25th ANNIVERSARY
OF THE
WHO REGIONAL ORGANIZATION
FOR
SOUTH-EAST ASIA
1948-1973
INTRODUCTION

The twenty-fifth anniversary of WHO and of the WHO Regional Committee and Regional Office for South-East Asia was celebrated on Tuesday, 18 September 1973, in World Health House, New Delhi.

The celebrations were inaugurated by the Minister of Health, Government of India (Mr R.K. Khadilkar). Messages received from Heads of State or Heads of Governments of Member countries were read, followed and preceded by short selections of recorded music characteristic of the different countries. Messages were received also from representatives of United Nations, the specialized agencies and an inter-governmental organization.

Statements on the health situation in the countries of the Region were read by the representatives of the Member Governments.

As part of the celebrations, a cultural programme was organized by the Ministry of Health and Family Planning of India in association with the Embassies of Indonesia, Nepal and Thailand in New Delhi on the evening of 20 September 1973.

This volume is being issued as a souvenir of the celebrations and contains texts of the speeches and messages mentioned above, as well as the addresses delivered by the Director-General of WHO and the WHO Regional Director for South-East Asia at the inaugural meeting and some photographs taken on this occasion.
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Text of the Inaugural Address

by

Shri R.K. Khadilkar,
Minister of Health and Family Planning,
Government of India

It gives me great pleasure to meet the distinguished delegates and observers to the twenty-sixth session of the Regional Committee of the World Health Organization for South-East Asia. It is a source of added pleasure to learn that the Democratic People's Republic of Korea has joined the South-East Asia Region. On behalf of the Government of India and on my own behalf, I heartily welcome you all to our country. I hope you will feel at home here and enjoy your stay in our capital city. It is a happy coincidence that, along with this session of the Committee, we also celebrate the twenty-fifth anniversary of the establishment of WHO's South-East Asia Regional Office.

The South-East Asia Regional Organization, with its headquarters in our country, was the first of the six regional organizations to be established. It has rendered noteworthy service in the prevention and cure of diseases and in the promotion of better health among the people of the Region. The relationship established between the countries of South-East Asia and the Regional Office is a model of true international co-operation. The countries of the Region have benefited greatly from the work done by WHO, and through it they have come closer together in their endeavour to meet the common health problems.

I am confident that the outcome of the deliberations of this gathering of eminent scientists and experts will help the people of South-East Asia immensely in their efforts to raise the health standards and in their fight to overcome the diseases and health hazards to which they are commonly subject. Most of the diseases in the developing and underdeveloped countries are, in the ultimate analysis, the products of poverty. They know that development alone can give them the capability to harness science and organization to the task of conquering diseases. Understandably, therefore, there is an accent on development everywhere in the Region. But then, unless development itself is directed with a social vision, there is the risk of creating fresh health problems in the process.

The health problems of the Region are many and are common to most of the countries. Communicable diseases like malaria, filariasis, tuberculosis and gastro-enteritis are widely prevalent and contribute to the high morbidity in the countries of the Region. Common environmental problems such as lack of safe water supply and poor sanitation also contribute to the high incidence of diseases. Environmental pollution arising out of urbanization and industrialization is a new menace. On the top of
this, the problem of population inflation threatens to offset the results of development - and of our endeavour to control and combat the various diseases through improved medical and public health measures. Most of the countries in the Region have therefore taken to population planning as a part of their over-all plans for development.

We have achieved a measure of success in our drive for the eradication of communicable diseases in India. Significant progress has been made in the eradication of malaria. In spite of some local reverses, malaria has ceased to be a killer, and no case of plague has been reported in the country since 1966. High priority has been given to the provision of community water supply and provision of good sanitation. Full advantage has been taken of the assistance received from agencies like WHO, UNICEF and UNDP for the implementation of the different programmes. Progress has also been made in the control of tuberculosis, leprosy, trachoma, venereal diseases and the like.

To provide basic medical needs to the eighty per cent of our population living in rural areas, we have undertaken a scheme of establishing primary health centres and sub-centres. It is from these centres that all health services radiate to the rural areas. Another important effort in providing health services to the people of the rural areas is the mobile training-cum-service hospital scheme. This is intended to orient the medical profession and the services so as to equip them better for responding to the needs of the people in these areas.

To counteract the effects of the menacing growth of population, the family planning programme has been taken up in India as an integral part of socio-economic development so as to bring a better balance between the population and the material resources of the country. As a result of the intensive drive for population control, more than 14 million men and women have been sterilized. About 4.7 million women have had loop-insertions, and another 2.2 million couples are using other conventional contraceptives. It is estimated that, as a result of the various measures, 13 million births have been prevented so far. Our endeavour is to bring down the birth rate from 39 per 1,000 to 25 per thousand population as early as possible.

I express my sincere gratitude to WHO and the other international agencies for all that they have done to assist us in alleviating human suffering. We remain dedicated to the ideals for which this organization stands, and it will be our endeavour to strengthen it in all possible ways.

It is with great pleasure that I inaugurate the twenty-sixth session of the Regional Committee of WHO for South-East Asia.
Scenes from a cultural programme arranged by some of the Member countries—Indian dance

A dance item from Thailand

A dance item from Indonesia
II. MESSAGES FROM HEADS OF STATE OR HEADS OF GOVERNMENTS OF MEMBER COUNTRIES

It is with great pleasure that I send my greetings to you at the 26th Annual Conference of the South-East Asia Regional Office of the World Health Organisation which is also celebrating its silver jubilee this year.

I note with sincere appreciation that the WHO has been rendering a great service to our war ravaged country ever since her liberation following catastrophic human sufferings. With its commendable assistance and cooperation we have been able to combat and avert malnutrition, disease and death in epidemic proportions.

With a view to fighting the menace of over-population and ensuring health and welfare of the people we have already launched our Integrated Health and Family Planning Scheme under the First Five-Year Plan. I confidently look forward to its successful implementation through our own efforts reinforced with the aid and cooperation of the WHO.

The field you are going to cover in the conference is of vital importance to our region. May your endeavour and accomplishment befit the silver jubilee year of your great organisation.

[Signature]

ABU SAYEED CHOWDHURY
(President of Bangladesh)
On the auspicious occasion of the 25th Anniversary of the South-east Asia Regional Office of the World Health Organization, I have great pleasure to convey to the Regional Director and his staff on behalf of the Government and the people of the Union of Burma, our congratulations and sincere good wishes.

The honourable but difficult task of the World Health Organization of promoting health in mankind has been achieved with remarkable success, and the Regional Office's share in this undertaking has been no small contribution.

May I take this opportunity to thank the World Health Organization and especially the Regional Office for the valuable assistance rendered to our country, and once again we wish the Regional Office every success and continued progress in reducing human sufferings and promoting the well-being of mankind.

NE WIN
(PRIME MINISTER OF BURMA)


I send my greetings and best wishes to the World Health Organization on the occasion of the XXVI Session of the WHO Regional Committee for South East Asia which will be held in New Delhi from September 18, 1973. This occasion is all the more significant because it marks the 25th anniversary of the WHO and its Regional Office for South East Asia. I am happy that this also coincides with the 25th year of the independence of India.

India has undoubtedly made considerable progress in the field of health and medical care but much more yet remains to be accomplished. WHO is one of those international agencies which have rendered substantial help in the eradication of human suffering. It has scored successes in the field of global health in many countries, besides India. Committees like this enable countries which share similar problems to discuss ways and means for promoting common health programmes in the respective countries.

I extend my hearty welcome to all the delegates and experts assembling here and wish the deliberations all success.

(PRESIDENT OF INDIA)
to fight against poverty and disease which still afflict the majority of people.

Indonesia puts considerable interest on the health problem, although we are well aware of other pressing ones remaining to be solved immediately. Such awareness is clearly demonstrated in our first Five Year Development Plan as it mentioned among others: "One of the main objectives of development is to improve the health of the people. Apparently the improvement of the individual's health constitutes an objective of its own. The amelioration of people's health will directly increase its productivity, thus accelerating the development process. Health improvement, therefore, is a human investment complementary to capital investment".

Great number of problems are still confronting mankind today. Including those of health, I am fully confident that through closer cooperations between nations all over the world, we can quickly find the answers to many of those problems. Actually on certain cases a problem can only be settled permanently through regional or international cooperation. This, undoubtedly, becomes a great challenge for this quarter of century old organization. Indonesia, consequently, fully endorses the work being conducted at present or in the future by the World Health Organization in its contribution to the well being, peace and just prosperity of mankind.

Thank you.


Sgd.

SOEKARNO, President.
Dear Mr Director,

On behalf of the Government of the Mongolian People’s Republic may I extend to you my sincere felicitations on the occasion of the 25th Anniversary of WHO and its Regional Office for South-East Asia, which will be celebrated during the 26th Session of the Regional Committee.

Yours,

I take this opportunity to express my Government’s appreciation of the contribution being made by WHO and your Regional Office to the development of Mongolia’s Public Health services. I am confident that our cooperation and common endeavour will further yield fruitful results in the years to come.

Please accept, Mr Director, my best wishes for greater success in your noble cause of protecting people’s health and for your good health and wellbeing.

Yours sincerely,

[Signature]

D. Tseveenisid
(Deputy Chairman of the Council of Ministers of the Mongolian People’s Republic)

Ibrahim Nasir
(President of the Republic of Maldives)
KATHMANDU (NEPAL)

NAGENDRA PRASAD RIJAL
(Prime Minister of Nepal)

It gives me immense pleasure in extending cordial felicitations on the 25th Anniversary Celebration of the South East Asia Regional Office of the World Health Organization.

WHO has been instrumental in strengthening the health services and promoting the health of the people by helping to control various communicable diseases of the region.

I hope WHO will continue its relentless fight against various diseases to help attain "the highest possible level of health by all people".

NAGENDRA PRASAD RIJAL
(Prime Minister of Nepal)

Prime Minister
Sri Lanka

Colombo, 9th September, 1971.

It is indeed a pleasure, on behalf of the people of Sri Lanka to send you congratulations and warmest greetings on the 25th anniversary celebrations of the South-East Asia Regional Office of the World Health Organization.

It was only 25 years ago that I had the pleasure of addressing you when your deliberations were held in Sri Lanka. On that occasion, I drew attention to some of the major health problems afflicting countries of this region. Communicable diseases like Malaria, Tuberculosis and mental diseases continue to remain in the forefront but I am happy to note that countries of this region have not suffered major outbreaks of diseases like smallpox or cholera during the last year.

I can confidently presume that this situation is largely due to the valuable assistance and guidance given by the South-East Asia Regional Office towards disease control and prevention.

Problems of environmental pollution which were also mentioned by me continue to develop and will soon be a menace in most countries of this region. The same is true of the population explosion in this region - an increase of 300 million in 25 years. These are already receiving the attention of the specialized agencies of the United Nations and international organizations but in view of the acute nature of these problems greater assistance to developing countries would be very desirable.

The World Health Organization has assisted my country in the implementation of the development plans particularly in the Health Sector in providing fellowships for training of Health personnel in certain disciplines for which my country is most grateful. However, development plans in the Health Sector in most countries are curtailed or delayed due to lack of supplies and equipment. If this aspect of assistance is stepped up through increased budgetary provision, it would largely contribute to improved delivery of health services to the peoples of this region.

I hope your discussions will be fruitful and I wish the meeting all success.

(Nagendra Prasad Rijal — Prime Minister of Sri Lanka)
Message
from
His Excellency Field Marshal Thanom Kittikachorn
Prime Minister of Thailand
to
The WHO Regional Committee at the 26th Meeting
at New Delhi

On behalf of His Majesty's Government it gives me a great pleasure to extend to all of you our greetings, and avail ourselves of this opportunity to express our heartiest congratulations on the occasion of the Twenty-fifth Anniversary of the World Health Organization.

