A Vision for Health Development in South-East Asia

Selected Speeches by
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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 cover a wide range of priority health development issues and were delivered by him, or on his behalf, at various national, regional and global level meetings and conferences. These include the sessions of the Regional Committee, the Health Ministers Meeting, the Health Secretaries Meetings as well as meetings of the Consultative Committee for Programme Development and Management. 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. This volume, meant for internal use complements the other volume of selected speeches (ISBN 92 9022 2670) covering the same period issued largely for an external audience.

The speeches are broadly classified into six areas and are presented chronologically for ease of reference. The title, name and period of the event are indicated in the footnotes.
Communicable Diseases
Visceral leishmaniasis or kala-azar is a critical public health problem that affects the poorest of the poor in Bangladesh, India and Nepal, the three endemic countries of our Region. While we know that about 147 million people are at risk in these three countries, an estimated 100,000 people develop the disease each year. This represents 20% of the global burden. More than 50% of kala-azar cases occur in districts across international borders. If untreated, the disease is mostly fatal.

Kala-azar drives the affected poor segments of the populace into further poverty, from which they cannot escape. It retards their socio-economic development and deprives them of a healthy and productive life.

The current trend indicates that the disease is spreading geographically, eastwards and northwards. There is also the increasing risk of co-infection with HIV/AIDS and TB. The elimination of kala-azar, therefore, is not only a great health challenge but also a unique opportunity for the South-East Asia Region. We all have to contribute to make this elimination a reality. There is a role for all partners to work together in this noble effort.

At the meeting of health ministers of Member States of the South-East Asia Region, held at Kathmandu, Nepal, in August 2000, it was recommended that a plan of action be developed for elimination of kala-azar.

At their meeting held in Maldives, in September 2004, health ministers from the three endemic countries of the Region, namely Bangladesh, India and Nepal not only emphasized this recommendation again, they also agreed to sign a Memorandum of Understanding for elimination of kala-azar.
It is a matter of great pleasure for me to inform you that on 18 May 2005, a historic event took place in Geneva, during the 58th World Health Assembly. The Hon’ble Health Ministers of Bangladesh, India and Nepal signed an MoU on kala-azar elimination. This is, indeed, a very laudable event, and a great step forward in ensuring political commitment at the highest level. The key partners were also present at the signing ceremony of the MoU.

This is the time when all partners in health should come together and take advantage of the political mandate, discuss new interventions and strategies, and build a successful partnership for eliminating kala-azar.

Kala-azar is a good candidate for elimination since there is no animal reservoir and humans are the only source of infection. Moreover, the sandfly, *Phlebotomus argentipes* is the only vector in countries of our Region. The vector continues to be highly sensitive to insecticides including DDT. That is the reason why effective vector control operations conducted during the malaria programme also resulted in controlling kala-azar as a collateral benefit. In fact, kala-azar was almost eliminated as a result of these operations.

*Miltefosine*, an oral drug, was developed as a result of collaboration and partnership between the WHO Special Programme for Research and Training in Tropical Diseases or TDR, the Indian Council of Medical Research, and the pharmaceutical industry. It has already been registered for use in India.

The drug can be given on an ambulatory basis, so that hospitalization of uncomplicated cases of kala-azar is not required. I hope that necessary steps will be taken to register this drug for use in Bangladesh and Nepal too.

Screening tests for rapid diagnosis of the disease like ‘rk39’ and Direct Agglutination Tests or the DAT have been found to be very useful. Therefore, invasive tests like one marrow and splenic puncture are not required routinely. This provides optimism for effective diagnosis and treatment of kala-azar, nearer to the patient’s home.

In addition, the Geographical Information System or GIS technology can effectively be used to focus on and guide the indoor residual spray operations. It can also help in the adoption of the strategy of integrated vector management.

I would, at this stage, like to mention about the constraints in the elimination of kala-azar. Resistance to Sodium Antimony Gluconate (SAG) is noted in about 60% of kala-azar cases in some districts in Bihar in India. While DDT can continue to be used in India, Bangladesh and Nepal will not be able to use it
since its stocks have either been exhausted or the national policy does not permit its use.

Pyrethroids are expensive and unaffordable when used over wide areas. Cases of Post Kala-azar Dermal Lesion or PKDL serve as a reservoir of the infection. Over the years, there has been a build-up of PKDL cases. Furthermore, these cases are difficult to locale and treat.

There is a large gap between the reported and estimated cases of the disease. A large number of kala-azar patients are being treated in the private sector where the treatment is often inappropriate. Moreover, adherence to treatment schedule is also incomplete since a large majority of patients are very poor, earning of less than one US dollar per day. They cannot, therefore, afford expensive treatment.

In pursuance of its efforts to eliminate kala-azar from the three endemic countries of our Region, the Regional Office has established a Regional Technical Advisory Group or the RTAG. The Group held its first meeting in December 2004, and recommended the elimination of kala-azar from Bangladesh, India and Nepal by 2015. The Regional Strategy for Elimination of Kala-azar was also endorsed, and goals, targets and objectives agreed to.

The RTAG defined the strategic pillars for elimination of kala-azar as follows: (a) early diagnosis and complete treatment that is operationally feasible to ensure outreach to the poorest people with appropriate diagnostics and treatment; (b) strengthening of disease and vector surveillance through an efficient, inbuilt management information system; (c) vector control through integrated vector management; (d) social mobilization directed towards behavioural change through effective communication strategies, and (e) clinical and operational research to support the elimination programme.

The Regional Strategic Framework for Elimination of Kala-azar from the South-East Asia Region 2005-2015, approved by the RTAG, and the Roadmap to Guide the Endemic Countries in Developing National Strategies and Plans for Elimination, were presented at the Consultation organized jointly by the Bill and Melinda Gates Foundation and the Indian Council of Medical Research, New Delhi, in January 2005.

The elimination of kala-azar not only needs sustained political commitment, but good technical support, mobilization of resources, improvement of managerial capacities, and removing of operational bottlenecks.
The affected country’s role is also very important. The elimination strategy and activities should have linkages with anti-poverty programmes in national plans, as kala-azar mainly affects the poor. Only then can we have concrete results. In this context, I am pleased to inform you all that the three endemic countries of our Region have already prepared operational plans for elimination of kala-azar.

Research is a continuous process. The search for new drugs and their new combinations; further development of robust and reliable diagnostic tests and their evaluation; effective treatment of PKDL cases, and studying the linkages between HIV/AIDS and kala-azar, are priority areas for research. Operational research, including ways to expand efforts for elimination of kala-azar through innovative and sustainable partnerships, should be explored. This meeting is being organized by the WHO South-East Asia Regional Office, in collaboration with and support from the WHO Special Programme for Research and Training in Tropical Diseases; and the Control, Prevention and Elimination (CPE) programme, WHO headquarters, Geneva.

I would like to thank all those present, especially partners, invitees and agency representatives from GTZ; the Bill and Melinda Gates Foundation, and from the Drugs for Neglected Diseases Initiative (DNDi), as well as representatives from the World Bank, UNICEF and USAID, etc.
Meeting of National TB Programme Managers

This annual meeting provides a useful forum for national programme managers, WHO and other key partners to discuss steps to boost tuberculosis control in our Region. Tuberculosis remains a major public health concern in all our Member States. More than one third of all cases worldwide are in the South-East Asia Region, which ranks first among all WHO Regions in terms of disease burden. We need to rank it first also in our response!

The year 2005 is crucial. We have less than a year from now to reach the global targets for case detection and cure. Member States and WHO are committed to achieve these targets. Some countries have already reached those targets, while others are well on their way. Member States deserve to be congratulated for this.

Reaching those targets, however, is not an endpoint. It is, rather, a starting point, highlighting the fact that NTPs have the capacity to deliver quality services. In order to control and eventually eliminate TB, DOTS activities need to be sustained and reinforced in the years ahead.

The Millennium Summit in 2000 adopted the Millennium Development Goals or MDGs. Combating TB is one of the identified goals. We have ten more years to halt and reverse the trend of this devastating disease. The reduction, by 2010, of the prevalence and mortality of TB by 50% has been identified as a crucial milestone on the way to reaching the MDG targets.

Bringing major diseases such as HIV, TB and malaria under control, will have a positive impact on poverty alleviation and on the overall economic
development of our countries. During this meeting, a comprehensive strategy for TB control to reach the MDG targets will be discussed.

Member countries should realize that sustained efforts from all stakeholders are vital in the years ahead. Identified strategies, built upon the vast experience in our Member countries and beyond, should guide us in implementing effective and efficient TB control programmes.

The DOTS strategy will remain the core of our future efforts. This successful strategy, however, needs to be adapted and expanded to address new challenges and to have a lasting impact. Quality control has to be routinely incorporated, not only to maintain laboratory standards, but also to guarantee continued success of all other aspects of the programme.

Efforts are needed to limit the spread of resistant strains and to reduce multidrug resistant (MDR) TB. MDR TB ought to be treated following strict guidelines, in order to ensure the effectiveness of the few drugs we have at our disposal.

DOTS alone, however will not achieve our desired goal. Or more precisely: DOTS, through the public health system alone will not do it. Most countries in our Region are characterized by a large private sector with a sizeable share in the treatment of tuberculosis. National TB Programmes have no other option than to reach out to their counterparts in the private sector, and to foster partnerships with all stakeholders. We have numerous successful examples and pilot projects in all countries, to engage with non-traditional health authorities.

DOTS services are increasingly becoming available in prisons, police and army health facilities, in hospitals of major industrial complexes, in railways and ports, in medical colleges, and through committed private practitioners. The involvement of these partners can contribute greatly towards further progress of the programme.

HIV is also increasing in several Member countries in the Region. Building on the ongoing collaboration on TB/HIV, the first “Intercountry Training of Trainers on TB/HIV”, conducted last month in Thailand with participants from five high burden countries, will be instrumental in strengthening collaboration between the two major disease control programmes.

At the international level, additional resources are being generated to sustain TB control beyond 2005. Governments, TB patients, NGOs, communities, service providers, development banks and WHO are lobbying for extra
resources. Additional resources provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Intensified Support and Action Countries or ISAC initiative, the Global Drug Facility, to name a few, are the visible results of the increased global political commitment. Sustainable financing is increasingly linked to performance-based implementation and to a maximal integration into general services in order to increase programme efficiency.

Soon after Dr Samlee took office in March last year, he declared TB control a “special project”. His presence is being missed today as this is a subject very close to his heart. He would like countries to use the current momentum for TB control to strengthen their primary healthcare systems. Three million TB patients every year in our Region is not a small number. We have the tools to diagnose and treat them.

We may argue that the programme costs are high. But the cost for not taking action now will be many times higher in future.

WHO will continue to advocate for TB at the highest policy level within and outside the Region. We are hopeful that the deliberations during this three-day meeting will provide guidance to countries in strengthening the National TB Programmes in the respective countries.
Training of Trainers on TB/HIV

The South-East Asia Region bears the major brunt of the global tuberculosis burden, accounting for more than one third of the world’s cases. The HIV epidemic has also increased dramatically in some countries. The Region now occupies an unenviable second place, following sub-Saharan Africa.

Both diseases are fuelling each other: tuberculosis is the most common opportunistic infection in people infected with HIV. HIV negatively affects TB treatment, due to a higher mortality. Together, TB and HIV put a heavy, additional burden on the health system.

The governments of our Member Countries are showing exemplary commitment to address this dual epidemic. The TB and HIV programmes are being strengthened through additional resources made available from various sources.

I have declared the tuberculosis programme a “special programme” for this Region. This will enable WHO to increase its focus to the core issues of TB control. In addition to the “traditional” components of DOTS, our strategic approach embraces new developments to address the growing problems of TB/HIV and multidrug resistance, cross-border disease control, and involvement of other healthcare providers.

In this regard, the organization of this first training course on TB/HIV is very timely and appropriate. Various initiatives and pilot projects are being undertaken in our Region. The training course is based on the evidence provided by these initiatives. Field visits are included to two sites, Ubon Ratchatanee and Chiang Rai, where participants will set first-hand experience.
The training aims at building capacity of the managerial and clinical staff, based at the intermediate and peripheral levels of five high burden countries, and at developing sound action plans to maximize collaboration between the two programmes.

Collaboration between the HIV and TB programmes will also strengthen the strategies to reach the Millennium Development Goals: the DOTS programme has a strong community and monitoring arm, while Voluntary Counselling and Testing (VCT) centres contribute to identifying TB suspects. The “3 by 5” initiative supports providing anti-retroviral treatment; TB programmes provide an important entry point for instituting anti-retroviral treatment. Strong messages emphasizing prevention of HIV and compliance with the ARV or TB treatment may emanate from both TB and HIV/AIDS centres.

I am confident that this course will provide the participants with the necessary skills to implement much needed activities in a collaborative way in their respective countries.

I also wish to thank the agencies who have worked together to organize this training course: the Ministry of Public Health, Thailand; the US Centers for Disease Control and Prevention-Global AIDS Programme, Atlanta and Bangkok; and the Research Institute of Tuberculosis, Japan; as well as the health departments in Chiang Rai and Ubon Ratchatanee for organising the field trips.
The South-East Asia Region, is the only WHO Region which is yet to achieve the leprosy elimination goal. However, our Region has made noteworthy progress in the past two decades.

The prevalence of leprosy has declined by 92% over an 18-year period from 1985, when Multi-Drug Therapy (MDT) was introduced in phases, in all countries of the Region.

Eight of the eleven Member Countries of the South-East Asia Region have achieved the elimination goal at the national level and have maintained the elimination levels. All countries have integrated leprosy services into the general health services, thereby increasing the accessibility to multi-drug treatment and enhancing awareness about leprosy being a curable disease.

The three remaining endemic countries – India, Nepal and Timor-Leste, have substantially reduced the burden of leprosy and are making concerted efforts to reach the goal by December 2005.

In spite of these achievements, it is a matter of concern that the Region accounted for 68% of the globally registered and 81% of the new cases detected in 2003. Within the Region, India accounted for 88% of the prevalence and 91% of new case detections in 2003. Therefore, WHO is giving the highest priority to India, followed by Nepal and Timor-Leste, the three countries which are yet to achieve the elimination goal.

While maximum efforts are being made in countries which are yet to achieve elimination, it is to be noted that in countries which have achieved...
national-level elimination, there are still areas where leprosy is highly endemic. These countries would therefore continue to receive WHO support to reach sub-national elimination.

I am happy to note that besides national programme managers, officials from states, divisions or provinces who are actually responsible for implementing leprosy elimination activities, and partners supporting leprosy elimination activities in the Member Countries are also attending this meeting.

This combination of planners, implementers and partners provides an excellent forum for reviewing the progress of elimination at national and sub-national levels. It will also help in identifying problems and constraints, and in evolving solutions to achieve the elimination goal at national/sub-national levels.

The main purpose of this meeting is to review the regional and national leprosy situation, identify constraints and refine the national and WHO regional strategic plans for 2005.

India, Nepal and Timor-Leste need extra effort and support to reach the elimination goal by the target date of December 2005.

WHO has been concerned about the high level of the annual new case detection reported in some countries, in spite of very effective MDT implementation.

Through the very systematic and in-depth studies on case validation conducted in India in 2003 and 2004, there is evidence that a substantial “over-reporting” of cases has occurred and this may be true for some other Member Countries as well. Every effort needs to be made to minimize and prevent such operational factors.

Those countries which have already achieved the target of elimination at the national level, should continue their efforts to achieve sub-national (district) level elimination. WHO will continue to provide technical assistance to these countries. One important strategy for these countries is to build and strengthen the capacity of the general health services to provide leprosy services and sustain the political commitment.

In addition, we need to find appropriate cost-effective approaches for prevention of disabilities and integration of persons cured of leprosy into the community. Rehabilitation of those in need should be community-based and provided within the existing services for all categories of the disabled. Advocacy and IEC will continue to be crucial activities.
The Global Leprosy Elimination programme has been one of the models for successful partnerships in achieving a health goal. In this context, we need to strengthen existing partnerships and co-opt new partners. I, therefore, welcome the participation of several partners like the Nippon and Sasakawa Foundations of Japan, Novartis, international NGOs – and their national representatives.

I am thankful to the Nippon Foundation for generously contributing to WHO’s global leprosy elimination programme since 1974. Their contribution has enabled WHO to provide a free supply of MDT to all endemic countries from 1995-2000.

Their example was followed by the Novartis Fund for Sustainable Development, which pledged the free supply of MDT from 2000-2005. We are deeply grateful to the Novartis Fund which has indicated that they will extend the free supply up to 2010.

I would also like to thank our partners like the World Bank, and other international and national NGOs for their assistance and contributions to the national leprosy programmes in our Region during the past many years.

The target date for achieving elimination regionally, including in the three remaining countries, is December 2005. To facilitate this, the WHO Director-General has decided to transfer the Leprosy Unit at HQ to SEARO. Work is now under way to implement this new policy.

I know the task at hand is not easy but I feel confident that, with your expertise, experience and sincere efforts, the goal can be reached and we can progress further towards a “World Without Leprosy” in a few decades.
Meeting of Regional Technical Advisory Group on Kala-azar

Worldwide, leishmaniasis is endemic in 88 countries with an estimated 1-1.5 million cases of cutaneous and 0.5 million cases of visceral leishmaniasis or kala-azar annually.

In our Region, three countries, namely Bangladesh, India and Nepal, are affected with approximately 147 million people at risk and at least 100,000 new cases occurring every year. In these three countries, nearly 100 districts are endemic and more than 50 percent of the disease is reported from the border districts.

You may recall that kala-azar is mainly a disease of the poor and which affects socio-economic development adversely. The disease accounts for a loss of about 400,000 DALYs each year.

In our Region, humans are the only reservoir of the disease. This, along with the continued susceptibility of the sandfly vector to DDT and synthetic pyrethroids make a strong case for its elimination.

As a collateral benefit of previous malaria eradication or control programmes, kala-azar was virtually eliminated in our Region. Unfortunately, the slow build-up of the foci following discontinuation or poor quality of indoor residual spraying led to the emergence of the disease which was, at times, explosive and associated with a large number of deaths.

India initiated a control programme for kala-azar with remarkable success in the 1990s. Between 1992 and 1995, there was a 70% reduction in the incidence and an 80% reduction in deaths. During the next seven years,

First meeting of the Regional Technical Advisory Group on Kala-Azar, Manesar, India, 20-23 December 2004. Delivered by Director, Department of Communicable Diseases.
however, the rate of decline slowed down. India is now targeting elimination by 2010. Both Bangladesh and Nepal have agreed to develop their respective national plans to eliminate kala-azar.

Kala-azar was almost eliminated from our Region using three control strategies namely (1) early diagnosis and effective treatment (2) disease and vector surveillance, and (3) indoor residual spraying as part of an integrated vector management strategy. These strategies are still valid.

With effect to early diagnosis and effective treatment, we have a very promising diagnostic test. The use of this test will reduce the need for invasive tests and will simultaneously lead to early detection of cases. Currently, the gap between the reported cases and the estimated cases is very large. A large number of patients are poor and seek services in the private sector where the treatment is often inappropriate and incomplete. The application of newer diagnostic tests and oral drugs will improve surveillance and bring treatment closer to the people.

One problem associated with treatment is Post Kala-azar Dermal Lesion (PKDL). These cases are difficult to locate and cure. They, unfortunately, become reservoirs and facilitate transmission of the disease.

The new oral drug, miltefosine, which was developed as a result of collaboration between TDR, the Government of India and the pharmaceutical industry, is safe and highly effective. Currently, the drug is undergoing the final phase of trials in India. In contrast, the currently available drugs are either toxic or expensive or are no longer effective and have to be injected.

With the use of the oral drug, hospitalization will not be needed thus considerably reducing the cost of treatment. Adherence to current treatment is unsatisfactory since 75% of the affected people earn less than US$ 1 per day and cannot afford the expensive treatment.

Surveillance of cases as mentioned above as well as surveillance of the vector is equally important. The sandfly vector is still very sensitive to DDT and synthetic pyrethroids. Now, GIS mapping can be undertaken to focus on and guide the indoor residual spray operations.

Unfortunately, in some countries, the DDT stock may have been exhausted or national policy may not permit its use. Switching to pyrethroids is difficult due to its high cost. To overcome this issue, WHO has issued new guidelines
on the use of DDT, particularly for the control of malaria in developing countries where the vector is still sensitive to DDT.

Thus, the issue of operational research on integrated vector management for elimination of kala-azar needs to be discussed thoroughly at this meeting.

Success in achieving the elimination of kala-azar requires sustained political commitment, mobilization of resources, overcoming the managerial and operational constraints and developing linkages with poverty alleviation programmes. Political commitment for the elimination of kala-azar in the endemic countries is high. Ministers of health from these three countries have recommended closer cross-border collaboration to eliminate the disease. At their meeting held in September 2004 in Maldives, the health ministers from the endemic countries, while endorsing their earlier commitment, agreed to sign a memorandum of understanding for the elimination of kala-azar.

Continued research for new drugs and drug combinations, further development and testing of robust and reliable diagnostic tests, effective treatment of cases of PKDL and studying the linkages between HIV/AIDS and kala-azar and many other operational research projects will be needed to strengthen efforts to eliminate kala-azar.

This is a formidable challenge since elimination requires effective and sustained intercountry cooperation and networking amongst institutions. Elimination of the disease is only possible when the targets and the goals are clear and simple indicators are used to regularly monitor progress. Enhanced surveillance of cases and the vector will be of utmost importance.

Elimination of kala-azar from the three endemic countries in the Region is a priority for WHO. A Regional strategic plan has been prepared and was discussed at an intercountry consultative meeting held in Varanasi, India, in November 2003. Following this meeting, the strategic plan was revised and a roadmap was prepared to guide the endemic countries in developing national strategies and plans for elimination of kala-azar.
First Meeting of the Regional Technical Advisory Group on Malaria

Malaria has a long history and continues to be a major health problem in the Region. The long battle to eradicate malaria failed to produce the desired results in the fifties. In fact, to make matters worse, malaria re-emerged in a big way in the mid-seventies with a total number of 6.5 million reported cases.

Through rigorous implementation of malaria control activities by all the countries in the Region, the number of reported cases declined to about 3 million per year during the nineties.

Presently, more than 70% of malaria cases are from India, while Myanmar reports the maximum proportion of deaths (more than 50%). Maldives has had no indigenous cases since 1984, while DPR Korea reported an outbreak of \( P. \) \textit{vivax} during the past 5 years.

While the reported malaria cases in the Region have declined, malaria caused by \( P. \) \textit{falciparum} has increased from 12.5% to more than 45%. The problem of multidrug resistant \( P. \) \textit{falciparum} has spread, accounting for 30% of the resistant cases worldwide.

The problem of drug and insecticide resistance makes the malaria control programme not only expensive but also difficult to manage.

Due to the weakness of the health information system malaria is underreported. It is estimated that there are nearly 20-30 million malaria cases and some 30,000 deaths in the Region annually. The actual burden of malaria...
would be 10 times higher than the reported figures. This has a significant implication on allocation of resources.

Malaria, as you are aware, occurs as several ecological subtypes. This includes forest and forest-fringe malaria, urban malaria, coastal malaria, malaria in developmental projects and the mining industry.

Malaria affects various population groups who are poor and vulnerable such as migrant workers, children and outreach population. Besides being a health problem, malaria has serious socio-economic and developmental implications.

In the South-East Asia Region, malaria outbreaks and epidemics are common. Malaria is also a serious cross-border problem.

All these factors necessitate the adoption of a stratified approach. Evidence gaps have led to the lack of visibility which is responsible for lack of sustained political will and a low level of people’s participation.

Malaria control programmes have long been implemented in all the Member Countries in the Region. Yet, significant progress has not been made. It is recognized that the number of technical experts in this field is shrinking and the health system needs a lot of strengthening.

Effective control of malaria requires up-gradation of the existing strategies and strengthening of the health system, expansion of access to the poor, marginalized and vulnerable populations. Tools and guidelines have been developed for increasing the capacity and consensus has been achieved on the key process and impact indicators to monitor the malaria programme.

Technical resource networks on drug resistance and transmission risk reduction have provided evidence for policy change. I am happy to inform you that Myanmar and Thailand have already revised their national drug policy and much progress has been made in Bangladesh, Bhutan, India and Indonesia.

A regional strategic plan has been developed and a roadmap prepared to guide the countries to develop national strategies in malaria control.

On the basis of the fourth round of applications, Member Countries in our Region received Global Fund approvals for proposals worth US$ 150 million. This is an excellent opportunity for the Member Countries to effectively scale up the malaria control efforts.
From the above points, despite the progress made, it is clear that malaria is still a major health problem in our Region. I strongly feel that we need to think of new approaches in the control of malaria in order to achieve a sustained impact.

I have established this Regional Technical Advisory Group to advise me on various strategic issues impeding the scale up of malaria control, including research and human resource needs. I am confident that your advice and recommendations will help us strengthen our efforts at malaria control in the Region.
Workshop on Treponematoses including Yaws

Treponematoses including Yaws are significant public health problems in three countries of the South-East Asia Region – India, Indonesia and Timor-Leste. Yaws is a localized problem, causing disability and economic hardship for people, most of whom are already poor. The disease predominantly affects children, particularly from the marginalized and vulnerable groups, and is thus poverty-related.

Cost-effective tools are available to detect and cure the disease, making it amenable to elimination/eradication like other diseases such as smallpox, guineaworm and polio. Keeping these factors in mind, I took the initiative to declare the eradication of yaws as a regional priority and an achievable goal. I am happy to know that the three affected countries – India, Indonesia and Timor-Leste have evinced interest in tackling this hitherto neglected disease. Interventions aimed at eradication will also prevent further spread of the current foci.

India and Indonesia have long experience in yaws control. India has made commendable progress, since the eradication programme was launched in 1997. In Indonesia, the programme had slowed down due to the emergence of other health problems that needed priority attention. Timor-Leste is initiating efforts to control yaws.

In the past, low priority was accorded to yaws and the disease did not draw the attention of policy makers and the international donor community.

There are many issues and challenges hampering progress towards achieving the eradication goal in the three affected countries. These issues,
which need to be urgently addressed are: the need to establish an integrated mechanism for yaws surveillance, including capacity building of the general health staff to recognize and treat yaws; improving case detection and ensuring prompt treatment of index cases and their contacts; mobilizing political commitment and adequate resources through advocacy and partnerships and, finally, creating community awareness on yaws, so that those affected can come forward for diagnosis and treatment.

I am confident that this workshop will achieve its expected outcome of obtaining updates on the current epidemiological situation of treponematoses with special reference to yaws in the Region. The experiences shared could help in developing an advocacy document aimed at policy makers in order to obtain political commitment and mobilize resources.

The workshop will also develop national strategic workplans for eradication in the light of integrated disease surveillance and integrated health systems. The main objective would be to strengthen the treponematoses control programme in the Region, with specific reference to yaws eradication.

A few international donors have evinced interest in yaws eradication. Therefore, the timing of this intercountry workshop is most opportune.

The key for success is policy support, political commitment and resource mobilization. I would, therefore, urge the participants to thoroughly discuss ways and means of drawing the attention of the policy makers and develop an advocacy and resource mobilization plan.

Yaws eradication, as other disease control programmes, should be considered as an entry point to strengthen primary healthcare in the affected areas. In this 21st century, the existence of a 100% curable disease like yaws should be considered totally unacceptable.

I assure the three affected countries that WHO will continue to provide the necessary technical support in the planning, implementation and monitoring of activities and in resource mobilization, to ensure attaining the goal of eradication of yaws in the near future.
Polio Eradication

I am delighted to be at the launch of the publications, which so vividly and effectively capture the spirit of the polio eradication campaign in India. These books make compelling reading, because they are authored by a person who has been so deeply committed and involved in pursuing the goal of a polio-free India. I have worked closely with Dr Harsh Vardhan, and am fully aware of his dedication and tireless efforts to achieve better health for all people.

As many of us would recall, when WHO launched the polio eradication campaign in 1988, India reported 35,000 cases of poliomyelitis. Having gone through a long and difficult path, the campaign has produced commendable results. This year, as of now, only 98 cases of polio have been reported so far in India. Therefore, poliomyelitis is at the brink of eradication from this country.

If present efforts are sustained and, perhaps accelerated, we can be confident that there will be no more cases of polio in India from next year onwards. India’s success, as is well recognized, is crucial to the completion of the global eradication of this debilitating scourge.

The success in the fight against polio in India is due, in a large part, to the dedication and hard work of health professionals like Dr Harsh Vardhan. This is in addition to the commitment of leaders, like respected Mr Atal Behari Vajpayee and Mrs Sushma Swaraj, who, during their tenures as Prime Minister and Health Minister respectively, spared no efforts to ensure full support to the campaign.

I would also like to take this opportunity of placing on record WHO’s deep appreciation of the efforts put in by thousands of health workers, NGOs,

Launch of books on Polio Eradication Programme in India “A Tale of Two Drops” by Dr Harsh Vardhan, former Minister of Health, Delhi State, Mavalankar Auditorium, New Delhi, 7 December 2004

Communicable Diseases
Rotary International, UN agencies and members of the community, for so successfully arranging the national and sub-national immunization days.

The books “A Tale of Two Drops” record these events very eloquently, and provide a close glimpse of the hard and meticulous tasks that has gone into the campaign. Once again I congratulate Dr Harsh Vardhan for his excellent work on polio eradication in India.

The books, I am sure, will provide useful lessons to health professionals not only in India, but also in many other countries on how to organize a successful disease control programme that can help eradicate diseases.
Malaria Control

In DPR Korea, we realize that malaria is still a major public health problem. After having effectively controlled malaria for over two decades, DPR Korea has witnessed a resurgence of the disease during the last 6 years. At its peak in 2001, an estimated 300,000 cases in DPR Korea and about 9,000 cases were reported from the Republic of Korea. The problem is of even greater concern across the border.

To address this problem, a strong health system and good public health infrastructure is indispensable.

In this part of the world, malaria is caused by P. vivax, a temperate strain which has a long incubation period and relapses. Malaria caused by P. vivax though not fatal, causes considerable discomfort and economic losses.

DPR Korea has successfully implemented the strategy of mass chemoprophylaxis with primaquine in a population of 300,000-400,000 for three successive years. However in future, this strategy needs to be fully supported with diagnosis and treatment of malaria cases to successfully interrupt transmission.

I am informed that insecticide-treated bednets have been introduced and operational studies are in progress to evaluate their impact as a personal protection measure and for interruption of transmission.

The governments have made special efforts to strengthen the health infrastructure for increasing access to quality diagnosis and complete treatment of malaria. This is coupled with improved surveillance and a stratified approach to direct the resources where they are needed most. These may have led to a
decline in the cases of malaria during 2003. The intensive support provided by the national governments as well as the collaborative efforts of the partners also contributed significantly.

This meeting provides a good example of collaboration between the affected Member countries and WHO Headquarters as well as the Regional Offices for the South-East Asia and the Western Pacific Regions.

Malaria control in DPR Korea and the Republic of Korea is within the purview of the South-East Asia and Western Pacific Regional Offices of WHO respectively. The two Regions have, in the past, collaborated in addressing the problem of malaria in the Mekong region. This meeting is yet another example of increasing bi-regional collaboration.

I am happy to note the increasing collaboration between DPR Korea, the People’s Republic of China and the Republic of Korea in the fight against malaria. A meeting was held last year where various technical issues were discussed. I hope that at this meeting operational details will be discussed.

Please remember that control of malaria is an intersectoral concern. I am informed that intermittent irrigation of paddy fields is cost-effective and is a deterrent for vector breeding. I hope that FAO, UNEP and other concerned partners will provide their expertise and support in environmental control of malaria.

This meeting augurs well for the control of *P. vivax* malaria in the affected countries since information will be exchanged, operational details will be worked out and plans prepared for follow up of the recommendations of this meeting. I hope that through a spirit of cooperation amongst the affected countries, effective malaria control would lead to improved health and prosperity of the people.

I take this opportunity to thank the Government of the People’s Republic of China and the Institute of Parasitic Diseases for hosting this meeting.
Antimalarial Drugs

South-East Asia is one of the most malaria-endemic Regions of the world. About 2.3 million malaria cases and 4,500 deaths are reported annually with frequent epidemics. The Region faces the threat of vector resistance to insecticides, changes in vector behaviour, resistance of Plasmodium vivax to chloroquine and multi-drug resistance of Plasmodium falciparum.

Financial constraints and lack of human resources have contributed to the persistence, and progression of malaria incidence in several countries. The multi-drug resistance problem with falciparum which was confined to two Mekong countries of the Region has gradually spread towards the West. This has resulted in the revision of national drug policies in South Asian Countries where artemisinin-based combination therapy has been adopted. An increasing number of P. falciparum cases have been observed in some Eastern States of India. The issue of drug resistance is complicated by the irrational use of drugs and the existence of counterfeit and substandard drugs.

Realizing that multi-drug resistance falciparum is a problem common to both the WHO Western Pacific and South-East Asia Regions, we have given it a high priority and endorsed it as a bi-regional issue. Efforts have been made to provide technical support to all Member Countries in order to regularly monitor drug resistance and use this evidence-based data for revision of treatment policy.

I would like to take this opportunity of reiterating my commitment to further strengthen national capacity of the Member Countries to tackle the problem of multidrug resistance.

This workshop has been jointly organized by the Regional Offices of the Western Pacific and South-East Asia Regions of WHO. It is, in fact, a follow-up

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Bi-regional Mekong Roll Back Malaria Workshop on Antimalarial Drugs, Hanoi, Vietnam, 15-18 November 2004, Delivered by Ag. Regional Adviser, Malaria, WHO/SEARO.
to the informal consultation on monitoring resistance to antimalarial drugs in the Mekong Region held in Phnom Penh, Cambodia, in 2000. It is also one step forward in strengthening bi-regional collaboration and partnerships among affected countries which is the principle of the Roll Back Malaria initiative.

I would like to thank my colleague, Dr Shigeru Omi, the Regional Director of the Western Pacific Region and the WHO Representative to Vietnam, as well as the organizers for organizing this workshop. I also thank our development partners, researchers and malaria programme managers for their contributions in combating multi-drug resistance malaria in our regions. Further, I am grateful to the Government of Vietnam for hosting this workshop.
Quality Control of Vaccines

Assessments conducted by WHO have clearly shown that the three vaccine producing countries of the South-East Asia Region (namely India, Indonesia and Thailand), have well established National Regulatory Authorities (NRAs) and competent National Control Laboratories (NCLs). The NRA and NCL serve as the backbone of the regulatory system that ensures the quality of the vaccines that are provided in your countries.

Over the years, the vaccine manufacturers and the three NCLs represented here today have gained extensive experience in meeting this responsibility. The staff of the NCLs are highly dedicated, qualified, and experienced in the development of national reference standards used for the quality control of vaccines. In order to draw upon this extensive and valuable experience and to foster better collaboration among vaccine producing countries of the Region, WHO/SEARO has organized this important meeting.

One of the key objectives of the South-East Asia Regional Vaccine Policy endorsed in 2003 is to ensure quality of vaccines in our Region through increased partnership among the Member Countries. One of the critical steps in meeting this objective is developing regional reference standards. This is particularly relevant as vaccine producers in South-East Asia assume an ever greater role in meeting immunization needs both in the Region and globally.

As the number of manufacturers increases around the world, supplying international reference standards becomes more problematic. Hence, an important task of the network would be to share technical information and collaborate in developing regional reference standards for use by all vaccine manufacturers and NCLs in the Region.
I am confident that the NCLs of our Region can meet this challenge. Please be assured that WHO is firmly committed to ensuring vaccine quality in the Region and stands ready to provide necessary technical assistance to the staff of the NCLs.

In closing, I would also like to convey my sincere thanks to the Royal Thai Government for agreeing to hold this important meeting in Bangkok. Their support underscores the priority given to this critical issue of vaccine quality.
Training on HIV/AIDS Care

HIV represents a major public health problem world-wide. Of the 38 million people currently estimated to be living with HIV/AIDS, two thirds are in Africa. Twenty-five million people have already died. The South-East Asia Region bears the second highest burden of HIV/AIDS after Africa. One fourth of the global total, over six million people, with HIV/AIDS live in this Region. In many countries, for example Thailand, AIDS has become the leading cause of death among young adults in some areas.

