Striving for Better Health in South-East Asia

Selected Speeches by
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Preface

This is the second volume of selected speeches and lectures delivered by Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, between 1997-2000. The speeches, delivered at various important national, regional and global-level conferences cover a wide range of health development issues. They also reflect the forward thrust of the collaborative efforts of WHO and its Member States in the South-East Asia Region as they strive for better health for all.

The speeches have been broadly classified into six areas and are presented chronologically for ease of reference. The title, venue and period of the conference/meeting are indicated in the footnotes.
Communicable and Noncommunicable Diseases
Leprosy Control

The Asian Leprosy Congress is an important forum to consolidate our efforts to eliminate leprosy. We know now that although the world and this region have made tremendous efforts in bringing down the prevalence of this disease, the original goal of elimination by the year 2000, will not be met. After an analysis of where we stand and how far we need to go, the target has been rescheduled to 2005. We must now work together towards eliminating leprosy over the next 5 years. Strategies laid down by WHO provide the framework for all of you to contribute to attain this goal.

WHO is committed to this goal and to supporting the efforts of Member Countries to achieve it. It is therefore important that at this meeting both planners and implementers are present. It is also very encouraging that we have here both stalwart supporters of the elimination programme who have for years provided financial and technical support, as well as those who have led the programme for so many years. Now, as we move towards elimination of this scourge that has existed since early human history, the people of the world, and in the South-East Asia Region, need our expertise and our commitment. Today, the South-East Asia Region carries 76% of the global caseload. India alone accounts for 66% of the global disease burden.

With the use of multidrug therapy (MDT), the prevalence rate of leprosy has substantially declined in all the countries. So far, ten million cases have been detected in this Region, of which 9.3 million have been cured.

However, the countries of the Region have made much progress during the last 15 years. With the use of multidrug therapy (MDT), the prevalence rate of leprosy has substantially declined in all the countries. So far, ten million cases have been detected in this Region, of which 9.3 million have been cured. Visible deformity among newly detected cases

The Asian Leprosy Congress, Agra, November 2000
has been reduced. I am happy to report that five countries in the Region – Bangladesh, Bhutan, Maldives, Sri Lanka and Thailand - have reached the elimination goal, while Indonesia is expecting to reach the target by the end of this year. However, due to the magnitude of the problem and other constraints including weak health infrastructures, India, Myanmar and Nepal are rescheduling the goal of leprosy elimination to 2005. These three countries have stepped up surveillance, increased patient treatment and are intensifying communication efforts to reach people and inform them that leprosy can be easily cured. At present the prevalence rate of leprosy in India is 5.07 patients per 10,000 population. By the end of 2003 around 1.2 million patients will have to be detected, enabling the start of treatment, which would reduce prevalence rates to 2 or 3 per 10,000, as against the eventual target of 1 per 10,000 population.

To work towards successfully achieving the 2005 goal, the first meeting of the Global Alliance for Elimination of Leprosy, chaired by the Government of India, will meet in New Delhi on 30-31 January 2001. The 12 leprosy endemic countries will work out concrete steps of action. This will be followed by an advocacy meeting on leprosy elimination.

I am grateful for the financial support from the Nippon Foundation, the Federation of Anti-Leprosy Association, Novartis and the International Leprosy Association. WHO will work closely with the donors, World Bank and DANIDA. I am confident that together we will achieve our target in changing the image of leprosy in the world.

I know the task is not an easy one. There is a lot of work still to be done. I am sure that, with your expertise, experience and dedicated efforts, the goal can be reached as targeted. The goal of 2005 is achievable. The next step after that should be the development of appropriate strategies for eradication of the disease in the following 15 to 20 years.
Dengue Haemorrhagic Fever

TODAY, Dengue/Dengue Haemorrhagic Fever is considered the most important resurgent tropical infectious disease. Epidemic dengue haemorrhagic fever (DHF) emerged in South-East Asia in the 1950s. In the past 20 years, rapid epidemiological changes have manifested as a result of continued population growth, uncontrolled and unplanned urbanization, increased inter-country travel and other societal changes. All of these have created conditions ideal for increased transmission of multiple, dengue virus serotypes in most tropical countries of the world.

This is the first international conference on DF/DHF to be held in Thailand. It would serve as a forum for exchanging the latest global and regional information on the prevention and control of dengue/dengue haemorrhagic fever. This could lead to policy formulation and action at the global, regional and country levels. It would also help to define major areas of research needed to contain the spread of dengue virus and its vectors, reduce morbidity and mortality in endemic countries; and advocate better understanding of the disease burden and commitment towards elimination of the disease as one of the major threats to public health.

The World Health Assembly passed a resolution in 1993 which urged Member States to strengthen their national and local programmes for the control of DF/DHF. In response to this

resolution, WHO’s South-East Asia Regional Office (SEARO) developed a regional strategy for the control of DF/DHF in 1995. A technical meeting on management of dengue epidemic was held in India in November 1996 and guidelines developed to deal with the outbreak. In 1997, a biregional meeting between SEARO and WPRO was held in Manila to strengthen country collaboration between the two Regions.

WHO is greatly concerned at the DF/DHF situation in this part of the world. In 1998, India, Maldives, Myanmar and Thailand from South-East Asia (SEA), and Cambodia, Laos, Malaysia, Singapore and Vietnam from the Western Pacific (WP) Region experienced epidemics of DHF. The disease continues to show increased incidence and geographical spread with more frequent outbreaks throughout the two Regions. DF/DHF was reported for the first time in Bangladesh in 1999, with more than 4,172 cases and 78 deaths reported in early 2000. Outbreaks were also reported from Maldives and, most recently, from Sri Lanka.

Here in Thailand, there is an annual, national celebration to mark the King’s birthday. But every twelfth year, it is a particularly auspicious occasion as in 1999, during the celebrations to mark the King’s 72rd birthday. On that occasion, he asked the nation to bring the scourge of dengue under control and a major intensification of activities ensued. The convening of this conference is closely linked with those efforts. Over the next few days you will be hearing more about some of them.

Also in 1999, an in-depth external review on DF/DHF prevention and control was conducted in Thailand covering the national dengue/dengue haemorrhagic fever prevention and control programme (NDPCP) and to provide technical advice to make the programme more effective. The Review Mission visited organizations, agencies, institutions and groups concerned with DF/DHF prevention and control in Thailand. It critically reviewed approaches, methods, procedures, epidemiological and economic data and outcomes, and had intensive discussions on the approaches that may have the greatest chance of success in Thailand. It was agreed that the primary emphasis of the NDPCP should be on the large urban centres of the country, using an integrated, community-based approach to Aedes aegypti control by larval source reduction. In 2000, a similar review of DF/DHF prevention and control was also conducted in Indonesia. The recommendations made by the Review
Mission are being implemented by the programme.

The expected outcomes of this Conference include refining/redefining the pathogenesis and pathophysiological concepts of the disease for better diagnosis, treatment and control; recommending concerned authorities on control and prevention of DF/DHF; strengthening of national capacity for research and training in related disciplines; catalyzing further interest in arboviral diseases and mosquito-borne viral diseases, as well as the development of a practical and feasible framework for further collaborative research in DF/DHF.
HERE is growing concern, at global, regional and national levels, about the problem of malaria, particularly multidrug-resistant malaria. This is a problem that is common to both the Western Pacific and South-East Asia Regions of the World Health Organization.

Many factors account for the present situation. Rapid and uncontrolled population migration and environmental degradation have changed the ecological balance. Inadequate resource allocations for communicable disease control in general and malaria control in particular have further aggravated the problem. The situation is getting more complicated with the spread of multidrug-resistant malaria.

There is now an urgent need to strengthen malaria control efforts. As I mentioned earlier, health status and disease patterns have been evolving as a consequence of environmental as well as social and demographic changes. In many situations, economic development has adversely affected the environment, and given rise to man-made malaria. With limited infrastructural capacity, it is always the vulnerable groups, such as women, children and migrant populations which have little access to health care, and are the worst affected.

The overall concern of the health authorities should be to deliver services efficiently and effectively. This could be through a comprehensive infrastructure covering the needs of the community at the periphery, with sustainable support from intermediate and central levels. Each country may need to review the basic components of health care at the first level of contact based upon the existing health problems and the health
infrastructure. I strongly urge the distinguished participants to translate the commitment of the six Mekong countries into action, especially at the community level, where people suffer the most. I am happy to note that community-based monitoring, as a tool for community involvement, would be an important topic of discussion at this meeting.

The main thrust must be on the expansion of health care coverage. Strengthening of the district health system is an essential step in identifying those segments of the population which do not have adequate access to health care.

To make more effective utilization of resources and to mobilize more resources through partnership, the programme must aim at making the highest possible impact on the malaria problem by refocusing activities and reallocating resources.

The first priority is to improve surveillance systems and develop mechanisms to quickly recognize and respond to the problems in a more urgent, systematic and effective manner. To be effective, prompt action must be taken on the information generated by the system. A ‘rapid response team’ should be established to act quickly on information received through the surveillance system. Most importantly, information should be shared by all Member countries for sound decision-making towards the achievement of the objectives of the “Roll Back Malaria” (RBM) Mekong Initiative. I am also very pleased to note that indicators to measure the progress of our efforts are high on the agenda of this meeting.

Realizing the complexity of the malaria problem in the Mekong Region, I would welcome our partners to review the joint plan developed by Member Countries. I would appeal to the donors to help countries which are affected by the disease and do not have resources at their disposal.
The HIV/AIDS Challenge

The HIV/AIDS pandemic is continuing unabated and will remain a major challenge in the new millennium. According to WHO and UNAIDS, 50 million people have already been infected with HIV worldwide, of whom 16 million have already died. In the 10 Member Countries of the WHO South-East Asia Region, we estimate that more than 5.5 million people are currently living with HIV/AIDS. Our Region has the second largest number of HIV infections – next only to sub-Saharan Africa. The epidemic is dynamic and evolving rapidly. Risk behaviours which promote HIV transmission are present in all countries and women and young adults remain particularly vulnerable.

Besides its devastating impact on health, the HIV/AIDS epidemic is a major threat to national development in the Member Countries. High-level political commitment, supplemented by a supportive policy environment, is crucial to combat AIDS. Our experience shows that countries which responded quickly and effectively, with high political commitment are now succeeding in preventing HIV and in reversing the increasing trend of HIV prevalence. We can be proud of many success stories documented in different countries of the Region. And of course, there is much that countries of the region can learn from each other. Moreover, since HIV does not respect international borders, intercountry collaboration to fight the common enemy must be considered as an important priority!

Because of the diverse impact of the disease, both WHO and other UN agencies continue to recommend a multisectoral response and broad partnerships to fight AIDS. We have noticed that many countries have made
special efforts to involve various sectors, particularly NGOs and the private sector. Financial support from WHO during the initial stages of the epidemic and now support from bilateral agencies, and the participation of NGOs, community-based organizations and of people living with HIV to some extent, has been very encouraging.

We, in WHO, remain committed to supporting our Member Countries in their fight against AIDS. We have now designated HIV/AIDS as one of the five WHO flagship projects. This means that WHO is committed more than ever before. WHO will continue to work closely with UNAIDS and other UN Co-sponsors and take a leadership role in supporting the health sector response. Facilitating the exchange of technical information and collaboration with all interested agencies, particularly in the public health aspects, are also important activities for WHO. To continue our advocacy role, AIDS will be discussed as an important agenda item at the meeting of the SEAR Health Ministers in Kathmandu in September this year.

While our collaboration with UNAIDS continues to grow and strengthen, we, as a co-sponsor, would like to see UNAIDS play a more strategic role. This could be by focusing more on advocacy and in forging and sustaining partnerships – to lobby for enhanced political commitment and support for the national AIDS control programmes. And to mobilize not only Governments but go beyond the Government sector to engage NGOs, the private sector and other relevant partners. We would like UNAIDS to continue to work more as an honest broker and to facilitate work of the UN co-sponsors, rather than compete with or duplicate the efforts being made by others, including the co-sponsors.
Regional Strategy for Vision 2020

There are nearly 180 million visually-disabled people in the world, 45 million of them unable to move about without help. Of these, 15 million live in the South-East Asia Region, which has another 45 million people with low vision and visual impairment. Visual impairment is a common cause of disability worldwide, next only to osteoarthritis.

The blind in the world are among the poorest. Many of them are women belonging to the marginalized and vulnerable groups. It has been estimated that blindness costs the world $25 billion annually in lost productivity. The cost is three times higher if the cost of rehabilitation and care-givers is included. Available evidence clearly shows that blind people die earlier than those with sight. Blindness, therefore, is not only disabling but economically crippling and responsible for many early deaths.

Of even greater concern is the fact that the burden of blindness is mounting sharply. It is estimated that there will be 30 million blind people in South-East Asia by 2020 if suitable action is not taken urgently. This is so because of the rapid increase in the size of the population and, more importantly, the size of the elderly population. Our health intervention measures have successfully reduced mortality allowing more people to live into old age. Blindness is closely related to age. As better health care increases life expectancy, the...
population also becomes more vulnerable to disabilities, such as blindness.

However, we must take a closer look at this. Is it a fait accompli that as the society ages, it must learn to live with more disability and blindness? Does it really have to be so? Are we really so helpless? Perhaps not!

When we review the causes of blindness, we find that, at least in this Region, close to 90 per cent of it is avoidable. In other words, it is either preventable or curable. More than 50 per cent of the blindness in this Region is due to cataract. Much of this blindness can be easily cured in less than 15 minutes with surgery costing not more than US$15. Yet, there is a backlog of 10 million unoperated cataract cases in this Region. This is not acceptable.

Preventing blindness from trachoma costs less than $3 per person. Blindness from vitamin A deficiency can be prevented by three capsules of vitamin A costing less than one dollar per child. Spectacles costing a few dollars, can help prevent blindness in hundreds of thousands of people.

Scientific knowledge and technical skills are available in abundance to eliminate the scourge of blindness from the globe. What is lacking is the determination to deal with this problem effectively. Realizing that elimination of avoidable blindness from the globe is an attainable goal, the World Health Organization has called upon its Member States to launch Vision 2020: The Right to Sight.

This is an effort to mobilize political and financial support to free the world from unnecessary blindness. That is why we are persistently engaged in this campaign to raise political, professional and public awareness. Following the launch of the global Vision 2020 by the WHO Director-General, launched Vision 2020 South-East Asia last September at the Regional Office. Following that event, Nepal in this Region became the first country to launch Vision 2020. You will witness the launching of Vision 2020 Indonesia by the Vice-President tomorrow. Events like these greatly help to create an enabling environment in support of our efforts to eliminate avoidable blindness by putting blindness high on the health development agenda.

Elimination of blindness no doubt requires technical expertise. In this context, ophthalmologists have indeed provided good leadership. Partnership with nongovernmental development organizations has been one of the most rewarding experiences. In fact, NGO contributions to prevention of
blindness programmes have been truly remarkable.

I feel, like many others, that blindness prevention also requires to be addressed in the context of overall health development within the framework of dignified human development. We must guarantee sight as a fundamental human right to our people. I would like to appeal to you all, particularly our friends from the media, to help us create the necessary environment for harnessing political, financial, professional and public support.

I expect that at this Consultation you will discuss in detail what we can do, how we can do what we want to do, and how we would know we have achieved the goals of Vision 2020. In other words, we need to develop a complete set of strategic plans with targets and indicators. We need both long-range vision as well as short and intermediate plans to guide national plans of action.

We will systematically proceed with national launches from now on. I hope you will also spend some time to plan how this may be done. It is my fond hope and belief that when the distinguished participants return to their countries (or remain in Indonesia) at the conclusion of this Consultation, they will work towards creating environments in support of Vision 2020 in their countries.

Let me assure you that WHO remains deeply committed to prevention of blindness in the Region. I have reviewed the recommendations of the last Consultation held in September 1999. I am pleased to inform you that we will soon constitute a Regional Coordination Group to facilitate greater cooperation and collaboration among all partners. We are also in the process of constituting a multi-disciplinary group within the Regional Office to maximize the input. We will also strengthen the relevant unit in the Regional Office to deal with the new responsibilities and opportunities brought about by the launching of Vision 2020.

I am confident that the deliberations at this Consultation will help us prepare the guide map, which will enable us to reach the goal of Vision 2020.
Prevention of Blindness

The countries of South-East Asia have made significant progress towards attaining a high level of socioeconomic development. Our Region has also made significant health gains in the last half a century. Reduction in mortality from major infectious diseases has led to a significant increase in the life expectancy of our population. Our health interventions have, however, had less impact on fertility. Thus, the population of our Region is increasing rapidly. The collective outcome is that more people are living to an old age.

We have been successful in adding years to the life of our people, but have we also been able to add life to the years? I am afraid that is not the case. In fact, the spectacular gains in life expectancy made in the last 50 years are often beset with illness and disabilities resulting from blindness, deafness and physical infirmity. Some people call this the failure of our success.

Let me turn to blindness. In the world today, there are 200 million visually disabled people, and 45 million unable to move about without help. One-third of the world's blind, nearly 15 million, live in the countries of the South-East Asia Region. This is equal to two-thirds of the population of Nepal or the entire population of Australia. The world over, every minute, 12 people become blind – four of them live in the South-East Asia Region.

Every year almost ten million people in our Region die without their sight being restored, most of them dying within ten years of becoming blind. The life expectancy of blind
persons is two-thirds of that of people who can see. The blind are among the world's poorest, though the rich are not immune from blindness. Women are among the worst victims of blindness not because of biological differences but because of a discriminatory social fabric.

As we enter the new millennium, there are real risks of an increase in the number of blind people. By 2020, the number of the blind would have doubled to 30 million in this region.

A close study of the causes of blindness brings out some striking facts: up to 90% of blindness in our Region is either preventable or curable, at very modest cost. A cataract surgery requires no more than 15 dollars to restore sight, as some excellent studies from this region, including Nepal, have conclusively shown. Further, trachoma blindness can be prevented at a cost of less than three dollars per person, and less than sixty cents worth of vitamin A capsules are sufficient to prevent a child becoming blind from xerophthalmia. Although the exact magnitude of blindness from uncorrected refractive errors is not known, the problem is sufficiently big to indicate the failure of our health care systems. It is a great anachronism of our time that at the close of the twentieth century, people should be blind for lack of simple optical devices like glasses, costing no more than five dollars. How will posterity judge our civil society?

If this is the human price of blindness, let me share with you the economic costs. Blindness costs the world 25 billion dollars in lost productivity. If the costs of rehabilitation and education and that of the carers, are also included, the amount will go up to 75 billion dollars annually. South-East Asia alone bears a net burden of 5.6 billion dollars every year. Obviously, this is a very high burden for our already poor economies to shoulder.

Every year Nepal is estimated to lose 88 million dollars because of blindness. This is nearly six times the country's annual health budget. This is also true of many other countries in the Region.

It is estimated that South-East Asia would require about 200 million dollars annually to prevent or cure major blinding diseases. As we have seen, the countries are losing 5.6 billion dollars annually, the cost of maintaining the blind will therefore result in a saving of 5.4 billion dollars every year. I cannot think of any other cost-effective health intervention or even a business enterprise which gives such high value for money and returns on investments.

We have the medical knowledge and the costs of prevention of blindness or its cure are modest. Why then is blindness increasing so rapidly?
We must wake up to the reality that blindness is not merely a medical issue. It is a developmental issue with social and economic ramifications. To overcome the problem we will need to recognize the multiple barriers involved. These include: geographic, social, cultural, political, economic and professional. I will briefly discuss only three of them - political, economic and professional. I see a common thread running through these apparently diverse determinants. The thread that weaves all these together is the mindset, our views of life and the events that shape those views. Let me illustrate.

The presence of the Prime Minister here today exemplifies political commitment at the top. However in the past, in our countries, such commitment has not always been available. This commitment is needed at all levels from national capitals to the regional and district headquarters and to the remotest villages. The political leadership must be encouraged to change their mindset and view blindness prevention as a developmental issue rather than just another health intervention.

Financial commitment must closely follow on the heels of this political commitment. Committing additional resources for blindness prevention activities should not be looked upon as a welfare activity. This must be treated as an investment with high returns. For every dollar spent on eye care, the return is at least 120 cents on every 100 cents invested. There are few investments which bring such rich and entirely safe dividends.

We must continue our advocacy for enhanced resources. At the same time, our health management system must gear itself up to the new reality that we have to learn to do more with less resources. We may all be doing our best. But that is not getting the desired results. We need to change tactics. This also requires a shift in mindset.

Another matter of serious concern is the issue of professional barrier. We all know that blindness due to cataract is a very easily curable condition. Yet, I am told that there are 10 million cataract cases in the Region because there are not enough eye surgeons available to operate. To alleviate the problem some countries have trained their general medical doctors while others have utilized non-medical health personnel to clear the backlog of cataract. This has been made possible.
by the understanding and excellent cooperation of ophthalmologists. But, in some countries, there are millions who remain blind due to cataract because the ophthalmologists are reluctant to let even medical graduates operate on cataracts. I understand that this reluctance probably stems from their concern for the quality of care.

Undoubtedly, we must provide the best available services. However, can we remain content with providing the best care for the few or should we endeavour to provide good care for the many? In our pursuit of quality, do we abandon our responsibilities towards the many who are left uncared for? If we don’t provide for them, we leave them to the mercy of the untrained. Or worse, condemn them to a life of perennial darkness and premature death. This ethical dilemma must be resolved soon, within the profession. No doubt your congress will deliberate on these issues and the moral and legal implications would only urge you: do not let “best” be the enemy of “good”. Time is of essence to the person blinded by cataract. If there are insufficient specialists to treat them and prevent blindness, let others be provided the proper training to deal with them. A change of mindset is needed. By widening our perspective to tackle ground realities we can make a significant difference to the lives of millions who need our help.

On the subject of human resources, there is a shortage of ophthalmologists in most countries of the Region. What is even more disturbing is that the number of ophthalmic paraprofessionals is even fewer in most of our countries. For example, our Region has about 11,000 ophthalmologists compared to about 8,000 ophthalmic paraprofessionals. No war has ever been won with more generals than soldiers. That paradoxically is the nature of our eye health care teams as they exist today. This must change if we are to win our war against blindness. I have no doubt that your congress will discuss this issue also.

I am very disturbed by the fact that half of the existing ophthalmologists in many countries do not operate on cataracts. In some countries trained ophthalmologists are doing general practice rather than eye care. At the same time, there is a concentration of eye health workers in large urban areas, whereas the vast majority of our population live in rural areas.

Does this not call for rethinking on our human resources policy? We intend to review the existing training policies and programmes for the entire spectrum of human resources for eye care. I am pleased to inform you that the first study in this series has already
been initiated. We hope to be better informed once we have the results of the study so that we may formulate policies based on more evidence.

I believe with our changed mindset, we can transform this story of human despair into a saga of success. The bold new initiative taken by WHO, in partnership with nongovernmental development organizations, is an effort that needs your worthy support. This is our last opportunity in this century to restore a fundamental human right to our citizens: the Right to Sight. The goal of Vision 2020, as this new initiative is called, is to eliminate avoidable blindness from the world by the year 2020 AD.

The strategy includes dealing with disease burden, particularly that caused by cataract, trachoma and childhood blindness. It also aims to improve the human resource situation and expand the infrastructure to fight the increasing menace of blindness. Priorities are expected to change with shifts in disease burden and with time. There is a partnership committee with the nongovernmental development organizations and the International Agency for Prevention of Blindness at the global level. To facilitate Regional cooperation I will soon be constituting a Regional Coordination Group. Aware of the greater role that the Regional Office will need to play, we are strengthening the relevant unit to deal with prevention of blindness.

