This will require the establishment of various mechanisms in the countries, such as a technical working group to prepare the draft proposal. There is a need to also establish a multisectoral country coordination committee. WHO is willing to provide any support necessary to prepare the proposals as well as in implementing them. An important function of the Regional Task Force is to suggest measures for developing country proposals and for mobilizing resources.

In addition to database, all countries should have strategic plans for HIV/AIDS prevention and care. The strategic plans are not only required for identifying country policies, strategies and priorities, but will also be very useful for preparing the proposals for submission to the Global Fund. I would, therefore, encourage those countries which do not currently have the strategic plans to go ahead with their development. The national strategic plans will also contribute to the development of the regional strategies and regional proposals for mobilizing resources from various sources including the Global Fund.
Micro-organisms and their toxins have been considered as potent weapons of wars since long. Biological weapons have often been projected as the most cost-effective means of waging war. Use of various microorganisms are biological weapons, or tools of bio-terrorism, has become a harsh reality in the contemporary world. In fact, modern tools of molecular biology have the potential to provide genetically engineered bacteria of any variety to meet the desired requirements. Genetic alterations in these organisms can induce greater virulence, resistance to conventional prophylactic and therapeutic agents, ease of spread and higher stability even in adverse ecosystems, making them far more dangerous than what they usually are!

An international initiative against the use of biological weapons has resulted in a large number of countries formulating treaties against the use of these weapons. It is hoped that the civilized world will soon reach an agreement to prohibit their use.

In the recent past, easy access to potential bio-weapons and availability of technology to produce them on a large scale have attracted terrorist groups towards these weapons. Terrorists do not require the kind of infrastructure and sophistication needed to build bio-weapons for use against armed forces in hostile countries nor do they have the objectives of decimating the enemy. With the objective of attracting widespread attention and striking panic in a target area these terrorists can utilize possibly any biological material, which fulfils some of the criteria of bioweapons.

Any of the thousands of biological agents that are capable of causing human infection could be considered a potential biological weapon. Only a small number of these, however, can be cultivated and...
dispersed effectively so as to cause cases and deaths in numbers that will threaten the functioning of a large community.

Of the recognized possible biological weapons, anthrax is rated the highest since it carries large case fatality rates; can be rapidly transmitted by aerosols, its ease of growing in large quantities in the laboratory and its stability in the environment.

Various Member Countries have perceived the threat of bioterrorism using anthrax. WHO has received numerous enquiries from Member Countries seeking guidance about the consequences of its use and steps countries should take to prepare for such an eventuality. While it is difficult to predict, anticipate and plan activities against a specific attack of bioterrorism, it is expected that the Member Countries of our Region should have adequate epidemiological and laboratory infrastructure and skills to rapidly diagnose the causative agent and quickly initiate an effective control response. Accordingly, the capability against biological weapons and bioterrorism needs to be strengthened. Strengthening the expertise and infrastructure available in these institutes should thus augment the national capabilities to fight the menace of bioterrorism.

To meet this objective, WHO has organized this workshop to enhance the skills of the epidemiologists as well as laboratory professionals to manage suspected episodes of bioterrorism effectively. The Workshop will address various issues that are currently being raised in the light of the anthrax scare related to investigation and confirmation of diagnosis.

Since laboratory skills are specialized and vital, these must be maintained and kept in a state of readiness to provide the desired diagnostic services. By making the designated laboratories a part of an international network of external quality assessment scheme (IEOAS) managed by international collaborating/reference laboratory these facilities would remain active and efficient. WHO can play an important role in ensuring this.

We are happy that experts from SEAR countries namely India and Thailand and CDC Atlanta with years of experience in dealing with these pathogens, are here to facilitate this workshop.
I am sure this workshop will provide the participants an excellent opportunity to learn from the experts. It is an important step to contribute in the regional efforts against bioterrorism. All countries have experience in dealing with infectious diseases, and the necessary infrastructure to respond to their outbreak. However, as their knowledge on use of anthrax bacilli as a bioterrorist weapon has been limited, this workshop shall be an important step to prepare for such an eventuality.
The malaria situation in the South-East Asia Region has remained almost static in the last decade. In 2000, the SEA Region reported 2.6 million cases and 4,853 deaths due to malaria. An estimated 88 per cent of the population in the Region lives in areas with risk of malaria. Furthermore, the estimated 21.65 million cases of malaria and 27,177 deaths is worrisome.

The SEA Region has ten Member Countries of which eight have been endemic. In the past 3-4 years, DPR Korea too has become endemic leaving only Maldives as the malaria-free country in the Region.

*P. falciparum* is the killer parasite. It is increasing unabated and now affects 46.6% of the total malaria cases in the Region. *P. falciparum* has developed resistance to antimalarial drugs and now there are reports of chloroquine resistance in *P. vivax* also.

The Region is under threat of drug-resistant *P. falciparum*, a problem that has progressed from mono to multi-drug resistance. An estimated 400 million population is at risk of acquiring drug-resistant malaria.

Drug resistance enhances malaria morbidity and mortality, and increases the treatment cost. This has serious consequences on the health and well-being of the poor populations.

International border areas, mostly located in remote and neglected areas, have a high focus of communicable diseases. I am happy to note that the Member Countries have reached a consensus on common border health problems which need joint efforts by the countries concerned to resolve. There has been a major shift from mono to multi-disease approach for controlling border health problems.

An estimated 400 million people are at risk of acquiring drug-resistant malaria.

The malaria problem has been exaggerated by the economic crisis, prohibitive cost of insecticides, civil unrest, cross-border migration and breakdown of health infrastructure in some countries of the Region.
WHO has supported the control of border health problems by organizing bilateral and intercountry cooperation. Cross-border control of communicable diseases is being addressed by multi-disease surveillance through a focused, targeted and coordinated response at the district level. A plan of action 2002-2003 to control cross-border communicable diseases is under development at the district level by taking areas on both sides of the border as one unit.

Under the RBM Mekong Initiative, six countries are jointly addressing the cross-border malaria problem. WHO, in collaboration with Thailand and Myanmar, has agreed to jointly address the problem in the border districts through a multi-disease approach covering malaria, TB and HIV/AIDS. In partnership with the South Asian Association of Regional Cooperation (SAARC) and the Environmental Health Project (EHP), WHO has initiated cross-border control of HIV/AIDS, TB, malaria and kala-azar in 11 border districts of Bangladesh, Bhutan, India and Nepal. The problem of multidrug resistance in the sub-region is being addressed in collaboration with academic institutions, bilateral and multilateral agencies, NGOs and the media.

The Roll Back Malaria (RBM) initiative, which was launched in the Region in 1999, is showing progress. Member Countries have selected 23 districts for piloting RBM. The situation analysis has been completed. Guidelines for the implementation of RBM have been prepared and are under adaptation in the pilot districts.

A Technical Support Network (TSN) secretariat has been set up in the Regional Office. In cooperation with the Member Countries and research institutions, applied field research projects have been funded in the areas of transmission risk reduction (TRR); surveillance, information management, and epidemic response (SIE); and drug policy and resistance (DRP). This initiative is expected to encourage applied field research that will resolve problems faced by malaria control programmes and strengthen collaboration among experts within and between the countries of the Region and beyond.

Applied field research is strengthening malaria control in the Region. In the last decade, many new technologies have emerged to help control malaria. Selective and integrated vector control, insecticide-treated mosquito nets and geographical information system (GIS) mapping are being used to plan and monitor progress in the control of disease vectors. In many situations, examination of blood smears through microscope was a serious handicap in the early diagnosis of malaria and providing prompt treatment. The availability of a new technology, Rapid Detection Test (Dipstick), has emerged as a simple but very sensitive and specific tool in the early diagnosis of malaria. Progress has been achieved in the area of drugs to treat malaria. Artemisinin is a life-saving drug to treat severe malaria and artemisinin-based drug combinations is a
promising approach to control the spread of drug-resistant malaria. To further reduce mortality due to severe malaria, a manual on “Management of Severe Malaria in Small Hospitals” has been prepared by the WHO Regional Office. Rational use of drugs by health providers is being encouraged.

Medicine for Malaria Venture (MMV), has entered into an agreement with the Confederation of Indian Industry (CII) for the development of new drugs. MMV provides a mechanism for maintaining the supply of new antimalarial drugs to meet the public health needs in rolling back malaria.

RBM is an integral part of health sector development. Countries of the Region are undergoing health system reforms as a result of decentralization. District health systems are in the process of becoming the focal points for the delivery of all health programmes. This will involve the transfer of resources, delegation of authority to district or sub-district and empowerment of local authorities, partners and communities in decision-making to identify needs and priorities. Against this background, Member Countries have drafted a five-year strategic plan of action to roll back malaria. The Plan of Action 2002-2003 for implementation in the pilot districts is currently under discussion.

WHO and partners support the ACTMalaria training network of 11 Asian countries. I note with satisfaction that this network is filling the gap in capacity development, promoting communication, sharing information, and conducting training courses in malariology.

I wish to reiterate that we need to change our perception of disease control in public health. A rational approach would be a shift from single to multi-disease surveillance and targeted interventions. Cross-border control of communicable diseases is a step in the right direction. Furthermore, the importance of participatory attack in the control of communicable diseases, patronage of non-health sectors, lasting political commitment and resource mobilization should be underscored and nursed.

I believe the Intercountry Consultation will deliberate on the plans of action and research support to malaria control. Malaria continues to plague civil societies and, is a major obstacle in the social and economic development of the developing world. Therefore, the plans of action should reflect the realistic response of all partners in combating malaria.
We are gathered here at a critical juncture in the historic process of improving immunization services and eradicating polio. The entire global community has been working hard over the last decade to eradicate polio. At the same time, immunization coverage with other important childhood vaccines have fallen in certain areas. This has led to concerns of reemergence of a few of these easily preventable killer diseases. Also, during the same period, new vaccines have been introduced, gained widespread acceptance, and become cheaper. However, they still remain outside the ambit of many national immunization programmes. While all-out efforts aimed at polio eradication must continue unabated until all parts of the world are free from polio, we need to redouble our efforts for the provision of access to immunization against other childhood diseases.

Since 1988, when the World Health Assembly established the goal of eradicating polio, substantial progress has been made in all parts of the world. Much of this global progress is due to what has been achieved in the South-East Asia Region, where one-fourth of the world population lives. Between 1988 when the global campaign began, and 2000, our Region has seen a 98% decline in reported polio cases.

Since our last meeting in Yangon in May 2001, I am pleased to report that no new case of wild virus positive polio has occurred in any country of our Region apart from India. In India, intense transmission is limited only to the two states of Bihar and Uttar Pradesh. This means that while India has further accelerated polio eradication activities, Member Countries who have been polio-free for more than three years are still conducting supplementary immunization activities. This underscores the point that our task is not
complete until all the countries in the Region are polio-free.

The results of the accelerated strategies are most encouraging: from 29 wild virus positive polio cases in 1999, Bangladesh reported just one case in 2000 and none so far in 2001. And from 1,126 in 1999, India is down to 265 cases in 2000 and 114 so far in 2001. Most encouraging for India is the fact that from 192 districts with wild poliovirus cases in 1999, the number of infected districts has come down to 89 in 2000 and 37 so far during 2001. Much of this success can be attributed to the strong support received from senior government and health officials at all levels.

Despite this commendable progress, much, however, remains to be done. Pockets of children in large, crowded, urban slums and hard-to-reach villages still remain unreached and unprotected. Also, areas near international borders have increasingly become zones of endemic wild poliovirus circulation. In particular, the border areas between India and Nepal and between Bangladesh and Myanmar continue to be of concern.

Building on the success achieved in polio eradication so far, it is important to identify the key elements contributing to this success and apply them to improve access and quality of routine immunization against childhood diseases. A matter of concern is that not only have coverage levels of many EPI vaccines declined during the last decade, but additionally, adequate attention has not been given to monitoring the quality of immunization. Introduction of newer vaccines and safe injection technologies also merit serious attention.

During the course of this meeting, we will discuss technical issues that will have a bearing on the immunization programme over the next few years. In particular, we will need to arrive at a consensus on new and sustainable immunization strategies that should be implemented by Member Countries. This will be necessary to achieve and sustain the routine immunization programme in future.

The deliberations at this meeting will, to a great extent, determine the WHO/SEARO Strategic Plan for Vaccines and Biologicals for 2002-2005. To facilitate the free flow of views and ideas, the format of this meeting marks a departure from previous years. There will be many concurrent sessions to promote more intense participation of the representatives from the countries and other experts so that sustainable and practical solutions to the problem of improving the reach and quality of routine immunization can be found. Recognizing the importance of communication strategies, the first day is devoted to achieving better communications for immunization programmes.

Given the importance of using the lessons learnt from polio eradication, this meeting will be dedicated to building on polio to achieve sustainable immunization...
This is not to deny the importance of polio eradication, which will also be discussed.

I would like to take this opportunity to convey my profound appreciation to all the partner agencies attending these meetings. I would also like to thank all country health officials whose tireless efforts oftentimes go unappreciated.

WHO, on its part, will continue to provide technical support to the programme and further strengthen our partnership. This TCG meeting is part of our support to accelerate regional efforts.
Children in the countries of our Region continue to bear a disproportionate burden of communicable diseases due to their vulnerability, poverty and undernutrition. The most common preventable causes of deaths in children under the age of five years are diarrhoea, acute respiratory infections, measles, malaria and malnutrition.

A lot of progress has no doubt been made in the control of diarrhoeal diseases. As a result, the number of deaths due to diarrhoea has declined. In 1980, an estimated 4.6 million children under the age of 5 years worldwide died due to diarrhoea. By 2000, this figure had decreased to about 1.5 million. The countries in Asia can be proud of the successes but there are continuing challenges to be addressed.

Despite the progress, more than 90% of all deaths due to diarrhoea occur in developing countries, especially in children from poor families. Even though mortality has declined, diarrhoea continues to be responsible for high morbidity. Hundreds of thousands of dehydrated children are brought to health facilities daily, and this is a considerable strain on the limited health care facilities in the developing countries. There has not been much change in the causes leading to diarrhoea. Repeated episodes of diarrhoea aggravate the levels of malnutrition with adverse affects on growth and development.

Many countries in Asia are affected by emergencies like floods, cyclones, earthquake and civil strife. Asia has also been affected by cholera epidemics and outbreaks and several pandemics have originated in the countries of Asia. In the past, cholera was responsible for a large number of deaths. Thanks to the improved case management and the widespread use of ORS, the case fatality rate has been brought down. In most situations case fatality rates are well below 1%. Outbreaks of dysentery are
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common. Through a system of surveillance, this problem needs to be contained effectively.

The achievements in the control of diarrhoeal disease are a tribute to the scientists, public health and the communities. Asia can be proud of the discovery of oral rehydration salt or ORS. This was not only discovered here but also applied world-wide. The simple but effective fluid therapy and food advice have not only contributed to substantial reductions in mortality but also helped in improving the nutritional status of children. The widespread application of measles immunization during the last two decades has helped to control the disease and reduce complications of measles.

In the area of diarrhoea control and management, WHO has worked closely with Member States, partner international agencies and with collaborating centres.

It has promoted two complementary approaches, namely health services and research. In the early 1980s, the focus of research was on etiology and epidemiology. It showed that while diarrhoea is caused by a variety of different organisms, the causation does not influence case management or preventive strategies. With the exception of dysentery, the course of diarrhoea is not influenced by the use of drugs. The focus of research then shifted to improvement of case management and prevention. The partnership between research and programme in the control of diarrhoea is an example to be followed by other programmes.

The effectiveness and feasibility of a package of 18 preventive interventions for diarrhoea control was extensively reviewed. The findings have helped to identify the most cost-effective preventive interventions. These include promotion of exclusive breast-feeding during the first six months after birth, introducing complementary feeding at the age of six months with safe, good quality foods given in adequate amounts and continuing breast-feeding up to the age of 24 months. Prevention of diarrhoea is possible through adoption of safe water, hand washing and sanitation practices. The ongoing Research on vaccines is at present quite promising.

The policy of linking research to priority interventions, which will have maximum impact on the countries burdened maximally, is unique to the diarrhoeal disease control programme of WHO.

However, there has always been a concern that while the efforts to reduce mortality due to diarrhoea are successful, there is the risk of the child succumbing to other infections like pneumonia, measles or malaria. Therefore, in 1990, WHO combined the diarrhoeal disease and acute respiratory infections control programmes. In 1995, an integrated management of childhood illness (IMCI) strategy was developed. Children often suffer from more than one disease at the same time. It is necessary to treat the child as a whole and not merely for one disease. This helps early recovery, saves cost and prevents retardation of growth and development.
IMCI effectively combines treatment of all illnesses that a child could suffer from, together with preventive advice and through counselling by health care providers. This is the best approach to ensure the optimum growth and development of children.

The IMCI strategy is based on building skills of health workers at all levels of health care. It also focuses on strengthening of the health systems, ensuring the availability of drugs and supplies and improving the referral linkages. Most importantly, IMCI derives its success through improvement of family and community practices.

While a it has been achieved, there remain many challenges and unfinished tasks. The coverage of measles vaccination must be enhanced considerably to achieve elimination of the disease. Cholera vaccines, which are effective are now available. The vaccines can be used proactively to prevent cholera epidemics. Progress in the development of rotavirus vaccine has been encouraging and this may be applied widely in the years to come. Recent research shows that exclusive breast-feeding for 6 months helps in reduction in the incidence of diarrhoea. Policy must promote exclusive breast-feeding widely. The recommendations on complementary feeding will not only contain the problem of diarrhoea but will also help in the prevention of under-nutrition. Low-cost methods are available for ensuring safe drinking water. Hand washing practices should also be promoted extensively. Impressive work has been done in the development of new formulations of ORS which will ensure safety and not adversely affect its efficacy. Research in micronutrients, especially in the role of zinc and vitamin A supplementation are encouraging. There is a need for consensus and then wide application of these findings in the communities. Sustained reduction of diarrhoea requires an enabling national policy and commitment.

WHO will extend its wholehearted support in the control of the lethal combination of diarrhoea and malnutrition.
While today there are exciting possibilities of adding new vaccines in the immunization schedules for countries, there is also a real concern about maintaining the safety of injections.

There is now a growing body of published evidence that, worldwide, the overuse of injections and unsafe injection practices together cause an estimated 22.5 million Hepatitis B virus infections, 2.7 million hepatitis C virus infections and 98,000 HIV infections. Among unsafe practices, reuse of syringes and needles without sterilization is of particular concern.

Unsafe injections can result in inadvertent transmission of blood-borne pathogens and infections. This in turn would result in high costs on treatment and a drain on all resources.

The very high burden of disease associated with unsafe injection practices has been identified in the last ten years, on the basis of well-conducted epidemiological studies.

WHO and UNICEF have always recommended safe injection practices and have also supported research and development of equipment to make injections safer.

It is also known that over 95% of all injections given globally, are used as curative injections. It is important that we now emphasize on the rational use of injections. As today the frequency of injections is extremely high, this exposes large numbers of the population to the danger of bloodborne pathogen transmission.

Therefore, to address the issue of injection safety, there is need for national policies which cut across preventive and curative services, and protect the rights of the consumers.

It is thus significant that these two global meetings are taking place now.

The TechNet is a network dedicated to the strengthening of immunization services and the Safe Injection Global Network.
(SIGN) is a multidisciplinary coalition to achieve safe and appropriate use of injections worldwide. Both are coordinated by a WHO secretariat.

Technet was established by WHO and UNICEF in 1989 to enable experts from various organizations to meet and resolve important technical and operational problems of immunization services.

The SIGN alliance was established in 1999 to promote and provide technical support to achieve injection safety across the entire health sector both in preventive as well as curative care.

TechNet and SIGN, are good examples of coordination mechanisms that have effectively pulled together committed and competent experts in the field of immunizations and general public health. The success of these networks lies in their development of innovative solutions to overcome various socioeconomic, geographic, logistics and cost barriers in order to enable health systems to be more efficient.

The two connected annual meetings will address two very important issues:
1. Immunizations with traditional and new vaccines and
2. Safety of injections in preventive and curative services.

Immunization has considerably reduced infant mortality rates and morbidity in children and contributed to a decrease in maternal mortality rates over the years. Vaccination continues to be the most cost-effective and safe health intervention that reaches children and mothers. The success of various immunization programmes is also spurring vaccine research for several communicable diseases that are traditionally treated with drugs.

For immunization to have a significant public health impact, it is essential to reach coverage rates of 80% or more with safe and good quality vaccines. Unfortunately, coverage rates have been declining in the developing countries over the past several years, thus threatening to erode the gains already made. Low coverage rates reflect both weaknesses in the delivery systems and a decrease in resources.

The predominant theme of the TechNet meeting this year is to focus on sustaining coverage and examine causes of low coverage. A new dimension that we need to add to our discussions is the inclusion discussion on of financial sustainability in our as part of the planning and decision-making process. The challenge for developing countries is to optimise resources to improve the quality of routine immunizations and prepare for introduction of new and under-utilized vaccines such as Hepatitis B, Japanese encephalitis, yellow fever and rubella.

Technet will address four broad areas. These are (i) factors that influence coverage
including financial sustain-ability; (ii) vaccine management; (iii) vaccine wastage; and (iv) logistics. A special joint TechNet/SIGN session will address challenges presented by introduction of auto-disable syringes.

While all immunization injections are generally agreed to be necessary, injections in the curative services are not always essential. Too often, practitioners and the public rely on injections as an easy therapeutic recourse despite other, safer options being available. Unsafe disposal of used injection equipment adds further to the complex issue of health waste management. Therefore, to address the issue of injection safety, a national policy is needed that cuts across preventive and curative services, and protects the rights of the consumers.

Since the launch of the SIGN alliance there has been significant progress. More than 20 countries have now conducted initial assessments and formulated national plans of action. Tools are being developed to educate the community about the risks associated with unsafe injections and to instill safer practices in patients and health care workers.

WHO is very committed to these issues. Through global alliances, GAVI and partnerships with donors, WHO will continue to facilitate the programme, provide technical support and ensure sufficient resources. Globally and in our Region, WHO is committed to supporting the governments who have the primary responsibility to ensure that health services are safe and equitable.

South-East Asia is a region where unsafe injection practices, including injection overuse and reuse of equipment in the absence of sterilization are particularly common. By holding the TechNet/SIGN meetings in New Delhi this year, we want to give a strong signal to the region that we should fight complacency and work hard to achieve safe and appropriate use of injections. The Delhi meeting will facilitate the implementation of a regional plan, which has already started in a number of countries with initial assessments.

The challenge for developing countries is to optimize resources to improve the quality of routine immunizations.
Today, dengue/dengue haemorrhagic fever is the most important resurgent tropical infectious disease. Epidemic dengue haemorrhagic fever (DHF) emerged in South-East Asia in the 1950s. In the past 20 years, rapid epidemiological changes have manifested as a result of continued population growth, uncontrolled and unplanned urbanization, increased intercountry travel and other societal changes. All of these have created conditions ideal for increased transmission of multiple dengue virus serotypes in most tropical countries of the world.

Out of a population of 1.5 billion in the South-East Asian countries, nearly 1.2 billion people are at risk of DF/DHF. Over the past ten years, on an average 0.1 to 0.2 million cases and more than 1,000 deaths due to DHF have been reported every year.

A policy decision regarding surveillance is the urgent need of the Region. No country has been able to set up laboratory-based active surveillance. Passive surveillance does not help in the prediction of epidemics. The lack of infrastructure to respond early and effectively to control epidemics is also a constraint. The lack of timely clinical diagnosis and proper case management are other critical areas which prevent our physicians and health staff from bringing down the case-fatality rate to less than 1%.

In 1993, the World Health Assembly adopted a resolution urging Member States to strengthen their national programmes for the control of DF/DHF. In response to this resolution, the South-East Asia Regional Office developed a regional strategy for the control of DF/DHF in 1995. A technical meeting on the management of dengue epidemic, held in India in November 1996, developed guidelines to deal with the outbreak. In 1997, a bi-regional meeting between the South-East Asia and the Western Pacific Regional Offices of WHO was held in Manila to strengthen country collaboration between the two regions.
Following an external evaluation of Thailand’s national dengue control programme in March-April 1999, an initiative to control dengue to coincide with the 72nd birthday celebrations of His Majesty the King of Thailand was started. In June 2000, an external evaluation was carried out in Indonesia, which had experienced its largest outbreak of DF/DHF in 1998. The recommendations made by the mission are being implemented.

The First International Conference on Dengue/DHF, supported by the Regional Office, was held in Chiang Mai, Thailand, in November 2000. The Conference, which was attended by over 700 health specialists from 41 countries, adopted the Chiang Mai declaration on Dengue/DHF calling for the strengthening of efforts to control dengue in the new millennium.

WHO is greatly concerned over the DF/DHF situation in this part of the world. In 1998, India, Maldives, Myanmar and Thailand from South-East Asia, and Cambodia, Laos, Malaysia, Singapore and Vietnam from the Western Pacific Regions experienced epidemics of DHF. The disease continues to show increased incidence and geographical spread with more frequent outbreaks throughout the two regions. DF/DHF was reported for the first time in Bangladesh in 1999; subsequently, more than 4,855 cases and 85 deaths were reported in early 2000. Outbreaks were also reported from Maldives and, most recently, from Sri Lanka. WHO is closely monitoring the current DF/DHF situation in the endemic countries of the Region. We have alerted the Member States about possible outbreaks of DF/DHF this year.

This meeting is being held to further strengthen the regional strategies and develop strategic plans for prevention and control of DF/DHF. The objectives of this consultation include critically reviewing the current available tools for dengue prevention and control and to improve strategies based on the success stories in the Region; reviewing global and regional strategies in the light of regional experiences; developing a regional strategic plan for dengue prevention and control, and formulating recommendations to improve programme implementation.
The role of laboratories in facilitating various health care activities has grown considerably in the recent past, both in developed as well as developing countries. The emergence of HIV/AIDS and infections such as hepatitis B, C and E, which cannot be accurately diagnosed without laboratory tests, has highlighted the importance of health laboratories. Prevention and control activities for many diseases of public health importance can be planned realistically only if the exact magnitude of these problems is accurately projected based upon laboratory results. Early detection of epidemic-prone disease and useful surveillance also demand exacting support from health laboratories.

Health laboratories are expected to generate reliable results in order to support decision making as well as clinical and public health activities. Various factors influence the quality of the results. Apart from trained manpower and standard methodology, these include appropriate equipment as well as quality of reagents and kits in particular has assumed critical importance because of variations in quality. These also consume considerable amounts of scarce resources. The market for diagnostic kits in India alone is estimated to be $100 million per year. It is growing at a rate of 20 per cent per annum and, in the days to come, increased resources will have to be allocated for their procurement. Only a part of these diagnostic reagents is indigenously produced. Most of these have to be imported, which makes quality assurance a complex task.

In every country, a mechanism exists for regulating the quality of pharmaceutical products such as drugs and vaccines. WHO provides technical support to Member Countries in strengthening their regulatory agencies. International movement of vaccines has also been better harmonized. However, much needs to be done to develop

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*Intercountry Workshop on Policy Guidelines for Quality of Diagnostic Reagents, Jakarta, Indonesia, 8-11 May 2001.*
effective mechanisms that ensure the availability of quality reagents and kits for health laboratory services. WHO, with the help of experts, has brought out draft guidelines on quality of kits produced locally or those that are imported. The guidelines encompass legal, technical and administrative aspects and provide a strong base for assuring the quality of diagnostic reagents and kits.

This initiative by WHO brings together experts from the Region as well as from Australia and the United Kingdom. Their collective wisdom will help in finalizing the guidelines for use and adoption by Member Countries.
As you are aware, WHO, along with UNICEF, the World Bank, and the Rockefeller Foundation, is one of the co-sponsors of the International Vaccine Institute. WHO is pleased to acknowledge the progress made by the Institute since its creation, especially in the year 2000. In particular, we commend the establishment of a programme to accelerate the development and introduction of vaccines against cholera, Shigella and typhoid. We are pleased that IVI has joined the global training network as a training centre for good manufacturing practices.

We are also impressed by the disease burden studies of Hib, pneumococcal, and meningococcal meningitis undertaken by the institute. The programme areas of IVI continue to be relevant for the countries in Asia and the Pacific. These include training and technical assistance in vaccine production, provision of expertise in vaccine research and clinical trials, and field evaluations of new vaccines that provide evidence for making policy decisions by governments. IVI, as a global institute, is well equipped to carry out these tasks. The challenge is to clearly map out IVI’s inputs and fill the identified gaps. It is critical that IVI maintains an active dialogue between the countries, WHO, other participating agencies and global alliances like the Global Alliance for Vaccines and Immunization.

IVI should aim for greater convergence with other partners involved in immunization. Current capacity of IVI, is largely built up on experience and lessons learnt from work done in China, VietNam and Korea. IVI should expand the opportunities base and knowledge base through strengthened partnerships with collaborating institutes, NGOs and governments and the scientific community in other countries such as India, Bangladesh, Thailand and Indonesia.

Over the past few years, the capacity of the national control authorities has been

Annual Meeting of the Board of Trustees, International Vaccine Institute Seoul, Korea, 5-7 March 2001.
growing; production capacity has been increasing; laboratory networks have been strengthened and country-level coordination of funding agencies has improved. These critical elements lend themselves to achievement of the strategic objective of regional self-sufficiency. IVI is invited to be a part of this process and participate actively in the development and implementation of the regional vaccine policy in South-East Asia.

Immunization continues to be a very cost-effective health intervention that is equitable and reaches the poor. IVI has an important role to play in reducing ill-health and death due to vaccine-preventable diseases through timely technical support to governments and building capacity.

The Institute has the potential to develop into a centre of excellence in vaccine research and development that is accessible to the developing countries. It should include as its core principle, a commitment to identify, mobilize and develop technical capacity of the scientific community in the Asia and Pacific Region. IVI should build on the appreciable progress that has already been made in this direction.

In conclusion, I would like to say that WHO, through improved coordination at HQ and the regional level, is developing a complementary role with IVI. While WHO will play a normative role, IVI is well suited to perform more down stream activities through its established programme of work. Moreover, WHO and IVI are committed to support the long-term goal of regional self-sufficiency in access to quality vaccines, capability in vaccine research and ability to introduce vaccine based on sound evidence.
It is appropriate that the First Meeting of the Global Alliance is taking place in India. Now is the time for the final push towards elimination of leprosy. This meeting commemorates World Leprosy Day and is of special significance to India. Since it is the death anniversary of Mahatma Gandhi (Father of the Nation), who took up the cause of leprosy patients so passionately. I hope that the First Meeting of the Global Alliance will be able to provide clear direction and support to concerted and coordinated efforts towards the elimination of leprosy as our challenge is to eliminate leprosy from all remaining endemic countries before the year 2005. In the South-East Asia Region, vigorous efforts are needed, especially in the case of India, Myanmar and Nepal.

The goal of elimination of leprosy as a public health problem at the national level by 2005 has to be translated into action for achieving subnational targets of leprosy elimination. Specific efforts should be made including mobilization of additional resources. Fostering partnerships and receiving long-term commitment from partners is particularly important to ensure support for the full period covered by the plan. WHO is ready to work with Member Countries to develop feasible and realistic plans of action.

We have adequate supplies of Multi-Drug Therapy (MDT) drugs of proven efficacy and countries should ensure that MDT drugs reach each leprosy patient. We now need to develop the capacity of general health services in order to get their maximum involvement. The general health services should be able to deal with most situations, with support from specialists for supervision, referral, training and evaluation at intermediate and central levels. The primary ownership of leprosy elimination should be with general health staff, with specialized leprosy staff providing referral support. Close monitoring of the progress of leprosy elimi-
Communicable Diseases

At district level in high endemic countries in our Region like India, Myanmar and Nepal should be made a priority for the next five years.

To promote early detection and voluntary reporting of suspected cases of leprosy, media campaigns and advocacy need to be given great importance by all affected countries. They should be synchronized and coordinated. Well-designed, pre-tested information, education and communication (IEC) materials are key to informing communities of the importance of early diagnosis and prompt treatment with MDT, to prevent deformities. We need to get the message across that leprosy is curable with MDT, which is available free of cost at every health centre and health post in the community.

We also need to ensure that MDT is available everywhere, at a time convenient to the people, and not merely at the convenience of the health staff. By doing this, we will be able to create a positive image for the leprosy elimination programme. The involvement of the entire population, scouts, school children, community leaders and others is essential in order to reach out to all leprosy affected persons, including their families and communities.

I would like to express my gratitude and appreciation to the Government of India for having agreed to Chair the Global Alliance and for hosting the first GAEL Meeting. Their vision and leadership will provide the inspiration to move forward. I am grateful that the Government of India has also made it possible for the State Health Ministers from the seven important states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh and West Bengal to be present here together with their Secretaries, Directors of Health, and State Leprosy Officers. I do believe that this interaction with global experts will inspire our ministers and officials from the states, and make them realize the importance of their contribution towards global leprosy elimination.

