

Regional Health Forum
WHO South-East Asia Region

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Editorial

The main objective of the Regional Health Forum is the exchange of information, experiences, ideas and opinions on all aspects of public health and health development. The publication is intended to serve as a platform where people can express their views, observations and experiences rather than as an official medium of the World Health Organization's policy or as reference material.

In view of the unprecedented tragedy that struck many Member States of the WHO's South-East Asia Region in the form of tsunami, this issue of the Forum carries a special message from the Regional Director, Dr Samlee Plianbangchang.

The articles covered in this issue are: *Induced Abortion: The Current Scenario in India*; and *Medical Negligence, Patients' Safety and the Law*.

The Notes and News section carries write-ups on important meetings including the Forty-first Meeting of CCPDM; Ninth Meeting of Health Secretaries; 22nd Meeting of Ministers of Health; 57th Session of the Regional Committee, and 55th Meeting of the Regional Director with the WHO Representatives. Several WHO publications on areas covering International Migration, Health and Human Rights; Managing Newborn Problems; MDG Drinking Water and Sanitation Targets and TB/HIV are featured in the Book Review.

This issue also carries the Declaration on Tsunami Relief and Rehabilitation Efforts issued at the special ASEAN leaders' meeting, held at Jakarta, Indonesia on 6 January 2005.

The next issue of the Forum will focus on "Healthy Mothers and Children", the theme for World Health Day 2005, slogan for which is "Make every mother and child count".

Readers are invited to forward their contributions in the form of articles, essays, letters, or comments written in an informal, anecdotal style. Suggestions on improving the Forum are also welcome.

Message from the Regional Director

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 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 while Bangladesh and Myanmar were the least affected.

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.

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 the WHO mission during this crisis possible. In conclusion, I may say that every disaster presents opportunities to further improve the health services for the people. We are facing a huge challenge, but I am convinced that we will succeed through our united efforts.



Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

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Induced Abortion: The Current Scenario in India⁺

K.G. Santhya*, PhD and Shalini Verma[#], PhD

Abstract

Although abortion services in India were liberalized more than three decades ago, access to safe services remains limited for the vast majority of women. This paper synthesises recent evidence on the induced abortion scenario in India, and explores some of the factors why women continue to seek and receive abortion services from unqualified providers. The review highlights that a host of factors, notably lack of awareness of the legality of abortion services; limited access to safe services; poor quality of services; and gender roles and norms, lead women to seek services from untrained providers. In the Indian context, where the preference for sons is particularly strong, the practice of second-trimester sex-selective abortions is becoming widespread, and thereby also placing women at risk of undergoing unsafe abortion. The introduction of new technologies and legislation is expected to make safe abortion services more accessible. However, the challenge remains in effectively implementing these measures. The paper concludes with suggestions for areas that need further programme and research attention.

Introduction

Despite the liberalization of abortion services since the early 1970s, access to safe abortion services remains limited for the vast majority of Indian women, particularly in rural areas. An overwhelming proportion of induced abortions (6.7 million annually as per indirect estimate¹) take place in unauthorized centres, which provide abortion

services of varying degrees of safety. At the same time, in recent years significant changes in the abortion scenario have been taking place in the country, which have had wide ramifications.

The Changing Face of Abortion

The period since the 1990s has witnessed major changes in the field of abortion

⁺ This article is taken from the publication "Looking Back, Looking Forward: A Profile of Sexual and Reproductive Health in India". It is a publication of Population Council, New Delhi, supported by WHO/SEARO.

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including the adoption of new legislative measures, the introduction of new technologies and the growing demand for sex-selective abortion. Some of these developments, such as the recent amendments to the Medical Termination of Pregnancy (MTP) Act and the introduction of innovative abortion technologies, such as the improved manual vacuum aspiration technique and medical abortion, are expected to increase the availability of safe abortion services. However, other trends, such as the growing demand for sex-selective abortion, are likely to increase the incidence of unsafe abortion and adversely change the gender dynamics even further.

Legislative measures

Recognizing the failure of the MTP Act of 1972 to make legal abortions widely available, the government amended the Act in 2002. With the amendment, the authority for approval of registration of MTP centres has been decentralized from the state to the district level.²⁻³ In the year 2003, the government introduced a further amendment to MTP Rules which has rationalized the criteria for physical standards of abortion facilities -- fixing different criteria as appropriate for conducting first-trimester and second-trimester abortions. While facilities such as an operation table and instruments for performing abdominal or gynaecological surgery, and equipments for anaesthesia, resuscitation and sterilization continue to be the minimum requirements for centres offering second-trimester abortion, the MTP Rules 2003 require a gynaecological or labour table rather than an operation table and resuscitation and sterilization equipment but not anaesthetic equipments for centres

offering first-trimester abortion.⁴ These rules also permit a registered medical practitioner to provide medical abortion services in the case of termination of pregnancy up to seven weeks, provided the practitioner has access to a facility for offering surgical abortion in the event of a failed or incomplete medical abortion. The Reproductive and Child Health Programme launched in 1997 and the National Population Policy, 2000 have also delineated a number of strategies to increase the access to safe abortion at the primary health care level.⁵

Amendments have also been introduced in the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act of 1994. This was necessitated as the PNDT Act had failed to curb the practice of testing for sex determination and consequent sex-selective abortion in the country.⁶ With the recent amendment to the PNDT Act, preconception and pre-implantation procedures for sex selection are banned in the country. The Amendment stipulates compulsory maintenance of written records by diagnostic centres/ doctors offering sonography service. Local authorities have also been given powers to ensure the enforcement of the Act.^{3, 7} With these measures, the government expects to prevent women from resorting to sex-selective abortions, which are conducted during the second-trimester and carry a high risk of complications for women.

Medical abortion

Medical abortion or abortion by orally administered regimens of mifepristone and misoprostol has recently been accepted worldwide as an effective and safe option for

early abortion. Clinical trials in a number of countries, including India, have shown that the use of the standard French regimen, which includes administering 600 mg of mifepristone during the first visit and 400 µg of misoprostol during a follow-up visit after two days, combined with a follow-up visit after two weeks, is effective in 95% of cases of early abortion (i.e. up to 49 days from the last menstrual period) and safe (major complications were reported in only 0.5% of cases).⁸

The Drug Controller of India approved the use of medical abortion in April 2002.⁸ Given the current situation in India, where abortion-related mortality and morbidity are high, medical abortion offers great potential for improving the access to abortion and safety, as it does not require extensive infrastructure and is non-invasive. Further, as the patient does not need to be hospitalized, medical abortion offers women greater independence, control and privacy. However, the potential for misuse is a matter of concern. In fact, although abortion tablets are required to be sold by medical prescription and consumed under medical supervision, these pills are reportedly widely available over-the-counter and unsupervised consumption is rising.⁹⁻¹¹ Plans to develop national guidelines to introduce abortion pills in family welfare programme are currently under discussion.

Apart from initial clinical research to explore the effectiveness, safety and acceptability of medical abortion,¹²⁻¹⁵ limited research has been carried out on issues such as women's experiences of this new method, availability, affordability and providers' perspectives, although some studies are currently under way.

Sex-selective abortion

With the introduction of amniocentesis to detect abnormalities of the foetus, sex determination techniques have been available in India since 1975. The expansion of facilities offering sonography in the mid-1980s made testing for sex determination widely and easily available. Although the government tried to curb the increase in sex-selective abortions by introducing the PNDA Act in 1994, the Act proved to be ineffective in preventing such abortions.⁶ This is not surprising given the strong "son" preference prevailing in most parts of the country, and the loopholes in the Act *per se* and in its enforcement.

Recent evidence, both direct and indirect, highlights that the number of sex-selective abortions has increased vastly.⁶ This is indirectly reflected in the latest Census figures that indicate that the child (0-6 years) sex ratio declined from 945 females per 1 000 males in 1991 to 927 females per 1 000 males in 2001.¹⁶ Although it is difficult to quantify precisely the prevalence/incidence of sex-selective abortion, a growing number of community- and facility-based studies provide direct and indirect estimates. A number of community-based studies in different parts of the country report a prevalence of sex-selective abortion ranging from 3-17% over different reference periods, i.e. two years preceding the survey to lifetime.¹⁷⁻²⁰

Facility-based studies report a much higher prevalence, for example, two in five women with one or more daughters, but no living sons had had an abortion in a Patiala (Punjab, India) hospital.²¹ Indirect estimates derived from NFHS-2 data indicate that among women who received ultrasound or

amniocentesis during antenatal check-ups, 6.4% of female foetuses can be assumed to have been aborted.²²

Available evidence shows that the practice of sex-selective abortion cuts across all socio-economic groups.^{19, 23-24} In several studies, sex-selective abortion is reported to be a family building strategy to achieve the conflicting goals of limiting family size and achieving the desired sex composition.²⁵ For example, the prevalence of sex-selective abortion is found to be higher among women with one or more living daughters but no living sons.²³ However, some studies report that sex-selective abortion is practised by couples who already have a living son or no children.^{19, 24} Further, evidence from qualitative studies indicates that sex-selective abortion is perceived and projected as an easy alternative to female infanticide, a way to save girl children from an unhappy life and a means to prevent dowry payment in future.^{20, 26} *To give birth to a female child would mean spoiling her life as well as her parent's life. So, we felt it was right to abort the female foetus [27-year-old woman with a son and a daughter].*²⁶