Ophthalmologists have a key role to play in this initiative. I am confident that the enlightened ophthalmic community will rise to the occasion in ensuring sight to all.
Stop TB Initiative

TUBERCULOSIS is a cause for deep concern. We are all aware that TB continues to be the major killer disease worldwide. The South-East Asia Region carries over 40 percent of this global burden. Of the 20 countries with a high burden of TB worldwide, five are in our Region. These include Bangladesh, India, Indonesia, Myanmar and Thailand. The rising trend of HIV infection and the emergence of multidrug resistance in the Region sharpens the urgency with which we need to act if this global epidemic is not to turn into a global disaster.

First the good news; all our Member Countries are implementing Directly Observed Treatment Short-course (DOTS) as a TB control strategy. Over the last few years, very good progress has been made in most countries in accelerating the coverage of DOTS. However, as yet only 25% of TB patients have access to DOTS. Although this figure is an improvement compared to the 10 per cent last year, this is just not enough! Given the current trends, only five countries of the Region will be able to achieve the set global targets by the year 2000. The need therefore is to accelerate, intensify and expand the DOTS strategy. At the same time, the quality of implementation has to be maintained.

Many countries in the South-East Asia Region are lagging in DOTS implementation because of lack of resources, both financial and human. This is partly due to the lack of political will, and inadequate management capacity at the country level. The lack of adequate information and

WHO, in partnership with several international agencies, plans to significantly expand global collaboration and investment in TB control. This is to accelerate the collective action against this scourge, especially in the high burden countries.

Regional Meeting on STOP TB Initiative: The Challenges and Opportunities at Country Level
Yangon, August 1999
awareness amongst communities and health personnel also contributes to poor coverage. Constraints posed by non-involvement of sectors other than health, including the private sector and NGOs, are additional problems to be addressed urgently. It is clear that the major problems are no longer technical in nature. They are largely related to political, managerial and resource constraints.

In order to give impetus to TB control worldwide, the Director-General of WHO, Dr Gro Harlem Brundtland, outlined a new initiative called STOP TB at the World Lung Health Conference in Bangkok in November 1998. WHO, in partnership with several international agencies, plans to significantly expand global collaboration and investment in TB control. This is to accelerate the collective action against this scourge, especially in the high burden countries. This initiative has four main components:

- A Global TB Charter for advocacy and commitment to tuberculosis control;
- A Global TB Action Plan to facilitate effective collaboration for tuberculosis control;
- A Global TB Drug Facility to ensure access to low cost and quality tuberculosis drugs, and
- A Global TB Research Agenda to facilitate collaboration on key research issues, such as control on multidrug resistant (MDR) TB and new tools for diagnosis and treatment.

Under this initiative, I would urge all Member Countries to (1) critically analyze the major constraints and develop effective solutions suitable to their own situations, and (2) enhance intercountry collaboration to maximize resources and, most importantly, to reaffirm their full commitment to control TB.

Together we must develop a framework for action within which partners can coordinate activities. Together, we must create a new environment for sustained support and commitment to the expanded implementation of the DOTS strategy. Attention to the continuous evaluation of DOTS programmes through operational research will ensure that we implement effective strategies in the most cost-effective manner. I would also like to emphasize the need to integrate TB control into the primary health care infrastructure to ensure sustainability.

Both Dr Brundtland and I recognize TB control as a major priority for WHO. We are fully committed to providing all technical and operational support to our Member Countries in the South-East Asia Region. In fact,
WHO has identified tuberculosis control as one of the five priority projects for special attention. These are called WHO flagship projects. We also recognize that DOTS is one of the most cost-effective health interventions available today. By expanding DOTS, we can make good quality treatment available and accessible to as many patients in the Region as possible.

We, therefore, plan to discuss issues relating to tuberculosis control as an important agenda item by the Health Ministers of the South-East Asia Region during their meeting in Myanmar in October 1999.

I urge you to critically review the strengths and challenges related to TB control in our Region. You should identify the best strategies and approaches to help control this important public health problem in all countries of our Region.
Towards Poliomyelitis Eradication

All of us who have gathered here today are part of an important historic process. Behind us is over a decade of an immense global effort to bring to an end a dreaded disease - Polio. Ahead of us are 16 crucial months to achieve the target of polio eradication. It has taken the combined efforts of the world community to eradicate the disease from many parts of the world. The effort must continue unabated until all parts of the world are free from the disease.

Over 20 years ago, the world made a significant breakthrough when it eradicated smallpox. With polio, the task has been more challenging. When we do achieve its eradication, mankind will have crossed another major landmark in public health. Much of the global progress must be measured by what has been achieved in the South-East Asia Region (SEAR) where one-fourth of the world population lives and where the disease burden is the highest in the world. I am happy to state that this Region has made steady progress.

National immunization days (NIDs) have been successfully held in conjunction with our neighbours. In December 1998 and January 1999, three WHO Regions - South-East Asia, Eastern Mediterranean, and Western Pacific - conducted synchronized NIDs. In the South-East Asia Region, supplementary doses of OPV were administered to 166 million children aged under 5 years at the same time. In India alone, 136
Striving for Better Health in South-East Asia

Million children were immunized on 17 January 1999. Across the globe, approximately 450 million children were reached at that time.

However, NIDs alone will not achieve polio eradication. It is important to maintain routine immunization at a high level. The quality of coverage to ensure reaching all children, is the key to its success. Surveillance of Acute Flaccid Paralysis (AFP) must be strengthened urgently. This was the recommendation of the Technical Consultative Group meetings last year.

In our Region, tremendous progress has been made in improving surveillance in India and Nepal. However, the indicators to measure the quality of surveillance are low in Bangladesh, DPR Korea, and Myanmar. Urgent attention must be given to strengthening surveillance in these countries. Unless there is a high level and quality of surveillance, it will take long before the Region can be certified free of polio.

As disease recognizes no geopolitical borders, all countries must ensure that cross border infection is controlled. All cases of AFP along international borders must be immediately notified to the designated national authorities, to neighbouring countries and to concerned international organizations. It is important to match coordinated NIDs with cross-border surveillance and immunization.

Despite what appears to be highly commendable progress, much still remains to be done in some countries of the Region. The danger is that large pockets of children live in vast and crowded urban slums. They are vulnerable to infection and are without vaccine protection. Unless they are all reached urgently, the transmission of the disease will not be curtailed. The recent cases of wild polio in Myanmar which was thought to have interrupted transmission, are a cause for concern. These must be reached urgently.

There are several challenges that need to be overcome to reach the last 10 per cent of unreached children. We cannot afford to falter at this stage. It will require immense efforts by countries to achieve full coverage. Polio eradication is a global movement. Eradication cannot be achieved within the target period without the efforts of governments, international agencies, donors and the community working in partnership. WHO, UNICEF, Rotary International, and the many donors who have been supporting the programme are already supporting this last phase.

The global focus now is on the South-East Asia Region. The world is
Looking to India to take the lead in this decisive battle. The country has already achieved so much, and has provided coverage to millions of children. It has in place a national surveillance system of world standard. Despite this, wild polio virus is still present in many pockets and new cases of polio are being reported.

I am happy that India has made a firm commitment to ensuring the final coordinated effort to push out polio, within the target date. Only if India succeeds can the world succeed.

WHO, on its part, will continue to provide technical support to the programme. Bringing together global and regional experts is part of our support. The Technical Consultative Group (TCG) meetings are held to coordinate global, national and regional efforts and this special TCG meeting has been held to support the accelerated regional effort. As in previous years, many of the partners that have contributed to, and participated in, accelerating polio eradication activities are here today.

A strong and cohesive partnership has emerged that has allowed countries to implement NIDs and surveillance with unprecedented success. Now we are expected to focus our partnership towards strengthening surveillance of wild poliovirus. Investigation of AFP among children aged under 15 years, additional rounds of NIDs and implementing door-to-door mopping-up campaigns in areas where transmission of wild poliovirus remains are critical to improved surveillance.

In summary, at this stage it is important to sustain our commitment and to use all our energy to overcome constraints be they administrative, bureaucratic, financial, or motivational.

I would like to take this opportunity to extend my profound appreciation to all the partner agencies attending these meetings, and all country health officials whose tireless efforts often go unappreciated. We recognize you to be the backbone of primary health care, particularly in difficult-to-reach areas. As I have said many times in the past, “reaching the unreached” remains our major challenge, be it strengthening of surveillance or administering of safe, high quality vaccines.
Alternative Approaches to Vector Control

The South-East Asia Region of WHO continues to carry a high disease burden of vector-borne diseases. Malaria remains at the top with around 25 million estimated cases and 26 000 deaths annually, as documented during 1997. Ten per cent of the population is now living in high-risk areas with multidrug resistant P. falciparum. Dengue/dengue haemorrhagic fever has emerged as yet another major public health problem with approximately 400 000 cases annually and a case-fatality rate ranging from 3 to 5 per cent. Japanese encephalitis outbreaks continue to afflict many rural areas in most countries of the Region. Lymphatic filariasis also continues to spread, both in urban and in rural areas. It is estimated that there are currently over 600 million people living in areas endemic to lymphatic filariasis in this region, while there are over 60 million who have various forms of the disease. Although leishmaniasis or kala-azar, which also has a very high mortality rate, is restricted to three countries (Bangladesh, Bhutan and India) of the Region, the disease is showing an increasing trend. Currently, about 60 million population are at risk from kala-azar. The reported number of cases in the Region during 1997 was 26 275 with 272 deaths (excluding information from Nepal).

Insecticides are no longer viable as an umbrella approach for malaria and other vector-borne diseases. This is largely due to vector resistance to most
insecticides used in control programmes, and a change in vector resting and biting behaviour from indoor to outdoor action. An important reason is the growing awareness about the use of chemicals, particularly chlorinated hydrocarbons, given their toxicity, and contribution to environmental pollution and degradation. High costs of alternate insecticides combined with the financial crises faced by some of the SEA countries, make it difficult to sustain these programmes at reduced level. These constraints are leading the countries to review their control strategies with a view to reducing dependence on the use of insecticides and to look for alternatives.

The Roll Back Malaria (RBM) Initiative, as a regional strategy for malaria control at this juncture, is a welcome proposition to reduce disease burden. The basic concept of RBM focuses on tackling the problem through multidisciplinary and multi-sectoral approaches, and resource mobilization with active participation of the communities. The main thrust will be community mobilization for personal protection and environmental management for vector control through school health programmes. The programme is a collaborative effort between WHO and other UN and bilateral agencies.

SEARO has just completed an external evaluation of DF/DHF control programmes in Thailand, which are largely community-based. I am sure the experts have studied the weak and positive links and would come up with recommendations to further enhance people’s participation and their commitment.

I hope that this Consultation will deliberate on all aspects of these important issues. These should include review of old and new technologies for their effectiveness and sustainability. Operational guidelines will be developed for each control intervention through community-based intersectoral cooperation. I also hope that this meeting will act as a catalyst in integrating various control interventions at the local level with the ultimate aim of controlling and reducing disease burden in countries of the Region.
Challenges in Eliminating Leprosy

Leprosy is a major public health problem. At the beginning of 1998, there were 804,396 leprosy cases under treatment in the world, of these 74.6% were in the South-East Asia Region. India alone had 523,344 cases, which constituted 65% of the global prevalence. I would like to stress here that if the global goal of elimination of leprosy is to be achieved, we first need to attain elimination of leprosy in India.

I have learnt with great interest of the tremendous achievement of the Leprosy Elimination Campaigns in India. Through these campaigns in 1998, over 450,000 leprosy cases were detected and introduced to Multidrug Therapy. I am very happy that WHO was able to supply MDT blister calendar packs, free of cost, to every patient in the world. This was due to the generosity of the Sasakawa Memorial Health Foundation, Japan.

The Forty-fourth World Health Assembly passed a resolution on the goal of eliminating leprosy as a public health problem by the year 2000 AD. This goal has created a new awareness and enthusiasm in the endemic countries, including India. However, the achievement of this goal depends very much on political will. I hope that your deliberations at this one-day consultation will lead to strategies to help complete the unfinished agenda in relation to elimination of leprosy.

The World Health Organization will continue to support the global efforts in combating the scourge of leprosy.
Eradication Programme requires intensive collaborative support from all concerned; in technical and scientific guidance, in mobilizing additional resources and in strengthening and fostering partnership between the government, nongovernmental organizations, policy makers and law makers as well as other international agencies. WHO assures you of continued technical support in intensification of case finding in Leprosy Elimination Campaigns (LECs); Special Action Projects for the Elimination of Leprosy (SAPEL) and in providing MDT for patients. Let us give of our best today for a leprosy-free society in the near future. This would prevent the next generations facing the ravages of the disease which has struck terror in mankind for thousands of years.
Control of Lymphatic Filariasis

Lymphatic filariasis is widely distributed in the countries of the WHO South-East Asia Region and constitutes a major public health problem. About 600 million people, nearly 50% of the Region’s population, live in endemic areas. As per recent estimates, about 61 million people are infected with filariasis. Over 20 million people have different manifestations of the chronic disease, leading first to temporary, then, to permanent disability.

Rapid population growth and inadequate sanitation in urban and rural areas have resulted in enhancement of transmission of Wuchereria bancrofti and expansion of its distribution. On the other hand, due to the long-term control efforts made by some countries, there is evidence of a reduction in the prevalence of brugiosis.

The control strategy, based on vector control and treatment of microfilaria carriers, practised in the Region till very recently, had a limited effect since it lacked the necessary political commitment and financial support.

It is gratifying to learn that, of late, there have been significant developments in regard to filariasis control based primarily on mass chemotherapy, supplemented by case management and vector control. These measures constitute the substance of the revised strategy for control of lymphatic filariasis.

Taking note of these developments, the WHO Regional Office for South-East Asia has decided to intensify its support to Member countries to reinforce their efforts to control lymphatic filariasis.

Consultation on the Control of Lymphatic Filariasis in South-East Asia, Pondicherry, November 1997
National control efforts need to be supported by networking and information exchange based on each country's experiences. Technology is available for effective control of lymphatic filariasis at prices affordable by a majority of the endemic countries in the Region. Commitment can help clear many administrative bottlenecks and ensure mobilization of adequate resources. However, research studies and management of the control programmes need to be strengthened to overcome technical and operational problems.

The need of the hour is to create public awareness about the magnitude of lymphatic filariasis and its health and socioeconomic consequences. This will lead to enhanced political commitment and help develop sustainable partnerships between governments, communities, NGOs, scientists and external partners.
Control of Malaria and Kala-Azar

The control of malaria and kala-azar is of vital importance to improve the health and well-being of the people in the endemic countries. WHO’s policy in this context is to reduce the health consequences of these diseases; ensure access to health services; secure cost-effective, technically sound and sustainable control measures; and encourage mobilization of resources.

Realizing that malaria constituted a major threat to global health and hampered economic development, the world community adopted a Global Malaria Control Strategy at the Ministerial Summit on Malaria Control in 1992. This Strategy aims to strengthen local and national capabilities through four essential elements: (1) disease management; (2) disease prevention; (3) epidemic detection and control, and (4) strengthening local capacities in basic and applied research. The Strategy also includes regular assessments for facilitating the defining of priorities and development of flexible, sustainable and effective malaria control programmes.

Having said so, I note with satisfaction that, to facilitate the implementation of the four basic elements of the Global Strategy, Member Countries have taken timely decisions to translate their commitments into action and have appropriately modified their national control strategies. This would ensure that effective and sustainable malaria and kala-azar control programmes are established in all areas where people are at risk.

In many cases, the spread of malaria is influenced by social conditions associated with development of rural areas and movement of populations.

Intercountry Border Meeting on Malaria and Kala-Azar, Dhaka, November 1997
It is now recognized that malaria control cannot be the responsibility of the health sector alone, since it is known that the spread of malaria is also linked to development activities, including exploitation of natural resources, road construction, new agricultural settlements and irrigation projects. In many cases, the spread of malaria is influenced by social conditions associated with development of rural areas and movement of populations. I would, therefore, underline the importance of a holistic approach while addressing this problem. Such an approach would require incorporation of malaria control activities, including anti-vector measures, into health programme with a wider perspective, such as healthy islands, healthy villages, health cities and environmental management and sanitation.

At the intercountry border meeting in Darjeeling in August 1995, recommendations were made for the development of Joint Action Plans to overcome problems encountered in the implementation of country strategies. Today, we gather here to review the progress made in implementing those recommendations, and, in particular, to suggest ways and means of tackling specific problems in border areas in an efficient and effective manner. The countries now have detailed information about the situation on the other side of the border, i.e. maps of bordering districts and health units, transmission seasons, the kinds of drugs regimens used, major vectors and control activities, existence of drug-resistant malaria and outbreaks, if any.

If maximum benefit is to be derived in border districts as recommended in the Joint Action Plans, control programmes must focus on the most vulnerable and high-risk groups, such as the underserved and the unreached: infants, young children and pregnant women, in all endemic areas; populations in areas sharing common international borders; migrant populations, particularly those engaged in forest-related economic activities, ethnic minorities; refugees, etc. The peculiar features of some of the border areas actually make populations there particularly vulnerable to the spread of communicable diseases. Once those people have crossed the border, they may not know how and where to seek health assistance.

Since a large number of people migrate illegally, they may not use the local health services for fear of being identified. In this regard, I would like to remind you that it is not sufficient to provide health services only for the permanent residents in a border area. Migrant populations, who are in a transit setting or residence should have an equal right to basic health services.
Any outbreak of malaria is likely to affect all residents on both sides of the border as vectors do not respect political boundaries.

It is gratifying to note that all efforts are being made by the countries to provide effective treatment to all malaria and kala-azar patients at the grassroots level. I would like to emphasize that prevention of these diseases through selective vector control is much more cost-effective than treatment. However, these two activities should be carried out simultaneously and in a synchronized manner.

There is another important issue to which I should like to draw your attention. You have, on your agenda, border cooperation and coordination as a priority subject for discussion. It is my belief that rapid and streamlined information exchange is the key to success. We should improve our disease surveillance systems, and transmit information to each other in order to facilitate the development of a concrete, feasible and workable joint plan of action to synchronize operations in border districts, share the experiences, and keep each other informed of major epidemiological events taking place on either side of international borders. Only through effective surveillance can we build early warning systems to detect impending epidemics and prevent their consequences.

It is my firm belief that efforts to coordinate our activities across borders should involve not only administrators and policy-makers at the national level, but also at the local level, as well as health care workers and field workers at the local, district and provincial levels. They are the persons who deal with health problems on the ground in border areas. This is one of the ways we can encourage the collaboration across borders. We have a joint responsibility for the people who live in border areas, and I urge you to make concerted efforts in this direction. I would also like you to consider the following actions for effective malaria control at the borders:

- Increasing of health services to migrant populations;
- Coordinated Information, Education and Communication activities;
- Synchronization of vector control;
- Rapid exchange of information, particularly in case of epidemics, and
- Monitoring of drug resistance and vector resistance.
THE World Health Organization attaches great significance to the prevention and control of communicable diseases in border areas. As we know, infectious agents do not respect international boundaries and can spread diseases from one country to another. In view of the serious problem of transborder spread, WHO has been supporting border meetings on the control of several important communicable diseases including HIV/AIDS, malaria and polio. Since 1995, several regional and bi-regional meetings have been organized to develop strategies to control cross-border transmission of diseases among countries in our regions, including Bangladesh, Bhutan, India, Myanmar, Nepal, Thailand, Cambodia, China, Laos and Vietnam. These meetings have made certain recommendations for the control of different communicable diseases by national governments and by international partners. The main thrust of these recommendations is on the importance of follow-up, not only at the national level, but also at local level in order to ensure that sustainable and effective measures are taken at the specific border areas involved.

Malaria continues to be one of the major health problems in countries of the South-East Asia Region. About 475 million people, comprising 35% of our population, live in areas of high to moderate malaria risk. Practically, all areas bordering the countries of the Western Pacific Region belong to this category. To further

AIDS in border areas needs special consideration because of the phenomenon of increasing population movement across borders leading to increased possibilities of HIV transmission, both among migrants as well as the local populations.
complicate the matter, multidrug resistant \textit{P. falciparum} malaria is highly prevalent in these border areas. The "epicentre" of multidrug resistance has recently spread from the Thai-Cambodia border to areas within Myanmar, Lao PDR, China and Thailand.

Realizing the gravity of the malaria situation in areas along the borders, the Member Countries of our Region decided, in 1995, to collaborate through joint action aimed at controlling malaria in countries sharing international borders within our regions. Towards this end several border meetings have been held, involving operational staff at district levels. The coordination and information exchange mechanism between border districts has also been established. I am sure a similar mechanism also exists within the Western Pacific Region. Recognizing that a successful programme can never work in isolation, I would make a humble request to all those present here today to extend the scope of the intraregional collaboration mechanism to also include interregional collaboration in order to fight border malaria at all fronts. We could even enhance our collaboration by sharing our resources, such as training and research facilities, and expertise.

While malaria has been a persistent problem, a new epidemic and a threat to public health has now emerged in Asia in the form of HIV/AIDS. This pandemic which started in the late 70s, in Africa and North America, has now expanded geographically, reaching countries and regions previously unaffected by it. And, it has spread mostly through sexual contact and injecting drug use. As a consequence, while the early cases acquired the infection abroad, the pattern of infection later transformed into a sustained transmission among local population groups with high-risk behaviour. Now, the infection has begun to spread among the general population as well.

AIDS in border areas needs special consideration because of the phenomenon of increasing population movement across borders leading to increased possibilities of HIV transmission, both among migrants as well as the local populations. As economies of the countries grow, people in search of employment and prosperity invariably move across borders in large numbers, thereby increasing their vulnerability to HIV. Many factors, such as lack of knowledge among the moving population about HIV prevention; poverty and inadequate living conditions; social isolation, and freedom from social control add to their
vulnerability. The efforts at preventing and providing care for those infected with HIV/AIDS it must, therefore, take into consideration the risk factors involved as well as the need to develop similar policies and strategies at local levels by neighbouring countries.

During the first Bi-regional Meeting on Control of Communicable Diseases in Border Areas, held last year in New Delhi, it was recognized that in the area of HIV/AIDS, a certain degree of collaboration across borders already exists between some countries. However, such collaboration should be expanded to cover the borders between other countries as well. This would require bi-regional as well as intercountry collaboration, including joint planning between countries, and identification of potential partners who would support action in this area.

Regarding the cross-border coordination of polio eradication strategies, a meeting was conducted in Yangon, in October 1996, by the governments of Myanmar and China. This was recently followed by a second meeting in July 1997 in Kunming, China, at which special attention was paid to cooperation in immunization and surveillance programmes between the Shan and Kachin states of Myanmar and the Yunnan province of China. Furthermore, a critical assessment of the implementation of the previous year's recommendations as well as the fresh recommendations targeted specifically at activities not yet undertaken was made. Such meetings illustrate the importance of the sustained commitment on the part of individuals at all levels, namely (1) national governments, which can draft policies that will allow action to be taken; (2) personnel, at sub-national and especially local levels, who will see that the action is carried out, where needed, and (3) international partners, including WHO, who can assist with the communication between governments and also provide resources and technical assistance, when needed.
Control of Parasitic Diseases

One hundred years ago, Sir Ronald Ross’s discovery led to the confirmation that mosquitoes transmit malaria and to the hope that this disease would soon be eliminated. After this great discovery, the fight against malaria was intensified with the help of new knowledge and new technology. However, malaria remains an enormous global public health problem.

I note with satisfaction that this Second Global Meet on Parasitic Diseases will focus on the recent developments in parasitology as well as on the new strategies for the control of parasitic diseases. Since these diseases are of medical and veterinary importance, it is vital that they are effectively controlled in order to improve the health and well-being of the affected population.

