Working Towards Better Health in South-East Asia

Selected Speeches by:

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Volume II:
March 2006 –
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Regional Office for South-East Asia

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Preface

This second volume of selected speeches by Dr Samlee Pliangbangchang, WHO Regional Director, South-East Asia Region, covers the period of March 2006 – February 2008. The first volume, 'A Vision for Health Development in South-East Asia, covered a two-year period form 1 March 2004 when Dr Samlee assumed office as Regional Director.

The speeches included in this volume were delivered by Dr Samlee at various fora and cover a wide range of subjects of priority interest to WHO and its Member countries in the Region.

For ease of reference, the speeches have been grouped under five areas and are presented chronologically. The title, venue and period of the event are indicated in the footnotes.

Communicable Diseases

Rabies control

Rabies is an ancient disease but we are yet to eliminate it in order for it not to be a public health problem. The vaccine to prevent rabies was developed in 1885. Cost-effective tools for elimination of rabies and the modalities for use of these tools are available.

Yet, rabies is still an important public health problem in developing countries, including those of the WHO South-East Asia Region. Human rabies accounts for about 55,000 global deaths each year. More than 99% of all human deaths due to rabies occur in developing countries. However, rabies remains a neglected disease in most of these countries.

Children and poor people are at the greatest risk

The South-East Asia Region contributes to about 60% of all global mortality due to this preventable disease. More than 2.5 million people undergo post-exposure prophylaxis after being bitten by rabid or suspected rabid dogs and wild animals. This causes considerable morbidity and economic loss.

Rabies is a zoonotic disease of public health concern in many countries of the South-East Asia Region. Dogs are the primary source of human rabies, with 96% of all rabies deaths in the South-East Asia Region occurring after bites by rabid dogs. Children and poor people are at the greatest risk.

The control of rabies in the canine population is fundamental to the elimination of the disease. The Regional Strategy for Rabies Elimination was drafted in 1998. The strategy focuses on: Reduction

World Rabies Day, SEARO, New Delhi, 7 September 2007.

of rabies in animal reservoirs through immunization of animals, especially dogs; and promotion of early human post-exposure prophylaxis.

These may seem to be simple though their application requires considerable effort. Political commitment is an important pre-requisite. There is a need for nationally coordinated programmes and activities in which all stakeholders actively play their roles. Communities should be closely involved in rabies control activities.

The abundance of stay dogs in metropolitan areas of countries in the South-East Asia Region is a growing problem. Dogs are prolific breeders. They can multiply rapidly and survive on food, water and shelter made available to them wilfully or through the improper disposal of garbage. The high turnover of the canine population is a real challenge to achieve desirable rabies vaccination coverage. On the other hand, it is difficult to restrain stray or ownerless dogs for the purpose of vaccination.

Local authorities and community-based organizations will have to play a greater role in animal birth control and welfare. Many NGOs in several countries of the Region are involved in surgical sterilization of street dogs in cities and towns. But this has had limited effect on the overall control of the dog population.

To improve the coverage of dog vaccination in inaccessible areas, WHO advocates coordinated field studies on oral vaccination. This method may constitute a useful complementary strategy to increase dog vaccination coverage.

Many people love dogs but due to a lack of understanding they rarely devote much attention to their health. This is especially true among the poor and rural population. Dogs are man's good friends, in many aspects; they are part of the family. Even stray dogs are considered a welcome part of the community in many societies.

There is need to promote responsible dog ownership, which includes rabies vaccination. This is a pivotal step to protect families, neighbours and communities from this preventable disease. Recent studies show that many people became victims of rabies because of negligence and ignorance. Inadequate medical services at the peripheral

level leads to their mortality. Advocacy to create awareness among the population at risk is a powerful tool to help in the battle against rabies. A comprehensive national control programme is needed for the elimination of rabies. It has to be a multisectoral programme, involving the health and animal sectors, with full responsibility on the part of the municipal authorities.

The elimination of dog rabies is difficult, but is not an impossible task. With determined political commitment and the innovative use of available tools, the elimination of dog rabies is an attainable goal.

Beginning this year, World Rabies Day will be organized on 8 September each year to promote political commitment and create awareness among the population at risk. WHO and OIE (Organization for Animal Health) are the co-sponsors of this initiative.

I earnestly urge governments, institutions, communities, professional bodies and other organized groups to recognize the gravity of the problem of rabies and try to prevent it with their best possible efforts. Please join hands to eliminate rabies as a public health problem in the South-East Asia Region.

AIDS in Asia and the Pacific

During the past few days, the participants have been sharing research findings on various aspects of HIV and STI prevention and control. This conference is very timely and an excellent opportunity to revisit and reinforce our commitment, the commitment to halt and reverse the HIV epidemic in Asia and the Pacific.

In the Asia-Pacific Region, we are at high risk of a massive spread of HIV. This is not only due to the large size of the population and the high burden of sexually transmitted infections (STIs), but also due to the prevailing risk behaviours and vulnerabilities as well as inherent social stigma.

We need to facilitate greater exchange of information

The complacency of governments is an issue impeding progress in the development of programme for HIV prevention and control. We have learnt over many years what works and what does not work in the prevention and control of HIV/AIDS. Still, there is a gap between what we know from research and the application of that knowledge by national AIDS and STI programmes. In addition, there is a need to increase research capacity in this area in countries of this Region.

We need to facilitate greater exchange of information, and further strengthen collaboration between researchers and programme managers. Research, along with HIV surveillance, monitoring and evaluation, are critical tools to generate evidence for informing policy-makers, planners and implementers. The evidence from research findings can ensure appropriate design and strengthening of programmes and services.

Eighth International Conference on AIDS in Asia and the Pacific (ICAAP), Colombo, Sri Lanka, 19-23 August 2007.

Ulcerative STIs increase HIV transmission by 15 to 50 times for women and 50 to 300 times for men. Studies have clearly demonstrated how STIs increase the infectiousness of HIV. Yet, STI prevention and control, including its surveillance, are yet to receive adequate attention.

The World Health Organization in the South-East Asia Region has launched a medium-long-term Strategy for the Prevention and Control of Sexually Transmitted Infections, over the period 2007-2015. The Organization is committed to working more closely with Member States in strengthening STI prevention, control and surveillance. Since the beginning of the epidemic, HIV prevalence among injecting drug users (IDUs) in many countries has remained at around 40%. However, in some cases, this prevalence has recently increased dramatically.

Research has suggested that there are workable interventions that may reduce the sharing of contaminated needles and syringes. Only a few countries in Asia, however, have started implementing such interventions. Furthermore, the prevention of mother-to-child transmission of HIV is complex. Whereas HIV transmission from mothers to infants has been virtually eliminated in industrialized countries, only limited progress has been made in scaling-up services for the same purpose in low- and middle-income countries. Some research findings have shown that low-cost antiretroviral therapy can effectively reduce mother-to-child transmission. Yet, only a few countries in Asia have reached the necessary scale of such an intervention.

It is estimated that 50% of all new HIV infections are among young people. About 7000 of these people become infected every day. Thirty per cent of the nearly 40 million people living with HIV/AIDS are in the age group of 15 to 24 years.

Thailand had successfully halted and reversed the HIV epidemic in this group of population in the mid-90s. From that lesson, a few countries have begun to offer youth-friendly prevention, care and treatment services. Recent data show that antiretroviral therapy may decrease the morbidity and mortality of HIV-associated TB. This treatment may also contribute to HIV prevention. Nevertheless, only a few national TB and AIDS programmes have embarked on their collaborative actions towards this goal. This includes, in particular, efforts to increase access to HIV testing, counselling, care and treatment.

Asia is not an exception to the inadequate coverage of preventive services for HIV prevention. Despite effective interventions, such as condom use targeting sex workers, and harm reduction targeting IDUs in several countries, the coverage of these preventive interventions across the Region has been far from satisfactory.

Financial resources, however, are not a bottleneck to address these shortcomings. The Global Fund for AIDS, TB and Malaria is one of many funding sources for country initiatives to scale-up HIV prevention and control. What is needed is our capability and capacity in programme development and management to ensure the most efficient and effective use of available resources.

HIV was first reported 25 years ago. We know what works to prevent its transmission. However, scaling-up of interventions in many countries is slow, not to talk about inadequate "to reach the unreached" programmes for those who need the services most. This is due mainly to the lack of political commitment, and weak public sector response, – particularly at the primary care level. Furthermore, social stigma is still an important obstacle, which is yet to be effectively overcome. Insufficient trained human resources as well as poverty and gender inequity, are all factors that hamper effective interventions.

To increase concerted efforts to scale-up HIV prevention and control, we must first reinforce the commitment of governments. Also, commitments of nongovernmental partners, the civil society, and people living with HIV have to be intensified and synchronized. We need to re-double our attention and efforts on key priority areas, where we can achieve the maximum impact.

I am confident that our deliberations during the course of this meeting have provided the necessary information and updates, as well as new ideas. These are for us to move forward more effectively in our collaborative actions to better prevent and control HIV/AIDS and other sexually transmitted infections. I would encourage the distinguished participants to review the relevant issues involved, and establish a strong network, as well as functioning partnerships for effective international collaboration. The collaboration that can help reinforce/redouble HIV/STI prevention and control actions, especially in the developing countries.

Tuberculosis control

Despite the progress made over the past decade, TB continues being a major cause of death in countries of the South-East Asia Region. The World Health Assembly in 2000 declared that by the year 2005 all endemic countries in the world should achieve two important targets in TB control. These targets are: 70% case detection, and 85% treatment success.

All countries in this Region have achieved and sustained 85% treatment success since 2003. However, by the end of last year, the overall case detection rate was still 64%. Nonetheless, all countries are moving steadily towards reaching both targets.

All countries in this Region have achieved and sustained 85% treatment success since 2003

To ensure success in TB control, we have also set a fresh target under the Millennium Development Goals. This target is to halt and reverse the trend of tuberculosis by 2015. This will be attained by sustaining what has already been achieved and by continued reduction of both prevalence and mortality rates.

However, data from the control programmes show a steady increase in TB case notifications. While this certainly reflects better diagnosis and reporting, it is a worrying situation. The majority of these cases continue to be among the younger age groups. This trend reflects ongoing transmission of TB in the community.

Joint Opening of South-East Asia Regional Meeting of Partners for TB Control and 11th Meeting of the Stop TB Coordinating Board, Jakarta, Indonesia, 27-30 November 2006.

In addition, we can see the re-emergence of TB which is linked to several other factors. Such as the spread of HIV that has perpetuated TB resurgence in this Region. We have, therefore, to seriously take care of those factors while developing TB control programmes.

The robust strategy for TB control, well known as DOTS, has paid us good dividends, until now. However, over the years, since the DOTS strategy was first introduced, there has been a significant environmental change, and many new challenges in TB control have emerged. Therefore, a new Stop TB strategy, 2006-2015, was launched earlier this year.

The key issue before us now is whether we have the means to implement this strategy successfully over the next 10 years. We have only limited resources, and we have to make the best use of whatever is available with us.

We have to utilize the existing health infrastructure and facilities in the most efficient manner. We have to develop mechanisms to effectively deliver services to where these are really needed. One of the key concerns is to reach the unreached; the poor, underserved, and marginalized.

Tuberculosis control is not an issue that can be successfully tackled by the health sector alone

We need to see how best to work with other sectors, so that there will be synergy in our efforts. This is important, especially since several socio-economic determinants are involved in the occurrence of the disease.

I am pleased with the progress made in developing private / public partnerships for TB control. This approach will take us a long way in ensuring efficient delivery of needed services. Operational research to provide evidence for the improvement of programme management is necessary.

Tuberculosis control is not an issue that can be successfully tackled by the health sector alone. It should always be kept in mind that the spread of TB is contributed by several social and economic factors.

Significant reduction of TB in countries is clearly linked to several conditions, such as: Improved standards of living; better nutrition; better

education; heightened community awareness; and increased demand for health services.

Tuberculosis control, therefore, requires a strong multisectoral approach, which has to be pursued through effective partnerships.

We greatly appreciate the support to TB control provided through bilateral, multilateral or private initiatives. These include the Global Fund and many others. Countries must ensure that this support is efficiently utilized to build their own capacities.

We have to ensure that our plans to alter the course of TB, TB/HIV and drug-resistant TB are effectively implemented in the years ahead. We must look forward towards a long-term sustainable development in countries. Increased investments in health care, especially by the countries concerned, will take us a long way in ensuring this sustainability.

We must engage in leveraging resources, not only within the health sector, but also elsewhere. Other ministries and departments, NGOs, civil society, business enterprises and industry have much to contribute to TB control.

The shift from a purely medical model to an intersectoral process, is essential for overcoming the many challenges faced in TB control. Without this approach, our goal of a tuberculosis-free world will remain illusive.

Let us now resolve that one day, everywhere in the world, TB will be part of history. But, for this to happen, we must be prepared to work with greater enthusiasm in the years ahead.

Leprosy elimination

On behalf of WHO, I wish to convey our deep appreciation and thanks to the Nippon Foundation and Sasakawa Memorial Health Foundation for their strong and sustained support to WHO Global Leprosy Programme.

Our thanks go specially to Mr Yohei Sasakawa, WHO Goodwill Ambassador, for his unwavering commitment and untiring efforts towards achieving the goal of a leprosy-free world. Mr Sasakawa, your inspiring leadership and impressive advocacy will certainly lead us a long way in our pursuit to attain this noble goal.

As we are aware, the Global Leprosy Programme was relocated to this Regional Office last year. This was decided by WHO Director-General, the late Dr LEE Jong-wook, who started his career in WHO in the area of leprosy.

It is time to document the success of global leprosy elimination

I express profound grief at Dr LEE's untimely demise; and wish to record our appreciation of his leadership and abiding commitment to the cause of leprosy elimination.

This meeting here is of special significance beyond India, which accounted for the highest burden of leprosy, has reported prevalence rate below 1 case per 10,000 population since last year. In addition, since August this year, Madagascar also has attained the goal of leprosy elimination.

These are significant milestones in our fight against leprosy. It is time to document the success of global leprosy elimination, so, that

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Annual Meeting of the Nippon Foundation / Sasakawa Memorial Health Foundation Advisory Board, SEARO, New Delhi, India, 9-10 October 2006.

other communicable disease control programmes can draw appropriate lessons from it.

As of now, five countries have yet to attain this goal. Brazil; Mozambique; Democratic Republic of Congo; Nepal, and Tanzania. I must also add Timor Leste our new Member State to this list. These countries will need greater attention and doubled efforts.

We also need to remember that the achievements of leprosy elimination are not uniform. Within the countries that have achieved the elimination goal at national level, there are still pockets of high endemicity. Therefore, our efforts need not only to continue, ensuring that the remaining countries achieve the elimination goal, but also, to direct towards further reducing the burden of leprosy in all countries.

Most leprosy-endemic countries have integrated leprosy interventions into their general health services. There is need to further strengthen this integration, and build the capacity of staff of the general health services. This is to ensure the quality of services, including timely diagnosis, prompt and effective treatment, as well as prevention of disabilities, and care of the disabled.

We know, that new cases will continue to occur, though, hopefully in smaller numbers. The low endemic situation in most countries renders its own challenges, which stem from complacency.

We have to work harder towards sustaining political commitment, adequate resources, quality of services; and retaining knowledge and skills of concerned staff. In addition, the previously disabled persons will continue to need proper care and rehabilitation.

The general awareness about leprosy has improved, and consequently there is a reduced social stigma. However, some of the leprosy affected continue to be the victims of prejudice and exclusion. Many countries still have laws that discriminate against people with leprosy.

I am grateful to the WHO Goodwill Ambassador, Mr Yohei Sasakawa, for his untiring efforts to bring leprosy on the agenda of UN Human Rights Commission. Our fight for the rights of leprosy affected, particularly those disabled, will not only continue; but also be intensified. We have to fight along with our partners, including the persons affected by leprosy themselves.

Furthermore, we still need research, particularly epidemiological and operational, that can help improve programme development and management. We also need research for better drugs or drug combinations that could further reduce the duration of treatment or minimize disabilities.

Better understanding of epidemiology and pathogenesis of leprosy, may lead to the development of interventions for primary prevention, which is important for our future programmes against the disease. Therefore, WHO's role in providing technical inputs and guidance to countries will, in no way, reduce or diminish.

In fact, in many ways, our role has now become more challenging. We are aiming at attaining a leprosy-free world. The remaining task before us is therefore much more difficult than what we have done for leprosy elimination.

One of the key factors responsible for the success of the global leprosy programme is the well-functioning partnerships. The partnerships between national programmes, WHO, bilateral/multilateral agencies, and a number of national/international NGOs. And I have to place on record the indispensable contributions from the private sector. These partnerships have to be continued, further strengthened; and new partners added.

WHO has been able to provide free MDT drugs to all endemic countries. This has been possible because of the generous support from the Nippon Foundation and the Novartis Foundation. We sincerely thank both foundations. We are also grateful to Novartis for agreeing to continue the free supply until 2010.

This annual meeting provides us with the opportunity to interact and share information on the achievements; as well as on the remaining issues and challenges. It is an opportunity to learn from our strengths and weaknesses, and jointly plan for the future.

The South-East Asia Region still has two countries which are yet to achieve the elimination goal – Nepal and Timor-Leste. We are enhancing our efforts to these countries, and expect them to achieve the elimination goal by 2007.

As you may recall, in 1985, there were 122 countries with a leprosy prevalence rate of more than 1 case per 10,000 population. Today, 117 of these countries have achieved the leprosy elimination goal; i.e., their leprosy prevalence rates are less than 1 case per 10,000 population. I am confident that the remaining countries will attain the goal in the near future.

It is estimated that, over the past 20 years, at least 4 million leprosy-related disabilities have been prevented globally. This is indeed a major gain in public health arena. The gain that has also significantly contributes to the overall impact on poverty reduction. It is a major contribution towards the achievement of the Millennium Development Goals.

Ultimately, we would like to see this world being free from this scourge

As said and implied earlier, the thrust and intensity of leprosy work has not only to continue, but also needs to be intensified; the efforts doubled, if we can afford.

The immediate priority now is to achieve the elimination goal in the remaining five countries. At the same time, we have to work harder towards further the reducing burden of the disease in all endemic countries. Ultimately, we would like to see this world being free from this scourge.

We earnestly request The Nippon Foundation/Sasakawa Memorial Health Foundation to continue their unstinted support to the Global Leprosy Programme.

WHO has developed 'Operational Guidelines' for implementing the "Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities". These guidelines are broad-based and flexible enough to be adapted by the national programmes, taking into account the ground realities.

This two-day meeting is an opportunity to review the progress during the last one year; and to finalize the Action Plan for 2007. This plan is for the scrutiny of the Advisory Board of The Nippon Foundation/ Sasakawa Memorial Health Foundation. We look forward to a favourable consideration by the Board.

Tuberculosis: A priority re-emerging disease

Tuberculosis is a priority re-emerging disease in the South-East Asia Region. In March 2004, WHO declared TB a regional "special project". This is important because more than one third of all TB cases in the world are in this Region. And, because TB continues to be a leading cause of death from communicable diseases in this part of the world. India alone carries two thirds of the regional burden from tuberculosis.

TB is undeniably linked to poverty and deprivation

Given this disease burden, the success of the Revised National TB Control Programme (RNTCP) in India means the achievement of TB control in the entire Region. And, in fact, this success is driving the achievement of the global TB control. I am therefore pleased that this joint monitoring mission is being organized to review further progress of India's RNTCP.

TB notifications in India are rising. This reflects better case detection and reporting. However, the possibility of a true increase in cases should also be investigated and verified. I am implying the threats posed to TB control by HIV infection and emerging drug resistance.

We also know that TB is undeniably linked to poverty and deprivation. Addressing TB will therefore require consideration of social and economic determinants. These factors are affecting mostly the poor who are at highest risk of the disease, and, who are least able to access the required services.

Joint Monitoring Mission, Revised National Tuberculosis Control Programme of India Briefing Meeting, SEARO, New Delhi, India, 3 October 2006.

Tackling TB can, therefore, be realized through effective partnerships with a wide range of stakeholders, including certainly the communities and civil society.

The South-East Asia Region, and India in particular, have already contributed a great deal to global TB control. Many of the key elements of DOTS strategy were developed in India. Similarly, many of the components of the new Stop TB strategy, launched by WHO earlier this year, had already been initiated in India.

The development of public-private partnerships for TB control is another striking example. Also, the collaboration between TB and HIV/AIDS control programmes is growing rapidly. The medical colleges have also been closely involved in TB control in India.

In line with the new global strategy, WHO's South-East Asia Region was the first to develop the Regional Ten-Year Plan to Control TB. This is now complemented by multi-year national plans towards achieving the Millennium Development Goals.

In recent years, external funding for TB control in the Region has increased dramatically. This is particularly with reference to the funding from bilateral donors and the Global Fund.

We, together with our partners, have vigorously intensified technical support to Member States. This is in response to their need to ensure managerial capacity to implement the additional interventions; and to ensure the best use of available resources.

I would emphasize that WHO is deeply committed to supporting TB control in India and in the Region as a whole. And, we will do everything possible to ensure India's success in TB control.

I would also like to recall the important role played by India in tabling a resolution that was adopted by the World Health Assembly last year on sustainable financing for TB control.

Widening the base of partnerships by generating sustained interest from donors will guarantee that TB control acquires necessary resources in the years to come. I would draw your kind attention to a number of

recommendations on this subject from the meeting of Health Secretaries held in June this year.

These recommendations are useful for us in moving forward in TB control. The Secretaries, among other aspects, discussed the new Stop TB strategy. And, they expressed unwavering commitment to translating the strategy into action in their countries.