While sex-selective abortion per se is little researched, decision-making related to sex-selective abortion is even less explored. Limited evidence available from a small-scale qualitative study, though not amenable to generalization, reports that the decision to pursue a sex-selective abortion is taken primarily by the couple; at the same time, providers appear to play a key role in providing information on sex-determination services: *"Either you get your abortion before sonography or after, I will charge you the same money but if God hears your wish and the foetus is found to be male, then you can escape from abortion. [41-year-old woman*

with four daughters narrating her experiences with a provider]".²⁶

Magnitude and context

Official figures report that about 0.6 million induced abortions take place annually in India.²⁷ Given that only approximately 10% of abortions are conducted by qualified providers in approved institutions,²⁸ and that abortions taking place at registered facilities are grossly under-reported,^{1, 25, 27} this represents only a fraction of the total number of induced abortions taking place in the country. Indirect estimates for the year 1991, using parameters arrived at on the basis of a small-scale study conducted in 1966, project the number of induced abortions annually at 6.7 million.¹

Estimates of the ratio of induced abortion derived from community-based surveys, again likely to be grossly underestimated as women tend to under-report the incidence of induced abortions in survey settings, show wide variations. For example, NFHS-2 data reveal that 1.7% of all pregnancies over a lifetime ended in induced abortions.²⁹ In comparison, small-scale studies report 3.4–14.0 induced abortions per 100 live births.^{18, 25}

Profile of abortion-seekers

While women of all age groups seek abortion in India, a recent review suggests that the majority of those seeking abortion are in the age group: 20-29 years.²⁵ A substantial number of adolescents, both married and unmarried, also seek abortion services. Between 1-10% of abortion-seekers are adolescents,²⁵ though a few facility-based studies report that the proportion of

adolescent abortion-seekers is as high as one in three.^{30, 31} Nationally, data from NFHS-2 show a lifetime induced abortion ratio of 1.1 among married adolescents.³²

The vast majority of women seeking abortion in India are married.²⁵ Among the unmarried, adolescents constitute a disproportionately large percentage of those who seek abortion. At least one half of unmarried women seeking abortions are adolescents, many of whom are below 15 years.³³

Reasons for seeking abortion

Although official records show that contraceptive failure and risk to mother's health are the leading reasons for women seeking abortion,^{1, 34} studies suggest a different picture. Several studies indicate that most abortions are sought to limit family size or space the next pregnancy.^{17,18,25} For example, in a study in Madhya Pradesh, women reported the achievement of desired family size as the reason in 41% of attempted abortions, and the need for spacing in 30% of abortion attempts.¹⁸ A few recent studies indicate that risk to women's health is also a relatively common reason for seeking abortion.^{17, 18} For example, a study in Madhya Pradesh found that women reported health reasons in 22% of attempted abortions.¹⁸

The not-so-commonly-reported reasons for seeking abortion include contraceptive failure, pregnancies occurring soon after marriage or occurring outside of marriage or problems with the foetus.^{18, 25} For example, a review shows that only a small proportion of women seeking abortion (less than 5%) reported contraceptive failure as the reason for an abortion²⁵. Even though the first pregnancy is highly valued and hence

women generally do not opt for induced abortion, a study in Madhya Pradesh shows that women mentioned a pregnancy that happened too soon after marriage in 6% of abortion attempts.¹⁸

Type of provider

Available evidence, though limited, indicates that the majority of abortions take place in private facilities.^{18, 19, 35, 36} For example, in a community-based study in Madhya Pradesh, more than one half of abortions among urban women took place in a private facility compared to one fourth of abortions in a public sector facility and the remaining resorting to folk methods or self-induction.¹⁸ However, a study in Rajasthan indicates that 50% of women sought abortion from a public sector provider,¹⁷ though it is not clear whether the service was dispensed in a public or a private sector facility.

The practice of self-induction or using lay practitioners is declining among abortion-seekers in general, though adolescents, unmarried women, rural and economically disadvantaged women still rely on these methods.^{18, 25, 37} For example, in a study in Madhya Pradesh, 56% of rural women relied on folk methods or self-induction.¹⁸

Mortality and morbidity

There is limited information on abortion-related maternal deaths in India.³⁸ A conservative estimate places the number of abortion-related deaths in a year in India at 15 000-20 000.¹ The official figures indicate that unsafe abortion accounted for 9% of maternal deaths in the year 1998.³⁹ However, evidence from facility-based

studies suggests that abortion-related complications account for 25-30% of maternal deaths taking place in hospitals.²⁵

Abortion-related mortality represents only a fraction of abortion-related complications, and many more women experience life-threatening and other morbidities. For example, in a community-based study in Madhya Pradesh, India, more than one in two abortion attempts among rural women (57%) and more than two in five abortion attempts among urban women (46%) resulted in at least one complication. The complications were severe in one third of abortion attempts among rural women and one sixth of attempts among urban women.¹⁸ The most frequently reported abortion-related morbidities are menstrual irregularities, backache, and excessive bleeding.^{17, 25} Little data exist on chronic abortion-related morbidities, including pelvic inflammatory disease, secondary infertility and the risk of future ectopic pregnancy.²⁵

As is widely recognized, abortion-related complications are higher when performed either by inadequately trained providers, or in unhygienic conditions. For example, a study in West Bengal, India reports a complication rate of 12.2% for abortions conducted by a specialist, 45.8% by a private general practitioner, and 100% by unqualified providers or paramedics.⁴⁰ Similarly, second-trimester abortions carry a higher risk of complications.^{25, 38, 41} A hospital-based study reveals that the risk of abortion complications is 12 times higher for second-trimester abortions than the first-trimester ones.³⁵ Unmarried adolescents, women who are illiterate and those living in rural areas are perhaps more prone to major abortion complications because they seek

late abortions or use the services of unqualified abortion providers.^{18, 25, 33, 38}

Factors Underlying Persistence of Unsafe Abortions

Despite the liberalization of abortion services and the introduction of safer abortion techniques, abortion continues to be unsafe for the vast majority of women seeking such services. Several factors operating at the individual, family, and community level contribute to this situation, some of which are discussed below.

Lack of awareness

Lack of awareness of the legal status of abortion and the facilities where abortion services are legally provided may lead many women to seek abortion from untrained and unqualified providers. Studies in different parts of the country show that even though abortion has been legalised in India for more than three decades, only a small minority of men and women know that abortion is legal.^{17, 18, 28, 35} For example, in a community-based study in Rajasthan, only one in six men and women were aware that abortion was legal. Even more alarming was that nearly four in five men and more than one in two women believed it was illegal,¹⁷ and formal services are less likely to be sought when women perceive abortion to be illegal.²⁵ Even when women are aware of the legal status of abortion, they may not be fully aware of the conditions under which abortion is allowed. For example, in a study in Madhya Pradesh, India while 15% of women knew that abortion was legal, only 9% knew the correct timing under which abortion was legally permitted.¹⁸

Misconceptions about the conditions under which abortion services are provided are common; for example, husband's consent is needed for seeking abortion.^{18, 42} Moreover, often women may not be aware of the existence of registered facilities where these services can be accessed.^{35, 43}

Apart from lack of awareness of the legal status of abortion and registered facilities, lack of awareness about pregnancy may contribute to many women, especially adolescent girls, delaying seeking abortion services and obtaining care from unqualified providers.⁴⁴

Limited access to services

Although the number of approved abortion facilities in India has increased significantly from 1 877 in 1972-1976 to 9 806 in 2001,⁴⁵ access to safe abortion services continues to be limited for the vast majority of women in the country. In fact, some of the clauses in the MTP Act, 1972 have in effect contributed to restricting the availability and access to abortion services.²⁷ For example, only gynaecologists or physicians who have received training in MTP are allowed to perform an abortion, and only in government clinics or hospitals, or institutions approved by the government for this purpose. Moreover, the approval of two doctors is required to abort pregnancies between 12 and 20 weeks' gestation. Stringent criteria for the approval of centres, although well intentioned, have in effect restricted the expansion of registered facilities in the private and non-governmental sectors.^{46, 47, 48} The decentralization of authority for the approval of MTP centres and the government's commitment to increase the access to abortion services at

the primary health care level may improve the availability of abortion facilities in the near future.^{2, 3}

Not only are approved facilities inadequate in number, but they are also distributed unevenly between and within states. For example, Maharashtra with 10% of India's population has more than one fifth of the total number of facilities in the country. In contrast, Bihar, also with about 10% of the total population, has only 1% of the facilities.²⁷ Within each state, the approved facilities are concentrated in urban areas, resulting in limited access for a vast majority of women in rural areas.^{1, 28}

Even where approved facilities exist, services in the public sector are rarely or erratically provided due to the lack of trained manpower or equipment or both.^{27, 49} For example, district-level teaching institutions, sub-district hospitals, community health centres, postpartum centres and primary health centres are required to provide abortion services. However, a situation analysis of abortion facilities in Gujarat, Maharashtra, Uttar Pradesh and Tamil Nadu shows that only about one fourth to nearly three fifths of primary health centres offered abortion services.²⁷ The most recently conducted national-level facility survey reports that only 3% of primary health centres provide MTP services. The survey also reports that most primary health centres lack essential equipment. Only one in six primary health centres, for example, have MTP suction aspirators.⁵⁰

Poor quality of services

Few studies have explored the quality of abortion services in the public and private sectors, particularly in the private sector.