Since 1996, when combination antiretroviral therapy first became available in developed countries, more than 20 million people in the developing world have died of AIDS. If antiretroviral therapy had been available to them, most of these people would probably be alive today. Today, antiretroviral therapy has significantly reduced morbidity and mortality from HIV/AIDS in industrialized countries. However, this life-saving treatment is beyond the reach of most patients in the developing world.

In September 2003, Dr LEE Jong-wook, Director-General of WHO, declared the lack of access to antiretroviral therapy as a global health emergency. In response, WHO launched the “Treat 3 million by 2005” initiative – known as “3 by 5”. Under “3 by 5” the global target is to get three million people living with HIV/AIDS in developing and middle-income countries on antiretroviral treatment by 2005. It is a step towards the goal of providing universal access to treatment for all who need it, as a human right. Member States have endorsed and thereby committed themselves to the World Health Assembly resolution on scaling up treatment and care.

The Regional Office for South-East Asia has been proactive in initiating steps to scale up care and antiretroviral therapy in Member States. In line with

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the global “3 by 5” target, the target for the SEA Region is to get 450,000 people on ART by the end of 2005. In the past six months, technical support has been provided to Member States through WHO country missions, development of tools and guidelines, recruitment of “3 by 5” country officers, and through resource mobilization and capacity building. The high-HIV burden countries in the Region have made important beginnings to start antiretroviral therapy programmes.

Thailand started scaling up ART in the public sector in 2000 and has demonstrated that this is feasible. Policy announcements to provide treatment were made on World AIDS Day 2003 in India, Indonesia, and Nepal.

As of July 2004, more than 50,000 people in the Region were receiving ART. Thus, there has been nearly a two-fold increase in ART coverage from that in November 2003.

Thailand and India have traditionally been the training hubs in Asia for public health and communicable diseases, particularly HIV/AIDS. WHO has been actively promoting the role of centres of expertise in the Region for capacity building.

Bamrasnaradura Institute, Department of Disease Control, Ministry of Public Health, Bangladesh, has been designated, since 1999, as a WHO Collaborating Centre for Training and Research on HIV/AIDS Clinical Management and Counselling. The training modules have been regularly revised by international experts. As of July 2004, 11 international courses – 7 on clinical management of HIV/AIDS including ART, and 4 on laboratory diagnosis of opportunistic infections – have been organized. A total of 220 participants from 16 countries have been trained by this institution. Similar intercountry training of trainers workshops have been held for HIV voluntary counselling and testing, quality assurance for HIV testing and CD 4 enumeration.
Regional Technical Advisory Group on Leprosy Elimination

I welcome you all to the first meeting of the Regional Technical Advisory Group (RTAG) for Leprosy Elimination. Thank you so much for accepting my invitation to be members of this Technical group. I am confident that the Member States in South-East Asia will greatly benefit from your combined wisdom and extensive experiences. Your contribution will be very important to the achievement of the goal of leprosy elimination in the Region by the target date of December 2005.

As you know, despite vigorous efforts and considerable progress, we in South-East Asia still have to work very diligently in order to achieve the goal of leprosy elimination. Eight of our 11 countries have achieved this goal at the national level, but they still need to tackle the disease burden at the sub-national level. This is to ensure uniform reduction of case load until the elimination target is reached in all sub-national locations throughout the country.

Three countries – India, Nepal and Timor-Leste – are yet to reach the elimination goal at least at national level; therefore, special attention and extra efforts are needed in order to attain the goal by the end of next year. The overall regional prevalence rate has steadily declined over the past ten years, from 6.12/10,000 population in 1994 to 1.91 as of March 2004.

The new case detection rate, which remained static for sometime, has also shown a declining trend, especially during the past two years. Now, key to the achievement of the goal in the Region is the progress in India, which, in 2003, accounted for 87% of the prevalence and 91% of the new case detections. Therefore, WHO accords the highest priority to India, as far as leprosy elimination is concerned.

First Regional Technical Advisory Group (RTAG) on Leprosy Elimination, SEARO, 11 October 2004
The Leprosy Elimination Monitoring (LEM) and Case Validation Exercises, conducted in India in 2003 and 2004 indicated that there was 25-30% ‘over-detection’, this was due to incorrect diagnosis and improper registration of cases. There were also other operational factors such as improper classification of cases, and over-treatment that led to delayed completion and release from the treatment regimen. Accordingly, the prevalence rates and new case detection figures are inflated.

Due to incorrect diagnosis and improper registration, there was evidence of “over-reporting” in India, Nepal, Bangladesh and some areas of Indonesia. Such operational shortfalls may also be observed in other countries of the Region.

Since the initiation of MDT during the mid-1980s, over 11.6 million persons with the disease had been detected, treated and cured; 10 million of these are in India alone. Thus, India will greatly contribute to the achievement of the global leprosy elimination goal. While seeking your advice and guidance on the best ways to move towards the elimination goal, I wish to share with you some of the remaining challenges. These are: (a) securing adequate resources through internal and external resource mobilization to ensure long-term sustainability of the programme; (b) ensuring the integration of leprosy elimination activities into the general health services; (c) in parallel, building the capacity of those services to ensure coverage and quality of leprosy care; (d) preventing “over-reporting” of new cases, which is delaying the achievement of the elimination target; (e) further reducing disability rates and ensuring community-based rehabilitation; (f) strengthening partnerships in order to augment the existing efforts in reducing the burden of leprosy; (g) ensuring access to MDT by the under-served, underprivileged and vulnerable population groups; and finally (h) sustaining advocacy and IEC activities to ensure enhanced political support and commitment, especially to the “Final Push” strategies.

In some countries leprosy will still be a public health problem, even if all countries in the Region achieve the elimination goal by 2005. As I said earlier, once a country attains the elimination target at the national level, efforts will have to be shifted progressively to sub-national levels; such as province, district and sub-district; this is in order to ensure uniform achievement of the elimination goal throughout the country. Therefore, there will still be a lot of work to be done in the years to come.
Furthermore, there is always scope for improvement of the treatment regimens, to make them more effective and further reduce the duration of treatment. There is continued need for laboratory and operational research. Review of our policy and strategies for leprosy elimination programme will also have to be undertaken regularly.

It is for these reasons that I considered it important to establish this Regional Technical Advisory Group to advise on various aspects of the programme, both technically and managerially. I have instructed our concerned technical unit to be in constant contact with all of the group members, and to establish a functional and vibrant networking, at least among the Group members, the Regional Office and country offices.
It is a great pleasure for me to be at the opening session of this series of meetings dealing with various aspects of Immunization, including communication. This is truly a special event, as it provides an opportunity to reinforce collaboration between WHO and UNICEF, in order to meet our common objectives on immunization.

I am particularly pleased to see many colleagues from different regions and different organizations attending these meetings. I look forward to a fruitful exchange of views and experiences on this occasion.

It is universally accepted that communicable diseases observe no boundaries.

Keeping this in mind, while trying to overcome political barriers between countries, public health leaders must address common challenges on the ground, in order to make health improvement in this part of the world possible.

This event deserves attention, because it is a critical time to ensure successful implementation of the immunization programmes; and reaching the immunization goals. The goals that will importantly contribute to better health of our children.

While the meetings this week will address a broad range of topics, let me focus briefly on only three major immunization issues. These are: polio eradication, surveillance, and injection safety.

Polio is now limited to six endemic countries in the world. Three of them; India, Pakistan, and Afghanistan; are in the regions covered by WHO/SEARO and UNICEF/ROSA.

Immunization Meetings (AEFI Communications Workshop, EPI Managers Meeting and Technical Consultative Group Meeting) at New Delhi, India, 9-13 August 2004
In spite of this situation, we can, however, say with confidence that remarkable progress has been made towards the achievement of polio eradication in our regions. The number of polio cases in these countries so far is the lowest ever. This provides us with the best opportunity yet to eradicate this scourge in the very near future.

These meetings will address the key strategies needed for the final push to ensure reaching the eradication target in the remaining endemic countries within a defined time frame. The virologists who are here will discuss the efficiency and effectiveness of the laboratory network, and provide advice and guidance on containment procedures. And, perhaps most importantly, the discussions will also dwell on vaccine options in the post-eradication era. WHO will be issuing guidelines on this matter in the near future, in order to help ensure our preparedness for post-eradication surveillance.

The meetings this week will provide an opportunity to participants from countries to express their views on how to deal with the transition from OPV, once eradication is achieved. Another key issue is surveillance. The AFP surveillance networks have been critical in guiding the polio eradication efforts in the Regions. While these networks must continue to focus on AFP until the certification stage is completed; the surveillance in Nepal, Bangladesh, Myanmar, and Indonesia has already been expanded to cover other vaccine preventable diseases.

In this connection, I hope that we would also discuss how the valuable human, infrastructure and material resources that have helped us in polio eradication could be channeled to address other communicable diseases, especially in strengthening the routine immunization programme.

As far as injection safety is concerned, a recent national survey in India found that over 65% of all injections given for immunization are unsafe. Unfortunately, this is also commonly the case in other countries in our Regions.

Although all countries in the Regions are introducing autodisposable syringes, these have not yet been fully used in the EPI programme. A major challenge in this connection is how to dispose the syringes which have already been used. The distinguished participants may provide an update on the options for safe and sustainable management of sharps waste; and advice on the operational modalities and procedures on this matter.
Dealing with Adverse Events Following Immunization or AEFI, represents a bridge between the issues of surveillance and immunization safety. Unsafe injections create further potential for AEFI, which can entirely undermine public confidence in immunization.

Most countries have now established surveillance systems for AEFI, which generate information that needs to be rapidly addressed. Steps should be taken to maintain such confidence through effective communication responses. The workshop starting today, will provide practical, hands-on experience in dealing with this important issue of immunization.

Immunization remains a moral imperative and a human right. Our efforts should be guided by the principle of equitably safe injections of high quality vaccine to all those at risk of contracting the diseases. This is a formidable challenge, but one that can be met successfully through tireless joint endeavours among countries, UNICEF, WHO and other partners.

The former First Lady of the USA, Eleanor Roosevelt once said, “The future belongs to those who believe in the beauty of their dreams.” I am sure if she were here today, she would agree that those who dream of reducing the burden of vaccine preventable diseases for the children of our Regions have a special claim on that future. I am confident that we can realize that future through our joint and intensified efforts.
Laboratory Support to HIV Diagnosis and Antiretroviral Therapy

HIV/AIDS is among the greatest health crisis ever faced by humanity. Already, this pandemic has killed 30 million people. Today, more than 40 million people are living with HIV, most of them in 34 developing countries of Asia and Africa. If not treated, 3 million will die every year of HIV/AIDS. Tragically, every sixth death will be of a child less than 15 years of age.

However, most of these deaths are preventable with specific antiretroviral therapy. Unfortunately, only a few are lucky to be on treatment. Of a total of 6 million who need this treatment worldwide, only 400,000 are currently receiving it.

In September 2003, WHO declared that failure to provide antiretroviral therapy to patients in developing countries was a global health emergency. Accordingly, WHO announced a new “3 by 5” initiative i.e. to provide 3 million people in developing countries with treatment by the end of 2005. This is only an interim target, with a longterm goal of universal access to antiretroviral therapy for all those who need it.

In countries that comprise the South-East Asia Region of WHO, 800,000 people who are living with HIV need ART. However, only 50,000 are presently receiving it. The target to be achieved is 400,000 by 2005 – requiring an eightfold scale-up in less than two years.

The primary objective of antiretroviral therapy is to prolong the survival as well as improve the quality of life of the millions of people living with HIV/AIDS. By bringing down the HIV load to a sustained, undetectable level, it is expected that ART will contribute also to HIV prevention.

Regional Workshop on Diagnosis of HIV and Laboratory Support to Antiretroviral Therapy, National AIDS Research Institute, Pune, India, 27-30 July 2004. Delivered by STP, Blood Safety and Clinical Technology, WHO/SEARO.
It is clear that laboratories play a critical role in successful treatment against HIV – by providing reliable support for the detection of anti-HIV antibody for diagnosis as well as for undertaking efficient monitoring of treatment effectiveness among those receiving ART. While monitoring of patients on chemotherapy is essential in all infectious diseases, it is of greater importance in HIV because of the life-threatening nature of the illness, and the potential of the virus to mutate and develop resistance to the drugs.

Laboratory support is essential in all areas of HIV diagnosis and management. The diagnosis of HIV infection cannot be established by any means other than serological tests by a laboratory. Enumeration of CD4 lymphocytes is a prerequisite for the initiation of antiretroviral therapy and monitoring its effectiveness. Both the immunological and microbiological monitoring of antiretroviral therapy depends exclusively on an efficient laboratory service.

The profile of antimicrobial agents to which opportunistic bacterial infections are susceptible is determined by the laboratory. This guides the physician in initiating appropriate treatment. Similarly, adverse drug reactions to ART are better understood through support from clinical chemistry laboratories.

Although laboratory support to AIDS programmes is very important, the desired infrastructure, expertise and networking require strengthening in most countries of our Region. In addition, it is important to institute quality systems in the functioning of laboratories since diagnosis, initiation of treatment and proper management of people on antiretroviral therapy depends upon reliable laboratory results.

Realizing the need to provide relevant information on the utility and infrastructure of laboratories to the national authorities, WHO has developed Regional Guidelines on HIV Diagnosis and Monitoring of Antiretroviral Therapy. This workshop will discuss the guidelines and the participants will get first-hand knowledge of the techniques, equipment and reagents which will be demonstrated during the workshop. We have invited National AIDS Programme Managers as well as national focal points for HIV laboratories. We sincerely hope that they will work, plan and implement antiretroviral therapy programmes together.

This workshop will also provide a platform to share experiences, understand the problems in our Region and formulate solutions to improve access to, and the quality of laboratory support to the AIDS Programme.

WHO will continue to provide all possible technical support to the countries for strengthening laboratory support to national efforts in containing rapidly evolving epidemics of HIV in the Region.
Nineteenth Meeting of National AIDS Programme Managers

HIV/AIDS continues to devastate families, communities and societies in many parts of the world, affecting primarily populations which are poor, vulnerable and socially marginalized. At the end of 2003, 40 million people were estimated to be living with HIV/AIDS; 25 million people have already died. Of the global total, two thirds are living in Sub-Saharan Africa. The South-East Asia Region ranks second with an estimated 6 million infected people.

Despite advances in drug development and reductions in prices of HIV medicines, only 400 000 patients in developing countries have access to antiretroviral therapy. Of these, 300 000 are in Brazil alone. Only 2% of patients in Africa and 4% in the South-East Asia Region are being treated.

In September 2003, the WHO Director-General, Dr LEE Jong-wook and Dr Peter Piot of 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 and requested technical cooperation in designing and implementing scaling-up programmes. However, the overall progress in “3 by 5” has been slow and needs a major thrust at national and international levels.

Many countries of 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.
In order to maintain the momentum, substantial strengthening of national health capacity is required. Scaling-up antiretroviral therapy is a major managerial and logistic effort, similar to DOTS expansion for TB control. Political commitment towards implementation of national strategic plans is essential. The streamlined funding mechanisms developed by the Global Fund and the World Bank are enabling many countries to access funding and expand AIDS treatment and prevention programmes faster than ever before.

Partnership is necessary to make antiretroviral therapy scale-up a success – both in increasing access to treatment and in ensuring the appropriate and rational use of drugs. Besides WHO, UNAIDS, other donors and foundations, partnerships should include people with HIV/AIDS, NGOs, community-based organizations, private business and academic institutions. Each has a unique role to play – this partnership should be harnessed and built on a long-term basis.

One of the concerns for scaling up treatment is the availability and affordability of drugs. While thanks to the generic competition from India and other countries, the prices have come down significantly, they are still beyond the reach of most patients. It is hoped that with rapid scale-up of antiretrovirals, because of the volume and the economy of scaling, prices will be further reduced. A major concern, however, is that, in January 2005, the TRIPS agreement may come into force in some countries including India.

The countries, therefore, must be prepared for this. One option would be for the generic pharmaceutical industry in the country to invoke the public health considerations of the Doha Declaration. The declaration clearly states that the TRIPS Agreement should not prevent members from taking measures to protect public health. Thus, the Doha Declaration will form a crucial element in expanding access to treatment.

Moreover, the scale-up of antiretroviral therapy should not be misconstrued as only focusing on treatment at the expense of prevention. Prevention still remains the bedrock of HIV/AIDS control programmes. The basic prevention interventions such as condom promotion, behaviour change education to reduce the number of sex partners, treatment of sexually-transmitted infections, harm reduction among injecting drug users, and finally, creating an enabling environment must remain a top priority, along with the provision of treatment.

This meeting of national programme managers is an excellent forum to exchange experiences on successes and lessons learnt and to give renewed
direction to our collective efforts towards HIV/AIDS prevention and care at the regional and national levels. This year, the meeting is held in conjunction with the Fifteenth International AIDS Conference which highlights the “3 by 5” initiative. This will give an opportunity to all the programme managers attending this meeting to also participate in the International Conference in the following week.

We have a lot of hard work ahead, and I am confident that you will strive hard to achieve our common goals. I assure you of continued WHO support in building national capacities and mobilizing resources to sustain and enhance every effort to improve the health of the people of our Region.
As you are all aware, the International Health Regulations (IHR) adopted in 1969 and currently in force, provide the only legal framework for security against the international spread of diseases while avoiding unnecessary interference with international traffic. This legal framework is restricted to only three diseases; namely cholera, plague and yellow fever.

Since the adoption of IHR in 1969, however, there have been several developments worldwide, including changes in disease patterns, and epidemiological changes.

While the globalization of infectious diseases is not a new phenomenon, increased population movements, growth in international trade in food and biological products; social and environmental changes linked with urbanization, deforestation and alterations in climate, have reaffirmed that infectious disease events in one country are potentially a concern for the entire world. This was clearly demonstrated during the recent outbreaks of SARS and Avian influenza.

Therefore, the need to revise the existing International Health Regulations took on an urgent dimension. This would provide a broader framework for protecting populations against the spread of infectious diseases across national boundaries and to respond adequately to public health emergencies of international concern.

Recognizing this need, the World Health Assembly adopted resolution WHA48.13 on new, emerging and re-emerging infectious diseases and WHA48.7 on the revision and updating of the International Health Regulations in 1995. The Health Assembly, among other things, requested the WHO

International Health Regulations

Second Regional Consultation on the Proposed Revised International Health Regulations, WHO-SEARO, New Delhi, 29 June - 1 July 2004. Delivered by Deputy Regional Director, WHO/SEARO.
Director-General to take measures to review the International Health Regulations.

Subsequently, between 1995 and 1997, a number of global consultations and working group meetings were held to secure agreement on the direction of the revision process.

To facilitate the revision process, the International Health Regulations Revision Project was established at WHO/HQ in Geneva.

Recognizing the need for participation of Member States in the Revision Process, the Health Assembly adopted Resolution WHA56.28 in 2003 urging Member States to give high priority to the work on the revision of the International Health Regulations and to provide resources and extend the necessary cooperation to facilitate the process.

Since then, a revised draft of the International Health Regulations has been developed and shared with all WHO Member States.

In February 2004, the WHO Director-General requested all Regional Offices to inform Member States on the progress made and requested Member States to critically review the revised IHR document.

Accordingly, the First Regional Consultation on the Revision of the International Health Regulations with the National IHR Focal Points was held in the WHO Regional Office from 13 to 14 April 2004. This meeting reviewed the draft revised IHR document and identified key issues, concepts and definitions that need further clarifications, which were forwarded to the IHR Revision Project Team in WHO/HQ. Moreover, it recommended conducting national level consultations on the proposed IHR document in each Member Country, with the involvement of other concerned sectors of the government.

Based on the recommendations of the First Regional Consultation Meeting, all Member Countries in this Region have conducted national consultations on the proposed IHR. I believe these were conducted with the full and active participation of all national stakeholders.

Similar consultations on the proposed revision of the IHR were also held in all other WHO Regions. SEARO had the opportunity to participate at the regional consultation in WPRO, and learn from their experience.

Likewise, WPRO had participated in our own First Regional Consultation on the proposed revision of IHR. Such bi-regional cooperation is important
due to the proximity of the Member States of both the regions, geographically, culturally, and sociopolitically. We have also been working closely with our colleagues in WHO headquarters in this regard.

These regional and national consultation meetings, while appreciating the importance of the revised regulations, have identified a number of important issues, concepts and terminologies that need further clarification and discussions. This is necessary to ensure that the Regulations are not only revised on schedule with as much consensus as possible, but are also implemented effectively.

Some of the significant issues identified at the various regional and national consultations on the proposed IHR document include:

The need for clearly defining the strategic level, authority, and allocation of functions of national IHR Focal Points and the support they need;

The scope of the International Health Regulations, with regard to public health emergencies of international concern, as spelt out in the revised IHR also raised considerable debate. The issue was whether non-biological hazards (chemical and radiological) should be included or whether the IHR should be limited to infectious diseases and diseases of unknown aetiology. This may need to be further discussed;

Refining the decision instrument to determine public health emergencies of international concern (PHEIC), with suggestions to include lists of disease conditions;

Clarifying some of the definitions used in the legal document such as “excessive measures”; “affected areas”, and “public health measures”; and

Outlining clear mechanisms for notification of public health emergencies of international concern by concerned national authorities to the World Health Organization.

I am sure many more issues would have been raised at various national workshops. These may require further clarification / deliberation, in terms of reservations or concerns you may have from your own national perspectives.

Members of the secretariat as well as the resource persons from the Regional Office, WPRO and WHO Headquarters will be happy to provide you with the required technical support in this regard.

While it is clear that the International Health Regulations need to be revised, we need also to review existing core capacities and facilities vis-à-vis those required to implement the revised IHR.
Keeping this in mind, we have set aside a session to review existing core capacities in our Member States and to identify areas that require strengthening and support. In this session, we will critically assess and discuss existing strengths, gaps and needs with regard to core capacities for disease surveillance, early warning on outbreaks, epidemic preparedness, notification and response at national, sub-national, district and community levels. The discussions should also identify the required capacities to undertake public health measures at ports of entry and exit as per the revised Regulations.

I look forward to your deliberations in terms of reviewing issues and concerns on the proposed IHR document, such as definition of a specific term in the articles, possible legal implications, perceived sovereignty issues or scope and the role of various agencies. In addition, your suggestions to strengthen the core capacities required for effective implementation of the revised IHR, would be most appreciated.
Database for Selected Diseases

Efficient data management is the key for effective surveillance and response. It is an essential component in the mechanism of identifying, anticipating and forecasting outbreaks and epidemics. The process of developing and strengthening disease surveillance and efficient data management skills has been a continuous effort of WHO for more than three decades. The World Health Assembly has, over the years, urged Member States successively to utilize more efficiently their existing facilities for effective epidemiological surveillance and called for further improvement of national, regional and international communicable disease surveillance activities.

Following the Global Meeting on Communicable Diseases Surveillance, including epidemic-prone and/or vaccine-preventable diseases, held at Cairo, Egypt in January 2001, which recommended integrated multi-disease surveillance as a means of achieving efficiency and effectiveness in surveillance, a High-Level Task Force was established by SEARO. It identified “Multi-disease surveillance and response” as one of the 14 priority areas for support under the intercountry programmes for the 2002-2003 biennium.

It recommended immediate implementation of the plan of work to support and assist Member Countries to develop multi-disease surveillance and response for priority communicable and epidemic-prone diseases. In pursuance of the same, the Regional Office developed a Regional Strategic Plan for Integrated Disease Surveillance.

The Regional Strategic Plan, while describing the goal, objectives, essential elements, guiding principles, strategic framework, priority diseases and health conditions, time-frame, implementation and management framework,
underlined the importance of establishing improved communications and data management skills.

You are aware that skills in handling computer and data management is essential to strengthen the surveillance mechanism. The availability of electronic tools has totally changed the outlook of modern surveillance. Therefore, electronic reporting of surveillance data is becoming more and more common. If properly designed, it could be linked easily with the Geographical Information System (GIS) which will further improve the understanding of disease dynamics and response mechanisms. It also provides an opportunity for multi-level and multisectoral integrated surveillance covering the entire range of diseases of public health importance.

In pursuance of the above, a regional database has been developed for integrated disease surveillance for selected diseases as identified in the Regional Strategic Plan. The conceptual framework of the same was presented earlier at an intercountry consultation, held in Myanmar in August 2002. This regional database envisages obtaining information on identified priority diseases from 11 Member Countries in the electronic format which can also be linked with geographic mapping.

The training course has been designed to facilitate bringing uniformity in surveillance mechanisms. This will also enable national data managers of the countries to understand one another’s strengths and weaknesses and provide opportunities in establishing national and regional databases with regard to priority communicable diseases. This is primarily a hands-on training and is intended to strengthen core competencies in data collection, handling and management at the national level. This will also facilitate data flow from the Member Countries in the Region.

I am sure you will agree that once this regional database becomes operational and Member Countries start sharing the information with the Regional Office in time and with an agreed periodicity, the core capacity in disease surveillance and response in the countries of the Region will be significantly enhanced.
Blood Transfusion Services

Blood is universally recognized as the most precious element that sustains life. Blood is neither a commercial product nor can it be synthesized artificially. With the increased access of people to healthcare services, the demand for blood and blood products is likely to increase. The responsibility for ensuring its continuous supply therefore rests with the healthcare providers who need to galvanize entire communities for regular and non-remunerated blood donations.

The blood transfusion services in Member Countries of our Region are at varying stages of development. Against an estimated annual requirement of 15 million units of blood, only around eight million units are collected. Voluntary non-remunerated donations vary from 40-93% in different countries. At the same time, in spite of overwhelming scientific evidence which shows that blood collected from professional donors is unsafe, they continue to be a major source of donated blood.

The safety of blood has assumed greater importance and relevance in developing countries where hepatitis B and hepatitis C are diseases of great public health importance, and where the HIV/AIDS pandemic is growing at an alarming pace. Today, the countries of the South-East Asia Region are estimated to have six million carriers of HIV, 85 million of hepatitis B and 25 million of hepatitis C.

As you know, blood transfusion is an efficient mode of transmission of HIV and viruses of hepatitis B and hepatitis C. Globally, 5-10% of HIV transmission is estimated to be through transfusion of blood. Only meticulous screening of blood with reliable kits and reagents can prevent such transmissions. Nearly all donated blood in the South-East Asia Region is now reported to be screened for HIV and hepatitis B. Many countries have already made screening of donated blood voluntary.
blood for hepatitis C mandatory. However, the quality of screening of blood requires improvement.

Blood comprises many components. At the same time, various clinical conditions warrant therapy with specific components. Thus, one unit of blood can be utilized for multiple patients as is the practice in western countries. In contrast, more than three fourths of collected blood in countries of our Region is utilized as whole blood. This leads to unnecessary wastage of a life-saving commodity.

Realizing the importance of blood safety, a Global Strategy for Safe Blood has been developed by WHO to improve the access to, and ensure the quality as well as safety of blood. The strategy focuses on a nationally coordinated blood transfusion service, supported with government commitment and a national policy. In our Region, only 6 of the 11 Member Countries have formulated a national blood policy. In the remaining countries, the policy is in varying phases of implementation.

Such a policy articulates the need for a very organized blood transfusion service. Experience shows that a multiplicity of hospital blood banks is inefficient, resulting in a financial burden that is 10 to 30 times higher than in a coordinated model. It also hampers economies of scale, as well as the introduction of quality systems and new technologies. The lack of uniformity in standards and operations compromises the safety and adequacy of national blood supplies.

As a part of the major Global Initiative on Quality Management, we need to integrate the quality systems in blood banks. Besides training of quality managers, a Regional External Quality Assessment Scheme has been initiated to promote quality in blood group serology and screening for infectious markers. Selected blood banks from nine Member Countries of the Region are participating in this scheme.

WHO will continue to provide all possible technical support to Member Countries for effective implementation of the Global Strategy on Blood Safety. In this consultation you will be addressing specific issues including planning and implementation of national policies; organization and strengthening of nationally-coordinated blood transfusion services, and devising an appropriate regulatory framework with a sustainable infrastructure, that has government commitment and support.

This provides a platform to share experiences, understand the problems, formulate solutions and subsequently utilize the collective wisdom in improving the access to, as well as the quality and safety of blood for our citizens.
Comprehensive Harm Reduction among Injecting Drug Users

Around 9.5 million people are living with HIV/AIDS in the South-East Asia and Western Pacific Regions of WHO. Injecting drug use (IDU) has been identified as a major mode of transmission, second only to sexual transmission of HIV/AIDS. Serious HIV epidemics among injecting drug users have been reported in China, India, Indonesia, Malaysia, Myanmar, Nepal, Thailand and Viet Nam. HIV prevalence rates of more than 50% among injecting drug users have been reported in some of these countries. Obviously, these have serious implications for the spread of the HIV/AIDS epidemic. It has also been demonstrated that the HIV epidemic can spread from injecting drug users via bridging populations to the general population.

We also know that there are efficient, cost-effective, pragmatic interventions for the prevention of HIV transmission among injecting drug users. However, there are formidable challenges and barriers which we must overcome in order to scale up services and thus have an impact on the epidemic.

The United Nations agencies have called for a comprehensive HIV/AIDS prevention programme, including a harm reduction approach targeting injecting drug users, in response to the spread of HIV through sharing injecting equipment. A strategy based on harm reduction means a comprehensive package of interventions that collectively reduce the negative consequences of injecting drug use for both the individual and the community. These interventions in no way undermine other efforts addressing drug use, such as programmes to decrease the demand for, and supply of, drugs.

Biregional Partners Meeting on Harm Reduction Among Injecting Drug Users, Melbourne, Australia, 19-20 April 2004. Delivered by Regional Adviser, HIV/STI, WHO/WPRO.
Scaling up HIV/AIDS/STI prevention efforts are part of WHO’s comprehensive strategic response to prevent and contain the spread of the HIV epidemic among and from vulnerable populations at an early stage. WHO is committed to assist governments, organizations and affected communities to rapidly scale up HIV/AIDS/STI prevention efforts, with particular emphasis on injecting drug users. WHO has taken the initiative to develop and implement tools for effectively scaling up harm reduction activities and to facilitate partnerships. We must now identify and mobilize the necessary resources for this task.

In addition to scaling up HIV/AIDS prevention activities for injecting drug users, WHO is committed to the important task of providing antiretroviral treatment to those already infected with HIV. The “3 by 5” Initiative of WHO and UNAIDS aims to provide antiretroviral therapy to at least half of the HIV/AIDS patients in need, in developing countries, by the end of 2005.

With a high percentage of new HIV cases in the Asia-Pacific region being among injecting drug users, many people who seek access to treatment through “3 by 5” will be drug users. We must ensure that, throughout the process, drug users have equal access to quality treatment and are not discriminated against, and that treatment regimes and delivery modalities are designed to ensure accessibility and suitability to this target population.

The involvement of the vulnerable and affected communities in all stages of planning and implementation of both prevention and treatment activities is a key to the success of our efforts. We can learn many lessons from already established drug user groups, associations and networks and they have a vital role in planning and implementing harm reduction interventions at every level. We should identify ways to support the establishment and development of such groups elsewhere.

In the fight against the epidemic of HIV/AIDS linked to the use of injecting drugs, WHO works alongside other partners within the UN system, the donor community, governments, nongovernmental organizations and affected communities. In this spirit of collaboration, a joint session with the United Nations Regional Task Force will be a part of this meeting’s agenda. This joint session will look at the important issue of harm reduction in closed settings like prisons, drug treatment and rehabilitation facilities and detention centres.

At the Second Biregional Partners Meeting on Harm Reduction among Injecting Drug Users, in August 2003, in Yangon, participants continued
collaboration on the development of a biregional strategic framework for a harm reduction approach to HIV prevention and care among injecting drug users in Asia. We are now here to garner consensus for this strategic document and subsequent action at country and regional levels.

You all have a very important task ahead of you. We are confident that you will not only make valuable contributions at the meeting, but also strengthen the collaboration, which is so necessary to success, and extend this effort to include more partners in the process. It is clear that we need a broad partnership across different sectors to effectively scale up interventions to reduce harm among injecting drug users.

This meeting provides an opportunity to exchange experiences on international good practices of relevance to both Regions. The focus for this 2004 meeting will be to develop strategies that will contribute to improved national and regional responses to the drug-related elements of the HIV epidemic, in particular, addressing involvement of affected communities, linking prevention programmes with care and treatment, and addressing the important issue of service provision in closed settings.
**Monitoring and Evaluation of the Malaria Control Programme**

Malaria is a serious public health problem in countries of the South-East Asia Region. During the last five years, the number of reported cases of malaria have varied between 2 to 3 million each year with about 4 000 to 5 000 deaths. However, it is estimated that about 21 million cases and 27 000 to 30 000 deaths occur each year. Malaria affects all age groups. India accounts for more than 70% of the reported cases while Myanmar reports more than 50% malaria deaths. Based on the DALYs lost, it is estimated that malaria is responsible for an annual loss of about three billion US dollars.

In the South-East Asia Region, the proportion of falciparum malaria has increased from about 12% to 45% during the last two decades. This has made our Region an epicentre for multidrug resistance, since nearly 30% of the population is at risk of drug resistance. While monitoring of drug resistance is important, controlling the spread of multidrug resistance will require policy review and revision.

The Roll Back Malaria (RBM) initiative was launched by WHO in 1998 with its focus in Africa. Seven countries from our Region have endorsed the RBM, while the rest continue to implement the Global Malaria Control strategy. Key indicators for monitoring and evaluation, recommended by RBM, have been adapted by the countries to suit their respective systems.

Following an external evaluation of RBM which, among others pinpointed the weaknesses in monitoring and evaluation, WHO headquarters have established the Monitoring and Evaluation Reference Group (MERG) to strengthen these components.
There are three strategic issues that I would like to point out. First, WHO fully realizes that the Health Management Information System in most Member Countries needs considerable improvement in terms of the quantum of data collected and their reliability, timeliness, integration and use. Most of the data are collected and reported by government health facilities. Only a few are collected by piggybacking the existing household surveys, such as the Demographic and Health Survey, Socioeconomic Survey and Multiple Indicator Cluster Survey, to supplement the health facilities-based data collection. This is further aggravated by frequent changes in staff, effected to accommodate the needs of various programmes, without considering the capacity of the system.

Secondly, to the extent possible, we need to differentiate between the indicators used for monitoring and those for evaluation. Monitoring is usually linked with the need to take immediate corrective actions whenever deviation is detected in a programme, whereas in evaluation, corrective actions need to be instituted through re-planning.

Thirdly, different levels of administration need different indicators for both monitoring and evaluation. I must admit that the issues I have just mentioned are not easy to resolve. However, we must move towards the right direction in resolving them.

WHO’s global commitment to malaria control is articulated in the UN Millennium Development Goals (MDGs). I trust that this meeting will also deliberate on how to collect the needed information for measuring the progress of MDGs.

The global fund for HIV/AIDS, TB and Malaria (GFATM), is investing additional resources to scale up the implementation of interventions for malaria control. Seven countries in our Region have been awarded funds by GFATM. The disbursement of funds by the GFATM will be based on the performance of the programme in respective countries, hence the importance of using simple and affordable tools for monitoring and evaluation.

Monitoring and evaluation cannot be discussed in isolation because they are part of a repetitive cycle of planning and implementation of activities. They must be viewed as a continuum of activities necessitating strong support from the health system. I would request participants to follow up the action plan from this meeting with their respective national officials responsible for health systems development to enable urgent implementation.

The meeting will also provide an opportunity for countries to contribute to the proposed Global Malaria Report 2004, being prepared by WHO/HQ, based on the currently available tools for monitoring and evaluation.
Noncommunicable Diseases and Mental Health
Prevention and Control of Deafness

It is heartening to note that the recommendation of the WHO intercountry meeting on “Development of a Framework of Proposed Regional Collaboration for Prevention of Deafness and Hearing Impairment” held in this same city in November 2003, to establish a regional forum for prevention of deafness and hearing impairment, has taken a concrete shape in the form of this meeting.