Before concluding, let me inform you of a new emerging challenge in TB control. That is the advent of the Extensively Drug Resistant (XDR) TB which has been reported in Africa.

It is more dangerous than Multi-drug Resistanct (MDR) TB which we have known. This threat will make it more difficult to carry out TB control programme. We have to be alert and be prepared for it. We have to do everything possible to prevent XDR TB in our Region.

I wish that this mission not only reviews the recent progress; but also, makes recommendations that the Government of India can apply in moving forward rapidly and effectively in TB control.

Yaws elimination

It is an honour and privilege to participate in this very important event – the "Declaration of Yaws Elimination from India". On behalf of WHO, I would like to congratulate the Government of India on this laudable achievement. It is indeed an important milestone in the field of public health in India.

WHO places on record its deep appreciation of the concerted endeavours of the Government to eliminate Yaws from the country. The efforts put in by the Union Ministry of Health and Family Welfare as well as the endemic states and districts are particularly praiseworthy. This success is really the outcome of hard work on the part of concerned health staff, and the contribution from other stakeholders.

India has not reported any new case of Yaws since 2004

In this important exercise, the indispensable contributions from the Directorate-General of Health Services and the National Institute of Communicable Diseases must be specially recognized.

It is heartening to learn that India has not reported any new case of Yaws since 2004. This is indeed a remarkable achievement in communicable disease control. This status of zero-disease-incidence has been validated through a suitable process of annual appraisal by competent persons.

I am delighted to know that India is now aiming at Eradication of Yaws by 2008. Yaws eradication means that, in addition to zero-disease-incidence, there will be no evidence of transmission of the disease

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Declaration of Yaws Elimination from India, New Delhi, India, 19 September 2006: Remarks.

agent. This can be determined through sero-survey in the under-five children in the previously endemic areas. Once the eradication goal is achieved, the interventions against this disease can be discontinued. A part of the health resources can be saved for other priority health problems.

I am certain that the achievement of Yaws eradication in India will serve as a model to other endemic countries in the South-East Asia Region. Then, we, the Member States and WHO, can work collaboratively towards a Yaws-free Region. This will, of course, inspire and motivate other endemic countries in the world to take the path shown by India.

In addition to the health impact, this success will contribute significantly to poverty reduction. This is because Yaws is predominantly a disease of extreme poverty, affecting the most marginalized groups, in remote and hard-to-reach areas. I am confident that the success of Yaws elimination and eradication in India will be well documented and the lessons disseminated widely.

The other control programmes, particularly those for neglected diseases, like kala-azar, lymphatic filariasis, and trachoma, can also benefit from these lessons.

WHO is indeed very proud of being a partner with the Government of India in this important public health undertaking. I wish to assure all concerned that WHO will spare no efforts in supporting India's progress towards Yaws eradication. We also stand committed to being a close partner in the elimination or eradication of other communicable diseases.

The Fifty-ninth session of WHO's Regional Committee for South-East Asia held last month adopted a resolution calling for intensified efforts of all stakeholders to eliminate or eradicate tropical diseases from the Region. This resolution is another springboard for WHO and its Member States in this Region to further strengthen their collaboration in the fight against these diseases.

Avian influenza and pandemic preparedness

Today, there is a formidable challenge posed by emerging diseases. During the recent years, we have witnessed the outbreaks of Nipah and SARS. And now, we are facing the threat posed by avian influenza.

Basically, avian influenza affects animals, particularly birds and poultry. This virus has been found to be highly pathogenic, and entrenched in the poultry of several countries in this part of the world.

The disease has been characterized by a high case fatality rate; more than 50%

Outbreaks due to this virus have severely affected the poultry industry, impacting on the livelihood of many poor people. Equally alarming is that this H5N1 virus has now crossed over the species. It has already infected humans in ten countries globally. As of today, 232 human cases of avian influenza have been reported world-wide. Of these, 134 have died.

The disease has been characterized by a high case fatality rate; more than 50%. Recognizing the seriousness of the situation, WHO has been assisting Member States in taking steps to avert any potential for a pandemic.

After the first case of human avian influenza was detected, WHO convened a meeting of experts in 1999. A global preparedness plan for influenza pandemic was formulated. When more cases of human Avian influenza were reported, this plan was subsequently updated in

Regional Conference of Ministers of Health and Agriculture and Livestock on Avian Influenza and Pandemic Preparedness, New Delhi, India, 28 July 2006.

2004. It has been used by those responsible for public health and medical emergency, in ensuring effective response to the pandemic.

The plan contains, among others, the various phases of a potential pandemic. Globally, we are now in the Pandemic Alert Phase III, where infection in humans is rare. All Member States have already formulated national pandemic preparedness plans. These plans are only the blueprints for action. They will remain on paper, unless we implement them. I am glad to report that our Member States have already started implementing their plans. And we have learnt various lessons.

It is clear, among others, that, to be successful in implementing the plans, intersectoral collaboration, especially between agriculture and health is of paramount importance. In the countries where these two sectors have collaborated well, the outbreaks in animals and in humans have been contained.

Intersectoral collaboration, especially between agriculture and health is of paramount importance

We also learnt that we have to act promptly and effectively in a transparent manner. The Member States have re-affirmed the need for transparency in sharing information concerning avian influenza. They have also agreed to the voluntary compliance with the relevant provisions in the revised International Health Regulations.

To implement the pandemic preparedness plan, an adequate number of trained staff is needed. And, we need to have sufficient resources.

Today, we are at a critical juncture in the history of human infectious diseases. The influenza virus has been known to have caused major pandemics, with severe health and economic consequences. No one can precisely predict its occurrence. But now, we have some clue of the features of a virus with pandemic potential.

If the H5N1 virus undergoes mutation and/or reassortment, it could cause a major devastating pandemic. This is because very few people would be adequately immune against the disease. It is believed that, if an avian influenza pandemic begins, there will be a window of only few weeks to take action to contain it. It is really a very short time-span. Therefore, we need to be really well prepared now.

The catastrophic impact of not preparing or of inadequate preparation for this pandemic will be beyond human imagination. Countless deaths will occur, there will be disruption of travel and commerce, and our major activities will come to a grinding halt. There will also be a tremendous psychosocial impact on the affected population.

The participation in the meeting of ministers and partners from diverse areas reflects a clear commitment and dedication to the cause. I wish the conference all success.

Progress in leprosy elimination

It is time for us to take stock of the progress made during the recent past; and to plan for the future. It is time to review the reality on the ground, with the people who work in the field. And, it is time to see how our efforts at regional and global levels can help countries more effectively in their efforts to control leprosy.

Leprosy is an ancient disease. It is a disease of poverty and misery. It was recognized that the disease burden of leprosy was enormous, in both medical and social terms. In endemic countries, leprosy had always been a significant public health problem. The average global prevalence rate of leprosy was above 10 per 10,000 population in 1985. This was an important rationale for the global efforts to eliminate leprosy.

In 1991, the World Health Assembly passed a resolution, urging the endemic countries to reduce the leprosy prevalence rate to less than 1 case per 10,000 population, by 2000. This rate for leprosy is considered not to be a problem of public health importance. This is the prevalence rate of leprosy targeted for elimination. The target for leprosy elimination was subsequently postponed to 2005.

We expected all endemic countries to have reached this elimination goal at the end of 2005.

Not all those countries had achieved the goal; but, through the elimination efforts a lot was done and achieved. The reduction in the

Meeting of National Leprosy Programme Managers of WHO South-East Asia Region, Bangkok, Thailand, 15-17 May 2006.

leprosy prevalence rate in all endemic countries has been commendable indeed.

Now, 116 out of those 122 endemic countries have achieved the goal of leprosy elimination. In many of the successful countries, however, the achievements within the countries are not uniform. There are still areas of high leprosy prevalence rates within those countries. The countries that have reached the goal, and those that have not yet succeeded, will have to exert extra efforts to sustain the achievements of the past endeavours. They will have to further reduce the disease burden as much as possible. This is the most important remaining challenge of facing leprosy control programme. It has to be kept in mind in this context that, even though, the elimination goal is achieved, leprosy is still prevalent. The disease is still with us. Leprosy elimination is important, but it is only a step towards a leprosy-free world.

Advocacy for political commitment to leprosy control will have to continue, and with intensified efforts. This is to overcome complacency in countries; the complacency that is due to the understanding that leprosy has completely disappeared. Sustaining and maintaining care and services for persons affected by leprosy are essential indeed. Even more important, the quality of these services has to be further improved, in the light of available know–how and technology.

Leprosy elimination is important, but it is only a step towards a leprosy-free world

From now on, the services for these affected persons need to be provided in an integrated manner, within the general health care systems. Leprosy has to be considered as one of those diseases to be taken care of under general health care and services. This integration is very important, especially at the primary care level. Deformity due to leprosy must be prevented and properly corrected and the affected persons rehabilitated socially and occupationally.

It has also to be kept in mind that psychosocial and cultural determinants significantly contribute to the perpetuation and persistence of leprosy. This aspect has to be taken into account seriously when care and services are planned for leprosy-affected persons. Through a multidisciplinary approach, the social stigma associated with these persons has to be reduced or eliminated. The respect for their human rights has to be vigorously promoted and ensured. Social integration of these persons has to be assured through adequate education of the

community and the public at large. Since the disease is still prevalent, surveillance has to continue with improved information.

For the surveillance of leprosy to be effective, it has to be made a part of the integrated disease surveillance system in countries. More research is needed to better understand leprosy, especially its epidemiology and pathogenesis. This understanding will lead to the possibility of primary prevention, which will be important for the leprosy control programme in future. Primary prevention that aims towards tackling disease determinants and risk factors should be made as the targets for programme interventions.

As I said, leprosy is a disease of poverty, with inherent psychosocial and cultural domains. The disease has been entrenched in the population for a long time; it will not disappear from the world easily.

We, therefore, need to keep the leprosy control programme viable and functional. The programme will have to be developed on the basis of better understanding and new evidence. Basic, clinical, epidemiological and operational research is required to produce new knowledge and new evidence for programme development and management.

We, therefore, need to keep the leprosy control programme viable and functional

Research institutions should continue to collaborate with each other in pursuing this challenge. The leprosy control programme must be formulated to suit country and locality- specific situations. The situations that vary according to the socioeconomic and cultural contexts in the individual countries.

The countries will have to determine and decide on various aspects of the programmes that are relevant to their own specific needs and requirements. WHO global and regional strategies can serve as a generic framework to provide a broad technical and managerial guidance. WHO is ready to provide technical inputs to the national efforts in the development and management of leprosy programmes. And, WHO can provide technical and technological knowhow for specific areas of programme interventions.

WHO will continue to work closely with all partners, nationally and internationally, in rendering the required back-up to countries' efforts.

Since care and services for leprosy-affected persons are to be integrated into the general health services, the role of the leprosy control programme in future may not be exactly the same as before. The programme should emphasize, among others, evaluation of the effectiveness of care and services; ensuring the improvement of such effectiveness; pursuing research for new knowledge and new evidence; and advising on the new approaches to ensure a leprosy-free society. A leprosy-free society is our ultimate goal for the leprosy programme.

Actions on leprosy must be holistic, multisectoral, and multidisciplinary

On behalf of WHO, I would like to place on record our appreciation and thanks to the agencies, institutions and foundations for their most valuable support to WHO in its mission to help countries control leprosy.

My special thanks are extended, in particular, to The Nippon Foundation / Sasakawa Memorial Health Foundation for the indispensable assistance to the Global Leprosy Programme. Leprosy will continue to be on the agenda of WHO in the foreseeable future, and therefore, our combined wisdom and efforts will have to continue.

Our actions on leprosy must be holistic, multisectoral, and multidisciplinary, taking into account particularly the socio-cultural dimensions of the disease. And, like other diseases of the poor, poverty alleviation can play an important role in solving the leprosy problem in the community.

Let me also take this opportunity of informing the distinguished participants that, after several years of discussion, the Global Leprosy Programme has been relocated from WHO Headquarters in Geneva to the Regional Office in New Delhi. This is to ensure the efficiency and effectiveness of WHO services, by moving its global programme to where the need is the greatest. The leprosy burden in the South–East Asia Region is the highest; that is the reason why the Global Leprosy Programme has been relocated to this Region. We are now doing our best to prove that this is the right decision of WHO as far as leprosy in concerned.

Communicable diseases control

Communicable diseases continue to pose public health problems of high priority in this part of the world. We are faced with: new diseases, like HIV/AIDS, SARS and avian influenza; emerging diseases, like dengue and leptospirosis; and re-emerging diseases, like malaria and tuberculosis. These are in addition to other endemic infections of public health importance, such as meningitis, encephalitis, hepatitis and many more. Each year, our people also suffer from several ill-heath syndromes of unknown cause. During the past three decades, however, more than 30 new pathogens have been identified.

During the past three decades, more than 30 new pathogens have been identified

Combating communicable diseases has always been our challenge and this challenge will continue in the foreseeable future. During the 1990s, the communicable disease situation seemed to be getting worse in our Region. Severe outbreaks of several infectious conditions became more frequent. At the end of the decade, WHO's Regional Office for South-East Asia critically analysed those situations. We came to the conclusion that the deterioration of public health infrastructure had significantly contributed to such worsening phenomenon. We also concluded that, in such situations, strengthening public health workforce through appropriate education and training was urgently needed. Therefore, at the end of 1999, a Regional Conference on Public Health Education and Practice in South-East Asia Region in the 21st Century was organized in Calcutta. The Calcutta Declaration was developed as an output of the Conference. This Declaration has been used by WHO

Visit to National Institute of Communicable Diseases (NICD), NICD, Delhi, India, 25 April 2006.

as the basis for supporting the strengthening of public health workforce in the Region, with emphasis on education and training.

The Public Health Initiative, which is a strategy of high priority in WHO's work in the South-East Asia Region, aims to accelerate the pace of such strengthening. I am delighted to learn in this connection that the Master of Public Health Programme here is devoted to Field Epidemiology. This effort will contribute to the strengthening of public health workforce in the area of disease prevention and control.

The Field Epidemiology Training Programme was started in WHO's South-East Asia Region 26 years ago in a number of countries. This training programme has been a success story in Thailand. Unfortunately, in other countries, the programme did not thrive as expected. However, with the advent of emerging infectious diseases, like SARS and avian influenza, WHO is now trying to help revitalize the programme in several countries. Certainly, India is one of them, where WHO would like to see that the Field Epidemiology Training Progmamme is revived and is made fully operational. And here we are, at NICD, where both the short and long courses have been developed, and are being run for the health staff from other countries in the Region. This epidemiology course at NICD, I am sure, will greatly strengthen the professional status of Field Epidemiology.

Epidemiology is the backbone of any public health work

Epidemiology is the backbone of any public health work, including disease prevention and control. I am confident that all of us are aware that, to be effective, Field Epidemiology must be founded on the classic principle of epidemiology. The principle that is built on the recognition of the importance of interaction between the host agent, on the one hand, and environment on the other. Both the host and the agent have their own genetic endowments which influence their adaptation to the changing environment. Environment here is not only defined in the physical term; but also in social, cultural, economic and political terms.

The successful application of scientific breakthroughs in disease prevention and control has to take into account various environmental factors. Also, successful interventions in disease prevention and control are usually the outcome of sound programme development and management. Programme development and management should, therefore, be an important part of any public health professional course,

such as this one. This MPH programme is an excellent beginning for education of public health professionals. When we move along, and gain experience from running the course, there will be an opportunity to make the programme more and more perfect.

Furthermore, in many instances, multisectoral cooperation is necessary for disease prevention and control. Therefore, the opportunity for public health education, such as being provided by this course, should also be open to people from other sectors than health, such as agriculture and animal husbandry. WHO will be very happy to provide the required technical support in implementing and further improving the programme. The WHO sub-unit for Communicable Disease Surveillance and Response, located here at NICD, will ensure our full technical back-up to the course.

On this occasion, I would also like to wish the faculty staff members and students of the programme all the best in their pursuit to reduce the burden of communicable diseases in the South-East Asia Region. I look forward to the best contribution of the programme towards better health of our people, through prevention and control of diseases.

With these few words, I wish the Master of Public Health Degree Programme on Field Epidemiology of NICD all success.

Opportunistic pathogens in AIDS

The urgency to address the challenge of HIV opportunistic infections is widely acknowledged. I must congratulate the All India Institute of Medical Sciences (AIIMS) for organizing this important conference.

The conference will take us a long way in improving medical technology to fight these infections. With the increased access to antiretroviral treatment (ART), attention should now be drawn to the management of opportunistic infections.

Information on the pattern of these infections in our Region is increasing. Among 236,000 AIDS cases in Thailand, the three most common opportunistic infections are tuberculosis, pneumocystic pneumonia, and cryptococcal meningitis. Similar evidence is also observed from cross-sectional hospital surveys in India and Myanmar.

Allow me to draw your kind attention to the impact of the most common HIV opportunistic infections on public health gains. HIV is the major factor for the progression of a TB infection to become an active disease. South- East Asia accounts for 34% of the global tuberculosis burden, with 9 million new cases annually. Nearly 7 million of these cases are people living with HIV/AIDS. This is out of a total of 40 million world-wide. This makes our Region the second most affected, after Sub-Saharan Africa.

International Conference on Opportunistic Pathogens in AIDS & Third National Conference of Laboratory Medicine, AIIMS, New Delhi, India, 27 March 2006.

Regionally, four countries; namely, India, Indonesia, Myanmar and Thailand, account for 99% of people living with HIV/AIDS. These countries, at the same time, are among those with a high burden of tuberculosis.

The HIV prevalence among new TB cases amounts to 5.2% in India, 6.8% in Myanmar, and 8.7% in Thailand. Data from Thailand show that a number of these cases are among the younger age groups. The number of TB cases has also increased due to the high HIV prevalence in some districts of Thailand.

An increasing HIV prevalence could adversely impact on tuberculosis trends. This will happen, if we do not take stringent action to stop the spread of HIV infection.

In recent years, some progress has been made in this Region in promoting cooperation between the TB and HIV control programmes. India, for example, under the Global Fund for Fighting AIDS, TB and Malaria has carried out activities which include cross-referral from HIV testing and counselling to active TB screening. The referral is also undertaken from TB treatment centres to HIV case finding facilities.

An increasing HIV prevalence could adversely impact on tuberculosis trends

Important steps have been taken to address HIV care for TB patients who are HIV-sero-positive. HIV surveillance among new tuberculosis cases is being pilot tested in India.

Thailand is moving towards universal coverage with ART, which also includes all tuberculosis patients with HIV infection. In north-east Thailand, the proportion of TB patients accepting HIV testing increased from 33 to 58%t over two years. It was also shown that nearly 90% of those TB patients who were HIV-positive, were in need of (antiretroviral treatment) ART.

The morbidity and mortality of TB patients is reduced by 50%, when cotrimoxazole is given. Therefore, the WHO TB/HIV Strategic Plan recommends cotrimoxazole for all TB patients, who are HIV positive.

WHO also recommends that infants born to HIV-positive mothers receive cotrimoxazole for the prevention of pneumocystic pneumonia. During the early decade of the HIV epidemic, 60 to 80% of HIV-positive

adults developed this pneumonia, and up to 20% of them died. Mortality was much higher among infants. This happened in the US and Western Europe, when ART was not yet available.

With simple methods for diagnosis and treatment the most common HIV opportunistic infections are now being controlled. We must urgently build up the capacity of medical institutions for effective management of these infections.

With the occurrence of these opportunistic infections, the capacity of health laboratories for correct diagnosis also needs strengthening. The WHO Regional Office for South-East Asia (SEARO), brought together experts in the field to develop guidelines for laboratory work in this area. These guidelines were published in 2000, and subsequently updated. These are available through the SEARO website.

A "hands-on" training course on diagnosis of these infections has also been organized from time to time. The diagnosis of opportunistic infections is exclusively dependent on an efficient laboratory infrastructure. This is also true in the case of immunological monitoring of ART.

In 2004, WHO developed Guidelines on HIV Diagnosis and Monitoring of ART. These guidelines were revised last year. This is to keep pace with the evolving development in laboratory technology. The guidelines have been widely disseminated for use in all Member States.

Now, the National AIDS Research Institute in Pune, India, is being considered for designation as a WHO Collaborating Centre in this area. The centre will provide continuous support to countries in HIV diagnosis, monitoring of ART, and surveillance of drug resistance.

In conclusion, I would like to urge the distinguished participants to make optimal use of the knowledge gained so far in the fight against HIV-opportunistic infections. I would also urge that we pursue research for the development of tools for more effective management of HIV opportunistic infections.

We also have to devote more resources and efforts to further develop our laboratory medicine to ensure effective treatment of patients.

Dengue prevention and control

Dengue is a public health problem assuming increasing importance. Its outbreaks are now common in Asia and the Pacific. The epidemiological feature of dengue has been changing during the past several years. Generally, it is a disease of children under 15 years of age, in urban areas. Nowadays, dengue is increasingly reported in the older children and adults. And, it is spreading outward from urban to rural areas.

Over the past three decades, the incidence of dengue has been increasing in several parts of the world. As compared to the number of cases during the 1970s; now, nearly seven times more are reported.

It is estimated that 50 to 100 million cases of dengue occur annually

It is estimated that 50 to 100 million cases of dengue occur annually. Of these, nearly 25,000 are fatal. The death rates are high, if treatment is delayed or not proper. Appropriate case management by skilled health personnel can save lives dramatically. A vaccine for prevention of dengue is still in the process of development.

With improved case management, the overall fatality rate has shown a downward trend, from 2 in 1986 to 0.8% last year.

The outbreaks of dengue usually occur during the rainy season. However, due to changes in climatic conditions, this seasonal feature does not always follow the usual pattern. It is also believed that the disease causes substantial economic loss to the affected countries. In addition, its outbreaks can lead to a significant psychological impact on the community.