I would like to assure you of the continued commitment and support of the WHO South-East Asia Regional and Country Offices to fulfill the recommendations of the Global Alliance. We will ensure that our support to the high endemic countries is enhanced.

MDT services will also be integrated and strengthened to ensure sustainability of elimination status in the low endemic countries of our Region, which have already achieved the target. These are, Bangladesh, Bhutan, Indonesia, Maldives, Sri Lanka and Thailand.

The challenges ahead are daunting, but together let us convert them into opportunities. Let us give our best today for a leprosy-free society in the near future. Together, we can prevent future generations from ever having to face the ravages of this disease, which has struck terror in mankind for thousands of years.
Strengthening the Foundations of Health in South-East Asia
Family and Community Health
Adolescent-friendly Health Services

Adolescents are no longer children but they are not adults either. This is a period of rapid transition as adolescents go through many physical, psychological, sexual and behavioral changes.

Adolescence is generally considered to be a healthy period. Consequently, adolescents, their parents and even health workers may not appreciate the importance of seeking treatment/guidance when the adolescents are unwell or at risk. The adolescents may also underestimate the seriousness of the problem and thus delay seeking treatment.

In reality, a large number of adolescents in countries of the Region face dual health problems – those associated with under nutrition, early marriage and child-bearing, and the lifestyle-related health problems – including STI, HIV/AIDS, obesity, substance abuse, violence, injuries etc. A large number of adolescents are out of school, are malnourished, get married early, work in vulnerable situations, are sexually active but lack the relevant information and skills for negotiating safer sex. Employable but unemployed, they are exposed to pressure to use tobacco or alcohol. All these elements have serious social, economic and public health implications.

Adolescent sexuality has an overwhelming demographic impact. In some countries a large proportion of marriages and first births continue to occur among adolescent women. Nearly 40 to 50 per cent of girls in some countries of the Region are married and become pregnant before they are 20 years old.

According to available data, maternal mortality is three to four times in the 15-19 year age group compared to the 20 to 30-year age group. It is clear that unless the adolescent age group is targeted with effective strategies, there cannot be a significant dent in the overall Maternal Mortality Rate in this Region. Unprotected

Regional Consultation on Adolescent Friendly Health Services, Bali, Indonesia, 9-14 February 2004.
adolescent sexual activity is also responsible for a significant proportion of STDs and HIV.

Despite the biological, public health and social significance of this phase of life, adolescent health has not received adequate attention until recently in many developing countries. All adolescents should be able to access promotive, preventive and curative health services relevant to their stage of maturation and life circumstances. It is quite clear that the currently available maternal and child health programmes, school health services or reproductive health services will not be able to meet the needs of adolescent health and development.

Adolescents need a safe and supportive environment that offers maximum opportunities for development, information and skills to address their health problems and to deal with their personal difficulties and conflicts effectively. It is well recognized that health care providers and health care services cannot meet their needs alone. However, they can help to create networks to maximize the required resources for adolescents. Adolescents need a package of basic health services tailored to meet their specific health needs. These include reproductive health services; counselling and voluntary testing for HIV and other STIs; mental health services and counselling. Since there is no magic menu, each country should develop its own package based on existing policy and needs.

For a variety of reasons, adolescents are unable to obtain the health services they need. To fill the gap, adolescent-friendly health services is a strategy recommended by WHO. This defines the essential service package, core values, quality standards, and a process of quality improvement. This strategy requires policy support, linkages with services for adolescents, participation from the adolescents and community support.

Although the dimensions of quality are similar for all age groups, for adolescents the two A's – Accessibility and Acceptability– are the aspects naturally equated with "adolescent friendliness". There is also a need for privacy and confidentiality, ensuring removal of legal restrictions and cultural barriers that prevent adolescents from seeking guidance and health care, to make adolescent-friendly health services successful.

Existing hospitals and health centres can be made adolescent friendly and expand their existing services to cater to their needs. To complement and extend coverage of government-run health facilities for adolescents, other channels could be made available. Community or youth centres, marketplaces and other settings can offer community extension services for adolescents. Schools offer a critical entry point. Workplaces can offer health education and advice to adolescents. Adolescents are much more likely to obtain the services they need through networking among existing service providers.
Policy makers will want to know the cost of providing adolescent-friendly health services — that is, the marginal costs that may be added to the existing health system. One of the main concerns is likely to be service capacity, as rapid expansion could be problematic. However, the price of NOT delivering such services also needs to be demonstrated.

Health workers need to be “friendly” but they also need knowledge and skills to deliver the required package. Clinical guidelines and treatment algorithms are recognized tools to assist practitioner decisions about appropriate health care for specific clinical circumstances.

I am informed that a beginning in this regard has already been made in the Region. The concept of providing targeted, appropriate and “friendly” services to cater to the needs of adolescents is increasingly being recognized. Four countries (India, Indonesia, Nepal and Thailand) have undertaken pilot projects for providing adolescent-friendly health services.

In some Member Countries, there are programmes which focus on specific areas like substance abuse, street adolescents, HIV/AIDS, school health and reproductive health. Although they have played an important role, much more needs to be done to expand and integrate them and to improve their quality.

To provide the support needed, operational research is required to focus on the underlying factors contributing to the development of the numerous inter-related problems facing adolescents. Poverty, violence, sexual exploitation faced by the adolescent girls, teenage pregnancy, family conflict and gender bias in many of our countries should be considered while developing and expanding adolescent-friendly health services.
Since the Regional Conference on Public Health, held in Calcutta in November 1999, culminating with the historic “Calcutta Declaration”, we have taken several steps to carry forward the contents of the Declaration. The declaration emphasized the need for strengthening and reforming public health education, training and research by networking with institutions for improving human resource development. To address quality issues and equivalence of educational programmes, Accreditation Guidelines for Public Health Institutions were developed at a Regional Consultation held in Chennai, India, in January 2002. Some Member Countries have already adapted the guidelines for their own programmes. The University of Padjadjaran in Bandung has conducted a short course on Emerging Themes in Public Health for participants from the Region. This helped a small number of regional institutions to discuss networking in public health.

I am happy that we are moving away from a narrow, biomedical view of public health towards a more comprehensive process of mobilizing local, state, national and international resources for better public health action. While basic requirements and resources for public health vary from country to country, there are common problems in public health that countries share. What is required is to identify objective needs at intra-country or intra-regional meetings and develop networks for promoting public health.

The terms, partnership, alliance, coalition, consortium and network are often used interchangeably. There appears to be little agreement on which term most accurately describes the different institutional arrangements. Partnerships and network can be considered the two ends of the continuum with alliances in between. Networking involves a large number of parties who share common interests in contrast to partnerships where there are fewer parties.

The health sector has been focusing on policy reform over the past decades. This has coincided with shifting ideas worldwide.
about the welfare state and the role of the public and private sectors in the provision of health care financing. Currently, emphasis has been made on the links between health and economic development. Recognizing economic integration as a key issue in the current globalization process, WHO has strengthened efforts to assist Member States to understand multilateral trade agreements, macroeconomic policy and their implications for public health. Public health educators should play a role in enhancing this process. The public health schools should prepare their graduates for the changing circumstances.

The Millennium Declaration adopted at the Millennium Summit in New York in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. The linkage of health to poverty reduction and long-term economic growth are much stronger than generally expected. Public health programmes in most countries need to pay more attention on interventions to prevent avoidable deaths due to many diseases and conditions.

One of the major barriers to implementing change in public health has been the time it takes for countries to adopt changes in the curriculum of health professional schools. A WHO Study Group on problem-solving education for health recognized that “most health programmes have little training in the wider aspects of health, with the biomedical and clinical training not matched by comparable training in relevant social sciences”.

We may broadly consider the public health programmes to include 4 core areas:

- Epidemiology
- Statistics and information systems
- Health systems management, policy and planning
- Behavioural sciences including health promotion and health education.

Keeping in mind the changing needs of the health system, the educational institution should make use of advanced information technology and provide flexible course to cater to the changing needs. Adopting a multi-disciplinary approach in academic programmes and expanded exposure to practice settings should be considered. With greater focus on educational experiences, overall learning outcomes of public health graduates can be expressed in terms of performance standards. These performance standards are also useful in determining whether the graduates have the knowledge, skills and value orientations relevant to the needs of the communities where they will be subsequently employed.

Each public health institution may wish to select a particular area of Public Health, or related science and to develop it as an area of excellence. Strengthening of public health institutions in a collaborative and informed manner will eventually reduce the costs and avoid duplication of efforts. Such regional initiatives will facilitate the use of our own institutions for student and faculty exchange programmes and for fellowships, in a cost-effective manner.
The last few decades have seen significant progress in health development. Unfortunately, however, maternal mortality continues to be unacceptably high. More than half a million women worldwide die every year as a result of complications arising from pregnancy and childbirth. In 1995, around half a million maternal deaths occurred globally, of which more than 30% took place in the South-East Asia Region.

In 1987, WHO, UNICEF, UNFPA, the World Bank and other organizations directly concerned with maternal health, launched the Safe Motherhood Initiative. Although strong commitment from governments and development partners in implementing many activities has been achieved, more efforts are needed to further reduce MMR and IMR as stated in the Millennium Development Goals (MDGs). These are: a reduction of MMR by 75% and a two-thirds reduction of IMR from the levels in 1990 by the year 2015.

In the Millennium Development Goals framework, two indicators have been proposed to monitor improvements in maternal health, namely: the maternal mortality ratio and the proportion of births attended by a skilled health care provider, with the target of 90% by 2015. The concept of the skilled attendant should be well understood, to allow effective implementation. We all need to ensure that the Millennium Development Goals to reduce MMR and IMR and improve maternal and newborn health are placed at the centre of national planning. A strategic plan for reducing maternal and newborn deaths is needed in each Member Country to provide the necessary direction in this regard.

One of the main strategies adopted by WHO’s Making Pregnancy Safer initiative is increasing access to skilled health care providers. The initiative, launched in 1999, focuses on what the health sector, in collaboration with other partners and
Family and Community Health

sectors, can do to ensure that all pregnancies are wanted, all women can go safely through pregnancy and childbirth, and all infants are born alive and healthy. A global movement for skilled attendance has been initiated by WHO in the last year, which identifies crucial partners who can help implement the strategy, defines their roles and responsibilities, specifies essential actions at various levels, and provides an accountability framework for care providers, governments, civil society, global international development agencies and WHO.

The principal health sector-related causes of high maternal mortality are the poor quality of and limited access to maternal and newborn services and non-availability of skilled birth attendants, and essential obstetric and newborn care. Maternal and newborn services must maintain the highest norms and standards. Recently, WHO has taken an initiative in this regard by producing guidelines, entitled "Managing Complications in Pregnancy and Childbirth", and "Pregnancy, Childbirth and Newborn Care: A Guide for Essential Practice". They include technical standards for maternal and newborn care at first referral care and primary health care levels, respectively. These guidelines were introduced to Member Countries for adaptation and use at a meeting held in the Regional Office in December 2002.

Most maternal deaths can be avoided if preventive measures are taken and adequate care provided. Factors that contribute to these deaths occur within the community and the health care system, and many of them are amenable to change. These factors, which directly cause or contribute to the problem, can lead to the identification of potential solutions as well as to draw attention to the problem of maternal mortality. In this regard, the maternal death review can be a crucial method and is a necessary part of maternal mortality surveillance, which is the ongoing process of identifying maternal deaths, collecting and analyzing information, and using it for action.

Currently, some Member Countries have initiated such activities, while some others have not. Since this initiative has the potential to improve the quality of maternal health care, as well as reduce maternal deaths, the WHO Regional Office promotes its wide implementation in Member Countries. This consultation has been organized to develop proposals for action and to facilitate implementation of the activity in Member Countries by assisting potential implementers.

In improving the quality of maternal and newborn health services, it is very important that relevant professional organizations, agencies and institutions actively contribute to this effort. Contributions could be in areas such as advocacy, policy development, medical and midwifery preservice and in-service training and financing of referral services. To be effective, these contributions
Strengthening the Foundations of Health in South-East Asia should be undertaken in collaboration with concerned government officials and institutions.

In order to achieve the targets set in the MDGs, including improving the quality of maternal health services, partnership among all stakeholders is crucial. Coordinated activities among programmes and players will provide more productive results. More collaboration should be sought among government institutions, professional organizations, development partners and NGOs. We hope that contacts developed in this meeting will be strengthened in order to improve the implementation of the maternal and newborn health programme in each Member Country.
Traditional Medicine is practiced in virtually all countries of WHO’s South-East Asia Region. Even in smaller countries such as Bhutan and Maldives the science and the art of traditional medicine has been practised through the ages. Traditional Medicine practitioners in the Region have provided valuable health care and have evolved with time. Some practitioners have received 5 year training in a university in the systems of medicine they practice and, from among them, a sizeable number have followed postgraduate courses. Others have learned through apprenticeship under experienced practitioners.

The unique knowledge found in this tradition should be nurtured and used by the countries for the benefit of their people. However, little in life is immune from the changes that flow around us today; Traditional Medicine too must adapt to the forces that mould and influence our lives. Traditional Medicine, in the 21st century, requires a delicate balance between competing forces if we are to continue to benefit from it.

Many traditional medicines are derived from plants. These plants have to be used in a sustainable manner to ensure that while the medicines continue to be available, there is a continuing supply of plants as well. The knowledge in traditional medicine emanating mainly from the community must be made freely available to benefit the community. However, it is important to ensure that there are safeguards so that it is not commercially exploited with no reward to the community.

The increasing popularity of traditional medicine means that there will be a greater demand. What we need to ensure is that this demand is fulfilled without exploiting the patient and the consumer. It is also important to see that traditional medicine practitioners are regulated as a profession. It is equally important to see that such regulation is not...
so rigid so that it excludes the practitioners without formal education who, after all, form a sizeable proportion of those providing the services.

The recently published WHO Traditional Medicine Strategy has addressed these issues and provides a comprehensive framework for countries to develop their traditional medicine sector. The strategy advocates the formulation of a policy by the state as the first component of developing traditional medicine. Such a policy would provide the basis for sound action. At present India is one of the few countries developing such a policy and it is a logical and welcome outcome of the centuries of traditional medicine in the country and state encouragement through the Department of Indigenous Systems of Medicine and Homeopathy. From a policy will flow regulatory and legal mechanisms that will promote and maintain good practice, safety, efficacy and quality of therapies and equitable access. A policy will also help to ensure sufficient financial resources for research, education and for training.

Safety, efficacy and quality is the second component of the WHO Traditional Medicine Strategy. This is especially important for herbal medicines which can be influenced by numerous factors during cultivation, harvesting, storage and preparation into herbal products. The future potential of traditional medicine appears to be mainly in the treatment of chronic disease such as Diabetes Mellitus, various types of arthritis and bronchial asthma. Here what allopathic medicine has to offer is not very satisfactory. Again coupled with the potential of traditional medicine is the challenge too; any treatment for these conditions has to be safe and as free from toxicity as possible, as prolonged treatment is needed. Most of the components of traditional medicine being derived from plants have a natural advantage in being less toxic. Efficacy is the other challenge; any treatment has to be better than what is available.

Access is the third component of the WHO Traditional Medicine Strategy. While precise data is not available, it is clear that a large proportion of the population in the developing world depend upon traditional medicine for their health care. It is important to ensure that this access to, and availability of traditional medicine will continue. With increasing interest from the developed countries, there will be a demand for the services in traditional medicine and for the medicinal products themselves. The substantial benefits that can accrue from this should be shared between the holders of Traditional Medicine knowledge and those who made it available; this involves the complex area of intellectual property and patent rights. As we are all aware, this is an area which is evolving rapidly and countries have to formulate policies appropriate to their circumstances.

The fourth and last component of the WHO Traditional Medicine Strategy is ensuring the appropriate and rational use...
of cost-effective treatments in traditional medicine. Irrational use of medications is widespread in most systems of medicine. This is a regrettable fact. Rational use has two aspects; the first is the selection of appropriate products in Traditional Medicine itself and their proper use by the practitioner as well as the patient/consumer and the other is in the use of these products in combination with medications from other systems of medicines. Rational use thus poses a major challenge in the areas of education and training and also in regulating the profession.

The extensive programme of the International Seminar addresses several issues that have been articulated in the WHO Traditional Medicine Strategy. Ayurvedic Drug Standardisation, which is central to quality of the products, is one of the key subjects to be discussed at this International Seminar. There will be extensive discussion on education in Ayurveda, both in the developing and developed world and the issue of accreditation of ayurvedic practitioners in foreign countries will also be taken up. The globalisation of ayurveda is already evident by the number of international participants; the issue itself will be discussed in a Symposium. Management of chronic diseases such as Diabetes Mellitus and Rheumatoid arthritis and their complications will also be discussed.

The Gujarat Ayurved University was formally inaugurated 35 years ago but had its antecedents from the 1940s with a College of Ayurvedic Studies. It has many Postgraduate and Undergraduate institutes within Gujarat and has expanded to include institutions outside Gujarat State as well. The most recent example of its spreading influence is the Memoranda of Understanding with institutions in virtually all the continents of the world.

The Institute of Post Graduate Teaching and Research in Ayurveda of this University has been a WHO Collaborating Centre for many years. After the recent world-wide reorganisation of collaborating centres, the institute is being evaluated again to be redesignated as a Collaborating Centre.

I wish this International Seminar, which demonstrates the vibrancy of Ayurveda in the 21st century, all success. I am certain that it will contribute towards achieving the objective of “Health for All”.
Strengthening the Foundations of Health in South-East Asia

Intercountry Workshop to Develop a Framework for Collaboration between RBM and IMCI, WHO/SEARO, New Delhi, India, 12-14 November 2002.

Every year, about 10.5 million children die before their fifth birthday, with the South-East Asia Region accounting for nearly 40% of these deaths.

This workshop has been organized at a very opportune moment. In the scenario where public health initiatives are confronted with increasing competition for resources from other sectors, the need for exploring opportunities for cost-effective implementation of interventions becomes imperative. I believe that building effective partnerships between programmes at the planning, implementation, and monitoring stages would not only be synergistic, but also result in the most efficient utilization of resources.

As you would be aware, the Integrated Management of Childhood Illnesses (IMCI) targets the five most common causes of childhood mortality. These are: acute respiratory infections, diarrhoea, measles, malaria and malnutrition. Frequently, a combination of these conditions is responsible for the largely preventable mortality in children below five. Every year, about 10.5 million children die before their fifth birthday. Countries in the South-East Asia Region account for nearly 40 per cent of these deaths.

The IMCI strategy has three components: These are: improvement of health provider skills; improvement in the health system, and improving family and community practices.

Dr Gro Harlem Brundtland, Director-General, WHO launched the Roll Back Malaria programme in 1998 to globally revitalize malaria control activities for reduction of malaria mortality. The major thrust of RBM activities in the Region includes enhanced diagnosis and management of malaria; transmission risk management; health system development and development of regional support networks. A major thrust of the strategy suggested for RBM is forging partnerships, community mobilization and scope for multiple interventions.

Countries from our Region report about 3 million cases of malaria and 4,000 deaths every year. Of these, the proportion of cases...
and deaths in children is not known. It is well documented that malaria contributes to the high prevalence of anaemia and malnutrition. Loss of school days due to the illness affects scholastic achievement.

I am concerned by the high prevalence of childhood illnesses and malaria, which besides weakening the individual, also retard the pace of development in our Region. These diseases usually afflict the people who are unable to access health services either due to high cost, or the distances and other social reasons involved. It has been documented that a significantly large proportion of curative care is provided by private providers, often at high cost. Often, the care provided may be inappropriate. We need to orient the health system to make it more responsive to provide services in an integrated manner. At the same time, it is known that even when services are provided, utilization by the community is low. This underscores the need to improve family and community practices that induce a better utilization of services.

IMCI and RBM have some in-built features that lend themselves to collaboration. Both programmes share the objective of reduction in mortality and burden of diseases in children, and also employ similar strategies. Health systems development, more meaningful involvement of families and communities, community-based interventions, drug policy and management, and forging partnerships are some of the elements of the strategy of both IMCI and RBM that are completely amenable to integrated implementation at country programme level. In addition, collaboration between the two programmes is logical, since the population they target is similar, and the same health provider delivers the interventions for both through the same health system.

I am happy to learn that both IMCI and RBM have recorded progress in selected Member Countries of the South-East Asia Region. As far as Roll Back Malaria is concerned, 24 pilot districts in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand have been identified. A situational analysis has been completed.

IMCI has been introduced in eight countries of our Region with relatively high infant mortality rates. These are Bangladesh, Bhutan, India, Indonesia, DPR Korea, Myanmar, Nepal and East Timor. IMCI has developed an 11-day course for training of providers at first-level health facilities and a 5-day course for basic health workers, tools for follow-up training and a district planning guide. A unique feature of the IMCI training programme is their focus on ‘hands-on’ training on build the skills of the health worker. In addition, a formal “follow-up” after training is built in to provide support to the workers in their real life work situations. The Child and Adolescent Health and Development Unit in the Regional Office has also developed tools for strengthening family and community practices related to child health.

I am pleased to inform you that SEARO has taken a lead in developing integrated
guidelines for doctors and health workers for managing priority communicable diseases in adults. These guidelines follow an approach similar to that of IMCI. I would suggest that the collaborative activities explore the possibility of introducing the algorithmic approach for management of malaria in adults also. This would go a long way in reducing the burden of malaria across all age groups.

The countries participating in this workshop have selected districts for RBM pilot projects and have introduced the IMCI strategy. The challenge before us is to identify and integrate implementation of areas common to both IMCI and RBM. Chances of success of collaborative activities would be higher if these were to be initiated in districts where at least one of the two programmes is firmly established. Collaboration is possible at several levels of the health care delivery system. These include introduction of community-based interventions, demand generation and influencing family and community practices, diagnosis and management of cases employing a common protocol at first-level health facilities, and adoption of common protocols for referral and case management at secondary and tertiary-level health facilities.

The framework for collaboration that emerges over the next three days will need to be field-tested in a few districts before it is recommended for large-scale adoption. The WHO Regional Office for South-East Asia would be happy to provide technical and other assistance to countries for field-testing the framework for collaborative activities between RBM and IMCI developed in the workshop. Additionally, WHO could identify opportunities and constraints and document the progress of implementation, and lessons learnt. The experience gained in the initial phase will lead to the development of a model that will encourage the expansion of RBM-IMCI collaboration in other districts/provinces.

It is important to realize that what is being proposed is not a new programme, but an initiative to optimize resources available for RBM and IMCI for achieving the targets and goals for malaria and reduction in mortality rates in children. While working towards the framework for IMCI-RBM collaboration, we must give cognizance to experience and evidence from other regions. I am confident that the expertise and experience of the participants would help us in evolving a framework for effective collaboration between Roll Back Malaria and Integrated Management of Childhood Illnesses that would not only be useful for countries in our Region but also provide a model for other regions.
During the past three decades, countries of the South-East Asia Region have witnessed global political and economic changes and their impact on the health of populations. Rapid globalization and liberalization, has brought about changes in the lifestyles of people of all ages. In our search for equity and social justice, disadvantaged, marginalized and vulnerable groups had assumed greater significance.

Sound macroeconomic policies and stable economic growth are essential for sustained investment in health. Health, welfare and economic growth are inherently interlinked. Our experiences in the Region have shown that improved health has contributed to economic growth. The importance of investing in health to promote economic development and poverty reduction, however, has not yet been fully appreciated. Economic gains should be accompanied by social welfare policies focussed on the underprivileged. Extending the coverage of crucial health services, including a smaller number of interventions, to the world’s poor could save millions of lives each year.

The Health for All (HFA) Policy endorsed by Member States in 1977 was a move towards integration of health and welfare. While the basic principles of HFA and primary health care are still valid, there is need for a change in orientation for achieving the goal. To this end, what is now needed is a new paradigm for health: a framework for new public health action, taking into consideration the current and changing economic, social and political realities as well as demographic and epidemiological profiles of the individual countries.

The World Health Report, 2000, has gone beyond the traditional goals and indices of health, and introduced “responsiveness of health systems” and “fairness in financing” as goals to be achieved.
Thus, these measures reflect the extent to which health and welfare are integrated into the health systems of countries.

Strengthening of health systems is one of WHO’s strategies along with reducing the excess mortality of poor and marginalized populations. In order to provide better services and protect the poor, a balance between the public and private sectors is considered essential. The current shift in health sector reform is more in terms of ‘demand’ orientation rather than ‘supply’.

The Declaration on Health Development in the SEA Region in the 21st Century made by the Ministers of Health in 1997 reiterates our faith in basic human rights in the attainment of the highest possible level of health, social justice and gender equity.

We are convinced of the central role of health; the inter-relationship between poverty and ill-health, and believe that people have the right to health information and education. In the countries of the SEA Region, the structure of health and welfare systems varies from country to country based on the political structure of the governments. However, the areas of concern in health and welfare are common to most countries.

It is a simple, yet sad truth that health and welfare services in many countries are, by and large, not adequately responsive to the needs of the poor and vulnerable. However, progress is seen in integrated health and welfare developments initiated by NGOs, governments, and universities. I will provide a few examples to illustrate these developments.

Considering the NGO assisted developments, the micro-credit Grameen Banks introduced in Bangladesh, support the most vulnerable segments of the population, particularly women and those without any collateral. One of Sri Lanka’s largest NGO’s, Sarvodaya, has demonstrated a sustainable health development programme through community participation. An eye hospital in eastern Nepal actively seeks incurably blind persons and assists them in social and economic rehabilitation. It should be noted that many of the health and welfare systems have been introduced by NGOs on a smaller scale.

Ayadaw Township situated in the central dry zone area of Myanmar provides an eloquent example of partnership between government departments and NGOs. This township received the Sasakawa Health Prize in 1986 for its successful health development activities. The Mongar district in Bhutan is another example of intersectoral action, where the project achieved total coverage in primary health care and received the Sasakawa Health Prize in 1996. Decentralization of central authority to the district health system seems to be one of the keys to its success. In Indonesia, Sasakawa prize was awarded to PKK, a family welfare movement for its countrywide contributions to community nutrition, and care of mothers and children of under 5 years of age.

Women’s groups in different Member Countries have raised awareness about gender violence. Their contributions to legal
reforms related to dowry violence and sexual abuse against women have been significant. The Women’s lawyers’ Association in Bangladesh, Kalyanamitra in Indonesia, and Saheli in New Delhi are a few of the NGOs who have successfully campaigned to prevent violence against women, that is, welfare for the women.

Government interventions in integrated health and welfare sectors are on the increase. WHO has been involved in facilitating these welfare activities in the countries of the Region, through advocacy and technical support to the health systems. “Basic minimum health needs” has been the concept promoted in all countries. Thailand is well known for its well-developed primary health care and welfare system and for the recently adopted “30 Baht scheme” for treatment of priority diseases.

Sri Lanka is well known for its success in health and education where the Government provides free health services and free education to all. Here, the private sector, has also contributed to the health care of those who can afford such services. The Government of Indonesia has embarked on ‘decentralization’ as the key to health sector reform.

In India, the Departments of Social Welfare, Department of Health and Family Welfare, and Education, and the AIDS Control Society have organized camps to provide health checkups, counselling for literacy classes and skill development for women from weaker sections in Delhi.

Academic institutes and universities have taken steps to improve health and welfare systems in different countries. At the WHO Collaborating Centre for Health Professions in Vellore, India, students are trained along with health education and promotion to facilitate the poor and marginalized to learn skills in basic carpentry, wood work and related skills to earn a living.

A ‘teaching district’ concept has been tried out in village development committees (VDCs) in Nepal. Primary health care principles were mooted by teaching institution with grass-roots level community participation. A revolving drug scheme has been successful in providing essential drugs, with community participation. There have been instances where university-based research studies have catalyzed changes in government policy, benefiting women. As a result of a university research study, working women’s maternity leave in Sri Lanka was doubled to 84 days with nursing break for mothers until the child is one year of age.

WHO has adopted a holistic approach to health and welfare activities in the larger context of sustainable development. In this regard the following provides some glimpses of such initiatives.
We have facilitated implementation of healthy cities in several Member Countries through community involvement, focus on poor and marginalized populations for better health, behaviour, environmental improvements and self-help activities. Such local area initiatives help to bring health closer to the people, thus promoting both greater meaning and sustainability to health action and, therefore, better welfare system for the people.

In so far as the Declaration on Public Health is concerned, the Regional Conference on Public Health organized by WHO in Calcutta is a notable achievement. The Conference concluded with the “Calcutta declaration”, which is well publicized in ministries and departments of health in the Region.

We are also in the process of establishing a network of public health institutions to facilitate implementation of these recommendations which are directly or indirectly linked to the development for further improving our welfare system for the people.

With regard to Human Resources Development, we have been in the forefront in advocacy for innovations in health personnel schools to introduce community-oriented education with community participation.

On the subject of Womens’ Health and Gender, we are committed to the promotion of gender equity and improving women’s health. Over the last two decades, there has been compelling evidence that there is a need to accelerate investments in women’s health. Women in the Region face immense odds because of gender discrimination. Through the development of tools and training, decision makers are assisted to analyze the effects of gender discrimination on women’s health and well being and to develop appropriate policy and programmatic responses for the overall welfare of the women.

Rehabilitation of disabled and displaced population forms an important part of our work. We work with both the ministries of Health and Social Welfare in formulation of policies for the disabled in implementing the UN Resolution of Equalization of Opportunities for the Disabled. The capacity of the countries in implementing community-based rehabilitation has been enhanced.

With regard to Essential Drugs, medicines have to be paid for either by the state, or the individual as an out-of-pocket expense. Often, this expense is beyond the means of the poor individual or of his or her family. Making medicines available and also ensuring their financing is difficult. Medicines must be made available on the basis of need rather than the ability to pay. A social health insurance scheme to which regular equitable contributions are made by members of society to take on the burden of catastrophic expenses when they occur is the best solution.

Another important concern is the health of the Elderly and Aging. The welfare of the elderly is a major concern with the emer-
gence of more and more nuclear families and the decreasing number of children. Hospitals in the future may have to increase the facilities for the elderly patients with chronic problems. Although several agencies have tried to do their best, the elderly still suffer a great deal from lack of effective coordination and integration.

In conclusion, I would like to emphasize the need for closing the gaps and inequities in health. We have to ensure basic health services to all, especially the poor, women and vulnerable groups. Based on our own experience and the report of the Commission on Macroeconomics and Health, I would like to stress the need for governments to adopt policies to increase investments for health. NGOs also should continue to expand their constructive role in integrating health and welfare activities.

The poor should be protected by risk pooling mechanisms and social insurance schemes. Specific interventions are needed for priority conditions with high burden of disease and greater risk factors. We should continue our endeavours to eliminate or eradicate specific conditions which will need massive economic investments. Member Countries should strengthen district health systems, empower communities, and develop appropriate human resources. We should also continue our efforts to provide a basic health package as a mechanism for universal coverage. Use of advanced technology in patient care needs to be rationalized to avoid exploitation of the poor. All of these activities will lead to the overall improvement in the welfare system for our people.

I am confident that this forum will provide an opportunity to review challenges in health and welfare systems development in the 21st Century and be able to discuss priorities and strategies to further develop, strengthen and integrate both systems. I am glad to know that the Symposium will discuss, interalia, priority research areas as well as, the impact of the private sector and recommend a framework for the development of health and welfare systems in future.
The countries of the South-East Asia Region face a major challenge from HIV/AIDS, TB and malaria. These problems are widespread and have had a significant impact on the quality of life of the people. It requires the broad-based participation of a large network and workforce to address them. Nurses and midwives, as frontline health workers with a deep knowledge of health and illness, have crucial roles to play in combating these diseases. It is therefore crucial that their potential to help address these important problems is fully utilized.

In addition, the resurgence of Tuberculosis further exacerbates the situation. The Region accounts for 30% of the world’s TB cases. TB is the most important life-threatening opportunistic infection associated with HIV in the Region and accounts for about 40 per cent of the AIDS deaths in Asia.

Moreover, the Region is also confronting the problem of a resurgence of malaria, which causes a heavy toll in both human and economic terms. There is also a heavy toll on the economy due to malaria morbidity in the Region. The spread of multi-drug resistant malaria has become a serious concern in countries in the Mekong Region. The Roll Back Malaria-Mekong initiative provides an opportunity to jointly plan and implement malaria control activities in the Mekong Region. WHO provides technical support to this initiative with a full time RBM-Mekong Coordinator. The countries have responded to the challenges by establishing a...
collaborative network for capacity building called ACTMalaria (Asian Collaborative Training Network for Malaria) with a membership of 10 countries that extends beyond the Mekong Region has been established for capacity building for malaria control among its members. Despite these developments, much remains to be done.