I recall with happy memory of the remarkable achievements being attained by the WHO's Regional Office for South-east Asia since its inception in this region. Through its dynamic actions and unfailing efforts, it has brought ease from sufferings and brightened the peoples of South-east Asia with joy, of which I am hopeful that it will continue to progress and achieve by raising the levels of health and standard of living more and more all over the region.

Thailand has and will give full support to this organization at all times. You may be assured that whatever concerns HEALTH, it has a firm place in one of the top priorities of the policy of our Government. We have never overlooked the health and living of our people. Nevertheless, the WHO's Regional Office for South-east Asia is the centre and mainstay of our region, thus we are dependent on its activities and guidance as a source of producing policy of prevention and cure.

In concluding my message, I wish the 26th Meeting every success.

Field Marshal

Thanom Kittikachorn

(PRIME MINISTER OF THAILAND)
Text of Address

by

Dr H. Mahler,
Director-General
of the World Health Organization

Looking back over the first twenty-five years in the life of our Organization, we see a series of successes and failures as well as a number of initiatives of which it is hard to say whether they have brought us nearer our goal or not. Our appraisal procedures thus need to be sharpened. Overall, I think it is fair to say that the successes have overshadowed the failures. However that may be, WHO today enjoys an accumulation of goodwill, and its reputation stands high, perhaps too high, for there is a danger: WHO cannot continue to draw indefinitely on its balance of goodwill without risk of eventual bankruptcy. If we have credit, that credit must be renewed; if we enjoy goodwill, that goodwill must be earned.

If we can speak of success, then part of it surely derives from the regional structure of WHO, one of the Organization’s distinctive features, which I believe has served us well. The Regional Organization for South-East Asia occupies a special place in the history of WHO, for, following the proposals expressed by four countries during the First World Health Assembly, it became the first to be established of the six we have today. In these developments an important part was played by the Government of India, which, following a resolution of the Executive Board, helped to set up the Regional Office in New Delhi, where the office has continued to work since the first day of 1949.

The value of regionalization is surely twofold. On the one hand, it enables the work of a world organization to be more closely, more adaptively adapted to the particular conditions and problems in different parts of the world. On the other, it establishes bonds between countries in the same region that are closer than could be expected if we worked only on the global scale and through individual country projects.

However, we should not be blind, Mr Chairman, to the dangers of regionalization. WHO must remain one organization; it should on no account become a mere federation of regions. Every country must have the opportunity to exploit the Organization as a whole. The fertilization process
of international co-operation through which the Region becomes more than the sum of its parts is operative also with reference to the world as a whole. In view of the fact that our financial resources are limited, it is very important that the greatest advantage be derived from this effect, whether it be made to work within the regional framework or outside it. No opportunities must be lost.

In any review of WHO's successes and failures during the first twenty-five years of the Organization's existence, the smallpox eradication programme must stand out. It seems to me that the Organization has shown its best potential in the way it has been able to promote this global undertaking - global in two senses: when the programme started, the disease was still endemic in most regions of WHO, and, secondly, the eradication of smallpox is a matter in which all countries have an immediate and practical interest. This enterprise is an example of WHO teamwork on the grand scale, with countries that have the disease, with countries free of the disease, with research institutes and scientists in both; all budget levels were drawn upon - national resources, of course, the WHO regular budget, the United Nations Development Programme, voluntary contributions, bilateral funds; with this marshalling of forces went a build-up of momentum through the pursuit of working relations with national staff. Some remarkable results were achieved - inevitably partial, since nothing is final until world-wide eradication is really secured.

If the goal is reached, great credit will accrue not only to the Organization but also to those Member States who have had the most serious problems to contend with. There is no denying that the eradication of smallpox would be a remarkable triumph from many points of view. However, if the enterprise were to fail, it would be an equally remarkable defeat. For WHO, it would in fact be disastrous: we were challenged to eradicate smallpox; we were provided with the resources; we moved a long way towards our goal, and to fail in such circumstances would be a very serious set-back indeed. It would inevitably raise doubts about the effectiveness of the interaction between the WHO governing bodies, the Secretariat and the Member States.

I recognize, of course, that in the global smallpox eradication programme the South-East Asia Region has the biggest share of work to accomplish, as 88 per cent of the world's cases occur in this Region. I am confident, however, that the dramatic effort now needed will be forthcoming.

Let us look beyond smallpox to the general lessons which this undertaking may teach us about WHO's activities as a whole. It seems to me that for success we need to have the kind of conjunction of forces that have stood the smallpox eradication programme in good stead so far. Conversely, if it has been asked, can WHO-assisted projects succeed if they are not backed by a strong national will? Unless there is an aggressive national identification with a project, is it worth attempting at all? As my predecessor
I wish to express my gratitude to you, Mr Minister, for sparing the time to be present at this celebration of the twenty-fifth anniversary of the World Health Organization and its Regional Office for South-East Asia and also for your enlightening address. We are most happy to have with us today Dr H.T. Mahler, the Director-General of the World Health Organization. It gives me particular pleasure to welcome on this important occasion, the Democratic People's Republic of Korea, which is attending the Regional Committee meeting for the first time. To all of you, distinguished delegates, observers and guests, let me express my thanks for joining with us in celebrating WHO's twenty-fifth anniversary and working to improve the health of the peoples of our Region.

Twenty-five years is a relatively short period in the history of nations. And yet it has seen great changes in the health situation of the South-East Asia Region. It is sometimes difficult to recall what conditions were like in 1947. Malaria was rampant. India alone had 75 million cases, causing untold anguish and perhaps 800,000 deaths a year. The situation was equally grim in other countries. Smallpox reigned unchecked, scarring, blinding and killing thousands. Plague and many other common communicable diseases were ever-present menaces. In fact, one of WHO's first activities was to help in the control of an outbreak of plague in Mysore State in India. Another problem was yaws, which afflicted millions and millions of people and was particularly serious in Indonesia and Thailand.

In most of the newly independent countries, doctors and nurses were particularly scarce, and there were extremely limited facilities for training and preparing them. Finally, many countries were still attempting to deal with their health problems on a day-to-day basis, and there was a dearth of overall planning, often an absence of rational goals and little attempt to improve training techniques.

What is the situation today, twenty-five years later, in the South-East Asia Region? First of all, several of the older menaces have been eliminated, and those that are still with us present far less of a health risk, although active campaigns are still being waged against several of them. Plague no longer represents a health problem in the Region; though some foci still exist, only a few sporadic cases are reported from time to time. Malaria, although attempting to stage a comeback, has been considerably reduced. In fact, from a total of 75 million cases in India in 1947 the...
Here, our achievements have been remarkable in that South-East Asia has made great progress towards attaining self-reliance and self-sufficiency both in the laboratory analysis and vaccine production.

However, none of the efforts to improve the health of the population can really succeed until there is coherent and effective national health planning aided by accurate and meaningful health statistics. Over the past years, WHO and the governments of the Region have laid particular stress on the need for evolving well-planned national health schemes which will integrate and improve the delivery of the health services. A series of courses on national health planning has been organized at both regional and national levels. There are now national health planning units in various stages of development in every country of the Region.

During these past two and a half decades, WHO itself has undergone significant changes. At the first session of the Regional Committee, representatives from six Asian countries were present. Today, the Region includes ten members: Bangladesh, Burma, the Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand. The initial budget for the Region was only 578,000 dollars, it has now grown to ten and a half million.

The twenty-fifth anniversary is an occasion not only for looking back on the early days and taking stock of where we stand today, but also for glimpsing ahead to see what the future holds. It would be very hard indeed to be absolutely sure of what the health situation in our countries will look like twenty-five years from now. But we can venture some modest predictions.

The major communicable diseases such as malaria, leprosy and tuberculosis will be brought under much greater control; smallpox we hope, will be only a historical episode from the past. Expanded and strengthened health teams will bring some form of health care to all sections of the people, wherever they may live, and particular attention will be given to outlying rural areas.

Although the population of the Region will have increased considerably, with the provision of better health care and the active and enlightened efforts of national family planning programmes, the steep rise in the population curve may begin to slow down and the prospect of a stable and healthy population may be in the process of becoming a reality.

In the wake of Asia's continued march towards industrialization and urbanization, we are now compelled to deal with health problems similar to those already encountered in highly developed countries and will be forced to confront them even more resolutely in the future. I refer here to the pressing problems of air and water pollution, the control of radiation, and a host of challenges presented by chronic non-communicable diseases. The
MESSAGES FROM THE REPRESENTATIVES OF THE UNITED NATIONS, THE SPECIALIZED AGENCIES AND OTHER INTER-GOVERNMENTAL ORGANIZATIONS
Text of Address

by

Dr John McDiarmid,
Resident Representative,
United Nations Development Programme

It is a pleasure and privilege to be associated with the commemoration of the twenty-fifth anniversary of the World Health Organization, which also coincides with the twenty-fifth anniversary of the Office of the World Health Organization at New Delhi. In India, as in many other countries, there has been close and effective co-ordination and fruitful collaboration between the UNDP and the WHO, for assisting the Government in controlling diseases and malnutrition and extending medical facilities to millions of people. We can legitimately be proud that our joint contribution to the national campaigns against smallpox and tuberculosis has yielded tangible results.

Twenty-five years is comparatively a small period in an international organization's life, but as Dr Candau, who recently laid down office as the General of WHO after a long record of distinguished service, has said, even the founders could not have foreseen the profound changes that have taken place throughout the world in matters affecting disease, health services and the aspirations of communities and nations. While social and economic changes have had their impact on this organization, there cannot be any doubt about the substantial contribution medicine and medical facilities have made to a better and fuller life for millions of people throughout the world. Expectation of life has increased everywhere, including in India, where it has risen from 32.6 years in 1940 to 50.3 years today.

Medicine, for instance, has changed the whole approach to tackling diseases like tuberculosis in India. For long, cure of tuberculosis was a costly, time-consuming and labour-intensive process involving the patient and costly nursing care in congenial isolation. But a revolution has taken place since then. Thanks to Dr Halfdane, the present Director-General of WHO, who worked at the National Tuberculosis Institute at Bangalore some 22 years ago, and a band of Indian doctors, it has been proved that medicine can cure at least 80% of the patients. The Chemotherapy Centre at Madras and the Tuberculosis Control Programme, supported by UNDP and WHO, are giving hope and cheer to millions who would have otherwise resigned to a life of miserable existence.

And there are many other important spheres in which UNDP and your organization are collaborating with the Government of India are family planning, nursing
education and training and improvement of the human environment. Health education in schools and colleges centered on family life, teaching and research in human reproduction, family planning and population dynamics in medical colleges and the strengthening of family planning aspects of nursing administration, supported by the United Nations Fund for Population Activities, UNICEF and WHO, may, in the long run, have better impact on India’s population control measures. We have made a beginning in the field of the environment by supporting the Central Public Health Engineering Research Institute at Nagpur in its research and training in environmental problems. As the plan of action for this new United Nations agency for the environment develops, UNDP and WHO can widen the areas of support to India. We in UNDP look forward to continuing fruitful collaboration with you for many years to come.

I should like to convey to you the Executive Director of UNICEF’s wishes on the occasion of this session and to extend to you, on the twenty-fifth anniversary of the World Health Organization, the congratulations of the Children’s Fund, and more particularly, the feeling of friendship, instead of comradeship, which the entire UNICEF staff has for its colleagues in WHO.

Relations between UNICEF and the various United Nations organizations and agencies are close. The particular relationship which UNICEF has with WHO is, however, unique in a number of ways.

It goes back to the word "go" in 1946. The largest share of UNICEF money has gone, and still goes, to health, nutrition and water supply, all of which are also in WHO areas of endeavour. WHO was the first agency to accept to provide from its own funds all technical advisory services to health programmes assisted by UNICEF, a *modus operandi* which is unmatched by any other United Nations agency and which is in force today.

So much in this brief message - and it is a lot - for the links between the two organizations. As for the people involved, the relationships cover the whole gamut of association between the human beings.

