A Vision for Health Development in South-East Asia

Selected Speeches by

Dr Samlee Plianbangchang
Regional Director
WHO South-East Asia Region

Volume I: March 2004 – February 2006
WHO Library Cataloguing in Publication Data

World Health Organization, Regional Office for South-East Asia.


ISBN 92 9022 267 0 (NLM Classification: WA 541)

© World Health Organization

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. For rights of reproduction or translation, in part or in toto, of publications issued by the WHO Regional Office for South-East Asia, application should be made to the Regional Office for South-East Asia, World Health House, Indraprastha Estate, New Delhi 110002, India.

The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

February 2006
Contents

Preface v

Communicable Diseases

Health and Development 1
Avian Influenza and Pandemic Preparedness 8
Malaria Control 14
Elimination of Leprosy 21
Elimination of Kala-azar 25
Challenges to Health 27
Tuberculosis Control 35
Emerging Infectious Diseases 38
Sexually Transmitted Infections 41

Noncommunicable Diseases and Mental Health

Chronic, Noncommunicable Diseases 45
Promotion of Mental Health 50
Health Promotion 54
Mental Health Legislation 58
Community-based Mental Health Care 61

Family and Community Health

Nutrition in Health Development 65
Maternal and Child Health 71
Obstetrics and Gynaecology 73
Sustainable Development and Healthy Environments

- Health Aspects of Emergency Preparedness and Response
- Health Aspects of the Tsunami
- Emergency Health Action
- Tsunami Affected Countries
- Trade and Health

Health Systems Development

- Improving Access to Health Care
- Social Determinants of Health
- Licensing of Vaccines
- Field Epidemiology Training
- Public Health Education
- MDGs in Asia and the Pacific
- Medical Education
- Access to Medicines
- Health Research
- Public Health Initiative
Preface

This first volume of selected speeches by Dr Samlee Plianbangchang covers a two-year period from 1 March 2004, when he assumed office as WHO Regional Director, South-East Asia Region.

The speeches, covering a wide range of priority health development issues were delivered at various national, regional and global level meetings and conferences. While reflecting the broad areas of WHO’s collaborative efforts in the Region, they also present Dr Samlee’s vision for health development in the Region.

The speeches are broadly classified into five areas and are presented chronologically for ease of reference. The title, name and period of the event are indicated in the footnotes.
Communicable Diseases
The theme for the Conference – “Roadmap to Healthy India: Vision and Challenges”, is very thought provoking indeed. Your deliberations on this subject will significantly contribute to the national efforts in disease prevention and control.

Over the past many decades, we have come a long way in the area of health and development. People are living longer, the literacy rate has increased with improved quality of education. Work opportunities and incomes have amplified.

The discovery of vaccines and effective drugs over the past 50 years have heralded a hope to conquer communicable diseases in the near future. We must particularly note that there has been considerable success in this area in India.

Small pox has been eradicated from the country for decades. Infant mortality which had been intractable to interventions, its rate has been halved in the last 50 years. Guineaworm disease has been eradicated. Poliomyelitis and yaws are on their way out. And according to the monitoring and reporting system, the national average prevalence rate of leprosy in India is now less than 1 per 10,000 population. This is the target for leprosy elimination.

The Revised National TB Control Programme is now saving about 600,000 lives every year. There is a strong policy commitment to the elimination of Kala-azar. The elimination target for this disease has been set for the year 2010.

The Annual Conference of Indian Society for Malaria and Other Communicable Diseases, Agra, India, 13 February 2006
Very importantly in this connection, the Government budget allocated for communicable disease control and elimination is increasing progressively.

The pharmaceutical industry is vibrant and making rapid strides. Production of generic antiretroviral drugs in India has revolutionized the care and treatment of people living with HIV/AIDS. The disease has been turned from a virtual death sentence to a chronic manageable condition.

A similar success story for manufacturing antivirals for avian influenza is likely to unfold soon. This will help us respond boldly and effectively to this new challenge. The potential impact on the influenza pandemic it may bring will be minimized.

These achievements, as mentioned, make us optimistic about the future. However, efforts to control communicable diseases must not only continue, but also be accelerated for a variety of reasons. The burden of communicable diseases still remains unacceptably high in our Region. About 40% of the 14 million deaths annually are attributable to these diseases.

It is very unfortunate that much of the brunt is borne by children, women, the poor and marginalized sections of society. WHO estimates that nearly 90% of all deaths in the developing world are caused mainly by six infectious diseases. These include: acute respiratory infections; diarrhoea; measles; malaria; HIV; and tuberculosis.

This is a great tragedy, because each of these diseases is preventable and treatable. And cost-effective public health interventions are available to tackle them locally at the country level. But, it is a pity that those who are most in need tend to have limited or no access to these life-saving interventions!

Nearly 18% of all deaths in children in developing countries are due to acute respiratory infections. An additional 15% die of diarrhoea.

A highly effective vaccine against measles has been available since the 1960s. Even then, about 200,000 children in our Region succumb unnecessarily to this disease every year.
Nearly 180 million people in South-East Asia live in areas at high risk of malaria. Every year 2 to 2.5 million malaria cases are reported, with 27,000 deaths. This is obviously an under-estimated figure. The coverage of preventive interventions, such as insecticide treated bednets, and indoor residual sprays remain generally very low. A severe form malaria due to Plasmodium falciparum has increased alarmingly from 12.5 to 45% of all cases over the past 10 years.

Even today, tuberculosis is the biggest killer of young adults, taking a toll of 1,000 persons every day. With continued DOTS expansion in India, we expect the number of deaths to decline significantly. However, the situation is likely to get complicated with the rapid spread of HIV, and emergence of drug resistant strains.

Since 1981, when it was first recognized, another dreadful scourge, HIV, is now spreading relentlessly in various parts of the world, including our Region. India, with an estimated 5.1 million people living with HIV, is next only to South Africa in terms of the number of infections. A massive scale up in the areas of prevention, care and treatment is urgently needed, not only in India, but throughout the Region. This is in order to achieve universal access to these services by 2010. We still have a long way to go in our fight against HIV/AIDS, till we can bring it under control.

The evolving phenomena of communicable diseases is unending. They never cease to give us unpleasant surprises! Over 30 new infectious pathogens have been detected in the last three decades. Most of these have originated in animals.

In the past three years alone, we have witnessed outbreaks of SARS, Nipah virus, Chandipura and avian influenza. These new pathogens, particularly viruses, remain unpredictable and versatile. They continue to emerge with a high propensity to spread across countries to newer areas.

The intimate contact between man and animal, which is a reservoir of infectious agents, adds a new dimension. This calls for strengthening of veterinary public health services, and a close cooperation between animal and human health agencies.

The epidemics caused by new and emerging infectious diseases challenge public health systems as never before. This trend
serves to remind the policy makers of the critical importance of public health infrastructure.

The plague outbreak of 1994 is still fresh in the public memory. This was not only because of the human deaths, but the resultant social disruption and economic losses.

Outbreaks of dengue fever, leptospirosis, Japanese encephalitis, meningococcal meningitis and viral hepatitis continue to occur unabatedly. Certainly, effective and timely response to these outbreaks does save lives. However, this will become possible only in situations where the public health system is intact and functional.

We may recall that SARS appeared in 2003 and spread to 30 countries all over the world. It killed about 800 people and inflicted an economic loss to the tune of US$ 18 billion to East Asia alone. Now, we are facing another challenge of a potential influenza pandemic. If this occurs, it will far surpass SARS in terms of the number of countries affected and the severity of health and economic disruption.

Avian influenza has complex epidemiological features, with several aspects still not fully understood. Given the existing environmental and socioeconomic situation, Asia is considered the most likely epicentre of this pandemic. The greatest impact shall be felt by countries with weak public health systems. Its severity will be most in the countries with inadequate resources and a feeble state of preparedness!

Within this context, the battle against communicable diseases needs to be intensified on several fronts. However, in view of resource constraints, we should focus urgently on some of the most important priorities as follows: First – Intensification of interventions efforts. We need to make every effort to scale up the available cost-effective interventions against communicable diseases. This needs to be done and achieved in both coverage and quality. A system approach to planning for scaling up and measuring progress is needed.

While efforts in this regard may be made in a phased manner, it is imperative to ensure that benefits from such interventions reach the most vulnerable groups of population. Only a strong
Second – Functioning public health system. An effectively functioning public health system is the key for responding to the challenge of communicable diseases. A system which consists of people who are trained and work in the field of public health. And a system which is constituted with a complete physical infrastructure. This includes, among others, effective surveillance, and early warning, with adequate laboratory back up.

Undoubtedly, India is home to several internationally acclaimed public health institutions. The need of the hour is to partner with them, enhance their capacity, if required; and work with them effectively to forge public health action in the fight against communicable diseases.

Networking between and among various institutions can harness the expertise available within the country and in the Region. In this regard, we really appreciate the support being provided by India to neighbouring countries in the public health field. We strongly believe and anticipate a greater role to be played by India in international public health in future. Moreover, various international financial initiatives such as the Global Fund for AIDS, TB and Malaria, provide an excellent opportunity to build public health infrastructure and capacity. This can help ensure long-term sustainability of public health programmes in countries.

Furthermore, the revised International Health Regulations also provide an opportunity to build core capacity; among others, in surveillance, early detection and reporting. Its implementation will contribute greatly towards containment of international spread of emerging infectious diseases. This international public health instrument will ensure minimal disruption in travel and trade across borders.

However, we must keep in mind that the public health infrastructure is as good as the people who operate it. A qualified and well-trained public health workforce is indeed critical for our success.

To develop and sustain an adequate number of competent public health staff at all levels is really a challenge. To motivate them to work hard and make a difference in the community and
the population need strong incentives. Opportunities for continuing education and upgradation of skills of these health personnel should be an important requisite in human resource management. The public health cadre should be exposed to both technical and managerial work in a balanced manner.

Third – Multisectorality of control measures. Controlling communicable diseases indeed requires a multisectoral approach. This is because these diseases are caused by an interplay of diverse factors. It is important to recognize the demographic, social, cultural and economic attributes of the diseases, which require a multi-pronged strategy.

Several key partners have important roles to play in the prevention and control of emerging infectious diseases. The national authorities should keep all partners on board right from the policy formulation through the implementation process.

The partners include, among others, private enterprises, academic institutions, the mass media, civil society and various international agencies. For example, control of vector borne diseases, notably malaria and dengue fever, require sustained efforts from several players. Similarly, zoonotic infections, including avian influenza, cannot be contained without close intersectoral collaboration.

Fourth – Intercountry cooperation. The microbes know no boundaries, therefore, intercountry collaboration is of fundamental importance in dealing with cross-border spread of diseases. One lesson from SARS and avian influenza is that sharing, among countries, of information, experiences, and expertise is very important indeed.

This intercountry cooperation can lead to better understanding of disease epidemiology, its transmission pattern and natural history. And, therefore, it can help cooperating countries in planning for joint interventions to respond to the pandemic in a synchronous, timely and effective manner.

Finally – Community involvement and partnerships. Public health efforts can generate the desired results only if the community or intended beneficiaries are actively involved in implementing the control strategies. A well-informed population can provide immense support to any public health interventions.
The public health machinery needs to be operational in communities through productive partnerships. Partnerships with the mass media and nongovernmental organizations are extremely important in securing public confidence and support and ensuring operational efficiency. These players have a wider reach and enjoy greater credibility with the population at large.

Sound and thoughtful risk communication can assist in preventing ineffective, fear-driven, and potentially damaging public responses. This is especially so during a serious crisis, such as the outbreak of an unusual infection. Appropriate risk communication fosters trust and confidence of the population that are vital in any emergency situation.

Communicable diseases deserve utmost priority in our scheme of things. WHO has been working very closely with the governments of Member States in the battle against communicable diseases since its inception. I wish to reiterate our commitment to providing all possible support in this fight.

The vulnerability of human race against the emerging infections has never been greater; the weapons available with us remain inadequate. The challenge before us is enormous, the options rather limited.

Though there have been significant achievements on several fronts; a lot more needs to be done to combat these scourges. I am confident that, with strong political commitment and support, and with efficient public health systems, we will meet this challenge successfully. The public health system that is developed on ecological and environmental bases; serving the entire population; able to reach the unreachable through multisectoral and multidisciplinary approaches. Proven strategies and tools are available, and so is the governments’ commitment and the willingness of the international community to work together. We together will accomplish this formidable task.

The need of the day is continuous vigil and continued preparedness with enhanced capacity at the local, national and international levels. I am sure that with our unwavering and enhanced determination and commitment we will conquer the communicable diseases in the South-East Asia Region within a reasonable timeframe.
Today, Avian Influenza is a serious health threat worldwide, affecting both animals and humans. It is one of the most formidable socioeconomic challenges anywhere. The huge impact of the current Avian Influenza outbreak on national economies of the affected countries is really a major international concern. It is a clear indication that infectious diseases are not merely a threat to health, but also have a wider implication on other aspects of development.

Even more worrisome is that the causative pathogens are ever-changing their nature to become more virulent. With the increasing volume of international tourism, travel, and trade; the infectious agents will continue threatening the health of people everywhere.

Emerging infectious diseases are the leading cause of morbidity and mortality in Asia and in many other parts of the world. In 2003, SARS was the first in this category of diseases to cause a pandemic of the twenty-first century. It spread to more than 30 countries around the world. Asia was the epicentre of that pandemic. And Asia suffered the most, both in terms of lives lost and economic disruption.

This year, Asia has found itself, yet again, in the same situation. But, perhaps facing a more deadly event this time. Human cases...
Communicable Diseases

of Avian Influenza have been found in Vietnam, Thailand, Cambodia; and in Indonesia.

Just last week, three cases of human avian influenza were reported in China. This could be the beginning of the first pandemic of influenza in this century. And Avian Influenza might cause this pandemic.

The challenge before us now is how to prevent and control Avian Influenza outbreaks successfully, in both animals and humans. This is in order to effectively mitigate the impact of the pandemic, if it occurs.

The outbreaks of highly pathogenic Avian Influenza (HPAI) in poultry, which started in 2003, have been historically unprecedented in scope and severity. The slow, but steady spread of the pathogen in avian species is now alarmingly highlighted. It has been found most recently in bird flocks across Europe.

According to FAO, this pathogen is really endemic, and firmly entrenched in poultry in many parts of Asia. With close proximity between humans and poultry, ample opportunity exists for the virus to be transmitted to man. It is believed that this will certainly give rise to a mutant strain of the agent, that can cause a pandemic in man with serious consequences. Human casualties and economic loss will be enormous.

As of today, the Avian Influenza or H5N1 virus has reportedly caused 129 human cases, of which 65 have died. So far, most of these cases have been linked to direct exposure to dead or sick poultry. This may imply that the virus is still unable to jump from man-to-man easily.

An influenza pandemic is indeed a public health emergency. And it is inevitable now. If it happens, there will be serious health, social and economic consequences world-wide. Only, when it will happen, is still uncertain.

We actually have a window of opportunity to prepare against this most deadly disease and its devastation. We must accord the highest priority to prepare ourselves as early as possible, before the inevitable pandemic strikes.
Keeping in mind that many countries in our Region are not well-equipped to handle effectively a potential pandemic in humans, they are likely to be the worst affected. At its peak, the pandemic is likely to overload the health care systems. There will be an urgent need for large number of hospital beds, doctors, other health care workers, vaccines, medicines, and many more.

We will need facilities to isolate a very large number of cases. Quarantine to be applied in the community to limit the spread of the disease will be another key issue. An issue that bears a number of social, economic and political implications. This situation could bring life to a grinding stop; affecting workplaces, industries, schools, tourism, and travels. In fact, all aspects of life will be overwhelmingly affected. The economic and social costs of the epidemic could be very high. However, we can certainly alleviate the adverse impact by anticipating its course, and being prepared to respond.

Pandemic preparedness planning is crucial indeed. This is to ensure that all the required resources are mobilized, coordinated and made available. Expertise and services are made ready for rapid deployment, in case of an emergency. The impact in terms of human morbidity and mortality, and the resultant economic loss must be minimized to the extent possible.

All Member States need to develop comprehensive, multisectoral plans, with full political leadership and support at the highest level. Multisectoral plans for preparedness and response should integrate the work of concerned sectors, particularly agriculture and health. This is to take into account, at the same time, the health of both animals and humans.

It would be unrealistic to prepare a pandemic preparedness plan in a short period of time, without adequate involvement of all stakeholders. As far as human health is concerned, even though the health sector may play a leading role, the expertise and support of a wide-range of disciplines will undoubtedly be needed in the development and implementation of the plan.

I am very pleased to say that most Member States in our Region have already drafted their national plans for pandemic preparedness. All such plans, however, require further review,
refinement and updating. And, most important, it has to be ensured that the work relating to both animal and human health is properly integrated in the same plans.

WHO, with FAO and OIE, is to provide technical and other necessary support to countries in preparing and refining these plans. WHO is also to help in investigating the outbreaks of human cases, when and where they occur.

WHO support is provided for strengthening countries’ capacities in disease surveillance and laboratory back up. The Organization is also procuring and stockpiling antiviral drugs and vaccine. This is to ensure the availability of these medical supplies for use by countries, when needed.

In addition to drugs and vaccine, we should also apply certain public health interventions in our preparedness programmes. We should go in a big way, through information and communication, to help educate people to be able to do everything possible to protect their own health.

We should tell people and the community on how to protect themselves through improved hygiene, sanitation, food safety, nutrition and physical exercise. We should develop a package of educational messages that are easily understood by lay people.

These messages should be translated into local languages and dialects, and disseminated as widely as possible. This approach will certainly increase the confidence of people and the community in preparing themselves to face the pandemic. These public health measures, at the same time, will have an important impact on the prevention of other communicable diseases.

Today, the world community acknowledges that partnerships are crucial for any development work. In this case, partnerships are important to ensure coordinated efforts of all stakeholders. These coordinated efforts will lead to effective containment of the rapid spread of infectious diseases across international borders.

Recognizing the need to ensure global health security for humans through a more effective enforcement of the international legal framework, the fifty-eighth World Health Assembly adopted partnerships are crucial for any development work.
The revised regulations will reinforce the need for strengthening core capacities of Member States for the prevention and control of infectious diseases. These capacities essentially include surveillance, outbreak investigation, laboratory back up, and epidemic preparedness and response. It is now the responsibility of each Member State to ensure such core capacities, in both technical and managerial terms. This is in order to fulfill the requirements for the enforcement of the revised regulations.

The implementation of these regulations will start by mid-2007. The two-year gap from 2005 is for Member States to build up their core competence and capacities. In addition to helping in resource mobilization, WHO will provide all necessary support to countries in this challenging exercise.

Countries in the Asia Pacific Region are unfortunately vulnerable to frequent outbreaks of communicable diseases. This is because of the prevailing socio-economic and cultural conditions. While countries in this part of the world face similar health threats, the ability to protect their populations from those threats varies widely.

We recognize that the full protection of the entire population from communicable diseases is difficult. However, we must help countries in every way possible to ensure the effectiveness of this protection as much as possible. Weak links in the prevention and control of communicable diseases must be anticipated, and plans prepared for strengthening such links.

In this connection, the Asia Pacific Strategy for Emerging Diseases has been developed. The strategy provides a framework to improve health protection of the populations through partnerships. With combined efforts from all partners and stakeholders, the weak links in such prevention and control will be strengthened through the implementation of this strategy.

Coupled with the revised International Health Regulations, the Asia Pacific strategy will help enhance the effectiveness of
Communicable Diseases

national and regional preparedness. And, the countries will be better prepared to respond effectively to Avian Influenza in humans and its imminent pandemic.

The role of public health institutions in combating emerging diseases cannot be overstated. Networking of these institutions can enhance the efficiency and development of required skilled human resources. These investments will then contribute effectively to the establishment of sensitive and responsive surveillance and early warning systems. The Field Epidemiology Training Programmes, among many others, have played a significant role all over the world, in the development of these resources.

In view of the challenges and based on our experiences in dealing with SARS and Avian Influenza, the development of skilled manpower should be considered a top priority. Capable and competent staff is the basis for ensuring the core capacities to deal effectively with the imminent pandemic of influenza. In pursuing this, we need expertise in various areas, such as, general public health, epidemiology, virology, and zoonosis. We also need expertise in other disciplines, such as, social and preventive medicine.

I am confident that this meeting will contribute significantly to enhancing our ongoing efforts in preventing and controlling Avian Influenza, particularly in humans. And, also in preventing and controlling other emerging infectious diseases. Let us all stay vigilant and work closely to overcome these formidable challenges facing us today.
The discovery by Dr Laveran in 1880 and by Dr Ronald Ross in 1897, of the transmission of malaria, was indeed a landmark in medical history. This scientific breakthrough helped greatly in understanding the epidemiology of malaria and how to control it.

It is well known that malaria was once the greatest killer on earth. It not only killed vast populations, but also impacted on economies and the livelihoods of people. Brigadier Sinton estimated in 1911 that the annual economic loss to India due to malaria was between £ 19 and 23 million pounds. This was a very large sum of money at that time. Throughout history, various methods had been used to control this mass killer, but without much success.

During the Second World War, DDT was used as a residual insecticidal spray to control the vector which was involved in malaria transmission. Shortly thereafter, chloroquine – a powerful antimalarial, and primaquine – a gametocidal were used. As a result, there were high hopes that malaria could soon be eliminated.

With the initiative and support from WHO and other international agencies, a global malaria eradication strategy was launched in 1955, with remarkable results initially.
During the 1950s, India accounted for 75 million malaria cases, and 800,000 deaths a year. As a result of the eradication programme, in 1964, there were only 100,000 reported cases with no deaths. Similar achievements were seen in all malarious areas elsewhere in the Region. But, unfortunately, this success could not be sustained; and the eradication of malaria has continued to be an elusive dream since the 1970s.

Today, malaria continues to be a serious public health problem in the South-East Asia Region, with Maldives as the only country which is free from malaria. Currently, the Region reports about 2.5 million confirmed cases annually, with nearly 5,000 deaths. These figures are obviously gross underestimates. The degree of underreporting of malaria cases and deaths is really indicative of the very weak surveillance system in countries. This, in turn, is a reflection of the poor state of national malaria control programmes.

Without knowledge of the actual disease burden, it will be very difficult to accurately assess the socioeconomic loss attributable to malaria. And it will be very difficult to seek more resources for its control. What we do know today about malaria in the Region is indeed very disturbing.