Meeting of Partners on Dengue Prevention and Control in Asia-Pacific, Chiang Mai, Thailand, 23-24 March 2006.

There are several risk factors involved in the outbreaks of dengue. Unplanned and uncontrolled urbanization can create problems in water supply and solid-waste disposal. This leads to an increase in breeding sites for the vector.

A weak public health infrastructure to control mosquitos is another important factor. The use of materials like plastic containers and tyres facilitate increased mosquito breeding.

Population movement within and among countries is considered to be another major cause of the spread of the virus. The vector mosquito can also travel long distances through modern transportation.

We are now revisiting our strategy for prevention and control of dengue. We will have to pay much more attention to multisectoral actions and community involvement in the control programme. These approaches have to be truly realized in operational terms.

Sectors other than health, such as public works and education, need to be really on board in vector control measures. In the outbreak-prone areas, epidemic preparedness and response must be in place, with the full involvement of people.

Surveillance and warning systems must be developed to ensure constant vigilance. Research, both clinical and operational, has to be built into the prevention and control programme.

Risk communication, through public information and education, is very important indeed. This communication must be continuous and sustained in the long term. This is an area that needs the full cooperation of the media.

Partnerships with all stakeholders, including NGOs, civil society and international agencies, are necessary.

Through a robust public health system, it is believed that we can ensure adequate political commitment, strong support from the public and sustainability of the control activities. Therefore, strengthening public health capacity of countries has to be the main component of the control programme.

This meeting will provide an opportunity to stakeholders to review the situation, and identify the remaining challenges. The meeting will examine the improved approaches to be used in prevention and control efforts. Not less important, the meeting will help further strengthen the required partnerships.

We will share our concerns regarding the seriousness of the disease. This common concern will further augment our determination and commitment in the fight against dengue.

I would like to take this opportunity to thank the Government of Japan for their generous support to the meeting. I thank the UN agencies, bilateral partners, foundations and others for their interest, and for sparing their valuable time to attend this meeting. I also thank the Royal Thai Government and concerned Thai officials for hosting this meeting.

Global leprosy programme

The primary purpose of the meeting is to deliberate on how best we can ensure our efficiency in the management of the Global Leprosy Programme. This is particularly the efficiency of communication between the Global Leprosy Programme and the Regional Programmes. This will take us a long way in being more effective in sustaining leprosy control activities in all endemic countries in the world.

Following the announcement by the Director-General in February 2005, the Global Leprosy Programme was relocated to this Regional Office. The WHO Regional Office for South-East Asia will do everything possible to ensure the efficient operation of the Global Programme.

It should be remembered that the Programme will continue to maintain its global mandate to serve all Regions of WHO, as required. We are happy to have with us Dr Vijay Kumar Pannikar, and Dr Myo Thet Htoon, the two international professional staff members of the programme.

This is another example in the history of the Organization of a global programme being relocated outside Geneva. In essence, this is a unique experiment which the Director-General and I, among many others, would like to see as another successful example. The example of moving global programmes closer to where the need is the greatest.

Inter-Regional Meeting of Global Leprosy Programme, WHO/SEARO,13-14 March 2006..

The implementation of the Leprosy Control Programme is now at the stage where the success of the elimination strategy has reduced the disease burden to very low levels. Also, there is a steady declining trend in new case detection. This has happened globally in the majority of Member States.

Most countries in the world have reached the elimination goal, while some others still need more time to accomplish their work. It is, therefore, important for us to review the past achievements and plan to tackle the remaining challenges.

The priority now is to support the national programmes in integrating leprosy control activities within their health systems, especially at the primary level. This way, in future, new cases will be able to easily access proper treatment and care at the nearest health facilities.

Most countries in the world have reached the elimination goal

Keeping this in mind, the leprosy control programmes have to focus, as priority activities, on sustaining gains achieved from the elimination efforts. At the same time, attempts will have to be made to further reduce the disease burden. This is especially so with regard to the improvement of quality of care; including the elimination of social stigma, and the promotion of human rights of the affected people.

It is a formidable challenge indeed, as the services will have to continue being fully in place as long as new cases keep appearing. Therefore, we need to enhance our efforts in resource mobilization for supporting the country programmes with a long-term vision. The Nippon/Sasakawa Memorial Health Foundation has provided the major back-up to WHO in this area since 1994. It is expected that they will continue doing the same, especially in the light of the new Strategy to sustain and further improve the services.

However, the level of funding from the Foundation is likely to be reduced in future. Therefore, we have no other option, than to expand our donor base. We have to work closely with all our partners in the spirit of mutual trust, respect and understanding. At the same time, we need to find ways to keep leprosy on the long-term agenda of WHO. We have to seek additional resource support from all concerned in WHO.

With the Director-General, I and my colleagues will do all we can to secure such support for the global programme. I trust that you will thoroughly discuss these and other issues during the course of this meeting.

Your deliberations and follow-up actions will certainly help improve our communication; and enhance the efficiency of our collaboration with all partners. These will ensure that we will be able to continue assisting endemic countries to effectively sustain leprosy control activities. We will be able to help ensure quality services to all people affected by leprosy, and its sequelae.

Noncommunicable Diseases and Mental Health

Legislative and policy actions for promoting health

It is increasingly becoming evident that all aspects of health development are multisectoral, requiring action from all sectors. And the Parliamentarians' Forum is an appropriate place to discuss the multisectorality of health issues in various areas of our concern. It is an important forum to reach consensus on the issues of priority public health problems. Therefore, the WHO Regional Office for South-East Asia has been convening the Regional Parliamentarians' Conference on topical subjects from time to time, to discuss multisectoral actions in specific areas of health concern.

To facilitate our deliberations, let me put the various issues involved in this connection in a proper perspective, within a broad framework. Before and immediately after the two World Wars, the world was busy fighting diseases. Efforts were devoted mostly to strengthening curative service systems for treatment of sick people, in particular. Public health programmes were developed and launched to control disease outbreaks and their spread, especially of communicable diseases. Until the World Health Assembly passed a resolution in 1977 calling for the attainment of health for all, health matters were virtually taken to be the sole responsibility of the health sector. It was only after 1977 that there was rapid change in the concept and approach to health development. Since then, this concept has been expanded significantly. So has been the case with health development framework and strategy.

Regional Conference of Parliamentarians on "Legislative and Policy Actions for Promoting Health", Bali, Indonesia, 8-9 October 2007.

Health is no longer the sole responsibility of the health sector. In fact, at both national and international levels, health has become a shared responsibility, calling for multisectoral and multiagency actions. All sectors, including health, have to work in coordination and cooperation to achieve national health development goals. Health development is considered a very important strategy for human resource development. Development sectors have therefore to recognize their individual health responsibilities. They have to take health concerns into account for developing and implementing their individual sectoral development programmes. They also have to ensure that their development activities do not affect the health of people adversely. In fact, they have to ensure that such activities contribute positively and provide health benefits to people in the community. Such responsibilities of various development sectors are termed the "healthy sectoral policies". These are policies under which respective sectors also have to invest.

Health is no longer the sole responsibility of the health sector

Nowadays, health issues are becoming increasingly public concerns, and these concerns are becoming the subjects for public debate. It is for this reason that health is increasingly acquiring a place on the political agenda for social and economic development. To provide good health to all citizens, regardless of their social and economic strata, is a goal for all governments worldwide. This is a goal that calls for equity and social justice in the provision of health care and services, and recognizes health as a fundamental human right.

In providing health care services to their populations, governments have to ensure universal coverage by reaching the unreached. The unreached are usually the poor, underserved, underprivileged, marginalized and vulnerable people. In this context, we have to work towards social control of health technology - technology that is socially and culturally appropriate and acceptable to all people in the community, and which is economically affordable by everyone in the community. Such a technology also includes information - information that enlightens the population to understand and recognize health risks, such as those related to the use of tobacco and alcohol.

Today, the world desires that all its people live longer and healthier. It wants all its people to attain a level of health that can permit them to

lead socially and economically satisfying and productive lives. However, to achieve this social goal, among other things, the burden of diseases must be reduced through primary prevention - prevention that is achieved through public health interventions, focusing on the management of health risks and health determinants. Furthermore, the world needs to use public health interventions for reducing poverty. Without health, there will be no economic productivity or progress. Thus, poverty will not be reduced. At the same time, the world also needs to use health as a bridge for peace. There will be no health if there is no peace. All these goals need multisectoral actions and healthy sectoral policies. All development sectors must invest in health if the ultimate goal of health for all is to be attained.

These issues must firstly be dealt with at the political and decision-making levels in countries. The parliamentarians' platform is an appropriate place for reviewing and discussing the issues involved as it is a place where we can push forward priority health concerns to be reflected on the national development agenda. For this, we need legislative actions, as well as national policy and commitment. For this conference, we have selected three areas of public health concern for our deliberations. These are: tobacco control; reducing harm from alcohol use; and health promotion. Health promotion is actually a cross-cutting area, involving many disciplines and sectors. However, for health promotion, WHO is presently focusing on diet, physical activity and lifestyle. As the secretariat members will be presenting the three subjects, I would not like to touch on their technical contents. At the same time, however, I would like to remind you that we need to concentrate our attention on legislative actions, policy options and innovative financing respectively, as far as the three areas mentioned above are concerned. I have briefly laid down a broad framework of health development that calls for actions by all sectors involved. The meeting may deliberate upon various aspects of those three specific areas of concern within this broad framework.

Preventive and social medicine

The Indian Association of Preventive and Social Medicine must be congratulated for organizing the Conference which will contribute significantly to the attainment of "India – Vision 2020: Strengthening Public Health – translating ideas into action". This is the theme of this Conference.

Taking into account the level of development in India today, the theme of the Conference is timely indeed. I am sure India can become a developed nation by the year 2020 as envisioned by His Excellency Dr A.P.J. Abdul Kalam, the President of India. Certainly, India has the potential, especially in the areas of know-how and human resources. India has the potential to move forward to that level of development by 2020. Only that health security for the entire population has to be the overriding concern in the process of national development.

It is universally accepted that health is at the centre of national socio-economic development

Good health for all citizens has to be ensured throughout such a process. The process that places special emphasis on health development in the community and at the grassroots level. The process that gives priority attention to the health of the poor, under-privileged, marginalized and vulnerable. The process that ensures reaching the unreached in all localities in the country.

It is universally accepted that health is at the centre of national socio-economic development; and health for all can lead to poverty reduction in any country. Therefore, good health for all people is an important prerequisite for the progress of any nation.

Thirty-fourth National Conference of Indian Association of Preventive and Social Medicine, AIIMS, New Delhi, 22 February 2007.

Balanced development in health care and services to ensure health for all people is the key issue in the development process today. This is especially in the developing world, where a large segment of the population is poor, underprivileged, deprived, marginalized and vulnerable.

Balanced development in this context means more efforts and more resources to be invested at community and grassroots levels. It is the development that gives adequate attention to primary care, focussing on health risks and health determinants. The development that attempts to keep people healthy through health promotion. The development that can prevent people from becoming sick through disease control and prevention. These are cost-effective interventions to reduce the disease burden in the community and in the entire population.

Primary prevention in health is one of the cost-effective strategies to reduce poverty in any community in developing countries. Since long, our health care and services have been concentrated in areas of secondary care. The care that places emphasis on treating the sick, especially in the medical institutions. Our health systems have therefore been overly oriented to curative and rehabilitative services; at the cost of promotive and preventive care.

To shift the emphasis from disease-based health services towards risk and determinant-based health systems, is really a formidable task. However, for our future efforts in health development for good health for all, this is a challenge indeed. As a prerequisite, we need to have the right workforce to engineer health systems towards the desired direction. To move efficiently along this course of primary prevention, we need a public health and community-based health workforce. The workforce that can effectively develop and implement public health programmes. The programmes that deal primarily with health promotion, disease control and prevention. The programmes that look after the health of the public anywhere.

We need the workforce that can mobilize people from all walks of life and involve them in the movement for health for all. The workforce that can ensure reaching the unreached everywhere.

Within this context, I would like to emphasize the critical role of community-based health workers. The workers who work at the grassroots, rendering services to the poor, underprivileged, marginalized and vulnerable. The workforce that can go anywhere in the country to reach the unreached. Community-based health workers are an important

group of people who can greatly contribute to the reduction of sickness; and the reduction of disease burden in the community.

To ensure balanced development in health care and services, we need to pay special attention to the public health workforce. The workforce that also includes community-based health workers. We need to reorient our strategy in the development of human resources for health to this new direction. To be able to do this successfully we need strong and sustained political commitment and support. As a prerequisite of this change, we need unwavering and long-term policy and strategy back-up at the national level.

In this connection, I am very happy to see that the Government of India has a clear policy direction to move towards public health and community health development. The Rural Health Mission and Public Health Foundation are a clear evidence of the Government's intention and commitment in this regard.

The Indian Association of Preventive and Social Medicine has an important role to play in this challenging task. The Association can help in strengthening and reorienting health infrastructures at the community and at the grassroots levels. This is to ensure health systems based on the primary health care approach.

The Department of Preventive and Social Medicine or Department of Community Health in medical colleges throughout the country can play a critical role in the production of public health professionals and practitioners. They can also contribute in a big way in the development of community-based health workers. With the current government health policy, Preventive and Social Medicine can make an important contribution to the achievement of India-Vision 2020.

WHO has placed emphasis in its collaboration with the Government of India on development in the public health area. We are also ready to collaborate with any organizations and institutions that are involved in the development of public health workforce and community-based health workers.

Once again, I sincerely congratulate the Indian Association of Preventive and Social Medicine for organizing this important National Conference. In the course of this meeting, I am sure, many new ideas will be generated. I am also confident that these useful ideas will be "translated into action" without delay.

Tobacco control

It is heartening that this Initiative has been launched to help high-burden countries in the fight against the tobacco epidemic. WHO is pleased to be a part of the Initiative. We also appreciate that of the 13 high-burden countries selected globally, four are from the South-East Asia Region.

As we are aware, nearly a quarter of the five million deaths annually from tobacco use worldwide occur in this Region. The Region bears a double burden because of the tobacco epidemic. The Region is both the largest producer; at the same time it is the largest consumer of tobacco products.

Nearly a quarter of the five million deaths annually from tobacco use worldwide occur in this Region

During the course of the meeting, we will be hearing about the tobacco control programmes in four countries of the South-East Asia Region. However, I should like to underline at this stage the complementary role of our Regional Tobacco Control Programme. The programme that aims to strengthen national capacity for the countries to be able to combat the tobacco epidemic effectively. Among others, this is being done through supporting Member States in the implementation of the WHO Framework Convention on Tobacco Control (FCTC).

The Bloomberg Global Initiative to Reduce Tobacco Use will certainly help expand the scope of our regional work in backstopping the public sector in Bangladesh, India, Indonesia and Thailand. The governments of these countries will be enabled to enhance their national tobacco control plans and to adopt and enforce control legislation.

Regional High-level Consultation on Bloomberg Global Initiative to Reduce Tobacco Use, WHO/SEARO, New Delhi, 22-23 February 2007.

They will be able to implement effectively the required policies and measures against tobacco use. These include, among others, the increased tobacco taxes, and a ban on tobacco advertising, as well as a ban on smoking in public places.

Except for one, all countries in the Region are now Party to the Global Treaty on Tobacco Control.

Collaboration among all partners at all levels is the key to the success of tobacco control programmes worldwide. As a partner in the Bloomberg Global Initiative to Reduce Tobacco Use, WHO in the South-East Asia Region will cooperate closely with other stakeholders, nationally and internationally. We will continue our efforts in contributing to the setting of international standards on tobacco control.

Our collaboration with the US Centers for Disease Control and Prevention on the Global Adult Tobacco Survey will be intensified. At the same time, we hope to work more closely with the World Lung Foundation. This is particularly in assessing the effectiveness of the implementation of tobacco control policies at the country level. Evidence from the assessment will be important for the improvement of tobacco control plans and programmes in countries.

The capacity to deal with the tobacco epidemic in most countries in the South-East Asia Region needs to be urgently strengthened. In their fight against this worldwide epidemic, the countries need support, in both expertise and funds. We, therefore, thank the Bloomberg Global Initiative to Reduce Tobacco Use for coming forward generously to help the high-burden countries. I wish that similar support could also be extended to other countries that have to pursue the same fight. The Regional Office and its partners are exploring means and ways to mobilize the required resources to support these countries.

To be able to assist countries effectively in their tobacco control activities, WHO capacity in the South-East Asia Region also needs strengthening. Nonetheless, with our combined efforts, I believe, we can progress decisively in implementing the tobacco control agenda in the Region.

The Regional activities under the Bloomberg Global Initiative to Reduce Tobacco Use will be reported to the forthcoming Regional Meeting of National Tobacco Control Managers to be held next month.

Sustainability of any programme is important to make a real impact. Sustainability can be ensured through strengthening of country capacity. I am sure this Initiative can contribute significantly to strengthening country capacity in tobacco control.

As we are aware, the Initiative is initially designed for two years in the South-East Asia Region. In the process of its implementation, country capacity strengthening will be particularly emphasized.

However, WHO and its partners need to think of future support to countries after two years. This is to ensure long-term sustainability of the achievements, until tobacco use is no longer a threat to public health.

At the same time, commitment and investment of concerned countries are important indeed in ensuring such a sustainability. We hope that the country participants will take back with them the conclusions and recommendations of the consultation. And we hope that they will initiate action accordingly in their respective countries without delay.

This consultation is another milestone for tobacco control in the South-East Asia Region. It should provide a unique opportunity for us to learn more about the Bloomberg Global Initiative to Reduce Tobacco Use. It is an opportunity for us to know its partners, and the benefits this Initiative can bring about for the national tobacco control efforts.

I am confident that this consultation will bring us closer in our collaboration in the fight against tobacco use. This is an excellent opportunity to share vision and ideas in order to stride forward in unison for effective tobacco control.

I believe, by the end of the day tomorrow, we will have chalked out a coordinated framework. The framework that can bring about effective implementation of planned activities within the domain of this Initiative in the South-East Asia Region.

Tobacco use has contributed to many serious health problems worldwide. We should spare no effort in fighting against it. Together, we can win this formidable health threat.

School health promotion

The schoolgoing age is a period of learning, acquisition of knowledge, and pursuit of information. It is also the time when attitudes, beliefs, values and practices of individuals are inculcated. These inculcations could be either positive or negative. At the same time, these are likely to influence the development and outcome of one's goals in life.

There is a global consensus that "learning" and "health" go hand-in-hand and that, the health status of a child has a direct impact on his or her educational achievements. Furthermore, in order to achieve both the health and education goals for young people, it has become critical to address also the health needs of teachers, parents and communities. These health needs include not only physical needs, but also mental and social needs. There is evidence that programmes on health–promoting schools contribute significantly to the "quality of life"; not only of students, but also of others in communities. The concept of health–promoting schools provides an opportunity for each school to listen to, and to take into account in its teaching and learning process, the views of learners, teachers and parents.

There is a global consensus that "learning" and "health" go hand-in-hand

Children are not yet equipped with accurate and optimum health information, and life–skills. Therefore, they will not be able to address effectively the various challenges they are likely to face as young people. These young people who will become adults tomorrow are the future of their nations. Therefore, the promotion and support of their growth and development should be made an integral part of a country's

Intercountry Meeting on School Health Promotion, Bangkok, Thailand, 12-15 December 2006.

workplan. Countries in the South–East Asia Region of WHO regard the schoolage population as a vital component of national development process. WHO is committed to lend unwavering support to the development of health-promoting schools, in order to enable them to achieve both educational and health objectives.

The principles of "health promotion" can also be applied in the development and implementation of a school health promotion programme. Some selected approaches in this regard include: (i) acknowledging health as a fundamental human right; (ii) securing equity and social justice for health for all; (iii) earmarking a balanced social responsibility for the private and public sectors; (iv) integrating health content and life-skills across curricula and disciplines, and (v) promoting the local cultural values and practices that are relevant to society. In this connection, I find the holding of this intercountry meeting quite timely.

WHO and other international agencies, including NGOs, have a long history of working closely together in the area of school health. The concept of health-promoting schools is not new to countries in our Region. I hope that together we will be able to formulate a clear policy; and enumerate a practical strategy for the development of school health programmes in countries of our Region. A comprehensive agenda for the meeting is now before us. The recommendations derived from our deliberations on various agenda items will certainly help improve the delivery of school health in the Region.

The WHO Regional Office for South-East Asia organized two major consultations on school health, in 1997 and 2000. Furthermore, a guide for implementing health–promoting schools was prepared and distributed to Member countries for their use in 2003. The Bangkok Charter for Health Promotion was endorsed at the Sixth Global Conference on Health Promotion in 2005. In addition, the WHO Executive Board and the WHO Regional Committee for South-East Asia have resolved to support the commitments contained in the Bangkok Charter. A policy and strategic framework that we are contemplating now will take us a long way towards the full realization of the concepts of school health promotion, which is an important component of health promotion in general. In the process of realizing such concepts, multidisciplinary and multisectoral involvement and actions are indeed necessary.

Young people in countries of the South-East Asia Region are facing several health and social challenges. Poverty; cultural values and beliefs; lifestyle changes; changes in food habits and changes in the information consumption pattern are, among many other factors, affecting the young people's ability to grow and develop.

These factors can result in: school dropouts; delinquency and law–breaking behaviour; early and unwanted pregnancies; abuse of alcohol, tobacco and drugs, and several other consequences. These social and health problems, will eventually become a burden on society; the burden that needs special services; the services that have to be financed by taxpayers' money. Such a scenario highlights the importance of school health interventions that seek to prevent these problems. It should also be underlined that the provision of these school health services cannot be the sole responsibility of the health sector. The way forward is to encourage all stakeholders, such as families; teachers; peers; communities and civil society groups, to get fully involved.