Malaria is, presently, one of the five leading causes of death in children under five and often occurs in combination with other childhood illnesses. WHO estimates that over one million children die of malaria every year. Some 300 million people are believed to be infected with malaria parasites, with 90 per cent of them living in Africa. And more than two billion people, nearly 40 per cent of the world’s population, are at risk.

The enormous number of lives and days of labour lost, the cost of treating patients, and the other negative implications of the disease on development, make malaria a major social and economic burden. For example, the annual direct and indirect cost of malaria in Africa was estimated at...
US$ 800 million in 1987. This figure was expected to rise to more than US$ 1 800 million by 1995.

Presently, WHO has taken concrete steps to address the worldwide malaria situation. A Global Malaria Control Strategy was adopted by the Ministerial Conference on Malaria, in Amsterdam, in 1992. The Economic and Social Council of the United Nations subsequently endorsed the strategy in 1994. The strategy aims to strengthen local and national capabilities in disease management and prevention, including epidemic detection and control. Its aim is also to strengthen local capacities in basic and applied research so as to permit and promote regular assessment of every country’s malaria status.

Malaria control was largely based on mosquito elimination. Unfortunately, experience has shown that mosquito control is often not cost-effective in areas where the disease is most severe, and where the interruption of transmission cannot be sustained.

A joint WHO and World Bank meeting was convened in 1995 to address the operational issues in malaria control. The meeting emphasized the need to strengthen the planning and implementation capacities at all levels as part of a wider decentralization effort.

Any integrated and comprehensive malaria control efforts should cover case management and treatment and health education with the emphasis on community-based malaria education efforts. Any plan to improve the health of the people living in malaria-endemic areas must include the effective recognition, treatment and prevention of malaria.

The control efforts must place paramount importance on the reduction of mortality and severe morbidity due to malaria. Effective disease management, adequate personal protection and maximum coordination of donor participation must also be emphasized.

Efforts made by an individual sector towards combating malaria can only protect certain groups of population, like isolated islands in a sea of endemic malaria, with little impact on the general population. Thus, it is now recognized that malaria control cannot be the responsibility of the health sector alone. It is everyone’s concern. Intersectoral partnership being an important internal resource needs to be tapped and mobilized, if effective malaria control is to be sustained. It is therefore necessary to selectively promote the complementary involvement of the private sector and NGOs.
Experience has shown that there are many administrative, technical and operational problems that hinder control measures. A strong political will would, of course, resolve many administrative bottlenecks, but research needs to be undertaken to help overcome technical and operational problems.

The need for forging partnerships in the areas of health policy development and malaria control is vital.

In the past, policy-makers and researchers worked in separate worlds that led to less than optimal, or even undesirable results. However, strengthened partnership between researchers and policy-makers will encourage both to work together in formulating questions, considering research approaches, examining the results and in formulating and implementing policies.

Let me cite a few areas of research that may guide the decision-makers. (1) the use of remote-sensing technology for selective vector control; (2) the prevention of man-made malaria in development projects through, intersectoral partnerships; (3) inputs from health economists and behavioural scientists for cost-effective and sustainable control programmes, and (4) collaboration with industries and researchers in the development of new drugs and vaccines against malaria.

Before concluding, I would like to share WHO’s vision with you. We believe that access to health care and services is a basic human right. Towards this end, we must renew our commitment to achieving health for all in spite of economic uncertainty. And we must honour our contract with all the peoples of the world by forging new partnerships aimed at their health and well-being.

We need a greater understanding of the malaria problem. We also need meaningful partnerships between researchers and policy-makers and between industries and other related sectors. In order to achieve our common goal of malaria control, the approaches we adopt should be eco-friendly, cost-effective and sustainable.
Insecticide Resistance of Mosquito Vectors

The worsening malaria situation during the 1980s led the World Health Organization to declare the control of malaria a global priority. The World Declaration on Malaria in Amsterdam in October 1992 committed the Member States to the intensification of the control of this disease worldwide. Accordingly, the Global Malaria Control Strategy was developed with emphasis on the following key elements: case management, disease prevention, capacity-building for control, containment of epidemics, and basic and applied research.

In response to the World Declaration on Malaria, several initiatives have already been facilitated by WHO. A study group met in Geneva in 1993 to develop specific guidelines for the implementation of the vector control component of malaria control programmes. Among the many recommendations that the study group made, selective use of vector control and capacity-building deserve special attention. Subsequently, a regional consultative meeting of National Malaria Control Programme Managers of the South-East Asia Region was held in New Delhi in March 1995. It reviewed and adopted the revised malaria control strategy, as the regional objective and recommended reduction by 25 per cent of the malaria-specific mortality rate by the year 2000, particularly in high-risk groups, as compared to the 1995 level. An intercountry workshop on Planning and Implementation of Vector Control for Malaria was held in Bangalore, India, in December 1995. The workshop

The reappearance of several mosquito vectors in most Member States has been attributed to the failure of chemical control as a result of the mosquito vectors developing resistance to insecticides.

Intercountry Workshop on Insecticide Resistance of Mosquito Vectors, Salatiga, Indonesia, August 1997
further emphasized the importance of the vector control strategy in the context of the revised malaria control strategy, and recommended some policy guidelines to be followed in vector control efforts. These include focus on selective vector control; strengthening of research in vector biology and control, and the need to establish firm partnerships with other sectors, including the private sector as well as NGOs for effective and sustainable control of malaria and other vector-borne diseases.

The reappearance of several mosquito vectors in most Member States has been attributed to the failure of chemical control as a result of the mosquito vectors developing resistance to insecticides. In the present scenario, mosquitoes have developed resistance to all the major groups of insecticides, including biocides. The problem of vector control by chemicals is further aggravated due to the paucity of new insecticides. Mosquito control using insecticides on a selective basis for indoor spraying, impregnated bednets, larviciding and space-spraying has, therefore, been accepted as a global strategy by WHO.

In order to sustain this strategy and to make it more cost-effective, it is necessary to fully understand the type and status of mosquito resistance to insecticides in relation to the practice of insecticide usage. The cross-resistance pattern, the factors responsible for resistance, and their intricate behavioural or biochemical mechanisms also need to be carefully studied.

So far, the information available from Member States in the South-East Asia Region is very inadequate to establish an insecticide policy for the mosquito abatement programme. Thus, the meeting in Bangalore had strongly recommended that the information on susceptibility/resistance of vectors to available insecticides should be kept up to date in order to select the insecticide. It had further recommended that a workshop be organized to deal with monitoring of insecticide resistance and resistance management.

The success of vector control as part of the global and regional malaria control strategy thus depends upon a systematic review of the available vector control options and their selective use. The varied and changing epidemiological and disease patterns as well as the differences in infrastructure and resource base of different malaria control programmes should be taken into account. While the use of insecticides may continue to be an important component of vector control, it should also take into account vector and human behaviour, insecticide resistance, safety, cost-
effectiveness and environmental impact.

Also, selective vector control should be adapted to local conditions with special emphasis on the rational use of insecticides. It is important that attention is paid to the need to prevent or delay insecticide-resistance resulting from its excessive or improper use. This may require inter-ministerial policy and programme coordination involving the ministries of health and agriculture as well as municipalities and local administrations.

Finally, I should re-emphasize that insecticides are the cornerstone of the control strategy for disease vectors. Decisions on the use of insecticides must take into account different components of resistance management, high toxicity to vectors but minimum side-effects on humans, non-target organisms and the environment.
Emerging Infectious Diseases

The threat to public health posed by infectious diseases is a matter of grave concern. These diseases are the leading cause of death worldwide, claiming at least 17 million lives every year. In the South-East Asia Region of WHO, 7 million people die from infectious diseases annually. This vast disease burden not only places a great strain on the already stretched health services, but also adds to the socio-economic burden of families and individuals.

It is, therefore, most appropriate that this year's World Health Day theme is "Emerging Infectious Diseases: Global Alert, Global Response". This theme clearly stresses the need for all countries to strengthen efforts to successfully prevent and control infectious diseases.

About 10 years ago, it was felt that the major infectious diseases had been conquered. This was the result of some remarkable progress in controlling these diseases. Smallpox had been eradicated nearly two decades ago. Considerable progress had also been made toward eradicating diseases such as guineaworm and poliomyelitis. The incidence of the five childhood immunizable diseases was also greatly reduced.

Unfortunately, however, the optimism generated by these successes led to complacency and a false sense of security. As we have seen recently, many diseases thought to have been controlled are now re-emerging. For example, we see that malaria and tuberculosis cases are being reported in larger numbers than ever before. Similarly, after many years of very few reported cases, diseases such as plague, diphtheria, dengue and cholera are reappearing. In addition, many previously unknown diseases have been identified.
infectious diseases are now being reported from many parts of the world. It is estimated that over the last 20 years, over 30 new and highly infectious diseases have been identified. These include Ebola, HIV/AIDS and Hepatitis C. Unfortunately, many of these diseases do not yet have any cure.

What do we mean by emerging and re-emerging infectious diseases? The answer is quite simple. Emerging infectious diseases are those where the incidence in humans has either increased during the last 20 years or threatens to increase in the near future. This group of diseases includes those identified for the first time and old ones spreading to new geographical areas. It also refers to those diseases which were previously easily treated with antibiotics but have now developed resistance to drugs.

Re-emerging infectious diseases are those that have increased after a significant decline in their incidence.

In the South-East Asia Region, emerging diseases include HIV infection which causes AIDS, cholera, tuberculosis, malaria, dengue haemorrhagic fever, viral hepatitis, meningitis and Japanese encephalitis. Examples of re-emerging infectious diseases are plague and kala-azar.

There are also some infectious diseases that have occurred in other parts of the world but have the potential to appear in the Region; for example, Hanta virus, yellow fever and Ebola haemorrhagic fever.

Several factors contribute to the appearance of new diseases and the increase in old and previously controlled diseases. The most important factors are the increasing number of people moving across the world, overcrowding in cities resulting in poor sanitation and the increased exposure of people to disease causing agents. Other factors include poor public health infrastructure which is unable to cope with population demands, and the emergence of resistance to antibiotics linked to their irrational use.

Since 1992, a number of Member Countries and international agencies have taken steps to control these communicable diseases. The World Health Assembly, in 1995, adopted a resolution which urged all Member Countries to strengthen their surveillance for infectious diseases in order to properly detect re-emerging diseases and identify new infectious diseases.

In the light of new, emerging and re-emerging diseases, there is an urgent need to revise the International Health Regulations, a task that WHO has already initiated. The revised
regulations will facilitate the free flow of information on disease occurrence to WHO without the affected countries having to fear the imposition of totally unjustified restrictions on travel and trade. It would also protect countries from reporting on trade and travel restrictions.

In order to effectively face the challenge posed by emerging infectious diseases, WHO has identified three priority areas for action. The first, undoubtedly, is to eradicate or eliminate diseases such as poliomyelitis, guineaworm, leprosy and measles. While this might not require large expenditure, it is important that the necessary resources are mobilized to build on the gains made so far in the control of these diseases.

The second is the prevention and control of diseases which are major public health problems in our Region. These are tuberculosis, malaria, viral hepatitis, dengue/DHF, Japanese encephalitis, meningococcal meningitis, HIV/AIDS, acute respiratory infections and diarrhoeal diseases, including cholera. This can be achieved through the establishment of appropriate national and regional surveillance mechanisms.

The third is to take short-term and long-term measures to combat newly-emerging diseases. Since a speedy response is needed to effectively contain epidemics, rapid response mechanisms need to be built into the surveillance system.

What is also needed is strong and sustained intersectoral as well as inter-country collaboration. Our experience with National Immunization Days indicates the powerful impact that concerted efforts have made in the case of polio eradication.

I am confident that this year’s World Health Day theme will help to mobilize concerted efforts to effectively reduce the burden of emerging communicable diseases. This will be a very decisive step in our march towards the goal of health for all.
Family and Community Health
Child and Adolescent Health

Over the past decades, we have made considerable progress in reducing infant and childhood mortality in all countries of our Region. However, it continues to be high in some countries.

Acute respiratory infections, diarrhoea, malaria, malnutrition and measles are responsible for more than 70 per cent of deaths among children below five years of age. About 3.4 million children die each year in Bangladesh, India, Indonesia, Myanmar and Nepal together, due to these five causes. This represents about 40 per cent of the total under-five mortality, worldwide.

Responding to this challenge, WHO and UNICEF have developed an approach referred to as the Integrated Management of Childhood Illness, or IMCI. The IMCI approach has three key components:

- **We recognize adolescence as a special and critical phase in life and also as a continuum of childhood.**
- **Healthy development of adolescents is dependent upon several complex factors, e.g., the environment in which they live and grow and the quality of relationship with the families, community and peer group.**

Firstly, it focuses on improving the performance of health workers at first-level health facilities, through training and support. Health workers are trained not only in clinical skills but also in counselling skills to ensure appropriate treatment and prevention of all major childhood illnesses.

Secondly, the IMCI approach encourages the devolution of responsibility to the district level. It facilitates integration of the various services which have traditionally been provided separately. Technical support and guidance are also provided in key areas, such as improving the avail-

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Intercountry Meeting on Child and Adolescent Health and Development, Bali, March 2000
ability and supply of essential drugs, more efficient organization of work in health facilities, and improved supervision of health workers.

Thirdly, the approach envisages promotion of health, both at home and within the wider community. Systems are being devised to teach parents what to do if their children fall ill, when and where, to go for appropriate help, how to look after sick children at home, and the importance of following treatment advice.

I feel proud that ours is the first region to have initiated the development of the IMCI training package for basic health workers. In developing this training package, WHO has collaborated closely with CARE, India, and the Government of India. The training of health workers at the basic level will help in expanding IMCI services, besides improving the referral link between the first-level health facility and the community.

Indonesia and Nepal are the first two countries to have started implementation of IMCI. After a review of their experience in selected districts, they have expanded the programme to cover more districts. Bangladesh, Bhutan, India and Myanmar have also initiated the implementation of IMCI. In some countries, IMCI has been introduced in pre-service training in medical school. This will enhance the sustainability of the IMCI approach and ensure wider coverage. This meeting will review the progress and deliberate on the strategies for expanding this approach in a sustainable way.

During the reorganization of various departments in WHO/HQ, Child and Adolescent Health Units have been combined to form the new Department of Child and Adolescent Health and Development. We recognize adolescence as a special and critical phase in life and also as a continuum of childhood. Many children in this part of the world suffer from malnutrition and infections, while girls in some countries also suffer due to discrimination. Problems that originate in childhood affect adolescent health as well. Here are some examples:

Foetal malnutrition causes health problems throughout the reproductive years and beyond. It can result in stunted growth, iodine deficiency or vitamin A blindness.

Children who survive repeated cycles of diarrhoeal and respiratory diseases fail to attain full adult growth and end up as stunted adolescents. Girls who do not achieve their full growth potential are at greater risk of having low-birth-weight infants. Infections, such as poliomyelitis, may result in permanent disability. Perinatal hypoxia or infections of the central nervous system can also result in disorders of sight, hearing or speech
impediments. These affect not only performance but also self-esteem and personality development in the adolescents.

Differential access to food and care in infancy, child marriage, sexual abuse by adults or child prostitution can seriously affect the physical, mental and social wellbeing of adolescents.

Adolescence, the period between 10 and 19 years of age is a critical transition phase from childhood to adulthood. These are formative years when significant physical, psychological and behavioural changes take place. These years are also a time of preparation for undertaking greater responsibilities, and a time to ensure healthy, all-round development.

Healthy development of adolescents is dependent upon several complex factors, e.g., the environment in which they live and grow and the quality of relationship with the families, community and peer group. If these are positive, then the adolescents usually grow into healthy and responsible adults. If the environment is not safe and supportive, then they get into problems. Some problems which originate during adolescence have life-long consequences.

The use of tobacco, alcohol, other drugs and harmful substances, for example, pose a special threat to the health of young people. Often these habits start during adolescence but persist well into adulthood. Alcohol and drugs may also impair judgement and increase the risk-taking behaviour of young people such as, dangerous driving, unprotected sexual relations, accidental injury or violence.

The health of adolescent girls demands special attention. Their lower social status and relative lack of physical, social and economic power often makes them more vulnerable, among others, to physical violence; economically-coerced sex; sexual harassment; abuse at the workplace; and forced prostitution. This can be severely detrimental to physical and mental health during their adult lives. Unprotected sexual relations can often cause young people to contract sexually-transmitted diseases, some of which can have serious consequences during adulthood and in later life. Some STDs like HIV/AIDS, can prove fatal.

Over the past few years, there has been a growing recognition in the development sector of the importance of adolescence as a target period. Accordingly, many countries undertake activities targeted at adolescents. These activities are mostly in the NGO sector. These are small-scale experiences and are often targeted at a single problem, such as drug abuse, HIV among adolescents, etc. Most government health services are not usually adolescent-friendly.
WHO has supported intervention studies aimed at increasing access of services to adolescents. Now the time has come to collect the experiences and formulate strategies in order to strengthen adolescent health programmes. In this context, WHO/UNICEF/UNFPA have developed a framework on programming for adolescent health.

WHO/SEARO has developed a regional strategy for adolescent health which identifies a common vision for adolescents in the Region in the 21st century. The strategy defines the objectives, approaches and categories of priority intervention, e.g., providing safe and supportive environments, information and skills and health services and counselling. The regional strategy also recommends the development of national strategies and action plans. This meeting is expected to review the experiences in implementing adolescent health programmes and discuss various innovative ways through which adolescent health services can be strengthened within the broad framework of the regional strategy.

Together with our partners, such as UNICEF, WHO promotes the health of adolescents. The International Convention on the Rights of Child advocates for the rights of children and adolescents to enjoy the highest attainable standards of health and access to effective health services. These international provisions indicate the need to provide coordinated and continued support for children and adolescents as a continuum within the life span.

This joint meeting of health professionals involved in child and adolescent health programmes is an important effort in this direction. This is the first regional meeting of its kind jointly organized by WHO/HQ and SEARO.

This meeting will provide opportunities to all Member Countries and partners to exchange information and experiences in child and adolescent health programmes. I am glad that representatives from Member Countries, NGOs, professional organizations and representatives from multi and bilateral agencies are participating in this meeting. We hope that your deliberations will help strengthen the IMCI programme and develop an innovative adolescent health programme in the Region.
Gender Mainstreaming in Health

This meeting on Gender Mainstreaming in Health is the first of its kind in the Region. Unless we address gender inequities we cannot bring about improvements in the health of the poor and the disadvantaged. For too long, gender concerns have been ignored while formulating health policies and designing health programmes. The Health Ministers’ Declaration on Health Development in the South-East Asia Region in the 21st Century (1997) recognized that improving the health of women in the Region is a daunting challenge. The Declaration drew attention to gender-related factors such as women’s status in society; the many kinds of discrimination they face which also affect the girl child; the lack of women’s involvement in decision-making even for their own health; and violence.

We have paid dearly for this neglect of gender concerns in health policy-making. Nowhere else is the impact of gender inequity on health as striking as it is in this Region.

Let me share with you some evidence of gender-based imbalances in health found in the Region.

• Women in this Region are disproportionately affected by inequity due to poverty and gender. Their low health status is inseparably linked with these two issues. Women are the poorest in society and suffer inequity in access to health care throughout their life span. In four countries of

Technical Consultation on Gender Mainstreaming in Health, New Delhi, November 2000
Region (Bangladesh, Indonesia, Maldives, Nepal) female life expectancy at birth is the same or lower than male life expectancy. This is contrary to nature and the global norm where women outnumber men, and reflects women’s inequitable access to resources and services. In Bangladesh, Bhutan, India and Nepal less than 40% of the adult females are literate. This has a synergistic relationship with women’s poverty and low social status.

- Women’s health is determined not only by biological factors but also socioeconomic inequalities rooted in gender imbalances. Research evidence shows that gender based inequalities adversely affect women’s health in every phase of their lives.

- Analysis of conditions that are exclusive to women reveals that this Region accounts for 40% of the 585,000 global maternal deaths every year. Most women do not have access to cost-effective and essential obstetric care.

- This Region also has 38% of the eight million tuberculosis cases worldwide. Women progress from infection to disease much faster than men, and suffer a higher fatality rate. Gender inequity hinders timely reporting and access to services.

- Women are more susceptible to HIV infection than men due to biological and gender reasons. Their unequal decision-making role does not allow women to take protective measures.

- Women are at higher risk of mental illness than men. In a study in one country of the Region the prevalence ratio was 2.8 women to 1.1 men. Discrimination and violence also put women at greater health risk. Depression, anxiety, fear and sleeping disturbances are common long-term reactions to violence.

- Tobacco and alcohol have a greater impact on the health of women than men, and adversely affect the health of their babies.

- Today’s concern is to focus once again on these inequalities, and to find the means to address them.

- Redressing gender inequities should start with legislative and financial measures. Health policies and programmes should incorporate gender concerns at the planning phase itself. Dr Gro Harlem Brundtland, Director-General of the World Health Organization, in her address at the
Beijing Plus Five Meeting in New York earlier this year, said, "Investing in health makes good economic sense. Investing in women’s health makes more sense".

- There is compelling evidence for the need to accelerate investments in women’s health, which is one of the top priorities for Health Sector Reform in this Region to eliminate gender discrimination. I hope this technical consultation will lay the foundation for the incorporation of gender perspectives into policy frameworks.

- Gender mainstreaming is a process through which issues related to inequalities can be given special emphasis while formulating policies, designing programmes and providing services.
Making Pregnancy Safer

Reproductive Health connotes the right of women and men to sexual health and their right to having a wanted and healthy child. More importantly, reproductive health implies that every woman has the right of access to appropriate health care services that enable her to plan and go safely through pregnancy and childbirth. However, the existing situation in countries of the South-East Asia Region is far different.

Over one-third of all deaths among adult women in the developing world are due to reproductive health problems, as compared to some 12 per cent in men. Pregnancy is not a disease, yet, pregnancy-related deaths constitute the leading cause of healthy life lost among women of reproductive age in the Region. Every two minutes, every day, one woman dies as a result of complications of pregnancy or childbirth in this part of the world. Sadly, this Region alone accounts for 40 per cent of the global maternal deaths – one of the highest ratios in the world.

These grim statistics not only underline the continued neglect of women’s health but also reflect the silent deaths of a large number of infants during the first week of their lives. Available data indicate that over 50 per cent of infant deaths in the Region occur during the neonatal period. Nearly two-thirds of neonatal deaths occur within the first week of birth, largely due to maternal health problems. The consequences of reproductive ill-health are not limited only to women’s lives and their welfare. They affect as much the lives of their babies, both born and unborn.

Despite the growing awareness about women’s equal rights, gender inequity poses a threat to women’s health. Women’s low status in society further aggravates the problem.

43rd All India Congress of Obstetrics & Gynaecology of FOGSI King George’s Medical College, Lucknow, December 1999
In addition, pregnancy-related deaths result in socio-economic losses. As the victims of maternal deaths are in the prime of life, it severely affects all aspects of their family's welfare. This is because women provide care for children, the elderly and the sick and contribute to family income and its welfare.

We all know that most maternal deaths can be prevented. Safe and affordable technologies to prevent such deaths exist. Yet, a large number of women in need, particularly the poor, do not have access to such technologies. The appallingly high maternal mortality in the Region tellingly speaks of the tragic consequences of inequity in health and development. Despite the growing awareness about women's equal rights, gender inequity poses a threat to women's health. Women's low status in society further aggravates the problem. Over 60 per cent of pregnant women suffer nutritional anaemia, a major contributor to maternal mortality and low birth weight babies.