The proportion of the severe form of malaria (Plasmodium falciparum) is on the increase, to the extent that half of all malaria cases are now caused by this strain. Moreover, there is the added problem of resistance of vectors to insecticides, and behavioural changes among vector populations. Plasmodium falciparum, which has the potential to kill, has already shown resistance to commonly-used antimalarials. The frequent ecological imbalances created by human activities are also a cause for concern.

Over and above, the malaria situation is difficult to control because of environmental changes due to natural disasters, like the tsunami, super cyclones; or other adverse phenomena due to global warming. Under such situations, a uniform method of control, as practised during the “Eradication Era”, is no longer applicable. Rational planning is, therefore, needed to formulate a specific malaria control strategy for each problem area.
The malarious areas need to be precisely stratified, and an appropriate control strategy applied. Here too, a clear understanding of the disease epidemiology and entomology is essential for both stratification and intervention planning.

Besides the above-mentioned aspects, malaria control poses emerging challenges. In the rural areas, malaria has developed its own specific characteristics, warranting approaches which are different from those needed for the urban areas.

With growing industrialization and urbanization, many large, medium and small-scale development projects are being taken up speedily. In several cases, these are done without proper planning, leading to the occurrence of mosquito-breeding places. Furthermore, the migration of labourers from endemic areas into those which are malaria-free, or to cities and towns, also contributes to new foci of malaria. The same is true of irrigation projects, which are often designed without appropriate care being taken to prevent mosquito-genic conditions.

The areas along international borders are highly vulnerable to malaria infestation. Because these areas lack the public health measures to tackle communicable diseases, including malaria. And the frequent cross-border movement of people aggravates the already bad situation.

Keeping in mind the rapid pace of urbanization, and improperly regulated development activities, malaria control today requires new and locally-specific solutions. Special attention must be given to the vulnerable groups of population, particularly children and women, especially pregnant women. These groups also include ethnic minorities and the tribal populations living in remote areas, where public health facilities are not adequate.

In view of the evolving situation of malaria in the Region, I believe that we need a new paradigm in our strategy for malaria control. I would like to propose in this connection that we focus on a few areas as follows:

**Firstly**, we should invest more efforts in assessing accurately the burden of malaria in the Region, or throughout Asia. There should be an in-depth study on its socioeconomic implications.
There is need for a really sensitive surveillance system that can provide early warning of an outbreak. A system that can help to plan more rationally for prompt response to contain the outbreak and to prevent its further spread.

In addition to basic and laboratory studies and investigations, operational or action-cum-research is essential. This will lead to a better understanding of the problems associated with programme development, management and interventions.

The focus on locally specific data collection and use, according to the locally specific situation, must be emphasized. I am happy to note that in several countries, including India, many reputed institutions are working on research in various aspects of malaria. WHO is trying its best to strengthen research capacity in countries in collaboration with these institutions.

The priority area for research also includes the development of new antimalarial drugs and various combination therapies. A vaccine against malaria is not yet available, in spite of the tremendous efforts over several decades. It is likely to take several decades more, before any effective vaccines can be made readily available for use in the community.

In spite of the slow progress in vaccine development, several innovative tools are available, which are the products of tireless attempts of researchers. Newer tools and approaches for malaria control should be fully utilized. Such as rapid diagnostic test; long-lasting insecticide-treated nets; geographic information system; remote sensing. These new approaches also include knowledge on the vectorial capacity of sibling species, and advances made in the treatment of *P. falciparum*. At the same time, operational research must be built into the intervention programme to assess the cost-effectiveness of these tools and approaches.

Secondly, Member States must accord malaria a high priority, and the strategy for its control must rightly be brought on the national and international agendas. We must stress that malaria in Asia has its own unique problems and areas of concern. This aspect must be articulated, not only in countries, but also at regional and global levels.
The need for allocation of more resources is critical. This is in order to arrest the increasing trend of drug resistant malaria, and the emergence of *P. falciparum* as the predominant strain in the South-East Asia Region. In this regard, I am glad that all our Member States are committed to the “Millennium Development Goals”. The goals include the target to arrest and reverse the trend of malaria.

Thirdly, malaria should not be considered as an exclusive problem of the health sector alone. Its control requires a broad multisectoral and multidisciplinary approach.

Malaria is not only a medical and public health problem; it is also closely associated with environmental and ecological factors. Other sectors, such as agriculture, environment, forestry, education, and finance must fully share their respective responsibilities for malaria control.

Malaria control is a challenging area for high-level advocacy to promote healthy public policies, from which this public health intervention will also benefit. The involvement of the private sector, civil society and the community itself is necessary indeed. For long, the involvement of the private sector at all levels has been ignored. This involvement at the primary, secondary and tertiary levels of intervention is essential for malaria control. Our approach in this connection should now also include “public-private partnership”.

Community involvement in the interventions to control malaria will go a long way in strengthening public health services to serve the entire population. This is particularly so in the areas of enhancing health seeking behaviours, strengthening speciality services, and making full utilization of services provided. No less important, women’s groups can be effectively mobilized to contribute to community-based services for malaria control.

Fourthly, the malaria control programme should shift its emphasis from a mainly treatment-oriented approach to a well balanced combination of prevention and treatment. This is to ensure that we have more ways and means to reduce or stop the transmission of the malaria parasite. What might be suitable to be
applied in other continents may not necessarily be appropriate for use in our situation in Asia. Devices and tools need to be properly adapted, or even invented to suit our specific needs and requirements.

It is a fact that we have high morbidity, but low mortality due to malaria. This means that we may have succeeded in reducing the case fatality rates through early diagnosis and prompt treatment. But, we have not equally succeeded in reducing the malaria incidence. This implies that we are not successful in stopping or reducing the transmission of the malaria parasite. A better understanding of the ecological, social and behavioural determinants is essential indeed. This is to ensure the development of evidence-based policies and strategies that are really suited to each locality.

Therefore, among others, social mobilization and community involvement during the planning, implementation, monitoring and evaluation of the programme are very significant. This will create a better acceptance of preventive measures, such as in reducing mosquito breeding places and in the use of personal protection materials. Also, the utilization of treatment services will be appropriately promoted under this strategy. People and the community need to be empowered to be able to initiate and implement certain intervention measures, at least for individual and family protection.

Finally, we need a package of tools with proven effectiveness. A package that can generate the greatest impact, if properly applied in communities with different situations.

We also need to set and use a few indicators and targets as an integral part of the implementation of national malaria control programmes. These indicators and targets should be really measurable, relevant, reliable and appropriate for use in various situations.

Then, we have to put in place an effective mechanism to monitor systematically and regularly the progress of programme implementation towards achieving these targets. This, I believe, if pursued vigorously, consistently and honestly, will provide evidence
of our progress, in both coverage as well as quality. In turn, this will lead to the reduction of both morbidity and mortality due to malaria.

Before concluding, I would like to emphasize that we, all of us together – the Governments, international organizations, the public and the private sectors, and the people at large, are equal partners in health development, including in the control of malaria. Through these means, we can move further with certainty to ensure a malaria-free world and a healthier population. A population with a full potential for increased social and economic productivity in countries of our Region.

India has been recognized to be at the forefront of many pioneering research studies in malaria. Dr Ronald Ross, who was awarded the Nobel Prize in 1902, not only worked in India, but was also born in India, in Almora.

The Malaria Research Centre has taken the right decision to organize this important Conference in Delhi. Malaria research started with the discovery of the parasite in 1880; and now extensive studies on the genome are being conducted worldwide, including in India. This is the latest advancement in sciences for the uplift of human health. These research efforts will provide us more insights on the parasite, and its vector and host. It will be another breakthrough by the modern health sciences.

It is expected that research would help in the better understanding of the totality of the disease; medically, epidemiologically, environmentally and ecologically. And, it therefore, will lead to the development of really effective control measures and interventions. At the cutting edge of sciences, we must strive to ensure the full use of scientific and technological advancement for the welfare of the entire human population.
Elimination of Leprosy

We deeply appreciate the sustained support extended by the Nippon Foundation and the Sasakawa Memorial Health Foundation to WHO in pursuing the global leprosy elimination programme over the last thirty years. Also, we gratefully thank Mr Yohei Sasakawa, WHO Goodwill Ambassador for Leprosy Elimination. It is a great honour and privilege to have the opportunity of hosting this board meeting for the fourth successive year.

This occasion is particularly significant since the Global Leprosy Programme is now located in this Regional Office, which handles support to the geographical area with the highest burden of leprosy cases. It is also a special privilege to welcome our colleagues from WHO Headquarters as well as from the Regional Offices for Africa, the Western Pacific and the Americas.

This annual meeting provides an opportunity to share information on the achievements, as well as the remaining issues and challenges in our efforts to eliminate leprosy. We will review our strengths, discuss our weaknesses, and jointly plan for future endeavours. Certainly, in the process to move forward, we still need support from our main partners – the Nippon Foundation and the Sasakawa Memorial Health Foundation.

It is heartening to see the steady decline in the global leprosy burden. At the beginning of this year, the world-wide leprosy burden...
prevalence was below 300,000 cases. The annual new case detections last year totalled 407,000 cases. This indicates a very satisfactory achievement in the global reduction of the leprosy case load.

Only nine major countries are yet to achieve the goal of leprosy elimination. Six countries are in Africa, one in the Americas and two in South-East Asia. The complete list also includes a number of small countries with a population of less than one million each.

I am pleased to report that South-East Asia Region is very near to achieving the goal of leprosy elimination. The regional leprosy prevalence rate as of July this year was 1.04 per 10,000 population. It is expected to dip further to below 1 per 10,000 by the end of this year. Though, South-East Asia would be the last WHO Region to achieve this goal, this is a remarkable achievement, considering that the Region carries the heaviest load of the global leprosy cases. I wish to place on record the unwavering commitment and concerted efforts of Member States in the Region, in striving towards this significant milestone.

It should be specially noted in this connection that India, is moving steadily towards the leprosy elimination goal by the end of this year. This country carries the biggest burden of the disease in the world. As a result of intensified efforts, leprosy prevalence and case detection in India has moved towards a dramatic decline during the past two years.

The Region still has two other countries which may find it difficult to reach the goal by this year. These are Nepal and Timor-Leste. We are now focusing our efforts on these two countries. There is every possibility that Nepal will achieve the goal by next year, and Timor-Leste by 2007.

Together, we have achieved truly remarkable progress in leprosy elimination over the past two decades. In 1985, there were 122 countries, all with a prevalence rate of more than one case per 10,000 population. Today, there are fewer than 10 countries in this category.
The leprosy elimination goal has already been achieved by 113 countries. It is a major and commendable gain in international public health work, which has been achieved through the combined efforts of concerned national governments and their partners, which include international agencies and nongovernmental organizations. This is really a significant contribution to the attainment of the Millennium Development Goals.

However, at this particular point in time, there is still a lot of work to be accomplished. The top priority is to strive for timely achievement of the goal of elimination for the world in the remaining nine countries. Then, we have to work hard towards sub-national elimination in the individual countries to further reduce the disease burden of leprosy.

As the new cases continue to decline, this situation poses its own challenges. We have to intensify our efforts to ensure sustained political commitment; and to ensure adequate resources to maintain the gains achieved and the quality of services. We will have to continue enhancing knowledge and skills of the general health service staff; and ensuring that persons with deformity will continue receiving proper treatment and care.

Fortunately, WHO’s leprosy programme has not faced serious resource constraints. We gratefully thank the Nippon Foundation and the Sasakawa Memorial Health Foundation for the generous support provided to the programme since 1975. The programme also benefited from the free supply of drugs to all endemic countries. This was due to the funds provided from the Nippon Foundation, which defrayed the cost of drugs between 1995 and 2000.

Then, the Novartis Foundation started supplying the drugs in 2000, and continued thereafter. Novartis has already assured the continuation of such drug supply till 2010. We are very grateful to both the Nippon Foundation and the Novartis Foundation for their critical assistance to the global leprosy elimination programme. It is our hope that the Nippon Foundation and the Sasakawa Memorial Health Foundation would continue their generous support beyond 2005. This is to ensure that we will be able to
continue to address effectively the unfinished agenda, and to ensure the sustainability of quality services of the programme. This will enable WHO to maintain its continued back up to countries in their efforts to achieve sub-national elimination, which will further reduce the disease burden at all levels of operation.

The partnership between the Nippon Foundation and the Sasakawa Memorial Health Foundation and WHO has indeed grown in intensity and strength. We hope it would continue until we can reach not only the target of leprosy elimination, but also the ultimate goal of a leprosy-free world.

WHO has developed global as well as regional strategic plans for the period 2006-2010. This is to further tackle the remaining challenges in leprosy elimination. We are keenly expecting the full consideration by the Advisory Board of these plans. This two-day meeting is intended specifically to review and finalize the strategic as well as action plans for 2006, for which further support of the Foundations is indispensable for their implementation.
It is an honour to welcome you all to the Signing of the Memorandum of Understanding on the Elimination of Kala-azar between Bangladesh, India and Nepal. The signing of the Memorandum should help to reduce the annual incidence of Kala-azar to less than 1 per 10,000 population, by 2015, so that the disease will no longer be a public health problem in these three countries, and in the South-East Asia Region.

About 147 million people in this Region are at risk, with an estimated annual incidence of 100,000 cases. This represents 20% of the global burden of Kala-azar. In these three countries, more than 50% of the cases occur in the border areas.

Kala-azar is a disease of the poorest of the poor, driving them further into the poverty trap. A cause for added concern is the potential impact of coinfection between HIV and Kala-azar.

Kala-azar is indeed amenable to elimination. In the South-East Asia Region, the disease agent has no animal reservoir. Humans are the only source of infection, and the sandfly is the only vector. Fortunately, this vector continues to be highly sensitive to insecticides. Moreover, we now have an effective oral drug available, as well as newer and simpler tests for rapid diagnosis. Most importantly, there is a high level of political commitment among affected countries.

Ceremony for Signing the Memorandum of Understanding between Bangladesh, India and Nepal on the Elimination of Kala-azar, Geneva, 18 May 2005

Communicable Diseases
Efforts are also being made to mobilize additional resources to support the implementation of the elimination plan. Clearly, to achieve this target on time, sustained political commitment, successful mobilization of additional resources, and successful social mobilization are urgently needed.

During the Health Ministers’ Meeting in Maldives in September 2004, the Ministers of Health from Bangladesh, India and Nepal agreed to move forward with the target of elimination with joint efforts. Since then, an elimination strategy and plan has been developed under the guidance of a Regional Technical Advisory Group set up by WHO/SEARO.

The Health Ministers from the three countries are now not only signifying their political commitment to the elimination of Kala-azar, but also taking a major step forward, in ushering a healthier future for the millions affected by this disease. I take this opportunity of thanking all partners in supporting our efforts in this important endeavour, and look forward to the continuation of this support.
Challenges to Health

It is with great pleasure that I am addressing the Fifth Joint Conference of the Indian Society for Malaria and other Communicable Diseases and the Indian Association of Epidemiologists. I am well aware of the work done by these two bodies, and of their valuable contributions to health development in the country. I am particularly pleased to be here among some of my former colleagues, and also among the many eminent health professionals, with whom I have interacted for many years. The theme of the Conference – “Health Vision – Challenges”, is very appropriate and timely indeed.

Health challenges might be termed as what we can foresee in the future, or what still needs to be completed – the unfinished agenda. While looking ahead at the foreseeable challenges, we also have an obligation to finish the unfinished agenda. Now, allow me to dwell on some of the current issues and concerns in the health arena, with particular reference to the WHO South-East Asia Region.

Our countries, which are developing or least developed, present a vibrant and diverse socioeconomic and cultural picture. With over 1.6 billion people, the South-East Asia Region of WHO accounts for approximately 25% of the world’s population. It is estimated that the population would be over two billion by 2025 – an increase of about 30%. This is bound to affect population...
density, which is closely related to the occurrence and rapid spread of many infectious agents.

Adding a new dimension to the already challenging health situation, is the increasing trend in the prevalence of many noncommunicable diseases. We are facing a double disease burden which has been known to us for many years.

In 1977, “Health for All” (HFA) became the slogan for a global movement, which called for the attainment of a level of health that would permit every individual in the world to live a socially and economically productive life. “Health for All” is not merely a health, but a social goal as well. A goal that can be reached only through the efforts of all concerned sectors and disciplines, not merely health.

A year after the call for HFA, the Alma-Ata Declaration urged the world to embrace the primary health care (PHC) approach as the key to the attainment of the HFA goal. The World Health Assembly recently reaffirmed the validity of the principle of “Health for All” as the ultimate goal of our development efforts.

Today, HFA and PHC are still a coherent vision of global health, which can contribute effectively to other development perspectives. Turning that vision into reality calls for clarity on how the current challenges can be met through multisectoral and multidisciplinary actions, in the most cost-efficient and cost-effective manner. This entails the necessity for all countries, especially those in the developing world, to not only confront health problems and crises, but also ensure the sustained health of the population to contribute effectively to overall social and economic development.

This requires effective use of existing and new knowledge, technologies and innovations, along with robust health systems, policies and strategies for their application. New ways to organize health systems infrastructures is an imperative, in order to balance the overtly disease-based vertical interventions with integrated and comprehensive approaches to health service delivery.
The realization of health-for-all depends on the renewal and strengthening by all countries of the commitment to the implementation of its principles involving, among others:

- ensuring the highest attainable standard of health for all people as a fundamental right;
- transparent application of ethical principles to health policy, research and development, and service provision;
- implementing the equity-oriented health strategies that emphasize solidarity and social justice; and
- incorporating a gender perspective into all health programmes.

These elements of HFA principles are strongly interlinked, each strengthening the other. In support of the movement for health for all in the Region, the Health Ministers in 1997 adopted the Declaration on Health Development in the South-East Asia Region in the 21st Century. The Declaration spelt out the foremost challenges to the Region’s health scenario, which include:

- closing the gaps in accessibility to health care by ensuring basic health services to all;
- focusing especially on the poor, women and other vulnerable groups;
- creating conditions that promote good health and self-reliance;
- upholding and enforcing health ethics; and
- placing health at the centre of development.

As you are aware, all countries of the world have pledged to reach the Millennium Development Goals set out at the United Nations Summit in 2000. These include, among others, ambitious targets relating to nutrition, maternal and child health, infectious disease control, and access to essential medicines. The Goals provide us an opportunity to further accelerate our efforts to ensure healthier lives for millions of people, and lay the foundations for improved health for generations to come.
Over the past few decades, significant progress has been made in health development in this Region. This is particularly evident through the reduction of morbidity and mortality, and the increase in life expectancy. Despite these achievements, however, inequities in health continue, both within and amongst countries, the main reason being the disparities in access to health care services.

The Region has also witnessed an unprecedented, rapid growth in urban population. This has led to major health problems due to inadequate provision of safe water, sanitation, electricity, waste disposal and health care. Most countries in the Region have continued to maintain steady economic growth rates between 5-8 per cent since the late 1990s.

In spite of these economic achievements, the gap between the “haves” and “have-nots” is widening. There is a wide variation in the Human Development Indexes among countries in the Region, which harbours nearly half of the world’s poor.

The Region also accounts for nearly 30 per cent of the global disability-adjusted life years lost. Communicable diseases like malaria, tuberculosis, HIV/AIDS, and many vaccine-preventable diseases are still highly prevalent, and play a significant role in slowing down the progress in development, not only in health but in other sectors as well.

The outlook for expansion of coverage of essential health care in the least-developed countries is very difficult due to many factors; social, economic, environmental and political. The external and internal resource inputs for the development of health infrastructure are scarce indeed. Nearly 20-30 per cent of the population are hard to reach, mainly due to economic, geographical and sociocultural barriers. One of the important challenges in health service delivery is, therefore, to reach the unreached.

There is still a large gap in health development efforts; this is with regard to financing, organization, management and delivery of health programmes. Another significant factor aggravating the situation is the increasing competition for health workforce between the private and public sectors. This is greatly undermining
the effective placement of health workers in the public sector in rural areas to close the equity gap.

Even though affordable and effective health interventions are available and easily accessible, an estimated 530,000 women worldwide die from conditions related to pregnancy and childbirth every year. Our concern is that more than 30 per cent of these deaths occur in this Region, and that births attended by skilled attendants range very widely from 10 to 97 per cent. Globally, 11 million children under five years of age die every year with almost 30% of these occurring in our Region. Over half of the deaths are due to pneumonia, diarrhoea, malaria, measles and HIV/AIDS. The Region accounts for about 1.4 million neonatal deaths every year. High prevalence of low birth weight, approaching 33% in some countries, contributes to this high neonatal mortality.

By far, one of the biggest challenges for us is to prevent and control the HIV/AIDS epidemic. What is required is to scale-up interventions, ensuring effective care and treatment for every HIV-infected person. This is in parallel with preventive education to protect the whole population.

Another major task is to control malaria; malaria is linked to poverty as cause and effect; its endemicity is contributed very significantly by environmental and ecological factors. The disease disproportionately affects the poor living in remote areas that are out of reach of the routine health services. Hot spots for TB drug resistance are emerging in our countries. These have to be tackled with more effective drugs and through an innovative strategy.

Tobacco-related diseases kill about four million people every year world-wide, with over 500,000 of these deaths occurring in our Region. The Region has become a lucrative market for the tobacco industry, with tobacco consumption increasing rapidly, especially among the youth and the poor. A welcome development in this regard is the adoption of the Framework Convention on Tobacco Control by Member States of WHO. It is hoped that more stringent measures will now be taken to create a tobacco-free society, and ultimately a tobacco-free world.
Our Region has, perhaps, the richest heritage of traditional medicine. We should find ways of strengthening and developing it further, so that it can be used appropriately and in a balanced manner with modern health care systems. Poor countries should be very careful in importing sophisticated technology at high cost which is very often being used only by the privileged few.

In the current scenario, how can developing countries face these challenges in their endeavours achieve the HFA goal? It is not a matter of total lack of effective interventions that is posing the main obstacle to achieve faster progress towards that goal. Instead, it is basically inadequate accessibility to the available health services, especially among the poor and vulnerable and marginalized groups of population. The priority is, therefore, to find feasible and practical means and ways to scale-up these services, both in quantity and quality; and, equally important, to reach the unreached. Improved coverage with effective interventions that support all families and communities in preventing disease, promoting good health, and caring for children and mothers will surely result in significant progress towards the HFA goal.