WHO estimated in 2000 that globally, over 250 million people have moderate or worse hearing impairment. The total global average years lived with disability (YLD) for hearing loss or impairment is estimated to be 24.9 million or 4.7% of the total YLD due to all causes. It is the second leading cause of YLD after depression and also a major non-fatal disease burden.

Hearing impairment is also ranked seventh, among the disease burden for adults (15 years and above), contributing to a total of 26 million years of healthy life lost. Based on the available prevalence survey data, the WHO Regional Office for South-East Asia estimated in 2004 that at least 670 million people might suffer from moderate to severe hearing impairment. The majority of hearing impaired people are children or adults of productive age. Major causes of hearing impairment are infections, noise and ototoxic effect, which are preventable. There is also a social stigma attached to hearing impairment.

WHO and its Member States, together with international and national NGOs, had recognized the importance of the burden of hearing impairment and established preventive programmes since the early 1980s. Community-based primary ear and hearing care programmes were developed as part of national primary healthcare development programmes in many countries of the Region.

Sound Hearing 2030, First General Meeting, Bangkok, Thailand, 3-5 October 2005. Delivered by Director, Noncommunicable Diseases and Mental Health.
In order to promote sound hearing, countries of the Region adopted four main strategies: (a) creating awareness and advocacy on the need to promote sound hearing as an investment; (b) developing national integrated/multisectoral programme for promoting sound hearing with the involvement of all related sectors – health, education, social welfare, labour, industries, etc.; (c) capacity building for programme planning, resource mobilization and programme implementation, and (d) networking and partnership.

I am confident that the First General Body Meeting of the forum attended by experts and senior representatives from Member States will be very useful in sharing each others’ experiences in the development and functioning of regional collaboration through this forum in further strengthening prevention and control of deafness and hearing impairment in countries of the Region. I have noted from the programme that this meeting has to agree on the terms of reference, rules and procedures and a plan of action of the forum that would help and encourage countries to develop a national forum or similar body for promoting sound hearing programmes in their own countries. I would like to reiterate our commitment and full support to the Countries in developing and implementing appropriate national sound hearing programmes.
Health Promotion

The principles of “health promotion”, set by the WHO working group in 1984 remain valid even today. Based on these principles, in 1986, the first of a series of global health promotion conferences was organized by WHO, in Ottawa, Canada, to provide impetus and profile to the newly-emerging concepts of health promotion. As you are all aware, health promotion was defined as “the process of people to increase control over and improve their own health”. The five key actions of the Ottawa Charter have been widely accepted.

The four conferences that followed have further strengthened the Ottawa Charter. As a result, health promotion has become an agenda item for a much wider group of sectors than before. The emphasis now is not so much on public health policy as on “healthy public policy”, ensuring that all policies, such as fiscal, environmental, agricultural and industrial, promote health rather than weaken it.

In addition to recognizing the importance of intersectoral action for health promotion, the active participation of the public is also essential. Merely instructing people to adopt and follow healthy practices is ineffective when complex health behaviours are involved such as eating, smoking, exercise, drinking alcohol, and sexual behaviour. There needs to be a shift in the approach of experts from telling people “what they should do” to equipping them with the knowledge and skills to make their own decisions.

The disease prevention strategy in the past focused on the protection of people from proximal health determinants, for example, avoiding exposure to infections and vectors, chemoprophylaxis and vaccination. However, over the last two decades, the strategy has expanded to cover proximal as well as distal health determinants, both positive and negative. The positive determinants are...
the promoting factors for health, for example, physical activity and healthy diet, while the negative determinants are the health risks, for example, smoking, and irregular antenatal care.

The World Health Report 2002’s main theme, “Reducing risks, promoting healthy life” is the outcome of one of the largest research projects ever undertaken by the World Health Organization. The Report shows that a relatively small number of risks cause a huge number of premature deaths and account for a very large share of the global burden of disease. Reducing these risks would result in significant gains in the form of healthy life expectancy for people in all countries. These gains could be achieved through the greater use of existing cost-effective interventions and population-wide risk-reduction strategies.

During the past 20 years, following the Ottawa Conference, there has been considerable progress in health promotion implementation, especially, in developed countries. Most developing countries, however, have not demonstrated observable progress in this regard. The possible reasons for the slow progress might be the lack of national policy on health promotion; and the inadequate monitoring and evaluation of evidence-based effectiveness of health promotion measures.

One important indicator that demonstrates the success of public health is the increase in people’s life expectancy. The life expectancy at birth in ten out of 11 countries in the South-East Asia Region is more than 60 years. However, the point of concern is that the years-gain of such people are not always “healthy years”. Today, there is more number of older persons suffering from chronic diseases or disabilities. It is therefore, important that the ultimate goal of long lives should be to increase “healthy life expectancy”, and not merely to increase life expectancy. To achieve this requires a healthy life-course approach, which in other words means promoting health from conception to death.

Realizing the implications of the above situation in the Region, the World Health Organization will strengthen efforts to support Member States in the following areas:

(1) **Production and dissemination of evidence for effective health promotion**: Evidence-based practice is essential. Expanding the evidencebase is therefore high on the agenda of the international health promotion community, and it is becoming increasingly apparent that evidence is needed by practitioners for effective health promotion interventions, and by policymakers for policy decisions.
(2) **Formulation of healthy public policies, and sustainable health promotion efforts:**

- The challenges and opportunity of globalization require the development of sound transnational health promotion strategies, in particular healthy public policies at global and regional levels, to complement action at local and national levels.
- Appropriate mechanisms and approaches would be established to address the imbalance between governing global private goods, such as free trade, and governing global public goods, such as health.
- Health promotion shall be incorporated into the health system, while the integration of health promotion into other health initiatives such as primary healthcare, will be considered.
- Efforts would be made to achieve sustainable financing for health promotion, as demonstrated in many countries by effective initiatives, such as establishing a Health Promotion Foundation, and applying taxation measures to mobilize funds for health promotion, etc.
- WHO and the International Social Security Association have recently initiated efforts to incorporate health promotion into the social insurance system. Advocacy and political commitment, leadership, partnership at all levels and mobilization are among the important issues to be strengthened through this joint endeavour.

(3) **Increasing the institutional capacity to promote health:** The capacity to be built will cover: both the individual practitioner’s and the individual institution’s ability to promote and extend health; the funding level; leadership; institutional mechanisms that facilitate its employees to promote health and adopt positive attitudes towards change, and the competency level of its staff members. Such capacity will also cover the different health promotion infrastructure components.

I consider this workshop a very important and timely one. Experts and national focal persons will have a great opportunity to review the progress and constraints, as well as to plan for further improving and strengthening health
promotion in Member States of our Region. This is an important time of the year for all Member States to develop their respective work plans for the 2006 – 2007 biennium. This is also the best opportunity for concerned staff from WHO/HQ, the Regional Office and Country Offices, as well as national focal persons to work together to develop joint work plans that will ensure consistency and achievement of regional and Organization-wide expected results.

Moreover, I am pleased to inform you that the next global conference on health promotion will again be held in our Region, in August 2005, in Bangkok, Thailand, following the one held in Jakarta, Indonesia, in 1997. Your participation at this workshop will greatly contribute to the preparation for the global conference.
Risk Factor Surveillance

Noncommunicable diseases (NCDs) account for more than half of all deaths in the South-East Asia Region. Further increases in disease burden and age-specific incidence and mortality rates are expected due to the demographic and socio-economic transition and subsequent profound lifestyle changes occurring in the Region. These changes are enhanced by globalization and result in unfavorable shifts in the distribution and in the mean population level of major risk factors for NCDs. These include high blood pressure, tobacco use, high blood cholesterol level, low fruit and vegetable intake, physical inactivity, overweight, alcohol consumption as well as indoor and outdoor air pollution.

Recognizing the need for improving availability, validity and accessibility of core information on major chronic diseases, a Regional Strategy for NCD Surveillance was adopted in 2003. Collection of standardized data on NCD risk factors is an important target of this strategy.

As a follow-up, the regional capacity for conducting epidemiological surveillance of NCDs with particular focus on sustainable collection of standardized information on major risk factors has been strengthened. Member Countries have been supported in adapting and implementing NCD surveillance approaches promoted by WHO.

Standard surveys adopting WHO STEPS approach have been carried out recently in eight countries of the Region. In addition to providing valid information for advocacy and programme planning, the surveys are also being used as an evaluation tool to assess the impact of community-based intervention projects implemented in the Region.

Facilitating mechanisms were established at regional and global levels to assist Member Countries in implementing STEPS-related activities. These included production of tools and guidelines, conducting training, establishing of a regional pool of equipment, and establishing the Regional Statistical Support Group (RSSG). RSSG is an advisory body comprising experts in the area of statistics from the Region providing advice on statistical issues related to NCD surveillance activities.

During this workshop, participants will identify and address statistical issues in the context of planning for future national NCD surveillance activities. They will also identify and address methodological constraints in implementing NCD risk factor surveys in the context of the Region. In addition, a plan of action for RSSG will be developed.

I am confident that the collective knowledge, experience and commitment of experts attending this important workshop will ensure that these important objectives are achieved.
Noncommunicable diseases including cardiovascular diseases, cancers, chronic lung diseases and diabetes mellitus are assuming alarming proportions and becoming the leading causes of mortality, morbidity and disability in the WHO South-East Asia Region. They accounted for 51% of deaths and 44% of the disease burden in 2002. There is evidence that disease rates from these conditions are increasing in the Region.

The World Health Report 2002 reiterated evidence on the preventability of NCDs by risk factor reduction and through health promotion. The report revealed that five of the top ten global risk factors to health are obesity, high blood pressure, high cholesterol, alcohol consumption and tobacco use – all major risk factors for NCDs.

At the same time, results of community-based NCD prevention projects and national NCD control programmes clearly demonstrate that even modest risk factor reduction through adoption of healthy lifestyles bring about a huge public health benefit. Despite such evidence, effective public health action has not been undertaken so far to control the epidemic of NCDs. It is an appropriate time, therefore, to strengthen regional efforts to address this important public health priority.

Recognizing the global challenges posed by NCDs and the opportunities for their effective prevention, a Global Strategy for the Prevention and Control of NCDs was developed by WHO in 2000. In continuation of such efforts and to stimulate global response and provide a framework for action, the Global Strategy on Diet, Physical Activity and Health was adopted by the World Health Assembly in 2004.
Surveillance of NCDs and their risk factors is an essential element in planning and evaluating health programmes. In order to strengthen capacity for NCD surveillance in the Region, a regional strategy was adopted in 2003. Among other initiatives, it envisages establishing sustainable data-bases for NCDs and their risk factors at the regional and country levels.

Accordingly, a Regional NCD risk factor InfoBase was developed in 2004. It makes existing information easily accessible at one place and promotes utilization of available data for advocacy, programme development and research.

The current efforts of the NCD intercountry programme in the Region aims at fulfilling the need to provide an appropriate data management tool for sharing epidemiological evidence on major NCDs and their risk factors at country level. In this context, the establishment of NCD InfoBase is being supported in nine SEAR countries. National NCD InfoBase focal points and teams have been identified recently in participating countries.

I am pleased to welcome representatives of these national InfoBase teams and colleagues from all levels of WHO at this important intercountry workshop. As you are aware, the workshop is aimed at developing a consensus on the structure and management of NCD InfoBases and developing a plan of action for deploying them at country level. The excellent support extended by the Ministry of Public Health, Thailand, in organizing this meeting is greatly appreciated.
We are all aware of the toll exacted by the tobacco epidemic. Every year 4.9 million people die globally due to tobacco use. In the South-East Asia Region, tobacco kills over 1.1 million people annually. This has widespread social and economic implications for the Region. The WHO South-East Asia Regional Office has risen to these challenges and has been making concerted efforts to tackle the multisectoral dimensions of the tobacco epidemic in collaboration with Member States.

This workshop is taking place at a crucial juncture. The signing of the WHO Framework Convention on Tobacco Control (FCTC) was closed on 29 June 2004. Until that date, 168 countries had signed FCTC and 23 had ratified it. Ratification by another 17 countries will make the Convention enter into force.

The achievement of the SEA Region has been outstanding in terms of the number of countries that have signed and ratified FCTC. Ten of the 11 Member countries have signed and five have ratified it. Now, the non-signing countries can become a party to the Convention only by acceptance or accession to the treaty. Let us make sincere efforts to encourage the signing countries to ratify the Convention and to assist the only non-signing country to become a party to the Convention through acceptance/accession.

Meanwhile, the First Open-ended Session of the Inter-Governmental Working Group (IGWG) on FCTC was held in Geneva from 21 to 25 June 2004 to discuss the details of the issues that the Conference of the Parties (COP) to the Convention could consider. There would be another session of this group to finalize their recommendations for the First Session of COP. This has ushered

in the possibility of early entry into force of FCTC and set the tone for implementation of the Convention.

Another significant development is the change of workplan from the next biennium. For the 2006-2007 biennium, there will be no intercountry programmes under the Regular Budget. Countries will contribute to the newly-introduced planning concept of Regional Expected Results (RER). These RERs will be formulated and finalized through a structured consultative process between the Regional Office and the country offices.

The Regional Office has already drafted the RERs and has shared them with the country offices requesting their inputs, comments and agreement. This new system is expected to enhance performance by improving management, monitoring and evaluation of programme implementation. It should also improve coordination between the Regional Office and the country offices.

A number of tobacco-related studies were undertaken in the past few years in order to formulate policies and strategies to tackle the tobacco epidemic in the Region. These included studies on multisectoral mechanisms for developing comprehensive tobacco control; economics of tobacco control; health costs of tobacco use; tobacco control and poverty; women and tobacco; oral tobacco use; tobacco product regulation; community-based tobacco cessation, and other related topics.

The findings of these studies should be used for designing tobacco control interventions for the next biennium. Given the economic implications of tobacco control, activities in the area of economics of tobacco control should be included in the workplan for the next biennium.

Surveillance is an important component of FCTC. Successful implementation of FCTC would significantly depend on an effective surveillance system. Therefore, it would constitute an important element of the workplan for the next biennium.

The Regional Office has already operationalized the Regional Online Database System based on a Standard Regional Survey Template as part of the Global Information System for Tobacco Control.

Therefore, the two main objectives of this workshop would be to assess the progress of implementation of the ongoing workplan and to draft a workplan for the next biennium based on extensive discussions at the workshop.
The workshop will also provide an opportunity to identify difficult and problem areas and to recommend suitable measures for effective implementation of the current workplan. Likewise, with the efforts of all concerned, a suitable workplan could be drafted for the next biennium that could contribute to achieving the agreed RERs.

The goal that we have set for ourselves for effective control of tobacco is not easy to realize. The issue of tobacco control has to be dealt with keeping in mind the political, economic, environmental and social perspectives.

On our part, we assure you of WHO’s fullest support in your endeavours. Every effort would be made to assist Member States to undertake comprehensive measures for effective tobacco control in the context of the provisions of FCTC.

With your active involvement and participation, I am confident that this workshop will bear the desired fruits. I thank the Royal Thai Government for hosting this important workshop in this beautiful city of Bangkok. I am confident that the outcome of the workshop will have a significant impact on tobacco control in Thailand, including the ratification of FCTC as soon as possible.
Injury Prevention and Control

While countries of the South-East Asia Region have made great strides in health development, communicable diseases continue to take a heavy toll, and injuries have emerged as a major public health problem. An estimated 1.5 million deaths are reported as a result of injuries in the South-East Asia Region. While road traffic injuries account for 6.2 million severe injuries, millions more are treated for moderate and minor injuries.

The current epidemic of injuries, particularly road traffic injuries, is expected to increase by 144% in the Region, due to rapid motorization, increased mobility and scant attention to road safety, by 2020. On the other hand, high-income countries are expected to register a decline by 27% in such injuries.

As you may be aware, this year’s World Health Day theme, “Road Safety is No Accident”, highlighted the issue of road traffic injuries.

Similarly, the consequences of violence on the health of the people is also being recognized as an important public health concern. An estimated 131,000 people died in India and other countries in Asia as a result of interpersonal violence in 2000. The number of deaths is expected to increase by 35% by 2020.

For every death, 50 to 100 victims of domestic violence, sexual assaults and child abuse visit health institutions. Unfortunately, there are quantitative and qualitative deficiencies in human resources for injury and violence prevention in our Member countries. To meet this challenge, the Regional Office has supported the training of professionals in the area of injury surveillance, epidemiology and road safety planning. However, these efforts are inadequate.

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Intercountry Consultation on Strengthening Injury Prevention and Control Component in Medical and Nursing Education Programmes in Countries of South-East Asia Region, Manesar, Gurgaon, Haryana, 5-7 May 2004. Delivered by Regional Adviser, Disability Prevention and Rehabilitation.
to meet the requirements. There is therefore a need to formulate and implement a comprehensive plan for human resource development in the context of prevailing health systems in the countries.

The human resources needed for injury prevention are not limited to doctors and nurses. Several categories of allied health professionals are also needed. This intercountry consultation is the first in a series to develop and implement a comprehensive human resources policy.

Medical and nursing personnel constitute the bulk of the frontline health workforce engaged in injury prevention and care. It is therefore essential to strengthen training in injury prevention and care in their education programmes. I am confident that the leaders of nursing and medical schools and councils as well as other experts will share their experiences and develop a framework for strengthening teaching of injury prevention in the medical and nursing schools.

This, however, is not an end by itself. What we need is to strengthen capacity to deal with this problem at the grass root and primary care levels as well. I am confident that these aspects will receive appropriate attention in due course of time. I would urge you to initiate the process and implement the framework developed by you in your respective institutions and later at other institutions. This is crucial because, unless there is action at the national and local levels, the objective of this consultation will not be fulfilled.
Family and Community Health
One of the core functions of the World Health Organization is to provide policy guidance to Member States based on the state-of-the-art evidence. The initiative taken by the Child and Adolescent Health and Development Department at WHO Headquarters to support countries in developing child survival strategies including newborn health is praiseworthy. This becomes all the more necessary if countries are to achieve the Millennium Development Goal for Child Survival that mandates a two third reduction in under-five child mortality by 2015.

As you are aware, this year’s World Health Day theme is “Make Every Mother and Child Count”. It is indeed befitting that WHO is closing the year with an activity specifically aimed at improving the health and survival of newborn infants and children. It is evident that neonatal outcomes will not improve unless due attention is given to perinatal health.

I am confident that the deliberations during the workshop will highlight the continuum that is needed between maternal, neonatal and child health for optimal outcomes. This is an issue that has been eloquently addressed in this year’s World Health Report.

It is a matter of concern that in spite of substantial, overall socio-economic progress, over 10 million under-five children die every year, mostly from causes that are preventable or curable. The significant progress made from the mid-seventies to the early nineties in effecting a steep decline in under-five mortality is testimony to the fact that if all partners give focused attention to child survival, progress indeed is possible. It is unfortunate that in several parts of the world the rate of decline in child mortality has slowed down and, in a few countries, it has actually been reversed.

Workshop for Building Capacity to Support Countries in Developing Child Survival Strategies that include Newborn Health, WHO/SEARO, New Delhi, 5-9 December 2005. Delivered by Deputy Regional Director, WHO/SEARO.
In the recent past our understanding of the problem of newborn mortality and the interventions to reduce it has increased. The World Health Report 2005, the Child Survival Series 2003 and the Neonatal Survival Series 2005 published by the Lancet have raised hopes that a second child survival revolution is possible.

These publications not only provide guidance about medical interventions that are necessary for promoting child survival and health but also identify issues that national programmes need to consider during implementation.

The need to establish a continuum of care between maternal, newborn and child healthcare has already been alluded to. In addition, child health policies need to promote the establishment of mechanisms that span the home, the community, the first level health facilities and referral centres.

Universal access to evidence-based care for every mother and child is essential, if the MDG related to child survival is to be achieved. Considering that mortality and morbidity rates in mothers and children are highest in the poorest quintiles of the population, it must be ensured that no mother or child is denied care due to financial barriers. In most developing countries health financing is a challenge. What is needed is innovative and country specific solutions to achieve our health goals.

Family and community behaviours, predicated by socio-cultural factors, profoundly impact the health status of mothers, newborns and children. Child health policies and strategies need to devise mechanisms to promote practices that improve maternal, newborn and child health. This can be achieved by placing special emphasis on demand creation, coupled with attention to health system issues to provide effective and efficient services.

Maternal, newborn and child health services need to be at the centre of the health systems development agenda. No health agenda can expect to succeed unless health system issues are addressed. There are several cross-cutting issues that need attention. These include appropriate staffing with the requisite skills-mix, maintenance of an uninterrupted supply chain to ensure availability of medicines, equipment and services when and where needed, supervision and monitoring, and quality control, to name a few.

One of the important issues specific to maternal and newborn health is the availability of skilled personnel to provide round-the-clock services. Unfortunately, in many countries, including several in the South-East Asia Region, a very large percentage of newborns and mothers do not receive skilled
attendance during birth and in the critical days and weeks thereafter. This is a gap which needs to be addressed urgently.

The Regional Committee for South-East Asia discussed this issue at its September 2005 meeting and resolved to work towards ensuring skilled attendance at every birth. I am sure that this initiative will contribute significantly towards achieving the Millennium Development Goals in the South-East Asia Region.

It is increasingly becoming clear that substantial reductions in under-five mortality can be achieved only if we reduce neonatal mortality. Globally, neonatal mortality contributes to about 40% of child mortality. In our Region, of 3.1 million child deaths, 1.4 million occur during the neonatal period. One of the reasons is the perception that neonatal survival is dependent upon highly sophisticated and expensive technology. Fortunately, we now have evidence to show that progress in neonatal health and survival can, in fact, be accelerated through simple and relatively inexpensive interventions that can be implemented on a public health scale. Child health policies, therefore, need to include neonatal health and survival as a major component.

We, in the South-East Asia Region, I am happy to state, give high importance to neonatal health. A regional strategy for improving neonatal health has been finalized and countries are being supported in their newborn health initiatives.

The recent establishment of the Partnership for Maternal, Newborn and Child Health has provided a new forum for donor convergence and support. In this context, several partners are working together to respond to the demands of Member States. Member States need support to increase capacity at national level for development of strategic plans.

Planning will include assessment of child health epidemiology, and of the coverage of essential interventions, as well as identifying policy opportunities and challenges. To meet the expectations of countries, we need to establish a pool of experts who have a broad perspective on maternal and child health issues, coupled with specific technical expertise on neonatal health.

This workshop will enable participants to update their knowledge about the latest developments in child survival, health and development, and enhance their capacity to assist countries in developing or refining their child health policies.
Integration of IMCI in Training of Health Professionals

The Integrated Management of Childhood Illness strategy, popularly known as IMCI, seeks to improve the skills of health workers for integrated management of common childhood diseases. It also seeks to address health system issues and community and family practices that impact child health. In other words, the strategy focuses attention on factors that influence child health outcomes and utilizes every sick child contact for preventive and promotive child health interventions.

Providing care for sick children, combined with interventions to keep them healthy, is an integral and essential part of primary healthcare. Integrated management also means greater efficiency in training, supervision and monitoring. Wastage of resources is reduced because children are treated with the most cost-effective interventions.

Acute respiratory infections, diarrhoea, measles and malaria, together with underlying malnutrition, are responsible for about two-thirds of mortality in children under five years. A significant proportion of the children brought to health facilities suffer from one or a combination of these conditions.

In the past, child health initiatives generally tried to address health problems through a vertical approach. Thus, health workers trained under a specific programme tended to treat the presenting symptom alone. Often, other conditions that the child may have been suffering from were left unattended.

This vertical approach is obviously not an efficient way to manage child health problems. It prevents dealing with health issues in an integrated and holistic manner. IMCI seeks to correct this.

Intercountry Workshop to Accelerate Integration of IMCI in Pre-service Training of Health Professionals in the South-East Asia Region, Mumbai, India, 29 November – 1 December 2005. Delivered by Regional Adviser, Child Health and Development, WHO/SEARO.
Despite significant progress, child mortality remains high in many parts of the world. In 2000, for example, 11 million children under five years of age died globally, with the South-East Asia Region accounting for 3.1 million deaths. These deaths are unacceptable. We have an effective technology and interventions to avoid a large majority of these deaths. IMCI is one of them. If applied universally, these interventions can prevent over 60% of all under-five mortality.

The recent multi-country evaluation of effectiveness, cost and impact of the IMCI strategy carried out in five countries, including Bangladesh from our Region, has provided important insights. Evidence suggests that IMCI training for health workers managing children at first level health facilities can lead to rapid and even sustained improvements in their performance.

It has also been seen that children receive better quality healthcare in districts where IMCI is practised. Their health problems are more thoroughly assessed and they are more likely to be diagnosed and treated correctly. Also, caretakers are more likely to receive appropriate counselling. Not surprisingly, health facility utilization rates have registered an increase in health facilities where IMCI was introduced.

It is interesting to note that the introduction of IMCI is not associated with higher costs per child covered. In fact, in districts where IMCI was introduced, hospital-level costs decreased significantly as compared to districts without IMCI.

To be effective, however, we need to ensure that the benefits of the IMCI strategy reach those children who need it most. Quite significantly, it is seen that when all the elements of the IMCI strategy are implemented simultaneously, under-five mortality has declined by about 13% over a period of two years. This has obvious implications for the Millennium Development Goals which seek to reduce, by 2015, under-five mortality by two thirds compared to the 1990 levels.

In the South-East Asia Region, nine of the 11 Member States are at various stages of implementing the IMCI strategy. Bangladesh, Bhutan, Indonesia, Nepal and Timor-Leste are in the expansion phase. India and Myanmar are in the early implementation phase. While DPR Korea and Maldives introduced IMCI recently, Sri Lanka is considering introducing the strategy in the North-Eastern districts. Many countries have included neonatal care in their respective country adaptations.
In most countries, IMCI has been introduced in child health programmes through in-service training of medical officers, nurses and paramedical workers. While in-service training of staff ensures quick introduction of an intervention, it tends to be very costly and time-consuming as a very large number of staff have to be trained.

Further, in-service training disrupts programme implementation and clinical services as service staff have to be moved from their duty stations for training. Pre-service training of doctors, nurses and paramedical workers, on the other hand, has the advantage of young graduates coming into the workforce with the requisite knowledge and skills and starting implementation of interventions straightaway. Pre-service training has the added advantage of being more cost-effective and avoiding disruption of normal work that in-service training entails.

Furthermore, IMCI introduces an evidence-based protocol for treatment of paediatric conditions which will go a long way in ensuring quality care for child patients. It is for these reasons that WHO is promoting pre-service training in IMCI.

I understand that Bangladesh, India, Indonesia, and Nepal from our Region have gained some preliminary experience with pre-service IMCI training. I am sure this workshop will gain from that experience and will suggest the best way forward to rapidly introduce and expand integration of IMCI in the curricula of medical, nursing and paramedical training institutions in countries of our Region.
Continuum of Care for Maternal and Newborn Health

The core principle underlying the strategies to develop the Maternal, Newborn and Child Health Programme is the *continuum of care* as highlighted and impressed upon in the World Health Report, 2005. This relates to care throughout the lifecycle including adolescence, pregnancy, childbirth and childhood, as well as to the seamless provision of care, spanning the home, the community, health centres and hospitals.

The maternal and child health agenda, however, is as yet incomplete as an unacceptable number of pregnant women and children, especially newborns, still continue to lose their lives every year. Countries of the Region account for almost one third of the global maternal and neonatal mortality. The death of any mother or newborn is tragic. These deaths are all the more poignant since a large majority occur due to complications of pregnancy and childbirth, which is a natural process.

Experiences from the Region show that progress is indeed possible if programmes include evidence-based actions. Equitable access to effective interventions, with particular attention to quality of health services, produce the desired results even within resource-challenged settings. Countries that have successfully managed to make childbirth safer have one thing in common: they chose the path of providing access to professional skilled care before, at and after childbirth. Among several examples, the experiences of Sri Lanka, Thailand and the states of Kerala and Tamil Nadu in India are noteworthy.

We are fortunate that we now have the knowledge and the means to prevent a majority of these deaths. There is enough evidence about effective public health for maternal and neonatal health interventions. The challenge before us is to work together to ensure that these reach mothers and children who need them most.

Individuals, families and communities in their decisions and actions for health, and their expectations from health services, are important actors and resources for the health systems. A health system approach, thus, needs to inherently include strategies for working with health services as well as individuals, families and communities to improve maternal and neonatal health. We need to ensure that they have the knowledge and skills to facilitate decision-making and improve care-seeking behaviour.

WHO is committed to improve the health status of mothers, newborns and children. The WHO Director-General has assigned these as priority areas for programming. The World Health Day theme and the World Health Report in 2005 were devoted to maternal, newborn and child health.

In this Region, the burden of maternal morbidity and mortality, stillbirth and neonatal morbidity and mortality are staggering. In absolute numbers, approximately 174,000 maternal deaths and about 1.4 million neonatal deaths occur each year, while an equal number of stillbirths go unnoticed. The Region urgently needs to address these issues.

Member States in the South-East Asia Region reaffirmed their commitment to the health of mothers and their newborns at two high-level meetings this year – the 42nd meeting of the Consultative Committee for Programme Development and Management, and the 58th session of the WHO Regional Committee. Both these high-level meetings discussed the issue of Skilled Care at Every Birth as one of the key interventions to address the unacceptably high maternal and newborn mortality in most of the Member States. The resultant resolution of the Regional Committee on Skilled Care at Every Birth urges all Member States to fulfil their commitment of ensuring safe and fruitful pregnancy and childbirth to all mothers and newborns.

I am convinced that all of us have a role to play in the attainment of this goal, and that together we can do it. I wish you fruitful deliberations over the next two days at the end of which, I am sure, we will have a blueprint for establishing, implementing and ensuring continuum of care for promoting the survival and health of mothers and their newborns.

I would like to take this opportunity to extend my sincere thanks to ACCESS Programme of JHPIEGO, Johns Hopkins University, for their collaboration and support to this meeting. I hope this is the beginning of a long relationship between the two organizations for realizing our common goals.

I also take this opportunity to convey my sincere gratitude to the Director of the WHO Collaborating Centre, Siriraj Hospital, Dr Orawan Kiriwat, and her staff, for organizing all the local arrangements for this meeting. I would also like to thank colleagues from WHO headquarters and the Regional Offices for the Western Pacific and the Eastern Mediterranean regions for their support and participation.
HIV/AIDS is the greatest health crisis the world faces today. An estimated 40 million people are now living with HIV/AIDS. An increasing burden is being placed on women and children, who are experiencing growing rates of AIDS-related illness and death in many settings. Almost 95% of people with HIV/AIDS live in developing countries where healthcare, resources and drugs are scarce.

The HIV/AIDS epidemic poses a challenge to the health and overall socioeconomic development in countries that have been greatly affected by the disease, which in turn may affect nutrition, and food security. Healthy nutrition plays a role in alleviating the symptoms – e.g. diarrhoea, anorexia, sore mouth, muscle wasting - common with HIV disease.

The relationship between nutrition and HIV/AIDS is complex and not fully documented to date. There are many gaps in current scientific knowledge on the impact that HIV/AIDS and malnutrition have on each other, the role of nutrition in the management of HIV/AIDS and interactions between nutrition and ARV treatment.

Successful approaches to tackling HIV/AIDS care are characterized by comprehensive strategies that address health needs as well as psychosocial care and support. In this connection, HIV-infected women and children deserve particular attention as they represent a large proportion of the people requiring care and have specific nutrition, care and support needs. Action and investment to improve the nutrition of persons living with HIV should be based on sound scientific evidence, local resources, and programmatic and clinical experience with the prevention, treatment, and management of the disease.

Nutrition-related Care and Support for People Living with HIV/AIDS

Intercountry Training of Trainers on Nutrition-related Care and Support for People Living with HIV/AIDS, Jakarta, Indonesia, 3-7 October 2005. Delivered by WHO Representative, Indonesia.
The Fifty-seventh World Health Assembly in May 2004 called on Member States to pursue, as a matter of priority, policies and practices that promote integration of nutrition into a comprehensive response to HIV/AIDS. WHO is working with partner agencies and organizations in the United Nations system on the issue of food security for families whose livelihoods have been affected by HIV/AIDS.

WHO initiated a collaborative effort to develop approaches based on the latest available scientific evidence with respect to the macronutrient and micronutrient needs of HIV-infected people, the special nutritional needs of HIV-infected pregnant and lactating women and their children, and the nutritional needs of HIV-infected adults and children receiving antiretroviral treatment. The evidence was gathered with the assistance of the WHO Technical Advisory Group on Nutrition and HIV/AIDS.

In the South-East Asia Region, where more than 6 million people are living with HIV/AIDS, the highest number in the world after sub-Saharan Africa, prevalence of malnutrition is already very high. About three fourths or 79% of the world’s malnourished children live in our Region, while more than 60% of women in the reproductive age group are anaemic, and suffer from chronic energy deficiency.

The Regional Office for South-East Asia has been proactive in initiating steps to scale up collaborative efforts for capacity building to strengthen and broaden the scope of their efforts to extend provision of antiretroviral therapy and to find innovative ways to ensure that food and nutritional considerations are fully integrated into responses to HIV/AIDS.

Training on nutrition-related care and support for people living with HIV/AIDS is the first-of-its-kind in the Region. Participants will gain knowledge about this issue as well as about the basic communication skills required for effective counselling. The training will enable trainers to address and include sessions on nutrition in HIV/AIDS training programmes. It will also enable them to advocate for strengthening and broadening the scope of HIV/AIDS control programmes for developing innovative ways to address the range of challenges relating to food, nutrition and HIV/AIDS.
World Health Day 2005: Make Every Mother and Child Count

Tomorrow is our World Health Day and the Fifty-seventh anniversary of WHO. Every year, we have a slogan for advocacy. This year’s slogan is, “Make Every Mother and Child Count”. It relates to the health of mothers and children. Each of us has a role to play in contributing to the achievement of this goal – Make Every Mother and Child Count.

As we are aware, our Region accounts for one third of the global maternal and child mortality. This is in spite of our achievements in other aspects of social and economic development in the Region. To tackle the problem of maternal and child mortality effectively, we have to understand this aspect.

To reduce this mortality, we have to go beyond the health sector, beyond medical means. A desired reduction in maternal and child mortality depends, to a large extent, on multisectoral and multidisciplinary efforts.

Maternal and child mortality clearly has an important social and economic cost. Therefore, maternal mortality ratio and child mortality ratio have been universally used as the indices for social and economic development. Successful reduction in maternal and child mortality is not only a health gain, but also leads to social and economic gains for the countries.

High maternal and child mortality has been a trade mark of WHO’s South-East Asia Region. We have to help countries in our Region to move away from this trademark. We have to help the countries understand that maternal and child mortality has not only medical, but sociocultural and economic causes.

We have to help the countries develop appropriate policies, strategies and programmes for tackling effectively maternal and child mortality, fully taking

Address to WHO/SEARO Staff on the eve of World Health Day 2005 WHO/SEARO, 6 April 2005
into account its socio-cultural and economic dimensions. We have to advocate for political will, commitment and action in countries. Society as a whole must come forward to take the responsibility.

Social status, including the educational level of women must be raised, if we are to be successful in reducing maternal and child mortality. We have the knowledge and technology to prevent a majority of maternal and child deaths. But, these are yet to be applied optimally, within the local context and framework in countries.

More appropriate strategies and approaches for our Region to reduce maternal and child mortality are yet to be developed. We need new ideas and innovative tools in tackling this problem. WHO has to think anew and innovatively in this regard. Let us pursue, in a big way, in developing the improved or new tools for use by countries in our Region. Let us work together in the Regional Office, and collaborate closely with the countries to “make every mother and child count.”
Maternal and Child Health

The birth of a child is a joyous event in all parts of the world. The enduring charm of motherhood is celebrated in all societies. Yet, it is not often realized that every year almost 11 million children, globally, lose their lives from causes that are largely preventable. Similarly, more than half a million women die due to causes related to pregnancy and childbirth. The loss of so many children and mothers is all the more tragic since most of the causes responsible for these deaths are preventable through simple technology, amenable to implementation even in resource-compromised situations.