The other disturbing information is that men outnumber women in the South-East Asia Region. The ratio is 94 women to 100 men as against the global ratio of 106 women to 100 men. It is well known that in societies where women and men enjoy equal socio-economic opportunities, women's survival rates are higher than men's during each phase of their life-span.

Let me now briefly highlight a few strategic ways through which WHO is revitalizing its commitment to reduce maternal and neonatal mortality and to promote women's welfare. Safe motherhood is placed high on WHO's agenda. It is enshrined in the Organization’s core constitutional functions. The health interests of mothers and their babies are pursued through several WHO collaborative mechanisms with its Member States and other partners at all levels. For example, investment in women's health and elimination of gender discrimination have been highlighted as important areas requiring health sector reform in the Declaration on Health Development in the South-East Asia Region in the 21st Century.

A global strategy for Making Pregnancy Safer by reducing maternal and neonatal ill health has recently been launched by Dr Gro Harlem Brundtland, Director-General of WHO. A joint statement by WHO, UNFPA, UNICEF, and the World Bank has been issued in support of the Making Pregnancy Safer strategy. This strategy builds upon WHO's on-going global collaborative efforts on the Safe Motherhood Initiative and contributes to intensifying actions at all levels. The strategy focuses, among others, on addressing health sector actions for operationalizing the integrated package of effective and affordable interventions. For example, adaptation of
the Midwifery Standards developed by the WHO Regional Office for South-East Asia would be promoted through health systems. The other intervention ready for field testing includes the WHO module on Integrated Management of Pregnancy and Childbirth. The strategy aims to ensure that all women have access to skilled care and to essential obstetric care when needed.

Obviously, the implementation of the Making Pregnancy Safer, or MPS strategy, is a challenging task. It cannot be done by one or two agencies only. Whether all women in need have effective access to life-saving interventions depends largely on increased resources and the synchronized efforts of all partners. Effective implementation of MPS requires synergy of all development partners. Governments, political parties, parliamentarians, international development agencies, civil society, the private sector and individuals themselves constitute a formidable body of effective partnership. Such partnerships should be consolidated for developing and funding a country-focused MPS strategy for all women in need.

In this regard, I believe that you, as eminent scientists, have a responsible role to play. This impressive Congress of FOGSI constitutes, organizationally and individually, a formidable catalytic force for fostering, nurturing and realizing such partnerships to help ensure that every pregnancy is wanted and all pregnant women have skilled and appropriate care during pregnancy and childbirth, and even after childbirth.

I would like to urge that we all join hands in solidarity for building partnerships to support the implementation of safe motherhood as the main vehicle to promote reproductive health. I believe a more synchronized partnership would be able to mobilize increased resources for implementing the MPS strategy as a matter of social responsibility and economic good sense. In this regard, I can assure you of WHO’s unstinted support in your endeavors to realize women’s right to safe motherhood, and their right to life.
Role of Hospitals

Hospitals can be classified into four basic categories - the private, income generating hospitals; the charity hospitals run by religious or other NGOs; the industrial/military hospitals and finally, the public hospitals, both large and small. Traditionally, hospitals have been regarded as big institutions, rather awe-inspiring, by the layman, as a place for cure and a place for disease. For health professionals they are centres of technical excellence for both learning and practice. However, hospitals now need to re-think their traditional roles and look at aspects that they did not consider as part of health care. The reason for this is the growing trend of globalization.

Globalization is a modern phenomenon, a development of the last few decades of the 20th Century. It is characterized by interdependence and overlapping of all sectors – political, social, economic, military and cultural. Its impact is all-pervasive and encompasses all nations big and small – transforming society world-wide, negating the concept of territorial boundaries.

Since ancient times, man has been involved in trading in goods and services. In the twentieth century this has rapidly expanded and is still expanding due to various reasons including modern means of communications and trade liberalization. The driving forces behind this rapid expansion in trade are the new multilateral agreements of the World Trade Organization (WTO).

WTO is an international legislative body responsible for handling multilateral trade matters between nations. It was created on 1 January 1993, as a

Meeting on Role of WHO in the Development of Hospital Health Services in the Context of Globalization
Sukabumi, Indonesia, July 1999
successor to the General Agreement on Tariffs and Trade (GATT). WTO currently has 132 members and 34 applicants. Indonesia is a member of WTO.

WTO administers and implements the multilateral agreements on trade that become binding on members when they join the Organization. It also conducts multilateral trade negotiations and oversees national trade policies. WTO also has the role of resolving trade disputes between members and can impose trade sanctions against members who do not comply with their obligations under the agreements.

WHO, in collaboration with its Member States and other international bodies, has collected, analyzed and disseminated information on the implications on health as a result of these agreements. In this context, national, regional and international debates have been held on this issue.

Of the several trade agreements, four are more relevant to the health sector and could have both positive and negative implications. These agreements are:

- General Agreement on Trade in Services (GATS).
- Agreement on Technical Barriers to Trade (TBT).
- Agreement on Trade Related aspects of Intellectual Property Rights (TRIPS).
- Agreement on the Application of Sanitary and Phytosanitary Measures (SPS).

Of these four agreements, I would specially like to discuss GATS, which will have a profound impact on medical and health services all over the world including Indonesia. Some of you may wonder why I am talking to the hospital administrators about trade and tariffs. Let me explain.

GATS is the international trade agreement which covers trade in 'services' in all sectors including health. Services are normally thought to be intangible, non-transferable economic goods. However, under this agreement, trading of services may be done either across borders, or by consumption in other countries, or through foreign direct investment or by movement of personnel serving abroad. No country can treat products, including services differently on account of their origin. Many countries have agreed to open up hospital services as well as medical and dental services to foreign investors. In our Region, only India has included health while providing market access to foreign investors.

What would be the impact of these developments?
As many of you know, many Indonesians travel abroad seeking various health services. Most of them go abroad since specific advanced treatment facilities are not available in the country, or if they are available, they are not up to their standards. This results in some countries having a trade surplus in health care. Thus, for example in 1996, the United States had a trade surplus in health services by providing treatment for people from abroad. It is reported that in 1997 the four Mayo clinics alone in the USA, treated more than 10,000 patients from abroad.

The questions that Indonesia and Indonesian hospitals should be asking are: Can we offer a range of health care services covering a simple medical check up to specified tertiary care at competitive process? Can we develop services as per the needs of the different consumers? How should these services be offered as part of the trade negotiations? Should we remain dependent on government subsidies? How do we provide good quality services that can compete in the market?

Another area of trade is foreign direct investment in the health sector. This is a growing trend in our Region. In countries like India, Thailand and Indonesia, the commercial provision of health care through foreign investment in the form of specialized hospitals, which are commercial enterprises, is attracting many investors. What will be the impact of this? Some feel that this would enhance investment opportunities, increase competition for quality health care and remove the burden on the public sector.

Others feel that the foreign facilities would attract the best people from the public sector and thus lead to internal brain drain. It could also lead to squeezing of the domestic sector, and thus the smaller, less competitive clinics and hospitals could be edged out.

Another related area of globalization is Telemedicine. Trading in medical services can cross borders, using modern means of telecommunications. This is a new area of investment in our Region. This could improve the quality of care and improve skills and knowledge of the professionals but would also need substantial investment. It would also make professional advice available to clients at their homes, through on-line services on the internet, thus affecting the domestic market.

The last area of trade in health is the actual movement of personnel who supply health services. Thus there could be an outflow of health personnel creating a situation of surplus or shortages depending on the country.
Indonesia could be flooded with service providers from other countries. We are already aware of the large number of medical personnel from South Asian countries working in the UK and the Middle East.

All these issues need to be discussed and debated by the health authorities in collaboration with other sectors, professional organizations, and consumers. The goal is to define a consistent set of policy objectives, based on equity and social justice. A number of issues have to be settled, including the qualifications of professionals, accreditation procedures, delimiting professional quotas for employment etc. I would urge you to initiate a dialogue with the trade, commerce and health sectors about how hospital services could promote international trade, while maintaining public health interests. The services of WHO are available as a facilitator to such a dialogue, which could help in a better understanding and preparation for the impact of globalization in health.

Globalization is inevitable and desirable. However, it poses considerable challenges and uncertainties in the provision of health care. If we are not prepared for these changes, they could lead to policy mistakes, which could prove to be costly. Areas that require to be addressed include the opening up of the health sector and moving away from the monopolies that currently exist in this country and introducing competitiveness. Comprehensive health sector reform in medical care would be needed. The needs of the consumers would have to be addressed, making the system more open and accountable. In addition, it is necessary that the basic services for the poor and under served are not forgotten. It is better to be prepared to face the situation and to be pro-active in devising new strategies and policies. The time for action is now.
ADOLESCENCE is a period of transition from childhood to adulthood. These are formative years when the maximum physical, psychological and behavioural changes take place. These years are also a time of preparation for undertaking greater responsibilities, a time of exploration and widening horizons, and a time to ensure healthy, all round development. There are approximately 1.5 billion young people including adolescents (10-24 years) worldwide. In the South-East Asian countries, the proportion of young people varies between 28 to 34% of the population. Despite the biological and social significance of this phase of life, adolescent health has not received adequate attention, until recently in many developing countries, including those of South-East Asia Region. It is obvious that neither maternal and child health programmes nor school health services adequately address the special needs of adolescents.

For over 20 years, WHO has been advocating and promoting attention on adolescence. Now, our sister agencies – UNICEF and UNFPA, many NGOs, professional bodies and youth organizations are increasingly taking interest in the subject. I am happy to say that finally momentum has gathered in this Region and, for the past few years, governments have been focusing on adolescent issues. Adolescents in SEAR countries face problems related to early marriage and child-bearing. This puts the life and health of both the child and the mother at risk. At the same time, unprotected sexual relations in unmarried adolescents have increased in countries where the age at marriage is high. This increases the danger of unwanted pregnancy and abortions, often in

Adolescent health and adolescent development are positive concepts. Adolescent health comprises physical, mental and social well-being and adolescent development is closely related to adolescent behaviour.
hazardous conditions, as well as sexually transmitted diseases, including HIV/AIDS. Other at-risk behaviours among adolescents include smoking, alcohol use, substance abuse and violence.

Research on the underlying factors contributing to the development of these problems reveal that they are inter-related. Poverty, violence against adolescents, sexual exploitation of adolescent girls, family conflict, and school drop-outs are often associated with substance abuse and teenage pregnancies. Gender bias against girls, malnutrition and forced prostitution are other problems which affect the normal development of adolescent girls.

Further, negative community norms and environment such as smoking by elders, peer examples of problem behaviour, low sense of family or community attachment, and inadequate laws for controlling drug abuse and crime often spurs negative behaviours. However, there are also positive environments which protect the youth from negative influences. These include family cohesion and harmony, sense of belonging and caring, involvement and achievement in school, improved socioeconomic status of the family and employment opportunities for young people.

In SEAR countries, there are already some programmes which focus on specific conditions of adolescents, i.e., substance abuse, street adolescents, HIV/AIDS, school health and, in a few instances, counseling on reproductive health.

These programmes have trained a large number of trainers, including peer educators, and have generated awareness. In many instances, they have been successful, to some extent, in changing the negative behaviours. Experience has been gathered about which approaches work, which do not and what kind of local innovations are needed. Based on these successes, the time has come for countries in our Region to develop adolescent health programmes on a larger scale. However, as most of these programmes are run on a small scale, it is not possible to estimate their impact.

Studies have been conducted in the countries of other regions which have carried out large-scale programmes focusing on specific problems affecting adolescents. These have shown that single focus programmes do not have adequate capacity to change the lives of adolescents. This was because they were dominated by a problem-and-risk behaviour approach and did not intervene until the conditions became problems.
These programmes failed to address adolescents holistically and to include their families, their environment, and the overall context in which these behaviours occur. As we develop adolescent health programmes in our Region, we must learn from the experiences of other countries.

Adolescent health and adolescent development are positive concepts. Adolescent health comprises physical, mental and social well-being and adolescent development is closely related to adolescent behaviour. This period for young people is both a time of risks as well as opportunities. We must recognize these factors and strive for a holistic approach aimed at the overall health and development of adolescents.

At the implementation level, WHO and other UN Agencies, such as UNICEF, UNFPA, UNAIDS and UNDCP, are increasingly advocating focus on this crucial period of human development and are allocating resources in their country and intercountry programmes. There are also many NGOs who direct their efforts towards specific issues in adolescence, e.g., substance abuse, HIV, reproductive health problems, etc. Some programmes in the government sectors also address adolescent issues. These are all positive developments.

However, much more advocacy is needed at the country level so that governments, communities and families all recognize the needs, vulnerability and potential of adolescents. Failure to meet the needs of young people sets the stage for self-destructive behaviours and behaviours harmful to others. We have to emphasize that a relevant response to their needs will contribute to their healthy development and growth, to responsible adulthood and a positive contribution to society.

By their needs, we mean basic needs, such as equipping them with knowledge, skills, values, youth-friendly health services, education and social support and opportunities for self-advancement in an equitable manner to both sexes. We have to advocate that adolescents are at life's crossroads. Therefore, it is extremely important that their health and development should be an integral component of health and development plans and policies of our countries.

Our common goal should be to create an environment where young persons can enjoy trusting relationships within their families as well as with the adults in the community. They should not grow up as ignorant, abused, violent individuals. Our aim should be to create an environment where adolescents can grow up, physically
and mentally, healthy and strong, so that they can take on their roles as confident, balanced individuals and productive citizens. It is important to have a long-range vision and strategic planning if we are to reach this goal.

It is within this context that we are convening this meeting where we can collectively crystallize our vision and develop strategies. It is important that these are relevant to the social, economic and cultural context of the countries of our Region.

I am, therefore, happy to note that representatives from the health, education, youth and sports sectors in Member Countries, NGOs, major UN Agencies as well as young people themselves are participating in this meeting. I am confident that with the presence of such vast expertise in various aspects of adolescence, we can develop a comprehensive, yet feasible, strategy for health and development of adolescents and young people for our Region.

I am optimistic that with a multi-sectoral approach, networking and effective partnership among the relevant institutions and agencies at regional and country level, we shall be able to achieve our goal of attaining healthy development of adolescents in our Region.
Reproductive Health and HIV/AIDS

This meeting is an important landmark in our collective efforts to build sustainable partnerships for health. Partnerships for health is a new vision, which emanates from the fact that health cannot be achieved through the efforts of the health sector alone. Besides biological factors, health is affected also by people’s social, environmental and economic conditions. Spiritual, cultural and psychological factors also come into play. Achieving health should, thus, become a shared responsibility among several partners from all development sectors at all levels.

Besides biological factors, health is affected also by people’s social, environmental and economic conditions. Spiritual, cultural and psychological factors also come into play. Achieving health should, thus, become a shared responsibility among several partners from all development sectors at all levels.

In this regard, I would like to share with you a few positive examples of WHO collaboration with the Association of South-East Asian Nations (ASEAN). The World Health Organization and

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SAARC Parliamentarians Meeting on Reproductive Health and HIV/AIDS, Kathmandu, May 1998
ASEAN have been collaborating closely through a mutually agreed Memorandum of Understanding (MoU), in several key health areas. A coordinating mechanism bringing together ASEAN, and the WHO Regional Offices for South-East Asia (SEARO) and the Western Pacific (WPRO), and WHO Headquarters has been established to implement the Memorandum.

The main areas of cooperation covered by the Memorandum include the prevention and control of communicable diseases, including HIV/AIDS, aging and changing life styles, nutrition, prevention of injuries, promoting healthy cities/islands, and quality assurance of pharmaceuticals. Additionally, cross-border and politically sensitive issues, such as those involved in malaria, control of drug abuse, HIV/AIDS etc. are dealt more actively through inter-governmental bodies, such as ASEAN.

The Memorandum emphasizes the need to incorporate health into all poverty alleviation efforts.

The successfully completed National Immunization Days in 1997 and 1998 in ASEAN and SAARC countries reflect the strength of such health partnerships. Some 500 million children under five were immunized in two days during 1997 and 1998 in ASEAN and SAARC countries. This is a record number for immunization completed in two days. The development of the ASEAN Regional Health Development Plan is another example of such collaboration between ASEAN and WHO. From all accounts, WHO collaboration with ASEAN seems to be mutually beneficial in improving the health of the people in the ASEAN Region.

Another MoU between WHO and the South Asian Association for Regional Cooperation (SAARC) for mutual cooperation in dealing with common public health problems in Member States is in the process of finalization. Meanwhile, WHO has continued to collaborate with SAARC’s Regional Tuberculosis Centre located in Nepal.

The other effective partnership mechanism relates to the collaboration between the WHO Regional Office for South-East Asia and the International Medical Parliamentarians Organization (IMPO). Recently, WHO and IMPO collaboration has covered two inter-related priority health areas, namely, women health and environment, as well as population and development. Such collaboration is proving effective in promoting health advocacy and technical cooperation among countries.
WHO/SEARO has accelerated action to institutionalize health partnerships through several interconnected mechanisms and forums, such as the annual meetings of Ministers of Health and Health Secretaries, and the Regional Committee for South-East Asia.

Let me now highlight the existing and changing health scenario in the Region as it relates to reproductive health and HIV/AIDS.

Changing scenario: As we prepare to enter the 21st century, this Region is experiencing wide contextual changes. These changes range from increased assertion of human rights to changes in lifestyles, including sudden economic crisis, in some countries of the Region. These changes have touched every aspect of people's lives, including their health and traditional values.

Population growth: Despite the declining trend in total fertility in the Region, the population continues to grow. Between 1980 and 1995, the regional population increased by 35%. The regional population is projected to grow to more than 1.8 billion by 2010. A large number of people continue to migrate to urban areas. Such high population growth will obviously continue to increase the demands on the already overstretched civic services.

Poverty: The other related issue is that of poverty. The countries in the WHO South-East Asia Region (SEAR) are home to nearly half of the world's poor. As we all know, poverty is a major cause of under-nutrition and ill-health. Poverty perpetuates the vicious cycle of low productivity, high infant and maternal mortality as well as high fertility.

New, emerging and re-emerging infectious diseases: As the Region is passing through a period of prolonged epidemiological transition, the health problems of the affluent co-exist with those of the poor. The Region accounts for 41% of the worldwide death toll due to infectious diseases, and 40% of the global burden of tuberculosis.

The prevalence of curable sexually-transmitted diseases (STD), among women in the reproductive age group is reported to vary from 9 to 17 cases per 100 women in the Region. STD affects women more adversely than men because STD complications and sequelae among women can last for life and they can extend to the next generation. Besides, STDs increase the risk of HIV infection and transmission.

The AIDS pandemic has hit the Region. Some 8-10 million men, women and children are projected to get infected with HIV by the year 2000. Recent evidence indicates that HIV, the
virus that causes AIDS, can be transmitted through breast-feeding. However, given the overall benefits of breast-feeding to both children and mothers and the limited information available, WHO recommends that breast-feeding should continue to be protected, promoted and supported irrespective of HIV infection rates.

Reproductive health: Briefly, reproductive health implies the right of women and men in three important areas. Firstly, it implies the right of women and men to have satisfying and safe sex life. Secondly, reproductive health implies the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning as well as other suitable methods of their choice. Thirdly, reproductive health implies that every woman has the right of access to appropriate health care services that will enable her to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy child.

I will now briefly present some aspects of reproductive health problems in our Region.

Maternal mortality: Complications of pregnancy and child birth constitute the leading cause of death of women in the reproductive age. The maternal mortality rate in the South-East Asia Region is among the highest in the world - accounting for 40% of the world total.

Causes of maternal deaths: Most maternal deaths occur due to direct causes: haemorrhage, sepsis, toxemia, obstructed labour and unsafe abortion. Safe and affordable technologies to prevent such deaths do exist. What is missing are the resources, effective partnerships and will to act. Preventing maternal deaths is thus a matter of protecting the lives of women and their babies within the context of equity and social justice.

Though not reported widely, unsafe abortion constitutes a significant proportion of maternal deaths. Deaths due to unsafe abortion indicate, among others, a high level of unmet needs for family planning services of good quality. The contraceptive usage rate in the Region as a whole is only 40%. Furthermore, the proportion of women attended to by trained personnel during child birth is low in some countries. In some countries it is as low as 14%. It is, therefore, imperative that technologies should reach all women in need so that none may die from avoidable causes.
Adolescent pregnancies: An equally important issue in the Region relates to the existing high incidence of adolescent pregnancies. 40-50% of girls in some countries of South Asia are married and become pregnant before they are 20. A pregnant girl below 18 is 2-5 times more likely to die than a pregnant woman between 20-25 years. Such high risk pregnancies are avoidable with equitable access to quality counselling and birth-spacing services.

The three types of delays: Research has shown that three types of delays increase the risk to women’s life during pregnancy and child birth and after child birth. They are: delay in deciding to seek medical care, delay in reaching a medical facility with adequate care, and delay in receiving quality care at the facility.

Malnutrition: is a major contributor to ill-health, closely linked to poverty and inequity. Over 60 per cent of pregnant women in countries of the Region suffer from nutritional anaemia - a major contributor of maternal deaths.

Gender equity is also a major health determinant for women in the Region. The health consequences of gender discrimination are reflected in every aspect, including the health status of girls and women, and their lack of access to lifesaving health interventions for preventing maternal deaths or decision-making power in relation to reproductive health.

The next question relates to how WHO/SEARO is responding to improve the health of the people in this context?

Less than a year ago, the Health Ministers of this Region adopted a Declaration on Health Development in the South-East Asia Region in the 21st century. This Declaration is the result of extensive consultations among the countries in the Region. The Declaration was subsequently endorsed by the WHO Regional Committee for South-East Asia at its 50th session, held in September 1997. This Declaration, in many ways, has defined strategic directions and identified priorities. I believe it will serve as a most useful regional policy framework as we enter the new millennium. The five foremost challenges identified for urgent action in the Declaration are forward looking. These challenges call for:

- closing the gaps and inequities in health in our societies;
- creating conditions which promote health and self reliance;
- ensuring basic health services to all, especially the poor, women and other vulnerable groups;
- upholding and enforcing health ethics, and
- placing health at the centre of development.
As we see, these challenges cut across all major health concerns. The actions needed to tackle these challenges run through the domain of several development sectors, including NGOs and the private sector. No sector alone can tackle these issues on its own. In order to overcome these challenges, we need partnerships between individuals, communities, institutions, governments, inter-governmental organizations such as SAARC, NGOs and the private sectors at all levels. We have to work together to find out how each sector, while discharging its own sectoral responsibilities can, at the same time, contribute to health promotion and disease prevention. In fact, this is a key aspect of sustainable partnerships for health.
Preventing Maternal Deaths

WORLD Health Day, on 7th April, is a special occasion this year for it marks the completion of 50 years of the Organization’s service to humanity. In 1948, WHO came into being in response to the aspirations of people around the world for freedom from disease and for better health. The WHO Constitution defines health as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The founding members pledged to improve the health of the peoples throughout the world.

In 1978, the historic Alma Ata Conference on Primary Health Care became the turning point in the promotion of Health For All. Mother and child health were identified as one of the essential elements of primary health care.

Over the last five decades there have been major achievements in some areas of health development both globally and in the South-East Asia Region.

Smallpox has been eradicated, the major epidemics of plague and cholera are largely over, and most children today are protected from childhood diseases through immunization. Infant deaths have declined significantly and people are living longer.

However, despite many major achievements in health, a large number of women in our Region continue to die from preventable causes related to maternity. The maternal deaths in the South-East Asia Region are among the highest in the world, and nearly every two minutes a woman dies as a result of complications of pregnancy or childbirth. This accounts for 40% of all global maternal deaths.