It will require a strong focus of efforts on specific measures to strengthen and empower the community and encourage full involvement of the community in the development process. An integrated approach to health service delivery is to be considered as a requisite for health for all. This we all know well. It is, however, yet to be achieved on a much wider scale. To achieve it means not only an increased allocation of resources to identified priorities, but also strengthening planning and management processes to ensure equitable delivery of quality health care in a comprehensive manner.

Some of the specific issues to be addressed in this connection are: balance and relevance of human resource development and deployment for health service delivery; adequate financing of health and health-related activities; eradication of physical and social barriers to accessing health care by all; adequate supplies of safe and affordable drugs and vaccines; development of innovative mechanisms for improving health care coverage;
strengthening stewardship of health systems; working in partnership with other sectors, nationally and internationally; priority attention for provision of valid information to the general public; and promoting research as an integral part of health systems development.

What I have attempted is a brief outline of the health challenges that face the South-East Asia Region and how we may be able to overcome them. It may be said that the main focus now should be the delivery of an integrated package of interventions for reducing mortality, morbidity, disability, and risk factors.

It is very important that priority be given to investment in public health infrastructures, which place exclusive emphasis on disease prevention and health promotion. There is every reason to believe that our countries need a much stronger public health infrastructure to cope with all kinds of challenges in the field of health today.

The need for strengthening public health in this Region has always been recognized and we have been attempting to meet this need. Many of us here have contributed significantly to the development of public health in the Region in the past. During the last two decades, we have seen rapid changes in the epidemiological patterns of the prevailing diseases of public health importance.

At the same time, we have witnessed tremendous advances in health care technology; as well as in biotechnology and in the pharmaceutical sectors. Unfortunately, in most of our countries there has been a perceptible decline in both the quality and quantity of public health infrastructure, especially human resources and services.

With this in mind, WHO/SEARO organized a regional conference in 1999 on ‘Public Health in South-East Asia in the 21st Century’. The conference, which was attended by prominent public health experts, from both within and outside the Region, adopted the ‘Calcutta Declaration on Public Health.’ Since then, as follow up actions of this declaration, many activities have taken
place with WHO support to strengthen public health practice and education in the Region.

A strategy also needs to be adopted to ensure linkages among all stakeholders, including public-private partnership, focusing on prevention and control of emerging infectious diseases to assure health security.

Thus, public health programmes to be developed should be: environmentally and ecologically based; targeting the population, with special emphasis on the poor and vulnerable groups of population; developed and implemented through multisectoral and multidisciplinary action; and fully involving people from all walks of life in the development process.

To ensure health for all, the countries need to strengthen or enhance their policy actions to prevent ill-health and promote good health, through development of healthy public policies. High-level decision makers and political leaders need to be appropriately sensitized for their continued and sustained commitment to effective decisions and actions for health for all.

We are living in an era of vast opportunities which were denied to our ancestors. We have to grasp these opportunities firmly and move forward with a strong will, determination and commitment towards a healthier and happier future for all people.

Finally, I invite all the distinguished scientists of different disciplines attending this conference to join forces and lend your wisdom to contribute effectively to the fight against all odds to good health in order to make our Region and the world a safer and healthier place to live.
Tuberculosis Control

Tuberculosis continues to be a major killer. Each year, more than 8 million people in the world develop the disease; and over 2 million die of it. The South-East Asia Region is home to 40% of the global tuberculosis burden.

Despite the success achieved by national control programmes, TB continues to be a major problem threatening the health of the public. Poverty, migration, urbanization, work in high-risk environments, and the alarming spread of HIV/AIDS are exposing people increasingly to risk and making them susceptible to the disease.

When dealing with the tuberculosis problem, we have also to keep in mind the related social and economic factors. These aspects need to be taken into consideration when a tuberculosis control programme is developed and implemented. Tuberculosis is basically seen as a medical problem, but it cannot be tackled successfully through medical means alone.

There is now an increased commitment towards TB control, both at national and international levels. Global support has increased remarkably through mechanisms such as the Global Fund and the Global Drug Facility. Various partnerships have been developed to support the programme in a multidisciplinary and multisectoral manner.

Intercountry Workshop on Surveillance, Monitoring and Evaluation of TB Control Programme, SEARO, New Delhi, 21-24 September 2004
In March this year, I decided to proceed with TB as a Special Programme in the Region. By doing so, we hope to increase the profile of TB control programmes as a priority health intervention in the Member States, with particular attention to alliance building.

WHO has always given special attention to developing and strengthening national TB control programmes, underlining the importance of surveillance, monitoring and evaluation.

Reinforcing institutional capacity and investing in human resource development are key elements of WHO’s support. We, in WHO, are also fully committed to providing support to countries in developing sound policies, strategies and plans; and we are making use of our comparative advantage in mobilizing additional resources to help countries.

The DOTS strategy, which is a package, combining various key components of TB control, has been shown to be very effective in all regions of WHO. It is one of the most cost-effective public health interventions against TB available today.

This strategy has provided evidence that the incidence of TB and its burden can be reduced substantially, if at least 70% of the estimated cases are detected, and 85% of these cases are successfully treated. These are the targets set by the World Health Assembly in 1991, the targets which are to be achieved by the end of 2005. All Member States in our Region are poised to achieve these targets.

The United Nations Millennium Summit has included as one of the Millennium Development targets, halting and beginning to reverse the incidence of tuberculosis by 2015. Although these targets may seem very ambitious, it is necessary for us to now start monitoring vigorously the progress of our interventions. It is in this context that this workshop is most relevant and timely.

The workshop is aimed at providing necessary knowledge, understanding and skills for appraising the impact of our programme activities. It will serve as a benchmark for defining our milestones on the road towards our targets. I expect that this workshop will provide a better understanding of the merits and deficiencies of the current surveillance system and other measures...
being used for monitoring and evaluation of tuberculosis control. I also hope that the workshop will help us in developing and adopting the improved methods of data collection and management and, as a result, make our programme management more efficient.

This workshop is of a technical nature. It will impart specific knowledge and skills in assessing the progress made in our programme and achievements. The experience gained from such assessment will enable us to adjust our policies, strategies and plans, as required.

WHO is convening and facilitating the workshop as a part of our overall support to Member States in developing and improving national TB control programmes. I am confident that the vigorous follow-up action on the recommendations of this meeting will provide us with more reliable information on various aspects of the regional and country TB situations, which will have a positive impact on programme development and management.

We should not forget, however, that behind all these statistical information and figures are faces of so many people, patients and communities, who are suffering from TB, medically and socially. They really deserve our priority attention.

To be effective in the development and management of a TB Control Programme, the data and information from our surveillance system must also include those reflecting the related social and economic domains of the problems. It is our duty to think further on how to accommodate such important information requirements in our monitoring and evaluation exercise.

Please keep in mind that a well-conceived and well-run TB programme has the best potential to cure patients, medically and socially; to interrupt transmission of the infection; to reverse the trend of the epidemic; and to control TB until it is no longer a problem of public health importance.
Emerging Infectious Diseases

With the advent of antibiotics, some experts felt that one day infectious diseases will cease to be problems of public health importance. However, they have been proved wrong, as the arsenal of antimicrobials has not kept pace with the genetic ingenuity of microbes.

The high prevalence and incidence of infectious diseases still pose a great challenge, especially to developing countries, including those in the South-East Asia Region. It is estimated that infectious diseases are responsible for about 40% of the 14 million annual deaths in the Region.

The age-old foes of mankind, like tuberculosis and malaria, have not slackened their grip on our part of the world. Eighty per cent of our population lives in malarious areas, while tuberculosis kills more than 750,000 people every year. More than 6 million people are already infected by HIV in our countries.

Outbreaks of Japanese encephalitis, leptospirosis, hepatitis E and dengue are occurring regularly, and in wider and more geographical areas. As if this is not enough, the challenge has become more complex due to emergence of infectious diseases.

In the last few decades, more than 30 new microbes have been isolated. Some of these have played havoc due to explosive outbreaks leading to an adverse economic impact and global panic.

Consultation to finalize the Vision Document on Emerging Infectious Diseases in the South-East Asia Region, SEARO, New Delhi, India, 22-24 September 2004
SARS and avian influenza are the most recent examples. Economists and market analysts are simultaneously struggling to calculate the present and the future costs related to the SARS outbreak, initially estimated at US$ 30 billion in the Far East alone.

Micro-organisms, particularly viruses, are highly unstable, and possess remarkable genetic versatility, which allows them to alter their genetic make-up. At the same time many pathogens develop strains, which are resistant to known antibiotics.

To prevent and control emerging infectious diseases, or at least to reduce their health impact, concerted efforts of all concerned at all levels is necessary. Strong political commitment with adequate financial and other resources are essential prerequisites.

Epidemic preparedness and developing capacity to respond to the challenge of the outbreaks of these diseases demand additional inputs. These inputs are necessary to strengthen public health infrastructure and services in countries.

The strategies that need to be adopted include the strengthening of surveillance systems; application of epidemiological, molecular, biological and behavioural approaches; and establishing linkages amongst all stakeholders.

Public-private partnership focusing on early detection of emerging infectious diseases, and appropriate control measures will assure health security. Intercountry cooperation, exchange of information and risk communication will help prevent panic and hysteria, among other things. However, for preventing the international spread of these diseases, implementation of the International Health Regulations becomes obligatory.

Research is a crucial part of the preparedness and response to new and emerging diseases. Appropriately applied research will help in understanding the epidemiology and pathogenesis of the diseases, as well as in developing effective measures to counter the destructive attack of these organisms.
I would like to stress that WHO/SEARO is fully committed to assist Member States in improving their capacity in disease outbreak investigations and control. We also provide support to strengthen disease surveillance in countries, to enable them to fight effectively against emerging infectious diseases.

The purpose of drafting this “Vision” document is to alert all those concerned of the necessity of being well prepared to face this formidable challenge. I earnestly invite all to join forces and lend our wisdom in developing a conceptual framework and strategy that can contribute effectively to the fight against emerging infections; and thus make the South-East Asia Region and the world a safer place.

Last, but equally important, is the genetic manipulation of disease agents, and the deliberate use of those agents outside the realm of health improvement. This is becoming another emerging threat to health of mankind today. Our vision document may not be complete for future use, if it does not touch on this fearsome issue. This document can serve as a technical guide to countries in the Region in planning appropriate programmes for combating emerging infectious diseases.
Sexually Transmitted Infections

Sexually transmitted infections or STIs are common. In fact they are among the most common causes of illness in the world and have far-reaching health, social, and economic consequences. STIs represent a major public health problem in developing countries, worldwide and in South-East Asia.

More than 300 million new cases of curable STIs occur each year, with a global distribution that closely mirrors that of HIV. Each day, there are nearly one million new cases of STIs around the world.

The Asia and Pacific Region accounts for more than 50% of the global burden, with consistently high prevalence among high-risk and vulnerable population groups such as sex workers, migrant populations and other bridging population groups. According to the World Development Report 1993, the burden of disease in women of child-bearing age caused by STIs, excluding HIV infections and reproductive tract infections is the second highest for all groups of diseases, surpassed only by maternity-related disorders.

Each new STI infection carries the potential of serious complications including foetal loss, stillbirths, infertility, ectopic pregnancy and severe congenital infections. Syphilis alone, when present during pregnancy, results in foetal loss in one third of cases, and half the surviving infants suffer congenital disability. The

---

13th International Union Against Sexually Transmitted Infections, Asia Pacific Conference, Chiang Mai, Thailand, 6-9 July 2004
cofactor effect of STIs on HIV transmission suggests an up to eight-fold increased risk of HIV infection in the presence of STIs.

For genital ulcers, data indicate a 10 to 50-fold increase in the probability for male-to-female HIV transmission per sexual act, and a 50 to 300-fold increase for female-to-male transmission.

At the population level, STIs seem to be one of the key factors that drive the HIV pandemic in developing countries. At the same time, there is evidence that the treatment of STIs in particular presenting with genital ulcers, reduce HIV transmission.

There are many large-scale interventions that demonstrate the potential impact of STI control on HIV transmission. For example, Thailand reduced the incidence of curable STIs by more than 80 % in less than five years through a comprehensive effort that included both improved STI treatment and targeted promotion of condom use in commercial sex establishments. During this period, HIV prevalence, which had been increasing rapidly, began to fall. Through sustained application of these interventions, Thailand stabilized HIV transmission early and averted a far more extensive epidemic. Other countries, such as Cambodia and Myanmar, have started similar programmes.

The Sonagachi Project in Calcutta, India, is a good example of a successful peer education programme among sex workers. It also includes the provision of health care and social marketing of condoms. HIV prevalence among sex workers in the project area continues to be low and the prevalence of STI is declining.

In many countries in Asia, the management of STIs takes place in the private sector with lack of monitoring and supervision by the public sector. The Government responsibility to ensure that STI management in the private sector also follows national guidelines remains largely unregulated.

One of the most important challenges in STI control today is to reach the people who are most frequently exposed to infection. These people pose a major risk of passing the infection on to others. Such risk groups include sex workers who are often marginalized.
Strong STI prevention and treatment play a vital role in comprehensive programmes to prevent sexual transmission of HIV. However, large-scale programmes have yet to be implemented in many countries.

STI trends can offer important insights into where the HIV epidemic may grow, making STI surveillance data helpful in forecasting where the HIV epidemic is moving. Better linkages are needed between HIV and STI surveillance nationwide in order to better monitor the trend of the epidemic and the impact of programme interventions.

In September 2003, WHO and UNAIDS declared the failure to provide treatment to HIV/AIDS patients as a global health emergency and called for providing 3 million people in the developing world with antiretroviral therapy by 2005. By March 2004, 48 countries with the highest burden of HIV/AIDS had expressed their commitment to rapid treatment expansion. They have all requested technical assistance in designing and implementing scaling-up programmes.

Many countries in the South-East Asia Region have embarked on efforts to scale up antiretroviral therapy. Besides Thailand, which is already implementing a national treatment programme, other countries namely India, Indonesia, Nepal, and Sri Lanka recently announced initiatives on AIDS treatment.

However, the overall progress in “3 by 5” has so far been slow and needs a major thrust at national and international levels. In order to raise the momentum, substantial strengthening of national health capacity is required.

Scaling-up Anti Retroviral Treatment is a major managerial and logistic effort, similar to DOTS expansion of TB. Political commitment towards implementation of national strategic plans is essential. Nevertheless, “scaling-up” ART should not be misconstrued as only focusing on AIDS treatment, at the expense of HIV prevention.

For us, HIV prevention still remains the bedrock of HIV/AIDS control programmes. All the basic prevention interventions such
as condom promotion and provision, health promotion and education to reduce sex partners, and the management of STIs, must remain a top priority, along with the provision of ART.

WHO promotes the implementation of national strategic plans for scaling up quality STI services in the public and private sectors. WHO advocates the integration of STI services with reproductive health and family planning as well as AIDS programmes and promotes reaching high-risk groups such as sex workers and their clients.

WHO is providing normative guidance in the management of STIs and in HIV prevention, care and treatment in the public and private sectors. The Organization has taken the initiative to improve STI surveillance as part of expanded HIV surveillance and the monitoring of antimicrobial susceptibility to common STIs.

I and my staff will do our best to provide full support to the discussions during the conference. Once again, I thank the International Union against Sexually Transmitted Infections for inviting the World Health Organization to address the opening of this important conference. It is very timely that this conference is taking place just a few days before the 15th International AIDS Conference, to be held in Bangkok from 11th to 16th July 2004. I hope that you will be able to participate in that conference.
Noncommunicable Diseases and Mental Health
Chronic, Noncommunicable Diseases

Chronic, noncommunicable diseases have taken root as an important public health challenge in this part of the world. We have to combine our wisdom and unwavering efforts in the fight against this scourge, to reverse the increasing trend in morbidity and mortality.

Chronic, noncommunicable diseases (NCD) are the leading cause of death and disability. Its morbidity and mortality are increasing all over the world; and in all social and economic strata. It is really a world-wide health, social and economic concern.

In WHO’s South-East Asia Region, NCD account for 51 per cent of all deaths, and 44 per cent of the overall disease burden. Major NCD targeted for integrated prevention and control include cardiovascular disease, cancer, chronic pulmonary disease and diabetes. Ischaemic and hypertensive heart disease, stroke, and rheumatic heart disease account for 27 per cent of all deaths, and 10 per cent of disease burden in this Region. Almost half of the deaths due to chronic, noncommunicable diseases occur prematurely. NCD contribute to a huge economic loss and impose an enormous burden on the health systems.

Large segments of populations in India and other countries in South-East Asia are increasingly exposed to physical, social and...
economic environments that adversely affect human health. The consequences include the adoption by people of unhealthy lifestyles, in addition to undergoing mental stress. These conditions contribute significantly and increasingly to morbidity and mortality in the general population.

Available evidence points to the centrally important role of the common risk factors that can be modified or changed to reduce the undesirable outcomes of such conditions. Five of the top ten risk factors identified in the World Health Report on “Reducing Risks, Promoting Healthy Life” should be particularly noted. These are: obesity, high blood pressure, high cholesterol level, alcohol consumption and tobacco use.

In addition, I would like to add mental stress, which is really one of the main underlying causes of heart disease. All these are major risk factors for chronic noncommunicable diseases. These factors are intricately linked to the conditions affecting the heart, brain and many other organs and systems of the human body.

Recent estimates show that each year, at least 1.4 million people die in this Region as a result of sustained high blood pressure. And another 1.1 million as a result of tobacco use and high cholesterol level. Low fruit, low vegetable intake, and lack of adequate physical activity claim an additional 1.3 million lives every year. However, the current threat from chronic, noncommunicable diseases can be overcome with available know-how.

The application of simple, population-based interventions, such as reducing blood pressure level by limiting salt intake, can save thousands of lives. This will lead to curtailing the cost of hospitalization and rehabilitation. When applied in an integrated manner at every level of the community, the available interventions can prevent at least 80 per cent of all heart diseases and stroke. The interventions that are integrally comprehensive, population-based, and risk factor-centred can ensure the effective reduction of the occurrence of heart diseases.

The strategy for integrated NCD prevention and control has been proved highly effective in improving health conditions if it is
implemented through multisectoral and multidisciplinary actions. Satisfactory health outcomes from these interventions can be further enhanced by targeting individuals with high-risk behaviours. However, despite a well-established body of knowledge on the prevention of chronic diseases the problem persists. The interventions to control NCD have yielded only a marginal result, particularly in developing countries.

Cardiovascular disease, diabetes, cancer and other chronic diseases are still causing more deaths worldwide. Furthermore, in the poor countries, it is the young and middle-aged adults who are increasingly affected.

This situation has a significant impact on the productivity of the workforce. Therefore, these diseases are a major barrier to poverty reduction and are an obstacle towards achieving the Millennium Development Goals.

It is only recently that the environments in which we live, eat, work and rest have been recognized as being responsible for chronic disease epidemics. A modest investment to modify or improve these conditions can yield enormous public health and economic gains.

WHO’s programme on prevention and control of chronic, noncommunicable diseases is particularly targeting major risk factors. These include tobacco use, alcohol consumption, physical inactivity, imbalanced diet, obesity, and high blood pressure. The control is pursued through risk factor surveillance and integrated community-based interventions. This approach is based on the recognition that risk factors, particularly those that are behavioural in nature, operate throughout a lifetime. They are interlinked and cumulative. But, they can be addressed with a set of coordinated interventions, through multidisciplinary approaches.

To strengthen the evidence base for action, WHO is devoting its efforts to support the review and development of national NCD surveillance in countries. NCD risk factor surveys through a well-defined approach are being implemented, and national NCD infobases are being developed.
A regional network, “SEANET-NCD” was initiated recently. This is to facilitate exchange of information, promote the adoption of an integrated approach to NCD control, and support inter-institutional cooperation. The network will also help to ensure effective collaboration among multiple sectors and stakeholders.

Since there is adequate scientific evidence linking tobacco use with cardiovascular and other chronic disease, the World Health Assembly in 2003 adopted the WHO Framework Convention on Tobacco Control (FCTC). Following its adoption, most Member States in this Region signed and ratified the Convention.

The major focus of the Organization under this Convention is to build capacity for development and implementation of comprehensive national tobacco control programmes. This involves, at this stage, the formulation of related policies, strategies and legislation.

Public awareness of the harmful effects of tobacco use needs to be widely created. The awareness creation needs to be pursued through the implementation of appropriate information, education and communication strategies at all levels of society.

Modified dietary habits and optimal physical exercise can also greatly influence health outcomes. Furthermore, promotion of good mental health and effective management of mental stress are equally important. In this connection, the Global Strategy on Diet, Physical Activity and Health, adopted by the World Health Assembly last year, serves as a toolbox of policy options.

If effectively implemented, this strategy will lead to a significant reduction in the burden of chronic, noncommunicable diseases. Several countries in the Region, including India, are engaging themselves in a big way in implementing the strategy on Diet, Physical Activity and Health. A regional plan of action for supporting the implementation of national strategies is under development.

Recently, WHO released a comprehensive report on “Preventing Chronic Diseases: a Vital Investment”. The report
highlights the global action to prevent chronic diseases that could save the lives of an estimated 36 million people, who would have otherwise died by 2015.

Cardiovascular disease is the main contributing factor to the epidemic of chronic, noncommunicable diseases. This situation needs to be widely recognized as a major public health problem. WHO, in collaboration with its partners, including professional bodies like yours, aims at establishing a broader coalition, to enhance the combined action to fight against these maladies. Only united action can lead to sustainable results in this formidable challenge.

In the long-term perspective, a well-defined package of interventions must be developed and integrated into general public health systems. The systems that duly emphasize the implementation of health promotion and disease prevention. This will ensure that the interventions with disease risk factors as the entry points, will reach the entire population, in both urban and rural areas. This, in turn will enhance the “positive health approach” that ensures longterm sustainability of health gains from prevention and control programmes.
The subject of mental health promotion is rapidly assuming greater importance. During the last two decades, we have witnessed many changes in the world, in all directions, such as rapid globalization; trade liberalization; accelerated urbanization; as well as demographic, socio-cultural and political transitions. Simultaneously, we have seen significant technological advancements, improved communications, and the increasing involvement of multiple sectors in health development.