Relations between us can, we must admit, sometimes be perfunctory or unnecessarily formal. UNICEF and WHO staff, at regional, country or simply personal levels, now and then go their own ways. And there are occasionally bound to be stresses and strains, when we decide to stick to our guns and agree ... to disagree.

But almost invariably relations are active, constructive and sometimes intense, as is, for example, the case in this very Region and in connexion with our respective contributions to India’s Fifth Plan, WHO and UNICEF staff forming a single team in their negotiations with the Government.

And more significant, perhaps, is the warm companionship which exists around the world amongst so many colleagues in UNICEF and WHO.
All of which, Mr Chairman, is the best possible proof of a very live relationship, which has immensely benefited both organizations over the past quarter of a century and has surely had a lot to do with their rendering a better service to governments and to people, than either agency could have done separately. And on a personal note, I may say that I have personally been very much part of the long WHO/UNICEF "connexion" over the past 25 years, in five of your six WHO regions.

Need I say more? Yes, I think I should. While we look back at what has been achieved in the past 25 years, we cannot escape the fact that we have failed to make much headway against some of the massive problems which beset governments and afflict hundreds of millions of people in this part of the world: the racing increase in population, which wipes out much of the "achievement"; such ploddingly slow progress in providing people with the blessing of clean and plentiful water; a heart-rending inability to come up with solutions to severe malnutrition which kills and cripples countless numbers of young children ... which is my own greatest sorrow.

But do let me close, Mr Chairman, by wishing WHO another useful and bright 25 years, during which an end to some of these conditions will hopefully be within our reach.
like to pay tribute, faced a refugee situation of enormous magnitude and our organizations together with other members of the United Nations family collaborated in assisting the Government of India in dealing with this problem.

It is my honour to convey to you, Mr Chairman, and to the Honourable Minister of State for Health and Family Planning, with whom our office has such valued and memorable association, and to the distinguished members of the assembly, the warm greetings of the High Commissioner and to express to you, Mr Director-General, and to Dr Gunaratne and his staff, his most cordial wishes for the successful and effective continuation of the noble mission which you are pursuing. I am pleased to be able to participate in this session and wish the Regional Committee, most sincerely, every success in its deliberations.

WHO's contribution to the well-being of refugees is not limited to the support it gives to UNHCR. Indeed, in many countries refugees have benefited from vaccination campaigns carried out with WHO co-operation and from training facilities set up with its aid. Furthermore, refugees benefit from WHO expertise in such varied fields as the composition of food rations supplied by World Food Programme, the supply of drinking water in rural areas and the prevention and control of tuberculosis.

The above examples illustrate the ties which link our two organizations. These ties became stronger over the years following the growing involvement of WHO in refugee assistance. The pattern of the co-operation between the two organizations has evolved in the wake of the decentralization of WHO services and has resulted in the close relationship which now exists between the regional organizations of WHO and UNHCR representatives in the field, as evidenced by UNHCR's presence here today. In this particular Region, this close relationship was highlighted when in the recent past our host country, to the hospitality and generosity of which I should
countries. In the context of the Food and Agriculture Organization, I extend special appreciation for the role of FAO in this respect. FAO has contributed significantly to the progress of agriculture and food production, and its efforts in this regard have been recognized and acknowledged by the United Nations. FAO has been instrumental in providing assistance to member states through various programs and initiatives. It has also played a crucial role in dealing with food shortages, hunger, and malnutrition.

The importance of food and nutrition assistance to Member States has been highlighted in the past. The need for international cooperation and assistance in the field of agriculture and food production is evident, especially in developing countries. FAO has been at the forefront of providing technical assistance, training, and expertise to help Member States improve their food production and nutrition levels.

The past five years have been marked by significant advances in the field of agriculture and food production. FAO has been instrumental in these advances, and its work has been widely recognized. The organization has been at the forefront of providing assistance and support to Member States in the areas of agriculture, food production, and nutrition. FAO has been instrumental in dealing with food shortages, hunger, and malnutrition, and its efforts have been widely acknowledged.

In conclusion, the role of FAO in providing assistance to Member States in the areas of agriculture, food production, and nutrition cannot be overstated. Its work has been widely recognized, and its contributions to the progress of agriculture and food production cannot be overlooked. FAO has been instrumental in dealing with food shortages, hunger, and malnutrition, and its efforts have been widely acknowledged.

The theme of the FAO program is to provide assistance to Member States in the areas of agriculture, food production, and nutrition. FAO has been at the forefront of providing technical assistance, training, and expertise to help Member States improve their food production and nutrition levels. The organization has been instrumental in dealing with food shortages, hunger, and malnutrition, and its efforts have been widely acknowledged.

In conclusion, the role of FAO in providing assistance to Member States in the areas of agriculture, food production, and nutrition cannot be overstated. Its work has been widely recognized, and its contributions to the progress of agriculture and food production cannot be overlooked. FAO has been instrumental in dealing with food shortages, hunger, and malnutrition, and its efforts have been widely acknowledged.
I think my colleagues before me have expressed much more ably the various sentiments that one feels at a meeting such as this one. I would just like to add that, personally, I feel it is an honour and a pleasure for me to attend this meeting. I wish WHO much greater success in the next twenty-five years, and we, for our part, hope to be associated with that success through increasing co-operation and collaboration in the fields of population, nutrition and water supply.

Mr. A.D. Granger,
Director,
Area Office, International Labour Organisation,
New Delhi

The completion of twenty-five years in the life of any institution is without doubt a time for satisfaction and reflection. It is an occasion to take stock of what has been achieved and to plan the future work of the organisation in the light of its performance and achievements.

The activities of ILO in respect of occupational safety and health are as old as the Organization itself. From its establishment in 1919, the ILO has been actively engaged in identifying hazards to the safety and health of workers and proposing appropriate remedial measures through preventive action and legislation. It is interesting to note that over a third of the 280 international instruments in the form of Conventions and Recommendations adopted by ILO in its 54 years of existence are directly connected with, or closely related to, occupational safety and health. This point is illustrated by the very first international instruments adopted in 1919, which were concerned with the protection of the workers in specific industries. Recommendation No.4 covered lead poisoning and No.6, White phosphorus poisoning. ILO's most recent annual conference in 1993 discussed the control and prevention of occupational cancer with the intention of adopting an international instrument concerning this distressful subject.
Besides these international instruments, ILO has codified, for the guidance of Member Governments, model safety regulations for industrial establishments as well as for work in agriculture and forestry. New codes relating to work in coal mines, building, and construction are now in preparation.

Equally significant has been ILO’s efforts in the realm of research and exchange of information. During the last ten years, over 150 different studies have been published dealing with occupational health and safety. Let me mention two instances of this aspect of ILO’s work that might be of interest to this meeting. In 1960, ILO, together with a number of other international and regional organizations, set up some 30 national centres to draw upon the resources of the International Occupational Safety and Health Information Centre in Geneva and make information available readily and systematically, to interested people on all aspects of occupational safety and health in every type of work activity. The second activity I would like to refer to is the recent publication of the Encyclopaedia of Occupational Safety and Health, comprising nearly 1,000 articles written by 600 specialists drawn from 60 countries.

In carrying out its programmes in the field of occupational safety and health, ILO co-operates closely with WHO. As you are aware, the two organizations reached an agreement in 1954 on the co-operation and co-ordination that should take place between them in regard to their respective programmes in occupational health. In following-up this agreement and to facilitate closer co-operation between ILO and WHO, a joint ILO/WHO Committee on Occupational Health was established. The Committee held its first session in 1950, and, in the course of its various subsequent sessions, has made recommendations on many matters concerned with occupational health, training of medical personnel, co-operation between occupational health services and public health services and notifications of occupational diseases. The Fifth Session of this Committee, held in 1966, reviewed and discussed the basic needs and special problems of developing countries in the field of occupational health with particular reference to the role of paramedical and auxiliary medical personnel.

As a further instance of the close collaboration between our two organizations, I would like to refer to the other joint committee, viz., ILO/WHO Committee on the Health of Seafarers, established in 1963. Its work in co-operation with the International Maritime Consultative Organization in the realm of shipboard safety culminated in the publication, by WHO, of the International Medical Guide for Ships to meet the needs of a master faced with injury or disease on board his ship.

Several technical co-operation projects undertaken by ILO were carried out jointly with WHO. For example, the two organizations collaborated in the Philippines to train accident prevention personnel and to set up organizational services to improve the working environment. Another example of collaboration was the series of national seminars on the organization of industrial medical services held in Singapore and Korea in 1972.
V. STATEMENTS BY THE REPRESENTATIVES OF MEMBER GOVERNMENTS ON THE HEALTH SITUATION IN THEIR COUNTRIES
BANGLADESH

Statement delivered by Dr. T. Hossain

Background Information

The health administrative system, a legacy inherited from the colonial time, was primarily directed to the alleviation of suffering due to sickness, mostly catering to the needs of a privileged group concentrated in urban areas, at the cost of the toiling millions of rural population. Gradually, it was realized that most of the sickness is preventable and much of the mortality is unnecessary, and the cost of preventable diseases imposes a staggering burden upon the community. On the other hand, a reduction in the vast need of the curative treatment can only be secured through successful preventive work, and in many situations prevention is possible before cure is even a possibility.

With the attainment of independence from British rule, when the sub-continent was communally divided at the time of "Quit India", our generation of medical students just graduated. The division resulted in a large exodus on public health workers adding another hurdle to our inherited difficulties. Many of the dispensaries run by the district boards and philanthropic persons and organizations, mainly in rural areas, started to decay quickly. The medical units in cities and towns run by the Government also had its effect. There were approximately 300 posts of doctors in the service. Not even 70 persons were available to fill up the posts. On the other hand, there were only 4 medical schools offering licences for sub-assistant Surgeons, having an average of 300 students in four-year classes. The annual admission was about 250.

The only medical college, which was started in 1946 at Dacca, was in its second year of age. There were few private practitioners in the country. Health facilities in the rural areas were extremely meagre. Shortage of doctors and paramedical personnel became an acute problem. The public health service, in whatever rudimentary manner it was existing, had a tremendous setback, and cholera and smallpox continued to exact heavy toll of lives. Few Muslim doctors came from India, and with about 100 senior students who migrated from Calcutta Medical College, the Dacca Medical College produced the first batch of M.B.B.S. doctors in 1949.

In 1962 a decision was made to convert the medical schools for licentiates into those for graduates (M.B.B.S.), and admission into medical schools were stopped. One of the medical schools at Dacca was converted into a college of licentiates doctors with a two-year course of condensed M.B.B.S., and three other medical schools started M.B.B.S. courses. About 200
doctors were sent abroad for higher diploma in different subjects, mostly clinical. In four years' time, most of them returned with professional assignments to the established colleges. Two other medical colleges were started during the Third Five-Year Plan period. On the whole, in 24 years' time, the number of doctors increased from roughly 700 to 7,000, whereas in West Bengal it rose from 3,000 to 30,000.

The population of the country was a little less than five crores at the time of partition, and now it is estimated to be little less than eight crores. The doctor-population ratio is 1:10,000. The number of hospital beds is around 12,000. The number of the nurses is extremely meagre and is less than 1,000 throughout the country. Paramedical and technical personnel have also not been produced so far in any appreciable number. The public leaders did not have any say in public affairs. Dictation came from Rawalpindi.

Based on the 'Bihar Committee Report', a plan was also made, soon after independence, to set up rural dispensaries with four attached beds for emergency purposes to be constructed at the rate of 100 per year. It was also envisaged to streamline the health administration by "provincialisation" of district board health establishments, which were chronically suffering from shortage of funds, maladministration and dual control. The health services run by the District Boards of four districts, Myningning, Barisal, Chittagong and Sylhet, were taken over by the Government from 1 October 1954, and 100 new rural dispensaries were set up in these four districts with four beds in each dispensary. Chittagong Hill Tracts were under the direct administration of the Government from the very beginning. After the first year of implementation, the plan was not further pursued by them regime.