Approximately 30% of global maternal and child mortality occurs in the South-East Asia Region. The issue of maternal and newborn health poses a major challenge in the Region, besides the issue of child health. In 2000, nearly 174,000 women, including 136,000 in India alone, died from pregnancy and childbirth complications; also, nearly 1.4 million newborns died in the Region. The factors commonly associated with these deaths are the absence of skilled health personnel during childbirth; inability to provide emergency obstetric and neonatal services for complicated cases; inequities and vast gap in accessing maternal and neonatal health services in the community, and ineffective referral systems.

Most pregnancy and childbirth complications cannot be predicted, and therefore, the continuum of care, particularly Skilled Care at Every Birth, is crucial to save lives. The continuum of care that the mother receives before and during pregnancy, as well as during childbirth and the period soon after birth, is a critical determinant for the survival and well-being of the mother-baby dyad. The proportion of deliveries attended to by skilled health personnel is still very low in some countries of the Region. For example, it was less than 20% in 2002 for Bangladesh, Bhutan, Nepal and Timor-Leste. To achieve the

Millennium Development Goals and international development goals in maternal and newborn health, we need to have long-term commitments and investments in order to ensure that women have access to timely, safe, affordable, and high-quality maternal and obstetric care.

The deaths of over three million children under the age of five currently, is a heavy burden that our countries have to bear. About two thirds of all child deaths occur during the first month of their lives; and two-thirds of these deaths occur in the first week after childbirth. The causes of newborn deaths are mostly related to maternal health during pregnancy and to the inadequate care received during childbirth and during the immediate postnatal period. The causes of deaths of other children under five years of age include pneumonia, diarrohea, vaccine-preventable conditions like measles and tetanus, and other endemic diseases, such as malaria. While at present it appears that HIV/AIDS is not a major killer in children in the South-East Asia Region, we will have to be vigilant, as in parts of the world where the epidemic is raging a large number of children acquire the infection from their infected mothers. Malnutrition is a significant contributory factor in about 60% of all child deaths. This is especially significant for the Region where the malnutrition rate in children is particularly high.

The death of a large number of mothers and children is unconscionable, particularly as effective and affordable interventions for their prevention are available. The reasons for the high burden of maternal and child mortality also lie in the perception of individuals, families and communities of matters related to health in general, and maternal and child health in particular. These perceptions, which are critically dependent upon the availability of valid information, determine health behaviour, including seeking help in sickness and emergencies from appropriate healthcare providers. The access and affordability of preventive, promotive and curative health services provided to all sections of society in an equitable manner is another important factor.

The survival and well-being of mothers and children has broader social, economic and developmental dimensions. Poor health has been recognized as an important factor for families becoming poor. When a mother is sick or dies, not only is her contribution to the family, workforce and society lost, but the survival, education and development of her children are also jeopardized. Frequent illness and malnutrition have an adverse effect on the cognitive development, body size and strength of children. Investment in both maternal health and child survival is good investment. The World Bank estimates that for every dollar invested in child health, seven dollars are returned to society through reduced spending on social welfare and increased productivity of young people and adults.
Conclusive evidence that effective interventions exist for saving mothers and children is available. Among others, Skilled Care at Birth, including appropriate care of the mother during pregnancy and childbirth, and care of the mother and baby during and immediately after birth; universal acceptance of exclusive breast-feeding of infants up to six months of life; rehydration therapy during diarrhoea, antibiotic treatment for pneumonia, sepsis, dysentery and immunization are known to prevent maternal, newborn and child mortality.

Given the enormity of the task and the urgency for reducing maternal and child mortality in view of the reiteration of the international community to maternal health and child survival in the Millennium Declaration, it is only befitting that the slogan of the World Health Day 2005 is “Make Every Mother and Child Count”.

We, in the World Health Organization’s South-East Asia Region, recognize the media as an important partner in our activities to promote and protect the health and survival of people in our Member States. I particularly commend the role that the media played in spreading correct information during the recent SARS outbreak, which I believe contributed immensely to the early containment of the disease.

As this is the first time that we have invited journalists to promote maternal and child health, we would like to have your feedback on how we could build effective relationships towards meaningful actions for pregnant mothers, their newborns and children in the Region. We believe that the media can play an effective role. The reach and influence of the media could be utilized for advocating appropriate action that influences both the demand for and the supply of good-quality health. On the one hand, this could be done by providing state-of-the-art information about preventive and promotive actions that individuals and families should adopt, and on the other hand by becoming strong advocates for increased investments in the health sector.

I am convinced that all of us have a role to play in the attainment of this goal, and that together we can do it. I wish you fruitful deliberations over the next two days at the end of which I am sure a blue-print for the effective role that the media can play in promoting the survival and health of mothers and their children in the South-East Asia Region, will emerge.

I would like to take this opportunity to convey my sincere gratitude to the Director of the WHO Collaborating Centre, Siriraj Hospital, Dr Orawan Kiriwat, and to her staff, for organizing all the local arrangements for this meeting.
Integrated Strategy on Optimal Foetal Growth and Development

It is indeed a pleasure and a privilege to have leading experts from two regions – the South-East Asia Region, and the Western Pacific Region, at this bi-regional consultation for developing an integrated strategy on optimal foetal growth and development.

We are all aware that suboptimal foetal growth is associated with higher perinatal and neonatal morbidity and mortality. It increases the likelihood of premature birth, which again compounds perinatal and neonatal health risks. There is also evidence that foetal growth, as measured in late gestation, is dependent not only on the maternal environment, but also on events during the periconceptual period.

Good nutrition is essential both for maintaining maternal health and wellbeing, and for achieving optimal foetal growth and development.

There is increasing evidence linking good maternal nutrition and weight gain to positive perinatal outcomes, including reduced incidence of low birth weight and very low birth weight infants.

Food supplementation during pregnancy has been shown to improve birth weight, especially in malnourished women. Women with marginal micronutrient status may also be benefited by micronutrient supplementation, in addition to iron and folate.

This year in May, the World Health Assembly endorsed the Global Strategy for Diet, Physical Activity and Health. WHO now looks forward to its early adaptation and implementation in Member States.

The foetal origins of adult disease are now receiving attention, based on the observation that men and women who were small at birth have an increased risk of cardiovascular and hypertensive diseases. However, it seems that birth size, per se, is too crude an outcome measure to be used for the assessment of optimal intrauterine growth and development. Thus, a new vision of optimal foetal development is required for the 21st century. This vision will need to take account of both short and long-term outcomes, and to recognize that maternal body composition and diet can have long-term effects.

There are numerous causes of sub-optimal foetal growth, which I am sure you will be discussing further during this meeting. They include genetic factors, pregnancy at an early age, maternal education, nutrition and lifestyle factors such as physical work during pregnancy and smoking.

Disease patterns and environmental factors in the environment also influence foetal growth. Addressing all issues requires a comprehensive approach. A strategy that brings together all these aspects does not exist and thus guidance on global strategic directions towards optimal foetal growth and development is needed.

As far as research is concerned, WHO has five main approaches to supporting nutrition research. These include: multicentre/multicountry nutrition studies; regional nutrition research networks and initiatives; nutrition research and training through global collaborating centre networks in nutrition; direct technical/financial support for nutrition research activities by nutrition units, nutrition institutes and others; and collaboration within WHO on research projects having nutrition-related outcomes.

This meeting is a follow-up to two meetings organized by WHO, Headquarters. These are: (i) the advisory group meeting held in December 2002 to review the current situation, identify consensus issues and gaps; and (ii) the technical consultation in November 2003 for promoting optimization of foetal growth and development.

Let me, at this point, reaffirm WHO’s commitment to achieving the Millennium Development Goals. Nutrition and nutritional interventions are related to six of the eight Goals, and this meeting directly affects goal 4, related to reduction of infant mortality.

I am happy to note that government officials, experts and representatives from institutions, professional organizations, representatives from UN agencies and WHO Country Offices are participating in this meeting. I am confident that we will all contribute towards shaping the Integrated Strategy on optimal foetal growth and development.
Significant progress has been made in reducing child mortality globally. The child mortality rate declined from 85 deaths per 1000 live births globally in 1990 to 65 deaths per 1000 live births in 2000. Even so, about 11 million children under five years of age died all over the world in 2000. Almost one third of these deaths took place in the South-East Asia Region. These deaths are unacceptable. We have effective technology and interventions. If made available universally, they can prevent over 60% of all under-five mortality.

Acute respiratory infections, diarrhoea, measles and malaria, together with underlying malnutrition are responsible for over two-thirds of mortality in children under five years. A significant proportion of the children brought to health facilities suffer from one or a combination of these conditions.

In the past, child health initiatives generally tried to address health problems through a vertical approach. Thus, health workers trained under a specific programme tended to treat the presenting symptom alone. Often, other conditions that the child may have been suffering from were left unattended. This vertical approach was obviously not an efficient way of managing child health problems. It prevented dealing with health issues in an integrated and holistic manner. Integrated Management of Childhood Illness (IMCI), seeks to correct this.

The IMCI strategy seeks to improve the skills of health workers for integrated management of childhood illnesses. It also seeks to address health system issues and community and family practices that impact child health. In other words, the strategy focuses attention on both the “supply-side” and “demand-side” factors that influence child health outcomes.

Intercountry Workshop on IMCI, Safdarjang Hospital, New Delhi, India, 6-17 December 2004. Delivered by Regional Adviser, Adolescent Health and Development, WHO/SEARO.
In fact, the IMCI strategy utilizes every sick child contact for preventive and promotive child health interventions. Participants attending this workshop will learn how IMCI links up with various programmes including immunization, nutrition and malaria.

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

The on-going Multi-Country Evaluation of Effectiveness, Cost and Impact of the IMCI Strategy in five countries, including Bangladesh from our Region, has provided important insights. Evidence suggests that IMCI training for health workers managing children at the first level health facilities can lead to rapid and even sustained improvements in their performance.

The evaluation has also shown that efforts to implement interventions at the family and community levels have been too slow and too widely dispersed to achieve even minimal coverage. This underscores the importance of ensuring and maintaining adequate intervention coverage levels if rapid gains in child survival, health and development are to be achieved.

It has also been seen that children receive better quality healthcare in districts where IMCI is practiced. Their health problems are more thoroughly assessed and they are more likely to be diagnosed and treated correctly. Also, caretakers are more likely to receive appropriate counselling. Not surprisingly, it was seen that health facility utilization rates increased in those health facilities where IMCI was introduced.

An interesting finding is that the introduction of IMCI is not associated with higher costs per child covered. In fact, in districts where IMCI was introduced, hospital-level costs were significantly lower as compared to districts without IMCI. This was possibly due to improvement in quality of care and drug availability for under-fives at primary facilities. This prevented children from being admitted to hospitals.

Studies also reveal inequities in healthcare for poor children. The IMCI Strategy addresses the needs of the poor. To be effective, however, we need to
devise methods to ensure that the benefits of the IMCI Strategy reach those children who need it most. Evidence from Tanzania also indicates that when all the elements of the IMCI Strategy were implemented simultaneously, under-five mortality declined by 13% over a two-year period.

In the South-East Asia Region, nine out of 11 Member Countries are at various stages of implementing the IMCI Strategy. Bangladesh, Bhutan, Indonesia, Nepal and Timor-Leste are in the expansion phase. India and Myanmar are in the early implementation phase. While DPR Korea and Maldives recently introduced IMCI, Sri Lanka is considering introducing the strategy in the North-Eastern districts.

Since IMCI was introduced in the Region in the late 1990s, there has been a turnover in the senior management staff at the country level. This workshop has been organized by WHO in response to the need expressed by concerned Member States to train senior programme managers, trainers and paediatricians in the principles of IMCI. I am sure, upon completion of this course, participants will be better equipped to assist and guide their respective governments in the effective implementation of the IMCI Strategy.

In conclusion, I would like to reiterate the need to ensure adequate IMCI coverage both at the health facility and community levels for it to be effective. In order to achieve this, we need to strengthen partnerships with UNICEF, international organizations, NGOs and the community. We need to realize that in addition to developing health worker skills, the impact of IMCI is critically dependent on well-functioning healthcare delivery systems. In addition, it is important to achieve and maintain coverage at household levels.

I would like to thank the Government of India, especially the authorities of the Safdarjang Hospital and the V.M. Medical College for hosting this important workshop and for their hospitality and excellent arrangements.
Workplans for FCH Areas of Work

WHO is now 56 years old. From its inception in 1948 until today, there have been a lot of changes at all levels, nationally, regionally and globally.

In the Member States one can see: socio-economic change; political-governance change; and increased capability and capacity in development. At the international level, one can see: an expanded concept of health and health development; health as the centre of development; multisectoral and multidisciplinary involvement in health development; and many more agencies working in the health area.

To remain effective and credible in its support to Member States, there is a real need for change in WHO. This needed change has been recognized and called for in the Organization for several years. One of the important calls for change has been for the decentralization of the work of WHO towards country level. Already, for some years decentralization has been the overriding organizational strategy in WHO’s management reform. In this connection, there have been in-house exercises on: WHO strategy to work with and in countries; WHO country focus strategy; and now, the WHO country specific approach. As far as WHO/SEAR is concerned, the pursuance of WHO’s overall policy on decentralization is our overriding Organizational priority.

The following are the elements of decentralization in SEAR: Operationalization of country focus and country specific approach; Doubled delegation of authority to WHO Country Representatives; Horizontal collaboration among WHO country offices; Decentralization of certain regional and intercountry functions to country level; Maintaining the proportion of RB resource to country (75%); and Strengthening capacity of WHO country offices.

Joint Planning Workshop to develop 2006-2007 Workplans for FCH Areas of Work, New Delhi, 11-13 October 2004
The current trend is that most resources in WHO (RB+EBR) go to countries. Of the global resources, 75% go to countries and regions by the next biennium. WHO’s future work for direct support to countries will be mostly planned and carried out at the country level.

There are three main areas of WHO functions. These are: Direct support to countries; Normative work; and Intercountry coordination.

Priority efforts of WHO in the Region will be devoted to direct support to countries. To a large extent, normative work will be the byproducts of direct support to the countries. The country office functions will include: direct support to Country; contribute to normative work, especially in providing the required information; and promote intercountry cooperation through horizontal collaboration. Country offices in the Region will be the operational offices.

The Regional Office functions will include: Normative work; Intercountry coordination; Support to WHO country work, and strengthening WHO country office capacity; Coordinating Regional Policy and Strategy; Monitoring and Evaluation; and Oversight.

The Regional Office will be the Strategic Office. With these trends in view, joint planning between Regional Office and Country Office staff becomes very important. This joint planning should focus particularly on activities at the country level.

At the same time, think of piggybacking on country-level activities for the normative work. Think of how RO staff can support country activities within the framework of the country workplan. Think of how RO staff can help strengthen capability and capacity of country office staff. I am aware that this workshop will focus on expected results. However, we should not be prevented to think of other important aspects of our work in programme development and management within the FCH area.
Adolescents represent a positive force in society, now and for the future. They are no longer children but not yet adults and this period of change is full of paradox. They face dangers more complex than faced by previous generations and often with less support. Adolescents comprise about 20% of the population in Member States of the South-East Asia Region. Thus, there are about 350 million adolescents in this Region passing through a period of rapid transition with physical, psychological, sexual and behavioural changes. All this is happening in a changing world that contains both opportunities and risks.

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

Adolescent sexuality has an overwhelming demographic impact. In some countries, a large proportion of marriages and first-births continue to occur among adolescent girls. Nearly 40 to 50% of girls are married and become pregnant before they are 20 years old in some Member States of the Region. About 4 to 15% of the Total Fertility Rate is contributed by 15-19 years-old girls. Data show that maternal mortality is two to five times higher among adolescent girls compared to adult women.

It is clear that unless the adolescent age group is targeted with effective interventions, a significant dent cannot be made in the overall Maternal Mortality Rate for our Region. Unprotected adolescent sexual activity also contributes significantly to cases of STDs and HIV. About 50% of new HIV infections occur among young people every year.

Despite the biological, public health and social significance of this phase of life, adolescent health has not received adequate attention in public health programming until recently in many countries. It is quite clear that the currently available maternal and child health programmes, school health services or reproductive health services will not be able to address the special needs of adolescent health and development.

Adolescents do not appreciate the importance of seeking treatment when they are unwell by often underestimating the seriousness of the problem, and thus delaying seeking treatment. For a variety of reasons, adolescents are unable to obtain the health services they need. Adolescents need a safe and supportive environment that offers maximum opportunities for development, information and skills to address their health problems, and to deal effectively with their personal difficulties and conflicts. It is well recognized that healthcare providers and healthcare services alone cannot meet their needs. Adolescents need a package of basic health services tailored to meet their specific health needs. These include: reproductive health services; voluntary counselling and testing for HIV and other STIs; promotion of nutrition, and mental health services.

What is required are adolescent-friendly health services that are easily accessible. The strategy of providing adolescent-friendly health services is recommended by WHO. It defines the essential services package, quality standards, and the process of quality improvement. Although the dimensions of quality are similar for all age groups, for adolescents – Accessibility and Acceptability – are important aspects that are naturally equated with “adolescent friendliness”. There is also the need for privacy and confidentiality towards ensuring the removal of legal restrictions and cultural barriers that prevent adolescents from seeking guidance and healthcare. This would make adolescent-friendly health services successful.

The existing hospitals and health centres can become adolescent-friendly by expanding their existing services to cater to the needs of adolescents. Furthermore, the coverage of government-run health facilities for adolescents could be extended through other channels, such as community or youth centres, marketplaces and other settings offering community extension services for adolescents.
Health workers need to be “friendly” but they also need knowledge and skills to deliver the required package of services. Clinical guidelines and treatment algorithms are recognized tools to assist practitioner-decisions about appropriate healthcare for specific clinical circumstances. It is necessary to develop the knowledge, skills and competencies of health providers in the area of adolescent health.

I am informed that a beginning in this regard has already been made in the Region. The concept of providing targeted, appropriate and “friendly” services to cater to the needs of adolescents is increasingly being recognized. India, Indonesia, Nepal and Thailand have undertaken pilot projects for providing adolescent-friendly health services. The experiences from these pilots were shared during the Regional Consultation on Adolescent-Friendly Health Services, held in Bali, Indonesia, early this year. It was recommended that the capacity of countries in the provision of adolescent-friendly health services needed to be strengthened.

An Orientation Programme on Adolescent Health and Development for Health-care Providers has been developed by WHO in collaboration with UNICEF and other partners. This was conceived and developed with the active participation of its intended users and beneficiaries and was field-tested in 16 countries at the global level.

The Orientation Programme gives healthcare providers information on special characteristics of adolescents and appropriate approaches to address some of their health needs and problems. The programme aims to strengthen the abilities of healthcare providers to respond to adolescents more effectively and with greater sensitivity.

I am glad that our Region is the first one to organize a workshop to build a pool of regional experts who will provide support in building capacity at national level after necessary adaptation of this package. This is just the beginning of our efforts towards improving health services for adolescents. A lot more needs to be done. I am sure that your collective efforts at national level will pave the path towards improving the health and development of adolescents of our Region – a vision we all share together!
HIV Among Young People

Young people aged 10-24 years are at the centre of HIV/AIDS epidemics in many countries across the world. More than 50% of the newly infected HIV cases occur among young people every year. Considering that the South-East Asia Region of WHO is estimated to have 600 million young people, the problem assumes added significance.

Though many countries in the Region have HIV prevalence rates of less than 1%, there are areas of high prevalence in India, Myanmar and Thailand. In India, Nepal, Sri Lanka and Thailand, more females than males have been infected with HIV.

Another significant factor in the Region is that a large proportion of injecting drug users, commercial sex workers, and migrant workers are young people. A complex mix of biological and socio-economic factors make young people vulnerable to HIV transmission. For example, young people lack the knowledge and skills to delay the onset of sexual experience. The first sexual experience of many young people is often unsafe.

Some young males have their first sexual experience with a commercial sex worker. There is an increasing trend towards early sexual debut. The risk is higher amongst injecting drug users. Condoms and health services often are not accessed by young people due to lack of youth-friendly health services. There are prominent gender differences that adversely impact on HIV transmission in many societies in the South-East Asia Region.

In a special session of the UN General Assembly in 2001, goals were set to control HIV/AIDS in young people. The General Assembly and the Millennium Development Goals lay emphasis on reversing the rising trend of HIV/AIDS in...
young people. Member States in the Region are committed to achieve these goals.

In order to accelerate country-level health sector action in relation to HIV in young people, WHO proposes to involve a range of partners including the UN co-partners to maximize their contributions for achieving the global goals and commitments. The three core elements of the health sector strategy in this context are: (i) strategic information (ii) services and supplies and (iii) supportive policy environment.

WHO advocates for a comprehensive response, to build on what already exists and to promote intercountry collaboration. WHO will help the countries to develop operational plans with a focus on health sector response, assist in development of capacity, strengthen health systems and supplies, ensure development of linkages with the “3 by 5” strategy and mobilize partners.

I am glad to learn that a draft strategic framework for control of HIV/AIDS in young people is being developed. This will help in developing a common understanding amongst the countries and the partners on the core elements of the strategy. To support effective implementation of the strategy, an advocacy plan will be required to mobilize additional resources for accelerating and expanding the control programme for HIV/AIDS in young people.

I hope that this consultation will lead to some recommendations for creating a niche for control of HIV/AIDS in young people within the existing national programmes for control of HIV/AIDS, reproductive health, nutrition and control of STIs through youth-friendly health services. The focus of our efforts should be on reduction of vulnerability by fully involving the young people. The rights and equity issues should be included within the national operational plans.

WHO’s comparative advantage should be utilized to develop a health sector response by strengthening the capacity in countries to collect, analyze and disseminate age and sex disaggregated data. This needs to be linked to policies, programmes, and advocacy by including key biological, behavioural and programme indicators.

The services and supplies should be strengthened to increase young people’s access to prevention, treatment, care and support. A supportive policy environment would also be required to ensure that the health sector is able to provide the evidence base and examples of good practices. The strengths of a variety of programmes that are already functional need to be pooled.
The variety of settings and the vast reach of programmes within and outside the health sector that involve young people need to be tapped. The experience gained by the various adolescent and youth – friendly health centres should be utilized to offer STI/HIV, reproductive health and nutrition services. There are a number of complementary interventions that the health sector can promote in collaboration with other sectors to enhance the outreach of the programme.

Besides health, many other sectors – especially education, youth affairs and social welfare need to make a compelling case for the young people in the context of HIV/AIDS. Other sectors can complement the efforts of the health sector in increasing demand generation by involving the communities, especially the young people, by utilizing the media, and by involving the teachers.

Other sectors can also complement the efforts of the health sector in increasing the access and the use of condoms. This can be done by evolving locally acceptable strategies and formulating policies that destigmatize condom usage. It would be useful to consider integration of sexuality education and HIV prevention in the curriculum of schools through population education, life-skills education and other culturally acceptable programmes.

Innovative communication efforts can help create an enabling environment for programmes. For example, development of user-friendly and age-appropriate materials for young people, communication campaigns, peer education and life -skills methods, use of question box and telephone helplines can yield effective results, especially to address sensitive issues and address myths and misconceptions that fuel the HIV/AIDS epidemics.

Sustained political support and leadership are necessary for accelerating the response to HIV/AIDS control in young people. Several examples of leadership are available in the Region. We need to strengthen our efforts in order to achieve our desired goal of a healthier and happier Region.
The world has made significant progress in the area of child survival and development. Globally, the child mortality rate has declined from 85 deaths per 1000 live births in 1990 to 65 deaths per 1000 live births in 2000. In absolute terms, the number of annual child deaths has been reduced from 17 million in 1970 to 10.8 million in 2000.

The major causes of child mortality are well known. These are acute respiratory infections, diarrhoea, measles and malaria. Together with the often underlying malnutrition, these conditions account for almost two thirds of child mortality. Deaths in the neonatal period contribute to about 40% of the under-five mortality. It is unfortunate that many Member States in the Western Pacific Region and the South-East Asia Region continue to record high under-five mortality rates despite the availability of effective interventions and technology. Improving the coverage of effective child healthcare remains a challenge in many countries in our regions.

In the last two decades, a number of public health initiatives and programmes were launched and implemented with a view to addressing specific issues responsible for high child morbidity and mortality. These include the Control of Diarrhoeal Disease Programme, the Expanded Programme on Immunization and the Acute Respiratory Infections Control Programme, among others.

A strategy that addresses the major causes of child mortality called the Integrated Management of Childhood Illness, commonly known as IMCI, was offered by WHO in collaboration with UNICEF to countries in the mid-1990s. In the South-East Asia Region, nine out of the eleven countries have adapted
the IMCI strategy to suit their needs and it is at various stages of implementation. I understand that most countries in the Western Pacific Region also have adapted the IMCI approach.

Nearly all the child health initiatives mentioned earlier laid a strong emphasis on the management of common childhood health problems at the primary level. The primary focus was on improving the capacity of field-level healthcare providers.

In most settings, about 10% of sick children seeking treatment at the primary healthcare level need referral care. It is also well known that families often take very sick children directly to referral facilities. Severely ill children brought to hospitals often die as the severity of their illness is not appreciated in time or the capacity to manage these emergencies is limited.

The provision of effective, evidence-based care to severely sick neonates, infants and children in hospitals is an intervention that has the potential of saving many lives. Building capacity for immediate triage, assessment and management of severely sick children will contribute to our efforts in helping the countries to achieve the child health-related Millennium Development Goals.

WHO, in collaboration with partners, has developed a tool to assess the quality of child care at the referral level. The standard of care provided in referral facilities is assessed against a previously developed referral care standard. The tool allows an objective analysis of not only the quality of clinical care provided to children but also of other important factors that determine the outcome such as the status of drugs, supplies, equipment; laboratory support; staffing issues; friendliness of services to mothers and children; and discharge and follow-up procedures, among others. Last year, hospital assessments on emergency care for children, funded by our partner, AUSAID, were carried out in Cambodia, Indonesia, Solomon Islands and Timor-Leste.

These assessments reveal some common areas that need attention. These include the lack of standard treatment guidelines, lack of capacity for triage and emergency management of severely sick children and the need for better communication skills in healthcare providers.

I am very pleased to learn that a Training Course on Emergency Triage, Assessment and Treatment of severely sick children is now available and that this course addresses the critical needs of severely sick children in hospitals and other referral sites.
I am confident that after this first course in our regions, the participants will be able to influence hospital care practices for children in their respective countries and settings and develop concrete plans to build capacity in their countries to take this important new initiative forward.

I am also particularly pleased to note that this is a bi-regional activity between the Western Pacific and the South-East Asia regions. Many countries in our regions have remarkable similarities and share many common problems. The Regional Director of WHO’s Western Pacific Region and I have decided to proactively work together in areas of common interest in order to contribute to the efforts to improve the health status of people in our regions.

The two Regional Offices have worked together on many areas of common and global interest. To name but a few, we have worked together in the fields of malaria, SARS, avian influenza and communicable disease surveillance in the recent past and the issues that this training course addresses will add to the list of bioregional initiatives.

I take this opportunity to extend a warm welcome to all the participants and colleagues from the Western Pacific Region and, of course, also to the participants and colleagues from the South-East Asia Region. At the same time, I am confident that the skills learnt during the next few days would translate into the much needed reduction of under-five mortality in the countries of the two regions.
First of all, I would like to warmly welcome you all to the two important meetings: (1) South-East Asia Regional Workshop on Family Planning, Sexually Transmitted Infections and Skilled Birth Attendance; and (2) South-East Asia Regional Consultation for Development of the Global Strategy for the Prevention and Control of Sexually Transmitted Infections. These three areas of reproductive health deserve special attention.

For the first meeting, UNFPA and WHO are initiating collaboration under the Strategic Partnership Programme (SPP) for the introduction, adaptation and implementation of evidence-based practice guides developed by WHO. In 2004-2005, the partnership will be focused on family planning and sexually transmitted infections, while in the South-East Asia Region we also recognize the huge challenges for maternal and newborn health in the countries of the Region.

Knowledge management and changing behaviour are very important and challenging issues that we are facing in our efforts to improve the quality of services and client satisfaction. These have a significant impact on health and development. Promotion of evidence-based practices and guidelines is one of the first but very important steps in this process. Only utilization of, and adherence to, evidence-based best practice will ultimately help to improve the quality of services and client satisfaction.

In the area of family planning, most countries have achieved significant progress in the use of modern contraceptive methods during the last three
decades. In 2000-2002, the contraceptive prevalence rate in Bangladesh, Indonesia, Sri Lanka and Thailand ranged from 51% to 72%. However, in Bhutan, India, Maldives, Myanmar and Nepal it ranged from 20% to 48%, and in Timor-Leste it was as low as 7%. The quality of family planning services, predominance of non-reversible methods, the limited use of male methods and dual protection of condom, high levels of unmet need and discontinuation rate have become important issues to be addressed by many countries of the Region.

WHO estimates that globally there are around 340 million new cases of curable sexually transmitted infections (STIs) among men and women aged 15-49 years. In developing countries, STIs and their complications rank among the top five disease categories for which adults seek care. Among women of childbearing age, STIs – excluding HIV infection – are second only to maternal factors as causes of disease, death and healthy life lost.

The magnitude of the problem of STI and associated complications, and its strong linkage with HIV transmission, highlight the need to explore new and innovative approaches to prevent and control its spread. Approximately 10%-40% of women with untreated chlamydia and gonococcal infection develop symptomatic pelvic inflammatory disease, of whom up to 25% of cases will become infertile. Untreated STI and other reproductive tract infections in pregnant women are associated with spontaneous abortions, stillbirths, low birth weight, ectopic pregnancy and infertility, as well as severe congenital and/or perinatal infections. Syphilis alone, when present during pregnancy, results in foetal loss in one third of cases and half the surviving infants suffer congenital disability.

Furthermore, the 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. Therefore, the introduction of evidence-based practices is necessary in order to address these important issues.

Considering that the population at risk for STI/RTI will grow dramatically over the next decade, a global strategy that takes into account lessons learnt, new technological opportunities and partnerships and which seeks to tap into strengths of the communities themselves, is needed.
A draft *Global Strategy for STI Prevention and Control* has been prepared for inputs from countries in all regions. We hope that the participants can present their views, experiences and lessons learned at the second meeting in order to contribute to the finalization of the draft strategy.

As you are aware, besides those two elements of reproductive health, the issue of maternal and newborn health poses a major challenge in the Region.

Approximately 174,000 women, including 136,000 in India alone, die from pregnancy and childbirth complications; also, nearly 1.4 million newborns die every year. Factors commonly associated with these deaths are the absence of skilled health personnel during childbirth, inability to provide emergency obstetric and neonatal services for complicated cases, inequities and the vast gap in accessing maternal and neonatal health services in the community, and ineffective referral systems.

Most pregnancy and childbirth complications cannot be predicted, and therefore, continuum of care, particularly *Skilled Care at Every Birth*, is crucial to save lives. The proportion of deliveries attended by skilled health personnel is still very low in some countries of the Region – the figures for Nepal, Timor-Leste, Bangladesh and Bhutan were only 13.5%, 19.5%, 21.8% and 23.7% respectively in 2002; and for India it was 42.3%.

To achieve the Millennium Development Goals and international development goals in maternal and newborn health, we need to have long-term commitments and investments to ensure that women have access to timely, safe, affordable, high-quality maternal and obstetric care. This meeting should also look at this issue and how we can move forward to achieve the target of 80%, globally, of all births attended by a skilled healthcare provider, or 40% for countries with a high MMR in 2005; and 85% in 2010 globally or 50% for countries with a high MMR.

The focus on partnerships and integrated efforts at regional and country levels in undertaking key family planning, STI and “skilled care at every birth” issues should be continuously maintained. UN agencies, particularly UNFPA and UNICEF, international NGOs, other development partners including major donors, are obvious partners for future work in these areas of reproductive health.

I am happy to note that programme managers from the Ministry of Health responsible for the three programmes, experts and representatives from
development partners are participating in this workshop. Hopefully, the country experiences shared here will help to strengthen family planning programme and services, as well as efforts in improving maternal and newborn health in countries.

Finally, I am happy to note that representatives from Member States, WHO headquarters, UNFPA CSTs in Kathmandu and Bangkok, UNFPA country offices and other development agencies are participating in this meeting.

I am confident that strategic collaboration between WHO and UNFPA and the countries will be further strengthened. Your deliberations will help strengthen efforts towards improved family planning, STI and maternal and newborn health programmes in the Region in an innovative way. I would like to take this opportunity to convey my sincere gratitude to the Executive Director, Family Planning Association of Sri Lanka, Dr Abeysinghe, for organizing all the local arrangements for the meeting.
I am glad to welcome you all to this 8th Meeting of the South-East Asia Nutrition Research-cum-Action Network. Most of you are aware that this Network was established in 1990 by the WHO Regional Office for South-East Asia with representatives from government programmes, nutrition institutions and WHO collaborating centres in nutrition in Member States.

Since its inception, the Network has made valuable contributions to action-oriented research. The goal of this Network meeting is to promote and facilitate operations research according to WHO’s nutrition priority areas in the programmes undertaken by members of the Network.

The Regional Office has been supporting nutrition research for many decades. The results of the research have contributed substantially to policy formulation and action by governments, particularly in regard to iodine deficiency disorders and vitamin A.

As you know, real progress in health depends to a great extent on stronger health systems based on primary healthcare. We need to re-think how to effectively provide nutrition interventions through primary healthcare.

We are pleased to hear that in this meeting, along with sharing research experiences, relevant areas will be short-listed for priority operations research in the primary healthcare setting. Accordingly, a framework mechanism for networking, capacity building and dissemination will be formulated.

The Global Strategy on Infant and Young Child Feeding, jointly developed by WHO and UNICEF, was adopted by the Fifty-fifth World Health Assembly in May 2002. The goal of the Strategy is to empower all families to make and carry out informed decisions in conditions that support exclusive and continued
breastfeeding, and timely and adequate complementary feeding, for every child. There is sufficient evidence to show that when adequately informed and suggested, mothers can appropriately feed their infant and young children. Yet, not much is being done to implement this.

Likewise, appropriate infant and young child feeding is now recognized as a key intervention in the management of childhood illnesses. You are in key positions to identify what action is needed to improve the national figures for infant and young child feeding in your countries.

This meeting also aims to bring into the mainstream another crucial issue of growing public health concern: the elimination of iodine deficiency disorders. Although countries have included IDD elimination activities in their national workplans, their progress needs to be accelerated. WHO has started assessing these IDD control and prevention programmes in the countries, along with our partners, UNICEF and ICCIDD. Now, it is for you to identify the areas that need further attention in order to achieve optimal and sustainable iodine nutrition.

You will agree that advocacy for nutrition needs urgent attention and effective means to get the attention of policy-makers. Thus, the first requirement is a common understanding for possible nutrition advocacy tools.

We are at the beginning of yet another decade of challenge to combat malnutrition. However, the Network needs to further accelerate its pace. It also has the responsibility of seeking and extending possible collaboration with WHO collaborating centres in other regions with similar interests. This would lead to a better understanding of global nutritional problems and ways to minimize them through learning and sharing experiences.

The Regional Office for South-East Asia has also constituted an Advisory Committee on Health Research (ACHR) to provide policy advice to Member States in developing health research systems and further improving their health systems. This Committee consists of members from a wide academic background. Recommendations for nutrition research should ideally be conveyed to the higher policy body of research, which is the ACHR. Similarly, relevant future policies and strategies for research in the Region can be adopted and followed up by the Network members.