Efficient management of change is critical nowadays, if we are to succeed in responding to the new and emerging demands for better health-care and services. In this context, promoting optimal human growth and development, and the maintenance of good health during one’s lifetime has become an overriding priority in the development of health for all people. This is what we usually call “health promotion”, in technical terms. Yet, there is a tendency in some areas of health programme formulation to place an emphasis on a disease-based model, rather than taking the positive domain of health in the development process.

Generally, people recognize disease, which implies “bad health”, rather than “good health”, which is mostly taken for granted. These perceptions of the people need to be changed.

Health promotion has to be made a key public health strategy for all sectors of society, if improved or better health status of the population is to be achieved.
population is to be achieved. Health interventions should be pursued through “aggressive” rather than “passive” strategies. While saying this, one must also keep in mind that due attention has to be paid to providing the best treatment for the sick.

The double burden of communicable and noncommunicable diseases can be effectively reduced by implementing appropriate health promotion programmes. In spite of substantial progress made in the area of health promotion in several countries, communities continue to suffer from preventable illnesses, including preventable mental and neurological disorders. In fact, rates of suicide, substance abuse and juvenile delinquency are increasing. It is therefore an opportune time now to take stock of the issues relating to this matter, and chalk out a suitable plan for our future endeavours.

What is becoming increasingly clear is that we need more effective strategies for promoting mental health and mental well-being. The determinants of good mental health and the risk factors causing mental disorders have to be precisely identified. Information on these determinants and risks will be used as the basis for rational planning, and effective implementation of mental health promotion programmes.

There is a substantial amount of knowledge and experience, in life-skills education for adolescents. But there is a dearth of information on the content in many aspects of mental health promotion that can lead to meaningful programme development and interventions. In addition, we need concrete evidence on the effectiveness of programme implementation in reducing morbidity due to mental disorders.

Furthermore, sound strategies for mental health promotion must be formulated on the basis of specific socio-cultural contexts. For this, we also need the help of several disciplines, including sociology and social anthropology.

Many social determinants of mental health influence personal and group behaviours that affect the psychosocial environments of men and women. In other words, environmental conditions of individuals, families, and communities are affected by sets of social
determinants. These pertinent points must be taken into full consideration when mental health promotion programmes are formulated through a multisectoral and multidisciplinary process.

Development of communication strategies to promote and support dialogue in the matters relating to socio-cultural issues is necessary indeed. In addition, certain traditional practices, such as meditation, which have been used for centuries in this Region, are now acknowledged as being effective in promoting mental as well as physical well-being. Some of these practices have been proven to be effective. We may attentively consider selecting them for promoting mental health in the community.

Messages and activities to promote mental health and mental well-being should really reach out to individuals; young and old, men and women, in places where they live and work. People and the community must clearly understand what is mental health promotion, what it means, and what are its essential elements. We need an effective package of evidence, knowledge, and information for education of people and the community.

Ways and means must be devised to empower people and the community to be able to initiate and undertake interventions from their own perspectives. Realizing the concept of mental health promotion involves multiple partners. All stakeholders, including people and the community themselves, must come forward on their own initiatives, but in a well-coordinated and consonant manner.

It has been advocated that health must form a key component of good corporate practices. What has also to be ensured is that the private sector perceives the need to invest, not only in physical, but also in mental health. Evidence must be provided to demonstrate that mental health affects very significantly the productivity of the workforce.

Creating awareness among policy-makers in countries of the paramount importance of mental health promotion is also essential. This will lead to the recognition and integration of mental health promotion activities in the national health care programmes, with adequate funding. Countries must see actions in health promotion,
including mental health promotion, as justifiable social investments, that can contribute effectively to overall national development.

The Regional Office is in the process of developing a Strategic Framework for pursuing public advocacy of mental health promotion as an area of highest priority. This has been done through consensus building among prominent professionals and experts from both within and outside the Region.

At the same time, support is being provided for the preparation of country-specific plans, which will be consolidated into a regional working document for mental health promotion. This effort will lead to the formation of a regional network which promotes and facilitates intercountry cooperation in this area. It should also be mentioned that this mental health promotion exercise must be seen as a part and parcel of the recently-adopted Bangkok Charter on Health Promotion.

In the process of promoting mental health within this framework, there are many formidable challenges that need to be tackled with unwavering determination. To be really effective in fulfilling our desire in this regard, we need new thinking, new ideas, new approaches, and real innovations in our work. My humble suggestion in this connection is that we focus on a few things first, then we do them well, with clear ideas of what we are doing and what is expected from our efforts. I would like to see that our attempts in this exercise also include, as integral elements, operational research or research-cum-action, which can provide us with further evidence for future action.
I am very glad that the Sixth Global Conference on Health Promotion is being held once again in this part of the world. As we go through the 21st century, we will realize that the theme of the Conference – “Policy and Partnership for Action: Addressing the Determinants of Health” is timely indeed. It is almost 20 years since the first Global Conference on health promotion on this topic, and many things in the world have changed. In this perspective, health promotion has to keep up with these changes which include rapid globalization; trade liberalization; rapid urbanization; and demographic, social and political transitions.

Equally important are technological advancements; the faster pace of communication, and enhanced involvement of other sectors in health development. The participants at this Conference have fully addressed these issues during the course of their deliberations.

The sixth Global Conference on Health Promotion has been convened to meet these global challenges, and to effectively exploit the opportunity to further improve health promotion for better health of the population in the 21st century. We have seen the intense debate on a number of key subjects, covering policy and strategy relating to the determinants of health, such as health-friendly globalization, new and enhanced partnerships, and sustainable development.
Health Promotion has been identified as a key strategy to motivate all sectors of society in all countries to firmly commit maximum resources to public health. Public health services, which particularly emphasize the overriding priority of health promotion, have become a prerequisite to improve the health status of today’s and tomorrow’s population. If we expect the world population to enjoy a longer and healthier life in this century, we must place the development of health promotion in the right perspective.

The deliberations of the Conference will conclude with the endorsement of the Bangkok Charter for Health Promotion. This Charter aims to guide and engage all concerned stakeholders to reaffirm health promotion as an effective process to enable people to increase control over their own health, make a better decision and a better choice as far as their health is concerned. Thereby, their own physical, mental and social wellbeing will be improved. A healthier population ultimately means better national security, socially and economically.

While concerns are being raised on persisting inequalities in health, new opportunities are also arising for improved health promotion in various sectors. This can be done with effective processes to empower people to engage in self-determined action for the development of individual, family and community health.

The Charter calls for new and unwavering commitments to health promotion from all sectors of society. To ensure equity in health for the attainment of better health for all people, all those sectors must share responsibility for pursuing health promotion activities in all population groups, with special emphasis on the poor and vulnerable. On another account, we must join hands to engineer a global community in ensuring that globalization and trade liberalization are much more health-friendly. In this context, we must make sure that health promotion is seen as one of the core responsibilities of all governments worldwide.

We need to work hard to ensure the induction of health promotion as an integral part of national socioeconomic and political agendas. We must provide evidence that health promotion contributes effectively to the country’s social and economic development.

We must also make health a key element of good corporate practices, so that the private sector perceives the necessity to invest
in health safety and healthy environment at the work-place. We have to work together to make all this possible. This requires more investment in health, enhanced partnerships, and improved capacity of countries to pursue health development more effectively. We have to ensure effective translation of concept, policy and strategy into action and outcome at the grass-root level.

It is extremely important that countries see actions in health promotion as justifiable social investments that can contribute effectively to overall development. Therefore, all of us, after returning to our work, need to redouble our efforts to strengthen health promotion activities whenever the opportunity arises.

WHO, in the South-East Asia Region, will take forward the processes to stimulate and motivate all countries in the Region to commit their policies and resources to the implementation of the Bangkok Charter. We fully recognize and accept the cross-cutting nature of health promotion, as well as its huge potential to address the major risk factors of morbidity and mortality. In particular, we are aware of the social determinants of health that are influencing personal and group behaviours, as well as environmental conditions of individuals, families, and communities.

The outcome of this Conference, including the Bangkok Charter, will take countries a long way in reorienting their health promotion strategies to ensure social justice and equity in health care services. The outcome of the Conference will promote the assurance of respect for diversity, dignity and human rights in the health area.

In WHO’s South-East Asia Region, health promotion is a priority programme in all countries. Much has been done, and substantial achievements have been obtained in this area in several countries. Certainly, many formidable challenges still remain.

To be really effective, we need new ideas, new approaches and innovations in health promotion strategies and programmes. We believe that better health promotion will lead to better health status of the entire population, less disease burden, and a better economy for any particular country.

We consider that the double burden of diseases, communicable and noncommunicable, that we, in this Region, are facing today, can be effectively reduced through the
implementation of appropriate health promotion programmes. WHO, in the South-East Asia Region, is developing a Regional Strategic Framework, through a consensus building process among the Member States. This framework aims particularly to strengthen social mobilization and advocacy activities that link with political commitments and agendas and other supportive environments.

Interventions in health promotion should reach out to individuals, young and old, men and women, in places where they make daily decisions. This is in order to assist them in making informed choices regarding their own health and welfare. The individuals must be appropriately equipped with relevant knowledge and evidence for their effective daily decision-making.

Development of communication strategies that promote and support dialogue, in matters relating to socio-cultural and gender issues should be encouraged. Full participation of intended beneficiaries in the decision-making process in all health matters ought to be ensured at all times.

Efforts need to be undertaken to address emerging as well as controversial and sensitive issues in a manner that respects the rights of the individual and community, including the right to cultural beliefs and values. A sound health promotion strategy should be considered within specific socio-cultural contexts, which vary from place to place and from country to country. The establishment of a structured mechanism for policy and programme planning, monitoring, and evaluation; as well as documentation and dissemination of information shall be an integral part of all health promotion efforts at country and regional levels.

We have deliberated thoroughly for the last four days, on the health challenges and opportunities for health promotion. We pledged ourselves to abide by the commitments and strategies as outlined in the Bangkok Charter. The management of change is critical if we have to succeed in responding to the new and emerging demands for better health care and services, and health promotion.

We should, therefore, unanimously support the principles of the Charter, sustain our commitments to its implementation, work together, and cooperate with each other in order to achieve the objectives of our noble mission for health and wellbeing of all people of the world.
As we are aware, there have been substantial changes in the field of mental health during the last several decades. The era of ‘lunatic asylums’ is over, and we are now well into the period of community-based mental health care and promotion. Accordingly, WHO’s current priority is to work closely with Member States in developing strategies and programmes on community mental health.

While embarking on this path, there is a need for appropriate laws, regulations and rules as the requisite for facilitating the implementation of community mental health programmes. Appropriate laws will not only provide a legal framework for such facilitation, but also ensure sustainability of the development initiatives in mental health in countries.

According to the WHO Project, ‘ATLAS: country profiles on mental health resources’, only 50% of all the Member States in the world have modern mental health legislation. In our Region, only two countries, India and Indonesia, have enacted new legislation in mental health during the last 15 years.

In other parts of the world, 75% of countries in Europe and 33% in Africa had passed mental health legislations between 1991-2001. Several of our countries, including Bangladesh, Nepal and Sri Lanka are actively pursuing the review and updating of their laws in this area.
Most Member States have provided mental health care through the promotion of benevolent traditions and customs that recognize the human dignity of the mentally ill individuals. At the same time, observations have been made on some abuses of mental health laws; such as, imprisonment of innocent people by declaring them as ‘insane’; or annulling a marriage by declaring a woman ‘mentally ill’.

With the changing moral values of society, we can no longer depend entirely on the kindness of either the judiciary or medical profession in protecting such human dignity. Therefore, modern mental health legislation, which recognizes the advances in medical sciences, and, at the same time, protects human rights, assumes a vital role in this sensitive area.

The WHO Resource Book on Mental Health Legislation, developed in 2004, provides suggestions on how to frame legislation that can help mentally ill individuals overcome the many barriers that impede their right to humane and dignified care and treatment. Any modern mental health law must preserve, to the greatest extent possible, the individual’s right to voluntary admission and discharge from mental health institutions. It must protect an individual’s right to informed consent, guarantee the least restrictive form of care, and also warrant appropriate medical services to each person.

Given the limited resources available, how each Member State will implement such legislation needs careful consideration by the Government itself. Necessary advice and support from WHO on how countries should proceed with such implementation may be considered.

We must also take into account the issue of stigma against persons with mental illness. This certainly leads to their discrimination and isolation, and frequently affects their entire family. The situation usually deprives the patients of effective treatment and care, further aggravating an already serious condition.

However, for persons with mental health problems in our Region, there are still many positive and supportive socio-cultural
factors. The deeply-rooted spiritual and religious traditions, and strong family ties of the populations help improve prognosis of care for mentally ill patients.

While collective family decision-making is unique to our culture, some may argue that only the patient himself or herself has the right to decide. Certainly, in our deliberations during the workshop, we will discuss this important issue of consent, and come up with a balanced guidance.

In this meeting, there will be a critical review of mental health legislation in the individual countries, based on the WHO Resource Book. This analysis will be an important first step to elicit what is considered to be a good part of the individual legislation, and what could be further improved and how to move forward in this direction. WHO will be a close partner of the Governments in moving this agenda forward in the most efficient and effective manner.
Community-based Mental Health Care

The World Health Report 2001 clearly pointed out that mental and neurological conditions cause a significant amount of morbidity and disability all over the world. It is estimated that about 450 million people are affected by mental and neurological disorders and substance abuse. A large proportion of these people live in developing countries, including the South-East Asia Region.

The projected estimate of disease burden from neuropsychiatric conditions measured by using DALYs method shows an increase from 9% in 1990 to 14% in 2020. Therefore, these conditions are clearly an issue of emerging importance in today’s public health.

It is also known that a substantial proportion of persons with these conditions, particularly in developing countries, do not get appropriate treatment. This is the treatment gap that we will be reviewing and planning to tackle in the course of this workshop. It is very unfortunate that this treatment gap in developing countries could be as high as 80-90% of the affected population. This workshop provides and opportunity to discuss this vital issue and develop appropriate community-based strategies to reduce the treatment gap in a phased manner.
Traditionally, neurological and psychiatric services have been concentrated in tertiary care hospitals. Thus, large segments of the population, particularly those who live in rural and remote areas, have been deprived of such services. This is despite the fact that both neurological and psychiatric conditions are also common in these communities.

WHO’s priority in this area is to concentrate on community-based activities. We are, therefore, making efforts to develop programmes suitable for delivering, at least the basic minimum level of services, to everyone who is suffering from neuropsychiatric conditions everywhere.

Ideally, such services should be provided within the community, integrated with the basic health care services; rather than expecting people to travel long distances to tertiary care hospitals. Those who are delivering health care in the community should be trained to identify and manage these conditions effectively at that level.

In addition, affordable and appropriate treatment should be made readily available in the community itself, using the primary health care approach. No less important, the programmes should also address psychosocial issues such as stigma and rehabilitation.

Taking into account aspects of feasibility and practicality, our strategies in this endeavour should address the most common causes of morbidity. The identification of such causes is guided by the following simple criteria: there is a high prevalence of the condition in the community; there is a high morbidity from the condition; identification is possible through the use of resources available in the community; effective and low cost treatment is available; and good outcome of such treatment can be expected.

Many mental health conditions meet the above criteria, e.g. epilepsy, psychosis, depression, mental retardation, dementia, and alcohol and substance abuse. Some communities may have their own unique conditions, but these conditions can be satisfied by the above criteria.
The WHO Regional Office for South-East Asia, with the cooperation of experts in the Region, has developed community-based strategies to address most of these operational issues. We will have to ensure that these strategies will be really useful for implementation in countries of our Region, taking into account the local, socio-cultural situations.

Among other things regarding tools to be used, technical materials on community-based rehabilitation have been developed, tested and are ready for application. Training in the use of these materials is currently in progress for concerned health staff from three Member States.

There are a number of projects on adolescent mental health promotion, dealing with issues of specific relevance to this vulnerable group. Also, there are projects to support Member Countries in their efforts to protect communities from harm due to alcohol and substance abuse. In addition, there are many other activities being identified for the development of community mental health programmes.

Looking at the agenda of the workshop, attention will be paid to community-based strategies for closing the treatment gaps in the most common neuropsychiatric conditions; namely, epilepsy and psychosis.

WHO estimates that there are 15 million people with epilepsy, and at least 20 million with psychosis in countries of the Region. Both conditions are easily amenable to treatment with cheap and efficacious medications. Yet, unfortunately, the treatment gap in these two conditions is very wide as mentioned earlier. There are, however, many prevailing positive and supportive socio-cultural aspects in our Region that can help promote the effectiveness of the treatment of mental health patients. The deeply spiritual and religious traditions and strong family ties of populations help improve the prognosis of treatment of mentally ill persons.

We may specifically see the example of a community mental health programme in Thailand, where Buddhist monks in the community have taken a leading role in organizing mental health
promotion activities. The entire community then gets involved voluntarily, including community leaders, the police, businessmen and families of those affected. Such grass-roots activities are normally supported by the mental health hospital in this area. These community-based actions help very effectively in closing the treatment gap; clearly demonstrating that such successful initiatives can be valuable lessons for other countries to learn.

I hope this workshop will further strengthen WHO’s work in supporting Member States in their efforts to deliver, at least the minimum services, for neuropsychiatric conditions, through the use of community-based health care providers and other community assets. This area of work still needs our special attention. Let us work together to improve the situation, so that the whole population in our Region is mentally healthy.
Family and Community Health
Nutrition in Health Development

The theme of the symposium, “Nutrition in Developmental Transition”, is timely indeed. It is time to revisit nutrition with the view to ensuring innovative approaches in nutrition programmes with the ultimate aim of improving health for all within the framework of current developmental transition.

The process of development has been with us, and will continue to be with us, for as long as human beings exist. Within this context, let me touch on a few issues of contemporary concern. Countries in the South-East Asia Region are among the most populous in the world.

Nutritional Problems

Emerging from centuries of development during the mid-twentieth century, most countries faced two major nutritional problems. One was the threat of famine, with the resultant acute starvation; the other was chronic macro and micronutrient deficiencies.

In order to combat these problems, countries adopted multisectoral, and multipronged strategies. They invested in programmes that also aimed at improving the economic status of their citizens. They pursued interventions for the prevention, detection and management of nutrition and health problems.

Symposium on Nutrition in Developmental Transition, India International Centre, New Delhi, 30 November-1 December 2005
Within two decades, the spectre of famine and starvation almost disappeared; and severe forms of undernutrition significantly decreased. However, the reduction in mild and moderate undernutrition, and micronutrient deficiencies was very slow and suboptimal.

All countries in South-East Asia are currently undergoing rapid developmental transition in nutrition. This transition is taking place along with substantial changes in socio-economic, demographic, nutrition and health dimensions of the population. While rapid improvement in per capita income and reduction in poverty are welcome, the concurrent steep increase in overnutrition-associated health hazards is a matter of concern.

Countries, therefore, have to gear up to combat the dual issues of malnutrition and disease burden, by taking into account the priority concerns and the current challenges.

**Food and Nutrition**

Food and nutrition are the most important basic requirements of life. These contribute, to a large extent, to our growth and development; physically and mentally. They cater to the maintenance of good health and to longevity.

With proper food and nutrition, human beings will not get old too early, or get sick easily. Food and nutrition help ensure health and well-being that enable us to lead a socially and economically productive life.

To effectively harness these advantages from food and nutrition, we need knowledge. This knowledge generally comes from research in food and nutrition. In this context, we must thank the institutions that pursue such research. These institutions certainly include the Nutrition Foundation of India.

These institutions have helped accumulate the research outcomes to form a body of knowledge. This body of knowledge helps us in formulating policies and strategies that ensure the availability of appropriate food, and proper consumption of food for good health.

When we look forward to better health and a longer lifespan through better food, better diet and better nutrition, we need
more knowledge. These institutions will have to continue pursuing research in food and nutrition with the view to producing the relevant knowledge.

I am sure there is still a long way to go in improving our health and longevity through improvement in food and nutrition. We need life with social and economic productivity; not to depend on others unnecessarily. And this life comes mainly from availability of appropriate food and proper consumption of food.

If we need more knowledge for better food, better diet and better nutrition, what type of knowledge do we need? Different people will have different answers to this question. Let me leave this issue to the experts to help think further.

Knowledge and Practice

Another important concern today is the gap between knowledge and practice. While yearning for more knowledge, we must accept that, we actually know a lot about food, diet and nutrition. But, this knowledge does not help the general population far enough, especially the poor and underprivileged.

Knowledge on food, diet and nutrition continue to benefit mostly the upper layer of the population. Nutrition education today is still beyond the reach of the poor to understand, to follow and to practice.

Compounding this are the barriers due to socio-economic factors and traditional beliefs. Food consumption is a way of life. To a large extent, it is determined by such factors and beliefs. This is particularly so among the poor and underprivileged groups of population. Therefore, closing the gap between knowledge and practice in food, diet and nutrition is challenging indeed.

If we are really serious about health for all people, through food and nutrition this gap must be narrowed or even closed. I would, therefore, like to invite concerned institutions to pursue studies that can contribute effectively to the narrowing or closing of such a gap.

It may be a waste of time to go around telling lay people how many calories from this or that type of food should be taken per day.
Or how many grams of this or that type of meat should be eaten per day. These are too technical and too academic for the lay people.

Let us ask ourselves, how many in this room count calories or weigh our food when we eat? It is time for us to re-think about the most appropriate tools to impart knowledge to lay people in the most efficient and effective manner. This needs careful studies, certainly. Not only studies in basic or medical sciences, but also, in sociology and social anthropology.

**Dietary Intake and Nutritional Status**

Now, let me touch on another important issue, dietary intake and nutritional status. It is a matter of concern that, over the last three decades, there has not been much change in dietary intake; except among the affluent segments of the population. Energy intake in the low income groups is obviously inadequate. This is despite the fact that subsidized food grains are provided to the poor. Diets consumed by these people are monotonous, and do not contain sufficient pulses and vegetables. As a result, a mild and moderate degree of undernutrition and micronutrient deficiencies is widespread, even today.

The high rate of undernutrition begins in utero, and gets aggravated in infancy due to poor feeding practices. Then, it is perpetuated in childhood due to poor distribution of food in the family, and poor access to health care. Low intake of vegetables and fruits, poor bioavailability of iron, and lack of universal use of iodized salt are responsible for micronutrient deficiencies. These deficiencies are continuing as major public health problems, in spite of tremendous efforts to reduce or eradicate them.