Thereafter in a bid to bring the health services closer to the village population, the scheme for rural health centres with a comprehensive health care programme for every 50,000 population was introduced in 1961. The rural health centre scheme could not be developed as planned and had to be staggered for various reasons, including paucity of funds. At present, 150 rural health centres are functioning, whereas there are 287 health centres and 512 secondary centres functioning in West Bengal. Along with the introduction of the rural health centre scheme, several multi-purpose vertical projects like malaria eradication, family planning, smallpox eradication, tuberculosis control, etc., were also launched.

Vertical Programmes

The smallpox eradication programme was launched in the year 1960 at an estimated cost of Tk. 282 million for a period of 14 years in Bangladesh. The programme developed well, and a country-wide infrastructure was built up with reasonable success. The programme has spent about 330 million takas out of the 500 million so far earmarked to achieve the target. Such an enormous cost for any vertical programme is only justified by the time-limit of its operation; an expenditure representing a kind of capital investment and not a constantly recurring one. The enormous difference in cost between an eradication and a control programme was justified only on this ground. That is why, in its twenty-second World Health Assembly in 1969, recognized the failures recorded during the implementation of the malaria eradication programmes of different countries and revised the global strategy on long-term plans (control), as an integral component of general health service.

Family planning, on the other hand, has, by necessity, to be a continuous programme with the essential element of total coverage of the fertile population in time and space. The motivational aspect of the programme has so far been carried out by family planning workers, and the practical work has been done through medical professionals by the distribution of money. Emphasis must now be made on an action programme after the technical aspect has gained sufficient ground. The programme, so far, could not, however, be brought any more closer to the population beyond than a level except in two districts, where about 700 whole-time workers have been placed on a regular basis up to union level in a pilot study. On the other hand, it can be effectively brought at the doorstep of the rural population by a multi-purpose worker through monthly domiciliary visits over and above the static institutional (health and family planning) services for an action programme. He would be more acceptable to a family, because he is the man who looks after the health of the family, and thus the programme would be more effective when launched as an integrated programme and also economical both in terms of money and manpower.

The smallpox eradication programme also met with some success, but it is an essential problem of eradication or the maintenance of its achievement, an effective surveillance system is a pre-requisite for complete success. An adequate health infrastructure with a network of basic health service personnel has thus to play a crucial role in the eradication of smallpox and also needs to be operated as an integrated health programme.

BCG vaccination is still the most effective control method in countries like ours and can best be promoted by a house-to-house approach. A mass BCG vaccination programme against tuberculosis was started on the pattern of operations based on mobile teams of doctors and nurses with the aim of vaccinating in one sweep the largest possible number of susceptible children and adults but it was later realized that it cannot be effectively or as an emergency programme and long-term policies are to be evolved. The BCG programme as well as case-finding, domiciliary treatment and follow-up of tuberculosis patients needs to be integrated with the infrastructure of general health services for better results per taka spent.
Of all water-borne diseases, the incidence of cholera each year
takes heavy tools of human life and is a problem deserving special attention.
Currently available vaccine has been shown to be effective only up
to a limited extent, and the protection lasts only for a period of three
to six months at the most. Since vaccination affords only partial protection,
it is considered as an adjunct to other important control measures
like improvement of water supply, sanitation and provision of rehydration
centres for treatment within easy reach of the population, which can
only be provided when there is an adequate health infrastructure at rural
level. A higher fatality rate of cholera cases in our country is mostly
due to inadequate rehydration facilities.

Likewise, there are many other diseases which can be effectively
dealt with, only through integrated health services with an adequate
health infrastructure available at rural level.

Integrated Service

A major portion of the total allocation for the health sector is
at present allocated to malaria eradication and family planning programmes
whereas, on the other hand, an adequate health infrastructure with a perma-
nent network of basic health service, so vital for the effective imple-
mentation of health programmes and for the maintenance of the achievements
of the vertical projects could not yet be developed in the country.
On the other hand, there is a need for programmes to deal with other diseases
like diphtheria, whooping cough, tetanus, gastrointestinal diseases,
filaria, kala-azar, viral diseases, etc., to control them effectively
and eventually to eradicate them. The limited resources do not permit
several uni-purpose vertical programmes, an arrangement which is not only
economical but also almost impossible. It was thus considered expedient
to integrate the vertical projects into the general health services with
the ultimate aim of providing a comprehensive health care scheme for the
country, and the need for the services of polyvalent/multi-purpose health
workers was badly felt so as to prevent waste of scarce health workers
by visits to the same family by different uni-purpose workers at field level.
A plan has accordingly been prepared to develop an integrated health and family
planning service at thana level, 356 of which are rural, to create a health
infrastructure at the grass-root level for providing integrated and compre-
henhensive health services through thana health complexes and union sub-centres.
Thana health complexes will have 31 beds - 25 general (10 males and 15
females) and 6 maternal and child health. There will be out-patient clinics
for males and females, both for health and family planning purposes.
The main target will be to reduce birth rate, prevent premature deaths through
prevention of communicable diseases and promotion of health so that the
productive capacity of the population may be increased.

Recently, a task force of the World Health Organization had been
working with our participants for nearly six weeks to identify the problems,
quantify the requirements and forecast the achievement by 1978. A report
has been prepared and is under consideration by the Government.

Administration

To say a few words on administration, the then Provincial Govern-
ment had a Department of Health and Local Self Government with a Secretary.
In the health sector, there were three Directorates, namely Medical under a
Surgeon-General, Public Health under a Director and Public Health Engineer-
ing under a Chief Engineer.

The question of integrated posts of Surgeon-General and Director of
Public Health was under consideration for some time and was given effect
from 1958. The process of unification of preventive and curative services,
however, did not progress further beyond the amalgamation of the two
Directorates headed by the Director of Health Services and Director
of Public Health. The composite responsibilities of preventive and curative functions remained yet to be
combined at district and thana levels of health administration.

Public Health Engineering was then tagged onto Local Government,
which formed another department. Labour and Social Welfare along with
Health and Family Planning were eventually split into two ministries;
Health and Family Planning were integrated into one.

To do away with the complexities of dual administrations, health
services of all the districts were taken over by the Government in the
year 1972. The Thana Health and Family Planning Administrator has been
made responsible, in the integrated plan, for the organization, adminis-
tration and implementation of all health and family planning activities in
his area.

Soon after liberation, in spite of the gigantic task of rehabilita-
tion, the re-construction task was undertaken with a patriotic zeal. First,
an attempt was made to stop the "brain drain". The Post-graduate School
of Medicine was given all possible assistance to build up from an under-
nourished attenuated Institute into a full-fledged one. The College of
Surgeons and Physicians was given the authority to conduct all post-graduate
examinations at par with international standards. The National Medical
Council was re-organized, and it conducted an extensive survey of existing
undergraduate medical education. Necessary recommendation has been made to
standardize medical education, research and training. A Medical Research
Council has been set up to conduct country-wide research activities in
various fields.

The number of admissions in all eight medical colleges has nearly
been doubled from 850 to 1 475 during the last two sessions.
Unfortunately, nearly one third of the total number of posts of teaching staff are yet to be filled up. Nearly 500 doctors are serving in different capacities in the U.K. and elsewhere, and considering the value of their contribution, they are not returning. If trained persons would have returned, the problems would have diminished. Nevertheless, attempts are being made to fill up the vacancies with the locally qualified postgraduate doctors.

Bangladesh has few distinct advantages like a unified socio-cultural background, democratic government, unitary administration and total participation of the people. Motivation target has been achieved both in the rank and file and also in the society in favour of integration.

Shattered economy following war devastation, reconstructive progress in other fields, and chronic food shortage are our greatest enemies of the day. International goodwill, assistance and co-operation will help us, we hope, to get over these deficiencies.

It has been visualized that over 12,000 hospital beds will be added in the three health complexes by the end of the Five-Year Plan. There will be 356 (21-bed) hospitals in rural areas. The whole population will be taken care of through domiciliary visits by family welfare workers and sub-clinics. The message and materials of family planning and preventive measures will be effectively delivered on family basis throughout the country.

Simultaneously, referral hospitals will be built up at district levels and at medical education centres. Undergraduate medical education, nursing and paramedical technicalities will be built up according to the approved plan.

Post-graduate medical education is being improved. University status is being granted to the Institute of Post-graduate Medicine so that necessary faculties may be developed. The "brain drain" has got to be prevented at all cost.

Training programmes with WHO assistance is being planned under different programmes. The overall concern of WHO is well appreciated, and its impact since liberation has been felt. Our personnel went to Member countries to take part in different programmes, conferences and seminars. Simultaneously, we also played host to at least two regional seminars on paediatrics and population dynamics.

As a first step towards integrated health services, we are now carrying out country-wide training of health and family planning workers at all levels from top administrators to basic health workers. In short, under the given circumstances, we are trying our best to do the best of a worst job. We hope by mutual friendship and co-operation through this great organization, we shall reach the goal in the near future.

BURMA

Statement delivered by Dr Ba Tun

It is a great pleasure to be here with you on this important occasion of the twenty-sixth session of the WHO Regional Committee. May I, on behalf of the Government of the Union of Burma extend our greetings to the Government of India, the WHO Secretariat and the Governments of the countries of this region through our eminent representatives. My delegation welcomes the representatives of the Democratic People's Republic of Korea. As this year also commemorates the twenty-fifth anniversary of WHO and its South-East Asia Regional Office, may I, on behalf of our delegation extend our congratulations and sincere good wishes to the WHO Secretariat, especially to the Regional Director and his staff of SEARO.

May we next congratulate you, Mr Chairman on your being elected chairman of the twenty-sixth session and also the vice-chairman for being elected. We would like to compliment the Regional Director for his excellent annual report for 1972-73.

To proceed in presenting an account of the health conditions of our country past and present, Burma, 25 years ago, was a near devastated war-torn country, facing a horde of health and other problems. The health sector was confronted with health problems whose demands far exceeded the available resources. Whatever resources were available were concentrated in the large urban towns and the rural areas badly lacked in health facilities. The morbidity, especially of communicable diseases was extremely high, with high fatality rates. The health services were disorganized, and public health services were poor and deficient especially for maternity and child health care which, due to its deficiency, resulted in high mortality of infants and mothers.

We obtained our independence soon after the war in 1948, and hence plans for rehabilitating and redeveloping the socio-economic status of the country have been made, including plans for the health sector, which received priority consideration. Health problems were defined, the summation of which was the high incidence of diseases with rising magnitude of certain communicable diseases on the one hand and lack of health resources on the other.

Fortunately, we gained early membership to WHO in 1950, and our health services were thus augmented by WHO assistance, which commenced in 1951. Most of the disease campaigns selected for immediate action, were launched with WHO assistance. The initial special disease projects consisted of leprosy, tuberculosis, malaria and venereal diseases. These were followed soon after by trachoma, smallpox, filariasis and dengue haemorrhagic fever. These will be discussed in more detail later.
Although, almost from the onset of our post-war health planning process, we established specialized health campaigns, these were, as mentioned earlier, concentrated in the urban towns e.g., tuberculosis control work only existed in two major towns, Rangoon and Mandalay. Moreover public health services, for example maternal and child health, rural health centres and school health services, were ineffective as also general preventive work for other communicable diseases.

In 1962, when the Revolutionary Government came into power, health was amongst those which received top consideration. A thorough review was made of existing health services and facilities, and these were strengthened accordingly. The health policy had changed considerably, the foremost consideration of which was to augment and upgrade the health services for the rural population, which comprised about 85 per cent of the total population of Burma.

This was done by opening up health centres which were distributed so that they could be within reach of the vast majority of the rural population. There now exists about 1 008 rural health centres in all, and each of them is composed of a health unit with facilities for providing the basic health services. It is envisaged that special-disease-control activities will be integrated into these basic health services to enable the basic health services to be more complete and also to minimize duplication of labour. The health personnel in these centres are thus expected to be multi-purpose health workers in future. A pilot project is now in progress in Kyaukse District where the envisaged integration set-up is being tried.