In conclusion, I hope that on the basis of the ongoing situation analysis and current advanced knowledge, you will be able to revise, re-prioritize and restructure your strategies. Your efforts will contribute towards achieving a better and sustainable health and nutrition status for the people of our Region.
HIV and Infant Feeding

Nearly 6 million persons are living with HIV/AIDS in our Region out of 42 million globally. This makes South-East Asia, the second most affected Region in the world after sub-Saharan Africa. Of the estimated 800,000 to 900,000 people in South-East Asia who need HIV treatment, the majority live in India, Thailand, Myanmar and Indonesia.

As you are aware, HIV infection among children is increasing. Though breastfeeding is the best way to feed an infant, a voiding breastfeeding is also one of the ways to reduce the risk of mother-to-child transmission of HIV. At the same time, there are considerable risks associated with not breastfeeding, particularly in resource-poor settings. The relative risks of morbidity and mortality associated with replacement feeding vary with the environment and individual circumstances. Lack of breastfeeding has been shown to expose children to increased risks of malnutrition and life threatening infections other than HIV.

The new “Three by Five” goal set by WHO aims to provide three million HIV-infected people in developing countries with antiretroviral drugs by the end of 2005. Along with the emphasis on treatment, efforts in prevention, counselling and care also need to increase. Effective treatment, combined with prevention strategies, will be crucial for improving the health of the millions living with HIV/AIDS.

As you may be aware, in 2003, a framework for priority action on HIV and Infant Feeding was jointly developed by nine international agencies, namely: UNAIDS, FAO, UNHCR, UNICEF, WHO, WFP, the World Bank, UNFPA and IAEA. The main purpose of the framework is to recommend to governments key actions related to infant and young child feeding that cover the special circumstances associated with HIV/AIDS.

The major challenge in dealing with the HIV pandemic is the need to develop appropriate policies and guidelines. HIV and infant feeding is a complex issue with significant knowledge gaps.

Intercountry Workshop on HIV and Infant Feeding, New Delhi, India, 4-18 May 2004. Delivered by WHO Representative, India.
Where breastfeeding in general is protected, promoted and supported, HIV-positive mothers will still need special attention, as laid out in the Global Strategy for Infant and Young Child Feeding. They will need to be empowered to select and sustain the best feeding options. This would include general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the one most suitable for their situation. It is also important to protect, promote and support breastfeeding for those who are HIV negative or untested, and to prevent any spillover of artificial feeding to infants of uninfected mothers. Through this combined approach, it should be possible to achieve the ultimate goal of increasing overall child survival, while reducing HIV infection in infants and young children.

In this context, I would like to refer to an important area needing attention. This is with regard to counselling. Skilled infant feeding counsellors are needed, to enable HIV-positive mothers to take a fully informed decision on infant feeding methods. These counsellors can also counsel mothers who are HIV negative, or of unknown HIV status, about breastfeeding.

To address various issues related to the subject, WHO, UNICEF, and UNAIDS developed a training course on HIV and infant feeding in 2000. The course was aimed at developing the skills of healthcare workers to provide practical information to mothers on the risks of transmission and infectious disease mortality and the options for replacement feeding.

The need for this training course in South-East Asia emerged after discussions with organizations concerned with HIV and infant feeding. Health workers have not received specific training on HIV and infant feeding counseling. As a result, this component is conspicuously weak in prevention of mother-to-child-transmission (PMTCT) counselling.

It is therefore most appropriate that this workshop seeks to build regional capacity of trainers on HIV and infant feeding. It is also aimed at improving the knowledge and skills of health providers in counselling HIV positive mothers on infant feeding. Trained counsellors would also be an asset in developing community capacity to help HIV-positive mothers regarding infant feeding. This workshop will provide a forum to discuss avenues for country adaptation of the training package and for conducting future training programmes in your own countries. We hope that you will integrate this counselling and support into maternal and child health services, PMTCT centres, and simplify counselling to make it more relevant and to enhance its coverage.

I am confident that this workshop will achieve its aims in full measure. Finally, I would like to re-affirm WHO’s commitment to sustain and enhance every effort in improving the health of the people of our Region.
A Vision for Health Development in South-East Asia

Nursing and Midwifery

Nursing and midwifery personnel constitute a vital segment of the healthcare workforce. As noted by the Commission on Macroeconomics and Health, they can be a valuable resource for national health development. They can facilitate equitable access to quality health services particularly at the community level. In addition, they can help in scaling up the health system responses for achieving the Millennium Development Goals.

It is now well recognized that a skilled and competent nursing and midwifery workforce is essential for a well-functioning health system. It is also accepted that there is little point in having excellent doctors and other health staff, if nurses and midwives are not skilled and committed and if nursing and midwifery services are not appropriately supportive and complementary.

Our Region needs to have the right numbers of nursing and midwifery personnel with the right skills and attitudes, at the right places, and at the right time. We need to have competent and motivated nurses and midwives. They, in turn, should provide quality care, contributing to the provision of equitable and accessible quality health services. For this to happen, we need to have a well managed nursing and midwifery workforce.

There is strong evidence that a well-managed nursing and midwifery workforce contributes to reduced hospital morbidity and mortality. This, in turn, contributes to reduced costs, and to strengthening of effective health services. The deleterious effect of poor staffing levels and poor working conditions has also been documented. For example, insufficient staffing and poor support for nurses often leads to low-quality patient care.

A well-managed nursing and midwifery workforce is, therefore, a major contributing factor to cost containment, and quality improvement. It is also a

strategic government investment of the highest importance. Hence, problems confronting nursing and midwifery workforce need to be strategically addressed. For this reason, a regional multidisciplinary Advisory Group on Nursing and Midwifery Workforce Management was established in 2001. This group helped in addressing the problem of continuing shortage and maldistribution of appropriately skilled nursing and midwifery personnel along with inappropriate professional skill mix in many countries of the Region.

This Advisory Group concluded its work at the end of 2002 and produced guidelines on how the nursing and midwifery workforce can be effectively managed. These guidelines have now been widely disseminated to promote their application in countries of the Region.

In-depth country assessments carried out in 2002 under the guidance of the Advisory Group provided some interesting insights. For example, even though considerable progress had been made in countries of the Region, there were serious, systemic weaknesses in all components of the workforce management. These required comprehensive and sustained strategies as well as broader and more vigorous leadership and support to resolve.

Consequently, the management of nursing and midwifery workforce was included as an agenda item at the 56th session of the Regional Committee in September 2003. The Regional Committee adopted a resolution urging Member States to provide support and adequate resources to address priority issues confronting the nursing and midwifery workforce.

Nursing and midwifery workforce is now receiving greater attention at the highest level in the Region. The Advisory Group on Nursing and Midwifery Workforce Management, of which many of you were members, was largely responsible for this achievement. The Group’s work has been greatly appreciated and I am considering forming an advisory group in other priority areas to facilitate similar developments.

Despite these developments, much remains to be done to further strengthen our nursing and midwifery workforce. There will be intensified actions at country and regional levels towards ensuring effective management of the nursing and midwifery workforce. With this in mind, this new multidisciplinary Advisory Group on Nursing and Midwifery has been formed. It will help address priority issues in nursing and midwifery including facilitating, monitoring and evaluating the implementation of the action plan for strengthening nursing and midwifery at regional and country levels.
Your work poses a real challenge. It is now incumbent on you to provide advice on priority areas of work. This will include addressing important issues confronting nursing and midwifery in the Region, together with the proposed strategies to make effective use of nursing and midwifery resources.

It is also crucial that you suggest how to adapt the newly developed guidelines for effective management of the nursing and midwifery workforce according to country needs. The development and implementation of an associated action plan also needs your attention.

I look forward to the outcome of this meeting and assure you of WHO’s continued assistance and collaboration.
Sustainable Development and Healthy Environments
We know that the state of the environment influences human health in many ways. WHO and its partners devote much of their efforts in addressing ‘traditional’ environmental health risks, for example, providing clean water and sanitation, and reducing air pollution. In recent years, however, WHO has also become concerned over newer, emerging risk factors, over much wider scales.

There is accumulating evidence that some of the life support functions of the global environment are being stretched beyond their limits. One of the greatest environmental concerns is the effect that human activities are having on the climate of the planet.

The scientific community has learnt much about global climate change in recent years. The Intergovernmental Panel on Climate Change (IPCC) reflects a widespread consensus on climate science. Their 2001 report shows that human activities, particularly burning of fossil fuels, have caused atmospheric levels of heat trapping “greenhouse gases” such as CO2, to increase by more than 30% since pre-industrial times.

This has caused significant disruption to the global climate system: the global average surface temperature has increased by about 0.6°C over the last century; the decade up to 2004 has been the warmest since accurate records began in the 1850s, with nine of the ten warmest years ever recorded; many areas have experienced increases in rainfall, while in others, the frequency and intensity of droughts have increased.
As populations and economies grow, global emissions of carbon dioxide are increasing. The IPCC has projected that over the next century: global mean surface temperature will rise by between 1.4° and 5.8° C; the rate of warming will be greater than at any time during the last ten thousand years; and weather extremes are likely to become more frequent and severe, increasing risks of floods and droughts.

Weather and climate have many effects on human health. Over 600,000 people died in weather-related disasters in the 1990s. Temperature and rainfall influence the frequency and rates of diseases such as diarrhoea, vector-borne infections and malnutrition, which together kill over 3.5 million a year.

We can only make approximate estimates of the effects that rapid climate change will have on health. But our best understanding of these relationships suggests that climatic change since the 1970s may already be causing over 150,000 deaths annually; and that this burden will increase in the coming decades. The poorest populations, who have contributed least to the problem, are the most vulnerable to climate change.

What I have outlined so far is the global picture. However, the impact is local, and varies from place to place. Much of the attention so far has focused on the threats that climate change poses to low-lying areas, such as small island States. However, we are also beginning to realize that mountainous areas may have their own, equally important vulnerabilities.

Global temperature increases are greatest over land, at high latitudes and at high altitudes. We know that physical changes are already taking place in the mountainous regions. Perhaps the most obvious is the retreat of glaciers, in many cases causing large lakes to form in their place. The lake at Lower Barun Glacier in Nepal, for example, was not visible on maps published in 1967, but by 1996, it had grown considerably.

These physical changes bring health risks. Vector-borne diseases may well take advantage of warmer habitats at higher altitudes. More variable precipitation is likely to bring more floods and landslides.

A risk that is unique to mountainous regions is that of glacier lake outburst floods, which can cause many deaths. In addition, populations in many mountainous regions, and their neighbouring lowlands, rely on water from predictable, seasonal glacial melting. The retreat of glaciers therefore heightens the threat of water insecurity, which, in turn, increases the risks of diarrhoeal diseases and a reduction in agricultural production.
This is a cause for grave concern. But it does not mean that we are powerless to respond. Vulnerability to climate change is also influenced by our own actions, and there is much that we can do to protect ourselves. Sustainable economic development could allow the poorest populations to counter climate-sensitive diseases such as malaria; providing reliable access to clean water and sanitation could prevent water-borne and food-borne illness. Early warning systems and advice on good behavioural practice can reduce deaths in heatwaves, and environmentally-sensitive land-use policies can prevent deforestation and reduce flood risks.

While we can, and must adapt to climate change, this does not give humans a licence to continue to pollute the atmosphere. Decisions taken today will affect the climate for many decades, and many of the consequences will be permanent.

While many uncertainties remain, we know enough to have serious concerns over the threats posed by a rapidly changing climate. We have a collective responsibility to minimize the impact on the life support systems of our planet, and avoid imposing health risks on the future generations.

I would like to leave you with some thoughts on our shared global responsibilities. These were presented at this year’s World Health Assembly, by a leader from a neighbouring country threatened by climate change; His Excellency Mr Maumoon Abdul Gayoom, President of the Maldives. He stated that, in the case of Maldives, global warming ‘threatens the very survival of the nation’, not only through economic impacts, but also through its health effects; increasing vector-borne disease, reduced fish stocks, and salination of water supplies and agricultural land.

He also made it clear that the solution is to work together, across sectors and national boundaries, both to reduce and to adapt to climate change. His Excellency, the President concluded: “The links between the environment and health show that addressing the challenges in both areas calls for a global partnership, where everyone becomes part of the solution and none a problem... at the end of the day, prevention is still better than cure. And let that be our goal in promoting environmental health.”
Social Determinants of Health

This meeting has given us an opportunity to discuss in-depth the critical issues of Social Determinants of Health. We identified concrete steps forward to make a real difference in reducing health inequalities. If we are to make a real difference, we have also to carefully study the socio-political conditions in countries, and promote healthy public policies.

There is an urgent need to promote healthy behaviours and lifestyle; and address sociocultural issues in the most appropriate context. In fact, there are too many things to be done; how we address them strategically is crucial.

Health is a social goal. And we accept that responsibility for health and managing health inequity has to be shared by all concerned sectors. Outside the health sector, there exist an array of opportunities, institutions, individuals and organizations engaged in human development.

I am very happy that sectors beyond health participated in this regional consultation. This is an indication of our willingness to work together in addressing inequity in health. In this process we can draw strength from the positive experiences in the Region in addressing these issues. We plan to include this subject in future meetings of Health Ministers and the Regional Committee, so that we can move forward with adequate policy and political back up.

As highlighted during the course of the consultation, we have a fertile environment to refocus on the social conditions and determinants. The current global development agenda, and the Millennium Development Goals, present an excellent opportunity in this regard. Since the MDGs recognize the interdependence between health and social conditions, the opportunity to promote health policies that tackle the roots of unfair and avoidable human
suffering should not be missed. With this, I would like to gratefully thank the distinguished Commissioners and the Commission Secretariat who travelled a long way to enlighten us on various issues. I look forward to their continued support to our work in this area.

I thank participants from Member States who provided extremely useful inputs to the Consultation. The valuable contributions from representatives from bilateral and multilateral agencies, and civil society are very much appreciated. I sincerely thank them all. Our WHO colleagues from Headquarters and the Western Pacific Regional Office have actively participated in the discussions, and provided much-needed inputs in the process. Their inputs are deeply appreciated. Our SEARO staff members have also worked hard to ensure the success of the Consultation, and their work in this regard is very much appreciated.
A Vision for Health Development in South-East Asia

It is more than two months since the tragedy of the earthquake that resulted in the Tsunami on 26 December 2004. The disaster has left countless dead; and millions more homeless, with their lives shattered. This was really unprecedented in terms of geographical areas affected, and the severity of its devastation.

WHO’s response was also unprecedented, as far as coordination, management and logistics are concerned. Human resources had to be mobilized from everywhere in the Organization, as well as from outside. We, in SEARO, worked closely with HQ, particularly the Department of Health Action in Crises, in developing a platform for WHO’s response. More than 200 professionals from various disciplines have been deployed for WHO operations in the Tsunami-affected countries.

WHO had mounted a flash appeal to donors for 67 million US$ for financing its emergency operations, which have to be completed within 6 months. We have to move very fast to accomplish our tasks in time, otherwise it is likely that funds will not flow in as expected. It is like a “mission impossible”. However, we should look at it as a challenge to our capacity to deal with a crisis of this magnitude.

We must try hard to succeed in our work in this mission. As we can see, this work is for the Organization as a whole. If we fail, it will be the failure of the Organization.

We must also realize, at the same time, that donors are very concerned with our accountability in the use of their contributions. We have to be ready...
to demonstrate in the most transparent manner our accountability, in both financial and technical terms.

We are here to take stock of our experiences during the past two months, identifying our strengths and shortcomings. We will find solutions together for the problems and constraints facing us. It is our Organizational responsibility to steer our concerted action towards a common purpose during the next four months, keeping in mind the very difficult situation, both technically and politically.

To effectively respond to the needs of the countries during the initial stage of the crisis, we have to ensure the efficiency and effectiveness of our operations, especially in the coordination of technical resources, from both within and outside WHO. Specifically, during the course of this meeting we will clarify the process for implementation of the workplans of the flash appeals. We need to gain consensus on such workplans; consensus on management guidelines and procedures; and consensus on the tools for implementation, using the project approach.

In this connection, I would like to point out that our regular management styles may not be able to serve the purpose of emergency operations of this magnitude. There is a need to find innovative ways and means of working to ensure that we can accomplish our tasks on time and effectively.

WHO Country Offices have to continue to be the focal points at the country level under the leadership of WHO Representatives. The WRs will have to continue to ensure the most efficient and effective use at the country level of all available resources at their disposal, especially expertise which comes from various sources. Please keep in mind that under this type of operations, no office can work alone. The Country Office has to get help from the Regional Office, and the Regional Office has to get help from HQ and other Regional Offices.

To be effective, we have to depend on each other. Therefore, the spirit of cooperation among these offices is of paramount importance. This spirit will only come from our common concern with, and our common understanding of the situation that we are facing together.

I can state that such a spirit within the Organization has been strongly evident since the beginning of this catastrophe, in spite of some difficulties in the process. Now, we are looking at the way forward, whereby our unified direction and united force will assist us all in this challenging work.

Every disaster presents opportunities to improve the health of people. Together, we must seize this opportunity to further develop our technical capacity in disaster preparedness and response; and in supporting the countries in reviving and strengthening the health system infrastructure that was devastated by the Tsunami disaster.
Disasters and development were traditionally thought of as distinct from each other, rather than as linked social experiences and endeavours that needed to be addressed. Recent changes across the world, particularly in this part of Asia, have clearly shown the interlinkage between disasters and development.

There is, in fact, a synergistic and cyclical relationship between disasters and development. The goal of disaster and emergency management is to reduce risks, to create safer communities, and to safeguard the existing as well as the potential gains of development. Conversely, development that is risk approach-oriented prevents and mitigates the deleterious effects of catastrophic events. A good example would be establishing efficient hospital systems and training health professionals to attend to populations affected by an earthquake. But then, in many cases, hospitals themselves cannot withstand tremors and earthquakes due to poor construction. It then becomes a case of development creating more risks and vulnerabilities; this should be prevented. This is just one example from within the health sector.

There are, however, development issues impinging on wider areas, such as the environment, urban planning, and migration in which development may generate further risks and disasters if not addressed appropriately.

The health sector not only prepares for and responds to disasters but needs to involve itself in other sustainable development issues. After all, a risk to health is a risk to achieving development, with the reverse being true as well. In this context, risk management plays a key role.

First International Training Course on Disasters and Development (D&D-1), Bangkok, Thailand, 1-12 November 2004. Delivered by WHO Representative, Thailand.
This concept cannot be overemphasized. The health sector, in fact, can play a catalytic role in risk reduction in general. The 57th session of the WHO Regional Committee for South-East Asia adopted a resolution urging Member States to, among others, take necessary steps to reduce and manage risks and strengthen national capacity in various areas of risk management. This course is part of WHO’s commitment to support Member States in their efforts at disaster management and response.

To my knowledge, this course is a product of various experiences and the efforts of several experts. The concept of training leaders in the area of disaster risk reduction in the health sector was adapted from the LEADERS Course in the Americas, developed and managed by PAHO. This was merged with the general principles of the UNDP Disaster and Development training programme. The resulting basic framework for this course was then re-designed according to the context and needs of the Region.

At the end of this course, participants are expected to be able to promote the practice of public health risk/emergency management that contributes to sustainable development in a comprehensive and integrated way. This course is a collaborative effort of three organizations, WHO-SEARO, UNDP and Asian Disaster Preparedness Centre. I would like to thank our partners for their cooperation in this endeavour and look forward to more such ventures.

I am confident that you will return to your place of work with the knowledge gained in these two weeks. Furthermore, through the network you will be able to develop in the course of the training, I hope you will be able to translate the concepts discussed into action.
Arsenic Epidemiology and Research

One of the major burdens of disease caused by exposure to arsenic worldwide is from contamination of groundwater. Groundwater contamination, in excess of the WHO guideline value, has been observed in many parts of the world, including five Member Countries in the South-East Asia Region.

The affected countries are Bangladesh, India, Myanmar, Nepal and Thailand. Over 10 million tube wells are in use in the Region potentially exposing between 40 and 50 million persons to unsafe levels of water. The associated disease burden is projected to be around 12 million persons within 10 years.

WHO first assessed the risk of arsenic in drinking water in 1958 by producing the International Standards for Drinking Water. Our interest in arsenic has not stopped. In 1981, in collaboration with other UN agencies, WHO published the Environmental Health Criteria series, Arsenic and Arsenic Compounds, to evaluate the health risks to man from exposure to arsenic. Globally, the WHO Guidelines for Drinking Water Quality, published in 1993, has been used as the basis for the development of national standards for arsenic.

Realizing the serious health impacts of arsenic contamination in our Region, the WHO Regional Office for South-East Asia has provided, since 1996, policy and technical support to national governments of the affected countries. In 1997, the Regional Office held a regional consultation of experts and made 20 key recommendations for arsenic mitigation. These recommendations have been used as a basis for designing projects and implementing programmes by national governments, donor agencies and NGOs alike.

However, on reviewing the progress, it is evident that there are serious gaps in the methodology used for health risk assessment and research on arsenicosis in our Region. A standardized health risk assessment protocol is essential to gauge the extent of contamination and exposure and for determining the magnitude of health hazards and to design risk management strategies.

The absence of a standardized risk assessment module partly explains the wide range in the projected number of arsenic-affected patients in our Region. In order to address these issues, the Regional Office, in 2002, launched an arsenic mitigation initiative. This initiative is backed by the highest level of policy support from the WHO Regional Office.

First, a High-Level Task Force consisting of representatives from Member Countries recommended that intercountry collaboration on arsenic poisoning be intensified. Secondly, the Regional Committee for South-East Asia, adopted a resolution on arsenic poisoning which urged WHO and Member States to intensify collaborative efforts in this field. This was followed by the WHO Advisory Committee on Health Research recommending health research in arsenic mitigation.

The highlights of our arsenic mitigation initiatives consist of setting norms and standards and establishing guidelines for risk management by the formulation of standard case-definition, reporting and management.

The Regional Office has already provided technical support in various disciplines, including toxicology, dermatology, oncology, epidemiology and public health, in the formulation of a risk assessment module. This module is based on a problem-based approach for teaching arsenic epidemiology and scientific contributions were provided from Bangladesh, India and Thailand. This module was field-tested in April 2003 in Bangladesh and an edited version has now been produced. We have now reached a critical stage where this module has to be disseminated and promoted in the Member Countries.

I must emphasize that the role of WHO is to provide technical inputs in the development of “blueprints” for action. As the distinguished participants are aware, an evidence-based health risk assessment module will have tremendous public health significance. For instance, it will allow comparisons between different studies in the same country or in different countries of the Region and help in making valid estimates of the extent of arsenic contamination.
The lack of a health risk assessment protocol has led to a number of unsubstantiated estimates of the extent of arsenic contamination in the food chain and different modalities for the management of arsenicosis in the South-East Asia Region. In addition, substantial evidence-based research on arsenicosis has been lagging in our Region. These impediments will be removed when we adopt a regional health risk assessment module on arsenic epidemiology.

A well-recognized strength of WHO is the partnership it forges with other agencies and research institutions in fulfilling its normative functions. This workshop has brought together experts to share their experiences, which will enrich knowledge and practical approaches to deal with health risk assessment on arsenic contamination in our Region.

It is important to note that WHO’s role is basically to provide technical inputs in the development of “blueprints” for action. The blueprint for health risk assessment promoted during this workshop will be uniformly used in our Region to produce a critical mass of trained doctors, scientists and health care professionals who can respond to national needs and conduct proper operational research in this area. It will be the basis for university and teaching institutions to enhance their curriculum in arsenic epidemiology in affected countries. Eventually, it will help in programme implementation by national governments, donor agencies and NGOs.
Health Systems Development
Healthcare Beyond the Large Hospitals

Hospitals are the backbone of health systems. Whether they are large or small, hospitals have traditionally been regarded by the layman as important and rather awe-inspiring institutions for healthcare. With scientific and technological advances, the number of hospitals in our Region, especially in the private sector, has increased significantly during the last few decades.

Hospitals pose many challenges to those undertaking reform of healthcare systems. They are quite literally, immovable structures, set in concrete, usually many years previously. Their configuration often reflects the practice of healthcare and the patient populations of a bygone era. Their incompatibility with present needs ranges from major design problems, such as scarcity of operating theatres, to minor problems, such as the lack of power sockets for the ever expanding number of electronic monitors.

It is not only the physical structure that is difficult to change. Hospital functions are also resistant to change. This may be due to several reasons, but vested interests play a major role. Given these constraints, it is not surprising that hospital reform is viewed with trepidation by some health policy makers.

Yet, hospitals are a very important element of the healthcare system. Hospitals account for nearly 50% of overall healthcare expenditure in industrialized countries. There is also a disproportionately high allocation to the tertiary level of hospitals at the expense of first-referral facilities and preventive and promotive care. In developing countries, resources (and hence services) are generally concentrated at the tertiary level. Typically, less than 25% of the recurrent expenditures accrue to the primary level. Organizationally, hospitals

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Annual Academic Sessions of the Kandy Society of Medicine “Healthcare Beyond the Large Hospitals”, Plant Genetic Research Auditorium, Peradeniya, Sri Lanka, 10 February, 2005. Delivered by Director, Programme Management, WHO/SEARO.
dominate the rest of the healthcare system. Symbolically, they are viewed by the public as the main manifestation of the healthcare system.

The configuration of hospital services in a given setting reflects the tension between two competing objectives: centralization versus dispersion of hospital services.

There are two arguments for centralizing hospital services. First, hospitals and clinicians undertaking high volumes of work achieve better outcomes; and second, large hospitals achieve economies of scale. The counter argument for dispersing hospitals is that this improves population access and reduces inequalities.

Studies have shown that access is generally more important in relation to primary care, outpatient services, and screening programmes, with inpatient care being relatively less affected. These findings have important implications for hospital planning, since they show that hospital size is only one consideration. For example, the overall mix of functions required to meet the needs of the population served must be decided; and it must be then determined how each function can best establish a critical mass for providing good quality care.

Although resources and services are heavily focused on specialized healthcare, the main causes of illness and death in most developing countries are preventable and easily treated. This includes diseases, such as acute respiratory illnesses, diarrhoea, and malaria. It is estimated that 90% of illnesses could be prevented or treated at the primary level, provided that services are of good quality and accessible to the majority of the population. Significant portions of health budgets are, however, allocated to hospital-based services. This, unfortunately, does not favour the poor. Targeting health services to the poor would require less spending on hospitals and more on primary facilities.

Poor households are often located some distance from government health facilities. This means that members of these households typically face long journeys and high opportunity costs to obtain healthcare. Time spent away from economic activity represents much greater private opportunity costs for the poor, who, unlike their salaried counterparts, have to forego income in order to obtain medical care. These costs can dominate the decision to seek care. Studies have shown that halving the distance to public health facilities significantly increased their use among the population.

The key challenge is to know what the hospital of the future should look like. A prime issue will be the continually changing burden of disease. The
nature of the change will be different in every country, reflecting differences in, for example, diet, smoking rates and exposure to risk of injury or infections. Advances in technology will also have a great influence. The hospital of the future will need to respond to all these challenges.

Healthcare has become increasingly depersonalized, disease-centered, hospital-based, fragmented and expensive. There is a need to pursue a more community-centered approach to healthcare, addressing the main issues of equity and access to healthcare by all. It was this growing concern for social development issues which led to the declaration of Alma Ata in 1978, identifying primary health as the key approach to achieve the goal of health for all. The call for health for all was, and remains a call for equity and social justice. The South-East Asia Region, which is home to one quarter of the world’s population and about 40% of the world’s poor, has achieved significant gains in health through primary healthcare over the past decades.

Though the concepts developed in Alma-Ata continue to play a significant role in key aspects of regional health policy, in recent years, additional ideas have further shaped the policy environment. The recommendations of the Commission on Macroeconomics and Health emphasize the importance of investing in health as a means of improving economic development and highlight the need for intersectoral and community action for health as a way forward.

I would like to reiterate the need to increase investment for health. Except in the Republic of Maldives, the total health expenditure in the Region ranges from two to five per cent of the GDP. Most of this expenditure is accounted by out of pocket payments.

Furthermore, the internationally agreed development goals contained in the United Nations Millennium Declaration, Agenda 21 and the plan of implementation of the Johannesburg Summit require strengthened health services for all as a crucial measure to improving health, especially in the poorest countries of our Region. Several new structures, such as, Global Alliance for Vaccines and Immunization (GAVI), and the Global Fund for AIDS, Tuberculosis and Malaria (GFTAM), provide impetus to new ways of providing access to treatment within effective healthcare delivery systems within our Region.

The District Health System approach, promoted by the WHO South-East Asia Region to strengthen primary healthcare was a major breakthrough to deliver healthcare in an integrated, cost effective way. The Mongar District of Bhutan, winner of the prestigious Sasakawa Health Prize in 1997, is a success story reflecting this phase.
The primary healthcare approach, championed by WHO, triggered a variety of community development schemes. Examples are the Rural Health Development Scheme in Indonesia, and the Basic Minimum Needs initiative for quality of life improvement in Thailand. Broader development initiatives, such as the Model Village Movement in Bhutan and Sri Lanka were launched. These initiatives, through their broad-based intersectoral development approach, with the participation of the communities, were not confined to the narrow technical elements of PHC, but addressed socio-economic, environmental and cultural aspects as well. Several of these health initiatives in the Region also received international recognition.

With the double burden of communicable and noncommunicable diseases, and demographic changes, particularly an increase in the population of the elderly, the need for long-term and chronic care, and care to manage the activities of daily living, in addition to strengthening the basic healthcare services, has increased significantly. Moreover, given the escalating costs of health services, vulnerable and underprivileged groups will be even more deprived. Therefore, there is an urgent need for Member States to extend health services beyond hospitals.

This approach was earlier exemplified in our Region by a “Community Health Worker” (CHW) scheme launched in India in 1977, with the objective of training one CHW for each village. The underlying philosophy was to place people’s health in people’s hands. In Bangladesh, a village doctor scheme was launched in 1977 with the aim to train one village doctor for every village. Indonesia also adopted a “Village Community Health Development” programme in 1977. Thailand implemented various community-based health development schemes such as the “Lampang Health Project” in 1974 for training village health volunteers and village communicators.

This community-based approach is critical for addressing the challenge posed by HIV/AIDS and other priority public health problems. For example, HIV-infected TB patients with serious symptoms cannot be expected to visit a health centre for medicines every day. They should be included in the home-based DOT programme.

A major challenge facing the Region is inequity in health. Inspite of the increased coverage in health services through primary healthcare during the past two decades, 25 to 30% of the population does not have access to standard quality healthcare. The market- oriented approach and privatization of healthcare without effective regulatory systems has had a negative impact on
people’s health. In a private healthcare market, access to healthcare is dictated by the consumer’s purchasing power. In a Region where the majority of the people are poor and have neither sufficient information nor the buying capacity, a profit-oriented market system cannot serve the health interests of the poor. Besides, there is also a supplier-induced demand leading to technical inefficiency resulting from unnecessary use of highly sophisticated health services.

The countries of the South-East Asia Region face a major challenge related to increasing healthcare costs. Thus, accessibility to health services is an important issue that the Member States need to address. There is a continuing trend to shorten hospital stay. For cost-effective care, several health interventions can be carried out within the community or at home; e.g. antenatal care, immunization, safe delivery, newborn care, palliative care and management of chronic diseases such as diabetes and HIV/AIDS. Furthermore, for most people, home is the setting of choice for receiving care. Therefore, it is imperative to extend health services beyond the hospital walls, particularly to those in the greatest need.

Health planners have observed the rapidly escalating costs of healthcare in both the private and public sectors. This seems to be influenced by use of high technology in areas of specialization and super specialization, and by hospitalization and extensive investigations which make a major contribution to these increasing costs. Family medicine – with its orientation towards ambulatory or out-of-hospital care, preventive medicine and health maintenance, the selective way of diagnostic investigative procedures and the rational use of drugs and therapeutics – has been welcomed by health planners as a substantial way of controlling healthcare costs while preserving and expanding the quality of patient care.

There is a need for improvement of the quality of life and for the active participation of families and communities in promoting and protecting their own health. Empowering families and communities will increase awareness and the demand for quality health services.

There is a need to provide care rather than cure. Care requires people, rather than equipment, and generalists rather than specialists. Centralization of services in large hospitals has its limitations, particularly with regard to cost, and also because access is more important for patients and families. Thus, the existing healthcare system has to be reoriented towards the provision of holistic, integrated and continuous healthcare that needs to be extended beyond healthcare facilities and large hospitals. Restructuring of health services is required
to shift the emphasis from curative care (or to restore health) towards increased attention to health promotion and protection (or to build good health).

Healthcare services must be redesigned to meet local health needs as identified by the community. Activities and tasks should ideally be the responsibility of the person or institution best suited to perform them. Health personnel should refer patients for more specialized care and treatment when necessary. All services should place patients/clients at the centre of care and contribute to the development of a good relationship between the service providers and clients, based on mutual trust.

In conclusion, I would urge governments to provide to their people, particularly the underserved and the poor, a high quality of healthcare, while rationalizing high technology applications and working intersectorally to promote health. There is a need for the private sector and nongovernmental organizations as committed allies to join hands with governments and the people, empowered with a new sense of responsibility and participation, in pursuit of common goals for health. In fact, the future of health is linked strongly with the results of primary healthcare initiatives in countries of our Region.
Strengthening Health Information System

I extend a warm welcome to you all to this important consultation on strengthening health information systems in countries of Asia and the Pacific.

Reliable and timely health information is a critical component in health system development. Collection of relevant data and its related analysis to provide necessary evidence for assessing the development and performance of health systems at national and sub-national levels is a major role of any health information system. Providing timely feedback to programme managers has been a challenging task for the health information teams at all levels of the health system.

It has been observed that national health information systems often function vertically. They are centrally-oriented and overloaded with data, many of which are not fully relevant to programme management at operational levels. In addition, monitoring and evaluation processes of the health system are usually not systematically built into or connected with the routine health information system.

Bi-regional collaboration between the WHO Western Pacific Region and the South-East Asia Region has recently been initiated, and the field of health information, particularly joint publications, monitoring of basic core indicators and the progress on MDGs have been identified as priority areas. Since the beginning of 2004, this collaboration has been intensified.

This bi-regional consultation has been organized as an informal WHO meeting, (a) to discuss and formulate a framework for strengthening health information system in Asia and the Pacific; (b) to identify issues and challenges
in collection, compilation, analysis and dissemination of basic core health indicators including MDG indicators; and (c) to review and finalize the publication of the basic core health indicators, 2005, for Asia and the Pacific and the progress towards achievement of MDGs in Asia and the Pacific region.

As an outcome, a draft framework for strengthening HIS in countries of Asia and the Pacific will be formulated.

I am pleased to learn that a Health Metrics Network to strengthen health information has recently been launched. I look forward to using this platform in our Regions to provide further impetus to our efforts. The technical support and assistance of our colleagues from WHO Headquarters to this meeting and also to bring forward partnership with Health Metrics Network is very much appreciated.

Given the provisional programme of work, you have a challenging task ahead. I am sure you will share your experiences and expertise and consider better ways to effect positive change in health information systems. This would help to obtain more reliable and valid data for use in evidence-based decision-making and also for assessing health systems performance in countries of the Region.

I would like to emphasize that this consultation is very timely in the context of bi-regional collaboration for assessing the health situation in countries of both Regions.
Role of Thai Ethics Committee in Clinical Research

Ethics is a very special area of concern since it comprises thoughts, knowledge and practice of moral issues and aspects in one’s professional and, indeed, everyday life.

In the medical profession, ethics can be traced back to the time of Hippocrates. Up to this day, it is the pride of every medical practitioner to honour and uphold the Hippocratic oath. The message conveyed by the oath is very simple. It can be summarized as, “do no harm”.

Advancements in technology and communication have brought dramatic changes to health and healthcare, and have helped mankind to attain better health. At the same time, they have also widened the gap between the rich and the poor. Health systems in many countries, especially in the developing world, are unable to transfer the benefits of these advancements to the poor and the vulnerable groups who actually need healthcare the most.

Infectious diseases continue to pose a major challenge in the Region. Approximately six million people are estimated to be HIV positive. An estimated 1.3 billion people, or 85% of the total population of the Region are at risk of malaria. Furthermore, nearly three million people in the Region suffer from TB which claims 750 000 lives every year. The close relationship between TB and HIV is well known. In Mumbai, India, for example, 30-40% of TB patients are also HIV positive.