There is an urgent need to improve access to a variety of food, in order to achieve dietary diversification, for sustainable improvement in micronutrient intake. Better coverage under the national anaemia and vitamin A programmes, and universal access to iodized salt, are some of the interventions that could help the countries to achieve rapid reduction in micronutrient deficiencies.

Research institutions need to help with more concrete evidence to ensure the effectiveness of these interventions, through providing relevant evidence for improving planning and implementation.
Undernutrition-overnutrition linkages

Not less important is the issue relating to undernutrition-overnutrition linkages. There is growing evidence that undernutrition in early life may predispose to overnutrition and noncommunicable diseases in the later part of life.

This predisposition could be genetic or environmental; it could manifest itself at birth, in childhood, during adolescence and in adulthood. Therefore, prevention of intrauterine growth retardation through antenatal care; early detection and correction of undernutrition during childhood can go a long way, not only in reducing low birth weight and undernutrition, but also in contributing to a reduction in noncommunicable diseases in adult life.

One major lesson learnt from the research studies on undernutrition-overnutrition linkages is, it is never too early to start practicing a healthy lifestyle and dietary habits.

While countries of South-East Asia are yet to overcome poverty, undernutrition and communicable diseases, they are increasingly facing problems related to the rising incidence of overnutrition with associated noncommunicable diseases.

Energy Intake

Over the last three decades there has not been any significant change in energy intake of the population, except in the affluent families, especially in urban areas. But, at the same time, there has been a progressive reduction in physical activity in all segments of the population.

Reduction in energy use, with a change in dietary intake, results in energy imbalance. This appears to be the major factor responsible for the rising prevalence of over-nutrition in South-East Asia. It is very important now to urgently tackle the problem of over nutrition through ensuring proper food, nutrition and physical activity.

Role of Nutrition

Before concluding, let me mention briefly a few more areas in food and nutrition that need particular attention. This includes
the role of food and nutrition in the prevention and control of communicable diseases.

We are now realizing that food and nutrition can contribute significantly in the prevention and control of tuberculosis and HIV/AIDS. There is no need to mention about the prevention and control of other communicable diseases. Even though this role of food and nutrition is widely recognized, we need to pursue studies to provide more in-depth evidence in this important area.

With regard to micronutrient deficiencies, we have come a long way in their control and prevention. We have achieved the target for elimination of iodine deficiency disorders in some countries of the Region, and many other targets as well.

Currently, however, we are facing the issue of maintaining the gains from these achievements. This is another formidable challenge in the area of food and nutrition.

We need more evidence for effective policy and strategy formulation to ensure sustainability of the gains achieved through the development in food and nutrition, including micronutrient deficiencies.

When food and nutrition problems are tackled, these should also be tackled within the environmental and ecological context. This point may be kept in mind when food and nutrition programmes are developed and implemented.

I have placed my talk in a rather different perspective; touching on some of the issues, which, in my view, are also important to the future development to ensure good food and good nutrition for good health for all.

Finally, let me congratulate the Nutrition Foundation of India in organizing this important symposium. I hope that during the course of your discussions of the ongoing demographic, social, economic, nutritional and health transition, you will be able to suggest ways to combat more effectively the dual nutrition and health burden. Ways that can lead ultimately to good food, good diet, good nutrition and good health for the entire population, regardless of their socio-economic status.
Maternal and Child Health

During recent decades, the South-East Asia Region of WHO has made significant progress in several areas of social and economic development. Yet, every year, almost 200,000 women die during pregnancy and childbirth, a process which is supposed to be the most natural and fulfilling in human life.

Countries of the Region account for about one third of the global maternal and child mortality. Every year, more than 3 million children under five die, representing 30 percent of the global child mortality. A majority of these deaths are due to preventable or treatable conditions, like diarrhoea and pneumonia.

Most of the maternal and newborn deaths can be prevented if skilled care is available during pregnancy, childbirth and the post-delivery period. A significant proportion of child deaths could be prevented through simple cost-effective interventions; such as promotion of exclusive breastfeeding, oral rehydration therapy, and community-based management of pneumonia.

There have, however, been some improvements. Between 1980 and 2000, the under-five mortality rate in the Region declined by a third, and the maternal mortality ratio in Asia decreased by 15 per cent from 1990 to 2000. To accelerate the progress, we have to ensure that every mother and child always has access to effective health interventions, when needed.

Statement at: World Health Day Celebration, Vigyan Bhawan, New Delhi, 7 April 2005
Over the next few years, we need to develop and consistently implement more effective strategies to ensure Skilled Care at Every Birth. This will further improve access to maternal and newborn care at community level, resulting in positive and sustained outcomes.

As we are aware, it is targeted in the Millennium Development Goals that the maternal mortality ratio will be reduced by three quarters and the under-five mortality rate by two thirds. With a large population and high maternal and child mortality in the Region, the progress made by every Member State will be critical for the achievement of these Goals.

Fortunately, we have the knowledge and technology to prevent a majority of these deaths, but we are yet to apply them optimally in the best coordinated manner. It is, therefore, befitting indeed that this year’s World Health Report is devoted to the issues of maternal and child health.

The well-being of mothers and children is essential for the development of every nation; it has a broad dimension of social and economic development. Everyone of us has a role to play in preventing the death of mothers and children. In this connection, I would like to reaffirm the commitment of WHO in the South-East Asia Region to the cause that makes “Every Mother and Child Count”.

The well-being of mothers and children is essential for the development of every nation.
I feel honoured to be here at the National Annual Conference of the All India Coordination Committee of the Royal College of Obstetricians & Gynaecologists. I am happy to note that the theme of the conference is “Evidence - Based Clinical Practice Guidelines in Obstetrics & Gynaecology”.

The World Health Organization is committed to the promotion and implementation of evidence-based practices in health care. It is, therefore, most encouraging to note that your deliberations will cover many contemporary issues in evidence-based guidelines in such practices. These practices include identifying evidence, promoting research where evidence is lacking, and developing the guidelines based on the best evidence.

Maternal mortality continues to be a cause of serious concern in our Region. As you may be aware, the theme of the World Health Day this year is, “Make every mother and child count”. We have to do something meaningful on this occasion for the health of mothers and children.

Ninety-nine percent of all maternal deaths occur in developing countries. And, Member States of the WHO South-East Asia Region contribute to almost one-third of these deaths. In terms of cases, India accounts for the largest number of maternal deaths. This is socially and ethically unacceptable.
Reduction of maternal mortality is one of the key targets of the UN Millennium Development Goals. And, it is ranked the highest in WHO’s priority list.

As we all know, most maternal deaths are caused by conditions that are either preventable or amenable through timely interventions. WHO has supported many collaborative studies which have contributed significantly to the body of knowledge that is available today for addressing maternal mortality. As new evidence emerges, shifts in the approaches to interventions in this regard become imperative.

Not very long ago, many international agencies, including WHO, promoted antenatal screening for high-risk pregnancies. However, it has become evident today that every pregnancy carries a risk; and therefore relevant provisions have to be made to meet the needs of all pregnant women. Hence, it is recommended that every pregnant woman should have access to skilled care, with the availability of a skilled birth attendant, linked to a functional health care delivery system in order to ensure effective referral services.

WHO’s Practice Guidelines in Reproductive Health Care are based on the best available evidence, and were developed through intensive international consultations and reviews. Many of these guidelines have been translated into national and local languages, and adapted as national guidelines in Member States.

Yet another tool used to promote evidence-based reproductive health care is the WHO Reproductive Health Library. I am happy to know that this tool and other WHO related guidelines will be reviewed during the course of this meeting.

Here, I would like to mention that developing guidelines is one part of the process, but translating these into day-to-day practice is a key challenge indeed. Forums, like this meeting, provide the much-needed opportunity for dissemination of evidence-based information on issues of concern.

On the other hand, medical and nursing students can act as catalysts for change, as young minds are more impressionable.
We, the medical fraternity and WHO, should work together to ensure that these evidence-based guidelines and practices are reflected in their pre-service and in-service training programmes.

I urge you all to use every opportunity to share these evidence-based practices with all those who are responsible for the better care of women, particularly during their reproductive period. I would also like to urge you to include the teaching of evidence-based medicine in the medical and nursing curricula.

Specifically for India, the challenge in the field of obstetrics and gynaecology is to ensure that evidence-based guidelines are adapted in everyday clinical practices across all levels of care in the country. WHO will be happy to be associated with your efforts in this important area, and I look forward to your active role in improving reproductive health care in this country.
Sustainable Development and Healthy Environments
As we all are aware, approximately 200,000 lives were lost due to the earthquake and tsunami at the end of last year. It was one of the worst catastrophes of our times. The tragic event affected nine countries, and displaced an estimated 1.2 million people. This was in spite of the prompt response by the governments of affected countries and international organizations. Never before had we seen such global solidarity, unity and concerted efforts of all stakeholders, to help the affected populations.

This year, powerful hurricanes caused large-scale devastations in the Southern region of the United States. And, most recently, strong earthquakes severely affected several areas in Pakistan, India and Afghanistan.

Currently, more than 30 countries throughout the world are facing major, and often long-standing crises. As many as 500 million people in these countries are affected, or at risk due to these phenomena. Worldwide, it is estimated that between 2-3 billion people are at risk of disasters; either natural or man-made. It is unfortunate that this part of the world happens to be disaster-prone.

Countries in the Region have experienced several catastrophes in recent years. These include the earthquake in...
A Vision for Health Development in South-East Asia

Gujarat (India) in 2001; chemical blast in Ryongchon (DPRK) in 2004; bomb blasts in Bali (Indonesia) in 2002 and 2005. These are in addition to the yearly monsoon floods in South Asia. The worst episodes were in 1998 and 2004 in Bangladesh.

Adding to these are the continuing political and social conflicts in several countries of the Region. These conflicts very often create disastrous events, affecting large groups of people that require emergency response of various magnitude. The frequent occurrence of such events indicates the urgent need for effective emergency preparedness and response at all levels.

International agencies have joined hands to develop more responsive strategies. The strategies that can support countries more effectively in their efforts to save lives and reduce suffering of the affected populations. The World Health Assembly last year reaffirmed the need to strengthen countries’ capacities in emergency preparedness and response. This was to enable them to protect their populations efficiently during emergency situations.

The capacities required for effective management of disasters include, among others, risk assessment and development of national multisectoral policy and strategy. The ultimate goal is to enable countries to plan and coordinate effectively all activities relating to emergency preparedness and response. In addition, the countries will need to develop monitoring and warning systems to forecast a catastrophe.

Through education and communication, the information should be provided to people and the community, to enable them to be prepared to respond effectively to the emergency situations. Not less important, such information should also aim at dispelling myths about health consequences of disasters. People and the community should be prepared to help reduce the extent of destruction to physical infrastructures, including health facilities in the affected areas.

The WHO Regional Committee for South-East Asia, at its session this year, provided direction on several key issues. These are particularly for Member States to move forward urgently in strengthening their national capacities in this priority area. This
direction is in line with the Hyogo Framework for Action, 2005-2015, for Disaster Risk Reduction.

The Framework addresses specific gaps in the present responses to emergencies. It also highlights challenges that disasters pose to communities and populations around the world. In addition, the Framework expresses concerns with many related issues in almost all areas of emergency response. These areas are preparedness, including risk assessment; management of emergency; recovery; rehabilitation; reconstruction; and other critical aspects.

WHO, as the health arm of the UN system, works in close coordination with other partners, including those outside the system. The ultimate aim of WHO's work during an emergency is to help the countries in their efforts to save lives and to mitigate, as much as possible the suffering of their populations.

This involves primarily the identification of appropriate mechanisms to help countries to coordinate all players efficiently during an emergency. Coordination mechanisms at the country level are an important part of national strategies and plans for emergency preparedness and response.

Keeping in mind the lessons from various disasters, it is important to view all interlinked issues relating to disaster management from a broad perspective. To be effective, risk management and emergency response have to be carried out through multisectoral cooperation and actions. At the same time, international agencies, including WHO, will have to review and further strengthen their own capacities to ensure more effective support to countries.

The health component should be considered as an overriding concern in national emergency preparedness and response. Within their own potential, communities and people must be empowered to respond efficiently and effectively to emergency situations, at least during the first hours. This will help curtail further damage and destruction to the extent possible, before the arrival of assistance from outside.
This regional meeting is aimed at developing concrete steps to strengthen emergency preparedness and response in countries. With our common concern, and through our combined wisdom, it will be possible for this aim to be successfully pursued during the course of the meeting.

Health needs in emergencies must be responded through the most efficiently organized efforts of all stakeholders and players. This requires mechanisms and processes that can ensure coordinated, synchronized and prompt actions for the best response to those needs.

During this meeting, we will delineate benchmarks for our endeavours, and evolve a strategic framework and direction for efficient coordination and combined efforts. A framework and direction that can guide countries to move effectively towards the achievement of the best health protection of the affected populations.

This is an important forum to share our experiences and lessons; and work together towards that end. This may be only the beginning of a long process. The process which we will have to pursue jointly with countries, in both the short and long-term horizons.

Some countries have, however, launched programmes on emergency preparedness and response with commendable results. These are: preparedness in Bangladesh for floods and cyclones; strengthened capacity in community mental health during an emergency in Thailand; efforts to mitigate damage to health facilities in Nepal; updated legal framework to support disaster management in Sri Lanka; and decentralized preparedness and response in India and Indonesia. The experiences in Maldives, Bhutan, DPR Korea and Timor-Leste are also worth learning in this regard.

WHO is currently involved in building a regional information base, and network of expertise in this area. This will be another important tool for supporting countries in planning to address future emergencies more effectively. WHO will continue assisting countries in their endeavours to develop and improve emergency
preparedness and response programmes, in both the short and long terms.

To conclude, on behalf of WHO, I would like to convey our appreciation and thanks to all countries, organizations, and others who share our concern and responsibility to protect the health and welfare of populations affected by disasters.

Our grateful thanks are also extended to the countries and organizations that provided funds and other support to WHO during the previous crises. Given the sheer magnitude and the very wide scope of the catastrophic events, no one organization or sector can carry out the relief operations unaided.

Let us come together for better outcomes from our combined efforts in helping the affected countries and populations. We are looking at the way forward, whereby our unified direction and united strength will help us to successfully overcome the formidable challenge of disaster management.
Health Aspects of the Tsunami

We have been engaged for the past few days, in trying to learn from the Tsunami experience. While we looked closely at the Tsunami crises specifically, it is important to view these lessons in the wider perspective of our work in risk, disaster and emergency management, not just in health, but in all sectors.

Let me explain a few points to help us proceed in this direction. The Tsunami showed our weaknesses in various aspects of coordination, communication, and general emergency management. We have discussed them in detail and the points made are well taken. There is always room for improvement not only in the manner and timeliness of our work, but also in the appropriateness of our approaches.

However, the Tsunami also demonstrated the strengths and potential of the health sector in responding effectively. This was clearly seen in areas such as rapid health assessment, setting up of surveillance systems, and provision of health services including immunization campaigns in difficult-to-reach localities. This is where we were able to see an efficient and effective impact of our work as public health and humanitarian professionals in an emergency.

This was also seen in the setting up of the operational platform for emergency response and maintaining a coordination forum to keep all health actors unified in protecting the affected population.
Knowing our strengths and weaknesses, however, is not enough. We need to continue to review and analyse these critically, so that we can clearly identify the priorities in which investments are to be made in our future efforts.

Here, we may use the four E’s, namely, Effectiveness, Efficiency, Empowerment and Engagement as a guide in this appraisal.

Effectiveness: How well did the strategies we employed and the activities we conducted, reach the target population? What was the result? To begin with, we should develop some tools to measure such impact.

Efficiency: Although it is important to conduct assessments and provide health and health-related services to survivors or displaced people, it is equally important to consider the costs of our efforts against the benefits to the affected population.

Empowerment: Did our actions get transferred to a larger base of health professionals, humanitarian actors, or more importantly, the community at large? It is important that the actions are taken forward by nationals and the affected communities as this is what will prepare them better for a future disaster.

Engagement: It is not only important that we empower our partners and each other. We should also ensure that the decision-making process is collectively owned.

I think by using the four E’s, we can better map out our action in the rehabilitation phase and plan for long-term preparedness. This is why we are engaged in a lessons-learnt exercise.

As some of you may be aware, in September 2004, the WHO Regional Committee for South-East Asia adopted a resolution on emergency health preparedness. The resolution provided clear direction on several key issues for the Member States and WHO to move forward in strengthening national capacity in this priority area. Some of these included regional and intercountry collaboration, improving risk management, and building capacities in various areas of disaster management at the country level.
Substantial progress in addressing some of these issues has been evident after the Tsunami experience. We need, however, to examine in greater detail, how we can pursue this resolution and commitments systematically.

In the long term, the only way to ensure a more efficiently organized response to health needs in an emergency is to ensure institutionalization of the Emergency Preparedness and Response (EPR) programme within Ministries of Health. This should be part of a national disaster management plan.

Such a programme should deal primarily with the needs in the health sector for preparedness, response, recovery and rehabilitation, mitigation and prevention of various risks and hazards within the framework of national plan. This programme shall also map out the resources required – both human and financial, for responding to the needs of populations at risk and those affected.

The requirement of political and high-level policy backing to the programme should be explicitly elaborated. It would be WHO’s role to support the building and strengthening of such programmes in countries.

The strategies to achieve what we have discussed in the past two days would naturally depend on the effectiveness and efficiency of the health systems in the countries. However, what we need to do is quite clear from the discussions during the conference. It is just a matter of prioritizing what we need to do first.

From our experience of the Tsunami and its aftermath, we need to have both short and a long-term planning. Investment in disaster management and risk reduction in the health sector will go a long way in ensuring health protection during an emergency. In fact, not making the proper investments in human and other resources, would only help to compound the disaster.

The option is quite clear. We have to grasp this opportunity to be better prepared next time.
Emergency Health Action

I welcome members of the Global Steering Group for WHO’s Emergency Health Action and Health Action in Crises. This area of work has always been critically important to WHO’s mission during an emergency, either natural or man-made.

As we know, through their organized efforts, EHA and HAC helped to mobilize global resources for effective relief operations during the Tsunami crisis. The Tsunami of 26 December 2004 has been the biggest emergency WHO has ever dealt with.

More than anything else, the Tsunami crisis revealed the strengths and weaknesses of WHO in dealing with a disaster of this magnitude. Our experience has clearly shown us in which areas we can deliver our services efficiently, and what are our shortcomings.

Let me mention some of our strengths: It was demonstrated that WHO could be effective in its operations during emergencies. We could successfully set-up operational platforms in a very short timeframe, that, just a few years ago, might not have been possible. WHO’s work with other agencies was really remarkable, to say the least. It was through proactive actions in crises that we fulfilled our role as the health arm of the UN system. With a well organized response, we were able to better assist the Governments of affected countries.

Clearly, WHO has very good people and really competent experts, but our systems for preparedness are yet to be fully in
place and efficiently functional. If we want to respond efficiently and effectively, we have to be really well prepared. Preparedness is an area that we need to address in a systematic manner.

We have to be clear that there are urgent needs for preparedness on the part of our WHO country offices. While inter-country and inter-regional networks for mobilizing human and other resources exist, they need further strengthening.

As an Organization, we have to be realistic and practical in dealing with emergencies: We have to be prepared to respond rapidly. We have to be able to coordinate effectively, both internally and externally. We have to ensure that the EHA/HAC programme is institutionalized within the national systems.

The Three-Year Plan of the Health Action in Crises, I believe, is addressing several concerns, such as: Clarity and consistency in our concepts and operational definitions of preparedness for WHO Country Offices. Pre-arrangements with national governments, UN Agencies, and other International Organizations in activities related to preparedness, response, recovery, rehabilitation and reconstruction. Internally, within WHO, clear lines of communication and authority to be understood by all concerned.

All these issues can be summarized in Standard Operating Procedures and we need to have adequate capacity to fully implement them.

If we achieve the objectives of the Three-Year Plan, we can effectively address what Member States request from us. In the South-East Asia Region, we are trying to put together in the Three-Year Plan these elements as mentioned.

It is clear that we have to double our efforts to intensify our work in EHA/HAC to enable us to face multiple hazards and risks. WHO has gone through many emergency operations. Each time, we have learnt lessons to improve further.

However, we have to learn more in order to gain a better balance in our work in this area, which is full of emotion, competition and diverse interests of various stakeholders. Being
the technical agency in health in the UN system, we have a strong comparative advantage, that can lead us a long way towards achieving such a balance. What we have to always ensure is our technical competence and credibility, and our ability to move fast logistically and managerially. This needs, among other things, well coordinated and integrated efforts within the Organization.

The emergency operations during the Tsunami crisis proved that there was an unprecedented solidarity and cooperation in WHO. Let us try to ensure that this level of solidarity and cooperation continues and is further strengthened.
It has been more than two months since the Tsunami tragedy on the 26th of December 2004. This unprecedented disaster has left countless dead; millions more are homeless, with lives shattered. The Tsunami destruction extended to four out of six regions of WHO, the most affected being South-East Asia.

The affected areas in this Region include: Indonesia, primarily in Aceh province; Sri Lanka in its North, East and Southern Coasts; India, particularly the State of Tamil Nadu, and the Andaman and Nicobar Islands; Thailand’s six provinces in the South; Maldives; and Myanmar.

I would like to briefly inform that, in response to this disaster, a Tsunami Task Force was immediately established in the Regional Office, and our Operations Room was activated to function round-the-clock. Since then, the Task Force has been operating in close coordination and consultation with the WHO Headquarters Health Action in Crises team.

During the emergency phase, daily teleconferences were held among affected countries, Headquarters and the Regional Office, to ensure consistent communication, joint decisions and coordinated efforts. Satellite communications were established in the WHO country offices in India, Indonesia, Sri Lanka and Thailand; and in the field offices of Banda Aceh and Meulaboh in Indonesia. Wireless connectivity has been established in the field.
offices in Sri Lanka. In all affected countries in the Region, Operations Rooms were organized in WHO Country Offices.

During the early phase of the crisis, priority attention was paid to the provision of technical advice and guidance; in addition to sending emergency teams to the affected areas on the request of the countries. Technical guidelines and manuals were compiled, updated and disseminated widely for use by emergency teams in the field. These technical materials have also been found very useful by other agencies operating on the ground.

To ensure our capacity in the field, in addition to WHO emergency staff, WHO field staff from other programmes were also immediately deployed to the affected areas. Necessary medical supplies, such as drugs, antibiotics, water purification tablets and vaccines were provided.