There is no room for complacency. Intensified and concerted efforts from all concerned individuals, health care professionals and organizations are needed to address the problems of HIV/AIDS, TB and malaria. Recently, the Global Fund to Fight AIDS, TB and Malaria has been established to support countries in these endeavours. Several countries of the Region are now receiving support from this Fund to intensify efforts to address these priority health problems. It is crucial that nurses and midwives are aware of this development and make themselves available to assist in the preparation of country proposals for support from the Global Fund.

I would like to stress that the nursing and midwifery workforce can offer a valuable resource for coping with the HIV/AIDS epidemic and resurgence of TB and malaria. By virtue of their numbers as well as their close and continuous contact with individuals, families and communities in times of health and illness, they are recognized as a significant force in support of national health development. They can contribute substantially to national HIV/AIDS, TB and malaria programmes. For example, nurses and midwives can be involved in the programme for TB treatment. They can provide counseling and care for HIV/AIDS patients and families as well as provide support at home to people living with HIV/AIDS. They can also initiate an awareness campaign for malaria prevention. The potential and significant contribution by nurses and midwives to HIV/AIDS, TB and malaria prevention, control and care therefore has to be harnessed for cost-effective health care.

The HIV/AIDS Unit in the Regional Office recently conducted a review of the role of nursing in HIV/AIDS care and prevention in the South-East Asia Region. The review showed that the role of nursing in HIV/AIDS prevention and care is presently minimal at all levels, particularly at the managerial level. The potential of nursing services and education remained largely unexplored and/or undeveloped. Furthermore, collaboration between nursing and the AIDS programme appeared to have no structure or formalised mechanism for planning, information sharing or developing a nursing component for the HIV/AIDS programme.

For nurses and midwives to make substantive contributions to national HIV/AIDS, TB and malaria programmes, nursing and midwifery services must be strengthened. Necessary support should be provided to enable their optimal contribution to these priority programmes.

I would strongly urge participants at this Consultation to critically review country
efforts in building capacity of nurses and midwives in response to the HIV/AIDS epidemic and resurgence of TB and malaria. We need to develop effective strategies for capacity building and greater involvement of nurses and midwives in these programmes. We also need to have a better understanding of the obstacles hindering their participation.

At this juncture, I would like to underscore that gender issues have a significant impact on the health of both men and women. Women particularly have been the victims of gender inequity in accessing health services. Special attention therefore has to be given to meet their needs. For example, statistics reveal that the incidence of TB is greater in men. But we need to scrutinize whether the incidence of TB in women is really less or is it because women do not come forward for treatment. Nurses and midwives, therefore have to advocate for the inclusion of gender perspectives in the planning and implementation of health programmes.

I am sure that the strategies you will recommend will be realistic and implementable in the regional context. This is important to promote and facilitate greater contribution of nursing and midwifery to these priority programmes. Your inputs will be instrumental for WHO to provide effective collaboration to countries in the Region in strengthening their nursing and midwifery education and services to help address these major public health problems.
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It is now well recognized that the attainment by all people of the highest possible level of health depends mainly on the effectiveness of health systems in respective countries. Improving performance by strengthening health systems of Member Countries is an important strategic direction of WHO. In order to achieve this, we need to develop human resources to cater to health care needs as well as manage the health systems. This institution provides an excellent facility for management education, training and research in our region. Our Member Countries have already used these facilities for short and long-term training programmes.

In the context of health development, management is a process of working with and through individuals and groups and using other resources to accomplish health system goals. Managers require technical, human and conceptual skills.

Technical skills deal with the use of knowledge, methods, and techniques, which are taught in all disciplines. However, human skills in making judgements and using effective leadership and conceptual abilities to understand organizational complexities and achieving objectives are rarely taught.

In the past, decisions about the use of health care technologies were based solely on their clinical safety and efficacy. Today, spiraling medical costs as well as the unique burden of chronic diseases has sensitized both the private and public sectors to the problems of scarce resources and competing interventions. These problems have made health care managers adopt additional...
criteria in making decisions on the basis of evidence, for cost containment.

In order to achieve the competencies required for a manager, the medical community needs to derive knowledge from non-traditional disciplines such as psychology, sociology, economics, law, politics and management science. The Institute’s profiles show an impressive number of staff members with varied qualifications and experience to satisfy these requirements.

I am aware that this Institute has been involved in and has supported some exploratory management interventions in several areas. These relate to HIV/AIDS, women’s health, child development, and water and sanitation, as well as tobacco control. These interventions have contributed to the provision of services in Rajasthan and other parts of the country and are in addition to the academic tasks performed by the Institute.

Some of the Institute’s training programmes are particularly relevant to WHO’s work in strengthening health systems. These relate to health sector reform, decentralization, human resource development, health financing and public private partnership.

As you may be aware, WHO has expanded its traditional concern for peoples’ physical and mental well-being by emphasizing elements of goodness and fairness. Our overall goals of ‘National Health Systems’ are good health, responsiveness and fairness in financial contribution. Progress on these goals depends on how health systems carry out their functions of service provision, resource generation, financing and stewardship.

I expect the Institute’s academics to critically analyse the ideas expressed in various reports on health systems and contribute to further developments in this area. In this context, networking of public health institutions within the country, as well as in the Region, would be one of the effective mechanisms for overall development in the field of Public Health. WHO is currently trying to establish this networking.
Over the last decade, there has been significant reduction in infant and child mortality. However, similar reduction in maternal and new-born mortality has not been achieved during the last few years. The maternal mortality rate continues to be very high in seven countries of the South-East Asia Region. In 1995, around half a million maternal deaths occurred globally, of which more than 30% were in the South-East Asia Region. More than 90% of the maternal deaths in this Region occurred in Bangladesh, India, Indonesia and Nepal.

The principal health-sector related causes of high maternal mortality are poor quality maternal and newborn services, with limited access to and non-availability of adequately trained birth attendants and essential obstetric and newborn care.

Monitoring and evaluation of maternal and newborn health programmes is crucial for providing information about their implementation, and for assessing the effectiveness and impact of interventions made. To ensure that appropriate corrective measures are taken, the requisite monitoring and evaluation tools cannot rely only on impact indicators such as maternal mortality ratio. Maternal mortality ratio cannot be measured frequently, and by itself, cannot provide information on the quality of and access to maternal care. The process and quality of care indicators, both quantitative and qualitative, must be incorporated into monitoring and evaluation system of maternal and newborn health care/services. Regular reviews and monitoring to improve the coverage and quality of maternal and newborn health services should become a routine practice in all Member Countries.

In monitoring progress towards achievement of the International Conference on Population and Development (ICPD) and  

In 1995, around half a million maternal deaths occurred globally, of which more than 30% were in the South-East Asia Region.
Millennium Development Goals for maternal mortality, ICPD + 5 recommendation was to use the proportion of births attended by skilled health personnel as a benchmark indicator. By 2005, in countries where the maternal mortality ratio is very high, at least 40 per cent of all births should be attended by skilled health personnel; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent.

The health sector strategy for reducing maternal and perinatal morbidity and mortality, the Making Pregnancy Safe Initiative, has given special attention to skilled health personnel assisting in every delivery. The importance of access to a functioning health facility for obtaining appropriate care for mothers and/or their newborns when complications arise during pregnancy, delivery or postpartum period has also been stressed. Access, as well as utilization and quality of these services should become an important part of the process of monitoring and evaluation of maternal and newborn health programmes.

It is important that the monitoring and evaluation system of a health programme is simple and integrated efficiently with other relevant programmes. This would facilitate integrated and consolidated action, and avoid overburdening health providers with duplication in recording and reporting. Hopefully, this consultation can be used as an entry point for integrating monitoring and evaluation of various priority programmes within the context of the prevailing health information system.

We hope that all participants will actively contribute and suggest efficient processes and mechanisms for monitoring and evaluation of accessibility, utilization and quality of maternal and newborn health programmes. It is hoped that this exercise will be followed up for implementation at the country level. Effective functioning of monitoring and evaluation of maternal and newborn health programmes will, in turn, provide information for effective implementation of strategic interventions. This would contribute to our endeavour in saving the lives of mothers and newborns.
During the past two decades, we have seen a steady decline in under-five and infant mortality rates. In contrast, the rate of decline in neonatal mortality has stagnated. The result is that neonatal mortality in many countries contributes to over 60% of infant deaths. Each year, globally, an estimated four million babies die before one month of age. Between 40 to 50% of these deaths occur in the countries of the South-East Asia Region. Here, more than 1.5 million babies die during the neonatal period and an additional one million babies are stillborn. This is an enormous and tragic wastage of human resources.

The decline in infant and under-five mortality rates is attributed to successes in immunization, use of ORT in the treatment of diarrhoea, standard case management of pneumonia, the vitamin A programme and improved nutrition status. The drop in neonatal mortality rates can be predominantly attributed to successful immunization of women during pregnancy with tetanus toxoid. However, unless special efforts are made to reduce deaths during the first four weeks of life, the pace of decline in infant and child mortality is likely to slow down.

According to WHO estimates, infections, including tetanus, sepsis, pneumonia, diarrhoea and complications of prematurity and birth asphyxia are the main preventable causes of neonatal mortality. A major concern is the high proportion of low birth weight babies in the countries of the South-East Asia Region. Almost 20 to 30% babies are born with low birth weight and 40 to 80% of the newborns who die have low birth weight.

This enormous burden of neonatal mortality and low birth weight requires priority attention in national policies on programmes relating to health and development.
The poor start to human life in the countries of our Region is attributed to low female literacy, insufficient empowerment and the low status of women as well as low family income. Among the poor there is an intergenerational vicious cycle of under-nutrition in females starting from birth.

Pregnancy occurs early, women have too many children, often with an interval of less than two years. Access to health care and utilization of such services available during pregnancy are unsatisfactory. The vast majority of births take place under unhygienic conditions at home without any birth attendants for 20 to 25% of deliveries.

Thus, there is very little access to essential newborn care and obstetric care to very large populations. The lack of health care during the post-partum period adversely affects the health of both the mother and the newborn.

During the last couple of decades, there has been a global consensus to strengthen safe motherhood and reproductive health programmes. These programmes have received significant attention in countries of our Region where the problem of high maternal mortality is alarming. During the last decade, WHO has advocated an integrated approach to pregnancy and child birth. The Integrated Management of Pregnancy and Child Birth (IMPAC) is a step forward in this direction. The Integrated Management of Childhood Illness (IMCI) strategy is also being implemented in all the target countries of the Region. There is no doubt that these integrated strategies are cost-effective approaches. However, neither IMPAC nor IMCI adequately covers the first week of life which is the most vulnerable period and which contributes to nearly two-thirds of neonatal deaths.

Both the mother and the baby are vulnerable. While an integrated approach is advisable, it is necessary to assign adequate priority to meet their specific needs. It has been believed, erroneously, that reduction in newborn mortality requires expensive technology and institution-based care. Evidence suggests that most neonatal deaths (except those caused by congenital malformations) can be prevented by cost-effective interventions which do not require sophisticated equipment, or highly technical training.

Studies have shown that an Essential Newborn Package can improve newborn health and lead to some reductions in mortality. This comprises a skilled attendant at delivery; provision for clean delivery; keeping the newborn warm using simple measures; early initiation of breast-feeding and continuation of exclusive breast-feeding; home visits by the health worker or a volunteer; and essential immunizations. This package of essential newborn care, which directly contributes to improved neonatal health, should be accepted as a part of national policy and made accessible to all newborns. An additional package of services to include reviving asphyxiated babies; supervised
Family and Community Health

Home care of pre-term and low-birth-weight babies and timely referral of sick and very low-birth-weight babies will lead to additional reduction in neonatal mortality.

National policy should recognize that improving newborn health is not merely reduction of neonatal mortality. Healthy newborns grow into healthy adults which help increase productivity and reduce considerable social and economic costs resulting from illness and disability. Evidence also shows that if newborns and infants survive, mothers are likely to space better their pregnancies. This helps them to improve their own health and that of their children. In addition, spacing of pregnancy reduces fertility as well as neonatal deaths.

The special needs of the newborn deserve appropriate attention at the highest level on a scale similar to reproductive health, child health and control of communicable diseases. This will strengthen, rather than erode, integration of services. An enabling policy should strengthen the health system by making essential services for the newborn easily accessible.

It will be important for the programme to build on what already exists. Proven cost-effective strategies should be strengthened, consolidated and expanded. This can be done by doing more of what is known to work, and, whenever possible, to do it better. Interventions like tetanus toxoid immunization and exclusive breast-feeding can be scaled up without any delay. It should be possible to introduce a newborn care component into the existing safe motherhood and child survival programmes. For example, if post-natal care for the mother and the newborn baby becomes as common as care during pregnancy, it will improve the health of both mother and the baby.

Policy and advocacy must be supported by mobilization of resources – financial and human. The thrust should be on mobilizing resources and more effective utilization of existing resources. The strategy should be to plan for sustained allocation of resources.

The intervention strategies, including the essential newborn package should be further refined. Collaboration with institutions and researchers is recommended to advance the state-of-art of newborn care. This includes a continued search for low, cost-effective strategies and also the need to increase the evidence base for better understanding of the cultural factors which influence the family and the community.

Since the issues relating to reduction in perinatal mortality are complex and an integral part of women’s health, success in
improving newborn health requires partnerships with other sectors dealing with women’s well-being and development. Ministries of health have to advocate speeding up of national developmental efforts directed towards increasing female literacy, women’s empowerment, reducing gender discrimination, delaying the age of marriage, improving nutritional status and reducing poverty. Family planning efforts, including the unmet needs of contraception should also be intensified. Closer collaboration and integration are needed to improve health care during pregnancy, birth preparedness and ensure delivery by a skilled birth attendant.

Professional and academic organizations have an important leadership role in improving health of the newborn. Professionals have the responsibility for maintaining high standards of health care. In addition, they can advocate for essential care of the newborn, recommend standards of best practices, assist in training personnel and undertake and support research to further refine such care. Professional associations should also strengthen the ties between obstetrics, paediatrics and public health for the cause of maternal and neonatal health.

WHO in the South-East Asia Region has intensively supported the initiatives on safe motherhood, reproductive health, and child and adolescent health including IMCI. The WHO Collaborating Centre for South-East Asia on Training and Research in Newborn Care at All India Institute of Medical Sciences has been actively involved in organizing various meetings on newborn health. It established a regional network. There is now an increased interest from donors and development partners in improving health of the newborn. WHO is committed to providing technical support to countries and to promote partnerships at different levels in this regard. WHO will also continue to advocate the importance of saving the lives of the newborn. The presence of various partners here in this meeting such as the Ministry of Health and Family Welfare, UNICEF, USAID, BASICS, SNL, Save the Children, DFID, CARE, JHPIEGO, JSI, the World Bank, PATH and other professional bodies, reflects their increasing commitment to health of the newborn.
Nursing and midwifery personnel constitute a significant part of the health care work-force. In the South-East Asia Region, large segments of our rural and urban populations rely on nurses and midwives for health care in communities, health centres, and hospitals and other settings. In many rural areas, nurses and midwives are the first and often the only point of contact for health care, and are the only health care providers available.

The significance of the potential contribution of nursing and midwifery to the health of the population is not always recognized or acknowledged. Those who do understand the contribution that nurses and midwives can make also know that their role could be further enhanced. There are many reasons why that potential has not been fully realized.

Countries across the world are beginning to appreciate the cost-effective, good quality health care support which nursing and midwifery can offer. At the same time they also see that the nursing and midwifery resource is in crisis. This is a global concern and indicates a fundamental and major health work-force management problem.

This crisis manifests itself differently in different countries. The causes often differ and therefore the solutions must also differ. This is a situation in which we need to “think globally and act locally”. Globalization has resulted, among others, in (1) free movement of health care professionals; (2) new demands by the community for different levels of technical expertise; (3) different attitudes and behaviours of health personnel; (4) increasing pace of change; (5) access to new knowledge and (6) use of new technology.

Given this scenario, no country can afford to be complacent. The effective management of the nursing and midwifery workforce can make an enormous difference in addressing these challenges.

In her address to the Global Advisory Group on Nursing and Midwifery in November 2000, the Director-General of WHO acknowledged that nursing and midwifery services are vital for effective health services. She called for a better understanding of the causes of the crisis and encouraged Member Countries States to respond effectively to this challenge.

Consequently, the World Health Assembly adopted Resolution WHA 54.12 (Strengthening Nursing and Midwifery) in May 2001. This Resolution urges Member States to ensure the recruitment and retention of a skilled and motivated nursing and midwifery work-force. It requests the Director-General, among others, to provide support to Member States in setting up mechanisms for enquiry into the global shortage of nursing and midwifery personnel as well as in their efforts to strengthen the contribution of nurses and midwives to the health of the population.

Presently, the crisis in nursing and midwifery personnel in the developed world has resulted in large numbers of unfilled nursing posts. Part of the solution for these countries is to offer career opportunities to nurses and midwives trained in developing countries, including those from our Region. While we could be a part of the global solution, it is crucial that, at the same time, we need to effectively work towards solving our own problems of nursing and midwifery shortage in the region. The people of the South-East Asia Region also deserve to have access to good quality and equitable health services.

Despite efforts over a few decades to strengthen nursing and midwifery in most countries of the Region, shortages and maldistribution of nursing and midwifery personnel as well as inappropriate skill mix continue. In some countries of our Region, there are more doctors than nurses. This has a negative impact in terms of ensuring equitable, accessible and appropriate care to all sections of the community.

The issues confronting the nursing and midwifery workforce in our Region need to be addressed critically and strategically. I believe that some of the root causes of the problem remain unaddressed - low pay, low status, poor working conditions, and in some countries, lack of sufficient sanctioned posts. These problems have increased as our nurses and midwives accept jobs in developed countries with more attractive remuneration and better career advancement.

Nurses and midwives alone are not able to address these issues effectively. Participation of other major stakeholders is crucial. Therefore, I have established this multi-disciplinary Advisory Group to provide a strategic lead in taking this work forward. We are very fortunate to have such an experienced group of people to develop a strategy to meet the needs of our countries and to ensure that the strategy is understood, supported and implemented at the country level.

One of the lessons that we have learnt over the years is that in order to enhance the contribution of nursing and midwifery, it
needs political will, advocacy and support from policy and decision-makers, as well as from the medical profession and key stakeholders. Even then, this will not be easy to achieve as it is never easy to change years of conventional thinking and rigid attitudes.

We are charged with shaping the health workforce of the future. The pace of change will not slow down while the demand for good quality, responsive and accessible health care together with a skilled workforce will increase. We owe it to the people of our Region to be ready to meet those challenges. This includes ensuring that countries have sufficient numbers of health personnel with the right knowledge, the right attitudes and the right skills available where needed.

The nursing and midwifery workforce must be developed within the context of an integrated strategic framework for human resources for health. It makes no sense to look at nursing and midwifery in isolation. In order to make a strong and full contribution to health improvement, nursing and midwifery must be considered as integral and important components of health policy, planning and operations of a country’s health system. For achieving this, we need to have the right health policies and systems in place at local level within countries as well as nationally and internationally. These are daunting challenges. I am confident that we will succeed.

Your work poses a real challenge – to find new and better ways to look ahead and describe how the nursing and midwifery workforce should be managed in order to improve the access to health and quality health care for the people of our Region. The strategies you propose must not only be visionary but also realistic and implementable within the context of South-East Asia Region.
Traditional medicine is now an important component of the global health care scenario; the majority of the people in Asia and Africa use it to meet their health care needs. Traditional medicine is supported by the rich biodiversity of medicinal plants that are available in these regions. In addition, there are a large number of traditional medicine practitioners in these communities which makes the service readily available to the people at large. Historical circumstances and cultural beliefs too contribute to the extensive use of traditional medicine.

The widespread use of therapies that are outside the scope of “Western medicine” is not limited to the developing world. Recent surveys have shown complementary and alternative medicines being used extensively in developed countries too. Hence integration, regulation and dissemination of information about these therapies is not only a regional but also a global issue.

WHO has been active in the field of traditional medicine for many years. In September 1998 in New Delhi, the Health Ministers Meeting of the South-East Asia Region resolved that traditional medicine should be included in the delivery of primary health care subject to their demonstration of quality, safety and efficacy. A WHO Traditional Medicine Strategy will be presented to the Cabinet in early 2002. WHO has provided normative and country programme support to Member States to help them to integrate traditional medicine into their national health care systems and to ensure its appropriate, safe and effective use.

Traditional medicine in the South-East Asia Region now faces fresh challenges. There is increasing commercialisation of what was previously an activity that was engaged in by individuals in some communities. The knowledge and the
resources that are embedded in traditional medicine may be extracted for exploitation without due reward to those who have toiled in the area. Medicinal plants may be harvested without thought of re-planting to ensure sustainability and result in shortages. The active chemical components of herbal remedies may be patented without due recognition of the communities that initially identified the plants.

With an increasing number of educational institutions in traditional medicine in our region, there is a need to regulate training to ensure that acceptable standards are maintained. In some countries, the preventive and promotional aspects of traditional medicine are being taken out of health care institutions and being offered to other institutions with or without suitable facilities.

It is against this backdrop that WHO has convened this consultation on Panchakarma. Ayurveda is the predominant system of traditional medicine in the Region and Panchakarma is one of the important therapies in it. The consultation will discuss and formulate work plans for guidelines in Panchakarma, in addition to making plans for a short manual on the subject.

Panchakarma is not limited to treating illnesses but is also used for preservation and promotion of health in healthy individuals. Its increasing popularity has meant that Panchakarma is now being offered in hotels, spas and as part of package tours for domestic as well as foreign tourists in the Region. Hence there is a need for guidelines and regulations on how Panchakarma should be done and with what facilities, to ensure that quality is maintained and the clients whether sick or healthy – receive appropriate service.

Efficacy is one of the central questions facing traditional medicine. By long use, traditional medicine has been acclaimed to be effective but in the current climate of appraisal of health technologies, evidence is needed for traditional medicine too. This consultation will discuss guidelines for research in Panchakarma and it is hoped that further research will be able to provide evidence of efficacy.

For this consultation we have invited experts from countries where Panchakarma is practised. Most of you are from academia, but we have invited some who are advisers to ministries as well as administrators. I hope that this mix of practitioners as well as regulators will be the right combination to develop the guidelines. It is hoped that these guidelines will help in regulation besides providing practitioners an example of desirable practices. Thus this consultation will help to promote the ideal practice of Panchakarma and ultimately enhance traditional medicine itself.

I hope that this meeting will ultimately help in promoting the appropriate use of Panchakarma in Ayurveda. WHO would be pleased to further collaborate with its Member Countries in ensuring the due place of traditional medicine in national health care systems in the South-East Asia Region.
Food Safety

Food safety is of crucial importance in our Region. The objectives of any national food and food safety programme should be to promote safe and nutritious food. It has been observed that food-borne diseases are widely endemic and large outbreaks are regularly reported. Therefore, food safety programmes particularly in the South-East Asia Region must attempt to protect the consumers, who are already subjected to a heavy burden of disease and malnutrition. In the face of such enormous demands, it is essential that food safety programmes identify and focus on key priority issues.

WHO has, over the past few decades, provided substantial technical and financial support to Member Countries to control food and water-borne diseases in the South-East Asia Region. This support has included the identification and collaboration on certain priority areas specific to each country.

Since 1992, WHO has worked with national governments to achieve greater focus on action-oriented themes identified by the ICN Declaration as key issues. Some of the issues related to food safety include:

- incorporating nutritional and food safety objectives and components into development policies and programmes;
- improving household security of safe food;
- protecting consumers through improved food safety; preventing and managing infectious diseases;
- promoting breast-feeding together with appropriate and adequate safe complementary foods, and
- promoting appropriate diet and healthy lifestyles, and assessing, analysing and monitoring nutrition and food safety.

Realizing the dangers of unsafe food at any stage of the food chain, and to ensure Safe Food for All, Member Countries have developed a strategy for addressing food safety across the Region.

Regional Consultation on Food Safety in the South-East Asia Region, WHO/SEARO, New Delhi, India, 8-10 August 2001.
Substantial progress has been achieved since then by Member Countries, most of whom have revised, strengthened or developed their food safety programmes and policies. As a reflection of their commitment, the strategies were adopted as a Resolution on food safety at the 53rd session of the Regional Committee. Recalling the World Health Assembly Resolution WHA53.15 relating to food safety, a global strategy has been drafted recently.

In developing countries an estimated 3.2 million children die each year from diarrhoeal diseases. Hundreds of millions more suffer from frequent episodes of diarrhoea and consequent impairment of nutritional status. Although it has been well documented that food prepared under unhygienic conditions is one of the common causes of diarrhoea, little attention is given to educating caregivers about food safety. Moreover, the increasing use of chemicals in agriculture and preservatives in food processing resulting in chemical contamination of food have added new concerns to health.

Despite the importance attached to the need to educate policy-makers, health authorities, consumers and industry personnel regarding nutrition, food security and food safety, only limited attention has been given in the plans of action of Member Countries to the strengthening of national capacity to implement such broad information, education and communication programmes. Training of administrators, inspectors and analysts is the focus of human resource development within the food control structure.

I would like to emphasize the public health impact of malnutrition and food-borne diseases that persistent hunger, malnutrition and diarrhoeal diseases remain perhaps the major causes of disease and death worldwide. In South-East Asia, many millions suffer each year due to an insufficient supply of nutritious, safe food and clean water.

It should also be noted that although in a majority of cases the causes of food-borne diseases have been traced to biological contaminants, the harmful effect of chemical contaminants must not be underestimated. Such problems can arise when unscrupulous food processors use non-permitted additives, such as textile dyes instead of permissible food colours, and non-permitted preservatives, such as boric acid or formaldehyde. Besides, you are also aware that almost at any stage of production, food can also be contaminated with foreign material that could be a physical hazard to the consumer.

Besides human suffering, food-borne diseases cause substantial economic losses. These include loss of income, manpower and food, increase in cost of medical care and decrease in tourism and foreign trade. Also, an adverse reputation in food safety can severely affect the economy of a country through restrictions on food exports and a consequent reduction in their value. Such a negative economic impact aggravates the vicious cycle of increased poverty and malnutrition.
In conclusion, I would like to emphasize the importance of food legislation in accordance with the Codex Alimentarius Commission or CODEX. Food legislation provides the foundation for national food safety programmes. It plays a pivotal role in directing the food-related control efforts of food inspectors. It informs producers and processors of requirements regarding production and processing methods and product standards. It meets the expectations of the consumer regarding the quality of food.

Most of the food laws addressing food safety in the Region have not been evaluated for their relevance and effectiveness. As a consequence, in some countries, the basic food laws have not been revised significantly since the 1950s. Food regulations and standards too have stagnated in some countries of the Region.

It is desirable that Member Countries commit themselves to a “comprehensive revision of laws, regulations and standards for improvement of food safety for their populations in accordance with the guidelines of CODEX.

Since the regional review on food safety conducted in 1998, new developments have taken place in countries as well as globally. It is time to review the current situation. I hope that on the basis of the ongoing situation analysis and current advanced knowledge on food safety issues, you will be able to revise, reprioritize and restructure your food safety strategies.
Over the past few decades, the countries of our Region have made considerable progress in reducing infant and childhood mortality. However, it is still high in some countries.

Acute respiratory infections or ARI, diarrhoea, malaria, malnutrition and measles continue to be the common causes of morbidity and mortality in children below five years of age in the developing countries of the world, including in our Region. At least three out of four children taken to health facilities, suffer from one or a combination of these conditions.

These illnesses are responsible for more than 70 per cent of the global deaths in children under five years of age. In our Region, about 3.4 million children, particularly in Bangladesh, Bhutan, India, Indonesia, Myanmar and Nepal die each year due to diarrhoea, pneumonia, malnutrition, malaria and measles. This represents about 40 per cent of the total under-five mortality, worldwide.

In most of the Member Countries, diarrhoeal diseases and ARI control, and EPI programmes are doing well. Though nutrition and growth monitoring are a priority, malnutrition continues to be high in many countries of the Region. Often a child brought to the health facility is suffering from multiple illnesses. But most of our health workers are only trained to diagnose and treat either ARI or diarrhoea or malnutrition. Therefore, there is the danger of their focusing on the most visible condition while overlooking some of the other potentially life-threatening problems. This is because health workers lack the requisite training to recognize that a child may need treatment for more than one condition.

Responding to this challenge, WHO and UNICEF have developed a new approach the Integrated Management of Childhood Illness (IMCI), Semarang, Indonesia, 4-15 June 2001.
Illness, or IMCI. This approach helps considerably in reducing infant and child morbidity and mortality. Many other agencies, institutions and individuals have already contributed to this initiative.

The IMCI approach has three components. Firstly, it focuses on improving the performance of health workers at first-level health facilities through training and support. It ensures appropriate treatment of all major illnesses and speeds up the referral of severely ill children. It also focuses on exclusive breast-feeding, immunizations and vitamin A supplementation, where necessary.

Secondly, it encourages devolution of responsibility to the district level and integration of the many services which have traditionally been provided separately. Technical support and guidance are also provided in key areas, such as improving the availability and supply of essential drugs, more efficient organization of work in health facilities, and improved supervision of health workers.

Thirdly, the IMCI approach envisages promotion of health, both at home and within the wider community. Appropriate mechanisms are being devised to create awareness among parents about what to do if their children fall ill when and where to go for appropriate help, how to look after sick children at home and the importance of following treatment advice.

The objective of this workshop is to equip relevant health professionals with the knowledge and skills required for the implementation of IMCI. The workshop is expected to enable them to perform as national managers, national training consultants and facilitators or course directors for training courses in their own countries and in other countries of the Region. This workshop will have a multiplier effect, and will benefit the whole Region.

The 11-day course will help to strengthen the skills of health facility staff. Presently, a large number of children are seen by basic health workers in the Villages. I feel very proud to say that ours is the first region to have initiated the development of an IMCI training package for basic health workers. In developing this training package, WHO has collaborated closely with CARE and the Government of India. The training of health workers at the village level will help in expanding IMCI services, besides improving the referral link between the first-level health facility and the community. This package has been adapted by India, Indonesia, Nepal and Myanmar for training their basic health workers.

Effective communication of key health messages to mothers and other care takers is an important element in managing childhood diseases. Therefore, in order to ensure better health and nutritional status of children, communication forms an integral and crucial component of IMCI.

Providing care for sick children, combined with interventions to keep them healthy, is an integral and essential part of primary
health care. Integrated management also means greater efficiency in training, supervision and monitoring. Wastage of resources is reduced because children are treated with the most cost-effective interventions. Furthermore, duplication in resource utilization due to overlaps in separate disease control programmes is reduced as a result of IMCI.

At present, WHO, in partnership with UNICEF and other international agencies, has started implementing IMCI in many countries all over the world. In the South East Asia Region, Indonesia and Nepal were both “first-use” countries, and have expanded IMCI activities to cover more districts. In addition, these countries will also enhance the level of health care services available to the community. Some of the other countries of the Region, namely, Bangladesh, Bhutan, India and Myanmar, are now in the process of implementing IMCI, while DPR Korea and Maldives are in the introductory phase.

This seventh intercountry workshop in our Region is being conducted for training participants from DPR Korea, India, Indonesia, Maldives, Myanmar and Sri Lanka. In addition, participants from other regions will also be trained in this workshop. On completion of this workshop, the participants are expected to provide assistance and advice on IMCI to their respective countries. They will also help in the training, adaptation and monitoring of the IMCI approach in the other countries of the Region.

The challenge ahead is to extend the benefits of this training, through basic health workers, to the unreached populations. Another major issue to be addressed is the provision of credible referral support.

IMCI has demonstrated its efficiency in greatly reducing childhood mortality and morbidity. The time has now come to take this approach to scale.
It is an honour to address this very distinguished and eminent audience and the proud new graduates of the All India Institute of Medical Sciences. Many of you, in the areas of your own expertise, have made excellent contributions to the development of knowledge and the advancement of science and technology in this country. However, amidst this galaxy of talent and expertise, the day belongs to those of you who are today embarking upon careers in medicine, and in the service of humankind.

AIIMS has an unquestionable reputation as one of the most prestigious medical schools in India. It can hold its own with the best medical institutions in both the developing countries as well as the developed world. The outstanding achievements of AIIMS alumni have brought this Institute international acclaim in the health and medical arenas. To be a graduate of AIIMS has always been a privilege, and an international passport in the world of medicine. The advancement of biomedical science and technology, and health care in this country in the last 50 years has now become synonymous with the progress of AIIMS.