It is, therefore, very appropriate that the theme for World Health Day,

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Broadcast on World Health Day, 7 April 1998 on the theme of Safe Motherhood
this year, is "Safe motherhood". The slogan - "Pregnancy is special, let's make it safe" reminds us that while pregnancy is a natural process, yet every pregnancy carries some risks. Most maternal deaths occur due to preventable causes for which safe and affordable technologies exist. We must ensure that these services are available to all women who need them. Preventing maternal deaths is thus a matter of social justice.

In our Region as in many other developing regions, the causes of maternal deaths are deeply rooted in the continuing low status of women. The health consequences of gender discrimination against women are reflected in many ways. Many women are still illiterate, and we know that the higher the rate of female literacy, the lower the rate of maternal deaths. Many women and newborns die from complications related to childbirth due to inadequate maternal care during pregnancy and delivery. Inadequate nutrition also leads to complications. Over 60% of pregnant women in our Region suffer from nutritional anaemia which is a major contributor to maternal death.

Another compelling health consequence relates to women having to go through pregnancies which are too early, or too late, and most often too many which are too closely spaced. Or take the high incidence of adolescent pregnancies. This exposes young women to a much higher risk of maternal mortality even before they are biologically or socially ready to bear the demands of child bearing and child rearing. It also deprives women of educational opportunities.

The goals of the safe motherhood initiative, now a decade old, cannot be achieved until women are empowered and their rights, including the right to quality services, are realized.

Empowerment implies choice and decision. Too many women have too few choices. They often lack knowledge about issues affecting their own and their family's health. Empowering women means enabling them to overcome these barriers and to make fully informed choices, so they are able to articulate their health needs; have access to services with confidence and without delay and seek accountability from service providers and programme managers.

Over the years, WHO and Member States have sought to assure women's right to life by preventing all avoidable maternal deaths. In 1994 WHO launched an integrated package of interventions called, 'The mother-baby package'. This package consists of cost-effective interventions such as basic maternal care, childbirth...
attended by trained personnel, essential obstetric care, postnatal and newborn care as well as family planning. The most important element is the provision of these services to all women in need, in their own communities.

WHO continues to collaborate with Member Countries and other partners in implementing the Mother baby package in a phased manner. A Regional Reproductive Health Strategy has been developed and the training of personnel has been launched. Safe motherhood is the top priority of this strategy and already many Member Countries have developed their national strategies based on this.

Several countries in our Region have launched safe motherhood movements with multisectoral partnerships. In Bangladesh maternal health care is one of the essential elements of reproductive health. Its launch mobilized several sectors and NGOs. India has emphasized women's involvement and decentralized planning to district level to promote reproductive and child health. The Prime Minister of India, in his first broadcast to the nation recently, has made a commitment to personally monitor maternal health programmes and to ensure the doubling of female literacy within 10 years.

In Indonesia, the safe motherhood initiative was launched by the President and has started with the training and placing of over 54,000 midwives in communities. Earlier, by doing so, Sri Lanka had demonstrated a dramatic decline in maternal deaths. Nepal is promoting the social marketing of a locally produced kit for clean delivery. And, across the Region, WHO is promoting research and the formulation of quality standards in midwifery practice for safe motherhood.

Obviously, reducing maternal deaths requires a sustained effort from communities and health institutions.

Most important, perhaps, is the political will to make this happen. It is thus very encouraging that just a few months ago, the Health Ministers of the countries in the South-East Asia Region adopted a Declaration on Health Development in South-East Asia in the 21st Century. Safe motherhood, women's health and raising the social status of women form a key part of this declaration and of our direction for the future.

This year's World Health Day theme: pregnancy is special - let's make it safe, clearly underlines this too.

Let us remember that Safe Motherhood is a basic human right and a woman's right to life.
Let us empower women with both the knowledge and the means to have greater control over the choices that affect their health and their lives, their families and that of future generations. This will require political commitment and resources. Let us work together to ensure that, as we move towards the new millennium, the health of women is upheld by all of us as a human obligation, and that safe motherhood is something that from now on, every woman can be sure of.
Reproductive Health

ALTHOUGH the WHO South-East Asia Region consists of only ten Member States, it represents one-quarter of the world’s population. Despite the declining trend in total fertility in the Region, the population continues to grow. Between 1980 and 1995, the regional population increased by 35%. The Regional population is projected to grow to more than 1.8 billion by the year 2010. A large number of people continue to migrate to urban areas. Such high population growth will obviously continue to increase the demands on already overstretched civic services.

The other related issue is that of poverty. The countries in the WHO South-East Asia Region (SEAR) are home to nearly half of the world’s poor. As we all know, poverty is a major cause of undernutrition and ill-health. Poverty perpetuates the vicious cycle of low productivity, high infant and maternal mortality as well as high fertility. The health implications of the vicious stranglehold of poverty extends far beyond individual suffering. They threaten not only social cohesion but also fuel violence and mental stress in communities. They influence the quality of life, both of the present and future generations. Like the two sides of a coin, inequity and poverty reinforce each other. Almost 40% of people in the region do not yet have access to health care.

Complications of pregnancy and child birth constitute the leading cause of death of women in the reproductive age group. We need to establish approaches and mechanisms which would build stronger and sustainable partnerships for reproductive health among related sectors with a common goal.
of death of women in the reproductive age group. The maternal mortality rate in the South-East Asia Region is the highest in the world – accounting for 40% of the world total.

According to national data, the maternal mortality rate varies from less than 11 to more than 500 per 100,000 live births. The immediate causes of the overwhelming majority of maternal deaths are: haemorrhage, sepsis, toxaemia, obstructed labour and complications of abortion. Safe and cost-effective technologies to prevent them exist. As elsewhere in the developing parts of the world, a large number of women in need do not yet have effective access to such affordable technologies.

Over 60% of pregnant women in the Region as a whole suffer from nutritional anaemia, a major contributor to maternal deaths. Complications of abortion, though not reported widely, constitute a significant proportion of maternal deaths. Deaths due to complications of abortion indicate, among others, a high level of unmet needs for family planning services of good quality. The contraceptive usage rate in the Region as a whole is only 40%. Furthermore, the proportion of women attended to by trained personnel during childbirth varies from 14% to 95%.

An equally important issue in the region relates to the existing high incidence of adolescent pregnancies, mostly within marriage. 40-50% of girls in some countries of South Asia are married and become pregnant before they are 20. Such a high incidence of pregnancy in adolescents exposes a large number of young girls to a much higher risk of maternal mortality. Such high-risk pregnancies are avoidable with equitable access to quality counselling and birth-spacing services.

Gender discrimination against women is also a major public health problem in the Region. The health consequences of gender discrimination are reflected in every aspect, including in the health status of girls and women, and their lack of access to life-saving health interventions for preventing maternal deaths or decision-making power in relation to reproductive health.

Having presented the foremost regional issues in reproductive health, let me highlight some of the strategic collaborative initiatives undertaken towards resolving them.

Despite the difficult situation imposed by poverty, health inequity and gender discrimination, the Region as a whole has gained much ground in health development since the Alma-Ata Conference on Primary Health Care in
1978. For example, the basic health infrastructure has, in some cases, developed from almost zero to countrywide coverage during the last two decades. Currently, there are nearly three million community-based health volunteers in the Region who are trained and linked with the first level of the district health infrastructure.

The social and health status of the people in the Region improved significantly as reflected in the basic health indicators. In 1995, the adult literacy rate ranged from 27.5% in Nepal to 93.8% in Thailand. Life expectancy has increased in all Member Countries, ranging from slightly above 50 years to nearly 72 years in some countries. The infant mortality rate has declined considerably. It now ranges from a low of 18 to over 100 in some countries. The total fertility rate is on the decline in all Member Countries, with the regional variation between 2.10 and 6.8.

Recently, particularly since the International Conference on Population and Development (ICPD) in 1994, and the Fourth World Conference on Women (FWCW) in 1995, we have been witnessing an impressive rise in the awareness and assertion of equal human rights for women in all spheres of development. This includes reproductive health rights. The impetus provided by the ICPD to break away from the traditional model of target-oriented programmes has resulted in several useful outcomes. This, I believe, would greatly facilitate placing health, particularly reproductive health, at the centre of both individual development and national development policies and programmes.

The recent Declaration on Health Development in the South-East Asia Region in the 21st century, adopted by the Ministers of Health of the Region and endorsed by the Regional Committee a few months ago, reaffirmed the central role of health in development, including reproductive health and women’s health. To this effect, the WHO Regional Office for South-East Asia has taken a leading role to strengthen the continuum of national capacity to implement reproductive health programmes in the broader approach of primary health care.

Briefly, the main areas of WHO collaboration with the Member States include:

- Development of policies, coherent programmatic approaches, norms, guidelines and indicators for designing, implementing and monitoring programmes in reproductive health;
- International and national advocacy for increased resources.
needed for strengthening the delivery of reproductive health care through health systems based on promoting and facilitating primary health care;

- Research aimed at improving existing knowledge as well as developing new approaches and technologies, and coordination of global efforts in these areas, and

- Technical collaboration with the Member States in putting these policies and standards into practice so that programmes are strengthened and implemented more effectively.

In this context, I am pleased to report a few examples of the progress made since the ICPD in 1994:

A regional reproductive health strategy was developed with support from WHO/HQ and SEARO and in close collaboration with the national programme managers from all countries of the Region, including UNFPA country support teams and the Population Council. This has proved to be a useful product. The strategy has succinctly defined the essential reproductive health package needed at various levels of national health systems, starting from the community level upwards. Six Member Countries, namely, Bangladesh, Bhutan, India, Indonesia, Nepal and Myanmar have since developed their national strategies utilizing the framework of the regional strategy. We feel encouraged by the fact that these national strategies have been widely utilized by UNFPA and other donor agencies in developing their support programmes in the respective countries.

The other strategic areas of WHO/SEARO’s collaboration relate to the need to improve the quality of reproductive health care. SEARO’s collaboration in developing standards on midwifery practice for safe motherhood has progressed well. These standards have recently been field-tested. We expect to finalize them for wider application by the Member States by the end of 1998.

Several advocacy kits, developed by SEARO using research evidence, have been put to good use by the countries of the Region. To reinforce the momentum, SEARO has recently prepared an advocacy kit using compelling country-specific data to reinforce the slogan for World Health Day 1988, “Pregnancy is Special, Let’s make it safe”. This kit is addressed...
primarily to political leaders, policy and decision makers, health and medical educationists, corporate officials, professional bodies including NGOs, women’s health advocates, media groups and donors.

An equally important SEARO collaboration has been on reproductive health research concerning programmatic, behavioural and policy areas. More than 16% of research projects (7 out of 45), completed by the countries in the Region with WHO/SEARO support during 1992-1997, addressed reproductive and women’s health. The overriding purpose of this research was to improve the quality and access of reproductive health care through its integration into district health systems within the context of primary health care.

The only research supported in the policy area was on the evaluation of placement of midwives in villages in Indonesia. This policy was strategically linked to the birth of the Safe Motherhood Movement in Indonesia which called for training 35,000 community midwives and placing them at the village level. Historically, the Sri Lankan experience has also demonstrated a dramatic decline in the maternal mortality rate. This gain was achieved by placing fully trained midwives at the community level.

I confined my earlier remarks to regional challenges vis-à-vis reproductive health, and WHO/SEARO’s response. I would now like to submit a few reproductive health imperatives that have emerged. These are essential if the goals of the ICPD programme of action are to be realized.

- **The first imperative calls for Partnerships.** We need to establish approaches and mechanisms which would build stronger and sustainable partnerships for reproductive health among related sectors with a common goal. Achieving reproductive health should become a shared responsibility among concerned development partners at the global, regional and national levels. Given the nature and the scope of the ICPD programme of action, a much wider network of partners representing multiple disciplines would be critical.

- **The second imperative calls for strengthening national capacity.** The task is to integrate the essential package of quality reproductive health care interventions into the district health systems based on primary health care. This implies strengthening national capacity to the international level as well, including support to training programmes for all categories of
health personnel, for basic and continuing education.

- The third imperative calls for ensuring quality of reproductive health care. A key pre-condition to do this is the development of basic standards for each component of reproductive health care and strengthening of the national capacity to adhere to those standards.

- The fourth imperative calls for enhanced funding. The need is to have increased resources for reproductive health programmes including research and funds must be found for this.

- The fifth imperative calls for promoting community-based reproductive health services. This can be achieved through individual and community empowerment for self-care and self-protection, particularly against the leading cause of death of women of reproductive age, i.e. complications of pregnancy and childbirth. These services must be available to women where they need them, right at the community level.

- The sixth imperative requires a concerted commitment from all. We must now make a commitment to support national initiatives in selecting a few strategic reproductive health indicators and strengthen national capacity for placing them at par with other major criteria to assess the impact of development on reproductive health of adolescents, women and men.

- The seventh imperative calls for gender equity. In particular, the development and introduction of gender-based analysis of health development planning and research is vital. This would help policy makers to mainstream gender considerations in the policy, planning, monitoring and evaluation of health development programmes. Such a gender sensitive planning process would contribute to ensuring female equity in access to quality health care throughout the life-span.

In conclusion, I would like to make a call for all of us to join hands in solidarity and for building partnerships for reproductive health.
Safe Motherhood

Each year, 150-200 million pregnancies take place globally, of which at least 23 million develop serious complications. These complications result in the death of more than half a million mothers globally, forty per cent of these deaths occur in the South-East Asia Region alone.

During the past decade, infant mortality has declined substantially in virtually all countries of the South-East Asia Region, though it is still high in a few. Maternal mortality has also declined but is still unacceptably high in some countries.

Since the launching of the Safe Motherhood Initiative (SMI) in 1987, significant efforts have been made in the area of research, specially documenting the magnitude and type of problems, and development of appropriate and cost effective technologies and strategies. However, maternal mortality has not shown the same fast decreasing trend as IMR, in spite of the availability of adequate technologies and strategies. There are also other major contributory factors for MMR which are deep-rooted in our societies, i.e., lower social status of women and girl children, gender bias and son preference, early marriage, frequent pregnancies, lack of freedom of choice to limit family size, lack of antenatal and post-natal care, as well as lack of access to safe delivery by trained attendants. Illiteracy among mothers leads to non or poor utilization of the available health services, which, in turn, contributes to high maternal mortality. These stark

For attaining safe motherhood, good quality of care means attendance at delivery by midwifery trained personnel, development of an effective referral system with special emphasis at improving quality of essential and emergency obstetric care at first referral level.

Technical Consultation on Safe Motherhood Matters: Ten Years of Lessons and Progress, Colombo, October 1997
realities indicate that much still remains to be done to improve women's reproductive health and to ensure safe motherhood. In the South-East Asia Regional Strategy for Reproductive Health, we have identified an essential package of Reproductive Health interventions comprising safe motherhood, family planning, reproductive tract infection and sexually transmitted diseases with special emphasis on adolescents. These are being delivered as an integral component of PHC at various levels of health care in a phased manner.

I am very happy that this meeting has brought together decision makers and planners from governments and NGOs, specialists, researchers, donors and representatives from multilateral agencies to discuss key actions and some of the cross-cutting issues. This meeting is expected to draw attention of high level political leaders, the media and the civil society to the problem of maternal mortality and spark action and commitments to reduce maternal deaths.

In spite of efforts by all sectors, women's health throughout the life span remains far from satisfactory. High maternal morbidity and mortality, malnutrition and anaemia and inadequate freedom of choice to limit family size and improve their own health remains a challenge for a majority of rural women in our Region. Gender inequities still lead to serious deprivation of the girl child and women.

WHO SEARO has played an advocacy role in this regard. As a result, the Declaration on Health Development in the South-East Asia Region in the 21st Century, adopted by the Ministers of Health of our Region in August 1997 recognizes these challenges and envisages some action. Some of the suggested actions in the Declaration which will contribute in making motherhood safe include: investing in women's health and development, eliminating gender discrimination and disparities and ensuring universal access to good quality health care across the life span i.e. girl child, adolescents, reproductive age and the elderly. For attaining safe motherhood, good quality of care means attendance at delivery by midwifery trained personnel, development of an effective referral system with special emphasis at improving quality of essential and emergency obstetric care at first referral level. These few actions can make a difference between life and death of a woman. These actions are possible. Sri Lanka is one country which has carried out these actions at an affordable cost. I am happy that the organizers have chosen Sri Lanka as the venue for this meeting. Let us learn from the success story of Sri Lanka.
I would also like to stress that many determinants of ill-health, specially among women, arise from other sectors of development such as lack of education, environmental degradation and poverty. These issues can only be solved through partnership for health development at all levels.

Similarly, we recognize that families and communities are essential resources. They should be informed, motivated and fully involved as active partners for promotion of health, specially women's health, including attaining of Safe Motherhood.

Therefore, let us proactively seek partnership to make “safe motherhood” a caring and shared concern between sectors, between organizations and groups and between families and communities.
Integrated Management of Childhood Illness

A CUTE respiratory infections (ARI), diarrhoea, malaria, malnutrition and measles continue to be common causes of morbidity and mortality in young children in countries of the South-East Asia Region. At least three out of four children who visit health facilities, suffer from one or a combination of these five conditions.

These illnesses are responsible for more than seven out of ten deaths globally in children under five years of age. According to WHO estimates, about 2.8 million children die each year in Bangladesh, India, Indonesia and Nepal because of diarrhoea, pneumonia, malnutrition, malaria or measles. This represents more than a third of all deaths worldwide, in children below five years of age.

So far, Member Countries in our Region have made considerable progress in implementing national programmes for the control of Acute Respiratory Infections and diarrhoea. The problems of mal-nutrition, malaria and measles are also being addressed. However, in most countries, these are vertical efforts.

Since there is considerable overlap of illnesses at the time of presentation at health facilities, a single diagnosis for a sick child is often inappropriate. It is also likely that focusing on the most visible condition may lead to another potentially life-threatening problem being over-looked. Thus, as different treatments may have to be combined for several illnesses, management may become quite complicated.

Responding to this challenge, a number of WHO and UNICEF

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Seminar on Integrated Management of Childhood Illness (IMCI), New Delhi, February 1997
programmes have developed an approach referred to as the Integrated Management of Childhood Illnesses, or IMCI. Many other agencies, institutions and individuals have already contributed to this initiative which has many positive attributes.

Firstly, the IMCI approach focuses on improving the performance of health workers at first-level health facilities, through training and support. IMCI leads to more accurate identification of common illnesses in outpatient settings. It ensures more appropriate treatment of all major illnesses, and speeds up referral of severely ill children. It also focuses attention on immunization, vitamin A supplementation, if necessary, and to exclusive breast-feeding.

The experience with the management of childhood diseases has clearly brought out the importance of effective communication of key health messages to mothers and other caretakers. To ensure better health and nutritional status of children, communication therefore forms an integral and crucial component of IMCI. Further, according to the World Bank's "World Development Report 1993", IMCI is the intervention likely to have the greatest impact in reducing the global burden of disease. The IMCI approach is calculated to be able to prevent about 14% of such burden in the low-income countries. IMCI also ranks among the most cost-effective health interventions in low and middle-income countries.

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

To date, WHO, in partnership with UNICEF and other international agencies, has started implementing IMCI in six countries. The process of planning, adaptation and training of health workers, as well as subsequent monitoring, is being carefully documented in these countries.

In the South-East Asia Region, Indonesia and Nepal are participating as the first-use countries and I am happy to state that considerable progress has already been made in these countries. Furthermore, other countries in the Region are now discussing the issues relating to integration. The issue of expanding IMCI beyond the first few implementation
districts is also being discussed among partners.

I am delighted to see that all the priority countries which are faced with the highest infant and young child mortality rates are well represented here. It is also encouraging to note the participation of some of the donors who are interested in this programme. I am sure the Seminar will provide an excellent opportunity to discuss the various issues holistically.

Besides orientating the participants on the content and implementation of IMCI, I hope that this Seminar will also be used as a forum to discuss ways of expanding the programme. This should be done with the focus on developing and strengthening partnerships, and determining ways of obtaining greater participation of both academia and NGOs. Significant issues relating to quality assessment, as well as supervision and monitoring of the programme, I believe, will also be addressed since these are critical in determining the success of the initiative.
Sustainable Development and Healthy Environment
Intellectual Property Rights and Traditional Medicine

Traditional medicine is an important part of human health care. It is the sum total of the knowledge, skills, and practices based on the theory, beliefs, and experiences indigenous to different cultures used in maintaining good health as well as in curing diseases.

The use of medicinal plants in therapy has been known for centuries in all parts of the world. The traditional systems of many developing countries use medicinal plants in formulations or their extracts. Such use among various communities has even led to the discovery and development of a large number of drugs that are now used as therapeutic agents. Digitalis for heart failure, morphine for pain, colchicine for acute attack of gout, artemisinin for treatment of drug-resistant malaria are just a few examples of medicines derived from plant sources.

With the tremendous expansion in the use of traditional medicines worldwide, safety and efficacy as well as quality of herbal medicines and traditional non-medication therapies have become important concerns for both health authorities and the public. In addition to the safety and efficacy issues, another important issue relating to the protection of knowledge, innovations and practices of traditional and indigenous medicine has been receiving increasing international attention in recent years. The Council on TRIPS of the World Trade

Inter-regional Workshop on Intellectual Property Rights in the Context of Traditional Medicine, Bangkok, December 2000
Organization has just started the revision of Article 27 – 3(b) which deals with patentability of traditional knowledge. The conclusions and recommendations of this meeting could contribute to the revision of the Article.

The global herbal market and industry have been growing rapidly in recent years. Today, medicinal plants enjoy great potential for export. It must be noted that the vast majority of plant resources originate from developing countries. It is recognized that traditional knowledge plays a key role in the protection and sustainable use of biodiversity.

Developing countries are repositories of large resources of medicinal plants. In the past, multinational corporations have exploited these resources by converting them into products of commercial value without paying compensation for the knowledge which was transferred along with the material. At the Convention on Biodiversity held in Rio de Janeiro in 1992, members accepted the principle that bio-resources are the sole property of sovereign States and that they have the freedom to use them as tradeable commodities. However, most countries in the developing world have not so far enacted legislation to implement the resolutions passed at the Convention. It is necessary to invoke bilateral and multilateral agreements on the basis of accepted norms for the transfer of indigenous germ plasms used for research and development or for commercial production.

Access to plant resources and the associated traditional knowledge can provide substantial benefits to companies and research institutes in both developing and developed countries. There is growing concern that knowledge of traditional medicine is at times appropriated, adopted and patented by scientists and industry, with little or no compensation to its custodians, and without their prior informed consent. This is a trade issue, as such products often cross international borders.

The need to protect traditional medicine knowledge and to secure fair and equitable sharing of benefits derived from the use of biodiversity and associated traditional medicine knowledge have been fully recognized. At present, existing conventional patent law protection requirements are not applicable to 'traditional' knowledge. There is no agreement as to how and what would be the most appropriate and effective way to achieve protection of traditional medicine in developing countries.

This meeting is the fruit of contributions from the African, American, South-East Asian and the Western
Pacific Regions of WHO. These Regions also have the most important systems of traditional medicine in the world. Exchange of information and interaction would improve knowledge and capability to tackle problems facing these Member countries. The outcome of this meeting will provide Member countries with the basis for tackling issues of Intellectual Property Rights relating to their national traditional medicine programmes.
CONCEPTS of quality assurance or quality of health care were not explicitly mentioned in the 1978 Alma-Ata Declaration. The Health for All goal, using Primary Health Care or PHC as an approach focused on equity and social justice. The PHC approach provided a key route to achieve affordable universal coverage for all. But, quality assurance is critical to the success of the goal of Health for All. Quality assurance, in its broad sense, encompasses the issues of technical performance, effectiveness of care, efficiency of service delivery, safety, accessibility, interpersonal relations, continuity of services, choice of provider and treatment and physical infrastructure and comfort. Quality of care was emphasized at an international meeting organized by WHO in Almaty in 1998 to celebrate 20 years of the Alma-Ata declaration.