To describe the special campaigns in more detail, commencing with the tuberculosis project, this project was initiated in 1951 with technical assistance from WHO and material assistance from UNICEF. Initial work commenced with a mass BCG vaccination programme which was implemented throughout the country. By 1972, over 12.2 million children had been vaccinated. Two tuberculosis demonstration and training centres were set up in Rangoon and Mandalay.

At present, 868 health centres have BCG vaccination facilities with trained personnel, and about 85 per cent of the vaccination work is performed in these health centres. Direct BCG vaccination for 0-14 years group was initiated in 1969 and still continues. In addition, case-finding by direct microscope examination of the sputum and follow-up treatment for detected cases is in progress, and also direct BCG vaccination of newborns and young children.

Leprasy was, and still is, a serious health problem in our country. The high endemicity of leprosy was one of the salient confrontations of the health department after the war. In 1952, we obtained assistance from WHO, and anti-leprosy work has continued since then. An intensive case-finding and domiciliary treatment programme was established, and continuous surveys for new cases and follow-up treatment have been undertaken. So far, 250,000 cases detected through the surveys have received or are still receiving treatment. The infective lepromatous proportion of 35.9% and children proportion of 25.2% in 1962 were reduced to 23.4% and 14.4% respectively in 1972. A centre for reconstructive surgery was also opened in 1955.

The campaign against smallpox has achieved dramatic success. The smallpox eradication programme as it is called was initiated in 1964, and after intense combat work, as of 1970, Burma has been proclaimed a smallpox free zone. Surveillance and vigilance work still continues.

The malaria control programme was established in 1951, with WHO's assistance, and by 1953, it was on a nation-wide basis. In 1957, the programme was renamed as malaria eradication programme according to the recommendations of the Eighth World Health Assembly. In 1967, the malaria eradication programme was somewhat relaxed due to difficulty in implementing the programme in inaccessible and hilly regions of the country. The programme now continues to function only in feasible regions whilst the general health services undertake control and eradication work in the remaining areas. However, malaria eradication work has made progress. This is proved by the fall in the death rate due to malaria, according to available statistics for a ten-year period 1954-1964, from 91 per 100 000 of the population in 1954 to 5.3 in 1964. Malaria was one of the ten leading causes in hospital morbidity till about 1963, but is now only a small proportion of total hospital morbidity.

The trachoma control project started in 1964, also with WHO and UNICEF assistance. Trachoma work is centred round the dry zone of Burma, and commenced with prevalence surveys, followed by mass field treatment, and the area for mass treatment is determined by endemicity assessment, i.e., those with above 30 per cent endemicity. In these places, blanket mass treatment is given for all ages, and eye examinations are omitted. In areas where the endemicity is less than 30 per cent, eye examinations are first conducted, and only confirmed trachoma cases are given treatment. Clinical assessment as well as medical and surgical treatment are done by senior ophthalmologists, who lead the teams.

Filariasis control began in 1960 with a Filariasis Research Unit, which was established with joint agreement of the Government of Burma and WHO. After three years of research relating to the problem of vector control, a pilot vector control programme was started in 1966. The research programme terminated at the end of 1969, and as from 1970, it has been converted into a filarisis control project, under the direct control of the Health Department, with continued WHO assistance.
In recent years, i.e., since 1970, dengue/haemorrhagic fever has also been given much attention due to its high prevalence and rising mortality, especially in Rangoon City. This work is also conducted with WHO assistance and is being continued.

The above account sums up in general the work and progress of the disease control programmes. May I now present some of the other activities on health, commencing with medical care services. As stated earlier our policy now is to have even distribution of health facilities in both urban and rural areas of Burma. Accordingly our medical care services are free of charge and have been extended to all parts of the country. There are now 385 hospitals in the country, with the bed capacity of 24,000 giving a ratio of 1:1175. According to the type of treatment and bed capacity, the hospitals are classified into four categories:

1. **Township hospitals**, which give general health services, with standard bed capacities of 16, 25, 50, 100 and 150.

2. **Division general hospitals**, with specialist services and a bed capacity of 200.

3. **General hospitals with specialist services in Rangoon and other major towns**, with bed capacities ranging from 200 - 1,500, and

4. **Specialist hospitals giving specialized care in a particular discipline of medicine**, with bed capacities ranging from 50 to 1,500.

The unique feature of our medical care system is the two-way referral system, which is highly developed, especially in Rangoon Division.

Regarding rural health and maternity and child health services, these are being developed by the Government with WHO and UNICEF assistance. There are altogether 973 rural health centres and 250 maternity and child health centres. Up to date the health manpower in these public health sectors include 4,600 midwives, over 705 lady health visitors, 967 health assistants and 858 vaccinators, who as a team, implement the integrated community health service.

School health services commenced in 1957 in Rangoon and Mandalay and have now been extended to other large towns. Health surveys have been conducted of school children, with necessary follow-ups. There are now above 32 school health teams which operate in some of the schools, but they are still inadequate, and it is hoped that this important service will be enhanced with the joint co-operation of the Health and Education Departments.

The nutrition project which, as of May 1965, came under the direct control of the Health Department, was originally planned for a two-year period only. But in view of the increasing need for promotion of the work, it has now been established on a permanent basis. Activities on nutrition include nutrition and dietetic surveys, nutrition education, biochemical analyses of foods and, training in nutrition work.

Last but not the least is the work of the Health Statistics Division, whose main objective is to establish an effective health information service for collecting, processing, and consolidating the information received. It was initially established as the Vital and Health Statistics Department with WHO's assistance. In 1963, the two types of work were separated and whilst health statistics remained under the Health Department, vital statistics work was transferred to the National Planning Department. Priority development in health statistics work hitherto has been given to "hospital statistics", as hospital service is the single most expensive and utilized health service. A system for hospital reporting was established in 1964 and all hospitals in the country are covered, with about 95 per cent reporting. Collection of health manpower statistics was carried out in 1972, and is in progress. Collection of outpatient morbidity from both hospital out-patients and rural health centres is scheduled to be undertaken later this year, based on a cross section morbidity survey. In addition to its own work on health statistics, the Division lends assistance to ad hoc research work, and other special studies. Training activities include in-service training to central staff and staff from the periphery hospitals on hospital statistics as well as medical records work. A regional course for medical records officers was given in 1967 in joint sponsorship with WHO. The Division also conducts periodical national medical record technician courses. It is now agreed to upgrade this course to the regional level, with WHO's assistance. The first course is scheduled to take place in 1974. The Division's target objective is expected to be achieved by 1980 with WHO's assistance, and target implementation is envisaged to take place by systematic project formulation.

In future, our work on health is expected to conform to a more realistic planning based on correlation between social needs and available resources. The basic unit for implementation of health work will be the township. Information on health demands of every township will be studied through systematic data collection, and the supply of the health services will be made accordingly. Most of the present rural health centres will be upgraded to "station health units". In gist, the Township Health Organisation will be complete and self-contained, integrating basic health services with special health services.

Health manpower will be, as far as possible, in conformity with the health demands, with the overall objective of upgrading the quality of personnel: e.g., where the health units have hitherto been manned by health assistants as the responsible persons, they will be substituted by
Doctors. In order to meet the needs of the new trend and to maximize the available resources, the health services administration was reorganized, and the Ministry of Health assumed the role of the functional Ministry taking the responsibility for the integrated health care of the whole country.

May I, on behalf of our Delegation and on my own behalf, take this opportunity to express our deep appreciation to WHO for the valuable assistance given to Burma? We look forward to a long partnership with continued success.

Today we are commemorating the twenty-fifth anniversary of the inauguration of the South-East Asia Regional Committee of the World Health Organization.

I consider it a great pleasure to attend this meeting as delegate of a Member State of the South-East Asia Regional Committee of the World Health Organization and to celebrate the twenty-fifth anniversary of its inauguration.

Allow me to avail myself of this opportunity to extend my fervent greetings to the Regional Director, Dr Herat Gunaratne, and other staff members of the Regional Committee who have dedicated themselves for many years to the advancement of the work of WHO and especially the South-East Asia Regional Office and Committee and to the delegates of the Member States present here.

Health service, therefore, is a sacred undertaking for everyone who strives for the happiness of the people and for their betterment.

We think that, by accomplishing successfully its noble mission, the World Health Organization should contribute actively to the protection and improvement of the health of the people.

Under the wise leadership of Comrade Kim Il Sung, the great leader of the Korean people, and thanks to the correct health policy of the Government of our Republic, great progress has been made in the public health services of the Democratic People's Republic of Korea. The Government of the Republic attaches tremendous importance to protecting the lives of the people and promoting their health, applying the immortal Juche idea, which requires placing men in the centre of all consideration, putting everything at their service.

President Kim Il Sung, Head of State of the DPRK, said, "In our system, nothing is more precious than the people. We should develop our public health services to protect the lives of the people and further promote the health of the working people". The Government of the DPRK has striven to implement this instruction, regarding it as the fundamental principle of our health service.

The Government formulated, and has adhered to, the basic policy for preventive medicine, for universal free medical care, for a rapid development of medical science on the line of Juche, and for revolutionizing and
With independence, the approach to the problems of health changed, both conceptually and materially. It was recognized that, in terms of resources for economic development, nothing can be considered of higher importance than the health of the people. Health was given a priority. One of the Directive Principles of State Policy enshrined in the Constitution enjoined that "The State shall regard the raising of the level of nutrition and the standard of living of its people and improvement of public health as among its primary duties". Health became the concern of the whole community. This community responsibility took a concrete shape when health programmes were launched in 1951 under the auspices of the Planning Commission. The broad objectives of the health programmes during the first three five-year plans and also in the subsequent plans were to control and eradicate communicable diseases, to provide curative, preventive and promotional services in rural areas through the establishment of primary health centres in each community development block and to augment training facilities for medical and paramedical personnel, provision of better sanitation and water supply, and expansion of institutional facilities for treatment of the sick.

The health picture presented today in our country is hope-inspiring. There are unmistakable trends of improvement in health and well-being of the people. A child born today in India can expect to live for 50 years as compared to 32 years during 1941-50. The death rate has registered a fall from 27.4 in 1941-50 to 15.1 per thousand. Infant mortality rate, which is a sensitive index of the general standard of health and environmental conditions, has shown a steep fall from 183 per 1,000 live births during 1941-50 to 114.8 in the rural and 77.5 in the urban sector. More mothers and children are surviving child birth. With the implementation of various national health programmes and with the improvement of nutrition and environmental hygiene, people are becoming less and less disease prone. The results of the struggle to combat communicable diseases in India have met with phenomenal success. Significant progress has been made in the eradication of malaria in spite of certain local reverses which have to be expected in such a large-scale biological operation. The incidence of malaria has gone down appreciably over the last decade and a half. Malaria no longer claims a life.

There is clearly a significant trend towards decline in the incidence of tuberculosis. The number of reported cases of smallpox came down to 27,407 in 1972 against 157,487 in 1950, and the number of deaths in 1972 was 3,457 against 41,201 in 1950. In 1973, there has been no increase in the number of smallpox cases, particularly due to better reporting.

Epidemiologically, India can be divided into three broad groups of States, viz., smallpox free States, States reporting low incidence and endemic States. Seventeen States fall into the first group, nine in the second and four in the third. The present strategy and the main objective...
of the intensive campaign which has been launched recently is to maintain the smallpox free status in the 17 States, interrupt smallpox transmission in the nine States reporting low incidence by the end of this year and reduce the endemicity in the remaining four States.