We are just entering the new millennium. What is changing in the world of medicine and health? As societies evolve, so do patterns of disease. These changes partly result from advances in public health and medical care, and may also be perceived as a result of improved standards of living, nutrition, housing, and economic security as well as changes in fertility and other familial and social factors. During the first half of the twentieth century, infectious diseases dominated as causes of death even in the developed countries. Since World War II, a major shift in epidemiological patterns has taken place in the industrialized countries, with the decline of infectious diseases and an increase in noninfectious diseases as the primary cause of deaths. An increase in longevity has occurred mainly...
due to declining infant and child mortality, improved nutrition, control of vaccine-preventable diseases and treatment of acute infectious diseases with antibiotics. At the same time, starting in the 50s and 60s, the diseases of modern living such as cardiovascular diseases, trauma and cancer, emerged as predominant causes of premature death.

It is widely understood that the socio-economic environment is a basic determinant of the state of health of individuals and populations. With demographic explosion, developing countries have had to cope with growing needs for education, food and housing. At the same time many have had to face conflicts, unemployment, migration of large number of people to cities, degradation of the physical environment as well as globalization and trade issues. Developed countries have had a greater impact from lifestyle related diseases. Increasing levels of affluence have led to overeating, drinking and smoking habits. They also face an increase in pollutants, drug abuse and motor vehicle accidents, with a significant, negative impact on the health of these populations.

Today, the world is a global village. Events in one part of the world affect the health status of people in other parts of the globe. With rapid movement of large numbers of people by air, sea and rail, the possibility of disease transmission by travellers has increased. The health of all human beings is globally linked.

Yesterday’s Ebola or cholera outbreak ten thousand miles away may manifest itself today in the arrival hall of our local airport. With this possibility in mind, advocacy by international economic, political, and social justice bodies will be required to protect health around the world.

As we stand today in the aftermath of the Gujarat earthquake, we realize with admiration and relief, how the global community rushed to support national efforts to assist the people of Kutch moved by the enormity of the disaster. WHO also immediately consulted the State and local health authorities, and is assisting in disease surveillance to prevent epidemics, and has offered to support the government’s efforts to rebuild the health system there. However, the scale of the destruction compels us to improve planning to cater for emergency preparedness and disaster management of such magnitude.

The Alma Ata Declaration and Health for All goal represented an important step forward in international health and demonstrated the confidence reposed by the global community in the commitment of the WHO leadership in health. Control of tropical diseases such as malaria, filariasis, tuberculosis, onchocerciasis, leishmaniasis, schistosomiasis, helmintiasis and diarrhoeal diseases is of particular importance to the developing countries. WHO leadership in fostering wide ranging global partnerships and its technical advice in the eradication of smallpox and virtual eradication of
guineaworm disease, and poliomyelitis have been recognized as outstanding contributions to improve global health. Its initiatives in reducing nutritional deficiency conditions, chronic diseases control, defining human resource needs and health service financing have also been important for both developing and developed countries.

From the evolution of medicine and health in the world, we could say with conviction that many of the actions needed to reduce preventable diseases lie to a considerable extent outside the direct purview of the biomedical framework of genetics, medical care, public health and health promotion, but are more likely determined by social preconditions that are in the realm of human rights and justice. Paying attention to eradication of poverty and the reduction of the prevalent inequities in health care are now universally recognized as the necessary prerequisites to the advancement of health.

Let me next dwell for a moment on some of the salient aspects of development of human resources for health in general and medical education in particular. There is consensus regarding the urgent need to ensure the relevance and quality of human resources to suit the requirements of the health system and to address the changing determinants of health, to avoid imbalances in the production of professional human resources for health especially with regard to physicians, dentists, nurses and para-medical staff. In most developing countries, human resource development plans are in the process of being drawn up, and others are experiencing difficulties in balancing their human resources in terms of the overall quantity, distribution and the quality.

Doctors, of course, are at the apex of human resources for health, often providing the leadership in health teams, but medical education itself is facing new challenges. What is the role that medical education can play to meet these challenges? I believe that at both undergraduate and postgraduate levels it can function as an effective tool for producing doctors who would provide quality health care to the increasing population. An essential feature for achieving the goal of medical education is an enabling environment; by which I mean the conditions, circumstances and influences surrounding and affecting the education and development of students. Each of these should be analyzed thoroughly when responding to future challenges in medical education.

Progress in medical education should keep pace with the changing world of health and medicine. Nevertheless serious attention has to be paid to the merits and demerits of innovations in medical education. Relevance and quality should be the guiding principles for future development in medical education. I sincerely hope that the graduates of AIIMS who have had the opportunity of studying here, will fulfill their mission as products of an outstanding Institution.
WHO in general, and the South-East Asia Regional Office in particular, has had a long, productive and cherished relationship of close collaboration with AIIMS. Certainly, the fact that we are located in the same great city helps. But the reason for our partnership goes far beyond this. We recognize AIIMS as one of the most prestigious and eminent institutions in medical education, health care and in health research. Several departments within AIIMS have been designated as WHO Collaborating Centres where research on “cutting edge” issues is carried out in active collaboration with WHO. The expertise you hold in your portals is an invaluable resource to the entire South-East Asia Region and we have all benefited from this partnership over the years.

I can recall a few of the recent successful ventures in which we have collaborated. In medical education, your Centre for Medical Education and Research pioneered and served as the lead institution in the regional programme of using innovative research-based strategies for curriculum innovation. Now this has been adopted by many countries of this Region. Similarly, we have the initiative for cardiovascular health in developing countries which is an international partnership programme initiated by The Global Forum for Health Research and the World Health Organization. We are also working closely on a number of projects on nutrition. All of these will have a significant impact not only for AIIMS, and India, but for the entire Region, and in most instances, for the people of the whole world. We are very privileged to have your cooperation and I would like to thank you for all this.

WHO will continue to promote and support AIIMS in increasing the knowledge base in medicine and public health. We will continue to work with many collaborating partners, bringing together the health research capacity within countries, within other organizations and within public and private entities, and contributing to the effectiveness of regional and global health research efforts.

WHO will strengthen research capacity and support strategic research in key areas where gaps remain. It will work closely with WHO collaborating centres and national expert committees to ensure that scientific research undertaken there is of high quality and relevance.

Before concluding, may I once again congratulate you and wish you all success. As you walk into the real world, as responsible citizens, I am sure you will not only take advantage of the knowledge and skills that you gained here but will also remember to work towards the ideals and values of humanity with humility, compassion and caring for the less fortunate. I hope that you will continue to value the cardinal need to address issues of equity that you imbibed here in AIIMS. The leadership position that society bestows on you needs such reciprocity and you must be in the forefront of the challenges to bring about the essential changes in health and health care in this country.

Progress in medical education should keep pace with the changing world of health and medicine.
WHO’s South-East Asia Regional Office has been supporting nutrition research for many decades. The research has contributed substantially to policy formulation and action by governments, particularly in iodine deficiency disorders and vitamin A through nutrition interventions.

Besides taking stock of the research activities conducted in the last five years, this meeting intends to focus on a crucial issue of growing public health concern: the diet related chronic noncommunicable diseases (NCDs). It was believed in the past that noncommunicable diseases were not significant in developing countries. However, as a result of broad socio-economic changes including rapid urbanization, industrialization and the evolution of health services in both developed and developing countries, health and nutrition profile in recent decades have changed considerably.

The health status of populations in the Region is changing with economic advancement and the adoption of new urban-based life-styles and diets. For instance in urban areas, there are low levels of physical activity and exercise. Processed foods and saturated fats are being increasingly consumed and needs to be assessed, as they can be detrimental to health. The increasing consumption of tobacco and alcohol are an added health risk. The cumulative effect of these negative lifestyles is the higher occurrence of obesity and other degenerative disorders including coronary heart disease, diabetes mellitus and hypertension.

At present the prevalence of diabetes mellitus in countries of the Region ranges between 2.1-4.1 per cent in the adult population. In major urban agglomerates, the prevalence of diabetes mellitus is much higher at 6-12 per cent. Future projections indicate that each of the SEAR countries is facing the threat of a huge increase in the number of diabetics by the year 2025.

Nutrition Research
A recent report indicates that in Thailand nearly 20 percent of children aged 19 years or under are obese and 20-30 percent of adults are overweight. Recent surveys in India showed an alarming increase in the incidence of obesity during the last decade.

The growing burden of diet-related NCDs needs to be halted to avoid unnecessary loss of life and loss to the national economy in treating these diseases, which could be prevented at a lesser cost.

The 1992 International Conference of Nutrition, (ICN), called for strategies to counter diet-related health problems and to promote appropriate diets and healthy lifestyles. These would take into account both traditional and contemporary dietary patterns in their widest variation. The human requirement of essential nutrients should be considered to adequately meet the nutritional needs of practically all healthy population groups. ICN also called for sound epidemiological research to identify dietary risk factors for cardiovascular diseases as well as certain cancers.

This meeting and your decision to undertake surveillance, to develop strategies for control and prevention of diet related chronic noncommunicable diseases are very timely. You will be collectively creating a landmark at the beginning of the 21st century in addressing this crucial health problem of enormous magnitude.

This task of the Network needs to continue at an accelerated pace. The network has also the responsibility of linking with WHO collaborating centres in other regions with similar interests for better understanding of global nutritional problems and ways to minimize them through learning and sharing experiences with them.

Although our ability to influence the course of nutrition research is limited in financial terms, the WHO is well-placed to play a catalytic and sensitizing role on important nutritional issues in the region and in promoting and supporting research. The Organization can also act as a facilitator to encourage multilateral and bilateral agencies to increase their allocations for nutrition research in the Member Countries of the Region. Currently, WHO is supporting countries to improve their technical and managerial capacities to detect, prevent and manage malnutrition through the application of cost-effective approaches linking research to the implementation of programmes.

I would like to reaffirm that WHO/SEARO will continue to support the Network’s role in identifying key areas for action to address regional nutritional problems in order to achieve a better sustainable health and nutrition status for the people of the Region.
Traditional Medicine

Traditional medicine plays an important part in human health care. It is the sum total of the knowledge, skills, and practices based on the theory, beliefs, and experiences indigenous to different cultures used in the maintenance of health as well as in the amelioration of diseases.

Ayurveda as a system of traditional medicine in India, has received great importance for centuries. It is now used also in other parts of the world. There is a rich resource of other traditional medicines and practices in the countries of South-East Asia. This is supported by extensive bio-diversity in medicinal plants used in traditional medicine. In addition, a large number of traditional medicine practitioners are available for health care. Despite this, traditional medicine does not have primacy of place in our health care systems.

At the meeting of the Ministers of Health of WHO South-East Asia Region held in New Delhi in September 1998, the Ministers strongly emphasized that these resources should be used more effectively in the delivery of primary health care. They stated that there was a need to include traditional medicines, subject to the demonstration of their quality, safety and efficacy, in national health programmes. I hope that this meeting will take up this challenge and provide innovative approaches that will help us to derive the maximum benefit from Ayurveda.

The wide acceptance of traditional medicines by countries of the South-East Asia Region is a very positive factor for their use. However, the danger is that this could also encourage the use of unproven medicinal plants and traditional practices. Also, as several medicinal plants become scarce due to eco-destruction, there have been cases of substitution of effective plants by non-effective ones. It is extremely important to standardize plant products being used in traditional medicine. It is also important to

study the sociocultural influences in the use of traditional medicines. These are some of the issues that need your attention.

The world over, there has recently been an enhanced interest in traditional medicine. This has brought both expectations of economic benefit and dangers of exploitation. It is increasingly important for our scientists and administrators to understand the implications of intellectual property rights regulations on the use of plants. We certainly need to take steps to protect these remedies used for generations in our countries. The challenge is to find the correct balance between economic gain from the worldwide demand for herbal remedies and, at the same time, protection of our biodiversity.

There is also a need to discuss the regulations governing the use of traditional medicines and any changes needed in the regulatory process to ensure efficacy, quality and standardization of our traditional remedies.

With the tremendous expansion in the use of traditional medicines, worldwide, the safety and efficacy as well as quality of herbal medicines and traditional non-medication therapies have become important concerns for both health authorities and the public. In addition to the safety and efficacy issues, studies relating to the protection of knowledge, attitudes and practices of traditional and indigenous medicine have been receiving increasing attention in the international agenda in recent years. The Council on Trade-Related Aspects of Intellectual Property Rights, or TRIPS, of the World Trade Organization has just started the revision of article 27 – 3(b) which deals with patentability of traditional knowledge.

Developing countries are repositories of large resources of medicinal plants. In the past, these resources have been freely exploited by multinational corporations by converting them into products of commercial value, mostly without paying compensation for the knowledge which was transferred along with the material. At the Convention on Biodiversity held in Rio de Janeiro in 1992, members accepted the principle that bio-resources are the sole property of sovereign States and that they have the freedom to use them as tradable commodities. However, most countries in the developing world have not so far legislated to implement the resolutions passed at the Convention. It is necessary to invoke bilateral and multilateral agreements on the basis of accepted norms for the transfer of indigenous germ plasms used for research and development or for commercial production.

There has been a substantial growth in the international herbal market in recent years. It can be noted that the vast majority of plant resources, giving rise to biodiversity, are found in or originate from developing countries. It is recognized that traditional knowledge plays a key role in the protection and sustainable use of biodiversity.

Access to plant resources and the associated traditional knowledge can provide substantial benefits to companies...
Strengthening the Foundations of Health in South-East Asia

and research institutes in both developing and developed countries. There is concern that knowledge of traditional medicine is at times appropriated, adopted and patented by scientists and industry, with little or no compensation to the custodians of this traditional knowledge and without their prior informed consent. This is a trade issue, as knowledge of traditional medicine and products derived from such knowledge often cross international borders.

The need to protect the traditional knowledge and to secure fair and equitable sharing of benefits derived from the use of biodiversity and associated traditional medicinal knowledge have been fully recognized. At present, existing conventional patent law protection requirements of novel and inventive products do not seem to be applicable to knowledge that is "traditional" in nature. There is no agreement as to how and what would be the most appropriate and effective way to achieve protection of Traditional Medicines in developing countries.
Sustainable Development and Healthy Environment
Strengthening the Foundations of Health in South-East Asia
The South-East Asia Region of the World Health Organization continues to be affected by natural disasters and complex emergencies resulting in a severe impact on the health situation of the affected populations. Estimates suggest that 38 per cent of the persons affected and 57 per cent of the persons killed by natural disasters during the last decade were from South-East Asia. Rapid industrialization and urbanization are taking place in the Region, where large groups still live in poverty, while armed conflicts continue to affect several countries. The result is a complex environment with a potential for severe consequences on the health of the population.

These disasters have resulted in loss of lives and suffering as well as economic hardships for individuals and the community, besides having an effect on the national economy. These emergencies also represented major challenges for the governments and the civil society, and tested their level of preparedness and ability to cope with large-scale disaster situations.

Governments alone cannot respond to these emergencies. In order to successfully resolve these situations, WHO must work closely with partners, such as agencies of the United Nations, the Red Cross and Red Crescent National Societies, the International Federation of Red Cross and Red Crescent Societies.

Taking into consideration these situations and WHO’s technical expertise and capacity to interact with ministries of health in designing policy, it would be highly beneficial if we are to establish a framework of cooperation between IFRC and WHO/South-East Asia Regional Office through the Memorandum of Understanding that we will be signing today.

Together, WHO and IFRC will identify areas where ministries of health and the Red Cross and Red Crescent National Societies can collaborate.

Fifty-seven per cent of the persons killed by natural disasters during the last decade were from South-East Asia.
WHO/SEARO and IFRC will consult each other, at least on a yearly basis during the next three years, and discuss matters of common interest. The following areas of collaboration have been jointly identified:

1. Preventing and controlling communicable diseases, including HIV/AIDS, in the most affected countries of South-East Asia.
2. Promoting voluntary non-remunerated blood donations, in order to contribute to safe blood supply.
3. Enhancing collaboration in the preparedness and response phases to all types of emergencies, natural and complex disasters.

We see the signing of this MOU as an opportunity to use the comparative advantage of each institution so that support can be given to ministries of health in responding to the demands imposed by these events in our Member Countries. We look forward to seeing the fruitful results of this joint cooperation in the very near future.
Noncommunicable diseases or NCDs including cardiovascular diseases, cancers, chronic pulmonary diseases, diabetes mellitus, and other chronic conditions are becoming the leading causes of mortality, morbidity and disability in the South-East Asia Region. In 2001, they accounted for 50 per cent of deaths and 42 per cent of the disease burden measured through the disability-adjusted life years lost (DALYs). Major NCDs share common risk factors such as tobacco use, alcohol abuse, inappropriate diet and physical inactivity. They are on the rise in the Region due to demographic transition, urbanization, and other socio-economic and lifestyle changes which are being influenced by globalization.

Effective public health action has not been undertaken so far in the Region to control the epidemic of noncommunicable diseases. This is due, in part, to the misperception among decision-makers in general that noncommunicable diseases affect affluent people and therefore, do not require a public health response focused on the poorer segments of the population in developing countries. Other reasons for inadequate prioritization of NCD programmes are scarcity of resources and shortage of quality information. Although NCD morbidity and mortality rates in the South-East Asia Region are accelerating and affecting all socioeconomic strata of society, they remain largely unnoticed or ignored. This is despite growing scientific evidence that they can be prevented in a cost-effective manner.

Most available data on risk factors for major NCDs are from unrepresentative studies using a variety of research methods. Therefore, adoption of common approaches and standardized methodologies are needed to facilitate generation of comparable, valid and useful evidence. I am pleased to note that action aimed at generating such evidence in the Region is being enhanced. Eight Member Countries, namely, Bangla-
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desh; India; Indonesia; Maldives; Myanmar; Nepal; Sri Lanka, and Thailand are currently planning and conducting standardized NCD risk factor surveys using WHO’s STEPwise approach.

The current focus of the regional NCD surveillance programme is to strengthen country capacity to plan and conduct standardized surveys and to analyse and utilize their results. Regional mechanisms including training programmes, establishment of Statistical Support Group and setting up a regional pool of instruments for NCD risk factor surveys have been recently initiated in the SEA Region. A Regional Network for NCD Surveillance was initiated in 2002 in order to provide an appropriate forum for exchange of information, ideas and to develop consensus on collaborative programmes.

Member Countries are being encouraged to set up mechanisms for integration of NCD risk factor surveillance into national health information systems. This will ensure sustainability of the programme and appropriate utilization of generated evidence.

In order to facilitate effective use of this information, a global and regional NCD INFOBASE has been developed. This will facilitate making the data more accessible to different users. I am very pleased to know that the Regional Launch of the Global INFOBASE is to take place during this workshop.

Experience of NCD prevention in this Region is limited. While Thailand is relatively advanced in implementing integrated NCD prevention and control programmes at the national level, other countries, such as Bangladesh, India and Indonesia, have only recently initiated demonstration projects on integrated community-based NCD prevention with WHO support. Four Member Countries, namely, Indonesia, Maldives, Sri Lanka and Thailand are being supported in strengthening advocacy, building capacity and commitment for developing national NCD prevention networks.

This workshop is aimed at strengthening the capacity of Member Countries to manage, analyse and report data arising out of standardized NCD Risk Factor Surveillance activities based on WHO’s STEPwise approach. Since most of you are involved in implementing NCD risk factor surveys and are responsible for statistical analysis of data arising out of these surveys, I am sure that this workshop will benefit immensely from your technical inputs.

The process of developing NCD surveillance programmes in the Region clearly reflects the broad partnership that has been established, resulting in the achievement of tangible results. The continuous dialogue and close collaboration of WHO HQ, regional and country offices and WHO Collaborating Centres over the last few years has helped to set up a standardized instrument and standardized methodology for risk factor surveillance. In this regard, the pivotal role of WHO Collaborating Centres...
and, in particular, the Menzies Centre, which is instrumental in supporting NCD surveillance workshops in the Region needs special commendation.

We are gradually progressing from developing a common surveillance approach to building regional capacity for conducting standardized surveys followed by training in data management, and informing results of surveys to policy-makers and health system managers. It is apparent that we are making steady and definite progress in getting NCDs included in the main public health agendas in the Region. The momentum is gaining and I am confident that we will be able to address this challenge forcefully and effectively in the future as well.
In 1977, at the World Health Assembly, Member States resolved that the main social target of governments and WHO should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". The call for "Health For All by the year 2000" became an inspirational goal in health development. This was followed by the Alma-Ata Declaration in 1978 which identified primary health care as the key approach to achieve this goal.

It was widely recognized that an acceptable level of health for all could not be achieved by the health sector alone. It could only be attained through national political will and the coordinated efforts of the health and other social and economic development sectors.

In 1979, the UN General Assembly adopted a resolution recognizing health as an integral part of development. This was the beginning of a new public health movement which sought to secure for people the right to health. "Health promotion" became part of this movement.

In 1986, the first International Conference on Health Promotion, held in Ottawa, defined health promotion as the "process of enabling people to increase control over and to improve their health." This concept went beyond the traditional boundaries of health education. Health promotion also sought to improve health for all by securing the basic pre-requisites of health: an important one being equity. The Fifth International Conference on Health Promotion was organized in Mexico in 2000, where the Ministers of Health declared that health promotion must be a fundamental component of public policies and programmes in pursuit of equity and better health for all. They also called for the establishment of countryside plans of action.
for health promotion. All regions have responded positively to this call. A number of countries have developed national health promotion strategies and plans. Many countries, however, still have very limited resources and capacity. It is time now to strengthen the capacity at the local and country levels for effective health promotion. The challenge is to effectively use this global support for health promotion to build the evidence-base and capacity for its implementation at the community, national and international levels.

Different regions have achieved different levels in implementing health promotion policies and strategies. During the past few years, our Region has been emphasizing capacity building in healthy settings in Member Countries. This approach has prompted many initiatives on health promotion in schools, workplaces and hospitals.

I am confident that this consultation would provide a good opportunity to review activities, share experiences and the lessons learnt and to formulate the best guidelines and recommendations on how to further strengthen capacity for health promotion in all Member Countries.
A couple of decades ago, the South-East Asia Region would have been considered little affected by the tobacco epidemic. But times have changed. Today, the signs of a potential tobacco epidemic are visible everywhere.

The World Health Organization has initiated many activities to assess and reduce the harm related to tobacco in this Region during the last few years. Prevalence studies on tobacco use have been completed in most Member Countries of this Region. The study on Economics of Tobacco use is being finalized in eight countries. The Global Youth Tobacco Survey has been carried out in several countries, in collaboration with the US Center for Disease Control in Atlanta. This study will be further expanded during the next year.

As you know, in 1999, the World Health Assembly urged Member Countries to undertake specific activities towards the development and negotiation of the WHO Framework Convention on Tobacco Control (FCTC). The negotiations of the FCTC are in an advanced stage at present. The sixth and final meeting of the Inter-governmental negotiating Body (INB) is scheduled to be held early next year in Geneva.

Establishment of multi-sectoral and other mechanisms for comprehensive tobacco control became more important and urgent as the FCTC process advances. This process is expected to be completed in 2003, after which Member Countries would have to commence implementing its clauses at the country level.

Many countries of this Region have commenced initiating action on reducing the adverse effect of tobacco on their populations. It is well known that there is no single intervention or policy measure that will reduce the untoward effects of tobacco on social, economic and health status of the population. But, it has been shown that a range of measures implemented in tandem can reduce tobacco-related harm. Therefore, WHO is striving to strengthen the

capacity of countries to develop more comprehensive and effective strategies, policies and mechanisms.

This workshop aims to assist Member Countries identify areas for action in this respect. I am grateful for your untiring efforts in reviewing the situation in each of your countries on the existing policies for tobacco control at the national level and opinion polling on existing and potential multi-sectoral mechanisms for comprehensive tobacco control. I also wish to congratulate all of you for being able to carry out this review in a detailed manner, in a relatively short period of time.

Once the findings are discussed and finalized at this meeting, the Regional Office plans to present these findings to a gathering of policy-makers and NGO representatives of your respective countries early next year. The ultimate aim of this effort is to initiate action to make tobacco control efforts by both the government and nongovernmental sectors more comprehensive and effective in each of your countries.
Humanity has benefited significantly from the unprecedented health gains over the last 50 years. Globally, life expectancy has increased from less than 47 years during 1950-1955 to over 65 years in 2000. Our Region too has gained much from this revolution. However, the fact remains that these gains have bypassed millions of the poor and disadvantaged in our societies. At the same time, health concerns in the Region are beset by the reemergence of tuberculosis, malaria and the rising incidence of noncommunicable diseases. HIV/AIDS is threatening to offset our hard-won health and socioeconomic gains. In addition, we have to address the unfinished agenda in the face of widespread poverty and illiteracy, environmental degradation and population explosion, and gender bias against women.

We now have a rare opportunity to transform the health scenario and, in the process, stimulate economic growth and alleviate poverty.

Fifteen years ago, the UN Commission on Environment and Development broke new ground by placing people at the heart of the development process. Now, the Commission on Macroeconomics and Health provides a new global blueprint for poverty reduction and for stimulating growth in developing countries by scaling up investment in health.

The ultimate objective of growth is sustainable human development. Economic growth is only a means towards this end.

I firmly believe that the ultimate objective of growth is sustainable human development. Economic growth is only a means towards this end. Unfortunately, economic growth can happen without expanding employment opportunities. When its fruits benefit only the rich at the expense of the poor, the impact of economic growth can be devastating. Moreover, economic growth that concentrates only upon the present generation without any consideration for future generations cannot be sustainable. Therefore, growth needs to be equitable and sustainable. A suitable macroeconomic framework is capable of generating such growth.
At the World Summit on Social Development in Copenhagen, there was clear recognition that investment in people’s health is an essential element of sustainable development and social cohesion. This was reinforced at the recent World Summit for Sustainable Development in Johannesburg.

Ten years on from Rio, the world is beginning to accept that health is central to the whole concept of sustainable development. It is a key element in securing our common future.

Two years ago, world leaders agreed on a set of development goals for the Millennium. The Millennium Development Goals focus on poverty reduction in general and several health goals in particular. Thus, the Millennium Development Goals rightly underscore the linkages between overall poverty alleviation and investment in health.

The report of the Commission on Macroeconomics and Health provides the strategic framework for achieving the Millennium Development Goals pertaining to health. It will also contribute to the attainment of targets set by other international initiatives such as Roll Back Malaria and Stop TB. The Millennium Development Goals are an expression of humanitarian concern. They are also an investment in the well-being of rich countries as well as the poor. Our world can no longer remain divided between the rich and healthy on the one side, and the poor and diseased on the other.

The need to drastically increase resources to improve health is a critical element in taking this agenda forward. Fortunately, we have witnessed an increasing commitment on the part of a number of key industrialized nations and funding institutions to increase development assistance dedicated to health. The results can be seen in the new spending for health by the European Union. It can be seen in the pledges by the United States and other countries at the Financing for Development Conference in Monterrey, in March.

At the same time, considerable efforts have been made to find innovative ways to channel the increased health spending. GAVI and the Global Fund to fight AIDS, Tuberculosis and Malaria are key funding mechanisms, which are proving very effective.

Along with increased investments in health, there is an urgent need to develop and strengthen health systems that are effective, fair and responsive. The strategic framework of the Commission on Macroeconomics and Health stands on the twin pillars of increased funding and appropriate reforms for scaling up essential health interventions.

The agenda of your Conference will take you through the exciting story of the linkages between health and development. You will be apprised of the need to tackle a handful of diseases and conditions responsible for the present health deficit. But, increased
resources and their efficient and effective management shall be required. Political commitment is a must. The need of the hour is for a new partnership between the developing countries and the rich nations and development partners. Luckily for us, such a partnership is steadily, but surely, emerging. Let us accelerate the process, for we cannot afford to miss the window of opportunity now presented by the Commission on Macroeconomics and Health.

Health is multisectoral. The ministries of health or the health sector by themselves cannot achieve this new paradigm. It requires energy and commitment on the part of all sectors and the entire ambit of civic society. Parliaments are truly multisectoral: parliamentarians are the custodians of people’s security, welfare, and prosperity. Therefore, WHO and parliamentarians are natural partners.

I have no doubt that this Conference would greatly contribute to widen the concept of the centrality of health in sustainable development. I would urge the Hon’ble participants to convey the message of this Conference to their colleagues, the media, NGOs and others. Hon’ble Ministers and MPs are the best placed to convince their Presidents and Prime Ministers. We look forward to working with you to develop the road map for growth and poverty reduction by scaling up essential health interventions.
The countries of the South-East Asia Region have accomplished a great deal in terms of extending water supply coverage to 86 percent of the Region’s 1.5 billion people. For example, among the countries represented here today, access to improved sources of water supply was extended in the past decade to an additional 230 million people in India, 25 million people in Bangladesh, 10 million in Thailand, 7 million in Nepal and more than 5 million in Myanmar. All countries of the South-East Asia Region reported some growth in water supply coverage between the years 1990 and 2000.

A recent assessment of drinking water quality surveillance conducted by the Regional Office however, raises concern over the safety of water supplied for human consumption. Weaknesses were found in the surveillance programmes of all countries in the Region. Few countries are in a position to vouchsafe the quality of drinking water except in major cities. Groundwater is a significant source of drinking water in many countries of the Region, but this resource is frequently vulnerable to chemical contamination from natural sources or by anthropogenic activities. Elevated levels of naturally occurring arsenic have been found in groundwater on a wide scale in Bangladesh and parts of India, and to a lesser extent in Myanmar and Nepal. In Thailand, arsenic in groundwater has been found in only limited locations and is associated with mining activities.

Presently, the Regional Office is working actively with Member Countries to develop arsenicosis case definitions which are necessary prerequisites to estimating the size of the exposed population. Accurate exposure data are not yet available but it is already clear that arsenic mitigation programmes are needed on a large scale and efforts in this direction have, in fact, been initiated in each of the affected countries.

Water Supply Coverage

Intercountry Consultation on Verification of Arsenic Mitigation Technologies and Field Testing Methods, Kolkata, India, 9-12 December 2002.

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Numerous arsenic removal and field testing technologies have been developed and installed on a pilot basis in arsenic-affected areas of West Bengal, Bangladesh and limited areas of southern Thailand. Such technologies will be needed on a larger scale in future in those areas and in arsenic-affected areas of Nepal and Myanmar. Given the scale of the market, it is expected that researchers and commercial enterprises will continuously introduce new and emerging technologies. Several externally-supported investigations have already evaluated a limited number of existing technologies in recent years but the need still exists to build national capacity in the countries of the SEA Region in order to enable national institutions to independently verify the performance of other technologies.

Several national and international development agencies and researchers in the SEA Region and worldwide have been assessing arsenic removal technologies and field testing methods and various protocols have been developed to support such activities. Exchange of experiences gained through these activities will promote better understanding of the problem and will serve as a basis for the latter development of technology verification protocols appropriate for application in the countries of the Region.

It is expected that participants will gain enhanced knowledge about arsenic removal technologies and field testing methods for arsenic in drinking water and about verification protocols for these technologies. At the end of the Consultation, it is hoped that guidelines will be developed to support the preparation of verification protocols at the country level.

I am grateful to the Government of India and the Government of West Bengal for hosting this meeting. Since arsenic in drinking water first emerged as a public health concern in West Bengal in the 1980s, India has developed significant technical capacity related to arsenic mitigation technologies through state and central government agencies and research institutions. The concentration of expertise particularly found in Kolkata and the numerous arsenic removal technologies installed in its environs also make Kolkata an ideal location for convening this meeting.

I would also like to thank the US-Asia Environmental Partnership and the US Environmental Protection Agency for their support to this consultation. We look forward to their continuing support and collaboration in the followup activities that will emerge from the meeting.
I am sure the World Report on Violence and Health, the first comprehensive summary of the problem on a global scale, will help galvanize preventive public health action against violence at global, national and community levels. We must heed the Report’s urgent call for action because violence has come to permeate every aspect of our lives. It is most unfortunate that in the next one hour, 28 people in the countries of the South-East Asia Region will have either killed themselves or will die a violence-related death at the hands of another. These deaths represent only the tip of the iceberg. In the same hour, between 600 to 1,100 people will have visited a hospital for violence-related injuries. Besides these reported numbers, we also know that two-thirds of those physically abused will remain silent victims.

Globally, 1.6 million people die from violence every year. Where there is violence, health is seriously compromised.

Globally, 1.6 million people die from violence every year. Violence is among the leading causes of death for men and women aged 15 to 44 years worldwide, accounting for one in 7 deaths among males and one in 14 deaths among females. Of the countries in this Region, an alarming number of suicides are reported in Sri Lanka. "Violent conflicts" in society have taken a toll of several thousands of lives and made hundreds of thousands homeless. Where there is violence, health is seriously compromised.

In the past decades, strong public health measures and successful child health programmes have brought about a reduction in infant mortality rates. But having saved children from early death, it is equally important that we also protect them at all stages of their lives from violence and cruelty, which cloud their lives physically, psychologically and socially. Unfortunately, evidence shows that globally about 20 per cent of women and 5 to 10 per cent of men have suffered sexual abuse as children. In surveys from around the world, 10 to 69 per cent of women report being physically assaulted by an intimate partner at some point in their lives.