Responsiveness, which is one of the three intrinsic goals of a Health System, could also be regarded as a measure of the quality of care.

During the last few decades, concern for the quality of health care has been growing. This concern has, in part, been triggered by enhanced socioeconomic development, as reflected by higher public demand for quality of health care. A series of initiatives in this regard have been undertaken at sub-national, national, intercountry, inter-regional and global levels. The World Health Organization, along with other

A healthy district is an umbrella for various healthy settings, such as health promoting schools, healthy workplaces, healthy markets, healthy cities and healthy villages, etc.
UN agencies, development partners and nongovernmental organizations, has been playing an important catalytic role in initiating and sharing information and experiences in quality assurance programmes.

In October 1992, WHO organized the first International Consultation on Quality Assurance in District Health System based on PHC in Pyongyang, DPR Korea.

In December 1996, the WHO Regional Office for South-East Asia convened an Intercountry Meeting on Quality Assurance in Indonesia, followed by an International Practical Training Course in November 1997, also in Indonesia. Finally, in December 1998, it organized an Intercountry Meeting on Hospital Accreditation in Bangkok.

It is worth mentioning that the WHO Regional Office has been successfully assisting Member Countries in quality assurance of laboratory services. Within ASEAN countries, it assists in the adoption of Good Manufacturing Practice in drug manufacturing. However, with regard to accreditation of health institutions, a lot needs to be done. With this in mind, we are planning for accreditation of higher educational institutions in the near future. This would enable Member Countries of our Region to better compete in human resources in the global health market.

This meeting, eight years after the first quality assurance meeting in DPR Korea, is indeed very important and timely. We now need to review the status of quality assurance including accreditation programmes in our Member Countries. Subsequently, a Regional Strategy and Plan of Action on Quality Assurance in District Health System needs to be formulated. The presence of participants from other WHO regions would certainly give a good opportunity for exchanging views and experiences.

Why do we need to focus on quality assurance programmes in district health system? It is because while we believe that the need for focusing on the district is widely accepted, it is important to restate the reasons for this emphasis. The district is the most appropriate level for coordinating top-down and bottom-up planning; for organizing community involvement in planning and implementation, and for improving the coordination between government and private health care. Many key development sectors are represented at this level. The current trend in decentralization to the district level is another important reason. During the 53rd session of the WHO Regional Committee for South-East Asia in September 2000, Member Countries agreed to select one district as
a pilot for the ‘Healthy Settings’ approach.

It also encompasses various priority public health and medical care interventions undertaken at various levels in an integrated manner and enjoys the benefits of a sizeable political and administrative infrastructure and mechanisms which can make a difference in the health of the population.

In 1986, WHO defined a district health system as an interrelated element that contributes to health in homes, schools, workplaces and communities, through health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first-referral level and the appropriate laboratory, and other diagnostic and logistic support services. This definition, I am sure, could serve as a guide in determining the scope of the quality assurance programme in the district health system.
Impact of TB and Malaria on Poverty

At the threshold of the 21st century, it would be opportune for us to take stock of our achievements and the unfinished agenda. What are the challenges that we now face in our Region? What are the opportunities that await to be utilized?

The unprecedented health advances over the past 50 years have afforded people a healthier life and a longer lifespan. Life expectancy in 2000 has risen to 64, an increase of 17 years in five decades.

The recent certification of eradication of guinea-worm disease marks the second disease, after smallpox, to have been eradicated by the Region. We are now on the verge of eradicating polio and eliminating leprosy. Neonatal tetanus and micronutrient deficiencies can also soon be eliminated as public health problems.

However, while the age-old communicable diseases, such as tuberculosis and malaria have re-emerged, noncommunicable diseases, such as cancer and cardiovascular diseases, are also becoming serious public health concerns. New diseases, particularly HIV/AIDS, are posing a growing threat. Infant and maternal mortality rates continue to be unacceptably high.

Other problems affecting the health of our populations include widespread poverty and illiteracy, malnutrition and

Regional Conference of Parliamentarians on Impact of Tuberculosis and Malaria on Poverty, Dhaka, November 2000
anaemia and the low socioeconomic status of women. The ever-increasing population, rapid and unplanned urbanization and industrialization are putting an immense pressure on the environment, and provision of safe drinking water and basic sanitation for millions will continue to be serious challenges in the coming century.

If we were to pick one single, current, positive trend in health development, it would be the growing recognition of the centrality of health to all development. Today, globally, there is a much wider appreciation of the links between health and development, and between poverty and ill-health.

Poverty is multidimensional. It not only deprives the poor from access to the basic necessities of life, it disempowers them. It robs them of their rights, and marginalizes them. In order to launch a determined attack on both poverty and ill-health, the need for wide ranging partnerships is imperative. Top funding agencies and the developed nations are strongly supporting health initiatives as key to development.

Recently, at the G-8 Summit, leaders of the world’s wealthiest nations debated on urgent global issues at Okinawa in Japan. They gave prominence to health issues in their global agenda. While committing themselves to work with WHO, leaders of G-8 have promised to go much further in the fight against infectious and parasitic diseases, which, they said, “threaten to reverse decades of development and to rob an entire generation of hope for a better future.”

The G-8 Summit specifically agreed to work with WHO on ambitious targets to reduce the three “diseases of poverty”: AIDS, malaria and tuberculosis. These three diseases serve to impoverish people, and further marginalize the poor. The "massive effort" being now launched against these diseases will ensure that known successful strategies reach the dis-advantaged and needy sections of the population. Clear targets are being set for 2010, and a consensus is emerging between WHO and its partners to work together to achieve success.

Today, health is also high on the agenda of the finance ministers at the annual meetings of the World Bank and IMF, as they discuss poverty and debt relief. Health was the key theme in the Millennium Report of the Secretary-General of the United Nations. Health has a central role in the follow-up to the UN Conferences, in Beijing on Women, and, on Social Development in Copenhagen. It is now well recognized that health achievements are critical to the fulfilment of international development goals.
Poverty reduction is the overarching goal of the Asian Development Bank and central to the operations of the World Bank. This is because they are convinced, more than ever before, that health development, particularly of the poor, is one of the keys to alleviating poverty. No wonder, the World Bank, and the ADB, have substantially stepped up their assistance for health sector programmes and projects in developing countries.

The Director-General of WHO, Dr Gro Harlem Brundtland, has established a Commission on Macroeconomics and Health to clarify the economic links between health and poverty reduction. Through its work, the Commission will be able to provide guidance to introduce measures for improving health and human well-being. The Director-General has also constituted a Task Force on Health and Poverty Reduction. We must take full advantage of this changed scenario for the health of the people of our countries.

WHO and its Member Countries have launched several new initiatives for protecting and promoting the health of the poor and indigent. Priority has been given to the Roll Back Malaria, Stop Tuberculosis, Tobacco Free Initiative, Fight Against HIV/AIDS and Polio Eradication initiatives.

Take the example of Tuberculosis. Despite having been present for decades, it is probably one of the most serious infections today. In our Region alone, an estimated 40% of the population is infected with TB. More than 700,000 people have died of TB in 1999, despite the availability of a cure. Studies in India, Indonesia and Thailand have demonstrated the cost-effectiveness of the DOTS strategy for TB treatment. It has saved people's lives and billions of dollars through cured people and by their continued productivity. With the widespread increase of HIV/AIDS in the Region, TB control programmes also serve as an entry point for HIV prevention interventions. Recently, ministers of the 20 high-burden countries which carry 80 percent of the disease burden, met in Amsterdam and made a commitment for providing full coverage with DOTS in the next 5 years.

Malaria is said to be the single greatest cause of poverty in several developing countries of the world. In the countries of WHO's SEAR region, an estimated 25 million people suffer from malaria, and over 1.25 billion people are at risk. This Region has now become the epicentre of drug-resistant malaria and resistant mutants are spreading to new areas.

Nearly 400 million population lives in areas with the problem of drug resistance. WHO is spearheading
several cross-border initiatives for malaria control, including the Mekong Delta initiative.

It is often said that poor countries lack resources to provide proper health services to their teeming millions. The Nobel Laureate Prof Amartya Sen, however, has said, “... even when an economy is poor, major health improvements can be achieved through using the available resources in socially productive ways”. Prof Sen has further emphasized that good health is an integral part of good development. He has affirmed that “Good health and economic prosperity tend to support each other”.

The fact is that steady health development requires strong political will and social mobilization, rather than financial resources. This has been clearly shown by the remarkable progress that our countries are making towards polio eradication.

Women in our Region bear a disproportionate burden of poverty, ill-health, malnutrition and disease. A focus on women with a gender perspective is, therefore, a must in any strategy for poverty reduction.

The health consequences of poverty are severe, trapping the poor into the vicious cycle of sickness and penury. Conversely, it has been seen that once the poor are lifted out of destitution through improved productivity and better health, they do not tend to slide back into poverty.

Parliamentarians play an important role in giving shape to national policies. They are best placed to advocate for health with their presidents, prime ministers and finance ministers. With their vast experience in public life and civic affairs, Members of Parliament can recommend viable and practical strategies to meet the health needs of the poor. They can also play a major role in developing partnerships with the industry, development agencies, NGOs and decision-makers in improving accessibility and affordability of drugs, particularly to the poor. Since 1996, this Region has organized five conferences of parliamentarians on topical health issues in the perspective of sustainable development. This Conference aims at strengthening our partnership for health development with parliamentarians, and accorning higher priority to the health of the poor in national, political and developmental agendas. We are confident of achieving these objectives with the active participation of the Members of Parliament.
Historically, countries have shared their interest in protecting public health through international cooperation, international conventions and conferences. Efforts in international health cooperation actually intensified in the early 18th century when European nations applied protective legislative measures to prevent the importation of epidemic diseases by trading ships. Later, business interests in these countries seemed to clash with the concerns of governments for the health of their respective populations. After a series of international health conventions, the International Office of Public Health and Hygiene was established in 1907 in Paris. After a decade, based on a proposal by the Brazilian delegation, the League of Nations Health Organization (LNHO) was established in 1923. This was a precursor to the present-day World Health Organization. Shortly after the Second World War, in 1948, the World Health Organization was established to function as a leading international, intergovernmental health organization, taking over the roles of the League of Nations Health Organization, the International Office of Public Health and other public health regional bureaus.

Similarly, many other UN agencies such as UNICEF, UNDP and UNFPA emerged as international development agencies with specific mandates covering women and children, development and population, etc. The Bretton Woods institutions, such as the World Bank and IMF, were also established to support the developmental efforts of developing countries.

Since the 1950s, developed countries have established many bilateral development agencies such as United States Agency for International Development (USAID), ODA, JICA.
NORAD, GTZ and AUSAID, in order to support developmental efforts, particularly in the developing world. In addition to the UN agencies, numerous intergovernmental bodies and associations such as the Colombo Plan, the Commonwealth Secretariat, European Union (EU), Association of South East Asian Nations (ASEAN), South Asian Association for Regional Cooperation (SAARC) and OAU were established to strengthen regional economic, social and cultural cooperation. Innumerable international and national NGOs and foundations were also established rapidly, e.g. the Nippon Foundation, the Arab Gulf Fund, and lately the UN Foundation, and the Bill and Melinda Gates Foundation. All these international agencies, known as external donors, included health in their development programmes.

**Globalization and International Health**

There is no doubt that the countries of the South-East Asia Region have achieved their development objectives to some extent. However, from a comparative analysis of the Human Development Index (HDI) among SEAR countries, we can see the different development perspectives. Thailand, Sri Lanka, Maldives and Indonesia are having higher HDI values, while Bangladesh, Bhutan and Nepal are at the other end. India and Myanmar fall in between. This clearly reflects the regional disparity.

With reference to the global mortality for males (with the probability of their dying between birth and age five years and the probability of dying between age 15 and 60 years), countries have been classified in five main groups.

Group “A” countries, which include those of North America, Western Europe, Australia and Japan have low levels of both child and adult mortality. Group “B” countries, which include those from Latin America, the Eastern Mediterranean region, parts of South-East Asia and China, have intermediate levels of child and adult mortality. Group “C” countries have the same level of child mortality as Group “B” but a much higher adult mortality; these countries are located in Eastern Europe and Central Asia. Group “D” countries are from the main part of South Asia and sub-Saharan Africa, and have high levels of both child and adult mortality. Group “E” countries are all located in sub-Saharan Africa with extremely high levels of both child and adult mortality. When we review the infant mortality trends, we see a general decline in all countries. Yet, the situation in the least developed countries is not promising. The two most populous countries of the
world still show different trends. India’s current Infant Mortality Rate (IMR) is still higher compared to China’s in the mid-1970s.

Looking at the under-five child mortality figures for India from 1958 to 1996, using various data sources, one finds a declining trend, which slowed down during the mid- and late 1980s. This indicates that we need to take a critical look at the implementation of our public health intervention programmes.

Recent newspaper reports point to an alarming increase in IMR in some States of India. Even though 1998 data are preliminary, if we use these together with the available data of the last decade, we can clearly see the inequity. Orissa and Madhya Pradesh have remained at a higher level throughout, followed by Uttar Pradesh, Rajasthan and Assam. Bihar is at a low level at the mid-position amongst various States, comparable to the Indian average. Kerala has always stayed at the bottom. Interestingly, there are signs of IMR increasing in a few States. A further study may be required to get a clearer picture.

If we compare the differences in IMR among urban and rural populations, we can see the gaps becoming narrower but inequity still exists. The rate of decline also seems to have slowed down in recent years.

Let us look at the future trends of causes of deaths in the population of the developing countries, using the summary measure of the burden of disease, in terms of disability-adjusted life-years (DALY). Noncommunicable diseases are rising and their burden is expected to increase rapidly in the next 20-25 years in the developing countries. According to available estimates around 2 million people died of cardiovascular diseases in India in 1996. Nearly 30% of the total hospital deaths in Sri Lanka were also due to the same cause.

However, communicable diseases remain the major killers and cripplers of the population, especially young children and adults, in developing countries. In 1997, the South-East Asia Region accounted for almost 40% of TB cases reported globally. With the rapidly rising trends of HIV/AIDS, it is expected that TB will increase. This is why it is essential to implement the Directly Observed Treatment Short course (DOTS) for TB control vigorously as soon as possible in the country. India is a major contributor of the TB caseload in the Region. We hope that the new TB control programme in India will be able to effectively control the disease.
Compared to other regions, the HIV/AIDS epidemic started a decade late in our Region. While most of the other regions reached the plateau, the epidemic curve in our Region showed a rising trend. This is alarming. If this trend is not decisively controlled now, it will cause increasing child and adult mortality in the coming decades. A recent meeting of UNAIDS reviewed the situation. It would be important to follow how the National AIDS Control Organization of India and similar bodies in other epidemic countries address this problem.

Responses
After reviewing the international health situation, we need to examine the responses. The performance of health systems can usually be judged from the level of provision of services. Most of you would agree that Universal Child Immunization (UCI) has been a major effort launched by the health systems to eliminate or eradicate some diseases. If we look at the immunization coverage with polio vaccine in countries belonging to different socioeconomic groups, for the past two decades, we see a wide variation. The lowest coverage is in the least developed countries. It is also seen that the coverage improved vastly after the UCI initiative organized jointly by WHO and UNICEF with the support of international donors in the mid-1980s.

Recently, through a series of National Immunization Days in countries of our Region, polio immunization coverage has received a significant boost. Even then, the least developed nations need to make concerted efforts to maintain a higher level of vaccination coverage. How is India performing?

India still has the largest reservoir of polio cases in the world. Most of these cases are in a few selected States.

Let us take up another area of health systems, i.e. access to essential drugs. Too many people still lack access to essential drugs, and the majority of these live in the developing world.

Viewed from another angle, that of price differentials of some essential drugs, we find that drug prices vary 20 to 40 times in developed countries, compared to India. This situation might be reversed in the near future as India will have to accommodate the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). TRIPS is an international multilateral agreement, which is a powerful instrument for protecting the intellectual property rights, but, at the same time, has many implications on the accessibility of essential drugs.

There is another aspect of TRIPS. This relates to the origin of material
from Third World countries and patented in the United States, for use in the drug industry. Similar cases are also seen with regard to traditional medicine. Are we prepared for this? The expenditure on drugs and vaccines is the highest among the developing countries. How can we deal with the situation? With the TRIPS agreement coming into force in many developing countries as of 1st January 2000, and in five years' time in the least developed nations, we need to be prepared.

Recent empirical studies carried out by WHO and other agencies have shown that there are a lot of implications for policy and legal aspects as well as for service delivery. For example, drug prices will increase, negotiations for compulsory licensing and exclusive marketing will be tough, and pharmaceutical companies will need to be competitive. Can India lead other developing countries in addressing these challenges?

WHO, over the last fifty years, has been the main player in directing and coordinating international health. Now, it is one of the many, and no longer following traditional paths.

Since then, funds flowing from multilateral development banks have grown significantly - with the World Bank being the single largest financier of health development. Private multinational corporations (MNCs) are also coming in as major contributors to health development. Recently, Smith Kline Beecham, a multinational drug corporation, made a commitment for a unique collaboration with WHO. It will support the global programme on elimination of lymphatic filariasis. It will donate sufficient quantities of the anti-parasitic drug, albendazole, for use in all lymphatic filariasis-endemic countries for as long as it takes to eliminate the disease. This practice is based on the experience of another multinational firm, Merck & Co., which made a similar commitment to provide another anti-parasitic drug, ivermectin, for use in river blindness and for the control of lymphatic filariasis. The Bill and Melinda Gates Foundation recently pledged to help in improving child
immunization coverage in developing countries. It is a welcome pluralism but must be properly exploited in order to meet the diverse health needs of the developing world. WHO will use this opportunity by enhancing global partnerships for health and by mobilizing greater involvement of global private industries in helping the developing countries reduce the burden of diseases.

Addressing the Challenges

During the last few decades, WHO, together with its Member States and development partners, has been able to fulfil its role in directing and coordinating international health on many fronts. WHO has been able to reach a consensus on global policies and strategies for health for all, using primary health care as the key approach.

Over the past two decades, the HFA/2000 movement has provided developing countries with opportunities to strengthen their health systems based on primary health care. Countries which extensively implemented health for all strategies provide many successful examples of health development. During this period, WHO strongly advocated the importance of health being seen as central to overall development.

A few major communicable diseases, especially those preventable by immunization, have been virtually wiped out from many areas of the globe. A few are on the verge of elimination or eradication. WHO has developed norms, standards and guidelines in relation to various areas of health and biomedicine. This has been done through its extensive network of collaborating centres and institutions. WHO has also sponsored many international conferences. The Organization recently launched a few global health initiatives, such as Roll-back Malaria, Tobacco-free Initiative, Stop TB, etc.

WHO’s Role

Recently, WHO has redefined its mission and functions to meet the challenges of the 21st century. The original objective of achieving the highest level of health for all, as contained in its Constitution, will remain its foremost mission. WHO will continue to contribute to world health by increasing its technical, ethical, intellectual and political leadership.

WHO has recently adopted a corporate strategy, which provides its Secretariat the main directions for the next medium-term period. These are:

- Reducing excess burden of diseases;
Sustainable Development and Healthy Environment

• Promoting healthy lifestyles and reducing risk factors;
• Developing health systems that equitably improve health outcomes, and respond to people's legitimate demands, and
• Developing an enabling policy and institutional environment.

The four strategic directions are interrelated, and the challenge now is to find the right balance. Keeping in view the above four strategic directions, WHO's core functions have been redefined. These will be:

• Articulating consistent, ethical and evidence-based policy and advocacy positions;
• Managing information, assessing trends and comparing performance of health systems, setting the international health agenda and stimulating research and development;
• Catalyzing change through technical and policy support;
• Negotiating and sustaining national and global partnerships;
• Setting, validating, monitoring and pursuing the proper implementation of norms and standards, and
• Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery.

The new specific directions and core functions provide a clear focus for WHO's priorities. WHO's Governing Bodies will continue to provide guidance on the Organization's work from time to time, especially on how to set priorities, keeping in view its own declining resources.

I would now like to touch upon the issue of how India can play its role in addressing the challenges in international health.

Let me highlight a few challenges for India, within the context of international health development.

India is passing through an epidemiological transition. It shoulders the double burden of both communicable and noncommunicable diseases which will continue for the next 20-30 years. India has been singled out for being home to a few global priority diseases such as polio, TB, HIV/AIDS, cancer, diabetes, malaria and leprosy. A few of them have already been eliminated from many parts of the world. They have even been eliminated, from some parts of India. India thus needs to further improve its health systems performance, in terms of equity, responsiveness and fairness.
At the International Public Health Conference held at the end of last year in Calcutta, and also at the Indian Public Health Conference, held last month in Agra, it was debated and agreed that the issues of improving public health policy and practices be addressed seriously, especially in India. The public health community gathered at Agra agreed to implement the principles, concepts and policy directions of the Calcutta Declaration. WHO will be happy to collaborate appropriately in these endeavours.

It is well acknowledged that India is a leader among the developing world in the area of science and technology development. It has vast human and technology resources and has played a significant role in many international innovations. It has also led many international negotiations. India has participated in many forums relating to policy and strategy formulation in international health development. India has also contributed to international health cooperation through bilateral aid. It has supported intercountry cooperation in health development through its TCDC mechanism or through international agencies like WHO, other UN agencies and intergovernmental bodies.

I would like to conclude my presentation by stating that, since WHO was established more than fifty years ago, international health development has evolved with new waves of globalization. There are many players in international health. Many developing countries who received external assistance in the early days are now external donor partners. Multinational private corporations are mushrooming. They must be brought in to join in global health development. India, with its determined efforts to rise above the trap of poverty and ill health, can and must play a major role in international health. It can set an example by concentrating its efforts to eliminate or eradicate many global priority diseases. It can also cooperate with other developing countries in intensifying intercountry activities for reducing major disease burden and risk factors. WHO, I assure you, will continue to work closely with the Government of India, civil societies and development partners to fulfil the goals of health for all.
WHO's cooperation with ASEAN is a long-standing one. It dates back to the eighties when the regional collaborative programme in health and nutrition and the ASEAN cooperation in pharmaceuticals were launched. WHO was closely associated with the ASEAN Sub-committee on Health and Nutrition in the implementation of these initiatives.

WHO has always considered ASEAN as an important forum for advocacy and collaboration on health promotion in the countries which are members of both ASEAN and WHO. The ASEAN countries have been ahead of many other nations in reorienting their national policies towards a balanced socio-economic development process. We have always recognized the dynamism and farsightedness shown by ASEAN in placing health on its agenda of socio-economic development along with the promotion of human resources, poverty alleviation, equity and social upliftment of the disadvantaged and marginalized. These positive elements of ASEAN's socio-economic policy are consistent with WHO's approaches and have brought our two organizations together in a common mission of improving the health of the people of the Region.

Since 1994, WHO has taken fresh initiatives to reinforce WHO/ASEAN collaboration. These moves culminated in the signing of a Memorandum of

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Mid-Term Review of ASEAN-WHO Memorandum of Understanding, Jakarta, December 1999
Understanding between ASEAN and WHO (MoU) in April 1997. The MoU signifies a new phase of renewed and intensified collaboration between the two organizations. It represents the commitment of both WHO and ASEAN to consolidate and to expand cooperation to address the priority public health concerns of our common Member States.

We look upon ASEAN as an example of a political institution and forum, through which intercountry cooperation and partnership can be fostered, sustained and strengthened. Cooperation is crucial for any measure of success in improving the health status of our people. One must not forget that, despite our remarkable progress in health development over the past years, we still continue to face enormous challenges. We are carrying into the new millennium a backlog of old, re-emerging, and newly emerging diseases and also an unfinished agenda.