High priority has been given to the smallpox eradication programme. It is evident from the fact that the national smallpox eradication programme will continue to remain a centrally sponsored scheme during the Fifth Five-Year Plan. Emphasis on active surveillance has been laid and the main strategy in the intensive campaign which is being carried out now is the search for smallpox cases by mobilizing all health staff. The search will be carried out not only in all the districts of endemic States but also in the districts which reported cases in 1973 and free districts bordering endemic areas of other States. It is anticipated that in 26 States and Union Territories, transmission of smallpox will be interrupted and surveillance will be intensified to prevent recurrence of the disease in these areas. In the next year, all efforts will be concentrated in the four remaining States.

In the intensive campaign, in addition to mobilizing staff in the endemic States, arrangements have been made for an assessment in the non-endemic States also to ensure that smallpox free status has actually been achieved. In this campaign, in addition to the WHO resources, experienced epidemiologists from the state governments, national institutes and persons experienced in the field of smallpox have been involved in the implementation of the programme. I can assure you, Dr. Mahler, that smallpox will be eradicated from India and that the variola virus will be thrown away into the Bay of Bengal.

It is heartening to note that since 1966 not a single case of human plague has been reported in the country.

We have also given high priority for the provision of community water supply and sanitation. Efforts have been intensified to identify the community water supply problem as an essential first stage in the national water supply development. Rural water supply has been included in the "Minimum Needs Programme", with an allocation of Rs. 550 crores in the Fifth Plan, the highest among the programmes included in the "Minimum Needs Programme".

Draft bills for the prevention of water and air pollution have been drawn up and are under the active consideration of the Government.

There has been considerable expansion of institutional facilities for treatment of the sick. The number of hospital beds has increased from 113,000 in 1950-51 to 273,440 in 1972-73.

For providing health services in the rural areas, an integrated comprehensive scheme of establishing primary health centres in community development blocks was launched in 1952. The primary health centres and sub-centres form the nucleus from which all health services radiate in the rural areas. There are at present 5,197 primary health centres and about 28,434 sub-centres in the country.

Another major development is the starting of a Mobile Training-cum-Service Hospital Scheme. This is intended to reorient the medical profession and the services so as to serve the needs of the people, particularly in the rural areas, by providing medical care including specialist and family planning services at their doorsteps.

Stress is being laid in the field of health laboratory services as an integral part of good public health services for the control or eradication programmes of communicable diseases.

The Central Research Institute, Kasauli, has a complex of laboratories dealing with various kinds of sera and vaccines. Both fundamental and applied research are carried out at this institute.

Medical education has been receiving constant attention in India. Today there are 100 medical colleges with an admission capacity of about 12,800 as against 25 medical colleges in 1947 with an intake of about 1,900 students only.

To meet the urgent demand in the fields of both research education and specialist services, institutions like All-India Institute of Medical Sciences, Jawaharlal Institute of Post-graduate Medical Education and Research, National Institute of Health Administration and Education and National Institute of Communicable Diseases have been established.

The success of these and other health measures has presented us with a menacing problem of population explosion. Since the inception of planning in India, the importance of the balance between growth and material resources has been realized. At present, family planning is a top priority programme. A large-scale adoption of methods of limiting the family has taken place.

A vast organization for mass communication has been set up. Wide awareness of the desirability of a small family has been created in the remotest corners of the country.

Special measures like the legislation for medical termination of pregnancy have been taken.

As a result of measures already adopted, it is estimated that about 13 million births have been averted by 31 March 1973.
Food adulteration in this country is a matter of concern to the Government. In order to have quick and reliable analysis, which is the backbone of better implementation of food laws, the Government of India have a proposal to equip adequately the food laboratories in the country.

In the field of quality control of drugs, the concerned agencies are tightening up the screening procedures for new drugs before granting marketing permission and for following up the adverse reactions exhibited by such drugs when they are in general use.

In spite of all these achievements and progress, the task ahead is in no way insignificant. A lot still remains to be done. The nation does not rest on its laurels. The battle against diseases and the march towards wellbeing of the people have to be relentless.

The primary objective of our need-based Fifth Five-Year Plan, which is under formulation, is to provide minimum public health facilities integrated with family planning and nutrition for children. Attempts would be made to remove the imbalance between rural and urban areas in the provision of medical care facilities and to remove deficiencies in the infrastructure in rural areas, where 80% of India's population lives.

The accent during the Fifth Plan would be on (i) increasing the accessibility of health services in rural areas, further development of referral services and removal of deficiencies in regard to diagnostic and specialized services at district and sub-divisional hospitals; (ii) intensification of programmes for the control of communicable diseases, particularly, malaria and smallpox; (iii) integration of health, family planning and nutrition programmes; and (iv) augmentation of training programmes of multi-purpose health workers to prepare them to take up integrated programmes.

Under the "Minimum Needs Programme", plans have been worked out to establish one primary health centre per community development block and one sub-centre for every 10,000 of the population. In addition, one primary health centre in 4 blocks would be upgraded to a 30-bedded rural hospital, and 1-283 such rural hospitals will be set up by the end of the Fifth Five-Year Plan to serve as referral hospitals.

We are grateful to the South-East Asia Regional Organization and, particularly, the interest taken by the Regional Director, Dr. Gunaratne, for discussing with us the provision of assistance towards the implementation of the Fifth Five-Year Health Plan. WHO will be participating to assist in developing six national training centres on a regional basis for training paramedical health personnel, health auxiliaries as well as training of the trainers. Preparatory action in this direction has already been started. WHO has also assured us to assist in further strengthening the implementation of the rural health service programme at the State level and even at the district level.

Backward and tribal areas which have so far been neglected in the matter of health care are expected to receive first priority.

Family planning would aim at reducing the population growth rate to 25 per thousand of the population as early as possible. Facilities for medical termination of pregnancy would also be made available.

Proper integration of health, family planning and nutrition services would be brought about by utilizing the services of trained multi-purpose medical auxiliaries.

Before I conclude, I would like to mention that India and other countries of South-East Asia have benefited vastly from the humanitarian work of WHO and other international agencies, and they have come closer together in their endeavour to combat common health problems. I hope that the co-operation will continue till the countries of the Region achieve the objective of healthful living.
INDONESIA

Statement delivered by Dr R. Brotoseno

It is a great honour and a privilege for me, to be given this opportunity to deliver an address on this historical day, when we, who are members of the South-East Asian Region, commemorate the twenty-fifth anniversary of WHO and the establishment of its Regional Office for South-East Asia.

We must commemorate this important day, not only because anniversaries are traditionally celebrated, but mainly because, during this quarter century since the establishment of WHO, it has made a valuable and great contribution to the improvement and promotion of the health of the people all over the world.

This occasion takes us back to 25 years ago, when on 7 April 1948, twenty-six nations agreed on the WHO Constitution, which was officially ratified by 53 members on 24 June 1948 during the First World Health Assembly.

In these 25 years, the membership has grown from 26 countries to 137 countries to date, thus practically covering the whole world and realizing thereby the principle of "universality of membership".

This principle is of great importance in a world where politics usually determine everything. We note with pleasure that although WHO has experienced political pressures, the conviction that health is one of the basic human rights and everyone has the right to get the minimum health services continues to inspire and determine WHO decisions.

The struggle to achieve the important aim of WHO, that is, the attainment by all people of the highest possible level of health, is, step by step, being materialized. Much has been accomplished, but many problems still remain, which even today become a question for experts with regard to their solution.

In the 25 years of WHO's existence, many great changes have occurred in the world in all fields, in the political, economic, social, cultural, scientific, technological as well as educational fields. We note here amongst others:

- the emergence of new nations, former colonies becoming independent, especially the Asian and African countries. This not only increases WHO membership but also exerts a great influence on the decisions of WHO's policy and programmes.

- economic and working relations among various countries, becoming of an equilateral nature, rather than that of a mother country and her colonies.

- education developing and reaching more people at different socio-economic levels, thereby creating new demands.

- fast means of communication between countries, giving the impression that our world is becoming smaller, while, on the other hand, facilitating rapid spread of diseases from one country to another.

- developments in the field of science and technology, including medical sciences, with new prospects of accelerating the improvement of health.

- the development of factories and industries satisfying material needs but, on the other hand, causing environmental pollution, with an ill effect on human health.

- the rapid population growth, especially in developing countries, with decreasing population quality and rapid urbanization.

- the influence on and change in attitude of society in general, especially the youth, who demand greater share in determining their future.

All the above result in a greater demand by the population for the health services and for their better quality. We note with pleasure that although great changes have occurred in this world and its population, WHO, under the leadership of Dr Chiqlom and later of Dr Candau, has been able to adjust itself to the changing circumstances and development and endeavour within these changes to accelerate the achievement of its aims. The adapting quality of WHO can be seen in its determination of policies and programme priorities. In the year 1950, WHO gave priority to the eradication of malaria, maternal and child health services, eradication of lung diseases, venereal diseases, nutritional improvement and environmental sanitation. Now it emphasizes the strengthening of health services, development of health manpower, disease prevention and control, and promotion of environmental health, and this provides for flexibility and adjustments in line with national priorities.

After going through the role of WHO during the past 25 years, what we have to think of now is what we will do next.
In an era of rapid social change, with an increasing social awareness and increasing demands for justice and social welfare, and as a developing country, we still face various problems in the field of health, among others:

- numerous cases of infectious diseases, smallpox, malaria, cholera, tuberculosis, which are the main cause of deaths among the population.

- the poor nutritional conditions, especially among children aged 1 to 5 years, causing protein-calorie malnutrition, and vitamin-A deficiency, resulting in blindness.

- poor hygiene and sanitation, especially with regard to potable water in rural areas, which is the source of infection of various diseases.

- the rapid population growth and the high mortality and birth rates.

- insufficiency of health personnel and their uneven distribution.

- insufficiency of health facilities and the low utilization rate of these facilities.

- ineffective and inefficient health administration and management.

- poor consciousness of healthy living on the part of many people.

- low economic level with a too low income to pay for health services.

- the tropical climate, which is an ideal climate for the breeding of various infectious diseases.

The list of health problems can be stretched, but basically it is a "big problem with only very limited resources".

Under these circumstances, Indonesia enters her Second Five-Year Plan by establishing some basic policies among others:

- one of the aims of the development of the nation is to promote the welfare of the people, including health. Thus, health development is aimed at maintaining and improving the health level of the people as the realization of one of the principles of human rights, that is, everyone has the right to enjoy the minimum health services, while, on the other hand, man as the development factor has to be healthy, physically, mentally and socially, to be able to make the development in the socio-economic field a success.

The priority programmes are:

- providing health services to people in rural areas and development areas.

- health services for the young and those in the productive age group.

- priority health services, i.e., ambulatory treatment and preventive health measures.

- the health centre to be given priority in the health delivery system, providing the basic health services, i.e.,

  - mother and child health services,
  - eradication of infectious diseases,
  - environmental sanitation,
  - health statistics,
  - health education,
  - public health nursing,
  - medical care,
  - family planning,
  - school-health services,
  - nutritional improvement,
  - dental health, and laboratories.

- education and training of health personnel, which is hospital oriented, to be changed to be community-health oriented.

We are sure that in the efforts to secure "the attainment of the highest possible level of health", it is absolutely necessary that cooperation between nations should be maintained, not only from the point of view of epidemiology of diseases but mainly also from the economic angle.

Besides the leadership of the national health authorities, WHO can play an important factor in achieving the goals we all desire. The Indonesian delegate is convinced that under the leadership of the new Director-General, Dr Mahler, and Dr Gunaratne, our Regional Director, the chances of getting better and more even health services for everyone are greater in the years to come.
MALDIVES

Statement delivered by Mr Mohamed Zahir Naseer

It is indeed a great honour and privilege to have this opportunity of saying a few words on the historic occasion of the twenty-fifth anniversary of the establishment of the South-East Asia Regional Office of WHO.

On behalf of the Republic of Maldives, it gives me great pleasure to extend a hearty welcome to our new Member, the Democratic People's Republic of Korea, whose delegation is attending the Regional Committee meeting for the first time today. Let me also, on behalf of my Government, congratulate and express our felicitations to the Director-General of WHO, Dr H. Mahler.