Hundreds and thousands of women are sold for prostitution in this Region. HIV/AIDS will ruin most of these women’s lives, not to mention the cruelty and violence that are prevalent in this human trade. These are alarming figures. Between 4 to 6 per cent of elderly people experience some form of abuse at home. Let us remember that the number of the elderly in our society is increasing and the probability of their being affected by violence is likely to increase.

In the prevailing social scenario, victims who have been subjected to violence and abuse, try and hide these facts because of the fear of losing face in the society. In Bangladesh, 68 per cent of all physically abused women did not tell anyone about their suffering. In India, a fairly good percentage of the elderly people interviewed admitted to being ill-treated by their families.

Violence has serious implications on the health of the people affected. It also has implications on the development of a healthy society. Children, who are victims of violence, go through a process of development that often leads to maladjustment in society. They may legitimize violence as a means to solve problems as they continue to witness violence at home, at school or other public places. Persons who suffer violence, cannot provide optimal care to their children, and cannot contribute optimally to the development of society.

Because violence is so pervasive, it is often accepted as an inevitable part of human life. It is vital to change this attitude and sensitize the communities of the ill-affects of violence on society as a whole. Violence can, and must be prevented.

Violence is a very complex issue and must be addressed more comprehensively and holistically. The lack of a clear understanding of the extent and causes of the problem has resulted in not recognizing violence as a public health problem. There is now an urgent need to address this issue.

Violence affects people of all ages and sexes in all sections of society. It is caused by identifiable risk factors and is preventable. As in the case of other diseases, adopting a public health approach can help curb the epidemic of violence. This needs the collaboration of several sectors, including law, justice, welfare and civil society. The media can play a very constructive role by investigating and reporting acts of violence. It can make communities aware that these are just not acceptable.

Reliable information from within the public health system and other involved sectors will greatly benefit the information needs for the development of a successful programme on violence prevention. It is only with solid information that the problem of violence can be made visible. It would then enable us to advocate to people to acknowledge and respond effectively.

In order to move to a peaceful society from one that is becoming increasingly
violent, joint action among international agencies, national governments, civil society and interested individuals is needed. Together, we will win this battle, for a world without violence, a region without violence and a community without violence.

Violence prevention will be one of the core agendas of WHO’s public health actions. Therefore, we urge Member Countries, and the public health community to act together to tackle violence as a developmental issue. With global commitment and acknowledgement of violence as a public health problem, we can contribute significantly to building a non-violent, healthy and just society.
The countries of the South-East Asia Region have accomplished a great deal in terms of extending water supply coverage to 86 percent of the Region’s 1.5 billion people. During the past decade, for example, access to improved sources of water supply was extended to an additional 230 million people in India and some 25 million people in Bangladesh. All ten countries of the South-East Asia Region reported growth in water supply coverage between the years 1990 and 2000.

Yet, much remains to be done to improve water supply and sanitation services as a basic component of primary health care. While the growth in water supply coverage is encouraging, greater investment in infrastructure is still needed in order to reach universal coverage, and concerns exist about the safety of drinking water in communities where infrastructure is already in place. Drinking water quality surveillance programmes need to be strengthened in most SEAR countries, but it is known that drinking water quality in many water supply systems, both in urban and rural areas, is affected by certain risk factors. Deficiencies in disinfection practices, lack of continuous positive pressure, and unsafe water storage and handling practices at the point of use are all too common in many SEAR countries.

Of particular concern to WHO is the fact that growth in sanitation coverage in many countries of this Region has not kept pace with the increase in water supply coverage. Eight hundred and eighty one million persons, being 58 percent of the SEAR population, lack access to improved facilities for excreta disposal.

Many studies by regional investigators and others have documented widespread deficiencies in hygiene practices, such as hand washing, which are due to complex social and economic factors.

It is not surprising then that the disease burden due to illnesses related to water, sanitation and hygiene, remains high. In meeting of SEAR Water, Sanitation and Health Advisory Group, New Delhi, India, 6-8 May 2002.
India alone, 9.5 percent of all DALYs lost are due to diseases related to water, sanitation and hygiene. Some 2.2 million people, mostly children in developing countries, die each year from diarrhoeal diseases, but 43 percent of these deaths occur in the South-East Asia Region.

It is against this backdrop that the WHO Regional Office has considered it necessary to restructure and revitalize its Water, Sanitation and Health programme. For this reason, I have established the SEAR Water, Sanitation and Health Advisory Group, with the membership of an array of regional and extraregional experts representing a broad range of stakeholders.

The task of this new Advisory Group is to periodically review the Water, Sanitation and Health programme of the Region and to make recommendations for programme development. Additionally, members of this Advisory Group are requested to support the Regional Office on an ongoing basis in the development of specific programmes, project and activities, and in the mobilization of resources to support implementation.

In carrying out these tasks, the Advisory Group should keep in mind that achieving universal coverage with efficient and high quality water supply and sanitation services, will require a far greater level of capital investment than is available today and will require very significant sector reforms such as decentralization of services. Meeting the Vision 21 target of universal coverage by 2025 would require capital investment of the order of US$ 2 billion to 10 billion per year in SEAR countries, depending on the technologies used. These hard facts imply two essential roles for ministries of health in this Region: (1) advocacy to stimulate and target investment in water supply and sanitation infrastructure and accelerate needed sector reforms; and (2) promotion of low-cost interim measures to mitigate the disease burden resulting from deficiencies in existing services and poor hygienic practices.

Investments in water supply and sanitation render benefits to the health sector while the costs are borne by urban and rural development authorities, municipalities and other local government bodies. Simple logic dictates that health authorities should actively advocate the greatest levels of investment possible in this sector. However, effective advocacy depends on reliable information. If health ministries are to successfully take up the challenge of stimulating and targeting development in the water supply and sanitation sector, they must do more in the areas of applied research, information management, and linking environmental surveillance and disease surveillance programmes.

Simultaneously, ministries of health have a unique role to play in promoting low-cost interim measures to reduce the prevalence
of illnesses caused by unsafe drinking water, poor sanitation, and lack of personal and community hygiene. Simple measures such as hand washing, household level treatment of drinking water, and low-cost latrines have proven highly effective in lowering the rate of infectious diseases. Partnerships can be effective in promoting such strategies but the basic responsibility for health promotion and education necessary to bring about lasting behaviour changes rests squarely with the ministries of health.

In recent years, WHO’s Water, Sanitation and Health programme has focused greatly on strengthening national drinking water quality surveillance programmes. We see now that much more is required of us. How can the Regional Office help the countries of this Region, especially ministries of health, to respond to the challenge of advocacy, with all that the word implies, and the parallel challenge of promoting effective and low-cost interim measures?

No doubt new and innovative strategies are needed. Working through partnerships is one strategy, as I have already mentioned. Integration of water and sanitation programmes with community development initiatives is another. Establishing inter-agency coordinating mechanisms may be a third, and, we should not minimize the importance of social intervention strategies such as social marketing.
Humanity has gained significantly from the unprecedented health gains over the last 50 years. Globally, life expectancy has increased from less than 47 years during 1950-1955 to over 65 years in 2000. This increase has been more pronounced in the developing countries. Our Region too has gained much from this revolution. After eradicating smallpox, our Region recently eradicated the guineaworm disease. Now, leprosy is targeted for elimination. Together, we will soon eradicate polio.

Yet, vaccine-preventable diseases still pose a significant risk to the health of children in our Region. In the year 2000, measles alone struck an estimated 2-3 million children of whom about 10% died. Diphtheria and whooping cough still afflict children in underserved areas in many countries. Our Region contributes to over 40% of the global neonatal mortality. Our commitment to achieve the millennium goal of reducing infant and child mortality can be met only if we now assign a higher priority to neonatal mortality. Evidence-based essential newborn care is known to improve neonatal health and reduce neonatal mortality. This should therefore be a priority in the resolution of the forthcoming UN special session on children. The Director-General of WHO, Dr Gro Harlem Brundtland, speaking at the Global Consultation on Child and Adolescent Health, at Stockholm, made a plea for a special focus on saving the lives of millions of newborn babies who die during the first weeks of their lives.

The Region now has two opportunities to minimize the risk to children from vaccine-preventable diseases. The Global Alliance for Vaccines and Immunization (GAVI) provides an important opportunity. Over the next five years, GAVI will provide an estimated $200 million to our Region to strengthen routine immunization and introduce under used vaccines. The second opportunity is the attention and awareness...
that polio eradication has brought to routine immunization.

Polio eradication efforts have made remarkable progress in reducing the burden of this dreaded disease. However, there were still 268 cases in 2001, primarily in the Indian States of Uttar Pradesh and Bihar. India has made laudable efforts to reach the present stage. The last push would undoubtedly ensure a polio-free Region.

Unfortunately, health concerns in the Region are beset by the reemergence of tuberculosis and malaria as well as the rising incidence of noncommunicable diseases. HIV/AIDS is threatening to offset our hard-won health and socioeconomic gains.

The good news is that a Global Fund has recently been established to meet the devastating global impact of AIDS, TB and malaria. You will be pleased to know that about 800 million dollars would be available for disbursement during 2002. It may be recalled that various dimensions of the Global Health Fund were discussed at the Health Ministers’ Meeting in Maldives last year. In accordance with the Health Ministers’ recommendation, I established a Regional Task Force to guide regional and country efforts to ensure that our countries receive a fair share of the Global Fund. It is gratifying to note that 9 out of the 10 Member Countries of our Region have timely submitted 18 country proposals and one multicountry proposal for “quick start” funding. WHO was privileged to provide technical support in the preparation of these proposals.

While the progress towards tobacco control made by different countries of the Region is gratifying, I think we must remind ourselves of what needs to be done now for adoption of the Framework Convention on Tobacco Control. At the last session of the Intergovernmental Negotiating Body, it became clear that our countries would need to involve all relevant sectors, such as trade and commerce, education, information and broadcasting, labour and agriculture, and foreign affairs and judiciary, into the mainstream of the negotiating process at the country level. As the Framework Convention is due to be adopted at the Fifty-sixth World Health Assembly in 2003, it would now be opportune for the Ministries of Health to intensify the building of alliances with all relevant sectors.

We have to address the unfinished agenda in the face of widespread poverty, illiteracy and gender bias against women. In the current and coming decades, population growth, rapid and unplanned urbanization and industrialization, as well as environmental risks to health will continue to pose serious challenges to health development. Poverty is the root cause of most of these challenges. Fortunately, the growing recognition of the centrality of health in development provides a solid base for hope and optimism.
At this point, it may be recalled that fifteen years ago, the UN Commission on Environment and Development broke new ground by placing people at the heart of the development process. Now, the Commission on Macroeconomics and Health, consisting of eighteen of the world’s leading economists and health experts, has presented its report. This provides a new global blueprint for development to narrow the gap between the rich and the poor and stimulate growth in developing countries.

The report, Macroeconomics and Health: Investing in Health for Economic Development, sees investment in human resources as crucial to overcome the poverty trap in developing countries. It sees health as a key factor in economic growth and social development.

The Commission has found evidence to show that extension of crucial health services to the world’s poor to combat a handful of health conditions and diseases could save millions of lives, reduce poverty and spur economic development. The Commission has underlined that such an effort requires two initiatives. First, a significant scaling up of the resources currently spent in the health sector by poor countries and by donors. Second, tackling the non-financial obstacles that have limited the capacity of poor countries to deliver health services. The Commission urges each low and middle income country to establish a temporary national commission on macroeconomics and health to formulate a long-term programme for scaling up essential health interventions within the overall framework in poverty reduction strategies.

The World Summit on Sustainable Development, to be held in Johannesburg in August this year, is another major milestone in the work towards a world where we all can live well and healthy, and with dignity, without undermining the ability of future generations to do the same. Health needs to have a more prominent role in the forthcoming Summit than it had in Rio. WHO and national governments must stress the central role of health in the development process and the linkages between health and poverty reduction. We must stress the health risks and determinants beyond communicable diseases, and the impact of environment and globalization on health.

The problems are formidable but solutions exist. Interventions are available. Strategies to improve the situation are known. The call for action given by the Commission on Macroeconomics and Health must be acted upon. We must reinforce intercountry cooperation and partnerships with one and all.

I have no doubt that the current meeting would further enhance regional solidarity.
and promote the interests of the countries of our Region. During this meeting, the Health Secretaries will deliberate and propose practical mechanisms to further strengthen intercountry cooperation in the context of the programme budget for 2004-2005. The Health Secretaries will also discuss Risks to Health, the report of the Commission on Macroeconomics and Health, the Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO’s Medicines Strategy. As these topics are on the agenda of the forthcoming World Health Assembly, our discussions here will prepare us well for effective participation in the deliberations of the Assembly. We look forward to the guidance of the Health Secretaries in these important areas. I am confident that, as in Bali in 1997 and Yangon in 2001, the Health Secretaries will recommend practical ways to ensure full utilization of WHO’s Regular budget for 2002-2003.
Globally, safety is a growing concern in the face of rapid industrialization, mechanization and urbanization. Children saved by today’s immunization and nutrition programmes are dying of injuries and violence during their late childhood and adult life. A large number of deaths of economically active people are caused by unsafe products, inadequate knowledge to use them safely and hazards created by them. On the one hand, rapid changes in the lifestyles of people have attracted a high turnover of various consumer items, while on the other hand, a large number of people are struggling hard to possess these and risk their precious lives in the process. This has led to chaos in our surroundings. Our children are growing in an unsafe environment where we see the emergence of new diseases and conditions that either did not exist earlier or only existed rarely.

This world is precious because it is the only one we have. We, therefore, need to preserve it not only for our children, but also for posterity. From the highest mountain to the deepest ocean, pollution is increasing rapidly everywhere. Ecosystems from Antarctica to the rainforests in Africa and Latin America are being destroyed. This needs to be checked, before degradation of the environment reaches catastrophic proportions.

Globalization has brought with it a mixed bag of successes and sorrows. A product launched in one part of the globe, easily and quickly makes its way to distant markets. Those that are not well informed about the use of these products are at great risk from its unsafe use.

The South-East Asia Region comprising 10 countries including India bears a large proportion of the global burden of injuries. These injuries are viewed as “accidents” and therefore not considered preventable. Experiences from the developed countries, however, show that we can avoid most injuries, if appropriate safety measures are taken.

From the highest mountain to the deepest ocean, pollution is increasing rapidly everywhere.

From the highest mountain to the deepest ocean, pollution is increasing rapidly everywhere.
The National Safety Council of India has played a significant role in the past in this direction. It can provide leadership for instituting safety programmes for the whole Region in future.

I therefore, urge the delegates to deliberate and recommend strategies to make our communities safer. You will always find the World Health Organization supportive of your endeavours.
The world is witnessing a rapid increase in the mortality, morbidity and disability from noncommunicable diseases, or NCDs. According to WHO estimates, more than 2 million deaths a year, worldwide, are caused by lack of physical activity. Rapidly changing life-styles are often accompanied by change in diet and more sedentary living, which leads to obesity and cause a number of diseases.

A major cause of cardiovascular diseases, diabetes and obesity is lack of physical activity. Studies show that up to eighty per cent of coronary heart disease, up to ninety per cent of type 2 diabetes and about one third of cancers could be avoided through lifestyle changes. Physical activity and healthy diet reduce the risk of many diseases through their influence on blood lipids, blood pressure, body weight, glucose tolerance and other metabolic changes. Regular physical activity reduces the risk of NCDs and premature death, as well as visits to doctors and cost of medicines and drugs.

The benefits are both physiological and psychological.

This year’s theme for World Health Day focuses on physical activity with the slogan “Move For Health” and highlights the importance of fitness and a healthy, active lifestyle.

For centuries, civilizations have known that the secret of good health begins with good eating habits and regular exercise. Today, we have strong evidence to show that physical inactivity increases the incidence of several unhealthy conditions associated with chronic diseases and premature death. Over the last few decades, we have obtained scientific evidence to show a wide array of health benefits of regular physical activity.

Traditionally, populations of South-East Asian countries have been mainly agrarian workers, whose levels of occupational physical activity have been high. However, with rapid socioeconomic transition resulting in a sedentary way of life, the importance of regular physical activity cannot be over emphasized.

in more people undertaking urban-based industrialized jobs, there is an inevitable decline in physical activity. At the same time, non-occupational activity levels have continued to be low or have even declined in many countries. This change correlates closely with the increasing incidence of coronary heart disease, hypertension, diabetes, obesity and other noncommunicable diseases in this region.

The growing incidence of NCDs in the Region is a matter of great concern. Among these, cardiovascular diseases account for the largest share of NCD deaths. In Sri Lanka, NCDs contribute nearly forty-seven percent of all deaths, followed by forty-two percent in Myanmar, over thirty-seven percent in Indonesia, and nearly twenty-five percent in Bangladesh.

In countries of the South-East Asia Region according to the International Diabetes Federation, 5.3% of the population between 20 and 79 years of age is estimated to have type 2 diabetes and this number is growing. According to WHO regional estimates, over 40 million people are affected. Demographic transition, lack of physical activity and changing eating habits have contributed to the high prevalence of diabetes. It is estimated that India will face a large burden of type 2 diabetes by 2025 with the highest number of diabetic patients, globally. Already in urban areas fourteen percent of the population suffers from diabetes.

Modern living is rapidly leading to a sedentary life. Urban middle class women, supported by advanced technology in the home as well as affordable domestic help, are succumbing to obesity. In contrast, rural women who are engaged in labour-intensive farmwork and household chores are healthier.

Unfortunately, in many cities recreational areas have decreased denying children a safe play area and the benefits of outdoor sport. At the same time, children in the subcontinent now spend more hours watching their favourite sports like cricket and tennis on television, instead of playing these games.

The benefits of exercise include increased aerobic power allowing for increased oxygen intake, and improved cardiac efficiency; improved muscular strength and power leading to improved nervous control, increased muscle mass and increased psychological effort tolerance; and together with adequate diet, physical activity helps to maintain sufficient bone strength.

Regular moderate physical activity as well as good physical fitness prevent the development of hypertension, and also lower blood pressure. It also helps to maintain body mass through energy expenditure. Physical activity helps to reduce risk of colon cancer.

At the same time, physical activity appears to decrease symptoms of depression,
anxiety and tension. Physical activity is particularly important for young girls to develop strong bones and avoid osteoporosis in later life. It also helps women to have normal pregnancy and childbirth.

What can be included as physical activity? Physical activity can be defined as bodily movements produced by the contraction of skeletal muscles that expend energy above the base level. These can include occupation and household chores, recreational sports, exercise or transportation, like walking, cycling, jogging, swimming. In fact, any exercise that makes you breathe deeply can be included in the list of beneficial health inputs. This need not be limited to formalized competitive sports, but can certainly include them. One does not need strenuous workouts to keep healthy. Even moderate but sustained physical activity of around 30 minutes, undertaken nearly every day, over a long period, has a beneficial impact on health.

People at work can spread their physical activities throughout the day - climbing stairs, instead of taking the elevator; walking or cycling instead of taking a car and at home - gardening or doing household chores, sweeping, washing, dancing, or playing with kids etc.

The earlier we start regular exercise in life, the better it is. Children who are introduced to healthy lifestyles early in life are likely to continue with healthy practices later, with accumulated health benefits.

For the middle aged, more susceptible to noncommunicable diseases, living a physically active life provides continuing benefits. For the old, staying physically active can delay the onset of diseases associated with ageing. Regular exercise can also help in improving the condition of some diseases and disability already existing among the old, like heart diseases, diabetes, and arthritis. Also, exercise improves lung capacity of the elderly, builds up stamina, strengthens body muscle, increases bone density and is important to avoid osteoporosis, by keeping bones healthy. Besides the physical benefits, exercise and physical activity are known to help create a cheerful disposition and relieve depression, specially when these are done in a group, as it helps to overcome a feeling of isolation and loneliness.

One of the easiest and most natural activities all human beings undertake is walking. It is a year-round and habit-forming activity and an easily available option for increasing physical activity among the sedentary population.

Many countries have culture-specific forms of regular physical exercises. Yoga is one such form prevalent among South
Asians. This form of activity has been advocated to prevent the progression of coronary artery disease.

To ensure that the benefits of modernization and urbanization are not offset by sedentary and unhealthy lifestyles, we can all take steps to promote our health.

As we celebrate this day, I would like to suggest action at individual, community and national levels, which could help to meet the challenge of NCDs in the Region. Governments can initiate policies and programmes to create awareness about the health benefits of physical activity. By coordinating programmes of the health, education and urban planning departments, safe open spaces can be provided for exercise and to encourage physically active lifestyles. Youth and sports ministries can focus on the young and on educational institutions to ensure that adequate time and opportunities are provided for sports, and to organize sports and cultural events to promote physical activity.

Communities must demand more physical activity-friendly policies and programmes from their governments. Communities could also organize sports and other physical activities that would help create better understanding of the benefits of physical activity for all age groups. NGOs and the community can organize meetings to generate necessary policy and legislative support to such programmes. What needs to be ensured is that nobody is left out. Women, children, the elderly, the disabled, all have an equal right to an active and healthy life.

The media can raise evidence-based awareness about the benefits of physical activity and its link with prevention of non-communicable diseases.

On its part, WHO will support its Member countries in developing demonstration programmes for the community. It would develop policies and guidelines for what countries can do; how they can provide a supportive environment for physical activity and how they can make physical activity an integral part of their strategies to tackle noncommunicable diseases. WHO would also examine and address global and regional issues that have an impact on nutrition and physical activity, such as advertising, mass communication, world trade agreements, food labeling and novel foods.

Let us remember to use World Health Day this year as a starting point for a healthy lifestyle based on regular physical activity. Let us move for health, not just for ourselves, but for all.
Although the annual number of deaths among children less than 5 years of age has decreased, still every year more than 10 million children in developing countries die before they reach their fifth birthday. Seven in 10 of these deaths are due to acute respiratory infections, diarrhoea, measles, malaria or malnutrition and often a combination of these conditions. The environment in which the children live contributes immensely to their health or disease burden. Diarrhoeal diseases are associated with unsafe water and poor sanitation coupled with poor food handling practices. The poor air quality and toxins released may contribute to the recurrent episodes of ARI which millions of children in our region suffer from every year.

For the last three decades or so, environmental health has been understood as being merely maintenance of the environment. The issue is, however, more complex: environmental health is about promoting a healthy environment towards ensuring good health. Thus, the inter-linkages between health and environment are evident.

A good example is the one of indoor air pollution, where the exposure to a single environmental factor, namely, smoke from the use of bio-mass fuels or petrol-derived fuels results in an increasing number of respiratory infections. The severest impact of this environmental hazard is borne by the most vulnerable group, namely, children under five years of age.

Children’s environmental health problems call for a concerted cross-sectoral response. This is well documented in some of the countries where the use of leaded gasoline has been banned. This positive initiative not only contributed to lowering ambient air pollution, but also resulted in an increase in the average IQ of the student population due to reduction of the amount of lead in human blood. Certainly, this achievement was possible because of the close cooperation between all the concerned stakeholders.
There are other examples also of the benefits of successful interventions in the water sector. Yet, we need to recognize that long-term sustainable water management schemes can only result from fostering partnerships and collaboration among the different sectors. Now, we have a new challenge facing some countries in the Region: arsenic contamination of groundwater. In order to address this environmental threat, a concerted response will be required.

We should keep in mind that concerted responses addressing environmental hazards affecting children and adolescents will require their active participation. What is also needed is the involvement of their families, the community as well as schools and local authorities.

This Conference has highlighted the fact that the environment in which our children live today differs from the past, as we now have to deal with hazards that were not known or suspected just a few decades ago. The relocation of hazardous industries in developing countries as a result of globalization and decentralization may increase exposure to environmental health hazards. For this reason, it is most important that we produce evidence-based data to advise policymakers on this important issue. As this Conference stressed, the ongoing WHO initiative to develop a core set of Children’s Environmental Health indicators for policy support at national and international levels, can be instrumental in collection of vital data. I am very pleased to see that all these issues are clearly addressed in the Bangkok Statement.

Though this Conference is coming to an end, a new beginning is being made next week. WHO and UNICEF are organizing the First Global Consultation on Child and Adolescent Health and Development, titled “A Healthy Start in Life” on 12 and 13 March 2002 at Stockholm, Sweden. This high-level Consultation, to be attended by Prime Ministers and Health Ministers, is linked to the UN Special Session on Children in May 2002, where world leaders will reaffirm their commitment to building a world fit for children.
In 1998, when the Director-General of WHO launched the Tobacco Free Initiative, many expressed doubts about the achievability of its goal. Many did not believe that a global focus and such a momentum for tobacco control could be achieved.

Today, as we begin the third Intercountry Consultation, on the Framework Convention on Tobacco Control (FCTC) we can be justifiably proud of the progress we have made in our efforts to curb the tobacco epidemic. The gradual yet steady inroads made through judicial interventions in the implementation of existing laws and regulatory measures are worthy of note. The Tobacco Free Initiative has become a pathfinder in public health. And for public health to be effective, adequate legal backing is essential. And FCTC fulfills this requirement.

FCTC draws its strength from the huge public outcry against the devastating impact of tobacco use. The wide participation of WHO Member States underscores the urgency for such an international treaty. It is gratifying to note that all Member Countries in our Region have participated commendably in the FCTC process since the establishment of the Working Group by the World Health Assembly in 1999. The two previous consultative meetings in Jakarta and Thimphu have provided tremendous impetus to countries in their desire for a collective voice on FCTC. The outcomes of these meetings have provided positive inputs from the South-East Asia Region for the formulation of the Framework Convention.

We have barely 400 days to go to the year 2003, when the FCTC is to be adopted by the World Health Assembly. At that time, our commitment towards tobacco control would be put to test. We need to prepare ourselves to ensure that our current efforts culminate in the ratification of FCTC. We need urgently to put in place the necessary infrastructure and processes. This brings to...
mind two critical issues raised by the World Health Assembly Resolution WHA52.18 and the Regional Committee Resolution SEA/RC52/R7.

The call for countries to form multi-sectoral commissions was for two purposes; firstly, to bring the views and actions of relevant sectors into the mainstream of the FCTC process, and, secondly, to build a favourable climate that would support ownership by various sectors and lead to the ratification of the FCTC.

To achieve this, we need to widely disseminate the outcomes of both the consultative and Intergovernmental Negotiation Body meetings. We need to use these outcomes as launch pads for discussions with various sectors. It is necessary to take them with us along the process of FCTC negotiations for early and successful ratification and implementation of FCTC.

Another point worth noting is the involvement and participation of the public. So far, there is little knowledge among communities about FCTC and its implications towards protecting them against the hazards of tobacco. Nongovernmental agencies can be mobilized to explain the process to the public. The significant contribution of nongovernmental organizations to public health processes and interventions has been recognized globally. Their inputs to the FCTC process can also be useful, particularly in our efforts to build positive public opinion in support of FCTC.

Time is not on our side. Our vision and desire for a relevant and effective FCTC can not materialize if we fail to mobilize other sectors, the NGOs and the public. In the coming months, WHO, in collaboration with the United Nations Fund, would be supporting a number of NGOs across the Region to take the message of FCTC and tobacco control in general to the remotest communities in our countries. We look forward to technical support from tobacco control departments in Member Countries to national NGOs in formulating appropriate proposals to source available funds.

WHO is also in the process of launching a capacity building project in some selected countries. This project would strengthen national systems to deal with the tobacco epidemic in these countries. I would encourage all countries to take advantage of this support by WHO to ensure an effective and strong Framework Convention on Tobacco Control. Now is the time to protect the health of millions of adolescents and women entrapped by tobacco. It is a collective responsibility we cannot overlook. Future generations would never forgive us if we fail to make FCTC a resounding success as a public health tool. I am confident that our Member Countries will rise to the challenge.
We, in WHO/SEARO, would continue to provide the required technical and financial inputs to strengthen the consultative processes. The goal is to secure the adoption, ratification and implementation of a strong and effective Framework Convention that will protect our people.

In conclusion, I would like to convey my sincere appreciation to the Government of India for hosting this consultative meeting. We recognize the exemplary leadership role played by India in the process of developing a collective regional voice on the various clauses of the FCTC.
Most of the ten Member countries of WHO’s South-East Asia Region are undergoing significant social and demographic changes. Rapid urbanization and increased income have led to changing life-styles. This, in turn, has resulted in imbalanced diet, increase in tobacco consumption, and a more sedentary life. At the same time, with increasing life expectancy, the numbers of older persons have increased rapidly. These factors have led to an enhanced risk of developing major non-communicable diseases, particularly Cardio-Vascular Diseases (CVDs).

WHO estimates that, in 1998, there were about 12.4 million deaths from heart attacks and strokes all over the world. Of these, about 9.6 million, or about 77%, occurred in low and middle income countries. In India alone, in the same year, there were an estimated 26.9 million cases of CVDs and 2.8 million people died of these conditions.

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The World Health Assembly has attached substantial importance to the prevention and control of Noncommunicable Diseases (NCDs). There is a special focus on integrated approaches for the prevention of NCDs. Two landmark resolutions adopted in 1985 (WHA 38.30) and in 1989 (WHA 42.35), highlight the importance of promoting the prevention of cardiovascular diseases.

The global strategy for the control of NCDs was later developed and endorsed by the Executive Board and the World Health Assembly in 2000.

It would be worthwhile, in this connection, to mention that WHO’s corporate strategy has identified four strategic directions and six core functions for the Secretariat. The strategic directions are aimed at reducing excess mortality and morbidity, dealing effectively with the leading risk factors, strengthening health systems and placing health at the centre of the

Second Biennial Meeting of SAARC Cardiac Society, Ashoka Hotel, New Delhi, India, 11 February 2002.
development agenda. As you may be aware, the prevention and control of cardiovascular diseases is very much a WHO priority.

Based on the evidence, the WHO Global Strategy for control of NCDs identifies three common risk factors for CVDs i.e. diabetes, cancer, and chronic obstructive lung diseases. These factors are: imbalanced diet, inactivity and tobacco use. Interventions to reduce these risk factors will eventually reduce the burden of these four major diseases.

In the South-East Asia Region, WHO is in the process of preparing a regional profile of NCDs. The profile will provide the current situation of NCD burden as well as the limitations of the NCD surveillance system in the countries of the Region.

Lessons learned in the preparation of the Regional NCD profile as well as from other studies have shown that routine morbidity and mortality surveillance data are not very reliable. A new strategy has been developed for the surveillance of NCD risk factors, rather than the disease itself. On this basis, WHO is supporting six countries – Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand to initiate National NCD surveillance projects. Four countries are also being supported on community-based NCD prevention projects.

Realizing the extent of problems posed by NCDs, particularly CVD, the World Health Day theme for this year is focused on physical activity, with the slogan, “Move for Health”. Lack of physical activity, as is now being increasingly recognized, is a major cause of CVD, diabetes and obesity.

It is estimated that lack of physical activity contributes to more than two million deaths per year, globally. A combination of improper diet, lack of physical activity and tobacco use are estimated to be the cause of up to 80% of premature coronary heart diseases. As you are aware, WHO is pursuing an active campaign against tobacco use. There are also examples of legislation prohibiting or restricting the consumption of tobacco. Such measures, while they serve as a welcome beginning, need to be supplemented by vigorous efforts not only by governments but also by other organizations and individuals, especially from the medical fraternity.

Recognizing the high cost of tertiary care for chronic NCDs, including CVDs, WHO has urged its Member countries to give higher priority to the prevention of these diseases. In other words, to divert resources towards primary prevention, i.e. prevention and management of risk factors like hypertension, diabetes, lipid disorders and obesity. Successful implementation of the global strategy for the prevention and control of NCDs should be within the following framework:

- Generating a local information base for action
Strengthening the Foundations of Health in South-East Asia

- Establishing a programme for promotion of health across the life span and prevention and control of NCDs
- Tackling issues outside the health sector which influence prevention and control of NCDs, and
- Ensuring that health sector reforms are responsive to the challenge.

WHO believes that this is the time for global debate to be directed as much towards NCD prevention as to cure. With an increased focus on prevention, the entire public health community stands to gain.

I would like to take just a few moments to share with you some thoughts on the role of cardiologists. As we are all aware, heart disease is certainly not an affliction of the rich. Statistics clearly show the heavy burden carried by developing countries like ours. One question that often comes to mind is, in a situation where many in our rural areas do not have access to basic health services, how does one provide essential cardiac care? The other issue that is usually associated with cardiovascular diseases is that the treatment is beyond the reach of the poor. In fact, at times, it is even beyond the reach of the rich.

What we need to ensure, and this is where eminent cardiologists from SAARC countries can help, is to adopt an approach that will help basic cardiac care to be provided to those who need it, irrespective of who, or where, they are, and the resources at their disposal.