Our countries are already saddled with the double burden of communicable and non-communicable diseases. Added to these is the impact on health of environmental degradation, gender inequities, urbanization and industrialization. This only highlights the urgent need to ensure equity in access to health benefits for all sections of people across the socio-economic strata. It is clear that the scale of the challenges is too vast to be handled by one country alone. Globalization is making countries increasingly interdependent. With the growth in international travel, many health problems are crossing national boundaries.

It is true that we have witnessed unbelievable social and technological development in the present century. The new millennium may usher in an era of incredible technological developments which may totally change the landscape of health development and help solve many of the current problems. But new technologies may raise new challenges as well. A key challenge in the 21st century will be to address health issues through cooperative efforts in a spirit of partnership.

Technical cooperation in health among developing countries has led to fruitful outcomes in the past. ASEAN is an example of how countries and intergovernmental organizations can work together. The Jakarta Declaration on Health Promotion in the 21st Century has attached great importance to partnerships between countries and technology transfer. This partnership is multidimensional in scope. It should focus, among others, on the formulation of national policies for intercountry cooperation, shared use of
technical expertise, collaboration between centres of excellence, harmonizing of national laws to deal with cross-border issues, and multisectoral alliances both within and between countries. The supportive role of the international community, UN agencies, NGOs and civil society can greatly facilitate this process of inter-country cooperation and partnership in health. WHO attaches great importance to collaboration with ASEAN in this context.

It is obvious that we have to work hand in hand. As the Director-General of WHO mentioned in her address to the Fifty-second World Health Assembly, “Health is an immensely broad and complex area to cover. Even a global organization would lose its focus if it tries to do everything”. We need to be clear about our priorities. Our resources are limited. Therefore, we need to have a focused approach in addressing challenges to health development. WHO has set four strategic directions keeping in view the current and the future health determinants. These are:

- To reduce the burden of excess mortality and disability, especially that suffered by poor and marginalized populations;
- To reduce the risk factors associated with major causes of disease and the key threats to human health that arise from environmental, economic, social and behavioural causes;
- To develop health systems which: help to ensure equitable health outcomes and cost-effectiveness; are responsive to people’s legitimate needs; are financially and procedurally fair; and encourage public involvement, and
- To promote an effective health dimension to social, economic and development policy.

Within the framework of these strategies, we in WHO have focused on five priority thematic areas:

- Prevention and control of priority diseases;
- Health Sector Reform and Partnership Building;
- Improvement of the health of the marginalized and vulnerable groups;
- Healthy environment and lifestyle, and
- Regional technical cooperation among countries in technology and quality assurance.

You will agree that these themes reflect the major concerns and the
highest priorities of health development across the countries of the Region.

We are aware that some of the problems are most pressing. Diseases such as malaria and tuberculosis have re-emerged and are still dominant in the Region. HIV/AIDS continues to be a major threat and will possibly remain so well into the next century. We are committed to eradicating polio. We are also aware that noncommunicable diseases such as cancer, cardiovascular diseases, and mental illness can emerge as the most serious public health concerns in future unless people change their life-style and reduce the factors favourable to these diseases. In view of these imperatives, we have taken up five ‘flagship’ projects to address some of these problems on a war footing. These projects are:

- Roll Back Malaria
- Stop Tuberculosis
- HIV/AIDS
- Tobacco Free Initiative
- Polio Eradication

I believe that WHO's new strategies, the focused programme themes and the flagship projects are fully consistent with the priorities set out in the MoU and clearly define the current and future directions for a fruitful collaboration between ASEAN and WHO.

During the last two-and-a-half years since the MoU was signed, WHO and ASEAN participated in significant collaborative activities in a number of critically important priority areas for health development. In addition to the ASEAN pharmaceutical project in which WHO has been collaborating since the eighties, WHO has provided technical support to the development and formulation of ASEAN’s Regional AIDS prevention and control programme as well as TB control and disease surveillance programmes and workplans. It has also collaborated in the preparation of a five-year Medium ASEAN Plan of collaboration in Health and Nutrition. ASEAN Member Countries are actively involved in many of WHO’s promotional activities covering polio eradication, nutrition, food safety and malaria control. WHO is closely working with the Greater Mekong Sub-Regional countries in the Roll Back Malaria Initiative focusing on cross-border issues. It has also facilitated participation of delegates from a number of ASEAN Member Countries to the meetings of the ASEAN Sub-Committee and the Ad hoc Working Groups. These collaborative activities have laid a solid foundation for productive cooperation between our two organizations.

The progress of these programmes and plans, however, has been slow.
We recognize that lack of financial resources has been a major constraint. We are also aware that this problem is further aggravated by the economic crisis, which has severely affected many of the ASEAN countries. Also, the environment for global external assistance is becoming more and more unfavourable. As you know, WHO is a specialized technical agency. It has technical resources and its constitutional mandate is to provide technical support. It does not have the financial resources to provide any significant funding support. ASEAN has a distinct infrastructure with major donors as its partners. We feel that this offers a unique opportunity, which ASEAN can use to its advantage for mobilizing resources in support of its health programmes.

WHO can play an important catalytic role to facilitate ASEAN initiatives for resource mobilization. Within its available means, it can provide technical inputs for preparing technically sound and aid-worthy project proposals which ASEAN can submit to its partners. WHO can provide information on donors’ policies, priorities and funding preferences. WHO, on request, can take part in the ASEAN dialogue with the donors as a technical adviser to clarify technical issues and can work with the ASEAN Secretariat for technical monitoring of project implementation.

In our view, a regional programme like that of ASEAN, reflects a synthesis of the common priorities of the Member Countries. While the ASEAN Secretariat may take direct responsibility for the activities which are more amenable to a regional approach, individual countries may pick up such activities from the ASEAN plans as they consider their immediate priorities, include them in their national plans of action and mobilize funds both from bilateral and multilateral sources.

The bulk of the official development assistance from the donor countries, in fact, comes through bilateral channels. This offers the countries a relative advantage to access bilateral sources. We believe that such an approach may promote a shared responsibility between the ASEAN Secretariat and the Member Countries facilitating implementation of the ASEAN health programmes and projects. However, the success of the strategy will largely depend on the monitoring and management capacity of the Secretariat.

As you may be aware, our Region is in a transition. The health scenario is fast changing. The time is opportune to reflect on the strengths and weaknesses
of the process of our cooperation in the light of our experience with the MoU over the last two and a half years. We need to take stock of the collaborative initiatives undertaken by ASEAN and WHO and examine the successes and failures. It is necessary to analyze the opportunities and constraints responsible for the tardiness in the implementation of the programmes and plans of action we have jointly developed. We need to take a fresh look at the priorities set out in the MoU and see whether these are still valid or we to consider new priorities and look for new answers in the changing scenario. We have to determine our immediate focus among the priorities and see how best we can utilize our limited resources for maximum benefit. I hope the Mid-Term Review will address all these issues and come up with realistic recommendations for our joint and timely actions to meet the challenges facing us.
The South-East Asia Region is home to about 1.5 billion people. This is a quarter of the world's population, living in an area that constitutes only 5 per cent of the global land mass. In addition, nearly 40 per cent of the world's absolute poor live in this Region.

Rapid population growth, accompanied by very rapid urbanization; unmindful industrialization; widespread illiteracy, particularly among women; the generally low status of women, environmental pollution and degradation have all combined to increase the vulnerability of large population groups in countries of our Region.

It is obvious that the magnitude of the health problems faced by the vulnerable population is enormous. Generally speaking, women, children, indigenous people, landless workers, daily wage earners, the illiterate, and the disabled constitute vulnerable population groups. What they all have in common is poverty.

However, ill-health also leads to poverty; disease and sickness perpetuate and accentuate poverty. Investing wisely in health, therefore, contributes to poverty reduction.

I am happy to recall that, at the initiative of the Health Ministers of our Region, issues relating to poverty and health in the context of our Region were studied. As a result, a monograph on Poverty and Health was prepared. Among other things, it highlighted that the provision of adequate health care is a necessary precondition to...
accelerate poverty reduction and economic growth.

Unless the health status of the vulnerable populations is significantly improved, Health for All would remain a distant dream. Health, by itself, is a desirable goal. Therefore, the health of the poor and the vulnerable populations must be urgently addressed. This is because the health of a community, a country, or of humankind itself, is closely inter-dependent. Disease and ill-health anywhere threaten health everywhere. Secondly, the potential of the contribution of health towards socio-economic growth and poverty alleviation can never be realized if vast numbers of the vulnerable are forced to exist in ill-health, squalor and disease.

It is often said that poor countries lack resources to provide proper health services to their teeming millions. The Nobel Laureate Prof Amartya Sen, however, has said, and I quote: "...even when an economy is poor, major health improvements can be achieved through using the available resources in socially productive ways". Unquote. Prof Sen has further emphasized that good health is an integral part of good development. He says, and I quote again, "Good health and economic prosperity tend to support each other". Unquote.

The point is that steady health development requires more of political will and social mobilization than financial resources. This has been clearly shown by the remarkable progress that our countries are making towards polio eradication through National Immunization Days. Similarly, the large and growing incidence of cataract induced blindness in many of our countries can be very cost effectively curbed. Towards this end, we have launched a 20 year programme - Vision 2020.

We have evidence to show that health, education and nutrition are essential for building human capital, which, in turn, is vital for sustainable development. Experience also shows that economic growth may not automatically translate itself into human development. A link between growth and human development must be created through conscious national policies. The emphasis should be equally on economic growth, and distributing its benefits equitably. The most effective way of ensuring equitable distribution is through wise investments in public health and education.

Poverty and vulnerability are multi-dimensional. So is health. The determinants of health extend beyond biomedical reasons. Therefore, in order to launch a determined attack on both poverty and ill-health, the need for wide-ranging partnerships is imperative.
Since 1996, we have, in collaboration with the International Medical Parliamentarians Organization, held four conferences of Parliamentarians. These have been on Health in Development; Women, Health and Environment; the Health Impact of the Economic Crisis; and on HIV/AIDS and Reproductive Health.

The objectives of this Conference are to further strengthen the partnership between WHO, the Ministries of Health and the health sector, on the one hand, and Parliamentarians on the other. It is also hoped to enhance inter-sectoral action for health in the perspective of the inter-linkages between poverty and health. We are confident that participation of so many MPs would result in higher priority being given to the health of the vulnerable populations in national political and developmental agendas.

In view of the pivotal role that health plays in improving the lives of the poor and the vulnerable, parliamentarians are best placed to advocate for the health of these groups with their Presidents, Prime Ministers, Finance and Planning Ministers. With their vast experience in public life and civic affairs, Members of Parliament are most qualified to recommend viable and practical strategies for meeting the health needs of the vulnerable populations.
Striving for Better Health in South-East Asia

Nutrition Research

THE WHO Regional Office for South-East Asia has been supporting nutrition research for many decades. The results of this research have contributed substantially to policy formulation and action by governments, particularly in iodine deficiency disorders and vitamin A through nutrition interventions in the context of Primary Health Care.

It is regrettable that despite the progress achieved so far, the problems of malnutrition remain very acute in the Region. Thus, the comprehensive research-cum-action programme being developed for the Region as part of the global programme needs to address the specific problems of the Member Countries to use their own expertise to implement integrated and sustainable nutritional activities.

From a regional perspective, there are six key areas from which carefully selected high-priority nutritional research issues are to be identified. These are: nutrition surveillance, adolescent girls and maternal nutrition and low birth weight, infant and young child nutrition in order to prevent childhood malnutrition, micronutrient deficiencies, some biological research relating to energy and nutrition requirements, nutritional indicators and standards and family nutrition studies including behavioural studies – household dynamics and intrahousehold food distribution for individual nutrition security.

Although global improvements can be documented in the availability of food, higher literacy, better water supply and sanitation, reduced infant mortality and improved nutritional status of women and children, disparities exist among population groups within countries and among countries and regions.

The Organization is well placed to play a catalytic and sensitizing role on important nutritional issues in the Region and in promoting and supporting research.

Fifth Meeting of South-East Asia Nutrition Research-cum-Action Network, Salaya, Indonesia, June 1999
To find solutions to the disparities that exist among countries, research programmes must answer the questions as to why certain countries or communities do better than others in similar socio-economic conditions. Answers to these questions will go a long way in protecting and promoting healthy nutrition from conception to infancy and through adolescence to adulthood by increasing awareness of the main types and causes of malnutrition and their effects on the population. They will also help in finding the means to overcome those causes through better programme intervention.

Although our ability to influence the course of nutrition research is limited in financial terms, the Organization is well placed to play a catalytic and sensitizing role on important nutritional issues in the Region and in promoting and supporting research. WHO can also act as a facilitator to encourage multilateral and bilateral agencies to increase their allocations for nutrition research in the countries of the South-East Asia Region. Currently, WHO is supporting countries to improve their technical and managerial capacities to detect, prevent and manage malnutrition through the application of cost-effective approaches linking research to implementation of programmes.

I am indeed happy to note that the South-East Asia Nutrition Research-cum-Action Network has performed commendably well in conducting research relevant to the needs of the Region in line with the International Conference on Nutrition (ICN) goals which are: to reduce the prevalence of low birth weight to less than 10%; reduction of severe and moderate malnutrition among under-five children by half of the 1990 levels; reduction to less than 10 per cent or virtual elimination of iodine deficiency disorders; virtual elimination of vitamin A deficiency and its consequences, including blindness and reduction of iron deficiency anaemia to one-third of 1990 levels. I hope the findings of operational research undertaken following the fourth meeting held in Jakarta in 1996 will be appropriately disseminated and applied effectively in nutrition programmes not only in the South-East Asia Region but also in other regions to achieve the ICN goals.

The task of the Network needs to continue at an accelerated pace. The Network also has the responsibility of seeking possible collaboration with WHO Collaborating Centres in other regions with similar interests for better understanding of global nutritional problems and ways to minimise them.
through sharing and learning from the experiences of other regions.

I would like to reaffirm that WHO/SEARO will continue to support the Network in identifying key areas for action to address regional nutritional problems in order to achieve a better sustainable health and nutrition status for the people of the Region.
Pesticides Poisoning

PESTICIDES are commonly used in all countries of the South-East Asia Region to control insects, weeds and fungi that often destroy food crops, and also to control mosquito vectors responsible for vector-borne diseases. Besides, they are also used for domestic and industrial activities. These chemicals are, by definition, intended to kill insects that are harmful to humans. There is, however, growing concern in our Region about the adverse health effects of pesticides, because of their misuse and overuse. Since most countries in our Region are heavily dependent on agriculture, pesticides are often used to protect food crops and supplies. Due to the high incidence of malaria, filaria and dengue, insecticides are also used for the control of vector-borne diseases. Pesticides, therefore, play a very important economic role in the Region. However, we should be aware of their adverse impact on human health and the environment.

According to a report prepared in 1995, almost 13,000 cases of pesticide poisoning were admitted to hospitals in Sri Lanka with a case fatality rate of 10 per cent. This indicates the seriousness of the problem, since pesticide poisonings are under-reported in most countries in the Region.

Although our main concern is acute toxic exposures, we are fully aware that pesticides may also cause subtle effects on human health. These may be difficult to detect. For example, their effect on behaviour, or on the immunologic and reproductive systems. Other important issues of concern are pesticides categorized as persistent organic pollutants, or POPs, (and their effects on the
environment), and endocrine disruptors. Furthermore, the issue of some pesticides and solvents causing behavioural changes in exposed workers is causing increasing concern.

From time to time, reports have been published in countries of the Region on acute pesticide poisoning manifesting as skin diseases, allergies or polyneuropathies, or other disorders. Even though some of these reports provide comprehensive data, the evidence for planning a response to the problem is not adequately available. While many reports are already outdated, specific information about the circumstances of exposure is inadequate, and lacks comparability. This limits the possibility of aggregating data and exchanging information among countries. What we need to do is to harmonize the methodology, strategy and terminology used for collecting case data for its interpretation and further application.

Pesticide poisoning is not a problem exclusive to our Region. In many other parts of the world also, especially in developing countries, pesticides are misused, affecting human health and the environment. A global study is presently underway by the International Programme on Chemical Safety, or the IPCS, in a number of countries in response to needs expressed by health authorities and nongovernmental organizations. The initiative aims at strengthening the evidence base for health protection, through the setting up of a pesticide poisoning database.

Such a database will enable us to assess the real magnitude of the problem in the Region. It will allow us to study the incidence and severity of poisoning cases; to know which pesticides cause toxic effects and under what circumstances.

I am glad that the WHO Regional Office for South-East Asia (SEARO) is playing a leading role in the establishment of a Pesticide Poisoning Database, initially in five SEAR countries. India and Sri Lanka have been taking part in the pilot phase of this global IPCS project since 1997, playing a pivotal role in the development and testing of a format for case data collection and analyses. The results of the pilot phase of the IPCS project will be presented during this meeting. This, I am sure, will help to formulate the strategy and methodology for case data collection on evidence-based pesticide poisoning, and their analyses and interpretation.

After this Workshop, initiatives to set up the Pesticide Poisoning Database and to start a surveillance mechanism in SEAR countries will be strengthened. But, what is more
important is that it will be possible to share data, compare experiences and plan further action. This, in turn, will help in establishing a database in the remaining five countries besides expanding it in the five countries where it is now being initiated. This project is a pioneering effort by our Region. It is, therefore very important for it to succeed. This will help to promote the safe use of chemicals and enhance the quality of interventions for the protection of human health.
Improving the Health of the Vulnerable Groups

Considering the nature and scope of the subject, I have divided my presentation into four sections. First, I will highlight the impact of the economic crisis in general. Second, I will share the important lessons drawn from other countries and Indonesia in their efforts to mitigate the impact of the crisis on health. Third, I will describe the role of WHO and other development partners in health development. Finally, I will elaborate the role of WHO and universities in mitigating the long-term impact of the economic crisis.

Let me begin with Part One of my presentation. As you all know, the declining levels of income and consumption per capita as a result of the economic crisis have led to an increase in the poverty level. Indonesia, for so many years before the crisis, had enjoyed a relatively limited percentage rate in the World Bank poverty category. With the sharpest decline in the Gross Domestic Product (GDP), Indonesia is experiencing the largest increase in poverty among countries in the South-East Asia Region. According to the World Bank estimate, poverty in Indonesia increased significantly in the early part of 1999. Although the genesis of the economic crisis in South-East Asia may differ from country to country, it has more or less a similar

The Economic Crisis: Improving the Health of the Vulnerable Groups: Seminar on “Health Services in the Economic Crisis” The University of Padjadjaran, Bandung, April 1999
impact. Economic growth and health status are inherently interlinked. Sound macro-economic policies and stable economic growth are essential for sustained investment in health; these should go hand in hand with social development policies focused primarily on the poor and vulnerable groups, especially women and children.

Economic crisis may have direct and indirect effects on health. The possible direct effects are, among others, the increasing cost of health care due to increases in the prices of drugs and pharmaceuticals, particularly imported products. In Thailand, a study has revealed that higher drug prices adversely affected the treatment of AIDS patients in 1997-1998. Similarly, there has been a decreasing trend in the government allocation for health care services.

Moreover, economic crisis can have indirect effects on health status through its impact on other sectors as well. The crises have many dimensions beyond health e.g. rising unemployment, declining incomes, increasing crimes and violence, increasing school dropouts, decreasing hygiene and sanitation. These are adversely effecting the health status of the people.

What is the impact of the economic crisis on the development sector, including health, in Indonesia? I think, everyone in this hall will agree that Indonesia has experienced significant economic and political instability during the economic crisis. The Indonesian Family Life Survey data suggested that per capita expenditure of the urban households were more seriously affected by the crisis as compared to rural households. An Asian Development Bank (ADB) estimate states that about 1.6 million children in Indonesia dropped out of school in recent months. Substantial reduction in calorie and protein intake has resulted in malnutrition, particularly among pregnant women and children. Cases of marasmus and kwashiorkor, which were rarely seen in the past ten years, have now occurred in certain areas.

Due to low incomes, people seeking health care are shifting from private to public health facilities, resulting in more pressure on the latter. These will likely pose a danger to the poor and vulnerable groups who may not have easy access to the basic health services when needed.

In summary, the effects of the economic crisis on health in Indonesia are:

- Reduced food consumption and lower nutritional status
Decline in standards and a shift from private to public health services

Increased stress and deteriorating mental health and increased violence and high-risk behavior

Shortage of drugs and medical supplies

Loss of business by the private sector

Low purchasing power for the people due to reduction in their real income

Delay in the maintenance of equipment and facilities

Decrease in subsidies for public health facilities

Let me take up the second topic. I would now like to share the initiatives undertaken in the SEA Region to address the development needs of the poor. I believe we can draw many useful lessons from the efforts made in the countries of this Region.

On the basis of their responses to the economic crisis, in general, there are two groups of countries, viz., countries that are too weak to cope with the crisis, and countries that are strong enough to minimize the impact of the crisis.

Many countries in Africa fall under the first group. In the 1980s, developing countries in this continent faced severe economic crisis. Prolonged drought, failure in agriculture, oil price crisis, chronic civil wars, and poor economic policies contributed to the crisis. However, the crisis continues, although they have received massive inputs of food and health supplies from the donors.

Let me illustrate this point with a few experiences of countries that succeeded in coping with poverty. In Bangladesh, the "Grameen Bank" and the Bangladesh Rural Advancement Committee (BRAC) run countrywide informal credit schemes targeted at poor households who are otherwise excluded from formal credit schemes that insist on the collateral. The Grameen Bank has a membership of over 2 million poor families. BRAC was established in 1972 and it implements highly successful programmes aimed at poverty alleviation and empowerment of the poor. The main beneficiaries are poor women and their children. These NGOs have been able to uplift the quality of life of these families in the villages by placing health at the entry point for development.

Sri Lanka has a long tradition of successful state-financed poverty alleviation programmes, as well as nongovernmental initiatives. The
present Samurdhi Programme has supplanted the major income transfer programmes scheme which were operating earlier - mainly the Janasaviya and the Food Stamp Scheme. Samurdhi Programme attempts to rationalize the welfare system as a whole by focusing on credit for the poor and enhancing their income-generating opportunities. The agriculture sector in Sri Lanka thus becomes stronger.

In India, the Self Employed Women's Association (SEWA) and the Maharashtra Employment Guarantee Scheme have focused on health in the context of poverty alleviation in its various dimensions.

In other countries, such as Pakistan, Iran and Jordan, the Basic Development Need approach addresses poverty through integrated income-generating schemes, which also include a health component. This approach, coupled with advancement of primary health care services, has been particularly effective in reaching the vulnerable groups and in improving their health.

What are the key elements that have led to these successful efforts?

First, each of these innovative programmes has health built in as a part of an integrated effort to alleviate poverty. In fact, health effort is not an isolated activity but integrated and linked to the increased income-earning capacity. In Sri Lanka, it has been shown that investment in health improves the economic situation.

Second, these countries have implemented the community-based poverty alleviation programme. In Thailand, for example, primary health care, which focuses on the "Basic Minimum Needs" approach, has helped to alleviate poverty, especially among vulnerable groups in border areas during the last 35 years.

Third, in many developing countries, poverty alleviation programmes gained strong ownership by providing credits to local poor people (mostly women) by encouraging solidarity, group feeling and ownership. These have enabled "bottom-up planning" to be subsequently secured for a national policy.
Fourth, in most instances, investment in women’s health is recognized as an essential component of poverty alleviation.