Available evidence highlights the poor quality of abortion services. Often providers in the public and private sectors are not trained or are inadequately trained.^{27, 45, 51} The most recently conducted national-level facility survey reports that only 13% of primary health centres in the country have at least one medical officer trained in MTP. The situation is worse in several states including Bihar, Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh and West Bengal where only 2-6% of primary health centres have a medical officer trained in providing MTP services.⁵⁰ In a facility study in Haryana, nearly one third of the 52 private providers had not received any training on conducting an abortion. Similarly, in Maharashtra, more than one third of public sector providers and more than two fifths of private sector providers were reported to be untrained.⁵¹ Moreover, as there are few MTP cases in the training centres, trainee doctors do not receive sufficient practical experience in conducting MTPs. Therefore, even after training many providers do not feel competent to provide services.²⁷ Further, it is reported that most teaching hospitals prefer to offer training on electric vacuum aspiration, dilation and curettage and induction methods, rather than on manual vacuum aspiration, a relatively simple method of abortion.^{27, 49, 52}

The judgemental attitude of providers in public and private sector facilities, particularly in the public sector, is likely to force many women to seek informal sector providers who are unlikely to provide safe services: *"in the government hospital the nurses demand money and also use abusive language. In X's nursing home, the doctor does not use bad language. We can get an abortion and sterilization done on the same*

*day and return to our house. Hospitalization is just for one day. The waiting time is only one hour. Things are fast and if we have any problems we can go back to him".*³⁶ Studies show that providers often disregard the need to respect the privacy and confidentiality of women seeking abortion: *"privacy and confidentiality is not an issue with women. After all where can you get more anonymity than at a public hospital where thousands are milling around in the out-patient department?"*⁴⁶ Coercive contraception following an MTP is not uncommon, and many women reportedly refuse to go to a primary health care centre for an MTP because they do not want to get sterilized.^{36, 37, 53, 54} Further, several studies highlight that providers often insist on husband's consent, though the law does not mandate it nor is it preferred by women.^{17, 25, 37} In a study in Rajasthan, four in five women reported that the provider took their husband's consent.¹⁷ Moreover, even when services exist, providers may selectively refuse services to some women. For example, a study in Maharashtra reports that 40% of providers (of whom 24% were in legally recognized MTP centres) selectively refused services to unmarried and separated young women.⁵⁵

Studies show that pre- and post-abortion services have often been given a low priority. For example, a study among abortion service providers in slums in Gujarat reports that no physical or internal check-ups were carried out, and only cursory enquiries about medical and obstetric history were taken.⁴⁶ Moreover, women were not often informed of the possible risks of the procedure, potential complications and their treatment, need for a follow-up visit, and post-abortion contraception, especially the range of contraceptive choices available to prevent repeat abortions.^{27, 46, 56} A multi-state

study reports that less than one half of women were informed about the possibility of infection.²⁷ A study in Andhra Pradesh indicates that follow-up care was provided only in selected cases by auxiliary nurse midwives.⁵⁶ Moreover, emergency services to deal with incomplete abortion and life-threatening post-abortion complications are totally lacking in the current service delivery system.³⁸

Cost of services

Even though there is evidence that women are willing to pay for services that meet their needs and perceptions of quality,¹⁹ the financial burden of abortion services is substantial.^{42, 57} Economic constraints may compel many women, particularly those who are poor and dependent on others, to seek services from unqualified providers.^{17, 18, 58, 59} Unfortunately, in public sector facilities that are expected to provide services free of cost, it is reported that women incur hidden costs in the form of cost of medicine and illegal fees for staff.^{1, 27, 35, 52, 53, 58, 60} A study in Madhya Pradesh reports that only one in ten abortions in public sector MTP centres were provided free of cost.¹⁸

Gender roles and norms

Available evidence, though limited, reveals that gender roles and norms operate in many ways to limit women's access to safe services. Even though a number of studies report that the decision to undergo an abortion among married women is taken jointly by the woman and her husband,^{17, 18, 19, 61} a not-so insignificant proportion of women, especially unmarried and married young women, may find it difficult to take decisions on their own regarding abortion or

to communicate about abortion-related needs to those who wield power in the household,^{18, 62} leading to delays in seeking abortion and thereby jeopardising safety. For example, in a community-based study in Madhya Pradesh, husbands, unilaterally or jointly, played the major decision-making role in 20% of abortion attempts.¹⁸ Moreover, studies show that some women who wish to terminate a pregnancy may face opposition from the family.²⁵

Stigma attached to abortion, particularly when sought by women who are not currently married, may also compel women to delay seeking services or to seek services from confidential but unsafe providers.⁶³ For example, in a study in Pune, women seeking an abortion outside of marriage ranked confidentiality, discreetness and distant location of abortion services as the most important indicators of quality of services.³⁷ Yet another study in Pune reports that nearly one-fourth of unmarried women sought abortion services from traditional providers compared to 2% of married women.¹⁹

Finally, the increasing practice of sex-selective abortion also tends to place women at risk of undergoing unsafe abortion. Women attempting sex-selective abortions may not opt for legal abortion services. Sonography can detect foetal sex only at the beginning of the second trimester when the risk of abortion complications is much higher,^{19, 35, 38, 41} therefore sex-selective abortion-seekers are vulnerable to unsafe abortions.

The Way Forward

Although abortion services in India were liberalized more than three decades ago, the

vast majority of women continue to seek and receive abortion services from unqualified providers. As a result, many women die or suffer serious life-threatening complications. A host of factors notably lack of awareness of the legality of abortion services, limited access to safe services, poor quality of services and gender roles and norms lead women to seek services from untrained providers. In the Indian context, where the preference for sons is particularly strong, the practice of second-trimester sex-selective abortions is becoming widespread.

The introduction of new technologies and legislation is expected to make safe abortion services more accessible. However, the challenge remains in effectively implementing these measures.

Programme recommendations

- The widespread lack of awareness of the legal status of abortion services and women's rights under the existing law as well as of the facilities that offer abortion services call for socially and culturally appropriate information, education and communication (IEC) campaigns. There is also a strong need for efforts to promote awareness of the dangers of unsafe abortion practices and the gestational age at which safe abortion can be obtained. Equally important are communication efforts to remove the stigma associated with induced abortion.
- Given the uneven distribution of existing facilities, efforts to increase the accessibility of safe abortion services to hitherto unserved or under-served areas and population groups, including married and unmarried adolescents, need to be vigorously pursued. The lack of trained manpower needs to be addressed by improving training facilities and facilitating the training of private practitioners. The training curriculum should include new and safer methods of abortion, including manual vacuum aspiration techniques and medical abortion, as well as emphasise the quality of care elements.
- Given the poor quality of existing abortion services in the country, establishing service delivery guidelines regarding technical standards of service, patient-provider interaction, confidentiality, pre- and post-abortion counselling and care is critically needed. All existing MTP facilities should be regularly monitored and evaluated.
- The fact that many women seek abortion services to limit family size or space the next pregnancy highlight the importance of improving the access to quality family planning services.
- Finally, given that women, especially young women, have very little say in reproductive and sexual health decisions, including abortion-related decisions, the need for multi-sectoral activities to raise the women's status cannot be overemphasized.

Research recommendations

- Research on abortion has increased in recent years, but significant gaps in our understanding of the multiple dimensions of abortion-seeking behaviour prevail. The evidence on the prevalence and patterns of abortion is limited, and even the latest available estimates of induced abortion are more than a decade old. The need for assessing the incidence of induced abortion, using multiple and innovative methods of data collection cannot be overemphasised.
- Abortion-related needs and service-seeking patterns of many vulnerable groups including adolescents, and unmarried, divorced or separated women remain less studied and hence there is need for future studies to focus on these sub-population groups.
- The review highlights that the practice of sex-selective abortion is increasingly becoming common in many parts of the country. An in-depth understanding of the prevalence/incidence and perspectives of those involved in decisions on sex-selective abortion, clients' profile and experiences, is needed to formulate effective policies and programmes to prevent this practice.
- Very little information exists on abortion-related complications, especially chronic complications. Follow-up studies are needed to estimate the extent of these complications and their implications for women's health and well-being.
- There is a need to explore the potential of paramedics to conduct early abortion and provide abortion-related care through well-designed studies.
- Studies show that the quality of abortion services in the country is generally poor. The constraints that providers face in providing quality service need to be explored to design more appropriate interventions.
- While abortion *per se* is less studied, the pathways between pregnancy and abortion are even less explored in India. An in-depth understanding of the complex nature of abortion-related decision-making, provider choice and the actual utilization of abortion services would help in designing effective interventions to improve the access to services.