Can we, for example, train general practitioners to be able to take care of basic heart problems? Where timely intervention is of essence, can we find a way of training appropriate health personnel to provide emergency services? Services that could make a difference between life and death, like cardiac defibrilating? In this respect, WHO can also help to prepare training modules on immediate resuscitation for community and medical personnel, which can be life saving. What we need to ensure, is that we are not perpetuating a system, where the minority has everything, and the majority has nothing.

Towards this end, the government and various organizations (NGOs, the World Bank and other international institutions) at all levels also have a vital role to play in policy planning and implementation.

We must ensure that those who need care are provided that care in a timely and effective manner. Let us demystify cardiology. Let us climb down from our ivory towers and reach out to the people. Let us recognize our responsibility to our fellow brethren. Let us carry forward the torch of health for all.
I am sure, when this meeting ends, you will return to your respective countries with a new resolve and determination to make cardiology a much more understood discipline.

The guidelines for the prevention of heart diseases in SAARC countries, to be released during the meeting, will go a long way in preventing cardiovascular diseases and promoting heart health in our Region.
Injury Prevention

Countries of the South-East Asia Region have made great strides in health development. While communicable diseases continue to take a heavy toll, injuries are becoming a major public health problem. Road traffic injury, among others, was the ninth leading cause of the global burden of diseases in 1990. If the current trend continues, road injuries are projected to become the third leading cause by 2020. South-East Asia alone accounts for 27 per cent of the global mortality and almost one-third of the global burden from such injuries.

For individual sub-categories, 35 per cent of the global mortality due to road traffic injuries and 54 per cent of fire-related burns were estimated to occur in this Region. While 40 to 90 per cent of the population is dependent on agriculture, information on injuries related to agriculture is scanty. Available evidence shows that there is a large unrecognized burden due to agricultural injuries.

Injuries account for a high burden on the health and socio-economic sectors. Most injuries, unlike other communicable and noncommunicable diseases, occur among the young and economically active population. This leads to loss of immediate productivity and high costs of care, particularly during their later lives.

Although considered "accidents", most injuries are predictable and therefore, preventable if adequate measures are taken at appropriate levels. In this Region, it is only recently that injury prevention has begun to receive attention from governments and public health institutions. Only a few countries have national or sub-national programmes and policies on injury prevention. We must, therefore, make concerted efforts to ensure development of national policies and programmes in all countries. For this, we need to share the knowledge and expertise available in the Region, and globally, so that we can learn from our successes and failures.

Noting the gravity of the problem, countries of the South-East Asia Region have identified injury as one of the 14 key areas of activity. This consultation is one of the first steps to translate policy directions of the High Level Task force on Intercountry Collaboration into action plans. The regional strategy on injury prevention, expected to be developed at this consultation, would no doubt, provide guidance also for national policies and programmes on injury prevention, and the actions required for their implementation.

I am confident that the experts from Member Countries and international agencies will be able to develop a regional strategy on injury prevention that is applicable, acceptable and feasible within available resources. I urge the distinguished participants to take a fresh look at how we can bring together our knowledge-base and experience to address this challenge. We should, however, recognize that unless there is action at the national and local levels, the purpose of this consultation will remain incomplete.
South-East Asia is one of the most fascinating and heterogeneous regions, reflecting complex and varied social and economic conditions among the Member Countries. Although rich in sociocultural heritage, many parts of the Region face diverse challenges like illiteracy, poverty and malnutrition. The Region is home to one-fourth of the world’s population and unfortunately disproportionate, home also to one-third of the world’s blind persons. Cataract alone accounts on average, for 70 per cent of total blindness in the region. Trachoma is still a cause for concern in Myanmar and Nepal. Xerophthalmia due to vitamin A deficiency may no longer be significant as a blinding condition, but communities still exist in countries such as Bangladesh, India, Indonesia and Nepal that are at high risk. Nearly all countries of the Region are witnessing demographic shifts with increasing numbers of the elderly. Ageing-related conditions such as cataract, glaucoma, diabetic retinopathy and macular degeneration have emerged as major challenges for blindness prevention in the Region.

To meet these challenges, WHO has launched a global initiative — “Vision 2020: The Right to Sight”, in partnership with collaborating nongovernmental development organizations. Great strides have been made in support of this initiative in the Region. A Regional Strategic Plan has been developed through a series of consultations. This focuses on advocacy to put blindness prevention on the national health development agenda. It also emphasizes development of partnerships for mobilization of additional resources. The key strategies include development of an integrated approach to disease control, human resource as well as infrastructure at various levels of health system.

Recognizing that human resources are the most critical component of any health intercountry Consultation on Comprehensive Planning of Human Resources for Eye Care to meet the goals of Vision 2020: The Right to Sight, WHO/SEARO, New Delhi, India, 11-14 December 2001.
system, the WHO Regional Office for South-East Asia, over the last several decades has invested heavily in enhancing capacities for their development which also includes eye care personnel. While this has definitely made an impact, there still remain major areas of concern. These were mapped out at the intercountry consultations on Development of Regional Strategies for Vision 2020: The Right to Sight, held in Jakarta in 2000 and in Bangkok in 2001.

There is a general shortage of all cadres of eye care personnel in most of the Member Countries of the Region. Unfortunately, development of midlevel aphthalmic personnel in the region has been accorded low priority. The availability of sufficient number of trained human resources, when and where needed, is a prerequisite to the development, improvement and efficient functioning of a health system.

The goals of Vision 2020: The Right to Sight are linked to this comprehensive development of eye health system. Human resources for eye care are the most crucial and critical component of this system. I, therefore, expect to receive pragmatic and implementable recommendations, which will energize the activities of Member Countries towards this mission.
Over a decade ago, tobacco production and its perceived economic benefits were one of the major revenue earners and an entry point for socioeconomic development. Today, tobacco production and its use is a towering challenge to health and economic development.

With mechanization of tobacco cultivation and processing, tobacco production and trade in the South-East Asia Region has increased manifold growing steadily from subsistence level production in the 50s to giant commercial enterprises. Today, the eight tobacco-production countries in the Region account for a 10% share of the global unmanufactured tobacco export and 3% share of the global cigarette export market. India and Indonesia rank third and seventh respectively among the 25 leading producers of unmanufactured tobacco worldwide.

While many of these countries have gained economically through trading in tobacco, they have paid a heavy price in terms of health costs and human capital. Today, we know, tobacco costs the world over US$ 200 billion every year. Studies show that tobacco costs the countries of this Region much more than the revenue they earn from it. For example, in 1999, in India, tobacco-related health costs exceeded the joint revenue from tobacco export and taxes. The increasing trend in tobacco consumption in the Region is bound to accentuate this unfortunate situation.

The established linkages between poverty and tobacco have serious implications for this Region. In some poor families, as much as one-third of family income is used on tobacco products, at the expense of essentials such as food, shelter, clothing, water and health services. This perpetuates the cycle of poverty, illiteracy, disease and death.

The time has come for our Member Countries to critically assess the economic impact of tobacco.
implications of tobacco production and use, and to take action. The recent World Bank publication points to the negative fiscal balance or deficit, if I am to use the economists’ terms, that accrue to countries due to tobacco production and use. Unfortunately, most of our countries are yet to appreciate this economic truth.

It is in this context that the analysis that you are conducting becomes critical. In the South-East Asia Region, there is inadequate consumer information about the health risks of tobacco and the risks of addiction, as well as about the huge physical and financial costs to non-smokers.

The high illiteracy levels of consumers and inadequate education on the risks of tobacco use compounds the vulnerability of tobacco users and non-users. Tobacco users are not aware of the cost of their habit in financial and health terms. Given the high levels of nicotine and tar contents in the tobacco products of the Region, smokers and non-smokers, particularly children and women, are at increased risk of tobacco-related illnesses. It is therefore, important that governments take bold economic decisions that would protect vulnerable groups.

Increase in taxes as you all know, has been found to be the single most effective measure to reduce access to tobacco products, particularly among the youth, women and the poor. It is estimated that a 10% increase in cigarette prices world-wide would reduce consumption by 4% in high-income countries and by 8% in low and middle-income countries. Unfortunately, most Member Countries are yet to achieve tax levels that will make a real difference to tobacco consumption in the Region. Your work will provide the scientific basis and strong advocacy to enable countries to take such tax measures.

In 1999, the Health Ministers’ meeting asked WHO to support its Member Countries to conduct economic analysis of tobacco in selected countries. Last year, five countries, namely, Bangladesh, Indonesia, Maldives, Myanmar and Nepal were supported by WHO to carry out the study. I am happy to note that our support now extends to eight of our ten countries. The results of these studies would be critical for WHO’s advocacy work. For Member Countries, it should provide tremendous insights into the economic loss caused by tobacco and the need for action to protect the vulnerable. The report should crystallize and clearly define appropriate economic policy actions that governments must take. We have very capable minds here today to help us define these policy directions based on country data.
Recent history has shown that natural disasters are a common phenomenon in South-East Asia. Every year our countries are affected by natural hazards such as landslides, floods, droughts and earthquakes. During the last few years we have seen large-scale disasters such as the floods in Bangladesh and West Bengal in 1998, the super-cyclone in Orissa in October 1999 and, more recently in January this year, the earthquake in Gujarat. These disasters have resulted in loss of lives and suffering of people as well as economic hardship for individuals, and the community, besides having an effect on the national economy. These emergencies have also represented major challenges for the government and the civil society and tested the level of preparedness and ability to cope with large-scale disaster situations.

While WHO's focus in a disaster situation is primarily on the health aspects, as part of the UN family, WHO participates in the UN Disaster Management Team at the country level. The aim is to further strengthen overall disaster preparedness and early warning at country and regional levels within the UN, in cooperation with interested governments, regional organizations and other relevant sectors. Each of the UN agencies has a special mandate, and our activities in emergency preparedness and response are complementary. I appreciate the participation of members from other UN agencies, International Federation of Red Cross and Red Crescent Society, other NGOs, and the Asian Disaster Preparedness Centre in this meeting, and hope that this will contribute to improved collaboration at country and regional levels.

As the Gujarat earthquake is a recent example of a large-scale disaster, we have brought together some of the key players from the health sector who were directly involved in disaster relief. WHO wanted policy-makers and technical personnel
involved in disasters and emergencies in our region to learn from the Gujarat experience. This is the background for organizing this intercountry meeting which will focus on how we can learn to prepare ourselves better. Natural disasters are unfortunately a part of the unavoidable challenges we face, but with more attention to preparedness we can mitigate the effects and also increase resilience of the communities.

Although the majority of the participants for this meeting come from the health sector, I fully recognize the need for multisectoral collaboration in disaster preparedness and response. Emergency preparedness is the responsibility of all; it should be appropriately positioned into the community and administrative context, and be undertaken at all administrative levels of the government, the private sector and the civil society. Ultimately, it is an essential element that should be integrated in all development policies and strategies.

WHO would like to work with all partners: the governments in our Member countries, national and regional institutions working in the area of disaster preparedness, national and international nongovernmental organizations and donors in strengthening of emergency preparedness and response. However, I feel that often not enough attention and resources are given to disaster preparedness. This is a message also to the donor community: Funds for emergency response are easier to acquire than support for improving preparedness and response capacity, which in fact are very important and cost-effective in disaster mitigation.

Emergency preparedness should be based on vulnerability assessment. In this respect, I would like to highlight the need for more focus on the mitigation of disaster in health facilities and hospitals. In Gujarat, more than 200 health facilities were severely affected by the earthquake. Hospitals require special consideration with regard to mitigation of risks because of their complexity and to their role during disaster situations, especially in the diagnosis and treatment of the injured. In the event of a disaster, a hospital must be able to continue with the treatment of existing patients and serve the people injured in the emergency. To do this, the personnel must know how to respond, and the infrastructure must be in a position to work. Good systems for organizing and mobilizing personnel, equipment and supplies within a safe environment are fundamental for an effective response to any emergency.

Hospitals and health installations can suffer serious damage as a consequence of the occurrence of strong earthquakes or cyclones. It is necessary to construct new health facilities in such a way that they are capable of resisting the kind of natural hazards that might occur in the area. I would be interested to hear from our colleagues from Gujarat what is being done in this respect in the reconstruction of health institutions after the earthquake.
Experience shows that often 70-80 per cent of the immediate assistance in the aftermath of a major disaster is given by neighbours and people from the local community. Only those in the immediate surroundings of an emergency or disaster area can respond quickly and effectively. A community prepared for emergencies can rescue people rapidly and provide life-saving first aid: reliance on external assistance will lead to greater loss of life and harm to the community. Because the community provides the initial rescue and first aid, its capabilities should never be underestimated. With effective emergency preparedness, these can be used very effectively. It has been shown that mortality rates in some types of emergencies can be reduced by 10 per cent by simply placing the injured in the correct position and providing basic first aid. If preparedness measures are taken seriously, families and entire communities could be taught this type of self-reliance. This should also include the identification of hazards and vulnerability, and determining the effects of potential emergencies on the communities. Every level of government, in close co-operation with schools, nongovernmental organizations, Red Cross and Red Crescent Societies and other local resource groups, should support communities in this work. Local health personnel can play an important role in spearheading disaster preparedness at the community level.

In recent years, WHO has developed and documented considerable information of policy as well as technical issues related to disaster preparedness and response. Within WHO, the regional office for the Americas, the Pan American Health Organization (PAHO), has been the leading force in emergency preparedness. I am grateful to PAHO for making available to us two leading professionals, Dr Claude de Ville and Dr Luis Jorge Perez, who will serve as the main resource persons for the meeting.

The use of Internet and information technology makes access to information easier. I will encourage the participants to use Internet more extensively in searching for information on issues related to disaster preparedness. The Emergency and Humanitarian Action Department at WHO headquarters has recently produced the Health Library for Disasters in an electronic format in collaboration with PAHO, the International Committee of the Red Cross, UNHCR, the Sphere Project and UNICEF. I believe this has been made available to you as part of the resource material for the meeting. I congratulate EHA/HQ and Dr Xavier Leus for this initiative which emphasizes WHO's desire to effectively disseminate technical information on health topics to ministries of health, researchers, health workers, collaborating agencies and the public.
However, it would be a mistake if we relied only on technical information. Experience shows that the process and the people are more important than documentation. I would urge you to focus on the practical issues: do not let an emergency plan exist only on paper, but lay stress on practical training and simulation exercises. This should not be done in isolation to other health activities, concentrating only on disasters, but prevention and response strategies should be integrated for any scale of emergency.

This Regional Office would like to support activities to enhance the capacity of the SouthEast Asian countries on disaster preparedness and response. WHO recognizes the need to work closely with the governments and other partners, and I hope that this meeting will encourage and further develop this collaboration.
The Ottawa Charter of 1986 set the benchmarks for health promotion using different settings. Since then, there has been heightened focus globally and regionally on the development of healthy settings as an entry point for improving the health of specific target populations and communities.

The International Conference on Health Promotion in Sundsvall in 1991 called for the creation of supportive environments for public health action at the local level with the focus on settings for health that allow broad community involvement and control, to enable people to expand their capacities and develop self-reliance.

The Jakarta Conference confirmed that “settings for health” represented the organizational base of the infrastructure required for health promotion. Such healthy settings could create new and diverse networks to achieve intersectoral collaboration.

At the regional level, a number of consultations have been organized on the themes of healthy cities, health-promoting hospitals and schools, all towards further development of this approach.

A review of various country-level projects conducted in the Technical Discussions in New Delhi, prior to the 53rd Regional Committee Meeting in August 2000, identified a number of 8 challenges facing the healthy settings approach. If addressed, these could build on the positive achievements of healthy settings initiatives. These challenges are:

- Lack of political commitment at the local level; Limited involvement of the civil society;
- Lack of mechanisms to balance local and national priorities, and
- Lack of linkages between healthy setting activities that are community-based and those that are theme-driven.

The healthy districts approach, then, could add value to the healthy settings approach by improving intersectoral collaboration.

Healthy Settings

The healthy districts approach, then, could add value to the healthy settings approach by improving intersectoral collaboration.

Intercountry Consultation on Integrated Management of Healthy Settings at the District Level, Gurgaon, Haryana, India, 7-11 May 2001.
These findings have led to an awareness of the need to adopt a comprehensive local level system where most of the challenges exist, namely in the district, which is administered in physical and political environments that are manageable.

The healthy districts approach, then, could add value to the healthy settings approach by improving intersectoral collaboration over a range of settings.

The main objective of this Consultation is to identify strategies and mechanisms for integrated management and operationalization of healthy settings at the district level. The Regional Concept and Strategic Paper prepared by SEARO entitled “Healthy Districts Strategies Paper” and “Healthy Districts Concepts Paper” would be presented to you. Please provide your comments after going through it carefully. Your comments would be incorporated in it to make it regionally sensitive.

The Consultation will also identify critical elements for a training module necessary for establishing and managing a healthy district programme.

It is my hope that the outcome of this Consultation would provide a precise global direction on healthy settings. It should also serve as a framework for countries to implement pilot healthy district projects beginning in the year 2002.
Access to safe water and sanitation is a basic human right and to ensure that all our people have these basic rights, it can no longer be business as usual. World Water Day this year focuses on health, as water and health are intrinsically linked. While water is essential for life, safe water is essential for health. In the South-East Asia Region, there is a close relationship between the two. Nearly one million people, most of them children, die each year in this region due to diarrhoeal diseases linked to inadequate water supply, sanitation and hygiene.

Let the World Water Day 2001 serve as a clarion call to all to take action now to correct the current imbalance.

“No more business as usual” was the refrain of Vision 21. Vision 21 is an advocacy initiative of the Water Supply and Sanitation Council aimed at putting an end to what the Council describes as a global crisis in water and sanitation. The Vision 21 report points out that the massive efforts carried out by governments to extend water and sanitation coverage in recent years have barely kept pace with population growth. Conventional approaches to water and sanitation are costly and slow to implement. Achieving the international development target of halving the percentage of people unserved with improved water and sanitation services globally by the year 2015 will cost an estimated US$ 23 billion per year.

“No more business as usual” means that new approaches are needed. Waiting for the big projects to come is no longer an acceptable option because the health impact of inadequate water and sanitation services, together with poor water resource management, has already reached unacceptable proportions. Without new approaches, the situation will worsen. Our finite water resources face increasing pressures in the future due to rapid population growth.

World Water Day 2001 is an opportunity to come together in a common cause and put an end to what the World Health Organization (WHO) describes as a global crisis in water and sanitation. The WHO advocates for a new approach to water and sanitation, which includes a focus on health, education, and economic development. The Vision 21 report highlights the need for new approaches, as conventional methods have failed to keep pace with population growth.

Water and Sanitation

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urbanization and industrialization, climate change and natural disasters.

Several new approaches to tackle the problems of inadequate availability of safe drinking water as well as other related issues can be found in the new WHO publication Water for Health – Taking Charge, which is being launched today in commemoration of World Water Day. In this publication WHO endorses these new approaches, calls for new strategies as well as the return of some that have been lost over time... to confront the present situation.

Some of these strategies include the use of low-cost technologies that can be implemented quickly and to great effect, and can bring about behaviour changes that improve hygiene and reduce the burden of illness.

Water for Health... Taking Charge also calls on health authorities to return to their traditional roles in controlling water and sanitation-related illnesses. In this publication, WHO notes that “In the second half of the 20th century there was a greater emphasis on medical interventions which tended to push safe water supply, adequate sanitation and environmental management to the backseat. It asserts that a major structural adjustment of the health sector is needed in many countries in order to ensure:

- that the health sector can promote low-cost water interventions and behaviour changes not supported by other sectors;
- that it can function as an equal partner with other agencies in the planning, development, and management of water resources and basic services, and
- that it can provide other sectors with reliable data on water-related diseases and effectiveness of interventions to facilitate decision-making on water projects.

But the challenges are not for the health sector alone. In this new publication, WHO calls upon the water sector to incorporate health considerations in water policy, and to integrate health concerns in the environmental impact assessment studies that precede water development projects in most countries today. Many other challenges are laid down in this new publication for local communities, civil society, researchers, the private sector and external support agencies.

Water for Health-Taking Charge encourages us all to take immediate action to mitigate the devastating health impact caused by the current situation. Although advocacy efforts are clearly needed to speed up projects and increase investments, it is also clear that public health needs demand immediate low-cost and targeted interventions in order to reduce the large and ever-growing burden caused by water and sanitation-related diseases in the short-term.
International Health in the 21st Century

1. Historical Development of International Health

There is no single definition of international health since it involves many aspects related to health. Some describe it as “a systematic comparison of the factors that affect the health of the human population”. Others describe it as “the application of the principle of public health to the health problems and challenges that transcend national boundaries and the complex array of global and local forces that affect them”.

International health provides an understanding of the principles of epidemiology and public health, some understanding of the economic significance of illness, special consideration of the similarities and differences among people, familiarity with the structure and functioning of the government, especially the ministry of health and other sectors responsible for health, and humanitarian response to disasters and emergencies.

The history of international cooperation in health may be divided into the following three periods:

Before the first World War

In 1907, “L’Office Internationale d’Hygiène Publique” (OIHP), known as “the Paris Office” was established as the outcome of the agreement, in 1903, to establish a permanent “International Commission on Epidemics”. The main responsibilities of OIHP were “to collect and bring to the knowledge of the participating states the facts and documents of a general character which relate to public health and especially as regards infectious diseases, notably cholera, plague and yellow fever, as well as the measures to combat these diseases”.

After the First World War till the end of the Second World War

The League of Nations Health Office (LNHO) was established in 1920, in Geneva, without the participation of the USA. At that time,
there were three official international health organizations functioning separately: the International Sanitary Bureau in Washington, OIHP in Paris and the League of Nations Health Office (LNHO) in Geneva. The principles governing the work of LNHO were to inform national health authorities on matters of fact, to document them on methods of solving their technical problems and to provide them such direct assistance as they may require. In 1926, LNHO started publishing the *Weekly Epidemiological Record*, which WHO has continued to the present time.

**After the Second World War**

International health since the Second World War can be viewed as a series of consecutive and overlapping eras:

- Era of organization and integration (1940s–1950s)
- Era of consolidation (1950s–1970s)
- Era of programmes and projects (1970s–1980s)
- Era of health sector reform (1980s–1990s)

In 1944, a year before the end of the Second World War, the US government organized the United Nations Monetary and Financial Conference in Bretton Woods, New Hampshire, and invited representatives from 43 countries to attend. The main outcome of the conference was the establishment of the International Monetary Fund (IMF) and the International Bank for Reconstruction and Development (IBRD), or the World Bank.

The formation of the United Nations was the outcome of the “Declaration by the United Nations” (1 January 1942). The actual charter of the UN was drawn up by representatives from 50 countries in San Francisco during the period April–June 1945. Since then, the UN has established many agencies/organizations directly under the General Assembly which promote activities in development and health. These agencies are: UNDP, UNICEF, UNEP, UNHCR, WFP, UNFPA, Habitat and UNCTAD.

A number of autonomous specialized agencies, some inherited from the League of Nations, have also been linked to the United Nations, through specific agreements. These members of the UN family help to set standards, formulate policies, and provide technical assistance in their areas of expertise. Besides WHO, other UN specialized agencies that have a bearing on health issues include FAO, UNESCO, IFAD, UNIDO and the World Bank group.

The work of WHO is carried out by its Headquarters in Geneva, the six regional offices and the WHO Country Representatives’ offices in the Member States. Policies are determined by the World Health Assembly (WHA), held in Geneva in May every year, and attended by delegates from Member States, observers from affiliated NGOs, intergovernmental organizations and other agencies. During the Assembly, the
Director-General presents various reports on subjects of current interest, the budget is discussed and approved, and resolutions are passed. The Assembly may also make recommendations to Member States.

The WHO Executive Board (EB) meets at least twice a year, in Geneva, to prepare general programmes of work for the Assembly, review budget and financial aspects of WHO, and to take emergency action in the event of a calamity or epidemic. The Director-General is subject to the authority of the EB, which consists of 32 technically qualified persons who serve a three-year term as representatives of their respective governments. The main functions of the EB are to give effect to the decisions and policies of the World Health Assembly, to advise it, and generally to facilitate its work. The EB is responsible for preparing the agenda for the annual meetings of the Assembly and for taking emergency actions when needed. The EB may authorize the Director-General to take steps to combat epidemics, to participate in health relief to victims of disasters and to undertake studies and research on urgent health issues.

In the past, the WHO South-East Asia Regional Office (SEARO) and the Western Pacific Regional Office (WPRO) and their Member countries have approached the existing regional political fora and used them as a vehicle for cooperation in international health, namely ASEAN and SAARC. Several projects have been initiated, for example, in areas of essential drugs, communicable disease control (polio-myelitis, tuberculosis, malaria and HIV/AIDS) and disease surveillance. Other regional and bilateral health-related collaborative activities are: International Cooperation for Health Development in the 21st Century (ICHD), Greater Mekong Sub-region (GMS) Project, bilateral cooperation agreements with neighbouring countries and South-South collaboration.

Thailand has a long history of health development, starting from the First Five-Year Plan, in 1961 to the Eighth Five-Year Plan, ending in 2001. National and international health cooperation has been clearly reflected in these plans. With substantial progress in health development, Thailand is recognized as a resource country for technical cooperation with neighbouring countries of both WHO SEAR and WPR.

To address issues related to resource allocation and globalization, and to prepare for the health challenges in the 21st century, the Ministry of Public Health has established an International Health Development Mechanism. An interesting project under this mechanism is the “International health scholars network development project”. About 50 international health scholars among 203 applicants have been selected and trained in international health, negotiation skills and cross-cultural relationships.

2. Health Situation in the 21st Century

With over 1.5 billion people, Member Countries of the WHO South-East Asia Region account for 25 per cent of the world population. This Region also bears the
largest proportion of the global burden of communicable diseases which include tuberculosis, poliomyelitis, malaria and leprosy.

Between 1975 and 2000, the population in the Region increased by 61 per cent. It is estimated that the population will cross two billion by 2025 – an increase of nearly 31 per cent. This is bound to affect the population density in the Region, which is already over 226 persons per square kilometer as compared to the world average of 45.

However, the proportion of the elderly population is increasing due to longer life expectancy, both for males and females. This increasing trend, as shown in Figure 1, will lead to a change in the disease pattern as well as in the provision of health services.

Adding a new dimension to the already challenging health situation is the rising trend in the prevalence of noncommunicable diseases, such as cardiovascular diseases, cancer and diabetes mellitus. This is a direct result of demographic changes, with an increasing proportion of aged people who tend to develop these diseases and of lifestyle changes. The number of accidents, injuries and disabilities are also expected to increase dramatically. High maternal mortality ratios (40 per cent of the world’s maternal deaths)

![Figure 1: Proportion of elderly population, by sex, in SEAR and in the world, 1995-2005](image_url)
and low literacy rates for women and girls are also causes for concern. Women’s literacy levels, as is well known, have a close relationship with infant and maternal health and mortality.

Let us now take a look at health system across the world. The South-East Asia Region, with one-fourth of the world’s population, is passing through an epidemiological transition and most countries of the Region are facing a double burden of diseases. The recent World Health Report 2000 indicates that Indonesia, Sri Lanka and Thailand are low child and adult mortality countries while other countries in the Region suffered high child and adult mortality. The major causes of death and disability among low mortality countries are injuries and accidents, tuberculosis and perinatal conditions. While communicable diseases are still rampant, they also have non-communicable diseases such as cardiovascular diseases, accidents and injuries (Figure 2).

Widespread poverty in some countries of the Region poses a serious threat to health. Poor health aggravates poverty, just as poverty aggravates poor health. This is reflected in the high percentage of low birth-weight infants and malnourished children. With its multidimensional characteristics, poverty is also a major contributor to disabilities and shorter life expectancies. In a Region where millions live in poverty, the implications for health are obvious.

The health situation in the Region, however, is not entirely bleak. Over the past few decades, countries have made substantial efforts to reduce their population growth rates. The average annual population growth rate in the Region has declined from 2.2 per cent in 1975-1980 to an estimated 1.4 per cent 2000-2005. Life expectancies have risen and infant mortality rates have decreased. These improvements have been largely due to the vigorously sustained immunization programme. Efforts to control diarrhoeal diseases, acute respiratory infections and malnutrition have also contributed substantially. The Region is close to eliminating leprosy and to eradicating poliomyelitis. The Region was certified free of guineaworm disease in February 2000.

Recently, many public health experts have been debating on the proxy indicators for measuring health status. No measure is perfect for the purpose of summing up the health of a population. Usually, life expectancy at birth (LEB), which is also one of the summary measures, has been used for a century. The introduction of a new measure, introduced in health science and now being much debated in the present World Health Report, is ‘Disability-adjusted life expectancy-DALE’. DALE, or healthy life expectancy in simple terms, is most easily calculable and well understood (Figure 3).

DALE is estimated from life tables for each country and adjusted with the estimates for disability and other non-fatal health outcomes. DALE, being adjusted
from life expectancy, always has a lower value. On average, the adjustment in all countries is nearly uniform, at about seven years. Both absolutely and relatively, the adjustment is slightly less for richer, low mortality regions, despite the fact that people in those areas live longer and face a higher risk of disability.

According to WHO estimates, the global average LEB is around 64 years and the global DALE average is around 56 years. As per 1999 estimates, 24 countries, mostly from Europe and North America, Japan and Australia, have an equivalent of or exceed 70 years of DALE. The lowest ranking 32 countries have DALE of less than 40 years.

Except Afghanistan, all countries in this category are from sub-Saharan Africa. The rest of the 190 countries fall in-between.

Sri Lanka, Thailand and Indonesia are ranked at the middle with DALE around 60 years, while other SEAR countries have around 50 years.

Socioeconomic indicators, however, show wide variations among Member Countries. GNP per capita ranges from US$ 200 in Nepal to US$ 2,740 in Thailand. The adult literacy rate ranges from 27.5 per cent in Nepal to 100 per cent in DPRK, while Thailand has a literacy rate of 93.8 per cent.

Figure 2: Percentage distribution of top 10 causes of disability adjusted life years (DALY) lost in two mortality sub-regions of SEAR countries, 1999

UNDP has developed a Human Development Index (HDI) as an indicator of the quality of life, based on social indicators and economic indicators. From 1990 to 1996, Thailand’s HDI rank has gradually improved from 74th to 59th. However, in 1997, the first year of the economic crisis, the HDI rank dropped to 67th (Figure 4).

In 1997, the WHO South-East Asia Region accounted for almost 40% of the TB cases reported globally (Figure 5). Following India, Indonesia is a major contributor to the regional TB caseload. With rapidly rising trends in HIV/AIDS, it is expected that TB cases will increase in the near future. It is therefore essential to expand coverage with “Directly Observed Treatment-Short Course (DOTS)” therapy.

As compared to other countries of the Region, Thailand has been more successful in delivering health care services to the people. However, while overall HDI has improved and many important communicable diseases have been eradicated, eliminated or controlled, HIV/AIDS, tuberculosis and dengue haemorrhagic fever are still major public health problems. Surprisingly, Thailand is one of the five countries in the Region that has high TB prevalence, not only because of TB-HIV coinfections but also because of poor TB programme control management.
Figure 4: Trends in Human Development Index in SEAR and WPR countries, 1975-1998

Source: UNDP Human Development Report 2000

Figure 5: Reported tuberculosis cases by WHO Region, 1997

The country has achieved a 60 per cent tuberculosis cure rate (against a target of 85 per cent). Coupled with a low rate of case detection (about 30 per cent), the overall cure rate for active cases of tuberculosis in Thailand is estimated to be only about 20 per cent which is not enough to have any impact on disease control.

The National HIV/AIDS Control Programme has given emphasis to both prevention and care of AIDS cases. With the availability of antiretroviral drugs, it has to make sure that resources for disease prevention will not be reduced and diverted towards case management.

Compared to other regions, the HIV/AIDS epidemic started a decade later in South-East Asia. While most of the other regions have reached the plateau of the epidemic curve, the SEA Region is still showing a rising trend. (Figure 6). India, Thailand and Myanmar host a large reservoir of the cases. This is alarming. If this trend is not decisively controlled now, it will increase child and adult mortality in the coming decades.

3. Health Sector Reform

The term “health sector” is widely used for the industrial sector, financial sector and

![Figure 6: Trends in reported AIDS cases, by region](source: WHO/SEARO, STD/AIDS and Tuberculosis Unit)
agricultural sector. The term “health system” is interchangeably used with “health sector”. Interpreted broadly, “health sector” includes all activities concerned with the preservation and restoration of human health, so it incorporates more limited concepts such as health care system, health services and medical care services. “Health sector” specifically includes both public and private enterprises – that is, government services and the private sector.

As stated earlier, development of a sustainable health system is an important policy for the achievement of the goal of HFA. The health system must be able to respond to the health and social needs of people across their life span. To accomplish this, national and local systems need to reach out and engage citizens in improving their own health through emphasis on promotion of health and prevention of diseases.

The World Health Report (WHR) 2000 defines the health system to include all the activities whose primary purpose is to promote, restore or maintain health.