To the Regional Director, Dr V.T. Herat Gumaratne, I bring sincere greetings and warm good wishes, in appreciation of his achievements in the difficult tasks connected with the Region and for his services to the Republic of Maldives during the past years.

The Republic of Maldives comprises about 2,000 tiny islands, most of which are less than a square mile in area. Out of these 2,000 islands, only 198 islands are inhabited. Male is the capital and seat of the Government. The islands are of coral origin and are spread over an area of more than 500 miles from the north to the south and 80 miles from the east to the west.

The population of Maldives is about 122,000.

Twenty-five years ago, the only proper medical service available was a single small government dispensary situated in Male, which was not easy to reach by sailing boats.

Malaria, tuberculosis, filaria and leprosy were rampant all over the country. There was only one doctor from Sri Lanka to attend to the entire population at that time.

People depended mostly on the unqualified skills of the native physicians. When this failed, people had nothing to resort to, except the traditional charms.

But at present, things have changed considerably; now we are beginning to have our own doctors, nurses and paramedical personnel.

Today, the Maldivian Government has expanded the medical services to cover 14 of the 19 atolls. There is a modern, fairly well-equipped 40-bed hospital in Male, gifted by the Government of the United Kingdom.

With the help of WHO, we now have organized control programmes for malaria, tuberculosis, filariasis and leprosy. Thanks to WHO, 12 of the 19 atolls are now considered to be free from the risk of malaria.

A training course for additional paramedical personnel has been started just two weeks ago. A maternal and child health clinic was opened for the first time a few days ago in the hospital. BCG, polio, DPT and smallpox vaccination programmes are being conducted regularly every year.

When we look forward to the future, we have many problems confronting us, but we hope to surmount most of them with the help of WHO and other agencies and also with the co-operation of the local people.

Health statistics and vital statistics services at the central level will be developed by 1975. Twelve more community health workers will complete their training by 1975. This will provide the base for further expansion of atoll health centres. At present there are 14 atoll health centres. There are altogether 19 atolls which need health centres.

Community leaders in Maldives are usually the appointed atoll chiefs and island chiefs. Some of them also perform the duty of a "hakim", thus possessing basic motivation for the health problems. They have been increasingly involved in the Government health programme. The target is to involve them gradually.

UNICEF is examining the possibility of launching a nutrition programme with the help of a WHO team. It should expand gradually throughout the atolls, but, in the first instance, to one third of the atolls by 1975.

Training of the auxiliaries is to continue also in 1975, when the first batch of the community health workers will complete their training. There will be more hospital aids in 1975.

The availability of an adequate number of candidates to be awarded fellowships in health subjects will continue to be greatly handicapped by the unsolved general education problem in Maldives. Facilities are only available to study up to the ordinary level at present.

The community leaders will further avail themselves of the services of an adequate number of volunteers who could take up specific duties in health promotion and protection.

We are confident that assistance in the control and, later, surveillance of major communicable diseases will be continued by WHO. More attention will be given to the control of filariasis, especially in the south of the country. The total work on disease prevention and control largely depends on the availability of transport. It is envisaged that adequate transport will be made available in the near future.
Unlike the training of nurses and doctors, which presents considerable difficulty, the sanitarians do not require an advanced level of basic education. Therefore it can be expected that an adequate number of sanitarians, to support the water supply and sewage disposal system in Ulaanbaatar, will be trained. They will also be needed for food sanitation work, because of a fast-increasing tourist industry in the country.

We are looking forward to the construction of a water supply and sewage disposal system in Ulaanbaatar, which, we hope, will be in progress by 1975.

An active involvement of the community in environmental health work largely depends on the capability of the health centres to launch a systematic health education campaign. Some limited achievement in this field is expected shortly.

May I now wish the Organization every success in its endeavours to attain its ultimate goal of good health for all mankind?

MONGOLIA

Statement delivered by Dr Shagdarsurengyn Jigjidsuren

I am very glad to mention that the Mongolian People's Republic has been successfully co-operating with WHO for the last ten years. During this decade we made great progress in the field of public health. As a result of great attention and comprehensive material and financial support provided by our Government in a short period of time in the history of a country, some indications of health reached such a level as they are in the developed countries. In our country, more than 10% of the budget is designated for public health, and public health activities form part of the five-year plan in accordance with the long-term programme for the development of the national economy and culture, which gives an opportunity to develop evenly all branches of health.

Health services in our country are based on the following main principles:

1. The health of the people is a matter for the Government's concern;
2. Health services are planned;
3. They are free of charge;
4. Their main direction is preventive mass measures;
5. They are based on theoretical and practical achievements.

I am happy to mention that during this period many new specialized medical services, such as heart and neurological surgery, work on allergies, and endocrinology have appeared and have been put into practice, and that a number of hospitals and dispensaries (oncological, traumatological hospitals for occupational diseases, dispensaries for brucellosis, infectious hepatitis, mental health dispensaries, etc.) have been opened. In addition, a big specialized hospital for 600-700 beds with polyclinics has been constructed in Ulan Bator.

Now, all the aimags have created integrated (central) hospitals through combining the small ones.

Considerable attention has been given to the rural health services and a number of inter-soum hospitals have 25-30 beds and clinics of medicine, surgery, paediatrics, obstetrics and gynaecology and stomatology. So, during the last ten years, 26 inter-soum hospitals, 119 physicians' points, 339 fielders' points, combined (central) hospitals, and 78 clinics were constructed in rural areas. In this way, 79.8% of the soums have
physicians' points or inter-sumon hospitals; 62.9 per cent of the agricultural-cultural brigades have feldshers' points, and 93 per cent of the somons have chemists. Now there are 96.6 hospital beds, 19.2 physicians, 67.5 medium medical personnel per 10,000 population in Mongolia.

During the past ten years the annual per capita health expenditure has increased up to 168 tughrus, and each citizen can have a medical examination in polyclinics or at home 7.1 times and receive 37.7 tughrus worth of medicine per year.

During the period mentioned many progressive institutions of health services like dispensaries, district health services, intensive therapy and resuscitation units were newly established and started their activities. Scientific achievements, particularly in the field of chemistry, physiology and biology, were widely utilized for the purpose of diagnosis and treatment.

Also, a number of steps have been taken in the field of education and training of medical workers.

The medical faculty has become an independent institute providing a six-year course of study, where post-graduate training, aspiranture and ordination are organized and three to twelve-month training courses are being conducted.

Equal attention has also been paid to education and training of feldshers and paramedical personnel, and different kinds of courses in laboratory services, stomatology, pharmacology, obstetrics and gynaecology are conducted.

As a result of the above-mentioned measures, 24.1 per cent of all health workers are doctors (by receiving higher education), 70 per cent of whom are specialists.

Scientific research work in the field of public health has been increased by 39.3 per cent, and its material base strengthened considerably. At the present time, 9.9 per cent of all medical workers with higher education are doing scientific research work.

The relations of the Ministry of Health with foreign countries and organizations are rapidly developing, and at the present time 22 WHO programmes are operating successfully. The Ministry of Health has close relations with other United Nations organizations like UNICEF, FAO, etc.

Traditional and fruitful co-operation with the Health Ministries of the other socialist countries gives us an opportunity to exchange experiences and to join our efforts in control of and in taking preventive measures against some diseases which call for more attention, more efforts and more knowledge and experience.

Thanks to the comprehensive measures taken by our Government, the general health level of the people became much better, and the mortality from infectious diseases decreased by 2.2 per cent during this period.

Since 1930 our population has increased by 2.5 times; the general mortality rate has decreased three-fold; the child mortality rate has decreased eight-fold, and, consequently, life expectation has doubled and reached 64; the birth rate is 3.2 per 1,000.

Thank you, Mr Chairman, for giving me an opportunity to make a brief statement on our achievements in the field of health during the last 10 years since our country became a Member of WHO. Taking this opportunity, may I express my best greetings to the delegates of Democratic People’s Republic of Korea, participating in the twenty-sixth Regional Committee for the first time.
NEPAL

Statement delivered by Dr G.S.L. Das

I deem it a proud privilege to extend cordial felicitations on behalf of my delegation as well as my own behalf on the occasion of the twenty-fifth anniversary celebration of the South-East Asia Regional Office of the World Health Organization.

Five years ago, we celebrated the twentieth anniversary, under the inspiring presence of Dr Zakir Hussain, the then President of India. I had the good fortune to bring greetings on behalf of His Majesty's Government on that occasion. I consider it a lucky coincidence to be able to participate on this auspicious occasion also.

The World Health Organization has already come of age. The days of day-dreaming of adolescence are already over. The adulthood is manifest in the mature thinking, right decisions and prompt actions.

This Regional Office was the first to be established. Since its very inception, it has helped the Member countries to tackle the various health problems existing in them, which used to sap the energy of the masses. If we look back on the record of the last 25 years, we are filled with a sense of admiration and appreciation for what has been achieved with the help of the World Health Organization in this region. We can take as an example the efforts put in malaria eradication in Nepal, which has paid rich dividends; 80% of the population living in malaria risk areas have entered the consolidation phase and the areas once called the "Kalahandi" of Nepal (meaning valley of death) are now buzzing with life. The achievements in the field of smallpox eradication is another feather in our cap. It is hoped that in no distant future the whole Region will be free from smallpox. I have no intention of going over the long list of achievements to its credit, which is really impressive.

But I must add that there is no room for complacency, and much remains to be done. Eternal vigilance is required to maintain what we have achieved.

"Hunger is the worst disease. Disease is the worst enemy of mankind", said Lord Buddha.

I hope that the Regional Office will continue to wage its relentless war for the promotion of the health and happiness of the people of its Member countries until the aim of "attainment by all people of the highest possible level of health" is fulfilled.

SRI LANKA

Statement delivered by Dr L.B.T. Jayawardene

I consider it a distinct honour and privilege to represent Sri Lanka at the deliberations of the WHO Regional Committee for South-East Asia on the twenty-fifth anniversary of the Regional Office.

On this occasion, while expressing warm greetings on behalf of my Government, I wish to congratulate the Regional Director on his comprehensive and excellent report. I would also like to take this opportunity of extending a warm welcome to the representatives of the Democratic People's Republic of Korea, which joined the Region in May this year. My congratulations also go out to the Chairman and Vice-Chairman on their election.

During the 25 years of the existence of WHO in the South-East Asia Region, my country has made vast strides in the delivery of health care to its people. However, with the rapidly growing population, further problems continued to develop, and much remains to be done. The most acute problem has been the severe drain on our financial resources, as the expenditure on health has been gradually spiralling from Rs. 56 million in 1949 to nearly Rs. 270 million in 1973. By these heavy inputs and sustained efforts during the last two decades, Sri Lanka has extended its health services and embarked on a number of health programmes, achieving satisfying success in several aspects of health activity. This is amply borne out by the steady drop in mortality, the increasing expectation of life, which has risen from 52 years in 1957 to 67 years in 1970, and a considerable reduction in the infant and maternal mortality figures. One of the cardinal reasons for the successful execution of our health programmes has been the existence of the outposts of a well organized health infrastructure, which ensured our people adequate medical attention through a network of medical institutions located in the remotest areas of the island.

The most significant progress has been made in the control of communicable diseases like smallpox, cholera, tuberculosis and filariasis. Though in close proximity to endemic foci, the country has remained free of smallpox and cholera, owing chiefly to epidemiological surveillance measures, together with a regular and sustained vaccination programme for infants and pre-school children. The last outbreak of cholera was in 1953 and that of smallpox in 1962. Both were minor outbreaks.

Control measures against tuberculosis and filariasis have shown encouraging results. In the case of tuberculosis, an integrated control programme covers the entire country, and the sheet anchor of this programme has been the routine BCG vaccination of newborns in the majority of hospitals.
The problem of filariasis was confined to a limited area on the Western and South Western coast with a population of 2.5 million at risk. Parasite control activities had intensified as far back as 1963 and the infection rate had sharply dropped. This campaign has now been converted into a vector control project and was receiving assistance from UNDP and WHO.