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Medical Negligence, Patients' Safety and the Law

By Professor R.K. Nayak*

Introduction

An eminent English radiologist Robert Hutchison prayed:

*"From... too much zeal for the new,
and contempt for the old; from
putting knowledge before wisdom;
science before art: cleverness before
commonsense; from treating
patients as cases and for making
cure of disease more grievous than
the endurance thereof:
good Lord deliver us!"*

Ever since the formation of human history, the inherent sickness in one form or the other and mortality of human beings have made the diagnosis and treatment of diseases pertaining to humans a high-risk profession. The ancient risk relating to physical retribution to the physician has been replaced by the modern risk of economic compensation for the harm occurred. Patients' rights have been protected in various ways including creation of the institution of "Patient Ombudsman" in seven European Countries as an administrative system.²

It is also being suggested that in order to prevent physicians' wrongs in the absence of enforceable international regulations, an International Medical Tribunal be constituted with authority to judge and punish health care professionals in cases of violations of international human rights, and of norms of medical conduct³. It is being argued that the independent body such as the International Medical Tribunal should be established with the sanction and authority of the United Nations, and it could be based on the model of the International Criminal Court (ICC)⁴.

The Problem of Blameworthiness in Medical Profession

From 20th Century onwards, it has been witnessed awareness among people regarding the fundamental rights guaranteed by the constitutions in other countries and by the Constitution of India has increased. This has brought the medical profession under sustained scrutiny of both the public and by the courts. Health care professionals have faced legal actions instituted by the patients not only in India but in other countries as well.

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In the course of practice of medicine, healthcare professionals, just like other people in different areas, have to face errors despite prudence and care, such as wrong diagnosis and treatment, or by otherwise doing something, which is termed as “wrong” or “harmful” – to their patients. Any kind of wrong action or misjudgement may result in the death of a patient. This fallibility, inherent in the medical profession like in any other human action(s), is directly related with legal action. In fact, in the medical field, consequences are high and serious. Health care professionals will have to learn to bear with not only their technical know-how, but also with their moral fallibility in performance of their duty. It is said:

A good person is not described by a tabulation of single actions and choices bereft of context but rather as the Greeks saw it, by their “self-making” or the ability to learn from situations and, in consequences to change themselves for the better.⁵

Patients should invariably be informed about the mistakes in diagnosis or management – that is part of truth-telling and an issue that is hard to argue against.⁶ To hide such mistakes from patients or family is a violation of truth-telling in every sphere of life.⁷

Autonomy of Medical Professionals

Autonomy implies the ability to govern oneself in the best possible way. In Kantian theory it is the power to set one’s own rules to conduct its duties.⁸ But there is a difference between autonomy (or freedom) of the will and autonomy (or freedom) of action.⁹ In the medical world, it is essential

to know this difference. However, if the patient is suffering due to the influence of dementia, hypoxia, hysteria, drugs, alcohol and other such factors, he/she may be forced to lose his/her freedom of thinking or decision-making due to lack of the capacity to grasp the circumstance. Besides, if a patient is ill, is hospitalized and is in a weakened state of health, but it is quite rational to often lose the capacity to act prudently. “Such patients, however, may have some capacity to function, but may not be able to translate their clear will into action”. This loss of power and consequently becoming, as it were, a prisoner of the medical system is something especially feared by the patient.¹⁰

Actually, full autonomy of the will or action is a Plato’s ideal which can never be fully achieved, nor is it achievable under the human conditions. Biological (including genetics) factors put serious challenges to the abilities of medical professionals. The environmental, cultural, upbringing factors and social conditions to a great extent limit their capacity and willingness to perform their duties.¹¹ Kant who is considered an authority on the concept of autonomy, analysed this very well and said that only the “divine being” is truly autonomous.¹² The limits of autonomy are set by forces that are, in a sense, external to the will and beyond the control of man (and these may vary from time to time and from situation to situation).¹³ There are basic criteria which must be applied in determining the justification for an action, and they are:

- (1) It must be sufficiently informed;
- (2) It must be based on adequate and broad-based deliberations;

- (3) It must be not be based on internal or external coercion, and
- (4) It must be in consonance or harmonious with an enduring world view.¹⁴

The information supplied to a patient must be easy for him/her to understand. Technical details are not normally grasped by patient and may be out of the range of his experience. These, therefore, will not be termed as "informing". It is aptly said:

Further, health care professionals should make sure that such information is truly comprehended. Comprehension means more than merely the ability to parrot facts. True understanding, in addition to an essential cognitive part, includes understanding on an emotional as well as, where possible, an experimental plane. It must include some understanding by the health care professional of what the diagnosis or condition means to patients: not just what it is scientifically, but what it connotes to and for patients: how it will be seen to impact on their daily lives and what it means emotionally for them, given their personal worldviews.¹⁵

Truth-telling

Truth-telling to a patient is an integral part and parcel of autonomy. A medical professional who employs all the cardinal tenets of autonomy in the performance of his duties must tell the absolute and unvarnished truth to his patient(s). Truth-telling, like other principles, works as guidelines to moral behaviour and not as an absolute entity. It cannot be followed without rationality. If it is,

then it becomes an end in itself instead of a means to a moral end.¹⁶ Cassel observed that sick persons lose their ability to think and decide about their problems. They are not merely normal persons with the 'knapsack of illness' strapped to their back.¹⁷ Often they may lose their adulthood and revert to a more childish form of existence: in a sense... they exhibit autonomy-surrendered behaviour."¹⁸

The practice of medicine and the role of health care professionals are seen as a money-making industry and patients are seen or treated as consumers of health services. The notion of the health care industry or health-providing mechanism has emerged due to "physicians as entrepreneurs or as workers in an entrepreneurial enterprise were enmeshed in mutual competition".¹⁹ This view has also undergone changes; patients and physicians interact and their interaction has assumed some good things. Pellegrino and Thomasma²⁰ have advocated that physicians should view closely:

- The patient's ultimate good or "good of the last resort";
- The good of the patient as a human being;
- The patient's particular good; and
- The bio-medical good.

The patient's ultimate good connotes the highest good that the patient expects. The "good of the last resort" may be based on religious belief or vision, "a secularly enunciated belief".²¹

With regard to the good of the patient as a human being, it involves choices and respect for his ability and competence. The

patient must be supplied with complete relevant information and complete different opinions by the physician. Any distasteful opinion must also be reverted to the patient. It is for the patient to choose or go with a particular opinion keeping in view a particular good. A patient may like to take a greater or lesser risk (e.g. in the case of a woman in the event that breast cancer is diagnosed) and decide accordingly. In such a case, a serious conflict may emerge between the patient and the physician. And patient in such a situation would like to refer her case to another health care professional(s). Compassionate negotiation can be the solution to the problem in such cases.

The bio-medical good is considered to be good for the physician-patient interaction and relationship as well. Eventually, patients seek the help of physicians in their own interest and *inter alia* for the good in mind. In case, if only higher good prevails, the question arises whether the bio-medical good be sacrificed, neglected or kept aside.²² In this regard it is said:

*It is often here that negotiation is at its most fruitful. Within the context of the patient-physician relationship, patients cannot be forced to pursue the bio-medical good if they believe it violates a higher value; on the other hand, it is here that patients cannot simply be abandoned to their autonomy.*²³

It is believed that health care professionals should treat patients as their friends, and not as consumers of services. "The relationship between physicians and their patients emphasizes the peculiar mixture of detachment and involvement."²⁴

Many times the physicians have to carry out professional duties, which are distasteful, disagreeable, painful, dangerous and not praiseworthy to their patients.²⁵ Rationality should govern emotion and to modify what Rousseau has said, "the primitive sense of pity, or compassion."²⁶ If any professional duty is performed rationally, based on medical ethics and in the interest of patients to provide them relief, it will outdo any unreasonable criticism to protect the human rights of those under treatment. India's *Ayurveda* system of medicine provides ample evidence about social medicine, medical ethics and the role of the doctor in serving the people in general, and in the larger interest of social good.²⁷

Law on Medical Negligence

Negligence in the medical world has assumed great importance in relation to the medical malpractices suits in various countries in Asia, Europe, USA and more so in India. In the area of patient-doctor relationship two important models dominate viz. one is based on paternalism and other is founded on the doctrine of informed consent. According to Dworkin's standard definition of paternalism means "interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of person coerced"²⁸ Such definition may serve the needs of patients but it does not serve the whole concept of welfare of the patients. Feinberg advocates a division in the definition of paternalism, one that preaches how to prevent harm and the other how to ensure the patient's good.²⁹ Feinberg divided paternalism into "weak" and "strong".

In Britain, the paternalistic model of the physician-patient relationship has both been a dominant feature in the medical profession since its inception.³⁰ This has been well emphasized in the modern English law through the famous Bolam principle,³¹ which states that a doctor is not liable in negligence when he acted "in accordance with a practice accepted as proper by a responsible body of medical men, skilled in the particular art". In the United States, the doctor-patient relationship is based on the doctrine of informed consent.³² As per the doctrine of informed consent, a patient must be supplied with all the necessary information about the nature of treatment, risks involved and the feasible alternatives, so as to enable him/her to make a rational and intelligent choice whether to proceed with treatment or surgery or not. In case informed consent of the patient concerned is not obtained, then the physician would face tortious liability. In *Roe v. Minister of Health*,³³ Lord Denning aptly said:

*It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against the hospital and the doctor. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. We cannot take the benefits without taking risks. Every advance in technology is attended by the risks. Doctors, like the rest of us, have to learn by experience, and experience often teaches in a hard way. Something goes wrong and shows up a weakness and then it is put right.*³⁴

Situation in India

Actually, the Constitution of India does not provide any special rights to the patient. In fact the patient's rights are basically indirect rights, which arise or flow from the obligations of a physician or health care provider under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. However, the basic rights of a patient, such as the right to know about his condition, or the right to participate in treatment decision-making do not exist in reality in medical practice. If at all they exist, they exist only on paper or in philosophical talks and discourses.