The health system has three goals or fundamental objectives, namely:

- Improving the health of the population they serve
- Responding to people’s expectations
- Providing financial protection against the cost of ill-health.

### 3.1 Eras of Health System Reform

During the 20th century, there have been three overlapping generations of health system reforms. These reforms were triggered by the perceived failures in health as well as a quest for greater efficiency, equity, responsiveness and better quality of care.

In the first generation, the national health care system, based on the colonial model of the 1940s was established. Although the intention was to have universal coverage, health services were used more frequently by the well-to-do. Too many people continued to depend on their own resources to pay for health, and ended up receiving poor quality of care. The problems were more severe in the poor countries.

On 7 April 1948, the Constitution of the World Health Organization came into force. It proclaimed that “the enjoyment of the highest attainable standard of health is one of the fundamental human rights of every human being without distinction of race, religion, political belief, economic or social condition”. The Constitution also noted that “the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states”. Despite the ambitious proclamations enshrined in the Constitution, large numbers of people in several countries were not enjoying an acceptable standard of health. By the late 1970s, nearly one billion people were living in poverty.
The second generation, which started in the 1970s, emphasized the promotion of primary health care as a means to achieve affordable universal coverage. The goal of Health for All (HFA) was adopted in 1977 and endorsed through a declaration at the Alma-Ata Conference in 1978. The declaration sought to create conditions where people have – universally and throughout their lives – as a fundamental human right, the opportunity to reach and to maintain the highest attainable level of health. The notion of classical universalism (providing all possible care to everybody) emerged from this principle. The call for HFA was, and remains a call for social justice. The Alma-Ata Declaration and the Health for All movement adopted primary health care as the key approach. Comprehensive PHC (providing a minimum of eight elements of PHC) emanating from this HFA movement was actually a manifestation of classical universalism.

Over two decades after the Alma-Ata Declaration, substantial improvements can be seen not only in the health of individuals and communities but also in their confidence, self-sufficiency and health awareness. However, it has been seen that providing PHC is a complex process. From the point of view of donor agencies, not enough is known about the interaction between social factors and the use and impact of interventions. Similarly, we need better knowledge of the interaction between the structure of the health care system and the health status of the population.

In general, the first and second generation of reforms were supply oriented. They gave little attention to people’s demand for health care, which is greatly influenced by the perceived quality and responsiveness. Instead it concentrated mostly on their perceived needs.

The third generation, which started in the 1990s, is under way in many countries, and is characterized by more concern with demand. This reform is due, in part, to the profound political and economic changes of the last 20 years, including the transformation from centrally planned to market-oriented economies, reduced state intervention in national economies, lesser government control and more decentralization.

The HFA renewal process was launched in 1995 in response to the rapid global changes and to ensure that individuals, countries and organizations were prepared to meet the health challenges of the 21st century. It is well recognized that HFA remains the central vision for health in the next century despite various constraints encountered during its implementation. It is for this reason that classical universalism was replaced by a new universalism that derived from selective PHC.

The renewal process led to the incorporation of additional elements that were not considered in the WHO Constitution. For example, the importance of a gender perspective and the need to see health as
being central to sustainable human development received added emphasis. Further, the growing importance of civil society in the governance of health was recognized for partnership possibilities, not foreseen 20 years ago. The importance of strengthening both local participation and structures for health and, simultaneously, acting globally to protect national and local health was highlighted.

WHO recognizes that the new policy has important implications for its work and will adapt its functions and structures accordingly. WHO will assist others to follow our lead and ensure that the greatest possible alignment of policies, resources and human input is devoted to the attainment of Health for All in the 21st century.

Thailand has long adopted the PHC approach as a vehicle to achieve Health for All. Policy and strategies have been implemented at all levels of public health infrastructure. With the renewed HFA goal and strategies, Thailand should carefully look at the new health challenges in the coming century.

This emerging development can be described as a gradual convergence towards what WHO calls a “New Universalism”. It called for high quality delivery of essential care, defined mostly by the criterion of cost-effectiveness and social acceptability, for everyone. It implied explicit choice of priorities among interventions. It welcomed diversity and competition in the provision of services. At the same time, it recognizes that if all services are to be provided for all, then not all services can be provided. The New Universalism combines universalism with economic realism. It recognizes private providers as an important source of health care in many countries (Figure 7).

### 3.2 Equity in Health Care

Health system reform aims at improving equity, quality and efficiency of a health system. The element of improving responsiveness was recently added. Universal

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**Figure 7: Coverage of population with interventions under different notions of PHC**

<table>
<thead>
<tr>
<th>Interventions included</th>
<th>Population covered</th>
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<tbody>
<tr>
<td></td>
<td>Only the poor</td>
</tr>
<tr>
<td>&quot;Basic&quot; or simple</td>
<td>Primitive health care</td>
</tr>
<tr>
<td>&quot;Essential&quot; and cost-effective</td>
<td>&quot;Selective&quot; PHC</td>
</tr>
<tr>
<td>Everything medically useful</td>
<td>(Never seriously contemplated)</td>
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Strengthening the Foundations of Health in South-East Asia

Equity in health should be differentiated from equity in health care. Equity in health (health status) means the attainment by all citizens of the highest possible level of physical, psychological and social well-being.

Equity in health care means that health resources are allocated according to need; health care is provided in response to legitimate expectations of the people; health services are received according to need regardless of the prevailing social attributes, and payment for health services is made according to the ability to pay.

To develop a sound policy to address the issue of equitable health and health care, and subsequently to monitor and evaluate progress, a health information system that provides disaggregated data is mandatory.

3.3 Efficiency of the Health System

The third generation of health system reform characterized by its market-oriented approaches, has led to the creation of inequity and inefficiency in health care. This is because in a market-oriented mechanism, supply (health services) is geared towards demand. Since the well-to-do usually have a better ability to pay, utilization of health services is usually tilted towards them, leading to inequity in the utilization of health care. Besides, there is also supplier-induced demand leading to technical inefficiency resulting from unnecessary use of highly sophisticated health services. Surprisingly, those countries that rely heavily on market mechanisms to achieve the high incomes they enjoy today are the same countries that rely most heavily on governments to finance their health services. Hence, it can be concluded that health is an important component of national welfare.

3.4 Health Care Coverage and Health Care Financing

Besides geographical and cultural factors the way a health system is financed, greatly influences the coverage or accessibility of the population to be served. More than two decades after the Alma-Ata Declaration, we have not seen the realization of universally accessible basic health care. The global picture is very uneven. Many countries are dismantling their social protection mechanisms in health instead of expanding them. Up to the 1980s, many socialist countries had established universally accessible health systems through a prepaid financing mechanism. A widespread movement of the health workforce into private practice accompanied the introduction of market economies in the 1990s, particularly in urban areas. These private practitioners usually favour direct fee-for-service payment. This eventually impedes achievement or sustainability of the universal coverage of care.

In Thailand, both the public and private sectors are large, providing all levels of health care. There is widespread use of the private
sector, especially for ambulatory care. Different population groups have different rights to care, and there is an increasing number of public and private arrangements. Compulsory social insurance covers those informal employment and finances care provided by the public and private hospitals (chosen by the insured). Civil servants have their own medical benefit scheme (voluntary health card). The poor can obtain a low-income card, which exempts them from fees charged in public facilities (Figure 8).

Households and the central government both account for approximately 40 per cent of health care resources. Smaller sources (each accounting for 2-4 per cent) include local governments, the social insurance scheme, private firms and private insurance companies. Donors are estimated to account for only 0.23 per cent. Roughly 6 per cent of the total expenses are administrative. Public and private providers both account for roughly 40 per cent of total health care spending. Only 8 per cent of spending by public agents flows to private providers, while approximately 29 per cent of spending by private agents flows to public providers.

3.5 Performance of the Health System
When Dr Gro Harlem Brundtland took over as WHO Director-General in 1998, her prime concern was that health systems development should become increasingly central to the work of WHO. It was also

Figure 8: Trends in coverage by health insurance schemes in Thailand 1991-1998

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<tbody>
<tr>
<td>Coverage of Population</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: Thailand Health Profile 1997-1998
emphasized that while the work in this area must be consistent with the values of health for all, the recommendations should be based on evidence, and not on ideology. As the World Health Report 2000 suggests, the boundaries of health systems should encompass all actions whose primary intent is to improve health. It breaks new ground in the way that it helps us understand the goals of health systems. The report is the outcome of an analysis of the world health systems in 191 countries, using five performance indicators.

In the World Health Report 2000, WHO uses health status indicators both for its level and distribution, responsiveness (level and distribution), and fairness in financing (distribution only). “Level” is an indicator that reflects the average values achieved while distribution is a reflection of the equity aspect (Figure 9).

- **Overall level of population health**: To assess overall population health and thus to judge how well the objective of good health is being achieved, WHO has chosen to use the measure of disability adjusted life expectancy (DALE). This has the advantage of being directly comparable to life expectancy and is readily compared across populations.

- **Overall level of population health distribution**: To assess this, the report uses the measurement of equality of child survival, across the population.

- **Responsiveness**: Responsiveness includes two major components These are (a) respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health) and (b) client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider).

- **Distribution of responsiveness within the population - how well people of varying economic status find that they are served by the health system.**

Figure 9: Framework for measuring health system performance

<table>
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<tr>
<th>Level</th>
<th>Distribution</th>
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<tbody>
<tr>
<td>Health status</td>
<td>✓  ✓</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>✓  ✓</td>
</tr>
<tr>
<td>Fairness in financing</td>
<td>✓  ✓</td>
</tr>
<tr>
<td>Quality (goodness)</td>
<td>✓  ✓</td>
</tr>
<tr>
<td>Equity (Fairness)</td>
<td>✓  ✓</td>
</tr>
</tbody>
</table>
In 1979, Thailand adopted the primary health care (PHC) approach. The period between the fourth and the sixth Plans (1977-1991), was an era of extending health care services to rural areas and decentralization of authority to the local level to resolve community problems. For about 20 years, Thailand has been successful in expanding services to peripheral areas and reducing the proportion of patients’ visits to secondary and tertiary care facilities (Figure 10).

Fairness in financial contribution (distribution only): It is not enough to protect or improve the average health of the population, if at the same time -inequality worsens or remains high because gain accrues disproportionately to those already enjoying better health. The health system also has the responsibility to try to reduce inequalities by prioritizing actions to improve the health of the worse-off, wherever these inequalities are caused by conditions amenable to intervention. The objective of good health is really two-fold: the best attainable average level (goodness) and the smallest feasible differences.

Figure 10: Proportion of OPD cases at different levels of health facilities

Source: Thailand Health Profile 1997-1998
There are good and bad ways of raising resources for a health system, but they are more or less good primarily as they seek to assess how fairly the financial burden is shared. Fair financing, as the name suggests, is only concerned with distribution. It is not related to the total resource bill, nor to how the funds are used. The objectives of the health system do not include any particular level of total spending, either absolutely or relative, to income. This is because, at all levels of spending, there are other possible uses for the resources devoted to health. The level of funding to be allocated to the health system is a social choice – with no correct answer. Nonetheless, the report suggests that countries spending less than around 60 dollars per person per year on health find that their populations are unable to access health services from an adequately performing health system.

There has been a feeling earlier that the larger the health expenditure, the higher the life expectancy that can be achieved. This is true to some extent but not always. Most countries in our Region have DALE (life expectancy years) of around 50-60 years, but the level of health spending (total health expenditure per capita in dollars) varied widely between 41 and 300 dollars. Indonesia incurs health expenditure as a percentage of GDP (around 1.7 per cent), and is also at a lower range on total health expenditure per capita (around 56 dollars). But it has almost the same level of DALE values as compared to Thailand which has five times health expenditure per capita. This means that there are other non-health determinants, such as education, transport, industries, construction, agriculture, food subsidies, etc., which play an important role in determining health status.

In order to reflect these attributes, health systems have to carry out certain functions. They build human resources through investment and training, deliver services, and finance all these activities. They act as the overall stewards of the resources and powers entrusted to them.

The overall health attainment measurement can only describe how well a country has done in reaching different goals. National health accounts and national health statistics provide such information for analysis. The health system performance index measures where a country stands relative to the best it could be doing, given its resources. However, it does not say how those health outcomes compare with what might have been achieved with the resources available in the country.

A measurement was made keeping in mind the most that could be expected of the health system with given resources (maximum attainable level). A specific value for each country – representing the expected level of attainment of a health system at one end
and the lowest that could be demanded of the health system (minimum possible level) - was estimated using econometric models. With this scale, it is possible to estimate for each country how much of this potential has been realized. In other words, comparing the actual attainment with the potential shows how far from its own frontier of maximal performance each country’s health system is.

This concept of measurement of health system performance is illustrated in Figure 11 in respect of two countries, A and B. The vertical axis shows the level of achievement with respect to the goal of the health system while the horizontal axis shows health system resources. The lower line or ‘minimum possible’ is the level of health that could be achieved with the worst health system. The higher line or ‘maximum attainable’ is the level of health that could be achieved with the best health system. Within the bounds established by the maximum and the minimum, country A, despite a low level of health spending and health attainment than country B, benefits system performance equivalent to country B. In other words, performance is measured in relation to what is achievable given the resources devoted to health. The relative achievement measured against resources available is the critical measure of the performance of the health system.

Although significant progress has been achieved in the past decades, virtually all countries are underutilizing the resources that are available to them. This leads to large

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**Figure 11: Measurement of health system performance**

![Figure 11: Measurement of health system performance](source: World Health Report 2000)
numbers of preventable deaths and disabilities, unnecessary suffering, injustice, inequality and denial of an individual’s basic rights to health. “The impact of failures in health systems is most severe on the poor everywhere, who are driven deeper into poverty by lack of financial protection against ill-health”, the report says.

“The poor are treated with less respect, given less choice of service providers and offered lower quality amenities,” says WHO’s Director-General. “In trying to buy health from their own pockets, they pay and become poorer.”

According to the World Health Report, the following are the main failings of many health systems:

- Many health ministries focus mainly on the public sector and often disregard the frequently much larger private sector health care.
- In many countries, some if not most, physicians work simultaneously for the public sector and in private practice. This means the public sector ends up subsidizing unofficial private practice.
- Many governments fail to prevent a “black market” in health, where widespread corruption, bribery, “moonlighting” and other illegal practices flourish. The black markets, which themselves are caused by malfunctioning health systems, and low income of health workers, further undermine those systems.
- Many health ministries fail to enforce regulations that they themselves have enacted or are supposed to implement in the public interest.

One key recommendation from the report is for countries to extend health insurance to as large a percentage of the population as possible. WHO says that it is better to make “pre-payments” on health care as much as possible, whether in the form of insurance, taxes or social security.

It is especially beneficial to make sure that as large a percentage as possible of the poorest people in each country get insurance. Insurance protects people against the catastrophic effects of poor health. What we are seeing today is that in many countries, the poor spend a higher percentage of their income on health care than the rich.

Thailand has an acceptable level of performance in areas of responsiveness, overall attainment and health expenditure per capita but a very poor level in the area of “fairness in financial contribution. The issue of health equity has been raised frequently in the context of health care reforms at national and provincial levels.

According to a report of the Ministry of Public Health (1998), Thailand has considerable health insurance coverage of either form (76 per cent). About 24 per cent of the population not covered by health insurance must either pay out-of-pocket fees for services or receive free or subsidized services from public health facilities. Considering the quality of
health service delivery and financing, however, there are many issues yet to be solved. The following are examples: technical efficiency (good quality output at lowest cost), allocation efficiency (preventive vs. curative), uniformity and equity of health insurance financing, utilization of unjustified high technology and geographical inequity in human resource and financial resource distribution for health care delivery. The European Union (EU) funded Health Care Reform Project of the Ministry of Public Health (MPH), Thailand, makes an explicit statement that the ultimate goals of the reforms are equity, quality, efficiency and social accountability.

4. Challenges and Health Impact of Globalization

National and local decisions are being affected, as never before, by global forces and policies. The rate of globalization in trade, travel and migration, technology, communication and marketing has accelerated dramatically over the past two decades, resulting in huge gains for some groups and severe marginalization of others. All countries now acknowledge their interdependence by the fragility of our shared environment, an increasingly global economic system, and the potential for rapid spread of infectious diseases. There is concern for the survival of cultural and ethnic diversity in many countries.

Disease transmission

With continuing improvements in transportation and communication facilities, international travel has grown dramatically. In the late 1990s’ more than 500 million annual trips across international borders were made by people on commercial aircraft alone. Virtually any place in the world can be reached within the incubation period for most infectious diseases. Rapid air travel, together with population movements of refugees and displaced persons’ has facilitated the spread of new and re-emerging infectious diseases. Infectious diseases do not respect international boundaries. An outbreak of disease anywhere is a threat everywhere, especially in the countries that are a major hub of international travel.

When an epidemic of infectious disease occurs, the affected country is always reluctant to report the real disease situation due to the fear of trade and travel sanctions by other countries. Unaffected countries usually overreact and apply inappropriate measures to prevent importation of the disease. Very few countries strictly practice the International Health Regulations.

Trade and economy issues (GAT, TRIPS)

The World Trade Organization (WTO), formally established on 1 January 1995, is responsible for administering trade agreements, serve as a forum for negotiations, handle disputes, provide technical assistance and cooperate with other international organizations. Seven countries in WHO’s South-East Asia Region, namely, Bangladesh, India, Indonesia, Maldives,
Myanmar, Sri Lanka and Thailand, are members of WTO. There are two agreements which are integral parts of the WTO Agreement that will have major implications on public health for Member Countries. These are the General Agreement on Trade in Services (GATS) and the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).

GATS is the first multilateral agreement on international trade in services. The world export of commercial health services is currently around 27 per cent of the world export of goods. There is a tremendous potential for growth in trade in commercial health services. GATS applies to international transactions in services. There are four types of supplies of services: (a) crossborder trade; (b) consumption abroad; (c) commercial presence and (d) temporary movement of natural persons.

Crossborder trade, which includes the supply of services from one territory of one Member country into the territory of another without involving physical movement of the supplier or the consumer, covers audio-visual systems, telemedicine and postal services. Telemedicine has been limited only within the respective territories of some countries of the Region.

Health services provided to foreign patients which require face-to-face contact between the patient and the doctor are covered under the mode of "consumption abroad". In spite of not making any commitments, the countries of the Region are participating in this mode of trade.

"Commercial presence" includes the sale of services, originating in one Member Country and establishing a commercial presence in the territory of another member. There are several instances of hospital services being set up through foreign direct investment even though no commitments have been given by the countries in their national schedule of commitments.

None of the countries in the Region have made any commitments under "Professional Services".

"Temporary movement of health personnel" is of primary importance to the countries of the Region, including Thailand. They have a competitive advantage in low cost, skilled and unskilled manpower which can be exported on competitive terms.

Several advantages can accrue from multilateral trade in health services.

Therefore, making commitments under GATS by countries of the Region in accordance with national priorities, objectives and policy would be desirable.

There is increasing interest in the possibilities that trade in health services might offer, essentially to increase foreign exchange earnings. The governments, however, need to consider the balance between trade in health services and ensuring access of the entire population to good quality and efficient services within their own countries.
The TRIPS Agreement has established a minimum universal standard on patents. All countries, regardless of their stage of development, have to follow uniform norms and standards for intellectual property protection. Under this agreement, all countries have to grant patents for pharmaceutical processes and products, in accordance with the transition periods available to them. The burden of proof shall be on the defendant that he has not infringed the right of the patent holder in regard to process. The domestic industry in Thailand and in India has developed substantial productive potential capable of copying innovations from abroad into marketable drugs domestically. The Agreement makes it virtually impossible for firms in Member countries to produce imitative and copied drugs.

Thailand and Indonesia have already amended their Patent Law in consonance with the TRIPS Agreement. Free riding on foreign technology will no longer be possible. Only patent holders will be the legal suppliers of patented drugs, which therefore will be more expensive. This will reduce the opportunity of governments in developing countries to provide low cost drugs to their own people. There is a wide degree of consensus that increased pharmaceutical protection entails a loss in welfare for individual developing countries and even for a group thereof.

An effective national drug policy promoting the use of essential drugs which are generic can provide substantial savings and relief to the consumers. It will also address concerns in regard to equity, efficacy, quality and rational use of drugs. The policy of aggressively promoting the use of generic drugs will be the best option for countries of the Region.

In the South-East Asia Region, only India and DPR Korea are considered to be self-sufficient in terms of producing raw materials for drug manufacturing. In Thailand, there has not been much technology transfer in the production of raw materials or intermediate input for the drug industry. About 48.5 per cent have to be imported for domestic production. The pharmaceutical industry in Thailand is small or medium-sized and therefore, research and development are limited to only drug formulary development.

The Thai pharmaceutical industry and health care system have to rely entirely on various overseas suppliers. Problems concerning the monopoly of patented drugs are due to the requirements of the new drug registration policy that indirectly provides intellectual protection to new drugs and pipeline products for at least two years while safety monitoring programmes (SMP) are being conducted. All these lead to high drug prices and many other consequences such as drug shortages, lack of research and development, lack of therapeutic competition, limited market exclusivity etc. Although the Ministry of Public Health has established mechanisms for monitoring and controlling drug prices, a more specific
infrastructure for drug price control has to be considered.

The Fifty-first World Health Assembly, held in May 1998, the meeting of the Ad hoc Working Group of the Executive Board, held in October 1998, and the Fifty-second World Health Assembly, May 1999, discussed the implications of the TRIPS Agreement on the health sector under the WHO Revised Drug Strategy. Resolution WHA52.19, urges Member countries to explore and review their options under the international trade agreements to safeguard access to essential drugs. The resolution also directed WHO to monitor and analyse the pharmaceutical and public health implications of these agreements.

5. Players and Partners in International Health

There are many players in international health. Besides WHO, other organizations in the UN system also have some responsibilities in health. The more active organizations are the World Bank, UNICEF, UNFPA and UNDP. WTO may become increasingly important in future.

Cooperation in health, however, has not been limited to collaboration through the UN and its agencies involved in health. Bilateral organizations such as the United Kingdom’s Department for International Development (DFID), the Swedish International Development Agency (SIDA), the United States Agency for International Development (USAID), among many others, have played important roles at international and at country levels. These agencies are often the main contributors to international health programmes through UN organizations, but they also provide assistance directly to lower income countries through bilateral agreements. International and national nongovernmental organizations (NGOs) have also made vital contributions to health development at both international and domestic levels.

6. Role of WHO

During the last few decades, WHO, together with its Member States and development partners, has been able to fulfill its role in directing and coordinating international health on many fronts. WHO has been able to reach a consensus on global policies and strategies for health for all, using primary health care as the key approach.

Countries that have extensively implemented health for all strategies provide many successful examples. During this period, WHO has strongly advocated health as being central to overall development. A few major communicable diseases, especially those preventable by immunization, have been virtually eradicated from many areas of the globe. A few are on the verge of elimination. WHO has developed norms, standards and guidelines in relation to various areas of health. This has been done through its extensive network of expertise,
collaborating centres and institutions. WHO has also sponsored many international conferences. The Organization recently launched a few global health initiatives, such as the Global Vaccine Initiative, the Tobacco-free Initiative (TFI), Roll-back Malaria (RBM), Stop TB etc.

6.1 WHO’s Corporate Strategy

Recently, WHO redefined its mission to meet the challenges of the 21st century. The original objective of achieving the highest level of health for all, as contained in its Constitution, will remain its foremost mission. WHO will continue to contribute to world health by increasing its technical, ethical, intellectual and political leadership.

WHO has recently adopted a corporate strategy which provides its Secretariat the main directions for the next medium-term period. It focuses on the technical work of the Secretariat in the following directions: Reducing excess burden of diseases; Promoting healthy lifestyles and reducing risk factors; Developing health systems that equitably improve health outcomes, and respond to people’s legitimate demands; and Developing an enabling policy and institutional environment.

6.2 WHO’s Core Functions

The four strategic directions are interrelated, and the challenge now is to find the right balance. Keeping this view, WHO’s core functions have been redefined. These will be:

(1) Articulating ethical and evidence-based policy and advocacy;
(2) Managing information, setting the international health agenda and stimulating research and development;
(3) Catalysing change through technical and policy support;
(4) Negotiating and sustaining national and global partnerships;
(5) Setting, validating and monitoring norms and standards, and
(6) Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery.

The new specific directions and core functions provide a clear focus for WHO’s priorities. WHO’s governing bodies will continue to provide guidance on the Organization’s work from time to time, especially on how to set priorities, keeping in view its own declining resources.

6.3 WHO Country Cooperation Strategy

The above strategic framework and core functions have been translated into Country Cooperation Strategy. The WHO Regional Office has worked with all Member Countries, including Thailand, to identify country issues/challenges and health priorities. A country-specific document has been developed and will be used as an important guideline for
WHO on how to effectively and efficiently support countries with available resources.

Thailand has identified the following priority areas for future collaboration with WHO:

- Support for health system reform, health system research, consumer awareness and protection and quality and efficiency of health care services;
- Continued support for disease surveillance and control programmes in priority areas, including HIV/AIDS, tuberculosis, malaria and dengue and support for research on infectious disease and vaccine development;
- Support for health promotion programmes, including current areas such as anti-tobacco, and new areas for collaboration such as healthy cities and environmental health, and
- Renewed support for technology transfer and human resources development.

7. Role of Ministry of Public Health

As mentioned above, there are many players in health development. The Ministry of Health has the most important role in developing a national health development policy and plan as a component of the National Development Plan. A good plan should address not only health but also all determinants of good health, for example, education, environment, economy, and physical and biological factors. All national and international partners in health development in any particular country should implement programmes within the framework of the national health development policy. The ministry of health will therefore, not only be planning but also coordinating, regulating and providing services covering all important health matters.

The ministry of health is the primary agency responsible for missions and essential services of public health. These include: (a) prevention and control of disease epidemics, (b) protection against environmental hazards, (c) prevention of injuries/disabilities and rehabilitation, (d) promotion of healthy behaviour, (e) responding to national/local disasters and restoration of health and (f) provision of health services and ensuring quality and accessibility of health services. The ministry of health will not be able to undertake these responsibilities all by itself. Strong partnerships and effective coordinating mechanisms with related agencies are required.

Thailand is one of the few developing countries that have clear development directions reflected in its National (Five-Year) Plans. Development is based on the lessons learned from several studies. The current year is the last year of the Eighth Five-Year Plan. The Plan targets on: (a) mortality reduction and increase in life expectancy, (b) reduction in health problems, (c) improving accessibility
among the underprivileged people, (d) improving accessibility and quality of health services, and (e) self-reliance and people’s participation in health.

8. Role of Universities, Centres of Excellence and Collaborating Centres

Universities are an integral part of health development. They play a most important role in human resource development of all professional health personnel. As a producer, the university should know what type of health personnel the user (ministry of public health) needs. The ministry of health should work closely with the university in curriculum development in order to get well-prepared health personnel and ultimately to reduce the cost of post-graduate training.

As an institute equipped with all areas of health experts, the university should play a more active role in providing technical support to the ministry of health, through research and evidence-based development.

In most countries of the Region, the university has a very small role in international health development, particularly in WHO’s collaborative programme development and implementation. The ministry of health should consider involving the university more in this area in the process of planning, capacity building, reviewing of proposals etc.

The World Health Assembly was convinced that universities could respond positively to the challenges presented by the strategies for health for all. It took the view that universities could respond in the following ways:

1. Reordering academic priorities to accord due recognition to primary health care problems, and health promotion and protection;
2. Developing broad-based curricula, related to current problems;
3. Developing mutually beneficial academic linkages with similar institutions at national and international levels, and
4. Broadening service and research interest in order to address the health concerns of society.

The central challenge to education in relation to health development in the 21st century is to identify the relevant competencies and appropriate attitudes required by health personnel to function effectively in low-cost, wide-coverage health care programmes.

These become the guidelines for formulating, and, later for evaluating educational programmes. I can summarize some of the key attributes required in a future public health graduate:

1. Understanding the political, social, health and biomedical trends and present realities, and anticipating the needs and interventions for the future.
2. Advocating equity and social justice, with evidence to support the argument that health is central to development.
and cannot be left entirely to market forces.

(3) Providing leadership in public health and mobilizing partners and resources.

(4) Analysing and applying planning and policy skills to build sustainable health systems.

(5) Mobilizing people to decide for themselves and paying special attention to the individual, family and the community. While doing so, it is important to take serious note of the underprivileged and those at risk, such as children, women and the elderly, so that they can be self-reliant.

(6) Schools of public health, as leaders in health care and not merely in public health, should play an active role in reorienting medical education by technical inputs in the preparation of undergraduate medical curriculum and teacher training, and not be confined to public health. Therefore, the university faculties should seek out and participate in the training of health professionals at several interconnected levels - within the basic curriculum, as inservice training for health workers involved in part-time public health activities, at the master’s level in public health, and also at the doctorate level for teachers and researchers in public health. Public health should also find a place as part of continuing education programmes.

Besides universities, WHO collaborating centres and national centres of expertise have come to assume a crucial role in the dissemination and monitoring of health development, both nationally and internationally. The role of such centres is increasing to cover not only academic areas, but also research and training, standardization, information and services.

As on 1 February 2001, there were seven collaborating centres in Thailand in various health development areas: Radiation Dosimetry, Deafness, Nutrition, Health Economics, Case Management of Dengue/DHF/DSS, Malaria Parasites, and HIV/AIDS. The designation of one institution as the WHO collaborating centre for Epidemiology and Training is under process. Besides, 15 centres, which have completed their designation period, are under review by WHO, for redesignation.

9. Medical and Health Research in Thailand

Health research capability building is most crucial for health system reforms. In the last two decades, health research capability has been strengthened in several ways in Thailand. To address the problem of lack of a good research management mechanism, Thailand established two effective national research promoting and funding agencies in 1992, namely, Thailand Research Fund (TRF) and Health System Research Institute (HSRI). Both have been established by
special acts which allow them to be more autonomous in budget and programme management. The Board of HSRI has the Minister of Public Health as its Chairman. It, therefore, has direct access to the Cabinet. As a result, the National Health System Reform Committee was established, with the Prime Minister as Chairman.

Several important health research studies (biomedical, health system operational) have been conducted in Thailand. The research is either conducted by the Ministry of Public Health alone or in collaboration with universities or NGOs. It is important to note that the research findings have been used for health programme development and for improving health service delivery. The following are examples of important health research projects:

1. Screening of newborns: The main objective of this project is to detect abnormal conditions, through biochemical analysis, from the newborn stage, for early interventions and prevention of early mortality and disability in the later stage of life.

2. AIDS vaccine development: This is a five-year (1998-2002) Thai-Japanese research project that has been trying to prepare an antigen for producing vaccine, by identifying a vector into which HIV genes can be inserted.

3. Anti-AIDS traditional medicine: This five-year project (1997-2001) has made some progress in identifying and extracting ingredients from 19 medicinal herbs. Some have immune-boosting effect, some HIV enzyme-inhibiting effect and some have antimicrobial effects.

4. National Health Examination Survey (NHES): Based on the results of the survey during 1987-1992, a first report on the status of the Thai people was published and widely used as a reference in the country and abroad. The second round of the survey (1996-1997) has also been completed and the report is being prepared.

5. Studies on status of health systems: Studies in seven areas related to health system have been carried out in coordination with the National Health Foundation, Health System Research Institute, universities, MoPH, Ministry of Commerce, etc. The outcomes of these studies will be extremely useful for health sector reform and for improving the health system in Thailand.

6. Research related to consumer protection: As mentioned earlier, in the 21st century, Thailand has given more attention to consumer protection. Examples of projects that have been completed are: Monitoring of the Use of Generic Name of Drugs and Management of Joint Medical Supplies that will help in substantially reducing the cost of health care services.
(7) Research for reduction of traffic accidents: Traffic accidents are the most important cause of injuries and disabilities in Thailand. This research package involves several agencies concerned in identifying research questions.

(8) Research on children, adolescents and families: This research study deals with the factors affecting the development of potential and quality of life of children, adolescents and families in short-term and long-term aspects. The results are expected to lead to improvements in policy, planning and implementation in this regard.

(9) Control of anaemia and iron deficiency: This project aims to build up a technical base and a linkage with operational-level personnel.

(10) Studies on economic crisis and health: A Health Intelligence Unit (HIU) in Response to the Economic Crisis was established in 1998. This unit is supported technically and financially by the Health System Research Institute and the National Health Foundation. The main functions are to monitor conditions related to health status and the health service system, and analyse and make predictions of what might happen in future. This would help the ministry of public health to appropriately prepare to cope with anticipated situations.

10. Conclusions

In conclusion, during the last 50 years, international health development has evolved with new waves of globalization. Many developing countries are still struggling with poverty, poor health and poor management of health care. There are many players in international health development. Some developing countries who received external assistance in the early days are now external donor partners. Multinational private corporations are mushrooming. They must be persuaded to join global health development efforts.