Young people in countries of the South-East Asia Region are facing several health and social challenges

In this connection, let me particularly emphasize the leading role of the Ministry of Education in the development and management of school health-promotion programmes. The Ministry of Health is one of the key players in providing technical support to such programme development and management, in collaboration with the Ministry of Education which knows best the needs of learners and teachers. And, learners and teachers are the cornerstone of education that leads to positive outcomes of societal change. In a way, the Ministry of Education is primarily responsible for this social change through the educational process. I am sure, WHO and other international agencies, both within and outside the UN system, are ready to provide full technical back-up to efforts of countries in this regard. In the course of this meeting, I also wish to see how we can clearly define our respective roles at both the national and international levels. This would enable our intentions and endeavours in pursuing school health promotion to be synchronized and made complementary to each other.

This would, in turn, ensure that our available resources, in terms of both expertise and finance, are utilized in the most efficient and effective manner, towards providing health and education to our young people.

Family and Community Health

Women's health and development

The subject assigned for my talk is "Women's Health and Development. The focus is on the role of women in development. As a prerequisite for women to play such a role effectively, they first have to enjoy a proper social status. And, they have to be healthy and properly educated.

These factors are closely inter-linked. And they are part and parcel of gender equity. If there had been gender equity, women would have enjoyed a higher social status, and be healthier and better educated. In such a situation, women would have been able to participate more effectively in social and economic development.

The development of women's health cannot be carried out as an independent programme

Within the context of gender equity, WHO has always exerted special efforts to promote the development of good health for all women. Some positive results have been achieved from this endeavour. Women's health indicators, as available, have improved. However, a lot more needs to be done to improve the health condition of women.

The development of women's health cannot be carried out as an independent programme, separate from others. It has to be pursued within the context of gender equity, which encompasses several social and economic dimensions. Gender equity has to be undertaken through a multisectoral and multidisciplinary approach.

There is evidence of improvement, as a part of the overall achievement in our attempts to improve the health of women. The

The Fourth Central Asia Medical Women Association Conference, Bangkok, Thailand, 14-16 June 2007.

average life expectancy of women in Asia Pacific had risen from 44 years during 1950-1955 to 70 during the period 2000-2005. Female mortality had dropped more than 40% since 1960 in most countries of this Region. This is according to the recent study of UNESCAP.

Some rather simple measures, like mobile clinics and emergency transport in remote areas, proved very helpful in reducing maternal deaths. However, maternal mortality in this part of the world is still unacceptably high. This is an issue of high priority for all concerned with development.

Still, about 60% of women in South-Asia have iron deficiency anaemia. Chronic energy deficiency is higher in females than males. And the nutritional status of women is always low compared to men. It is critical to enhance our efforts in the areas of nutrition and maternal health in organizing services for women. School lunch programmes for children and a nutrition package for pregnant women will help in a big way to improve women's health.

In many cases, women have difficulty in accessing health services. Women are often denied such access due to cultural beliefs and practices. And, it needs to be kept in mind, that women have, by nature, special health problems.

In many parts of the world, women have a heavier workload than men; yet, they consume fewer calories because of the practices that favour men. Measures to ensure equal rights of women to basic health services is crucial indeed. Healthy and educated women have a better opportunity to contribute effectively in the political arena.

While the literacy rates among women are rising, their political participation is also increasing. According to UNESCAP's recent study in the Asia Pacific, there had been a 50% increase in the number of women parliamentarians since 1997. Yet, in this Region, female enrolment in primary schools is still 26% lower than that of males.

It should be kept in mind in this connection that educating a woman can contribute to the education of an entire family.

Women are the key agents for change as far as health is concerned. Countries that have high female literacy have low infant mortality and

long life expectancy, and vice versa. Women tend to invest in children's health and education.

In general, women carry a higher family burden than men. About 80% of women in most parts of the world have decision-making responsibilities for health care in the family.

Women have a very important role to play in contributing to the achievement of the Millennium Development Goals.

It needs to be realized that female education is the best strategy that can lead ultimately to gender equity. A higher number of females in secondary education can lead to a higher proportion of women at the professional level, and vice versa.

It was found in the same UNESCAP study that barriers to employment for women cost the Asia Pacific Region US dollars 42 to 47 million annually.

In general, women carry a higher family burden than men

For effective contribution by women to economic development, a number of measures have to be in place. Among others, an attempt has to be made to reduce discrimination against women in employment. Harassment of women at the workplace has to be eliminated.

Fairness in wages and promotions is another aspect for ensuring women's opportunity to effectively contribute in economic terms. The contribution that can benefit both the country and the women themselves. Being economically better off themselves, women's health status will be improved.

As mentioned earlier, women's health has always been a priority concern of WHO. Realizing the multisectoral and multidisciplinary nature of this issue, WHO has been working closely with other stakeholders at the political level in advocating gender equity and women's health.

Gender-sensitive policies and gender-responsive actions have been promoted, especially in the development and implementation of national health programmes.

From time to time, the issue is discussed at the Regional Conference of Parliamentarians. Health Ministers have very often deliberated upon various challenges that can contribute to better health of women.

A number of studies have been launched by WHO to generate evidence on various aspects of gender and women's health. This evidence has been used for advocacy, and for the development of programmes that can contribute to better health of women. In our information system development, special attention is paid to disaggregation of data by sex.

WHO is also promoting the use of these disaggregated data in planning and management of health programmes in countries.

It is WHO's priority strategy to mainstream gender equity and women's health in all its programme areas. This is to ensure direct benefits to women from the services provided by those programmes.

In this strategy, particular emphasis is placed on certain areas, such as nutrition, maternal health, adolescent health, and communicable disease control.

Measures have also been taken to ensure the recruitment of more women to work as WHO staff members. And, we are promoting women to take high posts in WHO.

In the South-East Asia Region, women constitute more than 30% of its workforce. And women occupy 37% of the posts at director level. Yet, more needs to be done to ensure gender equity in WHO's workforce. And, we will continue our efforts in this direction.

The most recent World Health Assembly passed a resolution on integrating gender analysis and actions into the work of WHO. Among other areas concerned in this resolution, the WHO Director-General was requested to assess and address gender differences and inequality in planning, implementation, monitoring and evaluation of WHO's work.

We have achieved substantial gains in promoting women's health and women's participation in social and economic development. This is to ensure more effective contribution of the work of WHO to gender equity and women's health.

However, the gains are yet to be satisfactory. A lot more needs to be further pursued to ensure gender equity and good health for all women.

The key element in our strategy for this endeavour is political commitment. We will not be able to succeed as we wish in this mission, if political commitment is not forthcoming.

We have to work hard with parliamentarians, with several sectors and disciplines. And, very important, we have to work hard to overcome socio-cultural barriers, in order to uplift women's social status, educational level and health condition.

The beliefs and practices that lead to discrimination against women must be eliminated. In any circumstances, women must not be marginalized or excluded from the mainstream of social and economic development.

The beliefs and practices that lead to discrimination against women must be eliminated

To a large extent, men's attitudes and behaviours that are against women or are discriminating, must also be eliminated. All males are yet to respect females as their equals to enjoy the same social status and privilege.

As far as WHO is concerned, I can assure the distinguished participants, that we will continue to work closely with other players to ensure gender equity. We will do our best to promote good health and a better future for all women. So that they can be proud of getting involved effectively in the process of their national development.

Vaccine research

This is the first meeting of the Forum in the South-East Asia Region. This meeting is being held at a crucial period, when Asia is the focus of a potential global influenza pandemic – a pandemic that threatens millions of lives, and could possibly have a devastating impact on the global economy. What the world is waiting for anxiously is a vaccine to be available in time to avert the threat of the pandemic.

More than 40% of the global disease burden is accounted for by the South-East Asia Region. Consequently, vaccine-preventable diseases are our important regional concern. Therefore, the reduction of mortality and morbidity from these diseases in the Region will contribute significantly to the worldwide decrease of the burden due to vaccine-preventable diseases.

While the search for vaccines to combat new and emerging infectious diseases is an important pursuit, it is necessary that we find effective vaccines against some of the age-old scourges that continue to ravage humanity.

In this regard, I am happy to note that for the Global Vaccine Research Forum the need to find effective vaccines against tuberculosis, malaria and HIV/AIDS is a priority topic in all its meetings.

Despite all-out efforts, tuberculosis is responsible for nine million new cases and over two million deaths every year. Of these, three million

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The Seventh Global Vaccine Research Forum Meeting, Bangkok, Thailand, 3-5 December 2006: Opening Remarks.

new cases and more than half a million deaths occur in the South-East Asia Region alone. Similarly, 350 to 500 million cases of malaria occur globally every year with over a million deaths. While the battle against these ancient diseases continues, more recent public health challenges, such as HIV/AIDS are exacting an even more devastating toll on the world. An estimated 40.6 million people worldwide were living with HIV at the end of 2005, and over 3.1 million succumbed to the ravages of AIDS. Due to the sheer size of the population in Asia, the estimated number of people living with HIV, and those dying from AIDS in this continent are significant and are rising rapidly.

Last year, it was estimated that Asia had 1.1 million new cases with over 8.3 million living with HIV. AIDS claims over 500,000 lives every year. However, antimicrobials against these diseases have given us breathing space. But, the microbes have evolved faster than we could find new ways to overcome their resistance, or discover new antimicrobials. Therefore, the only lasting solution is to seek viable and effective vaccines against diseases of major public health concern.

AIDS claims over 500,000 lives every year

Today, there is new hope and renewed vigour in the field of vaccine development and immunization. This, in part, is due to the rapid development in technology and molecular sciences. It is also due to additional resources provided by charitable organizations, such as the Bill and Melinda Gates Foundation, and the formation of new global alliances, like the GAVI.

On behalf of WHO in the South-East Asia Region, I highly commend and sincerely thank the foundations, organizations and individuals who are bringing hope to the world's poor. I am happy to see that this year, a satellite symposium on Japanese Encephalitis or JE and dengue preceded the main meeting of the Forum. JE and dengue are major public health problems in many countries of the Asia-Pacific Region. I hope that the GAVI or some of the other development partners would support the endemic countries to introduce JE vaccination. It is now clear that immunization is the most effective and the only long-term and viable intervention to control JE. While JE remains primarily a disease of the rural poor, an urban menace, dengue, is affecting more and more cities across Asia. The rapid rise of mega cities and, unfortunately, the often poor civic infrastructures in these cities create a perfect environment for dengue to establish and flourish. In this context,

a vaccine against dengue would truly be a boon. And, it is my hope that the scientific community succeeds in finding one soon.

Several countries in this part of the world are major suppliers of vaccines for routine immunization. The South-East Asia Region has a great potential to participate, and to contribute to global research and development in vaccines.

I hope that this Forum will help focus attention on such a potential in the Region. Today, there is a wide divide in access to immunization between children in the poor and the rich countries. This divide can only be narrowed by investing in research and development for vaccines that are necessary for the developing world. Forums, such as this, are important to rectify the issue of divergence of global markets for vaccine supply, which has a significant impact on poor countries.

Sustainable Development and Healthy Environments

Emergency health actions

As all of us are aware, countries in this Region are more prone to natural disasters, especially cyclones, floods and earthquakes. We have observed that during the recent past, there have been more floods and more cyclones with greater severity. This might be contributed by climate change, which is an important international concern. Therefore, the Emergency Preparedness and Response (EPR) programme will continue to be crucially important in the foreseeable future.

Due to many reasons, more people will become vulnerable to the impacts of disasters, either natural or man-made. And the EPR programme will become increasingly important to ensure the health security of these vulnerable people.

We will continue doing our best in strengthening country capacity in EPR, keeping in mind the most difficult part of this effort. That is, to ensure effective coordination and cooperation among the concerned sectors and concerned agencies.

In the process, we have to keep in mind that health is only a part, even though a very important part, of EPR. Multisectoral coordination and cooperation is difficult, either within the national or international context.

While concentrating on the technical details of EPR, we may keep in mind that the implementation of these technical interventions will

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First Meeting of the Regional Technical Advisory Group for Emergency Health Actions, New Delhi, India, 20-22 December 2007.

have to be through multisectoral mechanisms. WHO is one of many stakeholders to ensure effective implementation of the EPR programme. Therefore, WHO has to strengthen its own capacity to work successfully in the multisectoral environment. I would like this Advisory Group to continue advising WHO on this important aspect; on how WHO can work better in such an environment.

Furthermore, WHO will have to help the country health sector in coordinating with other sectors during an emergency, especially in coordinating health inputs from international agencies. Often, WHO has to step out to directly coordinate health inputs from international agencies on behalf of the Government, especially in the countries with a weak infrastructure. To be effective, WHO needs competence and skills in this area – the area of coordination.

I would like to mention another important aspect – WHO is a technical agency. However, during an emergency, WHO may not be able to stay technical all the time. WHO may have to get involved in providing emergency health services, either public health-wise or medically.

Filling the service gap during an emergency becomes an unavoidable obligation for WHO. In this case, WHO also needs competence and skills in logistics and management. The competence and skills that are beyond what it needs for its technical function. WHO needs to orient itself to this requirement.

To be perfect in EPR is indeed utopian. However, we can become effective and helpful to countries during emergencies as much as they can expect from us. We will continue talking technically, while being aware of the reality and practicality on the ground. The ground that, in all cases, I may say, is different. We have to apply our technical interventions, keeping in mind those differences. Country focus and a country-specific approach become an important strategy for us in EPR work.

Environment and health

This meeting signifies a vital partnership to ensure a safe and healthy environment. Recent findings indicate that a quarter of the global burden of disease is due to environmental degradation. Every year, an estimated 6.6 million deaths in Asia are attributable to various health risks from the environment.

In the urban settings, where almost half of the world's population lives, civic amenities are unable to keep pace with the burgeoning population.

In the Asia-Pacific Region more than 20% of the population does not have access to safe water, and about 50% of this population has no access to sanitation facilities. Thousands of chemicals are circulating in the environment today. On the other hand, we are all aware of the extreme climatic changes, and its adverse health impact.

a quarter of the global burden of disease is due to environmental degradation

The complexity of relationships in health development among sectors, countries and agencies is clearly recognized. However, we have the potential and opportunities that augur well for intersectoral cooperation. The most conspicuous of these is the increased awareness among policy-makers of the need for multisectoral actions for health. Let us work together in a concerted manner to ensure a safe and healthy environment.

Ministerial Regional Forum on Environment and Health, Bangkok, Thailand, 8-9 August 2007.

Emergency preparedness and response

This Regional Consultation provides an opportunity for all of us to learn from the past, in order to be able to cope better in the future. This is particularly so in countries of the South-East Asia Region, where risks and hazards of various types are prevailing.

We have seen time and again that communities and nations have been able to cope with these events. Just a month ago, Indonesia witnessed a devastating earthquake in Yogyakarta. More than 6000 people died, over 20000 were injured, and 100000 to 600000 were displaced. In this event, two things stood out clearly. The first was that preparedness is vital. Joint preparations by the government and all concerned sectors with regard to the eruption of Mount Merapi helped to put in place important resources that were easily mobilized for the earthquake. Secondly, the lessons from the tsunami were demonstrated. A strong response by the government provided the desired direction to all humanitarian actors.

It is also worth mentioning that the operational guidelines developed during the tsunami helped in the emergency in Yogyakarta as well. A well-developed health system provides a strong base for an emergency response. The provincial health system of Yogyakarta is well resourced with health facilities and health professionals. The system that is in place can cope with the surge of patients. Assistance was mobilized from neighbouring provinces, and international support helped to augment what was already on the ground.

Regional Consultation on Emergency Preparedness and Response: from Lessons to Action, Bali, Indonesia, 27-29 June 2006.

We, in WHO, also learnt important lessons. We were able to better support the Ministry of Health in this emergency. We were able to coordinate better within the Organization and with partners. Our effectiveness and efficiency was demonstrated through prompt provision of necessary supplies and staff. It is heartening to note that we were able to respond quickly and effectively. Yet, there are still many emergencies that we have to face. We had a crisis in Nepal this year; the Timor-Leste civil conflict; and the floods in Northern Thailand. We can share the lessons learnt and apply them in the different contexts and circumstances. It is, therefore, important to revisit and discuss our experiences, with the view to derive the maximum gains from such lessons.

At this point, I would like to refer to the tsunami. It is exactly one and a half years since it struck six countries in the South-East Asia Region. It was one of the worst natural disasters in recent history. It caused unprecedented destruction; killing hundreds of thousands of people, and affecting a population of more than two million. The challenges were really enormous. There was no time to lose. We had to respond quickly and effectively, especially in the emergency phase.

At the same time, we had to work in a coordinated manner with all stakeholders. In such a difficult situation, WHO spared no efforts in supporting the affected countries. The very first attempt was to save lives and mitigate the suffering of the people. Because of the magnitude of the devastation, the tsunami emergency and recovery phase lasted for very long, that is, for one and a half years.

Now, it is time to focus more sharply on rehabilitation and reconstruction. Before we move on, we must reflect on what we have done well, and where we could have done better. This is with the view to make the best use of these lessons for the future.

At this meeting, we will review what has been done for the tsunami, and learn new lessons. We will also recapitulate the major directions and activities for rehabilitation and reconstruction. In the process, we can identify gaps and actions needed to enhance country capacity for emergency preparedness and response in the Region.

We have made good progress following the tsunami. We, together with countries: (i) Have set up disease surveillance systems; (ii)

Developed community mental health programmes; (iii) Strengthened emergency preparedness and response, and (iv) Improved the systems for management of wastes and water resources.

These are just a few examples. Psychosocial needs of the tsunami-affected people contributed to the changes in mental health legislation in Sri Lanka. Changes in the supply management system in Maldives were brought forth, mainly as a result of the response to the tsunami. In India, the government has improved its emergency coordination through a National Disaster Management Authority.

We cannot, however, become complacent as the tsunami revealed many gaps in our response. These were in the areas of policy, legislation, planning, human resources, operation and coordination. In almost all areas.

In many countries, there was no disaster management system in place, so response was delayed due to confusion about what needed to be done, and by whom. In some places, financial resources did not come through quickly, and therefore the response was held up. People with different skills and expertise were needed, but mobilizing them took time because there was no resource database.

The better prepared a country is, the more effective it can be in responding to any disasters

In many places, facilities collapsed because they were built without disaster-resistance in mind. Coordination among communities, districts, national governments, international agencies and nongovernmental organizations was not smooth. The global response was tremendous, but to be effective, it needed to be efficiently coordinated. The tsunami has demonstrated that the better prepared a country is, the more effective it can be in responding to any disasters.

We know that emergency preparedness is a part and parcel of national development. It is essential for governments to include it in their national development strategies and plans. This year, the World Health Assembly, once again, underlined the need to strengthen the capacity of Member States in emergency preparedness and response. Last year, the WHO Regional Committee for South-East Asia also provided direction on several key issues so that Member States can move forward rapidly in strengthening their national capacities for emergencies.

WHO has assisted countries in strengthening their capacities in the health sector. To this end, in November last year, we invited representatives from all our Member States in the Region to a meeting to discuss various related issues. This meeting then identified a number of key benchmarks that every country should aim to fulfil in mitigating disasters. These benchmarks include, among others: (i) A legal framework and functioning coordination mechanism; (ii) Disaster preparedness plans and standard operating procedures (SOPs); (iii) Community-based response and preparedness capacity; (iv) Risk identification and vulnerability assessment, and (v) Trained human resources; disaster-resistant health facilities and early warning systems.

Last month, when the earthquake struck Yogyakarta, we saw how important it was to meet these benchmarks. Indeed, the theme of this meeting is also to put together what we have learnt and how we can apply them in emergencies. Let us take them forward in the next three days as there is no end to learning. We need to keep ourselves constantly updated on all aspects of management of emergency. Let us keep the momentum moving towards better systems for emergency preparedness and response. This is with the view to ensuring that we will be able to cope with any emergencies in the most efficient and effective manner. Only then can we say that our efforts have not been in vain.

Management of heathcare waste

In October 2004, WHO launched a World Alliance for Patient Safety. This was in response to the World Health Assembly resolution on the subject. The Alliance is to help raise awareness and political commitment to the improvement of patient safety. This endeavour is expected to facilitate the development of policy and practices in this important area.

Healthcare facilities need to guarantee that hospital infections are prevented

The efforts towards safer healthcare are now becoming a worldwide movement. It is expected to bring significant benefits to patients in all corners of the world. A crucial element in ensuring patient safety is to provide a health promoting, hygienic and sanitized environment.

Healthcare facilities need to guarantee that hospital infections are prevented. WHO has given due importance to the sound management of wastes generated from healthcare activities.

Most of the estimated 1,000 metric tons of these wastes produced annually in this Region are not properly managed. The unsafe treatment of medical wastes poses a number of life-threatening risks. Those at risk are all patients, health personnel, waste handlers and the public in general.

Used syringes and transfusion tubes are collected by pickers, who recycle them back into the market. In some countries, this informal

Launching of the Distance Learning Certificate Course on Sound Management of healthcare waste by the Indira Gandhi National Open University (IGNOU) and WHO, IGNOU Campus, New Delhi, India, 10 March 2006.

sector represents approximately 3% of the total urban workforce. Most of the over one million people engaged in waste-picking in India are children.

Needle reuse and other unsafe injection practices are estimated to cause 1.3 million early deaths yearly. Healthcare workers are among the most at risk.

In this Region, prick injuries from contaminated sharps are estimated to cause about 200,000 cases of Hepatitis B; 85,000 of Hepatitis C; and 30,000 of HIV/AIDS annually.