Besides, people have an expectation that if anything wrong occurs or is done by medical professionals, then justice should invariably be done. It is reasonable for a patient to expect medical doctors to take into consideration all relevant factors involved in the treatment. At the same time, it is reasonable for the medical professional to provide all reliable technical or non-technical information about the treatment/surgery in one go to the patient. However, decision-making still remains in the hands of health care professionals.

The basic principle is that medical doctors and associated medical professionals are responsible and liable for wrongs and failures in the performance of their medical duties towards patients. In India, generally Section 304-A of the Indian Penal Code (IPC), 1860 is the relevant provision under which a complaint against a medical practitioner for alleged criminal medical negligence is registered. Section 304-A provides that whoever commits culpable

homicide not amounting to murder shall be punished for life or imprisonment for a term up to 10 years and fine as well. Section 337 of the IPC deals with hurt caused by an act endangering life or personal safety of others. Section 338 of the IPC relates to grievous hurt by an act endangering life and personal liberty of others. However, the simple lack of care attracts only civil liability. Therefore, only civil negligence may not be enough to hold a medical professional criminally liable.

In India, health care professionals or medical doctors must have reasonable skills, knowledge, and proper medical education and competence to carry on the practice of medicine. If they fail in the criteria as narrated then they will be liable for incompetence in one way or the other and may face:

- (1) Liability in respect of diagnosis;
- (2) Liability in relation to doctor's duty to warn the patient about the risks involved, and
- (3) Liability in relation to the treatment to be carried out.³⁵

The courts in India have generally followed the decisions and practices of the English law. The cases of negligence in India are directly related to existing facilities, infrastructure and level of acumen of medical professionals. In many cases doctors have been held liable for negligent acts, such as removal of a wrong eye or a kidney, based on pecuniary interest or where minimum facilities were available. In this regard, an important example is of eye camps or health camps where operations are performed without proper facilities. In

A.S. Mittal v. State of U.P.,³⁶ the Supreme Court of India held that if a survivor fails to conduct tests before the mass use of saline on patients, he is liable for negligence. In the Lions Club eye camp conducted at Khurja, in the State of U P 108 patients were operated out of which 84 patients' eyes were damaged due to post-operation infection of the intra-ocular cavity of the operated eyes. This was due to a common contaminating source. The Supreme Court held the doctors liable for negligence and directed that, in addition to the sum of Rs 5000/- already paid as interim relief, the state government shall pay a sum of Rs 12 500/- to each victim. The question of standard care was highlighted by the Supreme Court in *Dr Laxman Balkrishna Joshi v. Dr Trambak Babu Godbole*.³⁷ In this case, Anand, the son of the respondent, died due to shock resulting from reduction of fracture attempted by the doctor without taking the elementary caution of giving anaesthesia to the patient. The Bombay High Court, and later the Supreme Court of India, held that the doctor was negligent in the performance of his medical duty. The Supreme Court held that the duty of a doctor will include (a) a duty of care in deciding whether to undertake a case and (b) a duty of care in deciding what treatment to give or a duty of care in administration of that treatment. Any breach of these duties gives a rise of action for negligent acts towards the patient. The Court also observed that the doctor has the discretion in choosing the treatment, which he proposes to give to the patient in one way or the other. The discretion of the doctor is relatively wider in cases of emergency. In this way the Supreme Court of India has affirmed the English law on the subject, viz. that the

breach of duty of care is the basis for liability for negligence and secondly it lays down the standard of care i.e. the doctor must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care.

The Supreme Court of India in its landmark judgment in *Indian Medical Association v. V.P. Shanta*³⁸ laid down the law relating to professional negligence under Consumer Protection Act, 1986 and enunciated certain principles that medical practitioners, government hospitals, and private hospitals and nursing homes are also covered under the consumer law in the following categories:³⁹

- (1) Where services are rendered free of charge to everybody availing of the said service;
- (2) Where charges are required to be paid by persons availing of services, but certain categories of persons who cannot afford to pay are rendered service free of charge, and
- (3) Where charges are required to be paid by persons availing of services, but certain categories of persons who cannot afford to pay are rendered service free of charge.

The services provided in the first category by doctors and hospitals would not be covered by the services under section 2(1)(0) of the Consumer Protection Act, 1986.⁴⁰ But the services rendered by the second and third categories of doctors and hospitals would be covered within the ambit of the service defined in the above provision of the Act, 1986.

In a recent verdict in the *Dr Suresh Gupta v. Government. of NCT of Delhi*,⁴¹ the Supreme Court of India held that an error of judgment on the part of the doctor does not make him criminally liable. This came as a relief to the medical community in India. In the instant case, the appellant a doctor (plastic surgeon) was in the dock as an accused on the charge under Section 304 of the Indian Penal Code (IPC)⁴² for causing death of his patient, who was operated by him for removing his nasal deformity. The patient died during the course of the surgical operation.

The Supreme Court very clearly and categorically made the following observations on the law of negligence:

The legal position is almost firmly established that where a patient dies due to the negligent medical treatment by the doctor, the doctor can be made liable in civil law for paying compensation and damages in tort and at the same time, if the degree of negligence is so gross and his act was reckless as to endanger the life of the patient, he would also be made criminally liable for offence under Section 304-A of the Indian Penal Code (IPC).⁴³

The apex court said that for fixing the criminal liability of the doctor or the surgeon, the standard of negligence should first be provided whether it is "gross negligence or recklessness". The mere lack of necessary care, attention and skill will not constitute "gross negligence or recklessness".⁴⁴ The Supreme Court relied on the House of Lords, decision in *R. V. Adomako*⁴⁵ in which the principle is well elucidated:

*The laws of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established, the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterized as gross negligence and, therefore, a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred.*⁴⁶

The Supreme Court of India in its classic judgment reasoned that in every mishap or death during medical treatment, the medical man cannot be made criminally liable for punishment. In the absence of adequate medical opinion, putting guilt on the medical man would be doing great harm or disservice to the medical community at large. "Every mishap or misfortune in the hospital or clinic of a doctor is not a gross act of negligence to try him for an offence of culpable negligence."⁴⁷ Therefore, the Supreme Court relied on the English authorities, Alan Merry and Alexander McCall Smith, on their views that blame – a powerful weapon – should be used in an appropriate manner with defensible criteria as it has an indispensable role in human affairs. Some of the misfortunes or wrong are merely accidents for which no one should be held responsible. Some instances are of culpable conduct, which constitute the basis for compensation and, at times, for punishment. To be able to distinguish, different categories of wrongs or carelessness, calls for "careful,

morally sensitive and scientifically informed analysis".⁴⁸

The Supreme Court quashed the criminal proceedings against the doctor and set aside the orders of the magistrate and of the High Court of Delhi and held categorically in the instant case held:

*"We find that no recklessness or gross negligence has been made out against the doctor to compel him to face the trial for the offence under section 304A of IPC."*⁴⁹

The judgment of the Supreme Court has been referred to a larger Bench by the apex court itself for reconsideration. Nevertheless,⁵⁰ the verdict of the Supreme Court has opened a new vista for medical ethics in India. Laws in India do not prescribe any sets of rights for the welfare of patients. Health care professionals are also not bound to provide information on the course of treatment to the patient or his/her nearest relations or family members. Patients feel helpless in such situations and depend on the decision and acumen of physicians/surgeons about the proposed treatment. The Constitution of India does not provide any special rights to a patient. However, the rights are basically indirect rights which arise from the performance of duties of health care professionals. However, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 do provide some safety and rights to patients. The basic rights such as right to know about his condition, right to participate in treatment decisions, right to have discussion with the doctor(s) are alien to patients in the world of medical treatment.

Conclusion

The development of law on negligence pertaining to professionals' liability in countries of the South-East Asia Region is not known. However, the same needs to be developed. Excepting India, no information on what courts are doing, and what legislations exist in the Region is available on the Internet or in books. Therefore, the subject of law on negligence and patients' safety is very much needed, and it must be taken up in the right earnest by WHO. Any study of law on the subject in the SEA Region must also tackle the problem of speedy award of substantial compensation in cases of negligence, and awareness of one's right. This will go a long way in ameliorating the conditions of patients who have to suffer due to the negligence or reckless acts of health care professionals, and sometimes due to

quacks performing the functions of a qualified medical professional. To conclude, it will be apt to quote:

The practice of medicine is a social task in which the patient and the healer must respect each other's personal morality and moral agency. The vastly greater power (real or perceived) of the health care provider and specifically of the physician puts the burden of this fiduciary relationship largely (but not solely) on the shoulders of health care providers. While health care providers cannot – and act ethically – impose their own personal morality on the patient, neither can the patient ask physicians to violate their own personal morality...⁵¹. They carry a heavy responsibility in trying to resist the dictates deemed harmful to their patients.