What is clear in dealing with these crises at the country level is that the response of national authorities was remarkable, prompt and really effective. The local communities have demonstrated an outstanding resilience in this event, and I would like to pay tribute to the national authorities as well as the concerned communities for their very commendable efforts.

The work of WHO in responding to this emergency situation has been possible only with the close cooperation of national and local authorities. All WHO offices worked as one team in synergy with the efforts of the Member States and various partners.

The first 100-day emergency strategy was chalked out and implemented with the combined endeavours of many agencies, national partners in the government and nongovernmental sectors. This strategy focused on five priority needs of the affected areas: surveillance and response, including early warning systems to prevent disease outbreak; coordination of health activities for the efficient relief operations; ensuring access to essential health care for the entire affected population; provision of technical advice and guidance on critical public health issues arising from the crises; and coordination and restoration of medical supply chain for smooth functioning of health care systems.
WHO, in coordination with national and local authorities, has developed workplans to address the challenges during the coming months. WHO’s current objectives for supporting the concerned governments in responding to the tsunami crisis are: Supporting partners in the government in implementing effective public health action; Ensuring quality, coverage and accessibility of primary health care services; Coordinating and networking different groups that contribute to the provision of health services to the affected population; and Supporting the rehabilitation and reconstruction of health services infrastructure in the affected areas.

To ensure the efficiency of WHO’s inputs to the emergency operations, teams of WHO senior staff were formed to carry out a quick assessment of WHO performance on the ground. This was, among other things, to look into the issues relating to the coordination among WHO staff members and WHO coordination with other agencies, in the field.

In addition, WHO is acting as the health arm of the United Nations system operating in countries in response, recovery, and rehabilitation activities.

We have organized this meeting to take stock of the events and activities of the previous months with the view to analysing our past experiences. We are well aware that during the past two months of emergency operations, there might have been a number of unintended flaws and deficiencies in our hasty actions in trying to help save peoples’ lives and alleviate suffering of the affected population.

Now, we would like to gain a better understanding of the situation – past, present and future – in order to move forward more smoothly in supporting the affected countries more effectively during the next period. And, most important, we would like to have your views on how WHO can serve the countries better during the rehabilitation and reconstruction phase.

At the same time, we would also like to know about the countries’ own efforts, and how they tackled the crises during that emergency period. This will be very useful information for WHO to strengthen its EPR programme.
Together, we will review WHO’s role at the country level in the Tsunami relief operations and in the initial phase of rehabilitation and reconstruction; in particular, the commitment to the implementation of the country workplans of the flash appeals. In this exercise, the needs of the affected population must remain our priority concern.

Given the sheer magnitude and scope of this catastrophe, no agency can carry this mission alone. And this has been clearly evident.

Never before, have the organizations of the UN system demonstrated such spontaneous solidarity in responding to the immediate needs of affected countries during a crisis. This happened with unity, professionalism and speed.

I may say that every disaster presents opportunities to both the countries and international agencies to strengthen their capability and capacity in this regard. We must move in a more coordinated manner in responding to the need for enhancing the capacity of the health sector of Member States in the area of emergency preparedness and response.

In this process, we have to ensure the empowerment of communities and people to respond more efficiently and effectively to the emergency situation on the ground. I know we still face a huge challenge, but I am convinced that we will succeed through our united efforts for long-lasting benefits to the affected population.

WHO will provide full support to countries in identifying the existing gaps, and coordinate with the national authorities to fill those gaps in the health areas.
I am very happy to welcome you all to this important workshop that brings together participants and experts from three different WHO regions – the Western Pacific, Eastern Mediterranean and South-East Asia Region. The workshop will provide an opportunity for an exchange of views and experiences on trade, trade agreements and public health.

When we mention ‘trade and health’, the first thing that comes to mind is the issue of the TRIPS Agreement, and how it may affect the availability and affordability of medicines. This topic has been debated in numerous fora, and has received considerable attention over the past few years.

While this is extremely important, it is not the only area where health and trade intersect. Trade agreements may also affect food standards. The liberalization of trade in services may include health services; if so, it may have a profound impact on the way health care is provided. Thus, it would influence on who has access to such care, and who does not.

Yet, as is well recognized, health is a human right. Food, medicines and health services are public goods. Social justice demands that nobody be deprived of these essential goods and services.

Trade agreements and trade liberalization can be supportive of public health goals and objectives. However, it is not automatic.
It is, therefore, important to have the necessary policy provisions to ensure that national governments can steer and guide the health sector in the desired direction. The need to preserve policy space is particularly relevant when countries are acceding to WTO; yet, at this particular time, officials from both the trade and the health sectors may be unfamiliar with the effects trade policies and agreements can and do have on health.

Often, there is inadequate communication between the health and the trade sector. Without communication, there cannot be coordination, nor policy coherence.

Thus, at times, health officials may feel that they are not heard, while trade officials complain that the health sector does not tell them what they want. There is thus a need to facilitate dialogue between health and trade.

We in the health sector should ask ourselves whether we are communicative enough. Do we have a good understanding of the issues? Are we aware of the needs of trade negotiators, and of the pressures they undergo? Have we done sufficient analyses on policy issues? Are our views well-founded? Can we convey policy implications in a format that trade negotiators can use? Are we coherent among ourselves? And, do we respond swiftly and accurately when our views are being asked?

Meanwhile, representatives from the trade sector may wish to question themselves whether they ever really sought the views of their counterparts in health? Whether they really want to know? Is it not at times easier not to receive inputs that may entail a revision of negotiating strategies?

While these difficult questions need to be asked, we can also be satisfied at some developments. For example, public health has been included in discussions at the World Trade Organization. ESCAP, in its recent annual meeting held in Shanghai, adopted a resolution on public health. Trade and intellectual property rights are also on the agenda of the World Health Assembly. Awareness and knowledge on these complex issues are increasing among the developing countries.

WHO has helped in building this awareness. We have worked with Member States and with the WTO Secretariat in examining and explaining the different WTO agreements. We have supported studies
relating to trade agreements in the Region and encouraged public health schools to include global agreements in their training programmes. The documents provided to you at this workshop are tangible evidence of our efforts to make the multilateral trade agreements, like TRIPS, GATS and SPS, more understandable to health professionals. We have commissioned studies, and also conducted national and international meetings, workshops, and seminars. We will continue to support Member States in every possible way and provide a platform where different sectors can meet.

I am especially pleased to welcome today a number of representatives from the trade sector. Their presence provides a valuable opportunity to learn from them, to share our concerns and questions with them, and to establish or strengthen mechanisms for dialogue. But, to me, their presence here is also indicative of their interest in the health sector.

This interest is important, especially since in many developing countries the health sector is relatively small, compared to trade/commerce. It may be tempting for trade officials, while negotiating, to “trade health away”. Therefore, to trade officials, I would like to reiterate that health is not a luxury, and health care is not a peripheral issue. Health is central to development.

This is an interregional and intersectoral workshop bringing health and trade professionals together, from three regions of WHO. I hope it will also be an interactive workshop. I am convinced that a frank and open dialogue amongst us will be of immense value. We all have experiences to share, and we all will be able to learn from one another. This will help us to make sure that health and trade move in tandem for the benefit of our countries and our people.

I am, therefore, confident that you will all make use of the deliberations and discussions in the next two days to enhance your understanding, and to further strengthen collaboration between all parties involved.

I am particularly looking forward to the action plans that would result from this meeting. I am sure that they will contain practical ways and means to move forward in each of the countries represented here. I would like to assure you that WHO stands ready to continue its support and collaboration with you.
Health Systems Development
Improving Access to Health Care

Improving Access to Health Care: Reaching the Unreached” is very important indeed. This is especially so in the light of the current challenges we are facing in our efforts to ensure health services for all.

The three substantive areas covered in the programme for discussions during this meeting are: Financing Health care; Health Care Delivery, and Nongovernmental Sector in Primary Health Care.

These are important areas. If appropriate approaches can be found and pursued vigorously, it will take us a long way in improving access to health care and in reaching the unreached.

For my talk today, let me put things in a different perspective and in a broader context. This might help us think further in our efforts for such improvements.

All countries in the world are trying hard to make it possible that health care services cover their entire populations; urban and rural, rich and poor. To achieve this goal of universal coverage, WHO promoted, during the 1950s and 60s, the development of systems for delivering basic health services to all population groups. During the 1970s, 80s and 90s; the primary health care approach, which was considered to be the key to the attainment of the goal of health for all had been pursued.
Today, the goal of health for all, which was set by the World Health Assembly in 1977, continues to be an aspirational goal for health development efforts. However, it is estimated today that more than 800 million people worldwide do not have access to necessary health care and services, when needed.

Improving access to health care: reaching the unreached, remains a formidable challenge for all countries around the globe; developed and developing alike. But, it is much worse in the latter.

There are many reasons why we cannot succeed as we wish, in improving access to health care: in reaching the unreached. Let me focus on certain key issues relating to this matter, which may be of interest to this reputable body.

In this regard, the development of infrastructure for effective delivery of health care services is very important. We have invested a lot of resources and efforts to build up health infrastructure. One key question in this connection may be, how well can such infrastructure serve our purpose to improve access to health care? Whatever attempts we pursue in the development of health infrastructure, the emphasis is always tilted towards the provision of personal or institutional care.

The concern to bring health services to every community to serve the entire population, has always been an elusive desire which has not really materialized in practice. We are still emphasizing institutional care, which is provided mostly in cities or towns; and the care that mostly benefits privileged groups. Mainly only the sick, and often those who can afford, come for the services. We need to keep in mind that, for many reasons, there is still a vast majority of people who, even though they are ill, do not come to receive such institutional care.

There are many factors involved in the non-utilization or under-utilization of institutional care by people, especially the poor and marginalized. The reasons may be lack of physical accessibility, and financial ability, or psychosocial distance between care providers and receivers. We all know that to improve access to health care, to reach the unreached, such services must be provided as much as possible where the people live and work.
Primary Health Care

Nonetheless, today primary health care is still the right approach to improve access to health services and to reach the unreached. What is needed is that the development and implementation of primary health care must be really rooted in the community itself. And, as much as possible, primary health care must be developed and implemented by the people, for the people themselves.

Primary health care must be readily available to all people, who are in need, everywhere, especially the poor and marginalized. To serve its purpose, primary health care should be carried out through full responsibility of the people and the community. This responsibility must be at both individual and collective levels; and at all stages of development, i.e., planning, implementation, monitoring and evaluation. This is what we call “health for all and all for health”.

It is for the people from all walks of life to get involved in the process of development of their own health. This implies the need for particular efforts to educate and empower people to be able to take such responsibility effectively in such a process. Certainly, the government and we have to help in such education and empowerment.

There is also a need for effective advocacy at policy and decision-making levels in order to gain political will, commitment and support for the development of people’s health care systems. This will have to be pursued with the recognition that health is a fundamental right of every individual, regardless of socio-economic status. And, it must be done within the framework that ensures equity and social justice in health care.

Improving access to health care is really a public health concern today. We need a public health infrastructure and workforce to ensure that the services reach out to every corner of the country, geographically and psychosocially. We need public health services that are really community and population-based. Services that support primary health care as the main focus. Services that are developed on an epidemiological, environmental and ecological basis. Services that are developed within the context
of local situations and circumstances; socio-culturally and economically. Services that target especially the poor, underserved, underprivileged and vulnerable groups of population. And, most important, services that are developed and carried out through multisectoral and multidisciplinary involvement and action.

It is universally accepted that health is an important element of socio-economic development. Increasingly, health issues are becoming the concern of the general public and the political arena.

Health concerns are no longer confined only to the health sector. It is an important concern of other sectors as well. Therefore, sectors other than health should come forward to fully share responsibility for health development. They should devote their resources and efforts for developing and implementing health programmes in the areas of their concern. Why not, if the ministry of education is to run a programme on health education; the ministry of agriculture in the area of food, food safety and nutrition? And why not, if the public works department is to run a programme on water supply and sanitation.

There is certainly a big scope for other sectors to get involved in ensuring better access to health services that would lead to better health of the entire population. In this perspective, the health sector still has an important role to play in providing technical know-how to other sectors to play their role effectively.

The private sector has already been involved in the provision of medical care services. They should also be encouraged to go in a big way in providing such services to the poor and vulnerable. Nongovernmental organizations in general have done a very commendable job in helping to improve access to health care. To be really effective, policy decisions and back-up support at the highest level of the government are needed. This requires a lot of advocacy and promotion, to create awareness and interest in other sectors, including the private sector, and NGOs.

Not less important, the health sector must not monopolize the ownership of health, and should be ready to welcome other sectors to take care of health development in various areas. It should be underlined in this connection that the other sectors,
first of all, must appreciate health, and see the value of health contribution in their development process.

In this context, I would like to invite the attention of this distinguished group of professionals and scientists to the Report of the Global Commission on Macroeconomics and Health. The Report highlights the important contribution of health to poverty reduction, and to overall development.

**Public Health Workforce**

We need a public health workforce of a multidisciplinary nature to carry out public health programmes that can extend services wherever there is a need. Public health programmes mean programmes for the protection of health of the public, of the community and of the entire population. Such programmes include malaria control, tuberculosis control and control of other communicable diseases. The programmes which deliver the services in areas of maternal and child health, health education, nutrition, water and sanitation, immunization; and many others.

These programmes, if properly developed and implemented, can help improve access to health care to a large extent, and raise health status beyond the curing of diseases. We do not have enough doctors to go everywhere, actually in many cases, the provision of public health services does not need doctors. A lot of fundamental health problems can be effectively handled by other categories of health workers, if properly educated and trained. Doctors are trained mainly for personal and institutional care; we should try to keep them that way.

We should critically analyze the types of health problems that can be effectively taken care of by other categories of health staff, particularly community health workers, and then train and educate them accordingly. These health workers will be more than willing to go to the hardship rural and remote areas, to reach the unreached. However, in this process we have to keep in mind that regardless of the number of health staff we have, it will not be totally adequate to ensure access to health care by all.

As already mentioned, other sectors have to come in, to take care of health in their own respective areas of concern. Most
importantly, the people and community themselves must be educated and empowered to be able to take care of their own health, at the primary level. The people and community, therefore, need appropriate information, education and guidance in order to take action themselves effectively.

When we expect other sectors to be responsible for health, they also need to have public health know-how, and expertise. This is necessary for them to be able to develop and implement public health programmes in an efficient and effective manner.

We, in the health sector, produce public health practitioners and professionals, not just for the health sector’s use, but also for use by other sectors that are involved in public health work. In developing health programmes to ensure improved access to health care, reaching the unreached, we must strike a proper balance between personal and institutional care as well as community and population care.

Public health services must be strengthened to ensure the development of community and population-based health services. To be cost efficient and cost effective, public health services must emphasize health promotion and disease prevention.

We should have a policy that ensures optimal growth of the people, physically and mentally; and to ensure the maintenance of their good health with social and economic productivity. We should not wait for the people to get sick and then treat them. It is then too late to ensure for the well-being of people. Interventions at this late state are expensive, and, to a certain extent, they undermine the productivity of the country’s workforce.

Health promotion and disease prevention should be an overriding priority, not only at the policy, but also at all operational levels. While emphasizing this aspect of health development, we certainly cannot fail to prepare ourselves for taking the best care of the sick. We must have adequate facilities with qualified staff to treat the patients and rehabilitate the disabled. We must always keep in mind that, even though medical care in the institutions is necessary, this is an expensive way of providing health care services; it will not go very far in ensuring improved access to health care by all.

Health promotion and disease prevention should be an overriding priority
Access to Health Care

There are many other factors involved in access to health care: in reaching the unreached. It has been demonstrated that equitable distribution and efficient utilization of national resources have a significant impact on the improvement of people’s health. Improved education and improved social status of women also have an important implication on health of the population. War, social conflicts and communal violence significantly constrain the development of health of the entire population. When these happen, the poor and the marginalized are the ones who suffer the most. Therefore, peace and security, at local, national, or international levels, are important requisites for good health and well-being for all.

There is one more factor contributing to improved access to health care. All development activities by any sector must take health concerns into account as a priority consideration. Health should not be adversely affected by irrigation projects and other agricultural and industrial activities. Therefore, advocacy for healthy public policies have to be done at all levels of development in all sectors.

To attain better access to health care, reaching the unreached, is indeed a daunting and challenging task. Technological interventions may be only a part of the whole range of issues involved in this important subject. There are many other considerations to be taken into account.

The psychosocial context is also an important determinant of access to health care. Health care may not reach the unreached because of psychosocial and cultural barriers.

Population size is another factor. Certainly, it will be a more difficult task for a government to deal with a large population. Difficult terrain of the country often makes accessibility to health care impossible through regular service delivery.

The educational level of the general population is another important determinant. We have to invest more efforts in the population with low level of education, in order to get better access to health care. What has been said are some of the factors that
contribute to or hinder our attempts to improve access to health care, to reach the unreached. These may be useful when we critically review and revisit our development endeavours to attain the goal of health for all.

Public health plays an important role in improving the health status of the entire population and to ensure the effective contribution of health to overall development. We believe that improved access to health care can best be achieved through public health programmes and interventions.

WHO, in the South-East Asia Region, launched the Public Health Initiative more than one and a half years ago. This was with a view to intensify our support to the Member States in their efforts to strengthen their public health infrastructure and services.

At this stage, the focus of the Initiative is on strengthening public health workforce through the development of appropriate educational and training programmes. At least six countries in the Region are intending to establish new schools of public health for education at the professional level. In the process, we are also emphasizing the strengthening of public health education programmes in countries. We are promoting incremental development from what the countries already have, instead of creating new things, if not necessary. This approach will also bring us a long way in strengthening public health workforce in countries of the Region within their resource capacity.

Finally, I wish whoever is trying to achieve improved access to health care: reaching the unreached, all success in their endeavours. I would like to see that we use the comparative advantages of public health interventions and measures, in order to arrive at this desired objective. We, in WHO, are ready to render the required support for such endeavours.
I would like to commend our Director-General, Dr LEE Jong-wook, for his vision to establish the Commission on Social Determinants of Health. With the prevailing socio-economic, political and environmental challenges, the establishment of this Commission will greatly help in responding to the urgent need for better knowledge and evidence for planning for health.

The Commission will certainly be very useful in developing a technically sound basis for tackling health problems in a more efficient and effective manner. This global initiative will take us a long way towards ensuring health equity and social justice.

Focusing on the root causes of ill health, and on the factors contributing to good health in the development process will lead ultimately to better sustainability of health gains from the investment in health and health-related sectors. This global exercise will greatly contribute to more rational policy and strategy formulation, and to more focused programme planning for sustainable development in health.

The gap in health between the haves and have-nots in the world is ever widening. There is a deepening crisis in access to basic health services, particularly among the poor, underprivileged and vulnerable.

Regional Consultation on Social Determinants of Health WHO/SEARO, New Delhi, India, 15-16 September 2005
The South-East Asia Region is home to a quarter of the world’s population, and of about 40% of the world’s poor. The Region carries about 30% of the global disease burden. In spite of the increased coverage in health services through primary health care, 25 to 30% of the population does not have access to essential health protection.

Tackling health inequities among countries and within individual countries are indeed formidable challenges. Poverty, rapid urbanization, unhealthy lifestyles, low level of education, gender imbalance, and adverse effects of globalization aggravate the inequity. Epidemiological and demographic transition, as well as constant social changes have important implications on the health of the population, and on the manner in which health services are planned and provided.

Our sociocultural beliefs and values also have major implications on people’s health. However, the exact magnitude of these factors need to be fully and clearly understood in order to provide a better basis for development planning in health.

Rapid urbanization in the South-East Asia Region is heavily taxing the available civic amenities and services. Most of this phenomenon takes place particularly in the high population density or slum areas, with the associated problems of drug addiction, crime, violence, indoor and outdoor pollution, overcrowding, poor sanitation, and many more.

To solve these problems effectively, there is an urgent need to forge strong partnerships with all sectors and stakeholders, in order to create a viable and supportive environment. An environment that will ensure maximum multisectoral inputs to the health development process.

We must accept that the health sector alone is really not enough to bring about effective changes to ensure health equity and social justice. In fact, many solutions to health problems and health-related issues lie in sectors other than health. This understanding of the multisectorality of health needs to be universally recognized at all levels of development, and not only
Sectors other than health should take full responsibility for their particular areas of health; and take determined actions to solve those health problems, as far as they are concerned, by using their own sectoral resources.

Realizing the expanded health concept, and expanded role of health in the development process, we should be happy to see sectors other than health running health programmes in the specific areas of their concern. All sectors and all sections of society must work in a synchronized manner towards the same health goal, if the goal of health for all people is to be realized.

Issues of trade, debt, technology transfer, capital flight, brain drain, and more – all have implications on the health of the public. Certain aspects of globalization contribute to a higher standard of health. At the same time, globalization increases health risks and inequalities. More knowledge and more evidence on these implications are the essential tools to help us move forward in the most efficient and effective manner in pursuing health goals.

Given this scenario, I am happy that we are re-emphasizing the need to look critically at health determinants and health risks. This consultation provides a forum to review various issues relating to social determinants of health, exchange views and identify ways in which our Region can take forward the work of the Commission.

In the South-East Asia Region, efforts have been made to address determinants of health through various programme areas, including our efforts in reorienting public health education and practice. Under this initiative, we are focusing particular attention on the determinants of good health and disease risk factors, which are the domains of health promotion and disease prevention.

The Regional Office has already given the necessary impetus to capacity building in public health systems, with emphasis on health interventions that are focusing on health determinants and health risks. We believe that for this approach to be satisfactorily implemented, we have to really work within a multisectoral and multidisciplinary environment.

The Meeting of Health Ministers in 1997 adopted a Declaration on Health Development in the South-East Asia Region
in the 21st Century. This Declaration reaffirmed the basic principles of Health for All, and reiterated the close interplay between poverty and ill-health.

The foremost challenges identified by the Ministers were: closing the gaps and inequities in health in our societies; ensuring basic health services to all, especially the poor, women and other vulnerable groups; and upholding health ethics and placing health at the centre of development.

We, in this Region, have based our development planning on these strategic directions, which emphasize special efforts to tackle the root causes of health problems. This has been undertaken through consistent advocacy at policy and political levels, to enhance the incorporation of relevant knowledge and evidence in the process of health planning and development. The work of this Commission will help us expand the scope of our work in this regard, and help us go more in-depth in this challenging task.