Immunization against polio, diphtheria, tetanus and whooping cough has been stepped up in medical institutions and health centres resulting in greater coverage of the vulnerable age-groups with a consequent drop in the incidence of these diseases. Leprosy, with an incidence of less than 1 per 1,000 of the population, is not a major public health problem in my country. The rising trend in the incidence of venereal diseases characteristic in other parts of the world in recent years, has not been observed in Sri Lanka. On the contrary, there has been a decline, particularly of early syphilis.

However, malaria continues to be a health problem, and enteric infections account for nearly 15% of hospital morbidity. Although a serious epidemic of malaria in 1967-69 was controlled effectively, an increasing number of cases continue to be reported from certain areas and the progress towards eradication has not been as spectacular as anticipated, because of increasing tolerance of the vector to DDT, besides operational and ecological problems. This led to the establishment of a national malaria eradication training centre in 1971, and we are hopeful that a more vigorously applied programme on the basis of recommendations of the recent WHO assessment team will contribute to the final objective of eradication of the disease.

The high incidence of enteric infections is undoubtedly due to poor environmental sanitation, particularly in the disposal of sewage and the non-availability of clean water supplies to the majority of the rural population. Corrective measures such as the provision of piped water supplies in rural areas are making very slow progress owing to the high capital cost of such schemes. However, a significant step has been the development, with UNDP collaboration, of a comprehensive scheme for public water supply, drainage and sewerage for the South West coastal region. This scheme will cover the next 30 years, resulting in the full development of both water and sewerage facilities.

Since it has now been realized that the health laboratory services played an important part in communicable disease control, several laboratories in the island have been reorganized to undertake public health laboratory work in addition to the routine diagnostic tests.

A Quality Control Laboratory has been set up to ensure the purity, potency and quality of imported and locally manufactured drugs.

With the increase of life expectancy, ischaemise heart disease and cancer are beginning to occupy a more dominant position in our mortality tables. This has led to the steady expansion of the cardiology and cancer services, with increasing facilities for diagnosis and treatment.

Undernutrition in children, which is largely protein calorie deficiency, and nutritional anaemias in expectant mothers continue to be observed in various areas, and attempts are being made to control them by the administration of an indigenously grown protein calorie mix (wheat soyabrand; and haematinics respectively.

Urbanization and industrialization which are seen in most developing countries are rapidly gaining ground in my country too, thus creating certain environmental and occupational health problems.

The increasing use of insecticides, weedicides and pesticides in agricultural practice has given rise to new health hazards and has necessitated legislation to control the indiscriminate use, careless storage and handling of such dangerous agro-chemicals.

Since the rapidly growing population in a slowly expanding economy with extensive welfare benefits had caused a severe strain on the financial resources of the country, it was imperative to undertake population control measures in the form of a nation-wide family health programme with high priority. To this the nation is committed and at present is being generously supported by UNFPA.

This has also prompted the health administration to critically examine our health delivery services with a view to ensuring the fullest and best use of the existing facilities. This would in effect mean a phased programme of integration of the preventive services with the more expensive medical care services, with greater emphasis on the former. Greater attention will be paid to health education and active community participation in health activities so as to create a health conscious nation fully aware of its responsibilities.

The mobilization of limited resources and its deployment for maximal use can best be achieved by a carefully conducted man-power study. This is being done at the moment with WHO assistance.

A significant observation that has been made in this study is the rapid migration of highly trained personnel - the so called "brain drain" - to the more affluent countries. These personnel were often attracted by better employment opportunities outside the country. The better the training given to them the greater was the demand for their services. This problem has been discussed earlier in WHO. It is highly desirable that a solution be found in the near future, so as to prevent further obstacles to the provision by developing countries of the health cover that their people so urgently need.
For a quarter of a century, WHO has served our people through the South-East Asia Regional Office. It has given considerable assistance in the prevention and control of communicable diseases, with eradication as the ultimate objective. Inter-country training programmes, seminars and fellowships granted to our medical and paramedical personnel have in a large measure helped them to combat our health problems. For all this and more, we are indeed grateful to WHO.

In conclusion, I wish to state that my country will continue to work in close collaboration with WHO, and I am confident that, under the able guidance of our Regional Director and his assistants, all peoples in this region will be able to achieve the highest level of health in the least possible time.

THAILAND

Statement delivered by Dr Choed Tonavanik

On behalf of the Royal Thai Government and its people, I would like to extend the warmest congratulations to the Regional Director, Dr. Gunaratne, and the staff of the WHO South-East Asia Regional Office on the occasion of the twenty-fifth anniversary of the Office and also wish this Regional Office much progress and success in the future endeavours.

Thailand's associations with the World Health Organization and its activities through this Office have always been cordial and pleasant. We greatly and deeply appreciate the valuable assistance which the Office has rendered to Thailand throughout the past years in improving health conditions of the people in the country. Thai people are also very much thankful and grateful to the Office and its staff.

On this special occasion, I would like to make a brief review of the progress and success achieved in the health field in Thailand during the past 25 years.

Since 1948, Thailand has made enormous progress and succeeded in the development and expansion of medical and health services throughout the Kingdom. With modern means under the supervision and guidance of competent and well-trained personnel and with generous assistance from the World Health Organization, the Ministry of Public Health has been able to step forward in its task of disease reduction and prevention and health promotion, maintenance, and restoration. Because of the acute shortage of trained personnel and the serious lack of medical and health facilities in the face of numerous health problems, the WHO-assisted programmes were firstly directed towards the control and eradication of major communicable diseases: malaria, smallpox, yaws, tuberculosis, and leprosy. Starting in 1949, mass campaigns against these diseases were successfully planned, organized and implemented.

The large-scale operation had brought down the malaria death rate from 263 per 100,000 population in 1948 to 10 in 1970. At present, malaria, which used to be the number one single cause of death in Thailand from time immemorial, ranks eighth among the leading causes of death in Thailand.

With WHO assistance, in 1961 the Ministry of Public Health launched the programme to eradicate smallpox, one of the major health problems. It was expected, at that time, to vaccinate and revaccinate at least 80 per cent of the whole population within five years. Except for one imported
case in 1962, Thailand has been free from smallpox for quite a long time. However, the health authorities have not relaxed their efforts in the prevention of this age-old pestilence. Every year, three to five million people are vaccinated against this disease.

A mass campaign against yaws was launched with the assistance of WHO and UNICEF in 1950. The success of the programme was very impressive. During 1952-1962, more than 1.4 million cases of yaws were successfully treated and more than 2 million contacts were given prophylaxis. Only 23 infectious cases were detected in 1971.

By modern means of medical management and mass BCG vaccination, the death rate in respect of tuberculosis of the respiratory system had declined from 56 per 100,000 population in 1947 to 22 in 1970. The intensive case-finding and ambulatory treatment and care now cover the whole country through a network of tuberculosis control units. At present 1.5 - 2.0 million BCG vaccinations are being given every year.

Since the initiation of the WHO-assisted leprosy control programme in 1955, more than 40 provinces of endemic areas have been covered. Up to 1972, over 90,000 leprosy patients had been brought under treatment and rehabilitation. Out of these, 52,000 cases had been successfully treated and released from control. Rehabilitation facilities are provided and self-supporting settlements are arranged for the inactive cases.

An attempt has been made to gradually integrate the above programmes into the general health services. Yaws control and surveillance work, for example, has now been completely integrated into the general health services of all the provinces previously stricken with the disease, while the programme for leprosy control is gradually being integrated.

The success in the control of these quarantinable diseases can be attributed to programmes assisted by WHO in the provision of medical equipment, production of biologicals, strengthening of laboratory services, and in the improvement of the epidemiological investigation and studies.

WHO also has played a major role in the development and improvement of food and drug control; national community water supply; drainage, sewerage, and pollution control; strengthening of laboratory services; epidemiological services; vector-borne disease control; and national health planning and administration. It was also realized that health promotion services as well as medical care services must be improved in order to support the disease control and prevention activities. Therefore, maternal and child health, nutrition, school health, environmental sanitation, health education as well as medical care programmes were included in the WHO-assisted programmes. As time went by, increasing emphasis was placed on the necessity of integration of preventive and curative services and the strengthening of the infrastructure of basic health services. To remedy the chronic problem of the shortages of medical and health personnel, programmes such as medical education and training, education in public health, nursing education and services, were subsequently implemented in the following years. More recently, attention has been called to health problems related to or associated with the rapid increase of the population. Environmental pollution, socio-environmental engineering, integrated maternal and child health and family health services, teaching of population dynamics in medical schools, and health planning programmes are the latest additions to the long list of projects assisted by WHO.

The rapid decline of crude death rate and infant mortality rate during the past two decades can be attributed to the successful disease control programme assisted by WHO. The crude death rate had been reduced from 14 per 1,000 population in 1947 to 7 per 1,000 in 1970 while the infant mortality rate had declined from 80 to 23 per 100 live births during the same period. Between 1947 and 1965, life expectancy at birth for males had increased substantially from 49 to 55 years, while for females it had increased from 52 to 62 years.

Up to 1973, WHO has assisted Thailand in the development, implementation or strengthening of more than 50 health projects, out of which 31 are in operation at present. Nonetheless, one should not fail to cite at this moment just a few illustrations from the formidable list of WHO's spectacular achievements in Thailand, which have contributed significantly to the nation's socio-economic progress and the general improvement of living standards of the Thai people. We look back to the achievement during the past twenty-five years with great admiration to WHO for its endeavour in helping the Royal Thai Government in promoting the health status of the Thai people. Not merely the technical guidance from WHO that has proven invaluable to our health development programmes, but also the inestimable spirit of co-operation, tolerance, and devotion shown by its staff has been a great impetus to our health personnel in carrying out their difficult task of disease reduction and prevention and health promotion and maintenance in the rural areas.

Although considerable progress has been made in various health programmes, particularly in the field of communicable-disease control, there still remain many health problems to be solved in the near and distant future. The rapid decline of mortality has unfortunately resulted in the high rate of population growth, which adversely affects the health status of the people. The rapid increase of the population in Thailand has not only aggravated some existing health problems such as malnutrition, inadequate medical and health facilities, shortages of medical and health personnel, etc., but has also created many new health hazards such as deterioration of environmental sanitation in urban communities, spread of certain diseases resulting from internal migration, air and water pollution, etc. It also necessitates the consideration of demographic aspects in the
national health planning in order to meet the increasing demand of the future population. Thus, it is obvious that the national family planning programme should receive the highest priority from the government in the immediate future. At the same time, an attempt should be made to accelerate the socio-economic development process to meet that increasing demand. As nearly half of the population are under 15 years of age, special emphasis in medical and health care services should be placed on this group of the population.

Efforts must be continued to expand and strengthen the health infrastructure, and to increase health manpower in all categories. Parallel with this should be the phased integration of medical care, disease control, and special health programmes, leading to the development of comprehensive health care services. This is considered vitally important if the maximum utilization of limited health resources is to be realized. Improvement in health and medical care administration and management should be given special attention, and the application of modern techniques in this area should be seriously taken into account. More specifically, by realizing the important role of administrative and managerial aspects of health problems, all health personnel need to be reoriented to the new concepts of working environment.

Our health problems are many and our efforts to solve them are inexhaustible. Progress in solving old problems has often given rise to a set of new problems. Despite our spectacular achievements during the past twenty-five years, there is still a complex and formidable task ahead of us. However, the extensive health activities jointly undertaken by the Government of Thailand and WHO during the past years can be considered as promising for the future endeavour in raising the levels of health and living standards of the Thai people.

Once again, on behalf of the Royal Thai Government and its people, I would like to express our sincere thanks and gratitude to this office of WHO for the valuable assistance rendered to Thailand in the past and we look forward to its continuation in the future.