The proportion of unsafe injections in the Region may reach upto 70% of all injections. These injections are mainly among those given for therapeutic purposes.

A UN Convention classifies healthcare waste as the second most hazardous, after nuclear waste

In many countries, there are still improper practices in the management of medical wastes. Inappropriate incineration may cause adverse health effects due to highly toxic fumes.

Not surprisingly, a UN Convention classifies healthcare waste as the second most hazardous, after nuclear waste. In accordance with the "polluter pays" principle, it is the waste generator who should be responsible for safe management of its discards. Therefore, the health sector is accountable for the healthcare waste it produces.

In response to the environmental concerns, WHO framed a new global policy on this matter in 2004. This was in keeping with the relevant international agreements, such as the Persistent Organic Pollutants Convention. This new policy promotes an integrated, and "complete cycle" approach in healthcare waste management. The policy emphasizes the need for environmentally-sound treatment and disposal methods. Only incineration is seen as the last resort.

WHO also prepared guidelines on appropriate systems for safe management of solid waste from health facilities. These guidelines take into consideration local conditions, as well as occupational and environmental safety. Some of the pathways proposed for the treatment of infectious sharps were taken from the survey in India in 2002.

To promote the implementation of the new policy, WHO has published a number of documents on various related subjects. These include success stories of sound healthcare waste management. Guidelines for infection control in healthcare facilities were also developed.

As we all know, advocacy alone will not be enough to ensure implementation of the policy. It is capacity building at all levels that we need to focus our attention on.

In Aceh, Indonesia, a year after the 2004 tsunami, a Healthcare Waste Management project was launched. After an assessment, it became clear that training of health staff was a top priority. This was in addition to providing appropriate supplies to health facilities. Early this year, 20 training courses were conducted for different types of health workers.

Nearly 350 of these workers in Indonesia have now been trained in management of healthcare waste. Before the end of the project in May, another 150 health staff members will be trained.

Some of the experts who were involved in the development of the training programme in Indonesia have also contributed to the course that is being launched by IGNOU today. The IGNOU Distance Learning Certificate Course on Sound Management of Healthcare Waste has set the ground for India and its neighbouring countries. This will help countries to address the issue of healthcare waste in a more technically sound manner. I would like to congratulate the Vice-Chancellor and all the IGNOU staff members involved in this important endeavour.

Health Systems Development

Primary health care towards health for all

The theme of the Conference, "New Frontiers in Primary Health Care: Role of Nursing and Other Professions", is timely indeed. The topic for my talk today is "Primary Health Care towards Health for All". In this connection, all of us must be aware that this year is the 30th anniversary of the Alma-Ata Declaration on Primary Health Care. This Declaration was the outcome of the International Conference on Primary Health Care held at Alma-Ata, USSR, in September 1978. The Conference defined how "Health for All" could be achieved.

A year prior to the Alma-Ata Conference, the 30th World Health Assembly in 1977 decided, among other things, that the social target of governments and WHO in the coming decades should be the attainment, by all the citizens of the world by the year 2000, of a level of health that will permit them to lead a socially and economically productive life. As far as health is concerned, this decision of the World Health Assembly was really historical. The decision has been popularly known as "Health for All by the year 2000".

The overriding consideration underlying this decision was the increasing magnitude and severity of the world health problems, and the global concern with the unjust and unbalanced distribution of health resources throughout the world. The decision was based also on the consideration that health is a basic human right and a worldwide social

International Conference on Primary Health Care, "Primary Health Care towards Health for All", Chiang Mai University, Thailand, 4 February 2008.

goal. And that health is essential to the satisfaction of basic human needs, and to the quality of life of all people.

According to the Alma-Ata Conference, Primary Health Care (PHC) is the key to achieving an acceptable level of health for all people throughout the world. PHC is an integral part of social development in the spirit of equity and social justice. PHC is the key to health for all, anywhere and world-wide.

Even though, as we all know, the health for all goal could not be attained by the year 2000 as envisaged, health for all still exists as an aspirational goal, towards which all countries should strive in their health development efforts. And PHC is still considered to be the key to reaching this social goal of health for all.

By its definition, PHC is essential health care made universally accessible to all individuals and families in the community. It is the care that is socially acceptable and economically affordable to the people in the community through their full participation and involvement. It is the care that the community and country can afford.

PHC forms an integral part of the country's health system, of which it is the nucleus. And it forms an important a part of the overall social and economic development of the community. This definition of PHC was developed 30 years ago at the Alma-Ata Conference.

PHC principles and concepts have been applied by all countries in the world during the past three decades. The application of these principles and concepts has been carried out in a manner that suit the local socio-cultural, economic and political contexts of the countries concerned. These principles and concepts of PHC have been adapted, applied and extended progressively in their implementation to satisfy health needs and requirements of the individual countries; in both the short and long term.

In reality, many different forms and modalities of PHC exist throughout the world. The lessons from the use of those forms and

modalities of PHC can be usefully learned today. The lessons that can lead us a long way in our quest for health for all.

It has been evident that the proper application of PHC concepts has far-reaching consequences. The consequences that not only penetrate throughout the health sector, but also impact other aspects of social and economic development, particularly at community level.

During the past 30 years, PHC has significantly contributed to the positive changes in the ways that health systems in countries are developed and managed. And certainly, it has contributed significantly to the positive impact on health of people around the world.

During the past 30 years, more than 30 newly emerging pathogens have been identified

During the past three decades, there have been a lot of changes in all spheres around the world; socially, economically, politically and technologically. There have been environmental, ecological, demographic and epidemiological transitions. These changes and transitions come with formidable health challenges. The challenges that have significantly affected the ways we plan and manage health programmes for health development today.

During the past 30 years, due to ecological and biological changes, more than 30 newly emerging pathogens have been identified that can cause human diseases.

Now, we are facing several health threats that are due to global warming, climate change. At the same time, many of our health concerns today come with globalization. With globalization, the world's people live in a global village more and more; they share among themselves almost everything, including health and disease.

Technological advancement, particularly in information and communication, contributes positively and negatively to health. These are only part of all the challenges that we are facing now, and will be facing in the foreseeable future.

If we are to achieve Health For All, we need the strategies and technological tools that can help us tackle today's health problems in a

much more efficient and effective manner. And these strategies and tools have to be suitable for implementation through PHC.

The social goal of health for all is yet to be realized anywhere in the world. We will continue using PHC as the key approach to ensure good health for all people.

After 30 years, it is now time, however, to revisit PHC, its principles and operational modalities. This is with the view to ensuring continued appropriateness in the application, utilization, improvement and innovation of these principles and modalities of PHC.

We must recognize that adoption of the decision on HFA/2000 by the World Health Assembly in 1977 has contributed to profound changes in the concepts and scope of health development. Two years after the inception of the HFA movement, the UN General Assembly adopted a resolution underpinning health as an integral part of overall development. This was an important augmentation of the expansion of health development concepts and scope. Since then, health has gone much beyond the health sector.

The social goal of health for all is yet to be realized

All concerned sectors, including health, have to be intimate partners; to be collectively responsible for the development of health for all people. To be successful, health development for HFA needs multisectoral actions; the actions by all sectors, working together coordinatedly and cooperatively.

At the same time, individual sectors must also be cognisant of health concerns, when formulating and implementing their respective development programmes. This is what we call "healthy public policies"; whereby concerned sectors act individually to protect and promote the health of the population. It is the sectoral responsibilities and commitments to health of people in their individual development efforts.

To ensure health for all people, multisectoral involvement in health development, either individually or collectively, is critically essential indeed. This is "health for all by all sectors".

Furthermore, to achieve health for all, all people must be for health.

Through the PHC approach, people of all walks of life must be effectively educated and empowered, in order for them to get fully involved in health matters; individually or through community participation.

Community participation is the process, whereby individuals and families assume responsibility for their own individual health and welfare. This is also the responsibility for the health and welfare of the whole population in the community. In the process of this participation, the implementation of PHC should lead to a long-term sustainable development and self-reliance in health of the community.

To achieve health for all, all people must be for health

Health development is the key strategy for human resource development; the development of human potentials and power. A healthy population can contribute optimally to the national goal of social and economic development. And such development, in turn, provides the additional resources and social energy that can further facilitate health development that leads to health for all.

Primary health care is basically delivered by community health workers or other workers of community-based organizations. PHC has also been delivered by community volunteers of various categories, including health volunteers. These workers and volunteers have varying levels of skills. It is important to keep in mind however that, whatever the levels of their skills, these workers and volunteers must understand the health needs and the ground reality of the community they serve. Their services must be socially acceptable and economically affordable to all people in the community.

At the same time, these workers and volunteers must also be trained to be effective "change agents". The agents that can contribute effectively to the change in people's health knowledge, attitudes, behaviours and practices. The change that can help ensure effective involvement of all people in the community in solving their own individual health problems; and the health problems of the entire community. This is "Health for All" by "All for Health". The ultimate realization of "Health for All" will come from "All for Health".

I would also like to mention in this connection that even much before the HFA/PHC global movement, Thailand started training public health nurses. Many of these nurses have been assigned to work in and with the community, along with other professions. They have been closely involved in community health work and in primary health care development since the beginning.

Now, there has been a changing paradigm in public health, and a change in the way people perceive HFA/PHC. It may be timely to revisit the role of public health nurses. If this has never been done.

The role of Public Health Nurses may need reorientation in the light of the changing scenario in the health field, particularly in public health. It is without doubt that nurses who are performing health work right in and with the community continue their excellent contribution to health development at that level. And these nurses continue to form an important part of the team for overall community development.

PHC cannot function in isolation. PHC needs support from other levels of the health system; primary, secondary and tertiary care; this is for referral of sick people, when needed. This is necessary in order to ensure that people in the community will have an opportunity to enjoy the benefits of valid and useful technical knowhow; the benefits in the advancement of health sciences and technology, and for the people to enjoy the benefits from technologies which are too complex, or too costly to be applied through PHC in the community, especially in the rural areas.

The government must ensure the development of efficiently functioning health care referral systems. Moreover, community workers in health need support from professionally skilled people for guidance, education, training, and other technical back up. And certainly, the services through PHC need the security of logistic and financial backstopping, which have to come from the community itself or from the upper level.

Now, more and more, health issues become public concerns, and health concerns become subjects for public debate. Health issues are

reflected more and more on the political agenda for social and economic development. Health is becoming more prominent on the national development agenda. At the same time, we are also aware that poverty is the root cause of ill-health.

Attempts have been made to reduce poverty in the community through public health interventions. This is the place where PHC has to come in a big way to ensure healthy population and healthy workforce everywhere. Healthy population means more productive outputs from the efforts of economic development, in particular.

Furthermore, an attempt has also been made to pursue health activities as a bridge for peace. There will be no health if there is no peace. At the other angle however, health can effectively contribute to peace, especially through humanitarian health actions. It has been evident in many cases whereby public health interventions can be used as a powerful tool to create peaceful periods; such as immunization activities. This is another unconventional role for PHC.

PHC is an effective tool for public health interventions; the interventions that can ensure reaching the unreached; ensure equity and social justice in health. The Health for All goal will not be attained if the unreached are still unreached everywhere.

As we all are aware, we are yet to attain the social goal of health for all. There are many intractable constraints and obstacles impeding our progress towards this social goal of Health for All. Important among these are poverty, insecurity and lack of peace. These are determinants of ill-health. They are indeed a formidable challenge.

In this perspective, we may need to understand more clearly the global context of health for all movement. We pursue the social goal of health for all to fulfil the Constitutional objective of the World Health Organization. That objective is "the attainment by all people of the highest possible level of health".

With this in view, while pursuing the HFA goal, we cannot expect all people to be free of any disease or infirmity. The goal of health for all

is actually calling for "a socially and economically productive life for all people", not for all people to be without any suffering or ailments; physically, mentally or socially. The people may still continue harbouring diseases; silent or with a certain degree of declared morbidity. Very importantly in this context, the people should have longevity of life that is healthy enough to permit them to live independently and be socio-economically productive.

At this important international conference on PHC, let us once again reaffirm our unwavering determination and commitment to the attainment of the social goal of health for all through the PHC approach. Let us continue pursuing our untiring efforts to advocate for more political will, and for decisive political commitment to the development of national public health systems based on primary health care.

Role of Primary health care

It is indeed my special privilege to deliver this speech at this Commemoration Ceremony of 30 years of Health for All and Primary Health care.

Health issues in the next three decades will largely be an extension of health challenges of today, challenges that are posed mainly by demographic, environmental, ecological and behavioural changes that lead to a multitude of health risks.

The risks of chronic noncommunicable diseases will cause more illnesses, disabilities and deaths, especially in the developing world. At the same time, communicable diseases will continue to be a cause for concern with more new and emerging infectious pathogens. Outbreaks of communicable diseases with significant economic implication will continue to draw the attention of the public and policy-makers.

With the advancement in medical sciences, people will live longer due to the availability of better technological tools that are mainly used to prevent death and prolong life. This situation may lead to more disability and dependency; and requires preventive strategy in the years to come.

As far as health information is concerned, we will continue using morbidity and mortality data; as the main proxy indicators for indirect measurement of the level of health of the population. The efforts to identify practical parameters for directly measuring health will also gain

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Prince Mahidol Award Conference 2008, Commemoration Ceremony of 30 Years of Health For All / Primary Health Care On "Health in the Next Three Decades and the Role of PHC", Bangkok, Thailand, 1 February 2008.

momentum. By then, we will have more concrete evidence to develop an effective strategy for promoting positive health. While fighting illnesses and disabilities through curative and rehabilitative care, we will also have to invest more in primary prevention. This is the strategy that needs to be implemented through public health interventions with specific focus on health promotion and disease prevention.

We understand that Health for All can be achieved through the primary health care (PHC) approach. And we have observed that PHC has significantly produced a positive impact on the health of the people around the world during the past 30 years. PHC has profoundly influenced the ways in which national health policies and strategies are developed and implemented. The reform of health systems in many countries has also been undertaken on the basis of the Health for All (HFA) principle and the PHC concept. PHC has become an indispensable component of the public health system; and functions as a system that calls for equity and social justice in health.

PHC has become an indispensable component of the public health system

PHC promotes health as one of the fundamental rights of every human being. It ensures the availability of essential health care for the entire population in the community. PHC helps ensure that such care reaches the unreached everywhere, rural or urban. The special emphasis in the provision of PHC services is on the poor, underserved, underprivileged, marginalized and the vulnerable. The interventions to achieve HFA through PHC depend more and more on social measures that need to be implemented through multidisciplinary and multisectoral actions. Such actions involve a wide range of stakeholders in community, governmental and nongovernmental, civil society and other social organizations.

One of the ultimate objectives of PHC is to achieve HFA through All for Health. People of all walks of life need to be educated and empowered. This is in order for them to be able to contribute effectively to the development of their own health, of the health of their entire community and society. PHC workers have a critical role to play in the process of this education and empowerment. Health for all calls for a socially and economically productive life for all people. It is a social goal that can be achieved through the integration of social measures with technological interventions.

We must also keep in mind that effective PHC needs support from other levels of the health system for primary, secondary and tertiary care. It needs back-up support from educational and training institutions for building a trained PHC workforce.

The PHC concept was conceived 30 years ago. During this period the world has changed enormously in all spheres - demographic, environmental, social and economic. The health scenarios and profiles in all countries have also undergone palpable change. PHC needs to be revisited to meet the new challenges and fulfil emerging expectations in health development over the next three decades. Recognizing the importance of this transition after 30 years of PHC, WHO has been supporting a series of international gatherings and platforms where past experiences with PHC is reviewed and a course for its evolved role in the future charted out.

Effective PHC needs support from other levels of the health system

We are pursuing this endeavour to ensure the effectiveness of PHC in tackling current and future health threats such as climate change. We will use the PHC approach on a large scale to ensure health security in all communities around the world; and, we will use the PHC approach to ensure reaching the MDGs by the year 2015.

This Prince Mahidol Award Conference is one of the series. We, at this meeting, have reviewed various aspects of PHC, its past achievements and current challenges. We have made a series of recommendations on policies and actions for achieving a functioning PHC approach for HFA. Certainly, these recommendations will significantly contribute to the global efforts in revitalizing PHC.

Role of education in rational use of medicines

All of us agree that medicines are really important for our life. At the same time, we agree that irrational use of medicines is very prevalent and posing a serious public health problem. Medicines are used by many people inappropriately; either as overuse, underuse or unnecessary use, when not indicated. The problem has led to an enormous loss. In economic terms, the global estimate of this loss is about US$ 120 billion annually. This is a really unacceptable situation.

It is easy to ask people to use medicines rationally or appropriately. However, it is very difficult for people to decide on such rationality or appropriateness. Certainly, when people get sick, there is somebody to help take the decision on how to get well, and, in many cases, offer advice on the use of medicines. They are usually the health-care providers. Often, people can get help from their own peers in making such a decision.

Health-care providers actually play a key role in influencing the ways people use medicines. Attempts have been made in the past to promote this role of health-care providers to ensure that medicines are properly used. However, it is evident that only this approach is not adequate to help people get the right medicines in the right doses that are used for the correct length of time. To be able to make an appropriate decision on the use of medicines, the people themselves need to be equipped with the relevant knowledge and know-how.

Regional Meeting on Role of Education in Rational Use of Medicines, Bangkok, Thailand, 12-14 December 2007.

If we have to get better results from our efforts in promoting the rational use of medicines in the community, then the people themselves must be empowered to look after their own health more effectively. Therefore, educating people and consumers extensively on a large scale becomes imperative. This education should be extended from the community to the general population, and to the public at large and not only to the current clients of health-care facilities. And such education should start at an early age, and should be integrated into the educational system from the primary to the college level.

The rational use of medicines needs full awareness and strong advocacy at the policy- and decision-making levels in countries. In order to succeed in this formidable task, it is necessary to gain a complete political understanding, strong political will and unwavering political commitment. Issues relating to irrational use of medicines are very complex and complicated indeed. These involve a wide range of behavioural, psychosocial and economic parameters, which have to be taken into serious consideration when such education is planned. This is why we have invited to this meeting participants with widely differing backgrounds – but people who can make a difference.

The rational use of medicines needs full awareness and strong advocacy

In fact, these are the people, without whose participation it will not be possible to implement this important initiative successfully. These people are teachers, women's representatives, NGOs, consumer groups; they are in addition to doctors, other medical personnel and government representatives.

The ethical dimension, which is extremely important, must be integrated into and inculcated in this educational process. Among other things it should be made clear to all that to prescribe a more expensive medicine, when an equally effective and cheaper one is available, may be considered unethical. While accepting that medicines are important for people's health, the people must be made to understand at the same time that medicines form only one component of a range of interventions needed to stay healthy.

In order to remain in good health, people must be educated and encouraged to do other things than taking medicines. This can be achieved particularly through the regular and adequate practices for

health promotion and disease prevention; practices that generally do not require medicines. To stay healthy means, among other things, to have less need for medicines for curative purposes. This situation can lead to better and more informed decisions on the use of medicines.

Not less important, the people must be made to clearly understand the undesired side-effects of taking certain medicines, either in short- or long-term use. And they must always be told and convinced not to take any medicines unnecessarily. They must be told that, if they take many medicines without appropriate advice, one drug may interact with another to induce undesirable side-effects; or even decrease or increase the effect of one medicine to the detriment of the patient. This type of education of the people, similar to public education in general, is really a difficult task.

Many factors influence the level of success in promoting the rational use of medicines. These include, the level of education of people; strategy and approach to ensure effective educational process; body of knowledge and know-how to be imparted to people; and policy commitment and support at the national level.

As far as the level of education of people is concerned, our efforts should be directed towards functional literacy; whereby people are empowered to take care of their own health, even though they may not be able to read or write. Taking care of one's own health also includes the ability to make appropriate decisions on the use of medicines. We have to choose the right strategy and approach to ensure an efficient and effective process of education. We need to have resource centres for pooling bodies of knowledge and know-how for use as the content of the educational message. Certainly, we have to work closely with policy-makers at the national level to gain adequate political will, commitment and back-up support.

Rational use of medicines is a long-standing issue. Advancement in pharmaceutical sciences has enormously contributed to the positive impact on health. At the same time, it also leads directly or indirectly to an inappropriate use of medicines, and to the unnecessary use of more expensive medicines. This situation usually comes along with the undesirable aspects of promotion of the pharmaceutical products. We

should try in every possible way to control and prevent the unwanted impact of this technological advancement.

We understand that there are several population groups that need to be covered in our efforts to promote the rational use of medicines. In this exercise, we should pay special attention to the education of all people; people who may or may not be clients of health-care facilities. We believe that people themselves, if properly informed, can help in a big way in improving the rational use of medicines. It is really a daunting task, but is very challenging indeed. Being responsible for the health of the public, which is a fundamental human right; we have to work closely together to ensure that consumers are adequately informed on all aspects of this issue.

In pushing forward this important educational strategy to improve the appropriate use of medicines, we have to work with all stakeholders; the public and private sectors; governmental and nongovernmental organizations; civil society; and the communities themselves. To fulfil the purpose of this task, actions of several sectors and disciplines need to be extensively mobilized. This formidable challenge really requires unstinted determination and commitment of all concerned. WHO is ready to provide support, as much as it can, to help ensure efficient coordination and cooperation among all stakeholders.

Community-based health workers

Next year will be the 30th anniversary of the Alma-Ata Declaration on primary health care. It is time therefore to revisit the community-based health workforce - the workforce that has been the cornerstone of the primary health care movement since the beginning. This workforce consists of community health workers or CHWs of various categories, as well as community health volunteers or CHVs. These are the people who have contributed considerably to equity in health care at the grassroots level.