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35. This is the situation in the laws of U.K.
36. (1989) 3 SCc 223.
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40. Section 2(1)(0) Provides: "Services" means service of any description is made available to potential users and includes the provision of facilities in connection with banking, financing insurance, transport, processing, supply electrical or other energy, board or lodging or both, (housing construction) entertainment, amusement or purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service.
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42. Section 304, IPC provides "Whoever commits culpable homicide not amounting to murder, shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years and shall also be liable to fine, if the act by which the death is caused is done with the intentin of causing death...
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Comment

SEARO Notes and News

Announcement

World Health Day 2005: Make every mother and child count

WHO is pleased to announce healthy mothers and children as the theme for World Health Day 2005. This is also the subject of the *World Health Report 2005*, which will be launched on World Health Day, on 7 April 2005.

The slogan for World Health Day 2005 is "Make every mother and child count", which reflects the reality that today, the health of women and children is not a high enough priority for many governments and the international community.

The web site: <http://www.who.int/world-health-day/2005/en/> will serve as the official web site for World Health Day 2005. Visit us regularly in the months ahead to find information about how to organize your World Health Day 2005 events, and related advocacy material. For more information please contact: whd2005@who.int

WHO Responding to Health Needs of Tsunami-hit Countries

Even as countries affected by tsunamis are getting a full estimate of the damage, the World Health Organization is supporting the

Member States to meet their urgent health needs. The New Delhi headquarters of WHO's South-East Asia (SEA) Region has established a 24-hour Operations Room and a Senior-level Task Force to support the emergency needs of all affected countries in the Region. These include Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand.

The Task Force is focusing on disease surveillance and on providing technical advice to countries on good practices in outbreak situations and to reduce environmental and public health risks. It will also help in the development of proposals for present and medium-term restoration of public health services, as well as for procurement of life-saving drugs and water purification tablets. WHO is also making available guidelines on the management of bodies, and psycho-social help for people to deal with the trauma of recent events.

According to Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, "WHO is here to support our Member States to respond to this terrible tragedy. We are supporting countries both in their immediate health needs as well as in their efforts to restore the health services that have been destroyed. Our offer of help has been made to the countries, and

we will respond to any requests for help on a priority basis.

While we await country responses we have identified sources for procurement of essential medical supplies like diagnostics, life-saving medicines including antibiotics, vaccines as well as water purifying tablets and oral rehydration salts. We have also short-listed technical experts who can be made available to any country needing their support. Besides, technical experts from WHO headquarters and from the other WHO regional offices around the globe have offered their support and are standing by to go to any country, if needed”.

In the initial aftermath of the emergency, WHO is concerned about the outbreak of waterborne diseases, particularly as thousands of displaced people are being housed in make-shift shelters where there may not be adequate supplies of safe drinking water or sanitation facilities.

The SEA Regional Office has already ensured that the existing WHO Guidelines are made available to all country offices, for sharing with national governments, and for handling diarrhoea and other diseases that may emerge now. The Regional Office now plans to dispatch senior officials to work with WHO Representatives in the affected countries, both to ascertain country needs as well as to ensure proper coordination among all health agencies for the best support to countries.

Forty-first Meeting of CCPDM

Inaugurating the Forty-first Meeting of the Consultative Committee for Programme Development and Management (CCPDM),

held in SEARO from 19-21 July 2004, the Regional Director, Dr Samlee Plianbangchang underlined the opportunity presented by the meeting “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 WHO Director-General’s consistent message to improve the performance of WHO at the country level, so that we will be able to perform our functions more efficiently and effectively in supporting our Member States”, Dr Samlee added.

Highlighting the concerted efforts being made by the Regional Office towards strengthening of WHO country presence, the Regional Director stated that “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,” stated Dr Samlee.

Recounting the progress made in the recent past, Dr Samlee said, “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. 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", emphasized the Regional Director.

"Certainly, I will make sure that in the process of cooperation among WHO Country Representatives, the concurrence of the respective national health authorities will have to be secured, especially when such cooperation has policy, financial and political implications. With this mechanism, sharing of information and expertise among countries in the Region will be increased. Countries will have greater opportunity to support each other in their health development, with WHO acting as a catalyst and a facilitator", concluded the Regional Director.

Ninth Meeting of Health Secretaries, SEARO, 22-23 July 2004

Addressing the Ninth Meeting of Health Secretaries of Member States of the South-East Asia Region, the Regional Director, Dr Samlee Plianbangchang, reaffirmed his total commitment to health development and well-being of all people in all countries of the Region.

Recounting the many significant successes achieved over the last 50 years, Dr Samlee cautioned against any sense of

complacency, and said, "In our Region, even today, 175 million people are exposed to high risk of malaria. Six million people are living with HIV/AIDS. Tuberculosis continues to kill 750 000 people every year. 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. We have high ambitions; and we want to fulfill our technical role through efficient coordination, mobilization and management of all available resources", Dr Samlee emphasized.

In pursuing national health development, it was 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 were fully involved in the process of their own health development at all stages in the process. This will include also the 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 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", reiterated the Regional Director.

The Meeting discussed several subjects of topical interest including: Draft revision of International Health Regulations; Iodine deficiency disorders; HIV/AIDS, and Globalization, trade, and intellectual property rights.

WHO Launches Expert Report on Neuroscience of Substance Use

The World Health Organization's South-East Asia Regional Office (SEARO) recently launched the Expert Report on Neuroscience of Psychoactive Substance Use and Dependence, an authoritative report summarizing the latest scientific knowledge on the role of the brain in substance dependence. The launch took place during the International Conference on Mental Health and Substance Dependence, in Bangkok, Thailand. The Report* is the first of its kind produced by WHO, and cites an explosion of advances in neuroscience to

conclude that substance dependence is as much a disorder of the brain as any other neurological or psychiatric disorder.

"The Report's findings and their implications for treatment and policy are of special significance for South-East Asia," said Dr Samlee Plianbangchang, Regional Director, WHO/SEAR, on the occasion. "Our Region is plagued by high levels of use of amphetamine-type stimulants (ATS) and injecting drug users, as well as by a dramatic increase in alcohol consumption. A recent trend is the increase in glue, petrol and solvent-sniffing. A disturbing observation is that more and more young people are being drawn into this devastating habit", remarked Dr Samlee.

The Report states that substance dependence is multifactorial, determined by biological and genetic factors, in which heritable traits can play a strong part, as well as psychosocial, cultural and environmental factors. It has been known for a long time that the brain contains dozens of different types of receptors and chemical messengers or neurotransmitters.

The Report discusses new developments in neuroscience research with respect to craving, compulsive use, tolerance and the concept of dependence. It shows that psychoactive substances have different ways of acting on the brain, though they share similarities in the way they affect important regions involved in motivation and emotions. It also discusses how genes interact with environmental factors to sustain psychoactive substance-using behaviours.

The Report urges increasing awareness of the complex nature of these problems and the biological processes underlying drug

* The Neuroscience of Psychoactive Substance Use and Dependence report is a product of three years of work involving contributions of many experts from around the world. The project began in 2000 with a consultation in New Orleans, USA, during the Congress on Neuroscience. A meeting convened by WHO was attended by representatives of international societies and selected experts in the field. Twenty-five reviews were commissioned, completed and submitted and these formed the basis of the final report. Meetings were held in Geneva and Mexico to discuss the outline of the report and the background papers.

dependence. And it supports effective policies, prevention and treatment approaches and the development of interventions that do not stigmatize patients, and, are community-based and cost-effective.

The 22nd Meeting of Ministers of Health, and the 57th Session of the Regional Committee for South-East Asia

Speaking at the joint inauguration of the 22nd Meeting of Health Ministers and the 57th session of the WHO Regional Committee for South-East Asia, held in Dharubaaruge Hall, Karumba Maldives on 5 September 2004, the President of the Republic of Maldives, His Excellency Mr Maumoon Abdul Gayoom said, "One of the biggest challenges in the health sector for many countries of the Region, including Maldives, is that of matching resources with requirements, as resources are scarce, and needs are plenty". His Excellency added that preventive strategies, healthy lifestyles, efficient management of resources and international cooperation were essential to ensure sustainability. Referring to potential pandemics and the threat of new and re-emerging communicable diseases, President Gayoom said that SARS and avian influenza had affected most countries of the Region, and that the response to such outbreaks required strong national and regional collaboration as well as support of the international community.

Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, commended the remarkable progress made by the Republic of Maldives in both national and health development. Since 1980, in a

little over twenty years, life expectancy had risen from 50 years to 71, and infant mortality rate had decreased from 94 to 14 per 1 000 live births. Dr Samlee highlighted the strong link between health and development. He referred to the Global Commission on Macroeconomics and Health and its emphasis on increased investment in health to achieve social and economic development. "By scaling up investment in health, we can stimulate economic growth and reduce poverty, and these in turn, would further enhance health development. Countries need to recognize the centrality of health in sustainable development," added the Regional Director.