In addition to the technical contents, we need advice and guidance from the Commission on directions, tools and mechanisms for addressing social determinants in various on-going and new WHO collaborative programmes at regional and country levels. This Consultation is a good opportunity to learn more about the Commission’s work; its vision, mission and strategy to move forward.

More importantly for us, is to learn how the Region and Member Countries can contribute effectively to the work of the Commission, and vice versa. Our interaction with the Commissioners will provide us an opportunity to chart out concrete steps to reduce health inequalities, ensure social justice and accelerate the development of health for all. It is my sincere hope that the Commission will lay the foundation for awareness building, and for promoting debate and action on social determinants of health in the Region.
Licensing of Vaccines

Immunization has long been recognized as an essential public health intervention to save lives of our children. One of WHO’s roles is to ensure that all children are protected against vaccine-preventable diseases. In order to play this role effectively, we must make sure that all immunization programmes use vaccines of highest quality. This Consultation is an important step to ensure that vaccine quality control is effectively carried out in the Region.

As we are aware, the National Regulatory Authority (NRA) is ultimately responsible for ensuring vaccine quality in each country. South-East Asia is the first WHO Region to have assessed the work of all NRAs, and established plans for strengthening their capacity, in particular cases. The requirements for recognition of NRA depend on sources of the vaccines for use in the respective countries. However, all NRAs must have the capacity to undertake the licensing of vaccines.

Licensing is a process aimed at assessing the quality, safety and efficacy of vaccines, before they are allowed to enter the national market. For countries that produce their own vaccines, licensing is a straightforward process based on the work of National Control Laboratories.

In the South-East Asia Region, six countries procure EPI vaccines through UNICEF. Though the licensing procedure remains mandatory, these countries may not need to maintain the same

---

Expert Committee Consultation to Develop a Fast Track Mechanism for the Licensing of Vaccines procured through UN Agencies, WHO/SEARO, New Delhi, India, 13 September 2005
level of testing. However, the fundamental requirements for licensing must be developed for the individual countries. Therefore, this Consultation will address two important issues for these six countries: Identification of the current or potential regulatory constraints in procuring vaccines through UN agencies; and determining approaches to overcome these constraints, in order to meet national and international standards for vaccine licensing.

Addressing these issues is becoming more challenging due to several factors. The number of vaccines and the technical complexity involved are increasing. In addition to the basic EPI antigens, many new vaccines may be added to national immunization programmes in the near future.

Vaccines, such as those for Japanese encephalitis, the DTP-hepatitis B combination, and even the Rota virus are supposed to improve effectiveness and efficiency of the immunization programmes. Furthermore, newer ones, such as chimeric vaccines are on the horizon. And the older, such as measles vaccines, may now be available in new forms for administration, such as aerosolized spray.

While these new technologies in vaccine development promise additional improvement in public health interventions, they also offer new challenges for NRAs to ensure quality control. Another major challenge for licensing of vaccines is the implication of new international trade agreements.

This topic was discussed at the most recent meeting of Health Ministers of countries of WHO’s South-East Asia Region. The Ministers recognized the urgent need for strengthening country capacity in this important area and requested support from WHO.

The Trade Related Intellectual Property Rights or TRIPS, not only directly affects patents for vaccines, but also has an important implication on the work of NRAs. The Doha Declaration clearly states that the TRIPS agreement should be implemented in a manner that public health interest is protected.

Vaccines which are already pre-qualified by WHO, and procured through UNICEF may be in a special category for local licensing. However, cases such as these need careful consideration.
All in all, we have to develop licensing mechanisms to ensure vaccine quality. At the same time, the use of these mechanisms must not be beyond the capacity of the regulatory systems in our respective countries. The ultimate goal in this endeavour is to deliver really safe and effective vaccines to all children in need.

Our task now is to develop a “fast track” system, which satisfactorily addresses both these issues of quality and efficacy. This is a formidable challenge, as far as this Expert Committee is concerned, but it should not be beyond our capacity to do so.

In addition to concerned officials from Member States in the Region, representatives from the Developing Countries Vaccine Manufacturers Network and International Federation of Pharmaceutical Manufacturers have also been invited to participate in the Consultation. Concerned WHO staff members from both Headquarters and the Regional Office are here to facilitate the deliberations. I am confident that this Consultation will be concluded with a successful outcome.
Field Epidemiology Training

The National Institute of Communicable Diseases (NICD), is also a WHO Collaborating Centre for Epidemiology and Training. Field Epidemiology Training Programmes, commonly known as FETP, have played an important role in the development of skilled manpower in field epidemiology, all over the world. During the past decade, NICD, which is also a WHO Collaborating Centre for Epidemiology and Training, has trained 126 health professionals from 8 countries in field epidemiology. We deeply appreciate the contribution of NICD in creating a core group of trained manpower to combat epidemic-prone and emerging infectious diseases.

The proposed plan of the Honourable Health Minister to upgrade NICD to a national authority on disease surveillance, with expanded mandate of both communicable and non-communicable diseases is a very welcome initiative. As we are aware, the emerging infectious diseases have assumed considerable public health importance in South-East Asia.

During recent years, we have witnessed the emergence of a large number of novel pathogens in the world, in both animals and humans. Notable among them are HIV, viral hepatitis C and E, Nipah virus, SARS and avian influenza. The socio-economic and cultural conditions prevailing in this part of the world increase the vulnerability of the population to these infections.

The Tenth Regional Field Epidemiology Training Programme, National Institute of Communicable Diseases, New Delhi, India, 18 August 2005
The factors precipitating and perpetuating the emergence of infectious diseases include: (i) ecological changes, such as those due to agricultural or economic development activities; (ii) human demographic and behavioural changes; (iii) rapidly increasing international travel and trade; (iv) environmental degradation and climate change; (v) changes in technology and industrial processes, such as food production, processing and packaging; (vi) microbial adaptation and mutation; and (vii) the deterioration in public health and control measures. It is obvious that several of these factors will continue to exist along with mankind. Accordingly, infections will continue to emerge and probably increase.

It is essential that a suitable mechanism is developed to deal effectively with epidemics of emerging diseases. This is in order to reduce their impact on public health, the economy and on social cohesion.

Taking cognizance of the adverse impact of epidemics on public health, the Fifty-eighth World Health Assembly adopted the International Health Regulations (2005), which would come into force from 15 June 2007. Under these Regulations, Member States are obliged to detect, assess and notify all public health emergencies of international concern. And, therefore, Member States have to develop core capacities to be able to prevent and control such emergencies promptly.

It is not possible to always prevent epidemics or public health emergencies, but we can certainly mitigate their impact by anticipating them, and by being prepared. Countries with epidemic preparedness, and with adequate core capacities to respond promptly will certainly limit the adverse impact of epidemics.

Availability of an epidemic preparedness plan would also help ensure that all the needed resources, expertise and services are mobilized and deployed rapidly to reduce to the minimum the morbidity and mortality due to epidemics. This preparedness requires development of epidemiological, clinical, entomological and laboratory capacities to undertake efficient surveillance and investigation of epidemics.

It would be unrealistic for a country to prepare an epidemic preparedness and response plan in a short period without adequate
involvement of all stakeholders as this is a multisectoral and multi-agency exercise. The health sector, however, has to play a lead role in preparing and executing the plan, but this needs the expertise and support of other disciplines and sectors.

While talking about epidemics and emerging diseases, it would be appropriate to mention the pandemic threat by the Highly Pathogenic Avian Influenza (HPAI). The outbreaks of HPAI, which started in poultry in the Republic of Korea in December 2003, have, to date, affected 10 more countries including Viet Nam, Japan, Thailand, Cambodia, China, Laos, Indonesia, Malaysia, Russia and Kazakhstan.

The virus has also affected humans in four countries i.e., Viet Nam, Thailand, Cambodia and Indonesia. As of 16 August 2005, 112 cases, including 57 deaths, have been confirmed by laboratories in the four countries. Fortunately, the virus has not yet acquired the capability of human to human transmission. If this happens, a pandemic may start.

Although no one knows with certainty when and where the next pandemic of influenza would start and how severe it would be, the experts warn that it is imminent. There is a great possibility that it would begin from Asia, and could be very severe.

The great pandemic of Spanish flu in 1918-1919 killed 40-50 million people. It is, therefore, essential that all countries prepare a National Pandemic Preparedness Plan, which may be an integral part of the national disease surveillance programme for epidemic-prone diseases.

I am happy to know that India is in the process of preparing such a plan, and WHO is working closely with the Indian Government in this important task.

The Asia Pacific region is, unfortunately, at the epicentre of avian influenza and many other epidemics. The countries of the Region are interconnected, they face similar health threats, and their ability to protect their populations from those threats vary widely.
Given the vulnerability of the Region, coupled with the increasing globalization of public health, and the requirements of the International Health Regulations (2005); there is a very clear value in developing a common strategy for WHO in South-East Asia and the Western Pacific Regions. Therefore, the Asia Pacific Strategy for Emerging Diseases has been developed.

The goal of this strategy is to improve health protection in Asia and the Pacific, through productive partnerships for preparedness planning, prevention, prompt detection, characterization, and the containment and control of emerging infectious diseases. The Strategy will be discussed at the forthcoming WHO Regional Committee session in Colombo in September.

Let me say a few words about NICD. NICD has emerged as a premier institute in the field of public health, not only in India, but also at the regional and global levels. It has a strong, composite expertise covering the areas of epidemiology, entomology and laboratory.

The institute successfully coordinated the National Surveillance Programme for Communicable Diseases (NSPCD) which led to the launching of the Integrated Disease Surveillance Project (IDSP) in 2004. I am glad to know that IDSP will now be based at NICD, and plans are underway to establish a National Authority on Disease Surveillance.

NICD is the national focal point for the International Health Regulations and also houses two major WHO Collaborating Centres. In the area of training, in addition to the three-month FETP, the institute organizes many other training programmes in epidemiology, laboratory and entomology. Participants from many countries in the South-East Asia Region attend these programmes every year. There is also a plan to launch a two-year international field epidemiology training programme that leads to an MPH degree in Field Epidemiology.

The institute is already recognized as an Advanced Research Centre for conducting Ph.D programmes. NICD not only provides support to the States in India, but also to other countries in the
A Vision for Health Development in South-East Asia

Region. For example, last year, at WHO’s request, NICD extended assistance to the Royal Government of Bhutan in dealing with the outbreak of dengue fever in Phuentsholing town.

I, therefore, strongly urge that NICD take up a leading role in developing a network of public health institutes in India, that can link up with the regional and global networks. WHO is ready to extend full support to this initiative. I look forward to NICD being established as the world class epidemiology and laboratory centre for identifying various emerging disease pathogens.

In conclusion, the advances that are taking place in NICD are very impressive; especially the proposed MPH course, and construction of a Bio-safety level-3 laboratory. I congratulate NICD on its stellar work and multi-faceted service in the field of disease surveillance and control. The faculty and staff of this Institute may rightly be proud of their contributions in the fields of Public Health, Epidemiology, Surveillance and Diagnostics.

I visited NICD many times during the plague outbreak in 1994. This time, I can see a lot of difference with the renovation and development in the technical content of the work of Institute. There is also much more collaboration with WHO.
India has had a strong foundation in public health education. We have the All India Institute of Public Health and Hygiene in Calcutta; the National Institute of Communicable Diseases (NICD) in Delhi; the National Institute of Nutrition in Hyderabad, and the National Tuberculosis Institute in Bangalore. There are also many other public health education programmes being run in various medical colleges. All these institutes provide internationally reputed public health education programmes in specific areas.

During my days as a medical student in the early 1960s, many of our professors, if graduates from these institutes were considered to be real experts, and also very good teachers. I personally had the privilege to visit NICD once during the 1970s. I was very much impressed with many training curricula and programmes in epidemiology, developed and run by this institute. India is perhaps the only pioneer in this part of the world in the area of public health education.

However, we would not have realized the issues covering public health interventions and services in this country until there was a plague outbreak in 1994. This was followed by a number of outbreaks of other communicable diseases, such as malaria, meningitis, dengue fever, diarrhoea and others.

Some other diseases that were once under control, like tuberculosis, re-emerged. Then, we started talking about whether things had gone wrong with the public health system in the country.

Workshop on “Public Health Education in India: Issues, Challenges and the Way Forward”, New Delhi, India, 18 August 2005
This type of situation was worrying all of us, including WHO, which is a public health organization. In 1999, we had an in-house review of the situation at the Regional Office with participation of concerned officials from the Ministry of Health and Family Welfare. It was concluded that public health infrastructure and services in India needed urgent attention, otherwise the health of the public would be at a greater risk of becoming worse.

This type of public health situation was prevailing, not only in India, but also in other countries in the South-East Asia Region. Therefore, at the end of 1999, WHO convened a Regional Conference on Public Health Education and Practice in the South-East Asia Region in the 21st century in Calcutta.

The overall purpose of this conference was to critically review the public health situation, including public health education and practice in the Region; and to identify effective ways and means to improve or strengthen such education and practice.

In this perspective, we believe that the best way to strengthen public health infrastructure and services is through strengthening the public health workforce. And the best way to strengthen the public health workforce is through strengthening public health education.

The main outcome of that Regional Conference was the Calcutta Declaration on public health. This Declaration provides a broad strategy and framework of action for strengthening public health education in the South-East Asia Region in this century.

Since then, WHO has taken a number of actions in following up on the outcome of the Conference including the Calcutta Declaration. However, improvement in public health education still has a long way to go, if we would like to ensure the availability of effective public health interventions and services, which are the pre-requisite of good health for all people.

I left WHO in 2000 and returned in 2004. As a part of my promise to the Member States, since the beginning of my Regional Directorship, I have placed improvement in public health at the top of my priority list, and, therefore, the public health initiative
has been pursued by WHO with particular emphasis on public health education.

In this initiative, which has a five-year time-frame, we are pursuing activities in four main areas. These are:

1. Development of a regional strategic vision for improvement of public health education and practice in the Region. This is through a Strategic Advisory Group formed at the beginning of last year.

2. Networking of public health education institutions, by linking the corresponding national institutions in the Region and outside, for countries to help each other.

3. Direct support to countries in the establishment of public health education programmes/schools, and

4. Strengthening of public health infrastructure, including public health education, through collateral activities and contributions from existing public health programmes.

In practice, each country may have its own specific approach in strengthening public health infrastructure, education and practice. For India, the infrastructure for public health education already exists. As I mentioned earlier, we should start this improvement and strengthening from what we already have.

In addition, we should also pay special attention to the Community Medicine Programmes which are being run at various medical colleges. This approach, of involving medical colleges, will take us a long way in ensuring a close linkage between medical services provided through the network of medical institutions, and public health services, which are carried out in the community and for population at large.

At the same time, the Government of India has also launched an initiative to establish schools of public health through collaboration with the reputed schools of public health in the USA. This is also an excellent idea. These new schools may help to speed up the implementation of new ideas, new initiatives, and newly reformed educational programmes.

We urgently need a public health workforce to effectively develop and implement public health programmes in the country.
Public health programmes include malaria control, tuberculosis control, diarrhoeal disease control, water and sanitation, nutrition, immunization and many more.

There are some specific features of public health programmes that need public health expertise in their development and implementation. These are: emphasis on health promotion and disease prevention; community and population-based; ecologically and environmentally based; multisectoral and multi-disciplinary; towards health for all and all for health; and particular attention to the poor, underserved and vulnerable groups of population.

Furthermore, in the light of today’s global situation, many rapid changes have taken place. Many of these changes have a direct bearing on the health of the population, and on the way we develop and manage public health intervention programmes.

These changes include globalization, liberalization of trade, advancement in information and communication technology, rapid worldwide transportation, and advancement in health science and technology. These need to be taken into account seriously when public health education programmes are developed for supporting today’s public health interventions and services anywhere in the world.

In addition, to be really effective, public health interventions and services have to be framed within the socio-cultural, political and economic context of the country concerned. Public health education, therefore, needs to produce a public health workforce that can fulfil this basic requirement in health development in each country.

Public health work is meant to improve, not only the physical, but also the mental and social health and wellbeing of the population. Therefore, the country-specific situation is an important consideration in the development of a public health education programme. Effective public health work can certainly help reduce the workload in medical institutions – when people are healthy, they will not fall sick, and, therefore, they do not need medical treatment.

WHO will do everything possible to assist the Government of India in the improvement and strengthening of public health education in the country.
MDGs in Asia and the Pacific

As we are all aware, across Asia and the Pacific, over 700 million people live in extreme poverty. This is in spite of the fact that we are living in this age of internet, globalization and rapid economic growth.

Many of those people lack access to basic services, including healthcare. They struggle to survive on as little as 1 US Dollar or less a day. Often, they go to bed hungry, suffer illnesses, lack appropriate medical treatment, and do not have access to safe drinking water or sanitation facilities. This is in striking contrast to the situation of the better off people living in the same country.

The gap between the rich and the poor is unacceptably wide. The poorest 20% of the world’s population are 10 times more likely to die before the age of 14 than the richest 20%.

Similarly, in many developing countries, women have limited access to reproductive health services. Nearly 40% of all births worldwide are not attended by skilled health attendants. The number of women dying in childbirth will not be easily reduced.

In some least developed countries in the Region, a high proportion of women die in childbirth. Only less than 50% of pregnant women in these countries receive appropriate care before delivery.

Regional Ministerial Meeting on MDGs, in Asia and the Pacific: The Way Forward, Jakarta, Indonesia, 3-5 August 2005
With regard to sanitation, the coverage is very low. It is less than 50% in some countries, and even below 25% in some parts of the Region.

Most countries will not be able to slow down the spread of HIV/AIDS.

We believe that health plays a crucial role in the fight against poverty. It is therefore most appropriate that health is a key component of the Millennium Development Goals, which aim to reduce global poverty by half by 2015.

Six of the eight MDGs relate to health, covering the very fundamentals, such as survival of mothers, newborns and young children. They also address the major communicable diseases that predominantly affect the poor. HIV/AIDS, tuberculosis and malaria are not just the leading killers, but an economic deathblow for poor families.

Health-related MDGs set targets for the most important outcomes to be achieved. These include: fewer women dying in childbirth; more children surviving the early years of life; successfully dealing with the catastrophe of HIV/AIDS; ensuring access to life-saving drugs by people; and better health in all its forms for contributing to poverty reduction.

In this connection, I would also like to mention that the emerging infectious diseases, such as SARS and Avian Influenza, can affect our progress toward poverty reduction. The outbreaks of highly pathogenic avian influenza (H5N1) in poultry, which started in 2003, have been unprecedented in their scope and severity. The outbreaks have caused a huge economic loss to the affected countries in this Region, and seem difficult to contain.

If the outbreaks of Avian Influenza cannot be checked, these may lead to a future global influenza pandemic, which may start in Asia. It is predicted that if this ever happened, it would be the worst influenza pandemic with serious consequences, in terms of both human life and the economy of countries. Therefore, in reviewing our strategies to attain MDGs, the prevention and control of emerging infectious diseases may also be kept in mind.
Achieving various health goals is certainly a daunting challenge. Even though technology to address the various problems is available, we are not able to ensure that all the poor and the underprivileged will receive the services they need.

Through the Directly Observed Treatment Short Course (DOTS) strategy, we have a clear possibility to effectively control TB in many countries. However, in some countries, to make this service accessible to those who are in need is still problematic.

Similarly, many interventions are also inexpensive. It costs less than 2 US Dollars to immunize a child against key preventable diseases. But to get every child, especially in the poor communities, immunized is difficult indeed.

Nevertheless, no matter how formidable the challenge, there is a need to strengthen cooperation among countries in Asia and the Pacific. This is to ensure collective commitment to the attainment of MDGs.

In this context, I would urge that, as far as health is concerned, we jointly initiate action in four main areas: Firstly, we have to define a clear and practical strategy to strengthen health systems, with special emphasis on public health infrastructure. We need a strong public health workforce to successfully develop and implement public health programmes, such as disease control and prevention, immunization, maternal and child health, water and sanitation, environmental health, and nutrition, for example.

We need public health services that reach out effectively into the community and the entire population. We need to reorient our interventions in order to effectively reach the unreached. This requires effective stewardship, adequate health facilities and staff, especially at the peripheral level, to ensure universal coverage of health services.

As we have seen, at times, drugs are available in urban settings, but do not reach those in rural areas who really need them most. In many places, trained health workers are not available to provide essential care, and to carry out health promotion and disease prevention activities, which are prerequisites for sound public health interventions.
When health systems are weak, it is usually the poor who suffer the most. A strong public health infrastructure will guarantee sustainable development in health.

Secondly, we need additional funding for healthcare, and public health services. We need more investment in health, since health is often woefully under-funded. Indeed, significant progress in health development will not be achieved without adequate financing. Additional funding alone will, however, not be enough.

There is still room to rationalize the use of available funds by reducing unproductive spending, and thereby releasing the needed resources for priority and urgent health needs. Currently, the bulk of funding usually goes to urban areas – often for costly curative services – at the expense of essential health interventions in rural areas.

In order to reduce the high proportion of out-of-pocket health expenditure, various mechanisms of risk sharing need to be introduced. There is also a need to expand various social safety net programmes. This will enhance financial protection for the poor who constitute the vast majority in the Region. Indeed, international partners have a key role to play in providing more funds for health. There is a need for better coordination and alignment of external aid to ensure relevance to countries’ health priorities and needs.

Thirdly, there must be stronger multisectoral collaboration and action to ensure effective health promotion and disease prevention. Partnerships among stakeholders and empowerment of people are the foundations of successful multisectoral and multidisciplinary actions in health development.

Recent evidence suggests that significant reduction in child mortality can be achieved from several diverse actions. These also include improving access to drinking water, and increasing the years of schooling among women.

Responsibility for and commitment to the development of health for all people has to go beyond the health sector. Other sectors have to share such responsibility and commitment. The health sector alone will not be able to achieve the total health development goal.
Fourthly, we need to seriously address the issue of inequity in health, including access to quality health services and health outcomes. Disparities in access to health care can occur due to various factors, like income, location, ethnicity, and gender. Often, these factors are actually overlapping. There is therefore a need to develop programmes specially focussed on the underserved and vulnerable population groups.

The equity issue must be taken into consideration throughout the development process from policy formulation, resource allocation, to programme planning and implementation. For effective policy development and programme planning to ensure equity in health, there is a need for better evidence and better disaggregated data and information.