At this meeting, we are lucky to have Dr Mahler and Dr Amorn with us. To me, Dr Mahler is the father of the Health for All and Primary Health Care movements. At least, among my generation, when we think or talk of HFA/PHC, we first think of Dr Mahler. Dr Amorn has been the prime mover of primary health care development in Thailand, as well as in the South-East Asia Region. He is the one who brought the concept of Basic Minimum Needs to the Eastern Mediterranean Region, which later evolved as Basic Development Needs there.

Through proper development and deployment, CHWs and CHVs can help their governments considerably in moving forward on the long path towards realization of health care for all. This is especially true for the rural and difficult-to-reach areas. CHWs and CHVs are developed to become integral parts of the community. With their unstinted dedication and commitment, they can go to all corners of the community

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Regional Meeting on Revisiting Community-based Health Workers and Community Health Volunteers, Chiang Mai, Thailand, 3-5 October 2007.

to reach the unreached. They can also reach the poor, underserved and the underprivileged. As part of a long and difficult process, CHWs and CHVs contribute very substantially to their respective governments' efforts to realize the health-for-all goal. They are the vanguards in implementation of the primary health care approach, which is the key to the attainment of HFA. Due to their social and cultural affinity with people in the community, they can render health care which is acceptable to all people. In this respect, they are the effective "change agents" who help ensure involvement of people from all walks of life in health matters at both the community and grassroots levels.

Both, CHWs and CHVs have a better understanding of the health needs of people in the community. And both respect such needs of the poor, underserved and underprivileged better. Rural people depend a lot on CHWs and CHVs for health matters. A reduction in the burden of diseases would lead to reduction in poverty. Therefore, we have to prevent diseases from occurring. We can do this especially through primary prevention, focusing primarily on health risks and health determinants with proper development and training. Both CHWs and CHVs can contribute greatly to this preventive intervention. These are the people who can go right to the community to carry out health promotion and disease prevention activities. Moreover, their work can cover the entire population in the community, regardless of the socioeconomic status of individuals. However, in order to be effective, CHWs and CHVs need support. They cannot work in a vacuum. They need referral systems for sending sick people from the community to higher levels of care; primary, secondary and tertiary. They also need institutional support for their education and training throughout their careers in order to sustain their competence and skills. Furthermore, they need professional backstopping in planning, implementing and monitoring their activities to ensure efficiency and effectiveness of their work. Indeed, government policy and operational back-up are indispensable for effective development and deployment of CHWs and CHVs. To motivate them to work dedicatedly, these categories of health workers need to have a clear future, and a clear career ladder to move forward and upwards.

Since the inception of PHC nearly 30 years ago, things have changed significantly with regard to the health concept and operational

modalities of health development. As far as the health of the community is concerned, there has been an evolution of ideas from village health volunteers to more diverse models of community participation and involvement. There are many settings with a variety of health needs that require different forms of teamwork for community actions to address local health challenges - challenges that require great efforts of CHWs and CHVs to tackle health problems at the grass-roots level. Equity and social justice in health have to be the key features of development of CHWs and CHVs.

Community health actions require the combined force of both health workers in government systems and the community members themselves. For this approach to be productive, community health actions need capacity-building; capacity-building through interactive learning processes, with in-built research and development. The need for sustained community-based funds to ensure financial viability for such development is indispensable. For this strategy to be effective, it is important to build leadership of health personnel and health professionals at all levels to promote, support and catalyse the required actions. Multidisciplinary and multisectoral partnerships are the key to sustainable development of CHWs and CHVs. Such a strategy must lead to a change in social values to create self-responsibility, self-reliance, self-discipline and partnerships for health for all at the community level. In this context, it should also be understood that development of a community health workforce, including CHWs and CHVs, is not only good for the poor countries, but also for the well-off countries.

I hope you would gain valuable experience from the meeting that you can apply in your pursuit towards good health for all people through the primary health care approach. Let us pay a tribute to CHWs and CHVs for their hard work in communities, in the remote and difficult-to-reach rural areas.

Let us commit ourselves to actions that can lead to a betterment of these dedicated people, for these are the people who contribute considerably to health improvement of the population, especially the poor, underserved, underprivileged, marginalized and vulnerable.

Public health policy and action

It is a great honour to deliver the inaugural address at the third meeting of the South-East Asia Public Health Education Institutions Network (SEAPHEIN). I thank the Government of Rajasthan for allowing us to hold this important meeting in the State. I thank all participants for sparing their valuable time to come to share their experiences. I am very pleased to see many prominent public health figures in the Region gathered here. I also notice that we have colleagues from outside the South-East Asia Region from Japan, Viet Nam, Lao PDR and Pakistan. Public health has no boundaries. I specially welcome them to join the network activities. And I would like to see more coming from outside the Region.

Public health has no boundaries

The theme of the meeting, "Moving SEAPHEIN to Influence Public Health Policy and Action" is indeed encouraging and timely. For many reasons, it is time for us to revisit public health of countries in this part of the world. This is with a view to strengthening our public health systems and public health infrastructure.

This revisit should be done with unwavering conviction and commitment to "good health for all people, through the implementation of primary health care approach". This is to be done in the spirit of equity and social justice in health care; recognizing health as a fundamental right of everyone.

The Third Annual Meeting of South-East Asia Public Health Education Institutions Network (SEAPHEIN), Jaipur, Rajasthan, 25-28 September 2007.

While the basic philosophy and principle of public health may still be valid today, its concept and approach may need reorientation, in order to catch up with today's changing health scenario.

The framework for health development has significantly expanded during the last three decades. Governments worldwide have been striving for their citizens to live longer and healthier lives. They would like to see all their peoples lead a socially and economically productive life.

Among others, governments would also like to pursue health development with the following aims: to reduce the burden of diseases, communicable and noncommunicable, by shifting the emphasis of health care and services to promotive and preventive interventions; the governments would like to reduce health care expenditure to ensure cost-efficiency and cost-effectiveness in the use of available resources for providing health services; and the governments would like to reduce poverty, through the implementation of public health programmes, that benefit particularly the underserved and underprivileged. They would like to see health at the centre of overall development, nationally and internationally. And they would like to use health as a bridge for peace everywhere. There will be no health, if there is no peace.

Health has always been identified as a critical area in human resource development

Health has always been identified as a critical area in human resource development. Health increases human potential to contribute effectively to social and economic development.

To achieve these strategic objectives, the governments need to ensure: equitable access to health care and services by all people; reaching the unreached, who are usually poor and underserved; promotion of healthy lifestyles in the entire population; prevention of disease and illness as the key strategy in public health interventions. And, very importantly, in the process, they have to ensure long-term sustainable development and self-reliance in health in their own countries. Only those long-term sustainabilities can help countries move upward in their development efforts.

To reiterate, as far as health is concerned, the governments have to focus priority attention to primary prevention, and maintenance of good health for all, as the key strategy in their health development. To achieve these objectives countries need capability and capacity in public health interventions.

The countries need robust public health systems; the countries need a strong public health infrastructure. The countries need managerial capability to be able to develop and implement public health programmes effectively.

What do we mean by public health programmes? Public health programmes are the programmes that: need to be community- and population-based; serving the entire population. The programmes that focus their interventions on health risks and health determinants; the programmes that need to be ecologically and environmentally sound in their development and implementation; the programmes that must be developed within the socio-economic, cultural and political context of the country; the programmes that must be implemented through multidisciplinary and multisectoral approaches; the programmes that ensure health for all and all for health, whereby people of all walks of life are involved in health matters; and the programmes that pay special attention to the poor, underprivileged, underserved, marginalized, and vulnerable.

One of the strategic functions of public health is to provide full support to comprehensive community-based health development. The development that needs to be pursued through the primary health care approach; whereby community health workers of various categories and community health volunteers play a key role. We have to provide all possible support to these dedicated people; who can effectively serve the poor, who can reach the unreached.

In today's health scenario, there are many challenges that public health professionals have to face. Among the long list is climate change; climate change is coming from many development activities worldwide: but with a profound health impact; internationally and locally.

We are facing emerging and re-emerging diseases, many of which are without known origins; but all these diseases create a health emergency that require special and prompt public health actions. We are facing a double burden of diseases that need our special attention to primary prevention, health promotion and disease prevention. We are facing infectious diseases with no respect for national borders; their spread requires vigorous enforcement of International Health Regulations, to ensure international health security.

Coming in a big way with globalization is liberalization of international trade agreements, which significantly impact the planning and management of national health care services.

There is also rapid advancement in science and technology that have profoundly impacted the planning and management of health care and services for the entire population, including the development of the required human resources for such care and services. These are some of the current challenges in health development that we have to face squarely.

In the health scene, health issues are increasingly becoming public concerns; these concerns, in turn, become the subjects for public debate. And, these health concerns have been increasingly reflected on political agendas for social and economic development in countries.

In this perspective, health has gone much beyond the health sector. This is an important indication that effective health development really needs "public health interventions" that call for multisectoral actions, and for "healthy sectoral policies and commitments". These sectoral policies and commitments come from the sense of responsibility for people's health of each development sector.

Health issues are increasingly becoming public concerns

Public health interventions, to be really effective, have to be managed much beyond the traditional institutional boundaries. We have to go much beyond the traditional sectors and disciplines that we have got used to. And, we have to convince sectors other than health to commit themselves to their own health responsibilities. This is the foundation of "healthy sectoral policies and commitments"; which are not less important than "multisectoral actions for health".

A lot needs to be done in strengthening public health systems and public health infrastructure in our countries. We need a multipronged strategy and approach. And we need a lot of efforts and resources to implement such a strategy and approach. However, at this stage, let us focus our priority attention to the development and strengthening of public health workforce. The workforce that can take us a long way in strengthening public health systems and public health infrastructure.

Let us do this first through appropriate education and training in public health. Under our Public Health Initiative initiated in the WHO

South-East Asia Region in 2004, we have been supporting Member States in the development and implementation of public health education and training programmes.

WHO is also supporting the functioning of SEAPHEIN, which was also launched in 2004. This WHO support to SEAPHEIN will certainly continue in the foreseeable future.

WHO would like to see SEAPHEIN as a sustainable platform for countries in this part of the world to help each other in their pursuit to strengthen public health. We together, countries and WHO, will have to make a difference; this is as far as public health services for a healthier and wealthier population are concerned.

The countries need to have many more competent and dedicated public health professionals, public health specialists and public health practitioners. We need a critical mass of these people.

I am very glad to see that this meeting of SEAPHEIN will deliberate upon a number of important subjects that are relevant to our work under the Public Health Initiative. These include "Changing SEAPHEIN to Respond to the Challenge of Globalization"; and "Changing SEAPHEIN to Respond to the Challenge of Current Concepts of Public Health". Also, the meeting will discuss "Innovations in Teaching/Learning Methodology".

In this specific area of our concern may I suggest the meeting to examine carefully the need for reforms in public health education and training in a broader perspective. Believe me, this important area of public health really needs reform. We may not be able to afford any longer the continuation of traditional ways of doing things; when things around us are constantly changing.

This reform, as suggested, may include the three main areas, i.e. 1. Reform in the educational institutional structure and settings; where and how to organize such structure and settings to ensure their proper place in the national health systems, in the light of the changing concept and approach in public health. 2. Reform in the curricula and programmes for education and training of public health professionals, public health specialists and public health practitioners; what should be the best ways to develop such curricula and programmes; and what

should be their best contents. 3. Reform in teaching/learning processes, how to ensure in such processes the best ways to motivate and help students to effectively develop, among other important elements, their conceptual as well as their practical skills.

I am sure, with advancement in technology, especially information and communication, we can go a long way in such a reform process.

Changes in public health are dynamic, constant and certainly predictable in many cases; therefore, reform in public health in general and in education in particular is really needed. Otherwise, we will lag far behind in our health development, and our people will suffer unnecessarily.

With our capacity, know-how and knowledge of our own epidemiological, socio-cultural, economic and political context, we must be brave enough to think and act "outside the box". We have to create "leadership role models" in public health for our younger generations. If we don't do it, who will do it for us?

We are all here with the same objective. That objective is to find the best ways and means to strengthen public health systems and public health infrastructures in our countries. This is in order to ensure the most effective way to develop the health of all our people; to ensure that our people will live longer, be healthier, and wealthier. It is really "a noble task" in human resource development; the development of "human potential" to serve countries more productively in both social and economic terms.

Finally, let me wish you "all the best" and "all success" in your pursuit of this "noble task". The task that can contribute in a considerable way to the overall development of mankind; nationally and internationally.

Public health education

I would like to congratulate the Indian Council of Medical Research and the Postgraduate Institute of Medical Education and Research, Chandigarh, for their foresight in establishing this and other Schools of Public Health. These steps mark yet another milestone in improving and further developing public health education and research in India.

All of us agree that our public health systems need to be strengthened. And for this, we need strong public health education and research. Therefore, this and other such Schools of Public Health will contribute significantly to education and research in modern public health in India.

The principle of classic public health is valid even today

The principle of classic public health is valid even today. However, due to environmental, demographic, ecological and societal changes, we are presently facing new challenges in public health. Global warming with its profound implication on health; emergence of new diseases like SARS and avian influenza; re-emerging diseases like tuberculosis and malaria, and the double burden of communicable diseases and non-communicable diseases, coupled with rapid globalization and liberalization of international trade, call for new public health strategies and approaches. Therefore, public health systems need to be critically reviewed. The short educational courses that this institute has already embarked on are important. These will form the basis for development of courses at the masters and higher-degree levels. Subjects of

First Meeting of the Governing Board of Indian Council of Medical Research School of Public Health, Chandigarh, India, 27 July 2007.

epidemiology, health management and health promotion are among the core disciplines of public health. The policy and strategic guidance of this distinguished Governing Board will go a long way in enabling this and other schools of public health to contribute to the strengthening of public health systems and infrastructures in India.

One may ask as to why public health systems and infrastructures need to be strengthened. At the same time, we must accept that in this part of the world, public health has never been given adequate attention. Our public health infrastructures have never been appropriately developed to tackle the health challenges of the entire population. That is part of the reason why we have faced frequent outbreaks of communicable diseases, like dengue fever, chikungunya, malaria and many more. In fact, diseases once under control have re-emerged, like tuberculosis. And we are facing imminent devastation from new infectious agents like avian influenza. At the same time, we are yet to effectively tackle the unrelenting spread of HIV/AIDS. These and many more such diseases need public health interventions for their effective prevention and control. The aim to attain health for all can be achieved through reaching the unreached in order to ensure equity and social justice in access to and utilization of quality health care and services. It is here that public health measures and interventions become imperative indeed.

Health for all will not be achieved without public health interventions

Health for all will not be achieved without public health interventions through the primary health care approach. In this connection, it must be realized that community-based health workforce constitutes the backbone of the efforts to attain health for all. Community-based health workforce includes all types of community health workers and community health volunteers. These people are also another category of public health practitioners who serve the population at community and grassroots levels. Community-based health workforce needs particular attention in its development and strengthening through institutional support - the support that comes from various education and research institutions, including schools of public health. And, the support from public health professionals and public health specialists produced by these schools of public health.

Furthermore, in today's health development, we are emphasizing the reduction of disease burden. This is in addition to just prolonging

life by preventing death and disability through institutional care and services. Reducing the disease burden can be effectively achieved only through primary prevention - prevention that focuses on health risks and determinants and which needs public health measures aimed at health promotion and disease prevention. Reduction of the disease burden can also lead to poverty reduction, especially at family and community levels. With strong institutional back-up support, public health can base its work primarily in family, community and the entire population. For public health interventions to be effective, the back-up support of education and research institutions is really indispensable. And to be effective, public health work in this context must link with the higher levels of care: primary, secondary and tertiary, through functional referral systems. Furthermore, public health interventions should be developed and implemented in the context of local ecological, environmental and epidemiological factors.

Public health work is multidisciplinary and multisectoral

A public health system is part and parcel of a country's governance. The concrete foundation of Public Health should therefore be built within the country's socioeconomic, cultural and political framework. Public health work is multidisciplinary and multisectoral in nature. Therefore, we need to keep in mind that it will not be possible for the health sector alone to successfully pursue the ultimate purpose of public health - to reach the unreached everywhere for the attainment of the goal of health equity and social justice, and to ensure that health becomes a fundamental right of everyone. This is how we can reach the goal of health for all, through the efforts of all people, all disciplines and all sectors. Public health measures will have to ensure the involvement of citizens from all walks of life in health development at various levels - personal, family, community and national. Moreover, public health interventions have to pay special attention to care and services for special population groups, particularly those who are poor, underserved, underprivileged, marginalized and vulnerable.

The subject of public health is not new to us. Public health systems and infrastructures have been in place for a long time in this country. Therefore, the strategy to strengthen public health in India has to start from what exists. Since India is a very big country but with very few public health institutions, there is a need to have more. This is the justification for establishing a number of schools of public health in

India, including this one. The world has changed a lot during the recent decades. Approaches to health development have also undergone a change. Moreover, changes are taking place in various aspects of health situations. Therefore, in order for public health to be relevant to today's health development, the measures and interventions involved have to be critically reviewed and reoriented. We have to revisit our public health approaches to ensure their efficiency and effectiveness in today's health situations.

Teaching of, and research in, public health at various institutions will have to play a leading role in moving towards modern public health. This is how we can meet today's health needs of the population at all levels, everywhere. In the process of such development, effective coordination and cooperation among concerned institutions must be ensured. We really need a strong network of public health institutions in India. At the same time, we have to campaign for greater interest, attention and commitment from governments, at both the Central and state levels. Without the government's firm will and commitment it will not be easy to move forward towards strong public health systems for the country. In addition, we should bear in mind that whatever efforts we put in today for strengthening public health infrastructures will help us achieve sustainable development in the long term. In this context, therefore, what we are doing must be institutionalized, and what is achieved from our development efforts must be sustained as part of national systems. This is one of our challenges in this very important exercise.

The WHO South-East Asia Region has always accorded high priority to public health education, practice and research. In this regard, I would like to mention that a Regional Conference on Public Health Education in the South-East Asia Region in the 21st Century was held in Calcutta in 1999, which led to the Calcutta Declaration. The Declaration has been used as the basis for WHO to support Member States in the Region in their efforts to strengthen public health. In 2004, the Public Health Initiative was launched by the WHO Regional Office for South-East Asia with the view to accelerate the development and strengthening of public health education and research in the Region. As a result, a network of South-East Asia Public Health Education Institutions was formed. The primary purpose of the network is to

promote cooperation in public health education, training and research among concerned and related institutions, not only in the South-East Asia Region, but in other regions of WHO as well. The network which meets annually will be holding its next meeting at the Indian Institute of Health Management Research in Jaipur in September this year. I hope that all schools of public health in India will attend the meeting and join the network.

As I said, WHO, in the South-East Asia Region, accords high priority to supporting the development and strengthening of public health in Member States. We, in WHO therefore, look forward to a close and productive working relationship with all schools of public health in India. I am sure with unwavering determination and commitment of the Indian Council of Medical Research and Postgraduate Institute of Medical Education and Research, Chandigarh, all schools of public health in India will steadily grow into full-fledged institutions for public health education and research, to serve not only this country, but also the international community.

Finally, I wish the distinguished Board Members all success in their noble tasks in the area of public health, and in their efforts to strengthen public health education, training and research in India. We, in WHO, look forward with optimism to the day when schools of public health in India can contribute productively to the attainment of health for all in the country.

University of public health

We have every reason to believe that future achievements in health development depend on strong public health systems and a robust public health infrastructure.

Changes around us, nationally and internationally, are posing formidable health challenges. These challenges need effective public health interventions to be overcome. Among others, the important health challenges that we are facing today include: Emerging and re-emerging diseases, both communicable and noncommunicable; health consequences from global warming, which are worsening by the day; increasing health emergencies due to disasters, natural and man-made; health emergencies due to disease outbreaks with increasing frequency and severity; unrelenting spread of HIV/AIDS, with no effective solution in sight, and not the least important, the impact on public health of international trade liberalization, which seems to have no easy solution at the moment.

The new global health development strategy has moved steadily towards primary prevention

At the same time, the new global health development strategy has moved steadily towards primary prevention. This is with the aim to reduce disease burden, and ultimately to also reduce poverty in the community. Health interventions are now focusing, more and more, on determinants and risks, and, therefore, the focus of health development is being geared towards health promotion and disease prevention.

The aim of health development today is moving in the following directions: Promoting optimal growth and development for everyone;

Inauguration of University of Public Health, Yangon, Myanmar, 16 July 2007.

maintaining good health for all at all time, and promoting healthy longevity of life, which is socially and economically productive.

People will continue to fall sick, and they will need effective and affordable treatment in medical facilities. Today, increasingly, health issues are becoming public concerns. These concerns then become the subjects for public debate at both the national and international levels. And, more and more, health concerns are highlighted in political agendas for social and economic development.

We need to urgently strengthen our public health systems and infrastructure. This is in order for us to be able to face today's health challenges very squarely, and for us to be able to tackle health problems in the most efficient and effective manner. I am very pleased that this University of Public Health is being inaugurated. The University will certainly contribute very significantly to the development of the public health workforce in Myanmar. This is the first, but most important, step in strengthening public health systems in the country. With a competent and vibrant public health workforce, other aspects of the public health infrastructure will surely be improved.

The University will be a centre of excellence in public health that will serve the national interest in the development and promotion of health for all people. These include: the development that promotes equity and social justice in health care and services; the development that ensures reaching the unreached everywhere; the development that promotes the use of community resources and assets for local health care; and the development that promotes social control of health technology; the technology that is appropriate to the local specific situation; socially, culturally and economically.

The PHC approach is an important public health tool to ensure the attainment of health for all, whereby all people can lead socially and economically productive lives. PHC must be accorded the right place in our public health systems, and, the promotion of PHC must be carried out within the public health context.