Dr Samlee said that it would require strong political commitment and leadership to close disparities in health and to ensure that "all peoples in our Region will be optimally healthy". He said that Health Ministers were best placed to persuade their Heads of Governments, "that putting more money into health is a very sound investment for any country". The Regional Director expressed confidence that the two key meetings – the Health Ministers' Meeting and the Regional Committee Meeting -- would help forge greater regional unity and collaboration "for best gains from our health development endeavours". He said that international unity for health was the basis of WHO's establishment, five decades ago, and this solidarity was demonstrated during the recent outbreaks of emerging diseases like SARS and avian influenza. He added that already countries of the Region were benefiting from the Global Fund to fight the scourge of HIV/AIDS, TB and Malaria

The Regional Committee, which is the Governing Body of WHO at the Regional

level, discussed, among other topics, the work of WHO in the South-East Asia Region, for the period 1 July 2003 to 30 June 2004 as presented in the Report of the Regional Director. It considered the Proposed Programme Budget 2006-2007 and the report and recommendations of the Technical Discussions on Emergency Health Preparedness, held during the 41st meeting of the Consultative Committee for Programme Development and Management in July 2004. In addition, the Committee received technical updates on subjects discussed at the Ninth Meeting of Health Secretaries, held in July 2004. The topics were: Iodine deficiency disorders; Revision of International Health Regulations; Globalization, trade, intellectual property rights and health, and Establishment of regional cooperation on avian influenza prevention and control.

The Committee adopted four resolutions, including ones on: Emergency Health Preparedness and Iodine Deficiency Disorders in the South-East Asia Region.

Vision Document on Emerging Infectious Diseases in the South-East Asia Region

Addressing participants at the inauguration of the consultation to Finalize the Vision Document on Emerging Infectious Diseases in the South-East Asia Region, held on 22 September 2004 in the Regional Office, Dr Samlee Plianbangchang, the Regional Director said, "With the advent of antibiotics, some experts felt that one day infectious diseases will cease to be problems of public health importance. However, they have been proved wrong, as the arsenal of antimicrobials has not kept pace with the

genetic ingenuity of microbes. High prevalence and incidence of infectious diseases still pose a great challenge, especially to developing countries; including those in the South-East Asia Region," Dr Samlee added.

Expressing concern on the emergence of infectious diseases, the Regional Director stated that in the last few decades, more than 30 new microbes had been isolated. Some of these had played havoc due to explosive outbreaks leading to an adverse economic impact and global panic. SARS and avian influenza were the most recent examples. Micro-organisms, particularly viruses, were highly unstable, and possessed remarkable genetic versatility, which allowed them to alter their genetic make-up. At the same time, many pathogens developed strains, which were resistant to known antibiotics.

To prevent and control emerging infectious diseases, or at least to reduce their health impact, concerted efforts of all concerned at all levels was necessary. A strong political commitment with adequate financial and other resources were the essential prerequisites. Public-private partnerships focusing on early detection of emerging infectious diseases, and appropriate control measures would ensure health security. Intercountry cooperation, exchange of information and risk communication will help prevent panic and hysteria, among other things. Stressing that the Regional Office was fully committed to assist Member States in improving capacity in disease outbreak investigations and control, Dr Samlee said, "The purpose of drafting this "Vision" document is to alert all those concerned of the necessity of being well

prepared to face this formidable challenge. This document can serve as a technical guide to countries in the Region in planning appropriate programmes for combating emerging infectious diseases," concluded the Regional Director.

Fifty-fifth Meeting of the Regional Director with the WHO Representatives

Delivering his opening remarks at the Fifty-fifth Meeting of the Regional Director with the WHO Representatives, in SEARO on 8 November 2004, the Regional Director, Dr Samlee Plianbangchang said, "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. One of the important challenges for us at the country level now is to deal with the issues involving conflicts of interest among groups, locally and/or internationally. It is indispensable that we work together very closely between the three levels of the Organization in tackling the issues of such nature at all stages." At all cost, we have to try to stay neutral, approach the issue on a technically sound basis, and listen to all parties involved, including the media", advised the Regional Director.

Reiterating the increasingly important role of country offices in supporting Member States, the Regional Director added, "As far

as our work at country level is concerned, we are now pursuing our tasks so that our WHO country offices become implementing offices as far as direct support to countries is concerned.

"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," concluded Dr Samlee.

Health Ministers from South-East and East Asian Countries Commit to Work with WHO and Other International Agencies to Fight Avian Influenza

Recognizing the pandemic potential and the threat to public health posed by Avian Influenza, health ministers and senior officials of 13 countries from South-East and East Asian countries have pledged to accelerate joint collaboration in fighting the disease. They will work together towards the development of vaccines, diagnostic tests for human disease and research urgently needed to provide more concrete information on this evolving virus. While nationally they will develop and implement effective influenza pandemic preparedness plans, the countries have committed to cooperate on all important aspects, like sharing of experiences and knowledge, characterization of the epidemiology of the disease and defining appropriate public health responses.

Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region said that during the last three decades the number of infectious diseases had increased with more than 30 new pathogens newly identified. He said that we urgently need to strengthen global and regional cooperation

to ensure global health security. Dr Samlee said that the Ministers' forum exemplified the effective partnerships between countries and WHO working to ensure health security of people in this part of the world. He emphasized the urgent need for research to

better understand the Avian Influenza epidemiology, pathogenicity and the clinical aspects of the disease. He called for intersectoral cooperation and intercountry collaboration in the spirit of global solidarity.



Book Review

International Migration, Health and Human Rights

[ISBN 92 4 156253 6; Sw.fr. 10.-/US\$9.00]

This publication draws attention to important health and human rights issues that migration poses for health policy-makers. These include the magnitude of, and reasons for migration; migrating health professionals and “the brain drain”; forced migration and its health implications; detaining and screening at the borders; health and human rights issues of migrants once in the host country, and the most vulnerable categories of migrants.

This publication also examines important topical developments, including emerging infectious diseases such as Severe Acute Respiratory Syndrome (SARS) and international trade agreements, such as WTO’s General Agreement on Trade in Services (GATS). It recognizes the global economic benefits of liberalizing migration and urges that migration policies and programmes promote the health and human rights of migrants. This publication will serve as a guide to governments, policy-makers and other actors, and help them to design and implement health policies and programmes in the context of migration.

Managing Newborn Problems – A Guide for Doctors, Nurses and Midwives

[ISBN 92 4 154622 0; Sw.fr. 30.00/US\$27.00]

Every year an estimated three million newborn babies die during the first week of

life due to problems such as sepsis, tetanus, or asphyxia, or problems associated with trauma, low birth weight, or pre-term birth. This guide is written for doctors, nurses, senior midwives and other health care workers at the first referral level in low resource settings who are responsible for the care of newborn babies with problems during the first week(s) of life.

The guide, based on the latest available evidence, provides up-to-date, authoritative clinical guidelines that are relevant to a facility with basic laboratory facilities, selected essential drugs and supplies, and the capability to provide safe blood transfusion. In some settings, the guide will be relevant to large health centres that provide childbirth care and have the capacity to care for sick or small newborn babies.

Guidelines for the Inpatient Treatment of Severely Malnourished Children

[ISBN 92 4 154609 3; Sw.fr.10 .00/US\$.9.00]

Severely malnourished children need special care. This book provides simple, practical guidelines for treating these children successfully and takes into account the limited resources of many hospitals and health units in developing countries. It is intended for doctors, nurses, dieticians and other health workers with responsibility for the medical and dietary management of severely malnourished children, and for their

trainers and supervisors. The guidelines are authoritative and hospitals using them report substantial reductions in mortality. The instructions are clear, concise, and easy to follow. The aim is to help improve the quality of inpatient care and so prevent unnecessary deaths.

Serious Childhood Problems in Countries

with Limited Resources – *Background book on Management of the Child with a Serious Infection or Severe Malnutrition*
[ISBN 92 4 156269 2; CHF 20 .00/US\$.18.00]

This book – part of a series of documents and tools supporting the IMCI (Integrated Management of Childhood Illness) strategy – has been prepared as a companion to the WHO manual entitled *Management of the Child with a Serious Infection or Severe Malnutrition: Guidelines for Care at the First-Referral Level in Developing Countries*. This book is aimed at medical, nursing and other health care students, and presents a summary of the technical background and the evidence-base underlying the clinical guidelines. For treatment recommendations, the companion manual should be consulted. The book should also be useful for teachers of undergraduates in paediatrics and child health, and workers in child health as part of their initial training or continuing professional development. It focuses on the major causes of childhood mortality dealing with disease definition, burden of disease, aetiology and pathophysiology. It summarizes the evidence linking these factors to a good/poor outcome and the evidence that intervention can control the factor and/or improve the outcome.

Beyond the Numbers – *Reviewing Maternal Deaths and Complications to Make Pregnancy Safer*

[ISBN 92 4 159183 8; CHF 25.-/ US\$ 22.50]

Every year some eight million women suffer pregnancy-related complications and over half a million die. Most of these deaths can be averted even where resources are limited but, in order to do so, the right kind of information is needed upon which to base actions. *Beyond the numbers* presents ways of generating this kind of information. The approaches described go beyond just counting deaths to developing an understanding of why they happened and how they can be averted. It is directed at health professionals, health care planners and managers working in the area of maternal and newborn health who are striving to improve the quality of care provided. The publication includes a CD-ROM of sample data collection and analysis.