Even though under-five mortality has decreased by one third since the 1970s, the number of deaths in this age group is approximately 10 million

Workshop on the Role of Thai Ethics Committee in Clinical Research, Chiang Rai, Thailand, 29-30 October 2004. Delivered by Director, Programme Management, WHO/SEARO.
annually. Of these children, 70% succumb to acute respiratory infections, malaria, diarrhoea, measles and malnutrition and often to a combination of these diseases. In addition to the high incidence of communicable diseases, noncommunicable diseases are also increasing.

With the outbreak of SARS and Avian Influenza in recent years in many countries of the Region, the need for enhancing health security by maintaining outbreak alert and response mechanisms to respond rapidly to crisis situations has become obvious.

The high disease burden in the South-East Asia Region presents opportunities to researchers to develop new or improved medicines and vaccines to combat various diseases. The potential for research in the Region is thus very wide. It ranges from basic research and pragmatic research to applied research and health systems research. It includes advanced research on clinical trials and genetic determinants of health and disease. The rise in research activities in the Region increases the need for ethics in health research, especially when the research involves humans as research subjects.

Ethics in health research, though practised for many years in developed countries, is just beginning to emerge as an important issue in developing countries, including those in the South-East Asia Region.

Though ethical review committees exist in almost all Member States, it is acknowledged that there is a wide variation in the knowledge and skills of members of these committees. The functioning and quality of work of these committees also varies. As resources are limited, it is difficult to establish sustainable ethical review mechanisms. Moreover, many members of ethical review committees are not properly trained in research ethics. The quality of reviews is therefore questionable.

The mushrooming of ethical review committees in many Member States of the Region threatens the quality of the review work being undertaken by them. There is also the danger of international collaborative research tending to obtain ethical approval from weak and less stringent review committees.

On the other hand, many researchers also are not conversant with the ethical considerations when submitting their research protocols. This could be due to shortcomings in the teaching curriculum.

Keeping the above scenario in mind, the WHO Regional Office has taken several initiatives, over the years, to promote health ethics. These include: as
early as 1996, research ethics was brought within the ambit of the South-East Asia Advisory Committee on Health Research (SEA-ACHR) for the first time; the next year, the South-East Asia Health Ethics Network (SEAHEN) was established; in 1998, a Scientific Working Group on research ethics was formed and, in 2000, “Operational guidelines for ethics committees reviewing biomedical research” were produced and widely disseminated; and in 2000-2001, the Regional Office organized a training workshop for participants from all Member States in the Region on the importance of research ethics and how to establish an ethical review committee.

In 2000, the Regional Offices for the South-East Asia and the Western Pacific regions established the “Forum for Ethical Review for South-East Asia and the Pacific (FERCAP)”, based in Thailand. FERCAP now has 400 members in the South-East Asia and the Western Pacific regions.

WHO sees its role in promoting health ethics as: supporting countries in conducting training courses on ethics in health and research ethics; supporting countries in the conduct of national workshops and meetings on ethics; developing and regularly updating regional guidelines to assist Member States in strengthening health ethics; and developing training modules and case studies on ethics in health research which reflect the cultures and norms of Member States of the South-East Asia Region.

In conclusion, I would like to reiterate the high priority I place on strengthening health ethics in Member States of our Region. As I have said on an earlier occasion, we should work in a big way to promote ethics in public health through strengthening the capacity and raising the quality of ethical review committees, and to promote and strengthen the teaching of ethics in the curriculum of health institutions. This would help healthcare and health research to be practised with better respect for human rights and basic principles of ethics, so as to ensure equitable access to healthcare for every individual.

In this context, I would like to say that the Thai ethical review committees have a very important role in strengthening and improving the quality of the ethical review mechanism. They can, and should, fulfil this role by beholding the cardinal principle of research involving human subjects, which is, “respect for the dignity of every human being”.
National health authorities have the responsibility to ensure that drugs and vaccines used in their country are of good quality, and are safe and efficacious. To ensure the quality of drugs, manufacturing and all subsequent handling must take place under defined conditions and comply to prescribed standards. Legislative and administrative controls must reflect the special considerations that need to be applied to drugs, including vaccines.

To accomplish this, the health authorities need to establish and maintain a competent national regulatory authority or NRA. The NRA is responsible for ensuring that manufacturers comply with accepted national and international standards of good manufacturing practices. Though the primary responsibility for quality, safety and efficacy lies with the manufacturer, the NRA of the country is responsible for establishing procedures to ensure that the products and manufacturers meet the required criteria. It is important that these procedures are backed by legislation and are legally enforced.

As you all know, Thailand is a large vaccine-producing country. The Food and Drug Administration, which is the NRA for Thailand, is required to perform all the six critical control functions. These are licensing, surveillance of adverse events following immunization (AEFI), lot release, laboratory testing, good manufacturing practices (GMPs) and clinical trials.

To achieve the goal of standard quality of vaccines in the country it is essential that there is full compliance in the implementation of GMPs by manufacturers. Vaccine producers and drugs inspectors have a vital role and responsibility in implementing and enforcing the national and WHO GMP
requirements to ensure that good quality vaccines are available for children of this country.

There is an urgent need in Thailand for vaccine manufacturers to comply with GMP requirements and its enforcement by the NRA.

I am confident that, after the workshop, you will return to your respective offices with useful knowledge and skills to help implement and enforce GMPs for vaccines in Thailand.

I would like to conclude by expressing the hope that this training will bring you a step closer to achieving the goal of ensuring good quality and safety of vaccines used by the Royal Thai Government in its immunization programme.
Programme Planning and Management
Global Leadership Programme

With great pleasure, I welcome you all to New Delhi, and to the second round of workshops of the Global Leadership Programme (GLP). I am glad that this workshop is being held in the South-East Asia Region. I extend special greetings to our colleagues from Headquarters, AMRO and WPRO, who have come a long way.

All of you have gone through the first round of workshops of this programme in Tunis. I am pleased to note the positive results from the evaluation of those workshops. I congratulate you for your commendable achievements in this important exercise.

At SEARO, attempts had been made for those who attended the Tunis workshops to share their experiences with the other staff members who had no such opportunity. This was done by organizing a leadership seminar last August for all professional staff members. I understand that this second round of workshops draw upon the results from the evaluation of the first round.

It is really important that we learn from our past experiences, instead of starting something totally new. You have a heavy three-day agenda which contains many critical issues of leadership development.

Leadership quality is an indispensable element of good governance and good management. Therefore, the Global Leadership Programme is indeed relevant and important to WHO’s work. The issues relating to leadership have always been brought up for discussions at our staff retreats, organized regularly in South-East Asia Region.

Culmination of leadership quality in the individual takes time. Individual traits significantly affect the ability of a person to become an effective leader. However, training and coaching, such as this workshop, are necessary for a person to understand various steps in the process of becoming an effective leader.

Second Global Leadership Programme (GLP), New Delhi, 7-9 February 2006
Now look at our Organization. WHO is a specialized agency in health. Its work is spearheaded and run by specialists and experts. We need these people to become leaders to direct and lead the work of the Organization in various areas at various levels. In this connection, a theory, the “Spiralist Theory” stated that there was a process for an expert to be transformed into an effective leader.

This could be achieved through years of working experience, whereby an expert can have an opportunity to gravitate from his specialist orbit into the broad area of a generalist. A generalist who could see things in a broad perspective, without prejudice towards any speciality in particular.

In WHO, we need effective leaders at all layers, and in all compartments to lead the work of the Organization. We need leaders who have a well balanced capacity in both managerial and technical skills. Leaders who appreciate “information” as a powerful tool in their governing and managing the work. Leaders who are able to communicate concisely and precisely, who can make common people easily understand complex issues of a technical nature or otherwise.

We need leaders who are versatile, who really know many things, especially in the broad perspective. Leaders who are really focussed in their thoughts and action. The leaders who are charismatic. Charisma is really an asset of a leader. And, I must say, charisma and leadership actually enhance each other.

Not less important, the leaders should be disciplined, loyal, trustful and sincere. These are only some of the required qualities of effective leadership.

In addition, we need “role models” for promoting leadership development. Without a “role model” it will be difficult to convince people to emulate any leadership quality.

It should be noted in this connection, however, that scientists and specialists who have received Nobel Prizes are, in a way, the leaders in their scientific and technical fields. No one can deny that these people are the leaders who have greatly contributed to the welfare of mankind. Those people may not have an opportunity to manage a team of people with mixed disciplines. But, at least, they lead people thorough their ideas, their thinking and their scientific findings.

I believe this GLP will help in a big way in strengthening the Organization by developing leadership among staff members, who are leading and managing WHO’s work in various capacities. I thank the organizers and facilitators of the workshop for their time and efforts. I thank all workshop participants for their interest and enthusiasm.

Leadership can take us a long way in improving the efficiency and effectiveness of our Organization. Let us appreciate the leadership quality; and let us be efficient and effective leaders in our own areas of responsibility.
This is our most important internal meeting. It is time for close dialogue and interaction between WRs and the Regional Office staff. Instead of following the traditional ways of organizing and conducting the meeting, we have made a change in its agenda and programme.

The agenda consists of four main substantive items; these are: review of actions taken on the conclusions and recommendations of the last meeting; presentation and discussion on the reports of WRs; presentation and discussion on the work of various departments and units; and conclusions and recommendations of the meeting.

I hope this new arrangement would lead to a more effective dialogue and interaction among us. And this would lead to a closer and more collegial working relationship between the country offices and the Regional Office.

Colleagues, 2005 has been a year of hard work for us. We have faced a number of daunting challenges: earthquake and tsunami at the end of last year; persistent presence of Avian Influenza with human cases in two countries of the Region; severe floods in India; and the resurgence of polio in Indonesia. These are in addition to the emerging situations in some countries, which made our collaboration with them more difficult.

However, with understanding, patience and a tactful approach, especially of WRs, we have come through these difficulties successfully. I am very thankful to the staff members, particularly WRs, for their hard work throughout the year.
Our dialogues in the specific areas of work will continue; and, certainly, we will face new and emerging challenges. We have to be well prepared to face them squarely and courageously in the years to come.

Now, let us look at the WHO biennial programme budget, which is our main tool for collaboration with the Member States. We have already concluded and finalized the workplans for execution of the programme budget for 2006-2007 biennium. There is need now for very good preparation to implement these workplans, so that, right from the first of January next year, financial obligation can be effected and activities started without delay. Please keep in mind that from the next biennium onward, there will be no carry over of the unliquidated obligation. All activities in the workplans will have to be completed and funds liquidated by the end of the biennium concerned. Otherwise, the budget balance, after liquidation will lapse.

In connection with the workplans, I would like to specifically touch on Multicountry Activities (MCA). These activities are not compulsory, they are voluntary. The decision to have or not to have these activities is with the WRs and concerned national authorities in the individual countries. Let MCA depend entirely on the spirit and will at the country level to get involved in intercountry cooperation. There should not be any imposition from the regional level.

Now, let me touch on an important issue relating to the regional budget. A decade ago, not less than 80% of our budget came from assessed contributions; this was what we called the Regular Budget. The rest, which was only a small portion, came from extrabudgetary sources or voluntary contributions. Today, this ratio is reversed. For the 2006-2007 biennium, the assessed contributions or Regular Budget is only 28%, the rest comes from voluntary contributions.

As we are aware, only the assessed contributions are available for use from the beginning of the biennium. And these funds are used to finance most of the staff posts. Only a small sum of voluntary contributions will be available through transfer from the previous biennium.

For the forthcoming biennium, almost all voluntary contributions are yet to be mobilized. Therefore, resource mobilization will have to be the main priority activity of all technical units.

We already know that at the Regional Office, the assessed contributions are not enough, even to finance the core staff posts, or to maintain the routine operation of the Office. Not to talk about financing regional or intercountry
programme activities. All departments and units now have to prepare and implement vigorously their strategies and plans for resource mobilization. They have to work closely with their counterparts at HQ; to identify funding agencies and explore voluntary contributions from them. This has to be done without delay, if we are going to fully implement activities supported from EB funds as reflected in the workplans.

Coordination of resource mobilization is under the responsibility of DRD/ERO. They are ready to help departments and units in facilitating the process to mobilize extrabudgetary resources.

Voluntary contributions are also very important for WHO collaboration with the individual countries. Resource mobilization at the country level should also be given high priority. WRs and their offices have to move in equal pace to mobilize EB funds to support WHO country activities.

With the reversing trend in budgetary components (much less Regular Budget, much more extrabudgetary funds); we are compelled to reform the way we manage the available resources. We have to be much more efficient and effective than before in managing our work. We have to try to get more from less; to get the most from what is already available.

We have to be fully transparent, and ensure full responsibility and accountability in utilizing the resources. What is very important is that, we have to ensure that the countries will benefit from the work of WHO in tangible and measurable terms. We have to ensure that we can help countries reduce health problems and raise the health status of their populations.

Please devise effective tools to measure our achievements in this regard. At least, we should monitor regularly various morbidity and mortality trends in the individual countries.

In the years to come, we will give priority attention to monitoring, evaluation and oversight of our work. This is to ensure our efficiency and effectiveness. We will have to quickly identify deficiencies and shortfalls in the process of our operations, and rectify them without delay.

I liberally delegated authority to WRs and Department Directors. This was with the view to help facilitate efficient execution of their decentralized responsibilities and resources. I hope that this authority would be used responsibly and accountably.
Please keep in mind that the decision to delegate authority is not static or permanent. If it is warranted, more authority may be delegated, such as in an emergency. And, if it is indicated at any point in time, such a decision may have to be reversed.

During the 2004-2005 biennium, we were faced with a budget deficit of US$ 3.5 million. Certain economy measures have been put in place for some time already to curtail unnecessary or unproductive activities. This is with the view to balancing the overall budget at the end of the biennium.

For 2006-2007, in spite of a small increase in the Regular Budget, we expect to have a budget deficit of about US$ 4.5 million. This is due mainly to the cost increase from inflation; and due to a statutory increase in the staff cost.

This time, we have to start implementing economy measures, from the beginning of the biennium. This will be done in a more elaborate and systematic manner. DAF group will explain to you these measures in detail. I expect cooperation from everyone of you in enforcing these measures in the process of our programme implementation.

The projected budget deficit at the beginning of the biennium, and the applications of economy measures during the course of programme implementation are not new in the Organization. During the 1990s, the whole Organization had faced this budgetary problem for several biennia. However, we could successfully overcome the problem by implementing economy measures.

To offset the budgetary deficit is the total responsibility of both the Regional Office and country offices. We have to work together toward this end. As we are aware, work of the Regional Office is entirely in support of WHO activities in countries. Starting from the ensuing biennium, more staff support from the Regional Office to countries will be needed. The Regional Office will have to be ready to respond to the increasing demand for such support.

Now, let me briefly touch on staffing at WHO country offices. As all of us are aware, the countries do not want to see many staff members at the WHO country offices; especially those whose posts are financed from the Regular Budget. Furthermore, the countries do not want to see the WHO Country Offices operating under the high ratio of expenditure from the Regular Budget. They always voice their concern with this issue at the Regional Committee.
session every year. And they always request for streamlining of the operation of WHO country offices.

We are now in the process of studying the issue. There is a plan to move forward in this regard, case by case. We talked about a global standard framework for WHO presence in countries, including staffing of the WHO country offices. But nothing has come out for practice yet.

Furthermore, it might be impractical, to implement such a global framework across the board, worldwide. The best, therefore, is to look at the individual cases within the context of specific country situations; And to apply pragmatic approaches, case by case.

As already mentioned, our work in future will rely more and more on voluntary contributions. Both country offices and the Regional Office should have workable strategies to ensure strengthening of our own infrastructure. This may be done in the process of implementing the programmes supported with EB funds.

The strengthening should also include staffing to support such programme implementation. This is in addition to strengthening the capacity of the countries’ health systems. Additionally, we should earnestly negotiate with the funding agencies to finance the staff posts under the collaborative areas.

Whatever the situation, the Regional Office will have to be responsible for the staff and other support to countries. Therefore, close and cordial working relationships between the two levels is very important indeed. Communication between Country Offices and the Regional Office must always be kept open for constant dialogue. The Regional Office must be the first source of support, to which country offices will have to resort. Country Offices should not seek help from outside the Region without consulting the Regional Office.
Regional Working Group on Programme Budget

This Group first met after the 57th Session of the Regional Committee Meeting in the Maldives in September 2004. It has provided a useful forum for the Member States of the South-East Asia Region to meet and discuss budget policies affecting the Region. On this occasion, we are gathered to discuss the proposed policies and mechanisms to allocate WHO budget to the regions.

As you all are familiar, World Health Assembly Resolution WHA 51.31 first attempted to readjust the distribution of WHO’s Regular Budget to the six regions. Because of this resolution, the Regular Budget of SEAR and other regions decreased for 3 bienniums, ending with the current 2004/2005 biennium.

In May 2004, the World Health Assembly through its decision WHA 57(10) requested the Secretariat to develop, in consultation with Member States, the guiding principles for the distribution of resources with particular attention to countries in greatest need. Since that time there have been several drafts of the paper describing these guiding principles. A validation mechanism has also been developed to use data from countries to help measure their needs. Our Region has been most active in involving Member States in developing these guiding principles.

During the 115th Session of the Executive Board in January 2005, SEAR countries presented specific comments through the Executive Board Members. This was a result of the work of our Regional Working Group. At the 58th Session of the Regional Committee, the latest draft of these guiding principles was presented and discussed.
Many of our Member States expressed concern that the proportion of resources currently allocated to the South-East Asia Region does not reflect our needs. Furthermore, the draft presented at this Regional Committee session did not include the specific calculations proposed to determine regional needs. Given that this paper is likely to be finalized during the 117th Session of the Executive Board in January 2006, the Regional Committee asked that the Regional Working Group be reconvened at the earliest date. This would provide an opportunity for the working group to review the paper and the calculations in detail. The results of this review would be used by Executive Board Members from the South-East Asia Region to present at the Executive Board Meeting in January 2006.

I am pleased that the members of the Regional Working Group could assemble at such a short notice. The Regional Office has assembled the latest drafts of these papers and the details of this mechanism for review by this Group. We are also fortunate to have technical support from Headquarters to explain directly the details of the proposed policies and mechanisms. I know that you will work hard over the next two days to study the details of these documents.

I would like to emphasize that the allocation of resources is always a sensitive issue. No Region or country wants to reduce the quantum of resources it receives. Yet, we know that there are countries that have greater needs. Regional and global solidarity demands that we make the maximum efforts to channel resources to those in greatest need.

In some cases, we can measure needs with data. At other times, we must use our own experience and build a consensus on the decisions to be made. Therefore, we must give appropriate weight to consensus building and solidarity as we review these guiding principles.

Again, I would like to thank you for taking time to participate in this important meeting. I look forward to your specific recommendations. We will ensure that these are communicated to our Executive Board Members for the January meeting. Whatever the results, we can all be proud that the South-East Asia Region has shown that our countries can work together to develop a common position on this important issue.
The Twenty-third Meeting of Ministers of Health and the Fifty-eighth Session of the WHO Regional Committee for South-East Asia

It is indeed a matter of immense pride for all of us that His Excellency, Mr Mahinda Rajapakse, the Hon’ble Prime Minister of Sri Lanka is graciously inaugurating these two highest-level regional meetings of WHO in South-East Asia. I extend my heartiest greetings and a very warm welcome to the Honourable Health Ministers, distinguished representatives and esteemed invitees.

On behalf of the World Health Organization, may I thank the Government of the Democratic Socialist Republic of Sri Lanka; and especially H.E. Mr Nimal Siripala de Silva, for hosting these meetings in this beautiful island.

The Democratic Socialist Republic of Sri Lanka, then known as Ceylon, joined WHO in 1948. Since then, we have witnessed remarkable progress in her national health development.

The overall literacy rate in the country increased from 87% in the early eighties to 93% in 2003. Life expectancy at birth, which stood at 67 years for male and 72 for female in 1980, increased to 72 and 76 respectively in 2001. The infant mortality rate decreased significantly from 34 per 1,000 live births in 1980 to 11.1 in 2003.

The country has been polio-free since 1993. And leprosy has been eliminated since 1995.

We must congratulate the Government of the Democratic Socialist Republic of Sri Lanka for these impressive achievements. The achievements that were
contributed, among others, by a sound health system, based on equitable access to health care by all people.

During the past decade, we have observed significant changes at all levels of development in the health area. However, infectious diseases continue to cause a very large proportion of morbidity and mortality in South-East Asia. Simultaneously, we have to deal with the health risks relating to unhealthy lifestyles and environmental degradation. These factors are contributing to about 42 per cent of all deaths in this Region.

The issue that needs to be urgently addressed is how to meet these daunting challenges effectively in the face of resource and other constraints.

In this connection, the Commission on Macroeconomics and Health provided evidence that increased investment in health leads to economic growth and poverty reduction. Under the leadership of the honourable Health Ministers, many countries in our Region have been in the forefront in taking determined action in this direction.

To develop a sound basis for tackling health problems through a more rational process, the Commission on Social Determinants of Health was recently launched. The Commission is currently outlining and defining the major causes of ill health and the factors contributing to good health. Focusing on these causes and factors in the development undertakings will lead ultimately to the sustainability of health gains from the efforts of countries. This global exercise will certainly contribute to a more rational policy and strategy formulation, and programme planning for sustainable development in health.

Speaking within the overall context, a comprehensive expression of governments around the world for achieving the most reasonable well-being of their people is clearly reflected in the Millennium Development Goals. The MDGs identify a set of inter-related targets for addressing extreme poverty and its many related dimensions, with health being placed at the centre. However, progress towards the Millennium Development Goals in the Region is still uneven among countries. But, this can be accelerated, since effective technical interventions exist. We only need innovative strategies and more effective approaches in the implementation of these interventions.

In this perspective, it is also of paramount importance to focus our attention on promoting a healthy environment. However, to deal effectively with various environmental health issues is, in many instances, beyond the purview of the health sector. There is a need, therefore, to energize other sectors to the notion
that the health implications of their development activities are squarely their responsibilities.

Every year, our Region loses tens of thousands of women’s lives due to pregnancy and childbirth-related causes. Well over one million children die in the very first month of their lives. We have to ensure, among others, skilled attendance at birth, which will have a significant impact on the reduction of maternal and child mortality.

Also, let me highlight here the most serious health threat that we are facing today, i.e., influenza outbreak, the timing of which cannot be predicted. But, its rapid international spread is certain, once the outbreak becomes pandemic. It can be a grave danger for all people, and a serious threat to socioeconomic development of the affected countries. There is an urgent need for Member States to develop comprehensive, multisectoral influenza pandemic preparedness plans. Leadership of the Health Ministers and political support at the highest level is called for in dealing with this menace.

I have no doubt that the deliberations at these Meetings of the Health Ministers and the Regional Committee will be very productive, as usual. All of us will stand to benefit from the wisdom and guidance of the Health Ministers on the topical health issues. WHO, as the Organization of Member States, stands ready to provide any required support to the Governments in their efforts to pursue the development of health for all people.
Forty-second Meeting of the Consultative Committee for Programme Development and Management

Those who are familiar with the CCPDM meeting may be surprised to see this large gathering. We have a big group for the meeting because there will be a detailed review and finalization of the biennial workplans for 2006-2007. This will be carried out for all individual countries, and for the regional and intercountry programmes. All WHO Representatives and senior staff of the Regional Office are required to be here for this review and finalization. Therefore, for this meeting, we really have a heavy agenda, but there are only three days at our disposal. Because of this, most of the time there will be parallel sessions going on simultaneously. In this situation, the country teams will have to split themselves to cover all sessions.

CCPDM serves as the executive arm of the Regional Committee, which is the only constitutional body of WHO at the regional level. With this role, CCPDM is dealing particularly with matters relating to programme development and management of the Organization’s work in SEAR.

The highlight of the CCPDM agenda this time is the biennial programme budget for 2006-2007. In addition to review and finalization of the biennial workplans, we will look into a few more issues, such as criteria for distribution among countries in the Region of additional Assessed Contributions (Regular Budget) funds, and the ICP II successor arrangement.

The World Health Assembly this year approved a 4% increase in Assessed Contributions for the 2006-2007 programme budget. Out of this budget increase, US$ 5.797 million will come to the South-East Asia Region. After
allocating a little more than US$ 1 million to the Regional Office intercountry project, the rest will be distributed among Member States. The secretariat has done an exercise on the criteria to be used in distributing this budget increase among countries in the Region. The matter will be presented and discussed during the course of our meeting.

As you are aware, the supplementary intercountry programme or ICP II will cease from the next biennium. The Regional Working Group on Programme Budget Development, established by the Regional Committee last year, recommended, among others, procedures for multicountry activities to replace ICP II. We will discuss at this meeting how to proceed with the idea of multicountry activities.

I must remind distinguished participants that the purpose of ICP II is to promote cooperation among countries in the Region, and it has served this purpose very well during the past many years. But in developing ICP II, we had to pool parts of country budgets at regional level. This is against the principle of resource decentralization in WHO; we therefore decided to stop it. At the same time, we still see the need to have certain arrangements for promoting such intercountry cooperation. And this arrangement will not entail taking away WHO country funds. Therefore, the idea of multicountry activities which are planned within the individual WHO country programmes is mooted for your consideration.

The total WHO budget for SEAR during 2006-2007 is US$ 357 million, compared with US$ 285 million for the 2004-2005 biennium. This represents a 25% increase. However, 72% of the total budget for 2006-2007 is to come from Voluntary Contributions or extrabudgetary resources.

As we are aware, voluntary contributions are mostly earmarked for specific purposes by donors; only about 10% of these are unspecified. Therefore, the implementation of biennial workplans which integrate assessed contributions and voluntary contributions will have some limitation in financial flexibility. I would like the CCPDM participants to keep this in view while discussing the implementation of such workplans.

As part of WHO country focus and the WHO country-specific approach, the Regional Office staff are constantly encouraged to work with country offices, and get involved in the implementation of country programmes. To promote involvement of the Regional Office staff, joint planning between countries and
the Regional Office, through “Country Days”, has been pursued in the course of developing the WHO country workplans. This mechanism has proved very effective in promoting joint efforts and activities between staff at these two levels.

I should also mention that WHO has applied the principle of results-based management in its programme development and management. The joint planning between countries and the Regional Office has reinforced the formulation of expected results, which are the prime concern in our programme budgeting process. These expected results will also be used to drive the Organization’s efforts in resource mobilization for supporting the implementation of the workplans.

There are still a few more items on the agenda of this CCPDM meeting. The participants will review and discuss the draft 11th General Programme of Work of WHO, covering the period 2006 through 2015. This is the second time that we will see this document. Your views and comments on the draft before us will be presented to the Regional Committee at its forthcoming session in September this year.

In addition, we will review decisions and resolutions of the 58th WHA and 115th/116th sessions of EB. This is with a view to identifying and discussing regional implications of those decisions and resolutions.

During the course of this meeting, we will also get briefings from the country representatives who attended the latest sessions of the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (TDR), and the Policy and Coordination Committee (PCC) of the Special Programme for Research, Development and Research Training in Human Reproduction (HRP).

On the second day of the meeting, i.e. 6 July, there will be Technical Discussions on “Skilled Care at Every Birth”. As we are aware, several countries in our Region continue to have high maternal and neonatal mortality. If we are to achieve, in time, the targets set for the Millennium Development Goals, we have to do much more to improve the care of mothers and newborns during birth. Local experts and institutions have also been invited to attend the discussions. We expect that the discussions will help identify new initiatives that can lead to the development of a more effective programme for reducing maternal and neonatal mortality.
Now allow me to digress to another matter. CCPDM originated from a “Small Committee” established by the Regional Committee in 1980. The role and functions of CCPDM have evolved over these years.

In 1998, the Regional Committee decided that CCPDM take over the functions of its Sub-Committee on Programme Budget. Since then, as I mentioned earlier, CCPDM has served as an executive arm of the Regional Committee in matters relating to programme development and management. CCPDM consists of country representatives at high-level decision making from all countries in the Region. It meets once a year to prepare, as mandated by the Regional Committee, technical materials for consideration of the Regional Committee.

In order to further strengthen the work of the Regional Committee through this mechanism, I intend to call for more involvement of CCPDM. This may be in the form of sub-committees on various specific issues relating to programme development and management. To do so effectively, we need to have an annual workplan for CCPDM, so that its members will know in advance when to do what. If this is agreeable to the Committee, the secretariat will further discuss this development and propose a *modus operandi* for its consideration at a later date.

Furthermore, I would also like to point out that the roles of the Health Secretaries Meeting and the CCPDM meeting are very much related to each other, and therefore the work of these two important regional bodies need to be well coordinated. This is the reason why we have brought these two meetings together, back-to-back. With this arrangement, a lot of effort on the part of the WHO secretariat is required in the organization and conduct of the meetings. Therefore, from next year onwards, these back-to-back meetings are planned to be held at the Regional Office in New Delhi. Your convenience and comfort will be well taken care of, as usual, when we have the meetings in the Regional Office.

Once again, let me thank the Government of the People’s Republic of Bangladesh and its Ministry of Health and Family Welfare for hosting this meeting and for the excellent arrangements made.
The annual meetings of health secretaries have proved very productive during the past 10 years. This is particularly so with regard to the contribution from the meetings to the work of WHO in the South-East Asia Region.

The health secretaries, who normally attend the World Health Assembly and the session of the WHO Regional Committee, can effectively link the work of these bodies with that of their respective ministries. Therefore, the health secretaries can play an important role in the work of the Organization at national, regional and global levels. Their regular dialogue on the issues of common interest will take them a long way in contributing to effective intercountry cooperation. This was the reason for starting the annual meetings of health secretaries in 1996.

This has been a busy year for the health sector in the South-East Asia Region. We have to devote special efforts to reach certain goals established by the World Health Assembly by the end of this year, particularly with regard to: polio eradication; leprosy elimination; and treatment targets for tuberculosis.

At the same time, we have to contain outbreaks of several communicable diseases, such as malaria, diarrhoea, dengue fever and encephalitis. In addition, we have been overwhelmed by the severe damage and destruction caused by earthquakes and the Tsunami of 26 December 2004. However, countries in the Region have tackled these challenges in the most efficient and effective manner.

Most of these disease outbreaks have been control led, without much difficulty. And we can say with pride that with capable and prompt action by the governments of the affected countries, there were no disease outbreaks due to the earthquakes and the Tsunami.
There is clear evidence that during the past few decades, countries in this Region have made significant progress in health development. Increasingly, health concerns in countries have become a public and political issue. More and more, many sectors and professionals other than health have come forward to share responsibility for health development. To achieve health-for-all, it is necessary therefore, to fully involve all stakeholders and partners in facing health challenges.

Allow me to say a few words on achievements in health in our host country. In Bangladesh, during the past few years, many things have changed in the health area. The country’s environment, in general, is much cleaner, with less air pollution in the city of Dhaka. The people, in general, look healthier and livelier.

On reviewing the health situation, it is evident that the country’s health infrastructure has been strengthened significantly. More importantly, mortality and morbidity due to many communicable diseases have come down amazingly.

While the average life expectancy at birth increased to 64 years in 2003 from 44 in 1971, the crude death rate dropped from 17 per 1,000 population in 1973 to 4.8 in 2001. There was a remarkable drop in under-five mortality from 151 per 1,000 live births in 1990 to 82 in 2001.

Bangladesh has made very good progress in health within a rather short time span. The Government must therefore be congratulated for its commendable efforts in the country’s health development.

Allow me to take this opportunity also to follow up with you the implementation of WHO’s regional strategy on decentralization in the South-East Asia Region. This is the action we have taken on an Organization-wide policy. This strategy is to ensure, among others, the realization of WHO’s country focus and WHO’s country-specific approach in the Region.

After one year from the start of initiation of the strategy, an assessment was done. The result showed progress in a number of areas. At the same time, a number of deficiencies and shortfalls were also identified. On the basis of this assessment, we are now moving further by building on the successes achieved, and rectifying those deficiencies and shortfalls.

In this decentralization exercise, we, as WHO staff, always keep asking ourselves, “what benefits have countries in the Region got from WHO’s work, or will get?” This will serve as a reminder to us in WHO to constantly monitor and evaluate our work, and take necessary steps to ensure useful contributions to the countries’ health development. I would like to assure you, that despite all kinds of constraints that we are facing, WHO in SEAR will continue doing its best in serving the Member States.
The honourable health secretaries may recall that the earthquakes and Tsunami of 26 December 2004 resulted in an unprecedented devastation in six countries of the Region. Severe damage and destruction was caused in Indonesia, India, Sri Lanka and Thailand. Maldives, a small island country, was disproportionately affected. The least affected was Myanmar.

Nearly 300,000 people lost their lives, hundreds of thousands were rendered homeless, and the human suffering was enormous. This disaster evoked unprecedented international solidarity and response. WHO, as a part of the UN system, with other partners did its best to support those countries in their efforts to save lives and protect the health of the affected population.

This disaster is a timely reminder of the urgent need for a strong national plan for disaster preparedness and response, in which health is an integral part. During this meeting, we will discuss how to move forward in strengthening and increasing capacity of countries in emergency preparedness and response. The Member States and WHO will have to do much more in order to ensure better protection of the affected population when disaster strikes.

New, emerging and re-emerging diseases, including the recent outbreaks of SARS and Avian Influenza, have clearly demonstrated that potential public health emergencies of international concern can spread from one part of the world to the other in a matter of days. In order to adequately address such public health emergencies, Member States and WHO had embarked on a process to revise the existing International Health Regulations.
This process was successfully completed and the revised regulations were adopted by the 58th World Health Assembly in May this year. This is one of the important milestones in the international efforts to prevent the spread of public health emergencies, including the spread of communicable diseases. It is now the responsibility of all Member States to be ready to implement these revised International Health Regulations. Given the time and resource constraints facing Member States, effective implementation of these regulations poses a formidable challenge.

This Region continues to be particularly vulnerable to emerging and re-emerging communicable diseases such as SARS and Avian Influenza. Therefore, timely and effective implementation of the revised International Health Regulations is of paramount importance. In this regard, resources are urgently required for building the core capacity in countries, and closer cooperation among the Member States is urgently called for. In addition to resource mobilization, WHO will provide all necessary and possible support to countries of the Region in their endeavours in this regard.

The Region is close to achieving its goal of eradicating polio. While India, the largest country in our Region, reported 134 cases in 2004 – the lowest ever for that country, this year, only 18 cases have been reported to date. The eradication goal is therefore within sight.

However, the recent polio outbreak in Indonesia, due to importation of wild poliovirus is a harsh but timely reminder that we must complete the job of polio eradication soon, otherwise no country will be safe. Though the risk of importation of polio virus is equal among all countries, the risk of polio transmission within countries varies according to the level of immunization coverage and quality of the surveillance system. It is therefore extremely important for all Member States at this time to be cognizant of the risks, and ensure that the routine immunization programme and the surveillance system continue to receive adequate attention. This is to guarantee that all children, now and in the future, are protected, not only from polio but also from other vaccine-preventable diseases.

During the course of this meeting, we will discuss the use of polio vaccine in routine immunization programmes after polio eradication has been achieved. WHO will continue working closely with Member States in the development or reorientation of their national immunization policy and plans for the post-polio eradication era.
During the recent past, several emerging infectious diseases have originated from Asia. The prevailing geographical environment, socio-economic status of communities and the weak public health infrastructure have made Asia vulnerable to several emerging diseases. Outbreaks of SARS and avian influenza have conclusively demonstrated this vulnerability. It is also believed that an influenza pandemic is imminent and very likely to originate from Asia.

To combat emerging infectious diseases, Member States need to strengthen their public health infrastructure through the development and implementation of a robust strategy. Since most countries in Asia are covered by two WHO Regions, i.e. South-East Asia and Western Pacific, an “Asia Pacific Strategy for Emerging Diseases” has been developed through extensive consultations among WHO offices and national experts in these two Regions. This endeavour reflects the collective efforts and wisdom of public health specialists from this part of the world.