At the same time, public health interventions and services that we are striving for must be: designed to serve the entire population in rural and urban communities;interventions that are ecologically,

epidemiologically and environmentally based; interventions and services that are developed within the local socio-cultural and economic and political framework; interventions and services that are designed for implementation through multidisciplinary and multisectoral approaches; interventions and services that promote "health for all through all for health;" which can be realized through educational processes to empower the entire population, and the interventions and services that pay special attention to the poor, underserved, underprivileged, marginalized and vulnerable.

Community health work is the backbone of health development for the entire population

These are some thoughts, among others, which may be useful for consideration in the further development of this University of Public Health. I am certain that the University will become an indispensable institution to provide crucial back-up support to health development for all people in Myanmar. This certainly includes the role of the University in the development of community health work, which is among many other functions of the University. Community health work is the backbone of health development for the entire population in any community. It is the health work that is performed primarily by community health workers of various categories and community health volunteers. These people are an important part of the public health workforce, and they are in addition to public health professionals and experts. Public health professionals and experts are those who provide institutional and referral support to community health work. They, public health professionals and experts, are to provide crucial back-up support to health work at the grassroots levels.

This University of Public Health will have an overriding responsibility for the development and strengthening of these professionals and experts, so that they can contribute effectively, among others, to the development of community health workers and community health volunteers. The University can also help in a big way in the strengthening of referral systems by providing technical back-up. In this connection, we have to keep in mind that community health work cannot go the whole distance alone. Referral facilities for primary, secondary and tertiary care are important for effective community health work.

WHO will continue providing unwavering support to the next phase of development of this University of Public Health. In addition, the University can benefit from inter-institutional information exchange through the South-East Asia Public Health Education Institution Network (SEAPHEIN), and inter-institutional cooperation with related institutions in other countries of the Region.

We are living in an interconnected, interlinked and interdependent world, wherein global citizens share almost everything, including health risks. Work of this University of Public Health will, in future, surely transcend national boundaries. The decision to establish this University is indeed an important milestone in the history of health development in Myanmar. It is really a noble decision by the Government, as far as the health of the people of Myanmar is concerned. I sincerely congratulate the Government of Myanmar for this crucial move.

As part of the overall framework to strengthen the public health system in this country, I once again, on behalf of WHO in the South-East Asia Region, pledge our unstinted commitment to supporting the next steps in the development of the University of Public Health in Myanmar. And I promise to collaborate closely with the University in forging ahead towards the ultimate goal of securing health for all in the country.

Public-Private mix

I appreciate that the subject of "Public and Private Mix" has been revisited. The subject has been universally discussed within the context of health care financing for many years. Now, it is being dealt with in relation to health care for the urban poor.

There is no formula for public and private mix. It depends on local specific situations and circumstances. Let me, therefore, focus on health care for the urban poor.

Governments alone may not be able to shoulder the total responsibility for delivering health services to the entire population. The private sector is already engaged in rendering such services on their own initiative, with their own resources. It is in the best interests of the government to build a solid partnership with the private sector, in order to ensure complementarity of services by the two sectors.

This comes with the recognition that this private sector has done commendable work in the field of health for a long time. Particular appreciation in this connection should be extended to voluntary or non-profit organizations. These organizations pursue their mission on humanitarian and charitable grounds. We should give our highest commendation and grant sincere recognition to good deeds executed by them since time immemorial.

At another level, provision of health services has been viewed from a different perspective as an industry wherefrom benefits can accrue.

International Workshop on Public and Private Mix: A public health fix, Naresaan University, Pitsanulok, Thailand, 20-22 June 2007.

Therefore, providing health services becomes a means for earning income by some people.

This should be acceptable if such an earning is within a reasonable limit, with adequate social and ethical considerations and responsibility.

At the same time, it is widely perceived that private medical practice is mostly confined to curative care. The care offered by such practitioners is, in many cases, beyond the reach of the poor. This is due mainly to economic reasons; the inability to pay for the same. This gap can be partly tackled through an effective partnership between the public and the private sectors, between government and private enterprises.

This aspect has been demonstrated by the Universal Health Care Coverage that is being pursued in Thailand. It has been found very useful in ensuring accessibility to health services by the poor. Ensuring equitable access to quality and affordable health services by the urban poor is challenging indeed. The government and nongovernment sectors must accept this challenge together in a complementary fashion.

It is widely perceived that private medical practice is mostly confined to curative care

While the private sector concentrates its services on curative care, the public sector has to pay more attention to promotive and preventive services; services that can help protect the poor from being sick unnecessarily from preventable disease or illness. Very importantly, the government has to take total responsibility of caring for the poor when they fall sick. Due to various reasons these people, though based in urban areas, are often unreached by the health-care providers.

Regarding the "theme" of the workshop, I would like to draw attention to another aspect of the issue under consideration. It is an area that does not seem to be dealt with directly in the workshop programme.

It is primary health care, which all of us know well. Primary health care, if properly designed and planned to suit urban settings, can take us a long way towards ensuring that these unreached, underpriviledged and marginalized section of society are reached in spite of their poverty.

The principle and concept of the primary health care approach originated with the Alma Ata Declaration 30 years ago. This approach was perceived as a means whereby health for all people could be attained.

Its principle and concept, even though 30 years old, are still relevant to the current health situation everywhere in the world, if it is designed and implemented to suit local situations, socio-culturally and economically.

Primary health care can help bridge the gap in the health sector between the "haves" and "have nots". This gap is also created on account of a lack of financial resources, among others. Through affordable and socially acceptable technology, primary health care can ensure equity and social justice in health. It promotes social control of health technology, the knowledge and know-how of which have to be demystified for use by people in general.

Primary health care must be initiated and promoted by the government to benefit not only the poor but everyone in society. Certainly, the rich can greatly benefit from primary health care. In this context, we must understand that primary health care is quality care to ensure the protection of the least privileged population in a broad social and cultural context.

It is affordable and dependable health care at the community and grassroots levels in both rural and urban areas. It is to help keep people healthy; not to let them fall sick easily. Its main intervention is through educational and supportive processes. However, people will still be taken ill, a situation wherein curative services need to be provided.

In many cases, treatment and case management are also used as an important means for the prevention of disease. This is the situation when a hierarchy of care from the primary to tertiary levels is needed as a referral supportive system, the system which is to enhance the effectiveness of primary health care. And, this is the area where the private sector normally comes in.

The cost of health services at the higher levels of care, in most cases, is not affordable by the poor. The government should have a scheme whereby health services at the higher levels of care for the poor can be financially ensured. At the same time, the private sector should participate actively in the promotion of primary health care in the urban areas. This contribution from the private sector should be considered a noble mission, the goal of which is social welfare. It will

contribute to the good health of the entire population, with particular attention to the poor.

If primary health care is successfully developed, the issue of a financial gap in health services for the poor will certainly be alleviated. Through this approach, care at the individual and family levels will play an important role in ensuring good health for all. The success of this process depends, to a large extent, on the efforts of the community-based health workforce: the workforce that includes particularly all types of community health workers and health volunteers. These people are really important for the successful development of primary health care in both rural and urban areas. Very importantly, they can reach the unreached anywhere. They are agents for change for better health in the community through the educational process.

If properly developed, they are a wonderful 'role model' as far as health is concerned. But the community-based health workforce has been rather neglected in matters concerning its development, training, deployment and maintenance. The governments should revisit this group of people in a big way if equity and social justice in health care are to be assured. This is with the view to make them a tangibly strong force in pushing health development forward in this century.

Providing health services should be considered as humanitarian work

Certainly, to be effective, the community-based health workforce needs back-up support from various institutions, including higher levels of medical facilities, medical and public health schools, schools of nursing, and many other health-related training institutes. Health services are to protect the health of the population; these services are also to ensure the longevity of people through the prevention of death and disability.

Health services deal with human beings. Providing health services should, therefore be considered as humanitarian work. Those who are involved in such activities must be philanthropists, one way or the other. And, therefore, they should be fully equipped with the desired ethical and moral considerations and responsibility. They have to accept the basic principle that health is a fundamental right of everyone.

Health-care providers should fully respect this right of the consumers, the patients. Ethics in public health and medical practice

must be promoted and fostered in all practitioners. Public health and medical services should not be viewed primarily as commodities but as efforts to serve humanity.

If practitioners perform their tasks with reasonable ethical consideration, harmful medical practices due to negligence and/or carelessness will be eliminated. Culmination of ethics in medical practitioners is a challenging task. In such a practice, there are in many cases other considerations, which are often seen as the overriding interest. This situation sometimes compels medical practitioners to sideline the humanitarian perspectives as key considerations..

Training in ethics for medical practitioners is indeed vital in view of these realities. This is part of a long-term vision which will need sustained efforts to be fulfilled. For now, we will have to pursue better ethical practices through motivation and persuasion. All medical practitioners know their medical ethics well, I am sure. It is in practising these ethics that is the over-riding issue.

In order to ensure that medical practitioners put ethics into practice, we have to be patient enough to work hard without expecting immediate results and success. Training of medical students is important indeed and teachers must be "role models" for students to emulate.

Now, the development of "role models" becomes another challenge. Do we have enough role models for young people to emulate? We have to work towards developing such role models who meet the expectations. Those who are involved in teaching or coaching public health and medical practitioners should act as role models first and foremost.

We are firmly focused on and dedicated to pursuing our mission towards quality and affordable health care for the urban poor. Care that is safe and helpful to the cause of improving the health of the people. Urban primary health care is highlighted in this connection. This is with the belief that this approach can help ensure quality and affordable health care for the urban poor, provided primary health care is not allowed to degenerate in scope or content.

Primary health care can help reduce the dependency of the poor on curative services at the higher levels of care. And, thereby, to be

relieved of the financial burden due to costly medical care. In a realistically positive sense, primary health care can make all people healthier. Governments should pay more attention to, and invest enough resources in the development of, urban primary health care. The private sector is invited to contribute generously to this process.

Before concluding, let me leave the following notes for your consideration: populations have the right to be free from sickness. The situation in which health promotion and disease prevention play a key role. Therefore, primary health care can render benefits to the rich as well as to the poor. Primary health care should be practised not only at the primary level, but also at secondary and tertiary levels.

In a realistically positive sense, primary health care can make all people healthier

Last but not the least, health systems reform and ethics is really a locally specific issue that needs locally specific solutions. I, therefore, sincerely appreciate the various studies relating to the issue in front of us, studies that had been pursued locally in various settings in the countries in this part of the world.

I am sure our deliberations on the findings of these studies will lead us substantially towards a realistic and practical solution to the problems under consideration.

Strengthening health systems

Strong health systems are a prerequisite for the achievement of national health goals, including the Millennium Development Goals (MDGs). Without health systems that can ensure equitable health care, it will not be possible for countries to scale up the activities to prevent and control diseases. Health systems comprise all organizations, institutions and resources that are devoted to health actions. Health actions are efforts made, either in providing personal health care, or public health services; public health services are services delivered through multisectoral initiatives. The primary purpose of these efforts is to improve the health and well-being of the population.

Health systems have the responsibility to protect people from the financial costs of illnesses

In addition, health systems have the responsibility to protect people from the financial costs of illnesses. Also, health systems must ensure that, in the process of providing care and services, the fundamental rights of consumers are fully recognized, and the consumers are treated with dignity in such a process.

Today, there are several issues and challenges involved in the functioning of health systems. There is lack of access to care, especially by the poor, the underprivileged, the marginalized and the vulnerable. This is due partly to the lack of equitable distribution of health resources, particularly in the form of services. The lack of access to care contributes to inequitable health outcomes. This creates a gap between the "haves" and the "have nots". As a rule, the "have nots" are usually those who are poor, underprivileged, marginalized and vulnerable.

Regional Consultation on Strengthening Health Systems through Primary Health Care Approach, Pyongyang, DPR Korea, 18-20 April 2007.

Health Systems still have a long way to go to be able to ensure quality health care for all and everywhere. Certainly, people continuously need health services for their families, and communities and at their workplaces. And they also need integrated services to be organized at health facilities, especially in their communities, near their families. However, health systems are yet to meet these requirements and thereby satisfy all segments of the population. We are also facing a paradox in health services delivery. We are longing for more health facilities, and more health staff at village and community levels. However, in many countries the available health infrastructures and facilities in those locations are poorly utilized. This is an issue which is related to the responsiveness of health systems, to the needs, demands and requirements of people.

There are many explanations for the underutilization of health services. People do not avail of the health services because health facilities are too far away from their homes. This relates to the physical distances involved. However, even if the facilities are not too far, there are no roads, and no transportation. It takes a long time for people to visit the health facilities. This is thus an issue about the time involved. Secondly, people may not avail of the services because they have no money to pay for them. This is the financial reason. And, no less important, people may not come to health facilities because of the psychosocial gap. They do not understand the language spoken by health staff. Villagers may even be scared of the uniforms used by health care personnel at health centres. And they may not be treated with adequate dignity. This may be because they are poor; or due to their ignorance because of a lack of education. Often, people do not come to health facilities, especially in rural areas, because of the poor quality of health services. In order to improve health systems, all these and other factors must be taken into consideration: including the social and cultural dimensions involved.

As reflected earlier, health systems have a very broad concept that encompasses the work of many professions and sectors. To be effective in operational terms in strengthening health systems, we should first focus our attention on the health infrastructure. The infrastructure within the health sector is more manageable in the short and medium term. Simultaneously, we have to work hard for a long-term improvement of

health by other sectors. This is very important, especially in the context of "Healthy Public Policies", policies whereby all sectors have to have the "health concern" incorporated into all their development endeavours.

We will now discuss the topic of Strengthening Health Systems through Primary Health Care Approach. Primary health care came into formal existence in 1978 through the Alma-Ata Declaration. Its original definition is reflected in the Health For All (HFA) Series No. 1. It is a definition that is conceptual, and generic. It therefore, can be applied easily according to the local needs of countries. And its implementations are therefore different from one place to another. However, the primary purpose of primary health care is to ensure health for all; to close the gap between the "haves" and the "have nots". Health in the context of HFA, is a state whereby all citizens in the world can live a socially and economically productive life. Therefore, health in such a context is a social goal.

The primary purpose of primary health care is to ensure health for all

It was envisaged at the beginning of the Alma-Ata declaration that HFA could be attained through the primary health care approach. Primarily, primary health care is care to be made available, and socially acceptable to all people at the grassroots level. Primary health care aims to promote and support the involvement of people of all walks of life in their health development. This is what we call "Health for All and All for Health". Such involvement of people must be at various levels; individual, family, community and national.

Significantly, the goal of Health for All can be achieved if all people are involved in such a process through the primary health care approach. Primary Health Care is to ensure that health services reach the unreached everywhere, both in rural and urban areas. It also aims to promote equity and social justice in health; it aims to promote local ownership of care and services at the community and grassroots levels; and, primary health care is to promote social control of health technology.

During the past almost 30 years, primary health care has contributed very significantly to the improvement of health of people at all levels. There are numerous success stories related to primary health care; these success stories have been documented all over the world during these long years. Nonetheless, since 1978 until now, the world

has changed remarkably. Primary health care needs to be revisited. This is in order to ensure its relevance to today's health development.

In our efforts to strengthen health systems through the primary health care approach, our focus should be on health infrastructure - an infrastructure that deals primarily with health policy, governance, human resources, finance and facilities, etc. We should pay particular attention to development. In this regard, the development of community-based health workforce is very critical. Such a workforce can contribute significantly in achieving equity and social justice, and in reaching the unreached and universal coverage. It can also lead to a substantial reduction of the disease burden through health promotion and disease prevention. Such a reduction of the disease burden will certainly help in poverty reduction at the community, and ultimately at the national level. It will mark a long way forward for all countries in their efforts to have efficiently functioning health systems.

Primary health care needs to be revisited

I am confident however, that with our combined wisdom and mutual concern, we will be able to come out through the course of this meeting with a practical set of recommendations - recommendations that can take us forward in our endeavours to ensure quality health care and services for all people. Last but not the least, please keep in mind in this exercise that health systems are an integral part of country governance. Therefore the strategy for healthy system strengthening must be country-specific, responding to country-specific situations and needs.

Health research

The main role of the WHO Advisory Committee on Health Research (ACHR) is to advise the Organization on matters relating to research policies, strategies and programmes.

In WHO, there are two levels of the Advisory Committee on Health Research: global and regional. This Committee is for the WHO South-East Asia Region.

During the course of this session of the Committee, we will review implementation of the recommendations of the last session. At the last session, our deliberations were focused on the subject of "Research on Emerging Infectious Diseases". A number of useful recommendations were made. And those recommendations have been used as the basis of our research work in this important area.

Now, we are in Indonesia where Avian Influenza is rampant. I am sure the subject of "Research on Avian Influenza" will attract special attention of the Committee. And the Committee will provide useful advice on necessary research in this currently critical area.

At this session, we will also learn about WHO's global health policy and strategies, and the Committee will be informed of WHO's work in TDR Special Programmes. This is in addition to the work of WHO's Global Advisory Committee on Health Research. We would like to use the ACHR platform to ensure effective cooperation in health research between the three levels of the Organization.

Thirtieth Session of WHO South-East Asia Advisory Committee on Health Research, Jakarta, Indonesia, 14-16 March 2007.

During the meeting, there will be a brief review of WHO's work in health research in the South-East Asia Region during the biennia 2004-2005 and 2006-2007. Then, the Committee will deliberate upon key issues and challenges. These issues and challenges will be the basis for identifying priority activities for our future work, in both the short- and long-term.

One of the challenges for WHO today is to ensure national capacity in pursuing health research. Three main subjects have been selected for our deliberations in this connection: 1. Strengthening of human resources for health research; 2. Improving health research management; and 3. Promoting the utilization of research results. In our deliberations, it should be kept in mind that the three subjects are closely interlinked/interrelated.

During the recent past, there has been a concern with the progress in implementing the Committee's recommendations. It has been perceived in this connection that the work of the Committee can be made more effective.

Health research is an indispensable component of health development

During the course of this meeting, I would also like to invite the Committee to provide considered views on how to further improve the work of our ACHR. WHO really values the role of ACHR. And WHO is determined to vigorously pursue improving the effectiveness of ACHR's work.

Health research is an indispensable component of health development. Health research generates evidence for rational planning of health policies, strategies and programmes. With limited resources, health research for development must be on the basis of countries' priority health problems. Health research must produce evidence that is reliable and relevant to the intended use, especially the use in the development and management of health plans and programmes.

It will be a waste of resources, if the results from research are not properly utilized by policy makers, planners and managers. In this perspective, research capability and capacity in the countries are required. This is to ensure quality research that can produce reliable and relevant information. It is the duty of WHO to help strengthen such capability and capacity.

In this connection, I would also like to underline specifically the importance of countries' capacity in research and development. The research that can ensure countries' ability in technology development and innovation. For this, I wish to emphasize the critical need for country capacity. The capacity that can enable Member States to produce quality medicines and vaccines, to satisfy the demands of their health service systems.

WHO should also be able to help Member States to gain self-reliance in such a production through promoting and facilitating technology transfer. This is a long-term endeavour; the endeavour that can ensure sustainable development in the countries' health care and services.

This endeavour needs to start now. Otherwise, nothing will ever happen in tangible terms in this critical area of concern. Our collective wisdom will be very useful to this long - term development in the Region. We should vigorously promote and support this effort.

I would like to earnestly invite the ACHR to help develop a practical framework for WHO to move forward efficiently in this direction. The framework that also includes the promotion of partnerships among all stakeholders in research and development and technology transfer. This is the development that can respond effectively to the issues relating to medicines and vaccines in this Region. The development that needs unwavering political and operational commitment between the concerned governments and the private sector in areas of pharmaceuticals and biologicals.

I must admit that WHO also has to strengthen its own capacity in this area, so that it can support the countries' efforts better. We, in WHO SEAR, are working diligently through various means to ensure our best service to the Member States in this regard.

Research is an indispensable item of the development agenda. Research needs investment, in both human and financial terms. Most developing countries cannot afford such investment. We, therefore, need funds from outside to finance our research efforts.

At the same time, I must say that more efficient use can still be made from the resources that are already available with us. In this

connection, I would like to mention, among others, two areas of concern: One – poor quality research projects that need to be reduced or eliminated; and two – uncoordinated efforts that result in the duplication of activities in health research; these also need to be reduced or eliminated. If we can do these successfully, the use of our available resources, including research funds, will be maximized. In our WHO experience, these two areas are the real challenge in the management of health research.

For each financial period, WHO allocates a good sum of funds for supporting research and research-related activities. However, it is indeed a pity that the return from these activities is rather poor. This is the issue being faced both in the countries and in WHO.

Health research management, which is to be discussed by a working group, is a broad subject. I would like the group to be specific in its discussions; and to take into consideration the points I just mentioned.

Even though the subjects of strengthening human resources and utilization of research results will be dealt with by two other working groups, these two important areas are actually parts of overall research management. Therefore, the three working groups must keep in mind the inter-relatedness of the contents of their discussions.

Substance-wise, health research must be able to catch up with time

Substance-wise, health research must be able to catch up with time. Health development has evolved over time, according to changes, at both national and international levels. Health research must therefore be able to orient its course according to the changing environment. Otherwise, the results generated from research efforts will not be relevant to the needs of today's health development.

Our efforts must be in response to the countries' needs in their development endeavours, in both the short- and long-term, always keeping in mind that these countries' needs are not static. They are changing all the time. This is indeed a challenging task for all of us, who are working in today's public health arena.

Let us commit ourselves during the course of this session of ACHR to move forward unwaveringly, in ensuring that research is the real cornerstone of health development in the countries of South-East Asia Region

Health workforce development

It is well documented that the health workforce is the key component of health development to achieve positive health outcomes of the population. The correlation between the performance of health workers and the critical health indicators is well recognized and proven beyond doubt.