Meeting the MDG Drinking Water and Sanitation Targets – A Mid-term Assessment of Progress

[ISBN 92 4 156278 1; CHF.15.00/US\$.13.50]

The combination of safe drinking water and hygienic sanitation facilities is a precondition for health and for success in the fight against poverty, hunger, child deaths and gender inequality. It is also central to the human rights and personal dignity of every woman, man and child on earth. Yet 2.6 billion people – half the developing world – lack even a simple 'improved latrine'. One person in six has little choice but to use potentially harmful sources of water. This report prepared by WHO and UNICEF provides water supply and sanitation coverage data for 1990 and 2002 at

national, regional and global levels and an analysis of trends towards 2015. These estimates are critical for calculating rates of progress towards national goals and for highlighting priorities, especially those that target the underserved. This report is intended as a 'reality check' on how far we have come, and where we need to focus next, in order to fulfil our commitment towards the water supply and sanitation targets of the Millennium Development Goals.

TB/HIV – A Clinical Manual (Second Edition)

[ISBN 92 4 1 54634 4; Sw.fr. 15.-/US\$ 13.50;
In developing countries Sw.fr. 10.50/US\$ 9.45]

The revised edition of this popular manual provides a pocket-sized guide to the clinical management of TB, particularly in patients suffering from co-infection with HIV. Designed for use by busy clinicians, the manual aims to promote the best possible diagnosis and treatment in low-income countries where the prevalence of TB and HIV infection is high, case loads are heavy, and laboratory support may be limited. With these needs in mind, the manual combines the latest scientific knowledge about TB and HIV with authoritative advice based on extensive field experience in several of the hardest hit countries. Since there is increasing attention to the need to ensure high quality care of children with TB within National TB Programmes, changes in this second edition aim at improving the guidance on dealing with TB in children. The treatment of HIV infection has advanced enormously since 1996. Unfortunately, at present a very small proportion of all people infected with HIV globally have access to antiretroviral treatment. However, this proportion is sure to increase and clinicians involved in managing TB patients need to know about antiretroviral treatment. For

these reasons, there is a new chapter on antiretroviral drugs in the treatment of HIV infection. Throughout the manual, tables, flow charts, lists of do's and don'ts, questions and answers, and numerous practical tips are used to facilitate quick reference and correct decisions. Though primarily addressed to clinicians working at district hospitals in sub-Saharan Africa, the manual is also suitable for use in areas of Asia and South-America where the problem of TB and HIV co-infection poses a growing clinical challenge.

The Atlas of Heart Disease and Stroke

[ISBN 92 4 1 56276 5; CHF 50.00./US\$45.00]

Cardiovascular disease (CVD) now ranks as the world's top cause of death, causing one third of all deaths globally. Heart disease can no longer be seen as the problem of overworked, overweight middle-aged men in developed countries. In today's world, women and children too are at risk. Already 75% of all CVD deaths occur in the poorer regions of the world, and this is likely to increase in the future. The Atlas of Heart Disease and Stroke addresses this most urgent health issue in a ground-breaking, clear and accessible format, designed to inform UN agencies, government officials, politicians and other decision-makers, the media, researchers, and the general public, as well as provide an essential tool for the health professional. The Atlas charts in full-colour maps and graphics the wide range of issues relating to this global epidemic. The topics include - Risk factors: high blood pressure, tobacco use, inactivity, obesity, lipids, diabetes; women, childhood and youth; the global burden of CVD, including the economic burden; research; prevention; policies and legislation; treatment, and predictions.

Declaration on Action to Strengthen Emergency Relief, Rehabilitation, Reconstruction and Prevention on the Aftermath of Earthquake and Tsunami Disaster of 26 December 2004

(Special ASEAN Leaders' Meeting on Aftermath of Earthquake and Tsunami
Jakarta, 6 January 2005)

We, the Heads of State/Government, Special Envoys and Heads of regional as well as international organizations, who gathered here on 6 January 2005 in Jakarta, Indonesia, expressed solemnly our profound sorrow and our solidarity to overcome the unprecedented catastrophe befalling the Indian Ocean rim countries on 26 December 2004.

This unprecedented devastation needs unprecedented global response in assisting the national governments to cope with such disaster. This would entail efforts in emergency relief, rehabilitation, and reconstruction that may take five to ten years, with resources that cannot be borne by any individual country.

We deeply appreciate the generous contribution and assistance offered by many countries and the overwhelming expressions of support and assistance from governments, non-governmental organizations and citizens of the world at large.

We applaud the leading role of the affected countries in addressing this disaster, and we recognize the role of the United Nations in assisting the affected countries' coordination of international assistance at the emergency relief phase.

We underlined the need to coordinate better and ensure that those contributions would be effective and sustainable, to truly address the suffering of the victims and to prevent such calamity from recurring.

We expressed our continuing commitment to assist the affected countries and their peoples in order to fully recover from the catastrophic and traumatic effects of the disaster, including in their mid and long-term rehabilitation and reconstruction efforts.

To these ends, we agreed to:

1. Emergency Relief

- (a) Urgently mobilize further additional resources to meet the emergency relief needs of victims in the affected countries.
- (b) Request the United Nations to mobilize the international community to support the national relief emergency programs in the affected countries, and welcomed in this regard, the Flash Appeal by the United Nations. In this connection, further request the

United Nations to appoint a Special Representative of the UN Secretary-General for the above purpose; to convene an international pledging conference for the sustainability of humanitarian relief efforts; and to explore the establishment of "standby arrangement" at the global level for immediate humanitarian relief efforts.

- (c) Strengthen coordination and cooperation of the national, regional and international relief efforts, to ensure effective and immediate distribution of the assistance.
- (d) Support the efforts of the affected countries, as national coordinators, to ensure an effective channeling and utilization of assistance as offered by donor countries, international organizations and non-governmental relief organizations.

2. Rehabilitation and Reconstruction

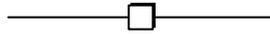
- (a) Support and emphasize the importance of national rehabilitation and reconstruction programs given the devastation of the basic infrastructures and services in the affected countries. The reconstruction and rehabilitation phase should link seamlessly with the humanitarian relief efforts.
- (b) Call on the international community, in particular the donor countries, the World Bank, the Asian Development Bank, the Islamic Development Bank, European Investment Bank, and related international financial institutions to provide the necessary fund for the viability and sustainability of those programs.
- (c) Establish a partnership, upon the request and the leadership of the country concerned, involving donor countries and regional as well as international financial institutions, to support the respective national programs of the affected countries.
- (d) Welcome the initiative of several countries on the moratorium of payments of the external debt of the affected countries to augment their national capacity to carry out the rehabilitation and reconstruction efforts.
- (e) Promote and encourage private sector participation in and contribution to the rehabilitation and reconstruction efforts.

3. Prevention and Mitigation

- (a) Support ASEAN's decision to establish regional mechanisms on disaster prevention and mitigation, inter alia:
 - The utilization of military and civilian personnel in disaster relief operation and an ASEAN Humanitarian Assistance Centre, as provided for in the ASEAN Security Community Plan of Action;
 - ASEAN Disaster Information Sharing and Communication Network, as provided for in the ASEAN Socio-Cultural Community component of the Vientiane Action Programme;
 - A regional instrument on disaster management and emergency response.

- (b) Establish a regional early warning system such as Regional Tsunami Early Warning Center on the Indian Ocean and the Southeast Asia region.
- (c) Promote public education and awareness as well as community participation in disaster prevention and mitigation through inter alia a community based disaster preparedness and early response.
- (d) Develop and promote national and regional human and institutional capacity, transfer of know-how, technology, and scientific knowledge in building and managing a regional early warning system and disaster management through international cooperation and partnership.

We believe that through concerted efforts, spurred by spirit of compassion and sacrifice and endurance, together, we will prevail in overcoming this catastrophe.



Guidelines for Contributors

THE Regional Health Forum seeks to inform and to act as a platform for debate by health personnel including policy-makers, health administrators, health educators and health communicators.

Contributions on current events, issues, theories and activities in all aspects of health development are welcome. Contributions should be original and contain something of interest to those engaged in health policy and practice, some lesson to be learned, some idea, something that worked, something that didn't work, in fact anything that needs to be communicated and discussed on a broader scale. Articles, essays, notes, news and views across the spectrum of health development will be published.

Every year, the May-June issue of the Forum is dedicated to the World Health Day theme of the year, which is mentioned in the December issue. Readers may send contributions relating to the theme for inclusion in the special issue.

Papers for submission should be forwarded to the Editor, Regional Health Forum, World Health Organization, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110002, India (e.mail address: editor@whosea.org).

Contributions should:

- be in English;
- be written in an anecdotal, informal, lively and readable style (so that sophisticated technologies, for example, may be easily understood);
- be in MS Word and sent with a diskette and a printout in double space, and
- not normally exceed 3000 words with an abstract (approx. 250 words) and a maximum of 30 references.

Letters to the editor should normally be between 500-1000 words with a maximum of six references.

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