Keeping in mind the above-mentioned concerns, the Fifty-eighth World Health Assembly in May 2005 urged Member States to ensure timely priority actions to accelerate progress towards the attainment of health-related MDGs.

It is also heartening to note that the Japanese Government recently convened a High-Level Forum on the Health MDGs in Asia and the Pacific. The Forum reviewed progress and successes, as well as the remaining challenges in our journey towards achieving these goals. It underlined the crucial importance of strengthening health systems capacity, promoting multisectoral actions, securing resources, and ensuring equity in access to quality health services.

To a large extent, some countries in Asia and the Pacific have already achieved certain health-related MDGs. However, among others, we need to redouble our efforts in strengthening and accelerating the required partnerships and collaboration.

I am confident that this Ministerial Meeting will be successful in developing a common strategy and platform for Asia and the Pacific to move forward more efficiently and effectively towards attainment of the health-related MDGs by 2015.
Changes taking place around us today pose a real challenge to the health sector and health systems. Advancements in science and technology are compelling us to improve the ways and means of providing healthcare services.

An educated and better informed population demands more and better health services. Thus, health staff trained yesterday may not be suitable to serve the consumers of today or tomorrow. We, health professionals, have to energetically reorient our systems in order to live up to the needs, demands and expectations of the community and the population. This is indeed a formidable challenge for all of us.

WHO and its partners have been well aware of this trend, and have devoted particular efforts to support Member States in ensuring that their health workforce is always relevant and effective in providing medical and public health services. Within this context, we will pay attention to the development of socially desirable health personnel through an appropriate system of education.

At this meeting we are going to focus our deliberations on medical education. This is in recognition of the critically important role of the medical profession in providing institutionally-based health care services to the community and the population.

Among the many important approaches in improving medical education, our attempt in the 1980s to achieve the objectives of
“Reorientation of Medical Education (ROME)” was very significant. In this exercise, we aimed at supporting countries to achieve better coordination between medical education and health services. It was to ensure that what was taught in medical schools can really be applied optimally in practice to benefit people and society. This was to promote a humanistic and holistic practice by the medical profession, through community-oriented and problem-based educational strategies.

During the past several decades, medical education has passed through a very long process of evolution and reform, in both content and process. Particular attention has also been paid to the development and training of teachers and other members of the medical faculty. In addition to providing medical services to patients, these teachers and faculty members are also expected to be a role model for the younger generations to emulate.

While there are many issues to deal with in furthering the improvement of medical education, this time we have deliberately chosen two important areas for our review and discussions. These are psychosocial dimensions and ethics.

The two areas seem to have been inadequately covered in our consideration in the past when medical education was developed or improved. We believe that proper strengthening of these two aspects of medical education will ultimately contribute significantly to improvement of the quality of medical care services.

There is a wide variation in the way psychosocial, behavioural and population perspectives are addressed in medical education. We may agree that there is an overemphasis on basic sciences and clinical training at the expense of other disciplines, which can provide opportunities for developing the “art” of medicine and ethical practice. There are areas for improvement in the content of educational programmes that can lead to the development of a positive doctor-patient relationship, including patient autonomy, revelation of truth about one’s illness, informed consent and conflict resolution.

In the medical profession, when faced with a life-and-death situation, the health and welfare of patients must come first, before any other concern.
any other concern. Medical staff is expected to be dependable, respected, sincere, trustful and humane, having a keen sense of sacrifice.

Acceleration in the privatization and commercialization of education and health services has further contributed to the erosion of professional values and credibility of medical practitioners. This is particularly so when there is no comprehensive and effective regulatory framework in countries. This framework, if it is in place and well functioning, will be an important arena in which professional bodies, such as medical councils or associations can play an important role in improving the quality of medical care.

It is very interesting to note that ethics in medical practice today is a major concern globally. For the medical community in general, ethics has transcended centuries of evolution from the time of Hippocrates.

The simple message conveyed through the Hippocratic oath that binds all medical doctors in particular, can be summarized as “do no harm” to patients – physically or psychosocially. The father of Thai modern system of medicine, Prince Songkhla, once told his medical students that they were trained not to be only healers, but also human beings. This was to remind future doctors of the utmost importance of maintaining the highest standard of ethical and moral values in the treatment of patients.

The South-East Asia Advisory Committee on Health Research (ACHR) has also emphasized the need to strengthen the knowledge base on ethics in medical education and practice. The ACHR called for reinforcing the integration and teaching of ethics in the curricula of medical schools. With the prevailing situation in the area of medical care, there is an urgent need to further reshape the medical curriculum in order to deal more effectively with psychosocial and ethical issues in today’s medical practice.

Chronic diseases are on the increase, overshadowing many acute disease conditions. Patients with chronic health conditions must usually engage themselves in long-term treatment. Patients then inevitably become principal caretakers to look after themselves. These patients have to effect behavioural changes in
order to adjust themselves successfully to the consequences of the illnesses. To effect such changes, patients need to develop psychosocial and behavioural skills, which have to be cultivated through proper interaction with their doctors.

The current trend in medical practice requires that medical education is determined through a sound balance between training in basic medical sciences and psychosocial and ethical domains. This is to ensure that the patient as a whole is always well treated—physically, mentally and psychosocially. The patient’s fundamental right to health and health care must be fully respected, regardless of their socioeconomic status. They must always be treated with dignity and compassion.

This meeting is one of the few occasions when the WHO Regional Offices for the Western Pacific and South-East Asia have come together to discuss issues of common interest. We will together pursue diligently our biregional strategy to support Member States in Asia Pacific in their efforts to improve medical care services through further reorientation of medical education.

The meeting is expected, among other things, to intensify coordination and cooperation among countries as well as between countries and institutions of the two regions. It will be very beneficial if these countries and institutions have an opportunity and a mechanism to exchange their experiences and learn to help one another with necessary support from WHO.
Access to Medicines

According to the constitutional principle of the World Health Organization, “Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. Health is therefore universally recognized as a fundamental right with its moral and ethical dimensions. The international framework for human rights also provides a powerful set of moral and legal instruments to strengthen people’s health.

The right to health, as enshrined in the international treaties, can be met, to a large extent, through equitable access to essential health services, including medicines. Let us look at this issue not only from the technical, but also the moral and ethical perspective.

By fostering the development of ethical review committees, the Forum for Ethical Review Committees in Asia & the Western Pacific has played an important role in promoting the ethical value in such accessibility. The first expected outcome of this conference, “the contribution to an international resolution on the availability of medicines” is really important. During the conference, we will focus attention on medicines being made available and accessible to the population at large.

An International Conference on Health Research and Access to Medicines in Asia and the Western Pacific: Forum for Ethical Review Committees in Asia & the Western Pacific – FERCAP/SIDCER, Chiang Mai, Thailand, 13-14 December 2004
“Equity and Responsibilities in Providing Access to Medicines: The Roles of Physicians, Researchers, Manufacturers and Governments”
During the past 25 years, the world population having regular access to essential medicines has gone up from 50% to only 66%. This slow progress leaves 2 billion people, especially in developing countries, without adequate coverage for such medicines. The people who suffer the most are from the poorest segments of the population.

There are many facets that can be strengthened to improve access to medicines. It has to be assured that a limited number of essential medicines are always available to all persons at all times, through the use of available resources.

It has been universally recognized that the supply of essential medicines should be on the basis of need, rather than on the ability to pay. About 50% of the medicines purchased by people are wasted, because they are prescribed inappropriately, and purchased at a much higher price.

There are many reasons why access to even a limited number of good quality medicines by the needy remains an elusive goal. In spite of the pioneering work by the World Health Organization and other international agencies, access to medicines has increased only in some countries.

Access to medicines is linked closely with their rational use. The players pushing forward the concept of rational use of medicines are too few, and are confined to only some governments, a few international agencies, and some non-governmental organizations. There are four groups of key players in this important area – physicians, researchers, manufacturers, and governments.

**What are the responsibilities of physicians in ensuring access to medicines?**

As professionals, doctors are not expected to have any other overriding considerations than providing the best services to their patients. This is a part of the ethics of the medical profession and the reason that patients trust doctors.

Ethics and trust are the cornerstones on which the doctor-patient relationship has functioned for ages. Doctors have the sole responsibility of seeing what is best for their patients, whether it is...
medicines, services or advice. They have a moral and ethical obligation to consciously prescribe the most cost-effective medicines for their patients.

The WHO Ethical Criteria for Medicinal Drug Promotion clearly states that drug advertisements should be aimed at promoting health through rational drug use, rather than just simply selling drugs for financial gain. Governments, by enacting appropriate regulations based on these criteria, can help doctors prescribe medicines rationally.

Physicians should attempt, as much as possible, to prescribe drugs within the Lists of Essential Medicines, which are prepared and regularly updated as part of the effort to enhance access. Drugs included in the List are those intended to satisfy priority needs of the people, selected on the basis of efficacy, safety and cost effectiveness. If prescribers – physicians or others, could restrict their prescriptions to these medicines, not only will there be better therapeutics, but there would also be sizeable cost savings for patients.

Purchase of essential medicines through pooled procurement can result in considerable reduction in expenditure on drugs. These savings can be used to procure more medicines, thereby increasing their availability and accessibility.

Education of the consumers to create awareness regarding access to medicines is an area that needs adequate attention. Patients or consumers as knowledgeable partners can be very powerful advocates to improve this access.

It is the responsibility of physicians to inform the patients about medicines they are prescribing. Doctors and other prescribers should fulfill this role, and regard it as part of their strict obligation to society in this context. Access to medicines therefore must be linked with rational prescribing and good compliance, which is, of course, in the hands of both the doctors and patients.

Physicians have an important role to play in the development of tools to facilitate rational prescribing and drug use. This may include the development of training modules to be included in
the undergraduate curricula of doctors, pharmacists, nurses, and other health service providers. Physicians, together with other relevant professionals need to prepare a Code of Conduct on the relationship between the medical profession and the pharmaceutical industry.

**What are the responsibilities of researchers in ensuring access to medicines?**

Researchers play a critical role in focusing their work in the areas that would lead to an increase in access to medicines. Research may include, among others, drug procurement and distribution; financing and pricing. Behavioural aspects, including those relating to compliance also need to be studied.

The research outcomes may lead to modification and improvement in the management of national health programmes, resulting in enhancing access to medicines. This type of research, therefore, needs a different mix of disciplines, which also includes economists, management specialists and social anthropologists. We need experts in health systems research to see that medicines reach all health facilities, and are available at all times, especially at the primary health care level in the community.

**What are the responsibilities of the pharmaceutical manufacturers in ensuring access to medicines?**

The responsibilities of the pharmaceutical industry should not only be limited to areas of drug development, production and marketing; but also in disseminating correct information about the drugs. The industry should work closely with other relevant players to ensure medicine accessibility.

The manufacturers should be socially conscious, and try to develop new drugs where there is a great need, even though the profits may not be large. Some proportion of their enormous budgets for advertisements, should be kept aside for developing new drugs for diseases prevailing in the developing world. There are several enlightening examples, whereby this has been clearly demonstrated.
One pharmaceutical industry, in collaboration with the World Health Organization, discovered a drug for river blindness, which has been provided free of cost to patients in Africa. The pharmaceutical industry has all the information about the new drugs that it is marketing. This information needs to be disseminated and shared with others whenever it is ethically warranted. The industry should provide appropriate, correct and timely information to the medical profession on every drug being introduced in the market.

**What are the responsibilities of governments towards their citizens in access to medicines?**

Healthcare is one of the most important fundamental requirements that citizens expect from their governments. This is especially in respect of guidance, provision, regulation, and control. Within the resources available, different governments use different approaches in providing medicines to their people.

The key role of the government is to develop measures to ensure equity in access to medicines by all who are in need.

The ethical responsibility in this regard is inextricably linked with the rational use of drugs, which is in the hands of service providers. No programme aimed at enhancing access to medicines can succeed without extensive training and continuing education of all concerned health staff. The government should encourage medical and public health institutions and professional societies to organize such training and education programmes. Courses in logistics of procurement, storage and distribution of drugs, and rational prescribing would be important areas to be covered. The curricula for health service providers need to be reviewed and revised to include the relevant contents, which would enable these health staff to ensure access to medicines.

The government needs to develop a robust drug policy based on the principles of ethics, equity and transparency. This policy should be strictly and uniformly enforced throughout the country.

The government should ensure that essential medicines are procured through the most efficient system, which guarantees their availability for people in need at all times.
The government should protect the public, as far as possible, from unjustified and unethical advertisements. This is easier said than done. The relevant laws need to be vigorously enforced; if necessary, these laws may be reviewed and strengthened.

The government has the responsibility to ensure the prices of essential medicines are kept at a level which is affordable by all people. There are various ways of doing this, and one may be to provide tax exemptions for special categories of medicines, such as those which are life saving.

The steep decrease in the price of antiretroviral drugs for HIV/AIDS in the past few years has shown the effectiveness of concerted efforts by all concerned partners. This is an illustration of how to lower the drug price through an internationally collective endeavour.

The government should support health systems research to ensure proper management of the national drug procurement and distribution system. Another unique role of governments is to empower people to be able to look after their own health through an effective educational process. Medicines play an important role in self and family care, as far as health is concerned.

Now, I turn from a general concern to an area of particular interest to the developing world. This is the area of new drugs for tropical diseases.

Although over 1,000 new drugs have entered the market within the past 25 years, less than 1% of those were for tropical diseases, which affect 80% of the world population. This obviously raises moral and ethical questions about choices of developing new drugs. The development of new drugs should not be considered as only a commercial enterprise. These are areas which governments, both in the developed and developing world should be addressing together on moral and ethical grounds.
The impressive list of co-sponsors, the wide range of countries represented, the large and diverse group of health researchers, and professionals involved in health care, signify the interest and the importance of the topics being covered by the conference.

Medicines are a vital element of medical care and public health interventions. If used rationally, medicines can take us a long way in curing diseases and cutting transmission of disease agents. However, to make quality medicines available and accessible to all people is a formidable challenge indeed.

It is estimated that about 30% of the population in Asia and the Pacific who are in need of medicines do not have access to them. There is a wide range of accessibility to quality medicines by people living in different parts of the world. The percentage of this accessibility is definitely much lower in Asia than in the developed countries. It is therefore important in this respect to focus attention on the issues of accessibility and availability.

To a significant extent, accessibility is also related to the management of health service delivery, which is to ensure access to medicines by whoever is in need. In general, access to medicines is influenced by a wide-range of factors, socio-economic and political, as well as to the lack of knowledge on the part of people themselves.
Strategies for ensuring access to medicines should be formulated through a multidisciplinary approach, embedded with the prevailing ethical and moral principles. No less important, such a formulation must also take into priority consideration the locally specific situations and circumstances.

The availability and accessibility of medicines depend on the demand for quantities and different varieties as well as on the procurement and distribution system. To fulfil the requirement for different varieties, new drugs have to be developed.

Development of a new drug has to be undertaken through a long process of research and development, which also involves clinical trials. Ethical considerations in this process are of paramount importance for both researchers and manufacturers in ensuring the availability and accessibility of quality drugs.

Once the drugs are available in the market, there is a need to monitor drug reaction, and to pursue clinical studies to ensure their continued efficacy and safety. Clinical trials used to be conducted mainly in the industrialized world. During the past many years, an increasing number of these trials have been conducted in the developing countries.

Today, a multicountry study in this area would invariably involve at least one developing country, if not more. There are also trials for new drugs used in prevention and control of tropical diseases. These, naturally, should be conducted in the developing world, where the diseases are prevailing in the poor population.

However, recent clinical trials by a manufacturer on drugs to control Leishmaniasis, a tropical disease, have given hope of a breakthrough in the treatment of a condition that has affected millions of disadvantaged people for ages. Let us be optimistic that this exemplary initiative will be followed by other manufacturers for other neglected tropical diseases. Providing quality drugs for these diseases which are widely prevalent in the developing world is a moral and ethical imperative for both researchers and manufacturers.
Clinical trials are different from other scientific experiments due to the involvement of human subjects. The fundamental rights of these subjects have to be adequately respected throughout the process of the trials. Here, the ethical committees can play a vital role as guardians of the interest of the subjects.

The Asia Pacific region, which accounts for about a half of the world’s population, presents a wide variety in socio-economic and health care settings. Therefore, ethical committees need to be aware of locally specific circumstances, and be adequately creative and innovative in protecting human subjects, through acceptable, standard procedures, while respecting the local context.
Public Health Initiative

There is every reason to believe that Member States in the South-East Asia Region need much stronger public health infrastructure to cope with all kinds of challenges in the field of health. The need for strengthening public health in this Region has always been recognized and we have been attempting to meet this need. What we are trying to do now is the continuation and acceleration of the work already initiated. Many of us here have contributed significantly to the development of public health in the Region in the past. We have to help countries to be well prepared to face health challenges, now and in future.

There are a multitude of complex health challenges today such as: new, emerging and re-emerging diseases; global warming and environmental degradation; increasing occurrence and severity of natural and man-made disasters; and deliberate use of biological, chemical and radiological agents.

During the past two decades, we have seen rapid changes in the epidemiological patterns of the prevailing diseases of public health importance. At the same time, we have witnessed tremendous advances in health care technology as well as in biotechnology and in the pharmaceutical sectors.

The rapid globalization of trade has had a significant impact on the health of people, particularly in developing countries.
Lifestyles and living conditions of large segments of the world population have also undergone dramatic changes.

At the same time, keeping in mind another angle of health development, we are emphasizing the need for, and promoting vigorous efforts in, disease prevention and health promotion – to help people to stay healthy.

Recognizing the central role of health in development, Member States are trying hard to combat ill health and keep their populations healthy, in order to ensure economic and social productivity in the development process. To be able to do these, a strong public health system is essential.

Unfortunately, in most of our countries there has been a perceptible decline in both the quality and quantity of public health infrastructure, especially human resources and services. With this in mind, the WHO Regional Office for South-East Asia organized a regional conference in 1999 on ‘Public Health in South-East Asia in the 21st Century’.

The conference, which was attended by prominent public health experts, from both within and outside the Region, issued the ‘Calcutta Declaration on Public Health.’ Since then, as a follow-up, many activities with WHO support have taken place to strengthen public health practice and education in the Region. One important activity was the meeting on “Future Directions in Public Health – Calcutta and Beyond,” held in December 2003 at the WHO Regional Office in New Delhi.

As Regional Director-elect, I promised to intensify efforts in strengthening public health in the Region, with particular emphasis on the development of public health workforce through educational programmes, relevant to the specific needs of the Region.

In order to fulfil this promise, we recognize that the development of effective public health for the Region should be based on the ecological, epidemiological, demographical and environmental perspectives of countries in the Region. The Region needs public health interventions that: - particularly emphasize disease prevention and health promotion; focus on the community
and the whole population; involve all concerned sectors and disciplines; involve peoples from all walks of life; and, not less important, pay special attention to the underserved, underprivileged, poor and vulnerable groups of population.

For the countries to make progress in sustainable health development, the establishment of effective public health systems is imperative. To meet this formidable challenge, we need to take action on several fronts.

Taking into consideration the background scenario of this Region, I have launched the “South-East Asia Public Health Initiative, 2004-2008”. This initiative aims to place the development and strengthening of public health high on the regional and national health development agendas, with the emphasis on public health workforce. In the process, we also hope to facilitate countries to define an appropriate package of essential public health functions, tailored to an individual country’s situation and needs. A preliminary document has been prepared to elaborate what we intend to do in the next 4-5 years in supporting the Member States in this development. This document will be introduced at the beginning of this meeting.

To implement the actions identified in the document, we will proceed step by step, taking into account our capacity in terms of manpower and budget. Certainly, we will need financial help from outside the Region to facilitate WHO’s technical activities in this regard.

As I said, the first thing we would like to pursue in this exercise is the strengthening of public health education in countries. This is to ensure the availability of a critical mass of public health practitioners and professionals required for future health development.

Quality public health education with a curriculum tailored to countries’ needs and a training programme grounded in the practical realities of field conditions are necessary for developing an effective public health workforce that is multi-disciplinary and multi-skilled. This is why the theme for this meeting is, “Public Health Education in the South-East Asia Region”.
What we mainly expect from this meeting is a conceptual framework for the development of a public health educational programme relevant to the needs and requirements of countries in the Region. And, no less important, such a programme should be suitable for implementation in the countries, taking into particular consideration their social, cultural, economic and political context.

There is a long-standing issue in this part of the world that the governments cannot find enough health staff willing to work in the areas of public health. As a result, public health programmes, such as the expanded programme on immunization, malaria control, tuberculosis control, diarrhoeal disease control, parasitic disease control, water and sanitation, and so on are suffering. These programmes cannot be developed and implemented effectively; therefore, we cannot control these diseases and the peoples’ health continues being affected and to deteriorate.

A weak public health infrastructure, including the public health workforce, contributes to the emergence and re emergence of many communicable diseases in various countries.

It is time for us to critically look at our system of public health education today, with a view to effect the desired changes, and to make it more effective in drawing the interest of those who would like to work in the area of public health. Certainly, education alone may not be adequate to be so attractive; a promising career ladder in public health is among many other things that must also be strengthened or developed.

WHO can advise the countries on the concepts and approaches in structuring such a career ladder and other incentive systems; however, it is for the governments themselves to pursue the development in keeping with their specific situation and circumstances.

I am fully aware of the huge tasks that lie ahead. Public health is a vast and complex area; to effect dramatic changes in public health in a limited timeframe is a great challenge for all of us. However, we should be neither discouraged nor deterred from making a fresh start and moving forward with a strong will and commitment.
We are fortunate to have this group of public health experts, which brings a wide spectrum of knowledge and experience to this important exercise. While pursuing this formidable task, it must always be kept in mind also that sustainable national development in health depends on strong public health systems and infrastructure. The Governments of the Member States should fully recognize this necessity.

We look forward to a fruitful association with you all in the coming months and years in supporting and facilitating the Member States in the Region to build a solid public health capacity in countries. At the Regional Office, we have an in-house task force for this exercise. The task force will work closely with the Strategic Advisory Group and other experts during this meeting, and throughout the period of the implementation of the initiative.
A Vision for Health Development in South-East Asia

Selected Speeches by
Dr Samlee Plianbangchang
Regional Director
WHO South-East Asia Region

Vol 1
2004-2005

ISBN 92 9022 267 0