The issues relating to health workforce are common among many countries across the world. In absolute terms, the acute shortage of health workers is also found in the South-East Asia Region. At the same time, consumers' demands for more and better services have emerged globally during the last two decades. This is also equally relevant to the South-East Asia Region.

The health workforce today has to address, among many others, a growing burden of chronic diseases, which requires a continuum of care. For this, health workers have to be particularly skilled in ambulatory and community care.

Disease outbreaks and natural disasters have put to the test the preparedness of the health workforce. Health workers themselves are also adversely affected in the conflict and post-conflict periods, either within or between countries. Their personal and family needs in this situation must be well taken care of.

Furthermore, the technological advances and growing consumers' expectations affect the ways health care and services are perceived and

Regional Consultation on Strategic Plan for Health Workforce Development, Bali, Indonesia, 18-20 December 2006.

practised. Adding to these concerns, among others, are the international trade agreements and the issues relating to intellectual property rights, which have profound implications on the health of the people. Health professionals today need to clearly understand these trends and their implications.

Many actions have been taken by WHO in an effort to help Member States improve the situation relating to the health workforce. During the recent past, the World Health Assembly has adopted several resolutions, addressing many related issues. Furthermore, the Global Health Workforce Alliance was launched by WHO in May this year. This is one among many other efforts to mobilize the support of key stakeholders in strengthening and developing the health workforce in countries.

The WHO Regional Office for South-East Asia has also taken many initiatives to strengthen the health workforce in Member States. Among other important events was the landmark Calcutta Declaration, adopted in 1999 at the Regional Conference on Public Health in South-East Asia.

The shortage of health workers is a critical concern almost everywhere

Despite all-out efforts to face the challenges, health workforce-related issues in the Region continue to prevail. In most countries, national information on various dimensions of the health workforce is inadequate. Comparatively, the data are more complete on the types of services than on management aspects; which determine the efficiency of service delivery. And the data are more complete on service providers than on supporting staff, who also contribute to the efficiency and quality of services.

Often, available data are limited to the public sector; and, within this sector, the data focuses heavily on doctors and nurses. Community-based health workers are often excluded from the head count. These workers are the key players to contribute to the reduction of disease burden in the population. However, these data help highlight a few important health workforce-related problems that need urgent attention.

The shortage of health workers is a critical concern almost everywhere. Many countries cannot meet the required threshold of doctors, nurses and midwives. According to one study, these staff members are needed at the ratio of at least 2.5 per 1,000 population,

in order to adequately provide essential health services. Below this level, the coverage of needed interventions to achieve the targets set under the MDGs will become very inadequate. In our Region, this figure is estimated at 2.12, with a range from 0.56 to 7.37.

Europe and North America, with 21% of the world population, have 45% of doctors and 61% of nurses. South-East Asia, with 26% of the world population, has only 20% of doctors and 8% per cent of nurses. Furthermore, a gross imbalance in the distribution of health workers is common among countries, as well as within countries. This is especially so in the developing world.

In most developing countries, there is a severe shortage of health staff in the rural, compared to the urban areas. On the other side of the coin, training is heavily tipped towards the production of physicians and nurses, at the expense of public health and management cadres. This situation creates a gross imbalance between institutional care and community care. The latter is really very much needed in the developing countries, where most of the population lives in the communities with inadequate health care institutions.

The past emphasis laid on the development of community-based health workforce is no longer visible. This is really a serious public health concern.

Inadequate competency and skills of the health workers to meet the expected standards of care is another important challenge in the Region. Many of the training institutions need to update or even reform their teaching methods and materials, in order to effectively provide need-based and job-oriented education. Often, these institutions lack a system to assure the quality of training. And there are very few opportunities available in countries of the Region for continuing education of health staff.

Incentive systems need to be strengthened or even created, to motivate and maintain the health workforce at a high standard of performance. Management policies and practices need to be reformed, to ensure efficient and effective development and deployment of health staff. These are essential elements for the management of health workers.

A conducive working environment is needed to ensure a fair management, career advancement, and personal development of health staff. Often, there is an increased attrition which surpasses the production of health workers.

In some countries, measures to motivate staff to stay on the job, such as providing dual employment opportunities with the public and private sectors, have led to a negative effect on the government services. There are many underlying causes for these issues, including the inadequate production capacity and migration of skilled health professionals.

Adequate orientation in the areas of public health, quality of training programmes, and availability of facilities for continuing education are essential in our countries. These factors are important for health workers to acquire the required level of competency and skills.

Effective management of the health workforce requires clear vision, robust policies and approaches with strong leadership at all levels. The Twenty-fourth Health Ministers' Meeting and the Fifty-ninth session of the Regional Committee this year was another landmark in the development of health workforce in South-East Asia.

The Ministers agreed that unwavering and intensified political commitment was needed in facing the challenges in this area. At the end of the deliberations during the Ministers' meeting, the "Dhaka Declaration" was adopted in this connection. This clearly reflects their strong determination to push forward the development of the health workforce in the Region. The Declaration urged the Member States to take several initiatives in this regard.

The Fifty-ninth session of the WHO Regional Committee for South-East Asia that followed adopted a resolution on strengthening of the health workforce. The above declaration of Health Ministers and the resolution of the Regional Committee are now the principal guide for the countries in the Region to move forward, in ensuring the quality and adequacy of the health workforce. The draft 'Regional Strategic Plan for Health Workforce Development, presented to the Fifty-ninth session of the Regional Committee was also thereby endorsed.

This consultation is being organized to revisit this strategic plan. During the course of our meeting, we will review the plan and identify

the activities to be carried forward by both Member States and WHO. I hope that only realistic and practical activities are identified for action.

Before concluding, I would like to underline some important points in connection with the development of the health workforce. Special attention should be paid to public health professionals and public health practitioners; the professionals and practitioners who can successfully develop and implement public health programmes. Public health programmes are the programmes that place emphasis on health promotion and disease prevention and control. The programmes that serve directly and equally all communities, in both rural and urban areas. The programmes that ensure equitable health care services to all segments of the population.

Equally important, particular efforts should also be devoted to the strengthening and development of community-based health workers; the workers who can ensure reaching the unreached; the poor, the vulnerable, the marginalized.

Particular efforts should also be devoted to the strengthening and development of community-based health workers

While the development of the health workforce is basically the responsibility of the health sector, all concerned stakeholders should be actively involved. These include educational institutions (which are often outside the health ministry), professional bodies and associations, civil society organizations, consumers' groups, and many more.

Today, health care needs a multidisciplinary health workforce, with multisectoral perspectives. We need a health workforce with a high sense of social responsibility and commitment.

Even more important, we need health workers with a high standard of ethical and moral values; and with a selfless interest. They should have with them only the interest of their clients and their people; especially the poor, the underprivileged.

There is still a long way for us to go in the development of the health workforce to ensure good health for all people, regardless of their socio-economic status. Let us face this challenge squarely together in the years to come. Let us hope that with our unwavering determination and commitment, we will be successful in pursuing this formidable, but noble task.

Human resources for health

Human resources are the core of health systems. The efficient and effective functioning of these systems depends on the team of motivated and dedicated health staff. There is ample evidence to show that the availability of competent health workers can contribute significantly to the overall improvement of the health of the population. Issues relating to the health workforce have always been a key concern in the development and management of health services.

The World Health Assembly adopted a resolution in 1977, urging Member States to work towards the attainment of health for all by the year 2000. It was realized in that context that no country in the world would be able to produce adequate health manpower to ensure the attainment of that goal; the goal that required all people in the world to lead a socially and economically productive life.

Human resources are the core of health systems

As an important component of the global strategy for health for all by the year 2000, the WHO programme on human resources for health was initiated. It was intended to develop human resources that could promote, among others, the involvement of people from all walks of life in health development. And this involvement must be at all levels: individual, family, community, sub-national and national.

This strategy needs development and intervention through the educational process that can empower all those people to be able to lead a socially and economically productive life. To be successful in this

Conference of the Asia-Pacific Action Alliance on Human Resources for Health, Ayuthaya, Thailand, 28-31 October 2006.

endeavour, a competent health workforce is indispensable indeed. The World Health Assembly resolution on Health For All (HFA) considerably broadened our perspective in health development. It is a development that requires efforts that go much beyond the health sector.

Now, six years after the target date of this global social goal, we are yet to realize health for all. Nonetheless, the concept of Health For All remains our "ultimate target" towards which all countries in the world should continue to stride forward. Since the adoption of the HFA resolution, health has been universally accepted to be at the centre of overall development in any country. While forging towards the Health For All Goal, we have witnessed many changes around us.

Advancement in science and technology has changed the way health care and services are perceived and practised

The world has changed rapidly in many ways during the past two decades. These changes have profoundly affected the development process in socio-economic, and thereby health sectors. The liberalization of international trade, for example, is affecting goods and services in health in a big way. People today are better educated; and today the world has increasingly become a global village. These changes have led to the demands by consumers for more and improved health care and services. Patients demand from service providers and the government more and better protection of their rights. Advancement in science and technology has changed the way health care and services are perceived and practised. All in all, however, one cannot neglect the changes in the socio-cultural dimension.

Due to several factors, people's lifestyles have kept changing. There is significant increase in health risk behaviours, especially in the urban settings. This trend contributes to the increase in morbidity and mortality due to chronic noncommunicable diseases. Furthermore, it is still a long way to go to ensure equity and social justice in health care. The unreached are yet to be uniformly reached. Health consumers are yet to be treated with equal dignity. Effective measures are yet to be in place to ensure equitable distribution of health resources.

As universally accepted, health is at the centre of development, and health can contribute significantly to poverty reduction. This vision will be realized only when much more attention is paid to the means and ways to keep people always in good health. More attention has to be paid to the reduction of morbidity; in addition to the interventions

to prevent death and limit disability. More attention needs to be paid to health determinants and risks in the development and implementation of health programmes. In such a process, there is a need to move towards positive, rather than negative health. Today, there are more ways to prolong healthy life. The current health development efforts should be geared towards healthy longevity, rather than simply a long life.

Today, demographic change has resulted in a larger population of the aged. There is an urgent need to look at the aging process and apply appropriate interventions at various stages of growth and development to ensure healthy aging. We should not wait for the people to get old, and try to limit disability and prevent death at that point. However, the aged population is already here with us, we have to take the best care of them. It is important now to ensure "life cycle care".

The efforts of health systems must be geared towards: the optimal human growth and development from conception; the maintenance of good health throughout; delaying the pathological process during lifetime; and limiting disability and dependency as much as possible, especially during the later years of life.

These are some, among many other issues, that need to be tackled by the health workforce in their efforts towards good health for all. While maintaining specializations in health professions, health staff in future will need to be versatile and broad in their vision. The vision that can help them see through a healthy life of people; and be able to ensure healthy longetivity of that life.

In addition to technical competence and skills, there is a need for the health workforce to possess a high degree of ethical and moral values. We need the workforce to be imbibed with a multidisciplinary and multisectoral perspective; the workforce that can really mobilize all stakeholders for effective health development at all levels. And, more important, we need the workforce with a strong sense of social responsibility and commitment.

International agencies and institutions should join hands to support countries in their efforts to develop a health workforce that suits development work in the 21st century. Considerations in the development

of a health workforce must take into account the required health actions at all levels, from the grassroots to the national. There is an urgent need to pay equal and particular attention to those who work in the community to serve the entire population. We need staff who can reach the unreached; to serve the poor, underprivileged, marginalized and vulnerable. These are staff members who can effectively provide promotive and preventive health care in the community. This is in addition to alleviating the suffering of the people and curing disease and illness.

There is an urgent need for a workforce which can get fully and effectively involved in the development and implementation of public health programmes. The programmes that deal primarily with health promotion and disease prevention. The programmes that aim at prevention and control of HIV/AIDS, malaria, tuberculosis, dengue, encephalitis and many other diseases. The programmes that can ensure clean water, good hygiene, sound sanitation, and other aspects of a healthy environment. The programmes that can reduce maternal and child mortality, and promote healthy populations in the remote rural villages.

A competent and dedicated health workforce can ensure sustainable health development

At the same time, there is a need to strengthen the capacity of professionals and experts in the related institutions and facilities; so that they are able to effectively support the efforts of those who work in the fields, in the community, and in the rural settings. These institutions and facilities have to play their key role in the development and training of a community-based health workforce, grassroot health workers. This development and training is one of the most important entry points for strengthening country capacity in health.

A competent and dedicated health workforce can ensure sustainable health development, and can ensure the attainment of long-term health goals in countries. Development of human resources for health has always been the key priority of WHO. WHO is always ready to fully collaborate with Member States and stakeholders/partners in these critically important areas. Last but not least, I would like to underline the importance of networking among concerned institutions and agencies, at both national and international levels.

This networking will certainly optimize the impact of their contributions and to the success in ensuring competent and relevant

health workforce, and impact on the overall development of human resources for health, especially in developing countries. In this connection, I would like to place on record my appreciation of the creation of the Asia-Pacific Action Alliance on Human Resources for Health (AAAH). I also deeply appreciate its efforts in organizing this first conference.

The conference will be another important platform for the international community concerned to share knowledge, and exchange information and tools in the area of human resources for health. I am sure that the outcome of this conference will take us a long way towards working closely to ensure the availability of the required health workforce for health development in the 21st century.

Medical councils

A medical council is an important body contributing to the improvement of quality and adequacy of medical care and services. Its role extends into various important areas, particularly in medical education and practice. Furthermore, its involvement in the development and management of medical services in a country is indeed very well recognized.

The role of a medical council has been evolving over time, according to the dynamic changes occurring in society. Consumers are increasingly demanding more and better services; this demand is often expressed through the political process. Also, patients' awareness of their rights for more efficient and effective health care is on the increase, while the consumers are demanding a higher degree of ethical consideration in medical practices.

Advancement in medical sciences has changed the way medicine is perceived and practised. With countries becoming more developed, the behaviours and lifestyles of people are changing in many ways. These changes, in one way or the other, are affecting the role of medical councils with regard to protecting the health of consumers.

Several countries in the South-East Asia Region already have medical councils. However, these councils are at different stages of development. Moreover, their roles may not be the same. Some are backed up by the required legislation, which vests them with a legal mandate. At the same time, some are in the process of acquiring the

Regional Consultation of Medical Councils in WHO South-East Asia Region, Thimphu, Bhutan, 17-19 October 2006.

necessary authority for their effective functioning. However, some countries do not have a medical council yet.

The main aim of this meeting is to stimulate the development and strengthening of medical council in countries of the Region. This would facilitate the exchange of information and experiences among participating councils. It will also promote further development of medical councils through intercountry cooperation among interested parties. Certainly, WHO will always be ready to facilitate and catalyse such cooperation. Countries which are yet to form medical councils have also been invited to attend this consultation.

I am confident that the consultation will certainly benefit these countries in their efforts to move forward in the development of medical councils. Through dialogue and partnerships, countries with well-developed medical councils can help those countries whose councils need to be strengthened further. Moreover, countries that are yet to have medical councils will learn from the more developed ones. This consultation is being organized at the request of a medical council of one of the countries in the Region. It being an important idea, I accepted it at once. I thank the particular council for a very useful and important initiation. In the course of this meeting, we will also present the experiences and good practices in the development and management of medical councils around the world.

I thank Professor Ranjit Roy Chaudhury for his dedicated efforts to compile useful information for this meeting. In addition, the meeting will also touch on some other issues of importance to the functioning of medical councils, such as: (i) Reciprocal recognition and equivalence of medical degrees; (ii) Evolving trends in improving the quality of medical education, and (iii) Legislation and registration for clinical practice.

A medical council is part of the medical services delivery in countries. It is therefore an integral component of a national health system. The council has to play its role within a vast area, encompassing many important fields; scientific/technical, socio-cultural, legal and political. It has to interact with a wide range of stakeholders, including academic institutions and professional bodies.

The role of a medical council in contributing to the quality and adequacy of medical care and services is indeed challenging. The development of a medical council needs strong professional leadership. And, it needs unwavering support from other players, not only in medical, but also in other related fields. Political blessing and commitment are really indispensable; without these, medical councils will not be able to develop their status up to the desired level. Within the national context, a medical council is an important mechanism to help coordinate the work of various players in the medical arena.

The development of such councils has to be energetically encouraged in countries. I hope that this consultation will have a significant impact on the work being undertaken in this direction at the country level. This consultation can act as an international platform to facilitate joint planning towards effectively achieving our common objectives in this regard. As an outcome of this consultation, I would also like to see that a regional network of medical councils is formed to ensure long-term collaboration among these councils. WHO stands ready to support the development and functioning of such a network.

Public health institutions network

We just celebrated the World Health Day 2006, the theme of which was "Human Resources for Health", with the slogan: "Working Together for Health". On that day, 7 April, the World Health Report 2006 was also launched. The Report identifies various critical issues regarding the health workforce, with a number of proposed solutions, and also reiterates long-standing problems.

The problems highlighted in the Report are: Inadequate number of health workers; imbalance in their distribution between rural and urban areas, and migration of skilled health professionals to places of better pay and better living conditions, etc. Even though attempts have consistently been made at all levels to solve these problems, they remain unresolved even today. At the same time, we have tried to move in a new direction in the development of Human Resources for Health.

This is in connection with the advent of Health for All or HFA. This is the goal that we have pursued to ensure that all people in the world can live a socially and economically productive life. The World Health Assembly passed a resolution on Health For All in 1977; and the Global Strategy to achieve HFA was launched in 1981.

In practical terms, it was realized then that most countries in the world would not be able to produce enough health workers to pursue the goal of HFA successfully. It was also felt in this connection that "All

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Meeting of the South-East Asia Public Health Education Institutions Network (SEAPHIN), Bangkok, Thailand, 3-7 May 2006.

people from all walks of life" must contribute to health development, in one way or the other.

The ideal way of achieving the HFA goal is to be able to get everyone involved in health development. This is the basic idea behind the development of Human Resources for Health in the broadest sense.

However, in order to arrive at the desired outcome through that process, we must pay immediate and special attention to the existing health workforce which consists of various categories of health staff.

We should appreciate that our efforts towards health for all have yielded commendably tangible health benefits. The health workforce has contributed greatly to these health gains. Today, our populations live longer and are healthier, even though HFA is still an aspirational goal. Nevertheless, as we see, much still remains to be done, if the goal is to be realized in the absolute term. The gap between "haves" and "have-nots" is still very wide indeed.

The ideal way of achieving the HFA goal is to be able to get everyone involved in health development

People are still struggling with a huge disease burden. The situation is further compounded by new, emerging and re-emerging infectious diseases. We, at the same time, face frequent disasters of increasing severity; either natural or man-made.

Moreover, environmental degradation is continuing unabated with tremendous adverse health effects. Globalization has brought a new dimension to health development, which needs a different vision in policy and strategy formulation.

With this scenario in view, the health workforce of today may not be perfectly relevant to handle heath problems of tomorrow. Given these challenges, we need to reform our health workforce to ensure its capacity to move forward towards health for all in the right direction.

Health services must be truly population-based, reaching out to all corners of the community, in both rural and urban areas. We need to produce a lot more public health workers and professionals to carry out public health programmes right in the middle of a community, in order to really serve the entire population.

The public health programmes that need public health workforce are: water and sanitation; disease prevention and control; nutrition; maternal and child health, and many more. We need multidisciplinary health staff who can work multisectorally.

Such staff should have adequate social and ethical responsibility, and they should be culturally sensitive when working with diverse population groups. At the same time, we have to ensure adequate numbers of health staff to work particularly at the grassroots level. Such grassroots workers comprise community health workers/rural health staff of various types, such as nurses and midwives, etc. These people constitute an important part of the public health workforce; they move around to reach the unreached, and contribute ultimately to equity in health.

This is an important public health function in countries, such as in Thailand a function that ensures the production and maintenance of adequate health workforce that serves the whole population with dedication and commitment. Such a workforce can help, in a big way, to promote and realize health for all through all for health.

We need an adequate number of health workers who appreciate the development and maintenance of good health for all, regardless of the socioeconomic status or religious and political affiliations of people. Such workers can contribute directly to reducing the disease burden in the general population, through health promotion and disease prevention.

In a way, such a reduction in disease burden can, in turn, help reduce the burden on services in health institutions, such as health centres and hospitals. This is the strategy that requires public health leadership; the leadership that can spearhead the development of health workforce at the grassroots level.

It is a formidable challenge indeed for a long-term vision of health development. If this is done, more health services will be provided through public health interventions, which place emphasis on health rather than on disease.

Such health services will be more socially, culturally, and ecologically relevant to the needs of people and the community at large. Both people and communities will be empowered through such public health measures to be able to handle health problems effectively.

In this connection, I would like to inform this august assembly that WHO's Regional Office for South-East Asia is contemplating to revisit Community Health, and to promote another wave of movement to intensify the development and maintenance of community health workers. This will be done under the current Public Health Initiative of the South-East Asia Region of WHO.

In view of its very broad scope, health development has to be pursued multisectorally

To fulfil our ambition in this direction, let us move forward vigorously towards the development of an adequate number of public health leaders " leaders who can collectively effect a change in health systems, and who can influence policy change at all levels.

Such a change would lead to innovative ways for the development of health for all. Let us move forward dynamically towards the broad concept of health development, through the bottom-up process a process that takes into account primarily the health needs and requirements of the poor, vulnerable, marginalized and underprivileged people.

In view of its very broad scope, health development has to be pursued multisectorally. The opportunity for public health education, as we are now dealing with, should therefore be open to people from other sectors than health, as well.

Administrators of public health education should therefore be encouraged to create a multisectoral climate and environment in their institutions.

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