Thailand, with its success in raising health status and alleviating poverty to the above-average level, should look for challenges in the coming century. It can set an example by concentrating its efforts on eliminating or eradicating many global priority diseases. At the same time, it needs to intensify its efforts on ways to reduce inequalities in health. It needs to find effective and efficient ways to reduce utilization of unjustified high technology and geographical inequity in the distribution of human and financial resources for health care delivery.

Thailand requires to strengthen its efforts at good governance in health. Considering the increasing participation of the private sector in health development, Thailand needs to ensure a balance between the cost of expansion of health care and the affordability, accessibility and fairness of allocations. Thailand needs to foster partner-
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ships both within and outside. Partnerships can be a springboard for effective health development.

Thailand could also cooperate with other developing countries in intensifying intercountry activities for reducing major disease burden and risk factors. WHO will continue to work closely with the Royal Thai Government, civil societies and development partners to fulfill the goals of health for all.

Lastly, many countries are falling far short of their potential. There are many shortcomings in the performance of one or more functions in virtually all countries. The health system is not only concerned with improving health. It must be responsive to the expectations of the people and ensure fairness. The ultimate responsibility lies with the government which should promote equity and efficiency and provide opportunities for wider participation, especially by the private health care providers, and the people.

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Intercountry collaboration in the South-East Asia Region has become an integral part of WHO’s collaborative efforts to support Member States in their health development. It has also proven to be an innovative and cost-effective approach in tackling common health issues affecting more than one country in the Region by facilitating the sharing of experiences among countries and taking joint and complementary action.

The Hon’ble Ministers of Health of SEAR countries, at their 18th Meeting in August 2000, discussed the rationalization of WHO’s resources to strengthen intercountry collaboration. They welcomed such an approach as a means of strengthening regional solidarity and as a response to the globalization of public health problems and issues. They also reiterated the need to ensure effective and enhanced participation of Member States in the planning, implementation and evaluation of inter-country collaborative programmes.

As you are aware, I responded to these concerns at the 53rd session of the Regional Committee, held in New Delhi last September, by announcing the establishment of a high-level task force to advise me on WHO intercountry collaboration for the biennium 2002-2003.

The main terms of reference of the Task Force are to:

1. Identify thematic programme areas of work for implementation through intercountry collaboration;
2. Identify intercountry/regional mechanisms for the effective and efficient implementation of intercountry collaboration, and
3. Assist the Regional Office in the joint planning of the draft intercountry programme Detailed Work Plans for PB 2002-2003, based on the identified thematic programme areas of work.

The first meeting of this Task Force took place in the WHO Regional Office, New Delhi on 1-2 December 2000. Some of you had participated in the deliberations of this meeting. The Task Force noted that as per the decision of the fifty-third session of the Regional Committee, an evaluation of the implementation of one priority ICP-II programme should be conducted.

The Task Force agreed on a process and time-frame for the development of programmes for intercountry collaboration. It also reviewed the specific factors, which had influenced the effectiveness of intercountry collaboration. It developed criteria for selection of thematic programme areas to be addressed through intercountry collaboration. Based on its detailed deliberations, the Task Force identified 13 content areas for developing intercountry programmes during the biennium 2002-2003.

In response to the recommendation of the first meeting of the Task Force, I identified two priority ICP-II programmes of the current biennium, namely 2000-2001, to be evaluated through a joint evaluation mechanism. These are: Improving the Health of the Marginalized and Vulnerable Groups; and HIV/AIDS. The results will be reported to the fifty-fourth session of the Regional Committee.

I convened an informal meeting of WHO Planning/Management Officers and Programme Managers from the WHO Country Offices and the Regional Office, on 18 and 19 December 2000. This meeting reviewed the guidelines and preparatory steps to be initiated for the development of detailed work plans for Programme Budget 2002-2003, for both country and inter-country levels.

Based on the interaction between the WHO staff in the WHO country offices and the Regional Office, draft work plans have been developed for each of the 13 content areas identified by the Task Force at its first meeting. The responsible Programme Managers have developed these work plans in close collaboration and consultation with their colleagues in other departments concerned. Further, these work plans have been shared with the WHO country offices for eliciting their comments as well as those from their national colleagues.

Now, these work plans are ready for your consideration. I would appreciate if you review these work plans, with a view to ensure that they address the principal concerns and issues of the content areas, identified at the first meeting of the Task Force.
According to the latest global burden of disease (GBD) estimates, around six per cent of the global disease burden worldwide, of which about 15-20 per cent are in the 0-4 age group, is linked to "basic hygiene". This includes water, sanitation, food and good hygienic behaviours. These estimates do not take into account vector-borne diseases, such as malaria, schisto-somiasis, severe infectious diseases, such as hepatitis and typhoid or non-infectious diseases, such as arsenicosis and fluorosis. The figures may, therefore, be significant but underestimated.

In the South-East Asia Region, over one million deaths per year may be attributed to diarrhoeal diseases caused by inadequate water supply and sanitation services and poor hygiene. A survey conducted in all countries of the Region in 1999 found that the majority lacked adequate coverage of basic services, especially in rural and peri-urban settings, and most countries lacked basic quality control measures, such as standard settings, monitoring and enforcement. Universal disinfection of drinking water, even in urban systems, is the exception rather than the rule.

In addition to the heavy burden of disease caused by diarrhoeal diseases, water contaminated with chemicals, such as fluoride and arsenic also exact a heavy price. In Bangladesh, about 20 per cent of 25,000 wells tested were found to contain arsenic levels that exceeded the permissible national standard of 0.5 mg/l, the WHO guideline value being 0.1 mg/l. About 95 per cent of 120 million people in Bangladesh draw drinking water from wells. Health authorities have already confirmed over 7,000 cases of arsenicosis and the number is growing. Widespread arsenic contamination of drinking water also occurs in West Bengal, India, and in certain confined areas of Nepal and Thailand. According to current estimates by UNICEF, over 66 million persons in India are exposed to excessive levels of fluoride.

Universal disinfection of drinking water, even in urban systems, is the exception rather than the rule.
Fluoride contamination of drinking water is also a serious concern in Sri Lanka, Thailand and some other countries of the Region.

While there is a need to strengthen the epidemiological database on water-related illnesses in the countries of the South-East Asia Region, the available information already suggests considerable preventable disease burden related to water and sanitation.

A 1995 survey in nine countries of the Region found considerable weaknesses in most national drinking water quality programmes. The 1996 Regional Consultation on Planning and Developing Drinking Water Quality Surveillance and Control Programmes produced a 20-point Action Plan for the Development of National Drinking Water Quality Surveillance, but this seems to have had little impact at the national level in most countries. Preliminary returns received through an ongoing survey suggest that present-day national authorities are not aware of the Action Plan and that there has been little advancement in the development of drinking water quality surveillance programmes at the national and local levels.
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Ethics is one of the major concerns that the SEA Region is faced with. In the medical profession, ethics has transcended centuries of evolution from the time of Hippocrates and it is the pride of every medical practitioner to honour and uphold the oath. The simple message conveyed by the oath can be summarized as, “do no harm”.

Ethical issues are increasingly becoming complex due to the technology revolution. Scientists and researchers around the globe are challenged with the emergence of new diseases. In the developing countries, there is a need for scientists to explore and invent new and efficient ways to prevent and treat infectious diseases. At the same time, the rising burden of noncommunicable diseases has also to be tackled.

The South-East Asia Region provides unique and rich opportunities for research with some countries having highly qualified experts comparable to the best in the developed nations on one hand, while continuing to bear the disease burden of developing countries on the other. This unique situation has attracted many researchers but has also necessitated the urgent need to strengthen research ethics to curb dishonesty and fraudulent ethical practices in health research.

Research, however, is an expensive proposition. Therefore, many developing countries cannot afford to conduct research on their own. International collaborative research, where research is carried out in developing countries, but is sponsored by the more affluent countries, is becoming increasingly popular. Such collaborative research may be a way of helping a developing country to address a public health problem. Sometimes, the foreign location is more convenient, efficient and less troublesome for conducting a particular clinical trial or, it might be a joint effort to address an important health concern faced by both countries.
When developing national ethical guidelines, various international guidelines on ethics including the Nuremberg Code, the Declaration of Helsinki issued by the World Medical Association and the guidelines issued by the Council for International Organizations of Medical Sciences (CIOMS), are always taken into account. The International Ethical Guidelines for Biomedical Research involving human subjects, prepared by CIOMS in 2002, in collaboration with the World Health Organization superseded that of 1993. Like the 1982 and the 1993 guidelines, this latest publication is designed particularly for low-resource countries to assist them in defining national policies on ethics and medical research, applying ethical standards in local situations and forming or redefining adequate mechanisms for ethical review of research involving human subjects.

While the content of the guidelines is important, the awareness of their existence and the capacity to implement them is also equally important. Information on the available ethical guidelines is not yet widely known. In addition to the need to establish the most effective way to disseminate guidelines among researchers, concerns are often raised on the effectiveness of local research ethics committees.

The issue of ethical review in collaborative research is important. Many studies have confirmed the gap in the development of ethical reviews between the developed and developing countries of the South-East Asia Region. Countries with much advanced health research systems showed well-structured national and institutional ethical review mechanisms. Several developing countries do not yet have research ethics committees and even when they are established, often there is a dearth of trained and experienced people. Individuals may lack the training and expertise to deal with the problems that arise in applying any set of guidelines. Countries with the least developed systems to review such research are most likely to be the most vulnerable to unethical research.

Developed countries must assist developing countries in building up their capacities to become equal partners in international research. Improving technical capabilities for reviewing research proposals involving human subjects and managerial training of members of the ethics review committee is the need of the hour. Capacity building should be expanded to include researchers to enable them to be better prepared when submitting proposals for ethical review.

Informed consent is an important focus of attention in ethical considerations in international research. It is a mechanism to explain all the implications about research to be undertaken to the participants before they give their consent to be research subjects. It can also be viewed as an agreement between the researcher and the research subject concerning the roles and obligations of each party in the study. Informed consent is a process and not a one-time procedure, which should be completely
documented. The concept of vulnerability of the study populations and the corollary obligations of the researchers, are central to the well grounded fear of exploitation of study subjects, particularly in developing countries. When informed consent is not obtained and the research is forced to go on, research abuses may occur.

The above is only the tip of the iceberg of the paramount issues in research ethics.

I am very happy to note that nearly 60 eminent scientists and researchers with multidisciplinary backgrounds from most countries of the South-East Asia Region are attending this important workshop. I am sure that you will participate fully and exchange your views and experiences freely. This is the beginning of a good collaboration, which will need effective follow-up action.

I wish to thank the National Institute of Health, USA, and all foreign experts who have come to our Region to assist in this process. I assure you that WHO will continue to provide technical support to assist Member Countries in strengthening their research ethics.
The countries in the South-East Asia Region of WHO are undergoing epidemiological transition. Chronic diseases are assuming alarming proportions. This is due to the demographic and socio-economic transformation that has occurred in recent decades along with profound lifestyle changes. Although the burden of infectious diseases is still large, cardio-vascular diseases, malignancies, diabetes mellitus, mental illness and genetic disorders are increasingly emerging as important health challenges. With rapid progress in the field of molecular biology and genomics, many diseases can be prevented, diagnosed and treated more effectively. Currently, genetic diseases and birth defects are largely underreported in developing countries. It is estimated that the actual frequency of severe genetic disorders and birth defects by age five reaches 78.6 per 1,000 live births.

Important advances in our knowledge on human genetics are creating remarkable opportunities and tremendous challenges. The completion of the first draft of the human genome in February 2001 was hailed as a scientific revolution. Health professionals are becoming increasingly aware of the pivotal role that genes play in ill health and better understand the importance of making appropriate use of advances in genetics in everyday practice. With proper leadership and the formation of strategic partnerships among public health, clinical medicine, health industry and academia, new discoveries in human genetics can be successfully translated into effective public health programmes.

Recognizing the potential of genomics for improving health, the Director-General of WHO requested the Advisory Committee on Health Research in January 2001 to prepare a report on the likely impact of genomics on world health. The report, published in April 2002, was written after a wide-ranging consultative process, including regional consultations. The Executive Board

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of WHO is currently considering the report and the process of preparing a WHO resolution on genomics is in an advanced stage.

Genomics is growing in importance as the general public becomes increasingly aware and demanding of genetic services and as knowledge of genes and their functions permits more effective interventions. Genetic epidemiology, eco-genetics, host-pathogen and gene-environment interactions, ethical, cultural, political and legal aspects of genetics as well as development of genetic services are becoming important and promising areas for research and application by academic institutions, public health preventive programmes and curative services. The ethical, legal and social issues surrounding genetics services need continuous close attention. Issues of autonomy, privacy, and confidentiality require special consideration, as genetic technologies and information begins to be integrated into clinical and public health practice. Similarly, the substantial increase in the patenting of DNA sequences by researchers in both public and private sectors has led to considerable debate and concern about the potential long-term consequences of this practice for society.

The rapid progress made in the area of genomics during the past two decades in the developed countries has had little impact on the status of genetic services in the developing regions of the world. In most of the SEA Region countries’ genetic services are at an early stage of development and in many, have yet to be established. There are numerous barriers for the delivery of basic genetic services. These include absence of reliable data and lack of clinical expertise. Furthermore, the health professionals are largely unaware of genetic risks and the possibilities of effective prevention of genetic disorders. The general public is developing fear towards genetics due to lack of knowledge and the sensationalist reaction of the media. A considerable burden of unmet needs in other priority health areas continues to divert the attention of medical professionals and public health policy-makers from genetic disorders and birth defects. Moreover, genetic services are often incorrectly perceived as expensive, inextricably linked to high-tech laboratory procedures and concerned only with rare diseases. There is also a common misperception that genetic services are mainly diagnostic rather than therapeutic, and that the prevention of genetic disorders and birth defects is limited to selected interruption of affected pregnancies.

In spite of the above-mentioned barriers, certain genetic health services have been initiated in some countries of the SEA Region, particularly at the tertiary health care level. The approach gives emphasis to clinical genetics, dysmorphology, cytogenetics and prenatal diagnosis of chromosome anomalies. Genetics laboratories in the Region are scarce and DNA-based diagnosis is only
incipient. In none of the countries are there comprehensive population-based programmes for the control of common genetic disorders and birth defects.

The challenges facing us are enormous. Complex issues related to genetic testing are emerging. Ethical concerns of obtaining informed consent, the rapid commercialization of genetic tests, and potential discrimination against and stigmatization of individuals and groups based on their genetic makeup need to be addressed. Another challenge is building necessary capacity and capability, strengthening internal coordination and promoting broad partnerships in establishing human genetic programmes. Many countries such as India, Indonesia, and Thailand have already developed considerable expertise in biotechnology. Promoting regional networking and strengthening collaboration between the countries of the SEA Region is essential to build a comprehensive regional programme on human genetics. Each country should be able to identify centres of excellence in genetics that can provide basis for referrals and training. There is a need for developing and strengthening genetic diagnostics, counselling, prenatal diagnosis and carrier detection. The new emerging areas of research for developing gene therapy and stem cell research require attention. There is a need to recognize the importance of teaching genetics to the professionals as well as to the public at large. Appropriate training in genetic counselling is essential in implementing effective public services. It is necessary to create awareness among the public on the need and availability of genetic services.

With the above considerations in mind and as a follow-up of recommendations made by the 26th Session of the WHO SEA Advisory Committee on Health Research, this three-day consultation will review the current status of genetic services in the countries of the Region, identify regional priorities and lay down the framework for a regional genetics programme. It will play an important role in strengthening collaboration between regional centres of excellence, and help in mapping of available expertise and technologies in the Region.
Governments throughout the world are increasingly recognizing that protecting their nationals in financially the fairest way possible is an important goal of health systems development. Keeping this factor in mind, as well as the very high level of out of pocket spending, the Regional Committee for South-East Asia, at its 55th session last year, selected “Social health insurance” as the subject for the Technical Discussions to be held prior to its forthcoming session in September this year.

In keeping with the spirit of the decision of the Regional Committee, the Regional Director organized an expert group meeting in March this year to understand and clarify the policies and programmes on social health insurance and to advise the Regional Director on how best to develop regional policy and strategic options for promotion of health insurance in the Region. The expert group reviewed various social health insurance schemes, both within and outside the Region, and developed the outline and content of a working paper for “Technical Discussions on social health insurance” to be held during the 40th CCPDM meeting, prior to the 56th session of the Regional Committee. Based on the outcome of the expert group meeting, the Regional Office prepared a draft working paper, which is also being used as a background paper for this consultation.

Health care financing is one of the major functions of the health system and is a key determinant for improving health systems performance. Health care financing also deals with collection of revenue, pooling of financial resources and purchasing of interventions. Among these, pooling is of particular importance in ensuring fair financing. Social health insurance is one of the mechanisms for financing and managing health care that is based on pooling. Social health insurance pools not only the health risks of its members but also the financial resources contributed by them.

Regional Consultation on Social Health Insurance, Hotel Novotel, Bangkok, Thailand, 7–9 July 2003.
Traditionally, countries in our Region have had very low levels of coverage for social health insurance, or for any form of health insurance for that matter. Rather, they have relied primarily on government tax-funded health systems. While this is also considered a fair method of financing, it is generally agreed that tax-based health financing is inadequate in itself to ensure universal coverage.

Social health insurance schemes and the government tax-funded health care financing have common characteristics in the context of pooling risks and contributions. However, there are some important differences in the tax-based systems, the funds from the people come indirectly through general tax contributions. The people, thus, are not aware of the amount they may have contributed specifically for health. In contrast, people covered under social health insurance schemes are aware of their contributions. It is generally conceded that these two methods complement each other in achieving universal coverage.

A majority of countries in this Region have adopted mixed health care financing mechanisms. They have social health insurance schemes which cover between 3-20% of the population. In most cases, these schemes cover only the organized sectors (i.e. employees of public departments and enterprises, workers in formal and informal production sectors and their families), where premiums (or contributions) can be easily collected. A few countries have tried to achieve universal or near-universal coverage through a combination of social health insurance and other risk pooling alternatives, such as community-based financing and a government subsidy for the poor, in order to ensure that the entire population is able to access essential health care.

Another policy challenge today is how to accelerate the development of community-based, health-risk-sharing schemes to cover people in under-served areas. Continuous and sustained support and incentives from national and local governments are required to improve the managerial skills and to...
provide opportunities for pooling funds to generate greater financial viability and sustainability.

There is a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from the basic goal of financially protecting the poor. The success of health insurance in achieving health reform goals is closely related to its particular institutional characteristics and managerial capacity.

We all know that the expansion of social health insurance schemes also depends on the stages of socio-economic and overall health systems development. At present, Thailand is the only country in the Region with near universal coverage. While this effort is commendable, it has its own constraints. Thailand is grappling with the equity issue, cost containment, quality of care, regulation and policy re-definition. Other countries have limited coverage of social health insurance which is concentrated only within specific population groups. These countries are attempting to attain substantial population coverage, improve efficiency, and promote equity and access. Efforts to increase coverage beyond these groups are frequently hampered by lack of administrative and managerial capacity, inadequate policy guidance and regulation. We need to develop appropriate policy options and strategic directions and a road map to improve the national capacity for expanding social health insurance coverage.
In September 2000, 189 Member States of the UN (including 147 Heads of State) adopted the United Nations Millennium Declaration at the United Nations Millennium Summit in New York. The UN Secretary-General proposed a road map in his report to the 56th United Nations General Assembly in which he spelt out the millennium development goals, targets and indicators. These goals are referred to as the United Nations Millennium Development Goals. Three out of the eight goals, five out of the 18 targets and 18 out of the 48 indicators are related to health. This, once again, highlights the fact that improvement in health is vital for future development and eradication of poverty.

I would like to point out that the Director-General designate, Dr LEE Jong-wook, in his address to the World Health Assembly last month emphasized the importance of commitment to achieving results at the country level. He stressed the need of pursuing aggressively measurable health objectives, including the Millennium Development Goals which set clear objectives for countries in nutrition; access to safe water; maternal and child health; infectious disease control; and access to essential medicines. These goals are strategic markers within a broad health agenda that builds on the Alma-Ata legacy.

The Regional Office also took an initiative in early 2000 to collect data sets on core health indicators from each country and published them in a brochure for general use. We will use this mechanism to improve the collection, collation and reporting as well as updating of these core health data sets. At the same time, in the spirit of one WHO, the Annex tables contained in the World Health Report will be updated to include UNMDG reporting, in addition to reporting by each technical programme.

As per the Millennium Development Declaration, all countries are required to collectively report progress towards achieving

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Regional Consultation on Reporting on Data Sets on UN Millennium Development Goals and WHO Core Health Indicators, WHO/SEARO, New Delhi, India, 17-19 June 2003.
the Millennium Development Goals. Thus, the national health authorities now have an additional responsibility for reporting annually the progress on 18 of the MDG indicators which are health related. I am glad that some Member Countries in our Region have initiated the multisectoral process of data collection and produced annual progress reports on Millennium Development Goals, while some are in the process of developing such reports.

During the process of data collection and reporting, we have found some challenges that need to be addressed. These include data definition, data sources, estimation processes and methodologies, agreement of final data etc.

It is, therefore, most appropriate and timely that all parties concerned have come together to foster a common understanding, which should help improve the collection and reporting on MDG indicators.

You would also deliberate on how best to meet WHO’s responsibilities with regard to reporting the 18 MDG health indicators, and in particular, the immediate process to be followed, leading to their publication in the Annexes of the World Health Report 2003, due for release in October.

I would urge you to review the availability and technical accountability of the Data Sets on the UN MDG and WHO Core Health Indicators, reported by the Member Countries and those produced by WHO.
Considering that approximately 2.2 billion persons constitute the global workforce, with our Region accounting for approximately 560 million workers, the timing of this Consultation is most appropriate.

It is estimated that a hundred million workers are injured, and 200,000 die every year, due to occupational accidents throughout the world. In addition, between 68 to 150 million people contract occupational diseases globally. Such high figures have a very severe impact on the health status of the global population. Furthermore, occupational injuries and diseases are more pronounced in the countries of our Region. Absence of relevant legislative, administrative and technological provisions or their application are major contributors to such health hazards. This is an issue that invites serious attention.

WHO’s first occupational health programme was established in 1950. A new strategy for further development of occupational health services was adopted in 1979, with the World Health Assembly stressing the need to organize primary health care services “as close as possible to where people live and work”. In 1980, the World Health Assembly reiterated the need for “a new perspective, integrating occupational health into the primary health care of under-served working populations, particularly in developing countries”.

WHO has been providing technical support to Member Countries in the Region to strengthen their occupational health services. Attention has been given to human resources development, promotion of research activities, and development of intersectoral collaboration and partnership. In 1996, the WHO South East Asia Advisory Committee on Health Research focused on the need to strengthen occupational health research. In 1999, the Jakarta Declaration

Intercountry Consultation on Regional Strategies for Strengthening Occupational Health in SEAR Countries, WHO/SEARO, New Delhi, India, 28-29 April 2003.
on Health Promotion, called for strengthening health at the worksite.

In order to provide evidence-based information for priority-setting and planning occupational health programmes, the WHO Regional Office has assessed the regional situation over the last five years. A series of surveys were conducted on occupational hazards, as well as the infrastructure and capacity for occupational health services in SEAR countries. The major findings of the survey indicated considerable under-reporting of occupational diseases and injuries. One reason could be the lack of systematic planning and clear tools and guidelines at the national level. However, the survey indicated that most Member Countries are actively involved in some aspect of occupational health, showing a clear commitment to the programme. It is therefore timely to consolidate different activities within a regional strategy on occupational health. This would greatly help Member Countries in formulating national plans of action.

With rapid economic development, globalization and privatization, occupational health issues will be increasingly important in the Region. What we therefore need is concerted efforts, based on solid evidence and sustainable partnerships to deal with these health problems. There is a need not only for blueprints for action but also to foster a regional network in occupational health.
Since the last regional consultation on health information systems held at Yogyakarta in 1995, most countries of the Region have further strengthened their health information systems. These efforts have been an integral part of strengthening the overall health care system. This, in turn, has resulted in making better use of information at all levels.

Reliable and timely health information is a critical component in health system development. Collection of relevant data and its related analysis to provide necessary evidence for assessing the development and performance of health systems at national and sub-national levels is the major role of any health information system. Providing timely feedback to programme managers has been a challenging task for the health information teams at all levels of the health system.

In view of this, many intercountry and national training courses on management of morbidity and mortality statistics, including appropriate use of medical records and expanded use of ICD-10 coding, have been organized in the Region.

It has been observed that the national health information systems are often too vertical. They are centrally-oriented and overloaded with data, many of which are not fully relevant to programme management at operational levels. In addition, monitoring and evaluation processes of the health system are usually not systematically built into or connected with the routine health information system.

One of the key activities to improve any system is constant monitoring and evaluation. You will, during the course of your deliberations, discuss how to further strengthen the monitoring and evaluation of health programmes as an integral part of national health information systems. I would like to stress that if proper and timely
monitoring and evaluation is conducted, the overall performance of the national health system could be improved.

This consultation will review the progress of health information systems in the countries. An action plan will also be developed for the Region to achieve a more responsive, dynamic and user-friendly HIS to serve the needs of the countries.

Given the provisional programme of work, you have a challenging task ahead. I am sure you will share your experiences and expertise and consider better ways to effect positive change in health information systems. This would help to obtain more reliable and valid data for use in evidence-based decision-making and also for assessing health systems performance in countries of the Region.

I would like to emphasize that this consultation is very timely in the context of health systems performance assessment currently promoted by WHO.

I would also like to urge that the strategies you develop and the mechanisms for their implementation should be practical and realistic. This would help us to achieve the desired goal of strengthening health information systems in the countries in support of assessing health systems performance.
Over the past few years, WHO has been focusing attention on identifying the reasons for the wide variation in the health status of Member Countries and ways and means to bridge this gap. A health systems performance assessment concept has been developed and the results reported in the World Health Report 2000 (WHR-2000). Most Member Countries in our Region were at the lower end of the ranking scale. This situation prompted serious concern in these countries since they had been trying hard to improve their performance on all fronts. WHR-2000 succeeded in generating widespread interest among governments, international agencies and other partner institutions to assess and improve health systems performance.

In consultation with the Ministers of Health of our Region, I had convened a High Level Task Force Meeting on WHR-2000 in July 2000 which was attended by senior health policy-makers from all Member Countries. WHO headquarters also provided technical support to this meeting. The Task Force reviewed the WHR-2000, particularly the concepts, principles and methods used and the results obtained, and recommended that WHO should:

- further fine-tune the concept of health systems performance and the measurement methodology and indicators used, taking into consideration the broad definition of health (for example, mental and spiritual well-being), and
- provide technical support to Member Countries for the development and fine-tuning of relevant data-base especially with respect to:
  - detailed information on Life Tables;
  - distribution of child survival or survival of any other age groups;
  - national health accounts, and

The Task Force also recommended that WHO should develop simple and practical mechanisms to measure responsiveness, using appropriate culture-specific parameters.
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The Task Force also recommended that WHO should develop simple and practical mechanisms to measure responsiveness, using appropriate culture-specific parameters.

It also recommended that there should be a continuous, two-way dialogue on data verification among the countries, regional offices and WHO headquarters with all possible sources within the Organization and with other UN agencies, especially for the preparation of future World Health Reports.

This subject was also discussed at the 53rd session of the WHO Regional Committee held in September 2000. Responding to the Director-General’s address at the Regional Committee, some delegates expressed concern over the assessment and ranking of their respective countries in the WHR2000.

At the 107th session of the Executive Board in January 2001, in her report on “Health Systems Performance Assessment”, the Director-General indicated that WHO would encourage a wider examination of the issues and proposed further action. The Executive Board, after a thorough debate, endorsed the Director-General’s initiative (among others):

- to establish a technical consultation process, bringing together personnel and perspectives from Member Countries in different WHO regions, supported jointly by staff from WHO at country, regional and global levels;
- to ensure that each Member Country is consulted on the best data to be used for assessing health system performance, and provided advance information on the indicator values that WHO obtains using these data;
- to establish a small advisory group, including some members from the Executive Board and the Advisory Committee on Health Research, to help monitor WHO's support for the assessment of health system performance, and
- to compile a report on the performance of Member Countries' health systems every two years.

The Executive Board also requested the Director-General:

- to initiate a scientific peer review of health systems performance methodology as part of the technical consultation process, including updating on methodology and new data sources relevant to the performance of health systems;
- to ensure that WHO consults with Member Countries and shares the results of the scientific peer review and its recommendations;
- to develop a multi-year plan for further research and development of the
framework and its relevant indicators to assess the effectiveness and efficiency of health systems as part of the technical consultation process;

- to report to Member Countries on the impact of health systems performance reports on their policies and practices.

The Director-General also reported to the 54th World Health Assembly, in May 2001, on the actions undertaken, such as establishment of an advisory group, and an expert team for peer review, as well as organizing technical consultations.

At the Sixth Meeting of the Health Secretaries, held at Yangon recently, the progress made in the Region was reviewed. The importance of informing Member States of the methodology used in rankings was emphasized. The issue of validity of data was again raised. Member Countries, in general, supported the concept of health systems performance assessment and provided examples of national efforts undertaken to improve the quality and availability of data in support of such assessments.

The Regional Office in collaboration with WHO headquarters, is working closely with four countries – India, Indonesia, Myanmar and Thailand – that would like to join a pilot effort to build the capacity for better assessing health systems performance through the global programme – “Enhancing Health Systems Performance Initiative (EHSPI).” Sri Lanka and Nepal have also expressed interest in participating in this initiative.

The range of important issues brought out on the health systems performance assessment in the Region convinced me that the timing of this regional consultation is very appropriate. I therefore invited high-level policy-makers as well as technical experts from the countries to join this meeting. The meeting, as you will notice, is structured in such a way that the first two days would concentrate on discussions on a wide range of conceptual and policy issues, while the next two days would focus on the technical details of methodology and data management. I expect that the meeting would provide avenues for:

1. listening to and reflecting on the widest possible range of views and ideas on health system performance assessment, to be carried out by WHO for reporting to Member States every two years, and

2. identifying the gaps in the process of data collection, analysis and reporting, with a view to improving the completeness and quality of available data on key outcomes related to health systems.

I am sure that with your rich background and considerable expertise in this area of work, the objectives of this consultation will be fully met. I look forward to receiving the widest possible range of views and ideas on health system performance assessment.
As you all know, WHO has been a strong advocate of primary health care, particularly during the past 25 years. Many changes have taken place since the WHO policy on PHC was initiated a quarter of a century ago. On the one hand, primary health care implementation faces new economic, social political, technical and institutional challenges in the face of increasing pace of globalization. On the other hand, the current trend in decentralization has provided an opportunity to speed up its implementation. This workshop is timely and your reflections on these issues will be extremely valuable.

However, I would like to emphasize that public health concerns are like clinical medicine. They require good history taking of the event and not merely looking into the presenting symptoms. A good policy review of PHC will only be possible if we reflect on the overall span of its implementation with its ups and downs and not limit ourselves to the current ongoing experiences.

I would also like to remind you that primary health care, adopted at Alma Ata in 1978, was not the outcome of theoretical dreams, ideas and perceptions. It evolved during the early years of the 1970s, as a result of widening inequity in health care at that time. Various experiences of good health care practices were reviewed and analyzed in developing and developed countries, both in public and private sectors. These examples of good practices provided the evidence on which primary health care of Alma Ata was formulated. Experiences in various countries of the WHO South-East Asia Region contributed to this. These experiences were documented in WHO-UNICEF publications such as “Alternative approaches to meeting basic health needs in developing countries”, and “Health by the people”, both issued in 1975.

All Member Countries of WHO’s South-East Asia Region committed themselves to
PHC as the key approach for achieving Health for All. Experiences in the actual implementation of PHC varied with success and failures. Lessons were learned and innovations emerged. Some countries such as Thailand integrated health development into local community development, through the Basic Minimum Needs approach for improving the quality of life. Their experiences were shared with other regions, and was adopted by the Eastern Mediterranean Region. Many countries organized and trained volunteers, particularly women, as enthusiastic, gigantic crash programmes to create PHC delivery systems. In some cases, health care policies were deviated and moved away from primary health care. The WHO South-East Asia Region promoted and supported the District Health System Approach for sustainable and comprehensive PHC development. The District Health System, based on primary health care, is broad enough to accommodate comprehensive implementation of PHC strategies. It is also flexible enough to adopt and respond to the new challenges.

Our Region has been committed to primary health care. This commitment was reaffirmed in the Declaration on Health Development in the South-East Asia Region, endorsement by the fifth session of the Regional Committee in September 1997. Since 1985, there have been ten winners of international awards for innovations and good PHC implementation in our Region. These rich experiences of our successes and failures will provide valuable inputs from our Region to the global PHC policy review.