The strategy aims to minimize the mortality, morbidity and economic loss due to emerging diseases in Asia Pacific. This strategy is being brought to the attention of the health secretaries for review and suggestions. Both WHO Regional Offices are planning to present the strategy to their respective Regional Committees in coming September. WHO and other international partners shall be providing the required support to national efforts in Asia Pacific in implementing this strategy.
This was supposed to be a longer meeting to be held in April. Because of the Tsunami disaster that struck 6 countries of our Region, we were too busy to hold this meeting as originally planned. However, this two-day meeting, I am sure, will be as productive as expected. Looking at the agenda, we have several important subjects for our deliberations.

Last year we launched, in a big way, a strategy on decentralization. This was in order to realize the country focus and country-specific approach in our Region. Managerial guidelines have been provided to facilitate the implementation of this strategy. More authority has been delegated to WHO Representatives. The WRs have been allowed to work horizontally among themselves.

ICP-II will cease in order to reflect the real picture of budgetary decentralization in the order of 75% of Assessed Contributions or Regular Budget allocated to the WHO country programmes. At the same time, we will try to maximize the benefit to be derived from the use of Voluntary Contributions or EBR, especially in strengthening WHO’s work in the normative areas, and in the strengthening the basic infrastructure of national health systems.

We have reoriented our planning process in order to ensure full and active involvement of Regional Office staff in the development and implementation of WHO country programmes. We are now exploring appropriate modalities for promoting intercountry activities within the context of WHO country level operations, especially the country programme budgets.
It has been more than a year since we launched our decentralization strategy. I am now assessing our performance in implementing the strategy in order to identify our strengths and weaknesses in such a process. The findings from the assessment will be the basis for us to rectify the weak areas.

While pursuing our WHO mission, please keep in mind that our biennial programme budget is the most important managerial tool for collaboration with Member States, either individually or collectively. And, particularly in our regional context, the decentralization strategy is our managerial instrument for enhancing the effectiveness of the development and management of the biennial programme budget at the country level.

In this context, delegation of authority and horizontal collaboration are the key approaches for efficient and effective implementation of the biennial workplans. At the beginning of the meeting, we will review the recommendations arising from our last meeting; this is with a view to assess how much we have done on those recommendations. Certainly, I think, we will find that actions on many of these are yet to be taken. We have to find out why the actions could not be taken, and revert back to them in order to ensure their timely implementation as much and as soon as possible.

We should limit the number of new recommendations, if many of the previous ones have not yet been implemented. I request your special attention to the pending actions on the previous recommendations. When making new recommendations, please ensure that they are realistic, practical and feasible within our means to implement.

With regard to the intercountry programmes, we have to reorient our strategy in their development and implementation. The successor arrangement of “ICP-II” is one thing that needs to be worked out. More ideas are needed. However, this arrangement will have to depend on the spirit, sense of solidarity and willingness on the part of the Member Countries in the Region to cooperate among themselves. This is something that we have to devote our time and efforts to in promotion and advocacy.

We, WHO staff, will have to encourage the countries and provide them with practical and convincing advice on this issue in the process of the preparation of the biennial workplans. At the same time, we have to pay particular attention to the role of Voluntary Contributions or Extrabudgetary Resources in the development and implementation of regional and intercountry programmes.
As I can see, in future, Voluntary Contributions will play an important role in WHO’s work under these programmes. Technical units at the Regional Office will have to pay special attention to this funding trend in the process of their programme formulation and preparation of their workplans.

The future role of CCPDM will be exclusively to serve as an executive arm of the Regional Committee, especially in matters relating to programme development and management; and it will be always convened at the Regional Office.

Starting from its 42nd meeting in July, a considerable amount of time of the Committee will be devoted to a detailed review of the strategic biennial programme budget and the biennial workplans, for both countries and the Region.

For the country workplans, the review at the CCPDM meeting will be done country by country, between the Country Team, which consists of the WHO Representative with a senior national health official at decision-making level; and the panel of Regional Office senior staff members chaired by DPM. As for the regional workplans, these will be reviewed at a plenary session of the meeting.

Regarding the issue relating to the distribution of additional funds from Assessed Contributions, the Regional Working Group on Programme Budget Development is yet to submit its final recommendations. Distribution of resources among countries is really a very sensitive issue; it has to be handled with utmost care. Being aware of this, we are moving towards integrated budget planning.

While getting used to planning for Assessed Contributions or Regular Budget, to integrate Voluntary Contributions or Extrabudgetary Resources in the process of budget planning requires particular attention. This needs to be done in parallel with the strategy development for resource mobilization and fund raising. The issue will be discussed in detail during the course of this meeting.

As we are aware, there has been a revision of the financial regulations and rules. To this effect, from the biennium 06-07 onwards, there will be no carrying over of the unliquidated obligations to the following biennium. It means that all obligated funds, especially those from Assessed Contributions or Regular Budget, must be liquidated within the biennium concerned. This is contrary to the practice that we have followed until this current biennium, whereby the
unliquidated obligation could be carried over to the first year of the next biennium.

By setting the end target clearly within the biennium under this change, the financial discipline will be strengthened and ultimately improve both the quantity and quality of programme implementation.

Therefore, from the next financial period, there will be no regional implementation targets as was practised, there will be no requirement for budgetary obligation at 75% by the end of the first year of the biennium, and 100% by the end of June of the second year. With this change, all of us (Regional Office and Country Offices) will have to pay particular attention in ensuring the complete implementation of the country workplans with high quality outputs and outcomes.

Concerning delegation of authority, I would like to know from WRs how useful it is in the implementation of their country workplans. I am fully aware that there are many deficiencies in this delegation that need rectification. We will review the process and the practice, and take action to improve the situation in a timely manner.

Concerning certain specific programme areas, we have learned a lot from our experiences in dealing with SARS, Avian Influenza and the Tsunami disaster. We will review the lessons learned with a view to improving our Emergency Preparedness and Response Programme. This is in order to ensure relevant and practical approaches in our relief and restoration operations.

For this, I would like to emphasize the necessity to have a robust EPR plan for each and every WHO Country Office. We will work closely with HQ and other partners in supporting the development of such a plan.

The WHO country EPR plan will be designed to fully support national disaster preparedness and response operations. The Regional Office and HQ will readily provide a back up in the most efficient and effective manner to the implementation of the country workplan during an emergency.

I think it is not too early to talk about our next meeting in November. Let me touch on a few aspects. I would like to go back to one of the practices that we used to follow sometime ago. It was a very good practice. That is, to have each WR prepare a precise and concise report on the country health situation reflecting the current issues, and on the work of WHO in the country during
the preceding year; this report is to be presented at the plenary session by the WR.

In addition to following up on the implementation of our initiatives, such as horizontal collaboration, there will also be discussions on selected technical subjects at our next meetings.

RD’s meeting with WRs in November will always be held at the Regional Office. The details of the 57th meeting will be prepared and sent to all of you well in advance.

I see the year 2005 to be a very busy year for all of us. When facing an overwhelming workload, we need to have time to think creatively of the right strategy to maintain or even increase our work efficiency. We must be aware of the limits of our own capacity and be ready to ask for help. No one can work alone.

When help is needed, firstly, please seek help within the Region; then we (Regional Office and Country Offices) together may ask for help from outside.

All of us have the responsibility to ensure integrity in pursuing the work of the Organization in the Region. Certainly, we are ready to work with anyone, anywhere, when it is indicated.

Last but not the least, this is just to remind ourselves that the platform on which we play our role is of multinature, and constantly changing over time, according to situations and circumstances. As international civil servants and health professionals at the same time, we have to learn how to strike a proper balance properly while playing our role on such a sensitive platform. For this we have to learn from each other. This meeting is the forum where we can share our experiences in this regard.

To be an effective WHO staff member is certainly more than being a technical expert. WRs, particularly, have to possess a high level of diplomacy, in addition to being capable managers, coordinators and communicators.
PB 2006-2007 Workplan Development

This meeting of country office planning focal points needs to pay special attention to the mechanism and process for the preparation of the workplans for 2006-2007 biennium. There is a need for effecting a change in the preparation of such workplans.

Among other things, to ensure a rational process in finalizing these workplans, I would like the first draft to be completed by the end of May this year. Then, we will refine and improve the workplans in June, to ensure quality implementation. The workplans will be finalized at the 42nd meeting of CCPDM, in July 2005.

At this CCPDM meeting, workplans of each country will be reviewed in detail by the country team and senior staff of the Regional Office. The country team will consist of the WHO Representative (from the WHO country office) and a concerned senior health official at the decision-making level.

After the CCPDM meeting, there may be some modifications and changes in the workplans. Then, the workplans will be submitted to the 58th session of the Regional Committee for endorsement. With this process, I am confident that the quality of the workplans will be substantially improved, and thereby their implementation.

This exercise is to help ensure efficiency and effectiveness of our decentralization strategy and delegation of authority to WHO Representatives. Furthermore, as we are all aware, from the next biennium, there will be no ICP-II. Intercountry activities will have to be planned and implemented differently; these activities will largely emanate from WHO country programme budgets, on the basis of the countries’ need for collaboration among themselves.
Within the context of direct support to countries, WHO country offices are intended to be operational/Implementing focal points, while the Regional Office provides the required support.

As we know, 75% of the regional Regular Budget is already in the WHO country programmes; about 70% of this amount is for programme activities to provide direct support to countries. Therefore, WHO regional and country staff and concerned national health officials have to work closely in the preparation and implementation of the country workplans.

Furthermore, there is a recent development, which is very important. The 115th session of the WHO Executive Board passed a resolution to effect a change in the Organization’s financial regulations and financial rules. The change is that there will be no carry over of the obligated budget across the biennium. It means that the obligated budget will have to be completely liquidated within the biennium concerned, otherwise the money will lapse.

This resolution of the Executive Board will be submitted to the 58th World Health Assembly for confirmation. The change, if confirmed by the World Health Assembly, will come into force from the 2006-2007 biennium.

In this connection, however, the on-going programme activities may be transferred to the next biennium, but their cost will have to be charged to the budget of that biennium. This change applies particularly to the execution of the Regular Budget. DAF and BFO will explain in detail this change when there is an opportunity. The change has an important implication for our planning process, whereby rolling of programme activities from one biennium to the next will play a significant role, particularly in the preparation of the workplans during the 2006-2007 biennium.

Once again I would like to emphasize the utmost importance of joint planning. This is especially so in the light of the situation that almost all resources for direct support to countries are at the country level. Regional Office staff has to go in a big way to help countries in the development and implementation of WHO country programme budgets, including the workplans.

The involvement of Regional Office staff in such a manner should be clearly reflected in the country workplans, in both technical and financial terms. The cost of the Regional Office staff’s travel to help countries in this connection will have to be budgeted in the WHO country programmes. This is because there will be very limited funds for staff travel in the Regional Office budget.
It is very crucial that technical needs of the countries are precisely identified and the relevant technical support from WHO is clearly defined for response. In this exercise, I have decided to recruit short-term planners to help in refining the workplans of Tsunami flash appeals; they will also help in this planning process to prepare the workplans for the 2006-2007 biennium. They will help technical units at the Regional Office, and help concerned staff members at WHO country offices. Please utilize their services maximally.

Let us move forward together as a unified team to realize our decentralization strategy and country focus approach. In unison, let our endeavours in this regard ensure the maximal utilization of all WHO available resources to support the countries’ health development, in the most efficient and effective manner.

Achieving the above objective, depends among other things, on good planning. In this planning exercise, let me emphasize the importance of an approach that is practical and realistic. Try to avoid too much theory or too much idealism. No one can be completely perfect in doing this type of work. Try to move in the way that all of us can conceive and comprehend clearly what we are attempting to do. This is to ensure that the workplans to be prepared collectively will be understood and be implementable by all of us.
The 26th of December 2004 will forever haunt our memory, because of the terrible earthquake that occurred in the Indian Ocean. The destructive waves of the Tsunami battered the shores of many countries and the WHO South-East Asia Region bore the brunt of it. Among our Member States, Indonesia, Sri Lanka, Thailand, India and Maldives were affected the most. Myanmar and Bangladesh were the least affected.

In response to this disaster, I immediately established a Tsunami Task Force, and activated our Operations Room to function round the clock.

The Task Force is operating in close coordination and consultation with the Headquarters Health Action in Crisis team.

The work of this task force is to: coordinate information from affected countries, and to ensure public health monitoring; mobilize and deploy human resources; manage finance and supplies; coordinate and facilitate logistics; and handle media and public communications.

A SEARO website on the Tsunami disaster was developed from the second day itself. It features a daily situation report and provides access to a range of key technical guidelines and manuals for the management of emergency situations.

Daily teleconferences are held between affected countries, Headquarters and the Regional Office to ensure consistent communication, joint decisions and coordinated efforts. Satellite communication has also been established with Sri Lanka, Maldives and Aceh in Indonesia.

In all affected countries in the Region, we have functioning Operations Rooms in WHO Country Offices. WHO operational units are being established at the field level outside the capital cities, in both Sri Lanka and Indonesia.

During the early phase of the crisis, priority attention was paid to the provision of technical advice. Technical guidelines and manuals were compiled and disseminated widely for use by emergency teams in the field.

WHO emergency staff, as well as field staff in other programmes, were immediately deployed to the most affected areas. Necessary medical supplies, such as lifesaving drugs, antibiotics, water purification tablets and vaccines were provided.

As mentioned by the Director-General, considerable concern has been expressed in the area of mental health, due to psychosocial trauma. WHO quickly responded to the request for technical advice and guidance in overcoming this important aspect of health problem.

The main focus of WHO’s work now is to coordinate with other international agencies in assessing the damage to health infrastructure; support the restoration of basic health services; and provide technical advice in the formulation of plans for rehabilitation and rebuilding. A Tsunami Health Bulletin will be regularly issued to report on the health situation in the affected areas.

A strategy for health action in emergencies during the first 100 days is in place. This strategy focuses on the five key priority needs: (1) disease surveillance and response, including early warning systems; (2) coordination of the activities of health aspects of the relief operations; (3) ensuring access to essential healthcare; (4) provision of technical guidance on critical public health issues, and on the strengthening of routine health services; and (5) coordinating the restoration of medical supply chain.

To respond to the immediate needs of the affected countries, we have mobilized from all WHO Regional Offices and HQ more than 60 professionals to help in Indonesia, 50 in Sri Lanka, 27 in Thailand, and 20 in Maldives.

To ensure the efficiency of our inputs to the whole operation, Additional experts are being mobilized and standing by to move in quickly as and when required. Through the Global Outbreak Alert and Response Network, more than 120 epidemiologists are on stand -by for immediate deployment.

Through the generous support of many countries, WHO has mobilized additional supplies and equipment, such as a mobile laboratory in Aceh.

To ensure the efficiency of our inputs to the whole operation, we are forming teams of senior staff to be sent to the affected countries and areas to
carry out a quick assessment of WHO performance on the ground, especially the coordination among WHO staff members themselves and coordination with other agencies. Equally important, we are monitoring very closely the utilization of financial resources to ensure transparency and accountability.

We now have a strategic plan for rehabilitation. As we enter the second phase, WHO will further refine this plan in close consultation with the World Bank and other key partners. However impressive the efforts of WHO may be, it is only a modest contribution to the relief operations, compared to the generous response of many friendly countries. We must appreciate the valuable contributions of all players in the field who came to help the affected population.

Given the sheer magnitude and scope of this catastrophe, no one organization can carry this mission alone. WHO is supporting national health authorities of affected countries in close coordination and cooperation with other agencies. Never before, have the organizations of the UN system demonstrated such an ability to respond to the immediate needs during a crisis with unity, professionalism and speed.

We have mounted an unprecedented response to this disaster. I would like to take this opportunity to thank the Director-General and all the Regional Directors of WHO for their sympathy, concern and solidarity. Their support to the South-East Asia Region in this difficult time is very much appreciated. We must thank the donors who have provided necessary funds to make WHO’s mission during this crisis possible.

In conclusion, I may say that every disaster presents opportunities to further improve health services for the people. We must move more efficiently to respond to the urgent need for enhancing the capacity of the health sector of Member States in the area of emergency preparedness and response. Now, we must seize the opportunity to help countries to rebuild and strengthen the local health infrastructure that existed prior to this calamity.

We are facing a huge challenge. I am, however, convinced that we will succeed, through our united efforts, to bring long-lasting benefits to those affected.
This meeting is considered to be one of the very important meetings of the Regional Office. It is even more important in light of the overall policy on decentralization of WHO, and the decentralization strategy in our Region, in particular. We are moving along with the policy trend of the Organization. Countries are now becoming the main focus of WHO work, and our WHO country offices are assuming great importance in WHO collaboration with Member States.

WHO representatives, as chief of the WHO mission in respective countries, have to shoulder a number of important responsibilities. This is to remind all of us that WRs are: technical adviser to the Government of the country of their assignment in the area of health; representatives of the WHO Director-General and the Regional Director; playing a diplomatic and political role as Chief of the WHO country mission; responsible for WHO programme development and management in their respective countries; coordinating WHO global and regional activities at the country level; providing the required technical and scientific information in all areas of health to the country; responsible for resource mobilization for country health development; and involved in the interagency coordination and cooperation, both within and outside the UN system.

In this perspective, therefore, WHO representatives need to possess the quality of a health professional/expert, administrator/manager/communicator/coordinator, diplomat and even politician, as said by one of our former Directors-General.

While functioning as WHO staff members anywhere, we must always keep in mind that we are international civil servants with our own specific code of

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conduct. Most importantly, we have to be honest and loyal to the Organization, technically sound and neutral in our decisions and actions.

One of the emerging important challenges for us at the country level is to deal with the issues involving conflicts of interest among groups, locally and/or internationally. It is indispensable that we work very closely among the three levels of the Organization in tackling such issues at all stages. At all cost, we have to try staying neutral, approach the issue on a technically sound basis, and listen to all parties involved, including the media.

It is a difficult task indeed, especially for WHO representatives when they are caught between conflicting interests. Whatever the situation, the Regional Office is always ready to provide the required support and back up to WRs in such a situation. I am sure WHO headquarters is also ready to help in every possible way. In any situation when WHO in the Region is involved, it is the Regional Director who primarily has to bear the responsibility.

For this meeting, there are several important items on the agenda. Most of these relate to our decentralization strategy and WHO programme development and management. I would just like to provide some background to help our consideration of the subjects. The Regional Office staff heard me say this a few days ago at the Retreat, so please bear with me.

Concerning decentralization in our Region, the elements of this strategy may be listed as follows: to pursue effective implementation of WHO Country Cooperation Strategy (CCS); to further operationalize WHO country focus and WHO specific country approach; to implement the idea of horizontal collaboration among WHO country offices; to pursue decentralization of certain regional and intercountry functions to the country level; and to maintain the high proportion of budgetary resources in countries (75%).

To provide critical support to the implementation of these decentralization elements, delegation of authority to WHO representatives is an important prerequisite. We have doubled such delegation since the beginning of this year. This delegation is not only in financial terms, but also in several other managerial aspects.

At the same time, the Regional Office will have to pursue extensively the strengthening of WHO presence in countries, especially strengthening capability and capacity of WHO country offices. This is to ensure that these offices will be able to shoulder more burden due to this decentralization, in both quantitative and qualitative terms.
As we know, it is also a policy of the Director-General to decentralize 75% of the WHO global resources to countries and regions. These resources will be mostly allocated for activities at the country level. In future, therefore, direct WHO support to countries will be mostly planned and implemented in countries.

In the management of WHO collaboration with countries in the Region, I would like to remind us that there are at least three main categories of WHO work: direct support to individual countries, normative work; and intercountry coordination.

Certainly, there are some other activities also to be carried out by us as part of our duty. As far as our work at country level is concerned, we are now pursuing our tasks so that our WHO country offices become really implementing offices as far as direct support to countries is concerned. In addition to direct support, WHO country offices are also responsible for: coordinating all WHO activities at the country level; contribution to normative work, especially in providing/supplying the required information; promotion of intercountry cooperation through horizontal collaboration between or among WHO country offices; involvement in interagency coordination and cooperation at country level; and resource mobilization.

In this connection, I should also mention that we will pursue our work in this direction so that the Regional Office becomes a strategic office, to be more effective in supporting WHO’s work at the country level. The strategic areas for Regional Office work will be: coordination of regional policy and strategy within the WHO global framework; performing normative work in coordination with headquarters and in collaboration with WHO country offices; promotion and coordination of intercountry cooperation activities; Monitoring and evaluation of WHO regional biennial programme budget. Pursuing oversight work to support executive management; providing support to WHO country work, as required; strengthening the capacity of WHO country offices; and involvement in interagency coordination and cooperation, and resource mobilization at the regional level.

In the areas of programme development, we will, during this meeting, focus attention on the biennial programme budget for 2006-2007. As far as we in the SEA Region are concerned, there are three main issues relating to this programme budget: there is a proposal for total global budgetary increase of 12.8%. We need all Member States to support this proposal. If we could get the above increase, WHO/SEAR would obtain about US$ 9 million more in Regular Budget for countries. Now, we need to come up with objective criteria for
distributing this increased amount among countries in the Region. ‘ICP II’ will cease to exist from the next biennium. We will have to work out its successor in order to protect intercountry activities and normative work in the Region.

However, in this connection, a Regional Working Group on Budget Development, consisting of high level representatives from all countries, has been established. This is in pursuance of the recommendation of the 51st meeting of CCPDM, which was endorsed by the 57th session of the Regional Committee. The Group is now working on the above three issues. It has met three times already and we will keep all WRs informed of the progress.

Trends in decentralization, at both regional and global levels, necessitate unified programme planning and management in the Region, whereby the focus is on WHO activities at the country level. Joint Planning between WHO Regional Office and Country Office staff, with inputs from concerned national authorities in terms of needs and requirements, will be of paramount importance.

In this process, in principle, the country will tell us “what”, and we will tell them, “how”. This joint planning exercise should start now on the plans of action for the biennial programme budget 2006-2007. To pursue this exercise efficiently and effectively, there is a need for operational guidelines, which are clearly understood by all concerned staff members, at both country and regional levels.

At the same time, we have to catch up and keep up-to-date with the new and future trends in the WHO global biennial programme budgeting process, of which we are a part and parcel. Furthermore, to ensure effective collaboration between WHO and individual Member States, we will have to review and strengthen the Government-WHO coordination mechanism. In this particular exercise, we have to keep in mind that such a mechanism has to be commensurate with the quantum of resources and activities to be coordinated; not too extensive or insufficient.

I would like to underline the importance of this mechanism, which is to facilitate the management interface between the government and WHO. If it is appropriately developed, it will go a long way in promoting collaborative efficiency and goodwill; if not, it can contribute to conflicts and inefficiency in our work with the Member States.

With liberal decentralization as we are pursuing now, monitoring, evaluation and oversight become very important management tools to protect the WHO Representative and his staff and WHO in the Region as a whole.
through ensuring transparency and accountability. Work of the Programme Planning and Coordination Unit in monitoring and evaluation of the programme budget, the reports of internal and external auditors, and monitoring and evaluation of specific programme areas by various technical units will be maximally utilized by the senior and executive management in the decision-making process.

All in all, in our business, we have to ensure high-quality performance, transparency and accountability. All of us have absolute responsibility to help ensure these.

In addition, an Internal Review and Technical Assessment Unit is now being established in the Regional Office to provide necessary information for executive decision-making. Care will be taken to ensure that the work of this unit will not duplicate or conflict with the work of the other concerned units, but, instead, supplement their work.

For this meeting, WRs may have brought with them many issues in the areas of administration and finance for discussions and clarification with concerned units in Administration and Finance. Many of these issues may have arisen from the implementation of our decentralization strategy. I hope they will get satisfactory replies and responses on those issues.

This is the Regional Director’s meeting with WRs, where the WRs will have to play a key role in the conduct of the meeting. However, I would like to see the Regional Office staff members participating as resource persons, at least. There are many things we can learn from each other. This is a learning process and is the best way for us to learn while pursuing our duties.

Therefore, this meeting should be kept open, as much as possible. I personally do not think that we have anything to hide from each other. We should be open and frank in our association and interaction.

While saying so, I must underline the importance of being positive and constructive in the course of our deliberations and in our day-to-day functioning. Adopting this approach will help us go a long way in maintaining our integrity, the quality of having high moral principles and of being united.

All of us are working towards the same goal – the health and well-being of all people; and, no less important, for the reputation and credibility of WHO. Therefore, we should not let the differences among us constrain our course of action towards this goal.
When my Government nominated me for the post of Regional Director, I thought that decentralization should be high in the priority list of my work, if I was elected. This thought came from my many years of experience in WHO during the past. And therefore, I made a start on decentralization in a big way upon my taking over as RD last March.

There are many reasons why we should take vigorous action on decentralization. What I am going to say further now is not new, some or most of you have heard it before.

During the 56 years of WHO’s existence, we have seen a lot of changes, nationally and internationally. In the Member States: there have been socioeconomic changes, including changes in the lifestyles of people; there has been political polarization leading to changes in the country governance; most importantly, countries have markedly gained capability and capacity in pursuing their own development agenda, even though at varying degrees.

At the international level: concepts of health and health development have expanded considerably; health has been globally recognized as the centre of development; health development has been pursued increasingly through multisectoral and multidisciplinary efforts; and during the past few decades, many more agencies have got involved in the areas of health.

Health does not belong exclusively to WHO any longer. WHO now has to be really competitive in order to remain credible and effective in its support to Member States. With this scenario, there is a real need for change in the way WHO is functioning.
One of the important calls for change has been decentralization of the WHO’s work at country level. And therefore, decentralization of the WHO work has become an important management policy of the Organization.

The Member States have also been longing to see WHO’s collaborative activities carried out closer to them; more relevant and responsive to their needs and requirements. However, progress in the decentralization process has been slow due to many reasons.

This is inspite of the fact that decentralization has been the overriding organizational strategy in WHO’s management reform for some years already.

To support this reform initiative, there have been some in-house exercises relating to: WHO strategy to work with, and in countries; WHO Country Cooperation Strategy (CCS); and WHO country focus and WHO specific country approach.

The pursuance of the overall WHO policy on decentralization is our overriding organizational priority in SEAR now. The following are the elements of our decentralization strategy in the Region: (1) to pursue effective implementation of the principles and concepts of WHO Country Cooperation Strategy (CCS); (2) to further operationalize WHO country focus and WHO specific country approach; (3) to implement the idea of horizontal collaboration among WHO country offices; (4) to pursue decentralization of certain regional and intercountry functions to country level; and (5) to maintain a high proportion of budgetary resources in countries (75%). Through this perspective, the Regional Office staff has to provide critical support to these decentralization elements.

As we are aware, delegation of authority to WHO country representatives has been doubled. This delegation is not only in financial terms, but also covers several other management aspects. Now, the Regional Office staff has to pursue extensively the strengthening of WHO presence in countries, especially the strengthening of capability and capacity of WHO country offices.

It is also a policy of the Director-General to decentralize 75% of the WHO global resources to countries and regions. These resources will be mostly allocated for activities at the country level.

In future, WHO work for direct support to countries will be exclusively planned and carried out in countries. This necessitates the need for a unified planning process to be pursued jointly by the Regional Office and Country Office staff.
In terms of collaboration with Member States, there are three main categories of WHO work at the regional level: (1) direct support to individual countries; (2) normative work; and (3) intercountry coordination.

In our decentralization strategy, ultimately WHO country offices will be operational offices with the following functions: direct support to individual countries; contribution to normative work, especially in providing the required information; promotion of intercountry cooperation through horizontal collaboration between or among WHO country offices; and interagency coordination and cooperation at country level, and resource mobilization.

The Regional Office in future, will be the strategic office with the following functions: coordinating regional policy and strategy within the global framework; performing normative work in coordination with HQ and in collaboration with WHO country offices; promotion and coordination of intercountry cooperation activities; monitoring and evaluation of WHO regional biennial programme budget; pursuing oversight work to support executive management; providing support to WHO country work as required; strengthening the capacity of WHO country offices; and resource mobilization and interagency coordination.

As said earlier, with these trends in view, joint planning between Regional Office and WHO country offices is of paramount importance. I have touched on the background of our decentralization strategy in a nutshell to facilitate our consideration and discussions.

For this Retreat, we will focus on three important areas: (1) horizontal collaboration among WHO country offices; (2) decentralization of regional and intercountry functions to country level; and (3) the issue on how country programme budget can contribute to intercountry activities (“ICP-II” successor arrangement).

Please keep in mind during our course of deliberations that these three areas are very much interrelated and overlapping, they are closely supporting each other. And, very importantly, these areas have a potential of sensitivity, which we have to handle with care and discretion.

There are three papers on these subjects prepared by Mr Helge Larsen to help us in the course of our discussions. Please suggest realistic and practical ideas on how to proceed with the operationalization of these three elements in the most efficient and effective manner.
The successful pursuance of this decentralization exercise depends entirely on the combined efforts of all staff members, at both regional and country levels. The organizers of the Retreat will try their best to make us clearly understand the operational concepts and approaches of the subjects under consideration.

This Retreat will not be ‘once for all’, but will be in a series, when we can have more opportunities to review together the operational issues on the ground, in order to ensure effective implementation of our decentralization strategy.

During the course of this Retreat, I will be available from time to time for any clarification, if needed. In this connection, I would like to thank DRD, DPM, DAF and all concerned staff members for their efforts in organizing this retreat.
Joint Planning exercises are becoming very important, particularly in view of the policy of decentralization by the Director-General. According to this policy, 75% of HQ resources are targeted for shifting to countries and Regions.

For many years SEARO has been following this policy, wherein 75% of Regional Regular Budget has been allocated to countries, keeping 25% for the Regional Office, mostly for salaries of staff and running cost.

In the light of the high proportion of the budget at the country level, leaving a small amount for intercountry or regional activities, we started implementing the supplementary intercountry programme (ICP II) during 1996-1997 which we have been doing for the last 5 biennia. We will continue implementing the DG’s policy and our strategy of 75% allocation to countries.

For 2006-2007, we do not plan to pool the country budget for supplementary intercountry programme any more. It means that the country budgets become very important resources for WHO programme development and management in SEAR.

In this situation, some WHO Country Offices do not have adequate capacity to deal efficiently and effectively with programme development and implementation at the country level. This calls for Regional Office staff to play a key role in supporting the country offices in programme development and management, including the process of programme implementation.

With this in view, close working relationship between Country Offices and the Regional Office becomes critically important. This close working relationship will begin with the preparation of workplans for 2006-2007 biennium, which is to start now. In this joint planning exercise, the Regional

Country Day – Bangladesh

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Office staff and the Country Office staff will work in partnership at all stages in the process to ensure effective formulation of the workplan.

I would like to emphasize that it is necessary to ensure that WHO resources at the country level are utilized for countries’ health development in the most effective and efficient manner. We should ensure that the WHO country offices have capability and capacity to deal effectively with their programme budgets in their respective countries. With this in view, we have doubled the delegation of authority to WRs at the beginning of this year, in order to ensure that WRs are able to efficiently coordinate and manage WHO collaborative activities at the country level.

Even before this liberal delegation of authority, WRs in SEAR countries had already enjoyed the biggest privilege in terms of authority and delegation from the Regional Office, as compared to other Regions. The broad delegation of authority will be important in terms of joint planning and programming, whereby the WHO country workplan will also accommodate certain intercountry activities. Therefore, WRs in the SEA Region are also allowed to work horizontally among themselves, in order to promote intercountry cooperation. Certainly in this exercise, they have to move systematically and in a planned manner.

Horizontal collaboration in this context must be appropriately planned. The country office staff will have the opportunity to learn in the process – how to think internationally, at least in a group of few countries. In this process, I think this privilege also makes it necessary that the capability and capacity of the Country Office staff is strengthened and so that they learn how to work beyond one country and to see what benefit the country can get from intercountry cooperation.

Furthermore, we are now considering to decentralize certain regional and intercountry functions to the country level. We have already initiated some activities in this regard – such as intercountry programme on arsenic poisoning in Bangladesh, as an experiment.

We are contemplating decentralizing certain activities of regional surveillance functions, especially laboratory services and training to Thailand. We may move activities in the areas of trade and globalization to a country, like Indonesia, where we have the capacity.

We will move very cautiously in this decentralization. In this exercise we have to ensure the most effective communication between the Regional Office
and the country offices. With effective support from the Regional Office, the Country Offices will go a long way in operating intercountry activities, whereby joint planning is becoming a cornerstone.

In supporting country offices, Regional Office staff may have to travel to countries and be stationed there for an extended period. In this situation, WHO country budgets may have to be utilized for supporting the travel of Regional Office staff to work at country level and therefore joint planning becomes very important.

To ensure relevance to the needs of country offices, requests for support from countries are essential. We are starting to strengthen the capacities of NPOs and general service staff, under the staff development and learning programme.

We know WRs have authority and responsibilities, in both financial and technical terms. WRs have technical capability which is to be supplemented from the Regional Office as necessary. WRs must have capacity to ensure financial and technical accountability. At the country level, the WRs role must include: programme development and management - in planning the programme budget and preparation of work plans.

Preparation of the programme budget and workplans are WHO’s responsibility. Do not expect nationals to prepare the programme budget and workplan. It is for the country to tell us what they need and what are their requirements for their health development. We have to respond effectively to those needs and requirements. We have to ensure sound technical inputs in responding to their needs and requirements. We should have the capability to do so in an efficient and effective manner.

What is most important is that we are accountable to WHO’s programme budget, both during the development and implementation phases. Whatever we are doing, we have to ensure high quality performance whenever we provide services to the countries.

The countries may implement programme budget through certain mechanisms – such as CSA/APW/TSA etc.

This is the area of involvement of the countries in the implementation process, under certain conditions. Otherwise, we are responsible for the operation.
In joint planning, we have to spell out very clearly how the Regional Office can help in the development and implementation of the country programme budget. How to prepare technical inputs in various programme areas during the development and implementation phases; and, no less important in the process, is how to be of help in strengthening country offices.

As far as planning is concerned, I would like to say that the methodology should be simple – not to use complicated methodology. The process should be streamlined, and easy to understand and follow. Whatever we are doing should be easily understood by all concerned.

We had a number of planning exercises – we had country days, we also had a planning exercise by the FCH group. But whatever exercise we do, these should be supplementary to each other. There should be no conflicts or duplication between these exercises, otherwise, the country office staff would be confused.

Dr Mark Brooks has the responsibility to guide us in the areas of planning mechanism and process as well as in the planning methodology. However, to go along with planning methodology, technical inputs from various programme areas are needed. Therefore, there must always be complementarity during the process of this exercise.

Also, in the development of AOW, objectives and country expected results, we have to be together in a simple and streamlined manner.
I am very happy to welcome you all to this brief ceremony of signing the Memorandum of Understanding between the World Health Organization, Regional Office for South-East Asia and the German Agency for Technical Cooperation, GTZ. This is yet another step towards strengthening our partnerships with the international community to work together for better health in South-East Asia Region.

Actually, the collaboration between WHO and GTZ is not new. GTZ has long been a WHO collaborating centre for Health System Development and actively cooperates with WHO at global, regional and country levels.

As far as the WHO South-East Asia Region is concerned, I am sure, the long-standing partnership between the two agencies will now be expanded and strengthened through this Memorandum of Understanding, which is a formal framework for collaboration.

As we are aware, the South-East Asia Region is home to 25% of the world’s population and bears a very high burden of global diseases. To tackle many formidable challenges, in the area of health for all in all countries, there is a need for concerted efforts by the international community. I am, therefore, very pleased that we are entering into a formal arrangement with GTZ, who has already been involved in a number of health development activities in several Member States of our Region.

These activities range from district health systems development and management to human resource development, social mobilization, operational

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Signing Ceremony of the Memorandum of Understanding between the World Health Organization and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Kurumba, Maldives, 8 September 2004

A Vision for Health Development in South-East Asia
research, and development of health infrastructure. In all these areas, GTZ has either directly supported WHO activities or supplemented our efforts to meet the health needs of our Member States.

As the international community moves towards the achievement of the Millennium Development Goals, it is indeed an opportune time to further strengthen partnership to respond more effectively to the needs of our Member States.

In this context, the MoU identifies several potential areas of collaboration. These include: health sector reform and decentralization; fair financing of health care and social health insurance; human resources development and management; strengthening of public health education and practices; quality management in health care; sexual and reproductive health; HIV/AIDS; prevention of drug abuse; health of children and young adults; and health promotion and environmental health.

Our joint efforts will focus on country-level operations. Under this MoU, country representatives of the two agencies will define the cooperation goals and activities for implementation, and provide reports on the progress, through a Joint Coordination Group.

We see the signing of this MoU as another milestone in the long-standing partnership between the two agencies. I am sure that our renewed efforts will help accelerate health development in South-East Asia. I very much look forward to the fruitful results of our joint cooperation in the years to come.
This is my first attendance at the Meeting of Health Ministers as WHO Regional Director. Allow me to express once again my gratitude and thanks to Member States in the Region for giving me the opportunity to be in this position. With this honour and privilege, I have pledged my total commitment to health development in the Region. I will work hard for WHO in South-East Asia, in order for it to live up to the expectation of the Member States.

Our Region is still plagued with a multitude of health problems. We, in WHO, will work more closely and diligently with countries to finish the unfinished agenda: Polio eradication, and Leprosy elimination.

We will continue pursuing elimination of filariasis, and start our work on kala-azar and yaws to eliminate them within a defined time frame. Most importantly now is to control the HIV/AIDS epidemic, which has the potential to devastate our Region. For this, we have to thank the Global Fund for providing much needed financial support to fight against this scourge.

Furthermore, we are yet to control malaria, tuberculosis, dengue and dengue hemorrhagic fever, diarrhoeal disease, and many more. We have to devote a lot of efforts to tackle the challenge of emerging and re-emerging diseases, such as SARS and Avian Influenza.

At the same time, we have to be well-prepared to fight against noncommunicable diseases; such as cardiovascular disease; cancer and diabetes mellitus, which are rapidly becoming problems of public health importance in our Region. Since we have discussed these subjects extensively in the past, I will not dwell more on them now.

Twenty-second Meeting of Ministers of Health

Twenty-second Meeting of Ministers of Health, Kurumba, Maldives, 5-6 September 2004
Instead, I would like to focus on how to make WHO in South-East Asia Region more dependable, efficient and effective in providing needed support to health development in countries. Since assuming office on the first of March this year, I have moved forward in a big way to implement the overall WHO policy on decentralization, with the focus on our work in countries. In order to ensure efficient, effective, timely and flexible services to Member States, I decided to double the delegation of authority to WHO Country Representatives.

With their increased role and responsibility, these representatives are now the real focal persons for WHO direct support to countries. They are to coordinate more efficiently the inputs from other levels of the Organization. This is to ensure the relevance and integration of our support at the country level.

In order to promote closer collaboration among countries in this process, WHO Representatives will now be able to take initiatives to work horizontally among themselves. However, they will have to proceed with this authority in a well-planned manner; using reliable tools for monitoring the progress, and evaluating the outcomes. And, most importantly in this exercise, the concerned national authorities must be closely consulted before taking action, keeping in mind the potentials of sensitivity.

In order to ensure efficient and effective WHO presence in countries, the capability and capacity of WHO Country Offices in management, planning and technical strengths will be enhanced. The Regional Office is now preparing a plan for such enhancement. The Country Cooperation Strategy (CCS), which all countries have formulated and implemented, is being used as a basis for such strengthening.

WHO country staff will receive additional training to ensure high quality performance in the management of WHO activities. In the process, we will make sure that the nationals who are collaborating with WHO will also benefit from this training programme. Within the context of WHO country focus, we are now moving towards the realization of country specific approaches. For each country, specific country situations, needs and requirements for health development will be more accurately identified, and used as the basis for planning. WHO Country programmes will be specifically tailored to those needs and requirements.

In order to move WHO activities close to countries as much as possible, we are contemplating to decentralize some regional and intercountry functions to certain Member States. These areas include surveillance; health systems development; trade, globalization and health; chemical safety; and more. This
is also to ensure the effective use of expertise available in countries in the work of WHO; and to further promote intercountry cooperation.

Strengthening of WHO Collaborating Centres and National Centres of Excellence will be supported through a clear workplan; and their expertise will be utilized optimally by WHO.

Government/WHO coordination mechanisms will be thoroughly reviewed and strengthened to ensure efficient, effective and cordial working relationships between WHO staff and national counterparts. Certainly, special attention will be given to supporting cooperation among countries, with particular emphasis on joint endeavours to tackle priority health problems, especially at the border areas.

We are all aware that success in intercountry cooperation depends on the spirit of regional solidarity and unity, which has to be considered within the broad social, cultural and political context. Within this spirit, our Member States in the Region will have the best opportunity to work effectively together for the attainment of our health goals.

In the decentralization process, WHO will have to ensure that our initiatives are really beneficial to the Member States. We have to monitor and evaluate our efforts at every step of the development. Therefore, an Internal Review and Technical Assessment unit is being established at the Regional Office, to help ensure that we are moving in the right direction according to plans, and in compliance with the established policies and strategies, rules and regulations.

If there is any evidence of deficiency and shortfalls in the process, corrective action will be taken without delay. This is to ensure that we only effect changes for the better. Sustaining gains from our development efforts on a long-term basis is really a key issue, particularly in the developing world. Sustainable national development in health needs strong public health systems. With this in mind, we are planning to pursue, as one of our high priorities, the strengthening of public health infrastructure in countries of the Region.

First, in this exercise, we will focus attention on public health workforce; through supporting the development and implementation of educational programmes relevant to the specific needs and requirements for health development in the Region.

A high level task force has been formed to prepare a conceptual framework on Public Health Education in the WHO South-East Asia Region in the 21st Century. This framework, which incorporates the socio-economic, cultural and
political contexts specific to our Region, will be used as the basis for WHO to move forward in the development of public health educational programmes in countries.

A regional network of public health institutions has already been established and is functioning. This mechanism will help promote intercountry cooperation in this important area; whereby countries can share information, experience and expertise.

While working to realize the decentralization of responsibility and authority to country level, we also review simultaneously our managerial processes in the Regional Office. This is to streamline such processes to ensure increased management efficiency through the elimination of bureaucratic hurdles and bottlenecks.

These are some of the initiatives we have undertaken as a management reorientation exercise in the South-East Asia Region during the short time I have been in office as Regional Director.

Of course, we need resources to do all these. With this in mind, we will first have to ensure the best use of our existing manpower and funds.

In parallel, we are making all-out efforts in mobilizing extrabudgetary resources for the implementation of our plans. My Deputy Regional Director has been given this critical responsibility for resource mobilization, to ensure availability of necessary funds for us to move forward.

My lines of action in these initiatives are based on two main premises: that during many decades of WHO's existence, the capability and capacity of the countries' health sector have increased remarkably, even though at varying degrees; and that it is an opportune time for WHO now to move its activities and services close to countries as much as possible, in order to ensure its effective contribution to health at the country level.

There are many things to be done, and we, in WHO, have a strong will, commitment and dedication to do all these. In addition to the tireless efforts of my WHO colleagues, success in this exercise will certainly depend on support from the Member States for which we earnestly plead.

This is just the beginning of my work, and there is still a long way to go to accomplish the tasks as mentioned. Through your wisdom, Excellencies, please advise and guide us on a clearer way through which we can move forward with more confidence in tackling these formidable challenges.
Joint Inauguration of the 22nd Meeting of Ministers of Health and 57th Session of the WHO Regional Committee

It is a great pleasure for me to address this joint inauguration of the 22nd Meeting of Ministers of Health, and the 57th Session of the WHO Regional Committee for South-East Asia.

Your Excellency, Mr President, we deeply appreciate your august presence to inaugurate these two important meetings. It is a clear demonstration of your government’s abiding interest in the health and welfare of people in the Region. I am very happy that the Hon’ble Health Ministers are able to spare time to come inspite of their heavy responsibilities at home. On behalf of the World Health Organization and on my own behalf, I extend my sincere thanks to the Government of the Republic of Maldives for hosting the meetings, and making the excellent arrangements. The Republic of Maldives joined WHO in 1965. Since then, we have witnessed remarkable progress in national development, in spite of scattered geographical location of atolls and resource constraints. Per capita income increased from only US$ 352 in 1981 to US$ 2,090 in 2002. Overall literacy rate also increased from 92% in 1980 to 98% in 2001.

In the health area, life expectancy at birth increased from 50 years in 1980 to 71 years in 2003. The infant mortality rate decreased from 94 in 1980 to 14/1,000 live births in 2003. The crude death rate decreased from 12 in 1980 to 4 per 1,000 population in 2000. Leprosy has been eliminated since 1997. The country has been free from polio for 23 years.

This impressive development was aided, among other things, by a sound health system, developed to serve the health needs of the country within its
national and local situations. We must congratulate the Republic of Maldives for these commendable achievements in health development.

This is the first time that I have the honour and privilege of addressing this distinguished audience as Regional Director of WHO South-East Asia Region. I do so with a total sense of responsibility and deep humility. It would never have been possible for me to be in this position without the trust and confidence reposed in me by the Member States in the Region, for which I am indeed grateful. Let me take this opportunity to re-affirm that I will dedicate myself fully and do my best for WHO and for the development of health for all peoples in South-East Asia.

With a dedicated health workforce, and with strong tradition of solidarity and close collaboration among countries in the Region, I am confident that WHO in South-East Asia will live up to any expectation of the Member States. To pursue my functions effectively, I will have to count on the goodwill, guidance and leadership of the Member States in the Region.

These two important meetings are being held to address the challenges that we face together, and to maximize the opportunities for better health of all our peoples. There has been a remarkable progress made in the development of health technology and interventions over the last 50 years. We, together, will have to ensure that our peoples too will maximally benefit from these advancements. This is one of our real challenges, in view of the resource constraints prevailing in countries.

Now, let us look at some of our achievements. We have eradicated smallpox and guinea-worm disease. Leprosy is now targeted for elimination by the end of next year. We will soon eradicate poliomyelitis from this part of the world.

On the other hand, our progress in health area faces formidable challenges due to the re-emergence of tuberculosis and malaria, and the rising incidence of noncommunicable diseases. HIV/AIDS is threatening to offset the gains from our health and socioeconomic development.

As we are well aware, our Region also has to contend with widespread poverty and illiteracy. Unchecked population growth, increasing environmental degradation, global warming, improperly planned urbanization, and rapid industrialization continue to pose serious risks to health.

These are the challenges waiting to test our capability and capacity in moving forward in health development in the years to come. However, these
may be considered as an opportunity for us to review our health policies and programmes, with the view to reorient our strategies and resources for maximum gains in the development efforts.

Fifteen years ago, the UN Commission on Environment and Development placed people at the centre of development. The World Summit on Sustainable Development recognized the centrality of health in the development process. The Global Commission on Macroeconomics and Health has also emphasized that increased investment in health leads to social and economic development. By scaling up investment in health, we can stimulate economic growth and reduce poverty; and these, in turn, further enhance health development.

The Millennium Development Goals recognize the critical role of health in reducing poverty and contributing to overall development. The MDGs are central to our agenda for forging towards a healthier world. It is to reiterate that within the context of these goals that health is both a goal in itself, and a key input towards other development perspectives.

The centrality of health in sustainable development must be recognized and operationalized through national development policies, plans and strategies. Strong political commitment and leadership at all levels are essential in these processes.

To ensure that all peoples in our Region will be optimally healthy, we need to close the disparities in health in countries and among countries. In order to do so, we need vigorous health systems in all countries, that can ensure universal access to quality health care and services for all. Health systems development will continue to be the key priority, that underpins all our efforts in the Region to improve peoples’ health.

As we well know, our countries are facing the double burden of communicable and noncommunicable diseases, as well as persistent poverty and severe resource constraints. The countries are finding it increasingly difficult to move forward in national development due to lack of necessary resources.

At the national level, health is still given low priority on the government agenda in many countries. Health Ministers are the best persons to persuade their Heads of States and Heads of Governments, as well as Planning and Finance Ministers, that putting more money into health is a sound investment.

However, all of us, at all levels have to continue pursuing in a big way to advocate for a prominent place for health in the national development agenda. Furthermore, we have to ensure the best use of available resources for health development.
To achieve our goals in this regard, among other things, we need to seriously review the area of human resources as a priority consideration. We need to particularly focus on strengthening the public health and medical workforce, to make them more socially and ethically responsible, and committed to the goals of health for all. More importantly, the involvement of people from all walks of life in health improvement and maintenance is needed. With these initiatives, we can go a long way in our quest for health for all.

International unity for health was the basis, on which the World Health Organization was established, more than five decades ago. This solidarity was clearly evident when we unitedly fought and contained outbreaks of emerging diseases, like SARS and Avian Influenza.

Similarly, the fight against HIV/AIDS will succeed only through international solidarity and cooperation. The Global Fund established to help fight against the scourge of HIV/AIDS, TB and malaria has been instrumental in providing much needed financial resources. I am pleased to report that the countries of our Region are getting due benefit from this Fund.

International cooperation is also required to ensure that the Framework Convention on Tobacco Control, adopted by the World Health Assembly more than a year ago, comes into force soon.

The problems and constraints in health development in our Region are daunting, and a real challenge to all of us. The best strategies and interventions to ensure equitable health care and services for all are yet to be realized through our combined wisdom and joint efforts.

Shortly after assuming office, the WHO Director-General, Dr LEE Jong-wook, said, “We must do the right things; we must do them in the right place; and we must do them in the right way”. I would like to add in this connection that we must do them at the right time.

It is time for us now to revisit our development plans and redirect our course of action to ensure our ability to effectively tackle health challenges now and in the future. I have no doubt that the ensuing two meetings would further enhance regional unity and collaboration to ensure the best gains from our health development endeavours. We look forward to the advice and guidance of the Hon’ble Health Ministers and the distinguished Country Representatives to the Regional Committee.

In conclusion, let me again thank His Excellency, Mr Maumoon Abdul Gayoom for his gracious presence.
Ninth Meeting of Health Secretaries:
Introductory Session

It is with great pleasure that I welcome you all to the ninth meeting of Health Secretaries. Please accept my greetings and appreciation for sparing your valuable time to be with us. Before proceeding further, let me say how happy and humble I feel to have the honour of addressing this distinguished group as the WHO Regional Director of South-East Asia.

When I retired about four years ago, I could never think that I would have the opportunity to come back to occupy this position. This has become possible only because of the trust and confidence reposed in me by the Member States in the Region. I am indeed grateful to them. Let me also take this opportunity to re-affirm my total commitment to health development and well-being of all people in all countries in South-East Asia.

The present time is one of great opportunities and challenges. Humanity has gained significantly from health improvements over the last 50 years. Globally, life expectancy increased from the average of less than 47 years during 1950-1955 to over 65 years in 2000. This increase has been more pronounced in the developing countries.

Our Region has also gained much from these developments. After eradicating smallpox, we recently eradicated guinea-worm disease. Now, poliomyelitis and leprosy are very near to the point of eradication and elimination. However, extensive intensification of efforts by all concerned parties is required to achieve these goals. Realistically looking into the future, there is no room at all for complacency.

Infectious diseases continue to be a major challenge. Our Region, even today, 175 million people are at high risk of malaria. Six million people are
living with HIV/AIDS. Tuberculosis continues to kill 750,000 people every year and about 200,000 children succumb to measles annually.

In addition, noncommunicable diseases are steadily increasing. We have now to address the double burden of communicable and noncommunicable diseases; in the face of widespread poverty and severe resource constraints.

In this context, it may be recalled that the Commission on Macroeconomics and Health has provided us with evidence that increased investment in health leads effectively to social and economic development. It is our task, therefore, to persuade our political leaders to increase resource allocations for health development, since this is a highly productive investment for any country. In view of the budgetary constraints faced by the Member States, we need to forge stronger partnerships with many development partners and sister agencies.

I will spare no efforts in strengthening external relations and resource mobilization for health in the Region. In this regard, I have asked my Deputy Regional Director to take this critical responsibility. We have high ambitions, and we want to fulfill our technical role through efficient coordination, mobilization and management of all available resources.

As I had indicated after my nomination by the Regional Committee last September, in order to ensure efficient and effective WHO support to countries in the Region, my special attention will be focused on meeting the following challenges: asserting and earning WHO leadership in health in South-East Asia; strengthening external relations, partnerships and resource mobilization; advocating the central role of health in social and economic development; further strengthening WHO technical capability and capacity, in order for it to function more proactively; and respond more effectively to the needs of individual Member States; strengthening WHO’s work in countries by delegating more authority to the WHO Representatives; making them work more horizontally; and moving technical expertise closer to the countries for timely response; further promoting intercountry cooperation, with particular attention to the joint endeavours to tackle priority health problems, especially in the border areas; and strengthening collaboration with other Regions, particularly the Western Pacific, through interregional activities in areas of common interest.

At the turn of the century, world leaders agreed on a set of development goals for the Millennium. These Goals focus on poverty reduction in general, and on several health targets in particular. The Millennium Development Goals (MDGs) are central to our development agenda. They reiterate that health is both a goal in itself, and a key input towards other development perspectives.
The MDGs are a call for closing disparities in health, and highlight the urgent need to ensure that health development contributes maximally to poverty reduction. Real progress in health depends vitally on stronger health systems based on primary health care. Without effective health systems that respond to the complexity of current health challenges, there will only be limited advances towards MDGs and other health priorities.

There has been a fairly wide perception that the public health infrastructure in the countries of our Region is not in a position to fully cope with the challenges of epidemiological and demographic transitions. It was against this background that WHO organized a Regional Conference on Public Health in South-East Asia in the 21st Century in November 1999 in Calcutta. The objectives of this meeting were to widen awareness of the importance of public health for sustainable health development, and to promote strategies for sound public health systems in our Region.

Since then, WHO has continued its efforts to strengthen public health workforce in the Region. Several national meetings have been held since with WHO support to strengthen the quality of educational programmes in public health. Two intercountry meetings have also been organized to promote the development of a network of institutions dealing with public health education. Consequently, a number of MoUs were concluded among those institutions in Bangladesh, India, Indonesia, Myanmar, Sri Lanka and Thailand.

To achieve our goals in health development more effectively, we need to seriously review the human resources for such development. We need to particularly focus on the training of public health and medical staff to be more socially responsible for, and committed to the goals of health for all. I am, therefore, initiating steps to help strengthen national centres of expertise and WHO collaborating centres to form an effective regional network to further support intercountry cooperation in this regard.

Please allow me to restate some known facts, lest they are overlooked. In pursuing national health development, it is necessary to address the fundamental determinants of ill-health, including poverty, malnutrition, discrimination, unchecked population growth, and environmental degradation. It will require ensuring access to basic health services for all; and ensuring that people of all walks of life are fully involved in the process of their own health development at all stages in the process.
This will also include our strategy to deal with the unfinished agenda to reduce child and maternal mortality. We have to work hard towards preventing the AIDS epidemic from exploding in our Region and elsewhere. Above all, this means a substantial increase in the resource allocation to health at national level to scale up the required health interventions. I may repeat that it is equally necessary to strengthen health systems and ensure efficient and effective utilization of all available resources.

I have no doubt that this meeting will further enhance regional solidarity and cooperation for and thereby contribute to better health and well-being of the people in our Region.

During this meeting, the Health Secretaries will deliberate on several subjects of topical interest. They will review the draft revision of the International Health Regulations in order to address the current health issues in the context of ever-growing globalization. They will discuss the issues relating to iodine deficiency disorders with the view to providing advice and guidance for further strengthening the prevention and control programmes in countries of the Region. They will also deliberate upon the issues concerning globalization, trade, and intellectual property rights in the light of their implications on health development.

In view of the looming threat posed by HIV/AIDS, the Secretaries will review the current situation and deliberate, especially, on the scaling up treatment strategy to meet the challenge in this area. They will also consider the development of regional cooperation for prevention and control of avian influenza, which is the latest emerging problem of global health importance.

This is my first meeting with you in this forum. It is really an honour and privilege for me to have the opportunity for a dialogue with the honourable Health Secretaries of countries in the Region. I would like to seek your advice and guidance on the subjects consideration, and, particularly, on the future direction of WHO’s work in South-East Asia. In view of the far-reaching implications of the last issue, I have enlarged this consultation by inviting some experts in the Region. We look forward to your valuable suggestions in all these important areas.
The situation in the world has changed a lot compared to 56 years ago, when the World Health Organization started its work. It is essential for the Organization to effect internal change in order to ensure its efficiency and effectiveness; and to live up to the expectation of its Member States and other partners.

The need for this change has been well recognized; efforts have been regularly made in the past, as a continuous process in the organizational management.

I now have the privilege to be the WHO Regional Director of South-East Asia. It is my duty to ensure relevance, efficiency and effectiveness of the Organization’s services to countries in the Region. With this responsibility in mind, I have initiated certain reorientations in the functioning of WHO in South-East Asia.

My lines of action in this regard are based on the recognition that: during this 56-year period, the capability and capacity of countries’ health sector have increased, significantly, even though at varying degrees; and that health development today is much more complex than when WHO started its work; this is in terms of both the content and process of development. My direction and actions are guided substantially by my previous experience of almost 17 years in various capacities in WHO/SEARO.

The first thing I did on assuming office in March this year was to implement the overall WHO policy on decentralization. We have gone in a big way in strengthening WHO’s presence in countries. I decided to double the delegation of authority to WHO Country Representatives, in order to increase their role in making the decisions about health services to the population.
and responsibility in serving countries. At the same time, we have planned to strengthen WHO country offices to increase their capacity in management, planning and technical strengths.

Through our development and learning programme, staff at both regional and country offices will receive additional training to ensure efficient and effective support to countries. In the process, we will make sure that the national counterparts also benefit from this training programme.

A prerequisite for this movement is the Country Cooperation Strategy (CCS), which all countries in the Region have already developed. This country specific strategy is being used as a basis for strengthening WHO’s presence in the individual Member States.

Another important decision made in this connection is to allow WHO Representatives to work horizontally among themselves without prior permission from the Regional Office. However, they have to do this in a planned manner, carry out activities systematically with good monitoring of the processes and evaluation of the outcomes. This approach is intended to contribute to the promotion of intercountry cooperation.

In pursuance of this horizontal cooperation among WHO Representatives, we have particularly emphasized that concurrence of the concerned national authorities must be secured before taking action. With the doubling of delegated authority, the WHO Representatives now have full responsibility for WHO’s direct support to countries. We will see to it that there is no imposition of activities on the countries from the Regional Office without request from the Governments through the WHO Representatives. But, certainly, regional and intercountry activities hosted by countries will continue.

The Regional Office staff are now supposed to provide full technical backup to WHO Country Offices in the development and implementation of WHO country programme budgets and workplans. An attempt will also be made to ensure that regional and intercountry programmes directly support and supplement the activities of the country workplans.

The WHO Director-General has issued an Organization-wide policy on country focus of WHO’s work. In this context, we, in SEAR, are intending to move one more step forward. That is the idea of identification and implementation of country specific approaches for each individual Member State. Efforts will be exerted to identify specific needs and requirements for
health development in the individual countries; then, country specific programmes will be developed to respond to those needs and requirements.

Certainly, the normative work of WHO will be enhanced, and be the primary responsibility of the Regional Office. Various guidelines, norms and standards, nomenclatures, generic training modules, for example, will be developed by the Regional Office staff in coordination with WHO Headquarters, using information from countries. These outputs from the normative function will be made available for application by countries.

In order to move WHO activities in the Region closer to countries as much as possible, we are contemplating to decentralize some regional and intercountry functions in areas such as surveillance, health systems development, trade and globalization, and chemical safety to certain countries. This is to ensure the effective use of country expertise in WHO work, and to further promote intercountry cooperation. Strengthening of WHO Collaborating Centres and National Centres of Expertise will be supported in a more concrete manner through this approach.

Needless to say, we will double our efforts in strengthening and promoting intercountry cooperation in health in the Region. In this process, the emphasis will be placed on cooperation for tackling priority health problems, especially at the border areas.

Success in all these efforts will depend on the spirit of regional solidarity and unity, which will have to be considered within the broad context of social, cultural and political dimensions. In the spirit of interregional collaboration between and among WHO regions, we will pursue our work diligently.

After my nomination by the Regional Committee last year, I was invited to Manila by the Regional Director of the WHO Western Pacific to discuss interregional collaboration. We pledged together to go in a planned manner in such collaboration; a number of specific areas were identified for the purpose.

With this collaborative spirit, I am confident that countries in the Region will have more opportunity to work together, or to work with country partners in other Regions, in pursuing health development, with catalytic support, and facilitation from WHO.

We need a good built-in mechanism to ensure that our decentralization and delegation of responsibility and authority are working as desired. Good planning is the prerequisite in this regard. We will proceed carefully with a
good plan which is to be implemented systematically under constant supervision. Good country workplans/operational plans are essential; all activities to be taken up in this connection have to be included in such plans.

Frequent dialogue between WHO Country Representatives and the Regional Director will be a means for monitoring actions taken at the country level. We plan to hold formal meetings between the two levels, Regional Office and Country Offices every six months. This is to discuss, among other things, problems and constraints faced in pursuance of such decentralization and delegation.

In this exercise, we will also have to ensure oversight of the activities carried out at both the Country Offices and Regional Office. In this connection, an Internal Review and Technical Assessment unit is being established, to help ensure that we are doing the right things according to plans, and in compliance with the established policies and strategies, rules and regulations. Most importantly, this is to ensure that our management initiatives are really beneficial to the Member States. In this process of a feedback mechanism, we will take immediate corrective action, if this is indicated through the information from our monitoring and oversight. I believe, we all agree that this is the time for change, and we have to make sure that we will only effect change for the better.

On another aspect of our efforts, we have faced the issue of how to sustain gains from development. Whatever we have developed, especially at the national scale, tends to become unsustainable in the long term. Sustainable national development in health needs strong public health infrastructure. With this in mind, we are planning to pursue, as our highest priority, the strengthening of public health infrastructure in countries of the Region. Many things need to be undertaken in this very important exercise.

However, we will focus first on strengthening and building public health workforce, through relevant educational programmes. A high-level task force is being formed to brainstorm and develop a conceptual framework on public health education in the WHO South-East Asia Region in the 21st century. Regional socioeconomic, cultural and political specificity will be particularly taken into consideration in this development.

This conceptual framework will be the basis for us to move forward in the development of public health education programmes in the Region. A lot of expertise already exists in the Region in this area. Therefore, a mechanism has been initiated to promote and facilitate intercountry cooperation; or inter-institutional cooperation.
A regional network of public health education institutions has already been formed. WHO will make sure that the network can start functioning, and provide an effective link between or among institutions in the Region.

At the same time, SEARO is fielding experts to certain countries to study the situation, and help plan for the development of their public health education programmes.

All these efforts need financial resources. And we all know well that WHO resources are very limited. With this in mind, I have paid special attention to resource coordination and mobilization.

As part of this exercise, we will also ensure the most efficient and effective use of available resources, through careful review and reorientation of current WHO workplans. If indicated, the budget will be shifted as appropriate, to where it is most needed for the development in priority areas.

At the same time, we are exerting special efforts in mobilizing extrabudgetary resources. Several proposals required for such mobilization have been developed, and dialogues with a wide range of potential donors have taken place. In this challenging task, we have yet to critically assess our efforts to see how much we were able to mobilize.

Moreover, on the issue of budget, we will try to ensure fair distribution to countries, through the objective assessment of technical needs of the individual countries. We are contemplating the establishment of an expert group to pursue such assessment and development of objective criteria for resource distribution to countries.

Now, we are also pursuing the streamlining of management processes in various areas of our operation at the Regional Office. This is to ensure increased efficiency through the reduction of bureaucratic hurdles and bottlenecks, and promoting cordial services to countries and other partners.

There are, perhaps too many things to do, and, maybe, too much to do. However, we, in WHO, have a strong will and commitment to do all this.

Success depends on the united efforts of my WHO colleagues, at both country and regional levels, and most importantly, on the support from the Member States in the Region, for which we plead.
Forty-first Meeting of the Consultative Committee for Programme Development and Management

We have recently completed the implementation of the programme budget for 2002-2003 biennium; and started implementing the 2004-2005 workplans. We are also ready to review the proposed programme budget for 2006-2007. Therefore, we will have an opportunity to assess our past performance, examine our current issues, and look ahead to the challenges during the next biennium.

In order to effectively chart our future course of action, we need to keep in mind the current WHO policy reorientations, and the leadership changes, at both global and regional levels. In this context, I would like to draw your kind attention to the Director-General’s consistent message to improve the performance of WHO at the country level in order to perform our functions more efficiently and effectively in supporting our Member States.

In this perspective, the future work of the Organization should be based on its successful past experience and avoid repeating the mistakes made in the past. In this context, we recognize that the ministries of health in all Member States in the Region have substantially increased their capability and capacity, to be able to pursue their own health development. Other partners are also involved in supporting such development.

There are major international initiatives, such as the Global Fund for AIDS, TB and Malaria to help finance the process of health development activities in countries. WHO, as a specialized agency in the UN system, plays a major role in providing technical support and backstopping to facilitate and catalyze such
a process. To play this role effectively, it is necessary for WHO to maintain its pivotal status as a lead agency in international health.

Our close relationship with the Member States, our global leadership in health, and our ability to provide effective support, put WHO in the best position to get involved as an important partner in the process of national health development.

To ensure efficient and effective technical support to countries, WHO needs the necessary budget. As we are aware, WHO does not have a big budget. Therefore, whatever is available should be utilized in the most efficient and effective manner to facilitate the Organization’s technical activities in its collaboration with countries.

To ensure such efficiency and effectiveness, we have allocated 75% of the WHO Regular Budget for supporting country activities in the South-East Asia Region. This is the highest regular budget allocation to countries, compared with all other Regions in WHO. This is why the WHO country offices in our Region, with backstopping from the Regional Office, are able to provide timely support to the Member States; as was demonstrated in emergencies, such as SARS outbreak and in developing proposals for the Global Fund.

WHO Country offices, along with the global and regional support provided to countries, is now termed as WHO Country Presence. The Director-General has put a high priority on strengthening WHO Country Presence in order to ensure maximum efficiency of WHO’s contribution to health gains at the country level.

In this Region, I am glad to say that we are already moving forcefully in this direction. The key instrument for strengthening WHO Country Presence is the Country Cooperation Strategy or CCS.

The strategy deals, among other things, with the analysis of national health problems, current involvement of various health development partners, and the strengths of WHO. These lead to clear definitions and requirements for WHO Presence in the individual countries. Specific plans are now being developed for strengthening WHO country presence, including WHO country offices.

While all our countries had prepared CCS in the past, we expect that at least five of them will review and refine their CCSs in the coming 12 months. At the same time, WHO is attempting to implement the “One-country budget” approach.
This is conceptualized as an integrated budget, derived from funds of all sources, reflecting the support provided to a country from all levels of the Organization. This approach should also facilitate joint planning among Headquarters, the Regional Office and countries.

Furthermore, in line with WHO’s policy of decentralization, I have doubled the delegation of authority to the WHO Country Representatives. This is to ensure maximum efficiency of WHO support to the country’s health development. This rather liberal delegation of authority should enhance the relevance and responsiveness of our technical services, and reduce the bureaucratic bottlenecks.

Now, looking back at the 2002-2003, biennium we all can take pride in our achievement in the implementation of our Regular Budget. Funds surrendered to Headquarters were just over US$ 2 million, less than half the amount surrendered during the previous biennium. However, the achievements in technical terms during the same period are difficult to quantify. WHO country programmes have often been spread over a large number of areas, making it difficult to measure our accomplishments.

Furthermore, much of our attention on monitoring and evaluation had been on the programme inputs and activities, rather than on the outputs or outcomes. Nevertheless, we believe our technical inputs had contributed substantially to health development in Countries.

For the last two biennia, WHO has emphasized the application of results-based management in programme planning, implementation, monitoring and evaluation. With this approach, there has been some progress in improving the quality of workplans. That has contributed significantly to the improvement in the measurement of results. However, it is well accepted that more efforts are needed to further improve the situation.

One of the main difficulties we have faced is that we have too many Expected Results. Assessing the progress and evaluating the achievements of so many Expected Results is really a difficult task. We will see this in the report to be presented at this meeting. All this leads to the conclusion that we must be more focused in our work.

Fewer Expected Results should make it easier to monitor and evaluate programme implementation in technical terms. The selected Expected Results should really reflect the country priorities and the comparative advantages of WHO. We need to urgently move in this direction, so that our work has a...
higher degree of effectiveness in contributing to health improvement in countries of the Region.

Another issue I would like to raise is the increasing influence of donor funds on WHO’s work. In the past, the Regular Budget supported most of WHO’s staff and activities. But during the last several biennia, the Regular Budget has decreased, while funds from other sources, especially extrabudgetary contributions, have increased dramatically.

During the last biennium, 59% of regional funds were from sources other than the Regular Budget. Funds from these sources increased to 67% in the current biennium; the budget estimates for 2006-2007 show that funds from Other Sources are likely to increase to about 69%.

WHO is, however, bringing more resources to our Region. This is very good, but we must ensure that these donor funds do not dictate the direction of WHO’s work.

The Organization and the Member States have to decide together what should be our policy, strategy and collaborative activities, then mobilize necessary funds from donors to do the job.

Our workplans for the Regular Budget and funds from Other Sources for the next biennium will be integrated as mentioned earlier. The issues and procedures relating to this integrated budget will be discussed in detail at this meeting. I look forward to your comments and suggestions in this regard.

I have already emphasized our desire to improve WHO Country Presence in the Member States. This is an exercise to ensure harmonized Organization-wide support for our countries. I have placed high priority on Regional Office support to activities at country level. The directors and regional advisers have been made aware that their main roles are to support country programmes. At the same time, they must also reinforce the normative functions of the Organization; such as development of technical guidelines, standards and norms, and generic training modules for use by countries. In addition, WHO Headquarters has also placed increased attention on country support; I am sure we will be able to call on necessary resources from Headquarters for the purpose.

As mentioned earlier, I have decided to delegate more responsibility and authority to our WHO Representatives. An important initiative in this connection
is to promote horizontal technical cooperation among them. This is envisaged to be a better way to encourage more technical cooperation among countries.

I will make sure that in the process of cooperation among WHO Country Representatives, the concurrence of the respective national health authorities is secured, especially when such cooperation has policy, financial and political implications. I am confident that with this mechanism, sharing of information and expertise among countries in the Region will be increased. Countries will have more opportunity to support each other in their health development, WHO’s catalytic support.

Now, let me dwell briefly on other issues to be dealt with during this meeting of CCPDM. Emergency Health Preparedness was selected as the topic for the Technical Discussions. This is in view that all countries in our Region continue to face natural hazards and complex emergencies. In all of these events, the protection and promotion of the health of the people is of the paramount concern.

Emergencies are an added burden to health systems in terms of both funds and efforts; they adversely affect the gains and potential gains of development. The issue of public health in emergencies is essentially tied to health development in general, and should be addressed accordingly. We hope that through these discussions, WHO will be more effective in supporting preparedness for national health emergencies.

Among other topics, during this meeting of CCPDM you will also discuss regional implications of the relevant decisions and resolutions of the 57th World Health Assembly, and the 113th and 114th sessions of the Executive Board.

We have a rather heavy agenda for this CCPDM meeting. I hope that all of you will present your views frankly and provide useful suggestions, and that we will be able to finish the meeting with very good conclusions and outcomes.

As I said, we are in the process of effecting necessary changes for more efficient and effective functioning of WHO in the Region. Therefore, your guidance is essential, indeed, for the development of our future direction.

I wish you success in your deliberations, and look forward to your valuable recommendations. I now have great pleasure in declaring this Forty-first Meeting of the CCPDM open, and wish you all an enjoyable and comfortable stay in Delhi.
A Vision for Health Development in South-East Asia

Selected Speeches by
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