There are, however, some lessons to be learned from countries affected by the various economic depressions/crisis. It has been seen that the effects of the crisis can be minimized if governments place health high in the development agenda as a whole, e.g. health is placed in the mainstream of national development. By developing healthy public policies and bringing partnerships to strengthen regional and international solidarity for health and development, the economic crisis, can, in fact, be turned into an opportunity for health.

Let us now take an overview of the situation in Indonesia. I am happy to note that the Government of Indonesia has made positive efforts in many sectors to mitigate the impact of the economic crisis.

As a short-term measure, the Government of Indonesia has provided supplementary feeding for children below five, pregnant women and lactating mothers with chronic energy deficiency. While this is necessary, endeavours should be made to ensure that these services are actually reaching the unreached. The Indonesian Food and Nutrition Vigilance System should be strengthened to identify those who need such services the most.

Another important development is the Social Safety Net in Health (JPSBK) funded by ADB and IMF. These include additional operational funds for the health centres for providing basic health and referral services to the poor and also additional operational funds to village midwives for providing maternal and child care and its referral services to poor women and children. While provision has been made to transfer funds directly to the districts, it is important to ensure that the funds are properly utilized for the benefit of the targeted groups at the local level. It is equally important that the staff at the district and peripheral levels gets appropriate orientation training for administering and managing the funds. Consideration should also be given to sustaining the programme in the long run and making the best use of available resources.

In the context of the economic crisis, a new health paradigm has recently been introduced. The paradigm has identified health protection and promotion as an integral part of the reform movement. Focusing on preventing sickness rather than treating the sick, is indeed timely and relevant.

I believe that while protection and promotion of health is the priority of
the Ministry of Health, access to quality basic health services by the poor and vulnerable group is equally important for ensuring equity and social justice.

The process of decentralization has been well thought of in Indonesia. In my view, effective decentralization is the key element for achieving high access and coverage in improving basic health services in general. Therefore, capacity building at provincial, district and peripheral levels is the critical factor of the decentralization process. While ensuring that these programmes are entrusted directly to the districts and the districts are fully empowered in terms of administrative and financial authority, it is equally important to adopt “accountability” within the health system.

The reform initiatives within the Ministry of Health have already been undertaken in this country. With the increasing trends towards health care privatization, particularly high cost tertiary care, efforts have been made to develop a policy of public-private mix. This should be within the context of the changing role of the Ministry of Health in the ongoing social, economic and political reforms.

From the long-term perspective, “Community Health Maintenance Assurance Programme” (JPKM) is indeed vital for improving accessibility and quality of health care. While institutional support for JPKM is fully developed, the Ministry of Health is also simultaneously using “Free Kartu Sehat” or health cards for free health services. The Government of Indonesia has recently announced its vision for a “Healthy Indonesia” by 2010. This is a welcome initiative. What is needed now are strategies and plans to achieve the goals within the stipulated time-frame.

Next, I would like to very briefly discuss the role of WHO and donor communities. I am very pleased to state that there has been a truly impressive response from the donor communities, particularly ADB and IMF, in providing funds to support the social safety net initiative, including health. They have extended support in preparing and processing new projects aimed at improving the effectiveness and resilience of the health systems. Priorities must now be established to make optimum use of resources available from external sources. ADB and IMF have appropriately invested in health, focusing on vulnerable groups, especially poor women and their children. WHO will be happy to further strengthen collaboration with the Indonesian Government and provide technical assistance to jointly develop relevant health policies, norms and
standards, and support research and development.

Cooperation among countries is the most appropriate mechanism for ensuring regional solidarity and self-reliance. In this regard, ASEAN and SAARC (South Asian Association for Regional Cooperation) can play crucial roles in strengthening health cooperation among the countries concerned. The programmes of both Associations have many common elements which focus on health development. It is a privilege for WHO to continue facilitating this cooperation process.

WHO has recently facilitated cooperation between Indonesia and India for the supply of drug raw materials. WHO has also facilitated linkages in human resources development, especially in nursing, between Indonesia and Thailand.

The World Health Organization has a unique role to provide and strengthen technical cooperation. From its very inception, WHO has been playing a catalytic role in collaborating with its Member States in their health development efforts. This role has assumed a new dimension in the wake of the economic crisis. In this connection, I would like to mention a few initiatives.

First, a Regional Consultative Meeting on Health Implications of the Economic Crisis in the South-East Asia Region was held in Thailand, in March 1998.

Second, a Regional Meeting of Parliamentarians on Economic Crisis and Its Impact on Health was organized in Jakarta in December 1998. This aimed to forge partnerships with parliamentarians to enhance advocacy for investment in health during the economic crisis.

In Indonesia, WHO has been playing a very vital role in bringing together all concerned to discuss issues emanating from the current economic crisis and its impact on health.

As the Regional Director of the South-East Asia Region of WHO, I would like to reiterate my commitment and assurance of our technical support for people-friendly health policies and health care reforms. I would also like to reaffirm WHO's support for institutional capacity building, monitoring and evaluation of the impact of the economic crisis, and for promoting
regional cooperation and solidarity for health development.

It is very clear that the Government of Indonesia and its Ministry of Health are very concerned about the implications of the economic crisis. They are doing their best to provide the essential health care services. I would like to summarize some of the key issues, which would help this effort:

- Present reforms initiated by the Indonesian Government are encouraging. These can, however, be implemented only with good governance, a democratic system, transparency, and a system free from corruption, collusion and nepotism.

- Many reform efforts are being initiated to modify the critical roles of the Ministry of Health. Those involved in this reformation process should pay attention to the changing health needs, and the global trends. Regarding the future functions of Ministry of Health, it can be more effective if the Ministry assumes the role of an "architect", and not a builder. The Ministry can therefore confine itself to policy formulation, planning, monitoring, regulating and setting norms and guidelines and provide public health services, focusing on the poor and underprivileged.

- And other sectors play a major role in determining the health status. Thus national sector development policy should be based on healthy public policies.

Lastly, another important subject is the potential role of the university in addressing the challenges in the economic crisis.

We all know that the basic operational concept of university in Indonesia is "Tri Dharma", namely education, research and community service.

In the area of education, the university has a critical role to produce adequate qualified human resources for country development as a whole. It should continuously involve itself in national capacity building to further develop competent human resources for coping with the economic crisis, including its impacts on health. The university should also have innovative visions to respond to any development changes through the establishment of appropriate human resource programmes. The programme may include the training of health and health-related personnel to acquire knowledge and skills needed to take up any critical challenges in the country, e.g. health management and health economics areas. Furthermore, areas related to hospital administration
and pharmaceutical/vaccine management need to be reviewed in response to recent international/global market economy challenges.

In the area of research, the university has been viewed as one of many authoritative research resources that has reliable and accurate information. The university should be sensitive to the dynamic needs of the people and the country's development. Therefore, the university may continue to expand its visions to have more multicentric research. Operational research may be conducted to find new methods and appropriate interventions to cope with the impact of economic crisis on various development sectors, including health.

In the area community service, I have observed plenty of encouraging efforts undertaken, such as Community Medical-Oriented Education programme. The university may be more pro-active and more responsive to the needs of the people and work with the community to overcome their local problems. University students should be further exposed to real problems through various programmes on community actions. Internships with the relevant sector/institution/company etc., may be explored by the university to equip graduates with the needed operational skills and practice. All these activities are essential to improve national capacity to solve priority national and local problems, including health.

I would underline that health problems cannot be solved in isolation from other sectors. Universities should attempt to build partnerships through resource networking. Experts in medicine, public health, dental medicine, nursing, nutrition, and biology should work hand in hand with experts in economics, agriculture, psychology, sociology and politics. Resource networks should extend between faculties and among universities.

It is now timely for universities in Indonesia to enter into international collaboration through the exchange of teaching staff under joint constructive educational programmes by respecting the international intellectual property code. At the initial stage, collaboration could be established within the universities in ASEAN countries. Later on, collaboration may be extended to other developed countries and regions.

Centres of excellence, collaborating centres and universities are important institutions for supporting the country in effectively implementing national policies. I would recommend to further improve the quality and number of the WHO collaborating centres in Indonesia. At present, there are only 9 collaborating centres in
Indonesia, including one with the University of Padjadjaran, as compared to 50 in India and 23 in Thailand. WHO could help in the development of collaborating centres; including multi-centric and multi-country activities in the area of capacity building, research and advocacy that could be organized in these collaborating centres.

In conclusion, the universities must become integral partners in addressing the challenges caused by the crisis. Universities represent an invaluable asset that needs to be mobilized for health development. The academic community must also participate in formulating healthy public policies for national development.

I would recommend that universities take urgent steps to work closely with the Ministry of Health and other sectors in order to get out from the present crisis at the earliest. I have attempted to outline some of the problems and suggest solutions. I can assure you that WHO will continue to work in close partnerships with you and the donors. What is most important is: we should "think globally and nationally, but act locally".

Last but not least, I would like to express my gratitude to the organizers, particularly the University of Padjadjaran, for giving me the opportunity to address this distinguished gathering. I would also like to thank them for organizing this important seminar which will help us to examine the nature of the crisis, its causes, the important lessons that can be drawn from it, and how we can respond with concerted efforts to minimize its adverse effects.
Medical Education

The World Health Organization has had a long and sustained interest in medical education, intensified particularly after the global initiative of Health for All. WHO considers human capital as the primary resource for health development since all the technology has to be delivered by people. It also makes good sense to ensure that human resources are fully developed as they consume as much as 60 to 70 per cent of health budgets.

In pursuit of these objectives, the WHO Regional Office for South-East Asia has organized a series of consultations on Reorientation of Medical Education over the past two decades. These consultations addressed contemporary issues in medical education. Community orientation and community-based education was the subject of the first meeting, held in the late 1970s. This was a landmark meeting which agreed on the concept of community orientation and the mechanisms to orient medical education towards community needs.

The meeting was followed by the Consultation on Developing Targets and Indicators for Reorientation of Medical Education or its acronym ROME. All the countries in the Region developed goals, targets and indicators to monitor the progress in reorienting their medical education programmes.

Simultaneously, nursing educators were also reorienting the nursing education programmes. Later consultations focused on increasing the responsiveness of medical education to societal needs and strategies for linking medical schools to health services. This ushered in a new dimension to the concept of quality in medical education. Quality now began to be considered not only as academic...
excellence in training institutions but also their ability to address and respond to societal problems.

Modern medical practice has evolved from the traditions of the ancient Greek, Roman, Chinese, Hindu and Arab medicine. This march from the era of overtly empirical practice to the modern scientific medical practice has been a long one and one of the most fulfilling sagas of human history. Medical education and medical schools have played decisive and determining roles in what has turned out to be a truly remarkable human endeavour. These changes occurred in stages, demystifying medicine and putting it on increasingly scientific and technological grounds. This resulted in the reaping of immense benefits by humankind and has led to the achievement of health benefits on a scale never imagined in human history.

In addition to providing better health care to the people of the world, the practice of modern medicine has also provided a lifestyle of unprecedented privilege to its practitioners and a high status in society, envied by many other professions. We need to remember that physicians were entitled to a position only slightly higher than slaves in the Roman Empire!

Unfortunately, despite the dazzling developments in the science and technology of medicine, a substantial segment of human society today is still deprived of basic health care. Some would argue that over-scientification of medicine is responsible for this sorry state of affairs. New technologies often increase the cost of health care. Also, with science and technology assuming the driving seat in health care, many complain that humanism has been pushed to the back seat. This is reflected not only in the case studies of individual patients but even more tragically in studies of population health. As a result, we find that one-fifth of humanity is outside health security networks of any kind.

At a consultation organized by the Association of American Medical Colleges in 1992, participants were asked two questions:

- Are we doing a good job of educating students for practicing medicine today?
- Are we doing a good job of educating students for practicing medicine in the year 2010?

An overwhelming 55 per cent voted "NO" in response to the first question, 65 per cent voted with an even larger "NO" to the second question; 20-35 per cent had serious doubts that they were
doing a good job at all. Had I cast my
vote, I too might have had to vote in a
similar manner!

Not all, therefore, seems to be well
with medical practice and medical
education. Should you concur with the
views of your peers? If indeed you do,
it is then incumbent on all of us
gathered here to find out what is
wrong, where have we gone wrong?
And, more importantly, how can it be
remedied? This indeed is one of the
purposes for organizing this meeting.

Of the several challenges that
medical education is facing today, I
would like to submit the following
challenges for you to reflect on during
the course of your deliberations:

- In the search for quality we must
answer the question: how does
medical education respond to the
existing abnormal situation of
availability of abundant technical
and financial resources on the one
hand and a large segment of
humanity deprived of basic health
care on the other?
- Can medical education take steps
to arrest the erosion of the image
of the medical community? From
an idolized profession; today it is
often regarded as a community of
merchants of medicine.
- In the context of free market
economy, privatization, and
globalization, how can ethical
medical practice be used to protect
consumers from unscrupulous
practitioners?
- How can you, as leaders, restore
and reinforce humanism in today's
technology-driven medical milieu?

I am fully aware that the questions
that I have raised are much beyond the
purview of medical education alone.
They go into the area of medical
practice as well as to the structure and
values of contemporary human society.
But as custodians of peoples' health
and leaders for the generation of new
knowledge, if we do not raise these
questions, who will? If we do not do so
now, it will be too late.
WE are now in the era of technological miracles, including in the field of communication. In many senses the world has shrunk, and today we really live in the global village. Satellite television brings us news and information across national boundaries. The internet offers a choice of references as well as original documents at the touch of a key. CD-Roms offer interactive sources of information through our personal computers.

The mass media, particularly the news media, have collectively a wide reach. Generally, they also have a high level of credibility, and the information they carry is generally accepted by their audience.

In the health area too, the media have a strong influence on people's knowledge, attitudes and practices. However, while news about health issues should be of interest to everyone, we must remember that journalism has its own needs and parameters. Journalists are looking for interesting stories, stories that make headlines, that convey the different and the unusual. This sometimes may not coincide with the ingredients of sound public policy, or be in accordance with the actual substance of health issues.

The health sector has information to impart, information that is important and relevant to the health of the...
population. But, sometimes, government spokespersons who interact with the media, are at a disadvantage. If they give good news, it may be disbelieved. Besides, if they brief the media from the government's point of view, and in some cases where the spokespersons have not been trained for media handling, their stories may miss the mark. Either the stories lack media worthiness, or the timing of the news release is wrong, as it competes for space and time with other major breaking stories.

The fact is that both sides need each other. Health ministries need the journalists to spread health news, which is often vital to the public interest. The journalist needs the health professionals to get a good story, and get it right. For the health sector it is important to develop a positive and active relationship with the media, which seeks to influence the coverage through greater understanding of the issues. There has to be professional understanding on both sides. The two important factors in this relationship are trust and transparency.

Typically, the media have been used to market healthy behaviour, which targets the individuals. That is also important as it informs about health risks. But we know that the major determinants of health are in both the social and physical environment; and the power of the media can be used very effectively to make that environment healthier. Media can play a strong advocacy role, by transferring the focus of health issues from individuals to policy makers, planners and executives whose decisions influence health policy, programme, and budget.

Take the example of the successful public litigation against the tobacco industry in the United States of America. Today, as a result of years of lobbying and informing the public about the hazards of tobacco, its consumption in the country is clearly declining.

The people there have recognized that tobacco use is a serious public health problem, and that powerful tobacco companies' lobbying is the primary barrier to public health intervention. This social revolution could not have taken place without responsible media coverage. Of course, it also needs active advocates who provide the media with sound information, backed by scientific findings that made it possible for the media to support the cause.

One of the main objectives of this workshop is to improve the understanding between the media and the health sector, towards a more professional and trusting relationship. It is important for both to understand and
appreciate the possibilities and limitations faced by each other. I am very happy that this workshop is bringing together three groups of professionals, each of whom can play an important role in health development in countries. We have here journalists, representatives from Ministries of Health, and concerned WHO staff.

WHO’s mission is to ensure the attainment by all people of the highest possible level of health. In order to achieve this objective, the Organization has, among other things, to provide information, counsel and assistance in the field of health.

WHO is a health consultant to Member States. Its role includes not only supporting national health programmes, but also ensuring availability of valid information on health. Within this context, we see a clear role for the media to work closely with the Ministry of Health and WHO.

WHO’s Director-General, Dr Gro Harlem Brundtland, is aware of the importance of media as a channel of information. Looking ahead to the new millennium, WHO has a vital role to make a “difference” to the health of all people. For this, the Director-General sees Information and Communication as the key strategy. WHO will assist governments to obtain evidence-based information on all priority health areas.

Hard facts are often the best selling points of a story for the media.

At the regional and country levels, we need to establish viable mechanisms for close interaction between the health sector and the media. We can help equip journalists with valid information, so that they can accurately assess the national and global situation and make their own judgements.

It is important that journalists have access to information. Where governments tightly control the media, information can be one-sided and the picture is out of balance. One major area of our concern is the need for responsible reporting. Media are accepted as a reliable channel of information. It is important that correspondents, as well as media gatekeepers carefully weigh the consequences of news to the public, particularly during emergency situations. Caution must be exercised to confirm the facts and avoid uncalled for sensationalism.

Take the case of the plague outbreak in India, not long ago. News on the outbreak caught the imagination of national and international media; the excessive reporting in this case exaggerated the situation and served to aggravate the panic. This led to untold economic losses to the country, at a time when the situation was not at all warranted.
Obviously, this is an area that should be taken up by this meeting. What mechanisms should we use for reporting emergency situations? What responses should Health Ministries be ready with? How do we ensure that the media are getting an accurate briefing, and are reporting a fair story?

I expect that a group such as this will have a very stimulating interaction, and will be able to suggest how we can get better at this. From here, the group can also help to identify what needs to be done at the country level. I look forward to your recommendations addressed to the media, to the health sector and to WHO.
Health Development and the Role of Universities

Let me, first of all, quickly describe the health scenario around us and how we have arrived at where we are now. The United Nations’ first development decade from 1960 to 1970 witnessed many activities in most countries to attain economic growth by the most direct and rapid means. Social development occupied only a secondary position in these development policies. The thrust was on rapid industrialization around cities to increase the gross national product. The hope was that the benefits would trickle down to the rural areas and to the poor. In spite of these efforts, however, the gap between the rich and the poor countries remained and became even wider, as did the gap between the rich and the poor within each country.

Thus the 1970s saw a change in approach - one giving due importance to social development as well. These changes included a shift in development strategies from pure economic growth to concern for the development of human resources and a more equitable distribution of income. Health development figured prominently as a major factor contributing to improved economic status of the poor, and a higher quality of life of the people. And, in the field of science and technology, the appropriateness of technology became a matter of universal discussion.

The Health-for-All (HFA) mission, launched at the thirtieth World Health

Lecture at Faculty of Medicine, The Airlangga University, Surabaya, Indonesia, December 1998
Assembly in 1977, set for itself the goal of the attainment by the year 2000 of a level of health that would permit all people to lead socially and economically productive lives. This long-term objective of “health for all” became the stimulus for action to reduce the intolerable inequities that existed in the access to health care and distribution of health resources.

In the area of health services, countries have been moving towards greater equity and social justice in order to achieve wider coverage of populations: to cover those who are marginalized and are living in the social and geographical periphery. The need to control the escalation of health service costs and balance these against their effectiveness have emerged as major challenges.

HFA recognizes that health is a fundamental human right which should be enjoyed by everyone. However, the need to protect this right is more relevant today than ever before. This recognition is well reflected in the emerging concepts of “health security” and “health accountability”.

The concept of health security is founded on equity. It is based on the principle that all human beings may live free from the risk of preventable illness and injury. It means that all will have equal access to quality health care that is both affordable and relevant. Health security includes the right to food in sufficient quantity and quality, to information needed for self-reliance, and to a working and living environment where known health risks are controlled. This calls for various forms of social and economic support and better knowledge and awareness about health. It also calls for intersectoral collaboration as an essential element in health development.

Health accountability begins with the obligation of the State and the responsibility of health professionals to provide health service to all.

WHO has endorsed these two concepts, and our policies and programmes have been oriented to ensure that all people, irrespective of their station in life and their circumstances, enjoy health security; and that the State displays and carries out its obligations in providing health service to all.

Priority issues for governments in health development

What is the current and emerging health scenario in South-East Asia that provides the context for our mission? What are the health concerns that need to be addressed by governments? What then are the responsibilities of today’s universities?
The health sector has been under tremendous pressure in responding to the ongoing global political and socio-economic restructuring. Every facet has been affected: health policies, planning and management of health services, education, training and utilization of health manpower, health-related research, and many others.

The health situation in the South-East Asia Region is characterized by a slow decline in crude death rates and infant and under-five mortality rates as well as a gradual increase in life expectancy. Indonesia, of course, has been doing remarkably well in respect of all parameters of health development as compared to other countries. The infant mortality rate, which is an important indicator of the standard of life, and which also reflects the educational level and effectiveness of the health care system, has declined during the last decade in most countries of the Region. But it still remains high (i.e. 60-100 per 1000 live births) in some countries.

Today, infectious diseases remain the leading cause of death worldwide, killing at least 17 million people. South-East Asia accounts for over 40% of these deaths that is, almost 7 million each year. What is worrying is that the spectrum of infectious diseases is changing fast, together with the dramatic socioeconomic changes.

While we acknowledge the importance of infectious diseases, we need also to remember that non-communicable diseases have emerged as the leading cause of death in developing Regions. Cardiovascular diseases, cancer, diabetes and mental disorders are some of the major diseases which contribute increasingly to morbidity and mortality.

Indonesia, like a few other countries in the Region, has achieved a high life expectancy and is now passing through epidemiological transition, where the infective component of the disease burden is being replaced and overtaken by the non-infective, chronic component. However, the HIV/AIDS epidemic and some other new and emerging diseases will continue to pose serious problems.

Before I share with you what we in WHO perceive to be the priorities and strategies for universities in general and faculties of public health in particular, I wish to emphasize some of the critical issues which have a direct bearing on health as a whole. Health developmentalists and public health educators like you have to be mindful of the implications of these issues.

Poverty, unemployment and social disintegration
Poverty is of course one of the predominant problems we face. No matter how poverty is defined and where the poverty line is drawn, South-East Asia contains a very high concentration of mass poverty. Even in countries with a better level of income, such as Thailand and Indonesia, a substantial number of people are living in poverty. One of the most serious consequences of poverty is ill-health. Poverty is the main determinant of a short life span, disease, disability and malnutrition. It is the basic reason why many babies are not vaccinated, why clean water and sanitation are not provided, why mothers die at childbirth and why life-saving drugs are not available in many countries. Poverty is the single largest contributor to mental illness, suicide, substance abuse and family and social disintegration. The rich are getting richer while the poor are getting poorer. A large number of people live in such abject poverty that even a severe bout of malaria puts a family into debt for years. Millions of people are caught in the web of unemployment with the serious consequence of inability to access health services and social facilities which influence health. Of special concern is the rapid and unplanned urbanisation with the attendant rural-urban integration, social alienation and disintegration.

Environmental sustainability

The 1982 UN Conference on Environment and Development emphasized the significant ill-effects of ecologically irresponsible and unsustainable development on human health. The effects of global climate change, ecotoxicity and depletion of both renewable and non-renewable resources threaten the health of all of us, of the poorest populations in particular. Their habitats are most vulnerable. What is needed is a system of economic development that protects the health of our ecosystem and the global life support system.

The public-private mix and privatization of health care

Most countries in our Region, including Indonesia, have been in the process of restructuring their economies to adjust to the global market. In fact the economic crisis in the Region has taken its toll on the health sector as well. The impact is being seen in numerous areas, particularly in the access and use of health services, availability of drugs and vaccines, nutrition and mental health. Under these circumstances, we need to be extremely careful in managing the health system. It is therefore heartening to see that Indonesia, along with its neighbours, has very proactively taken
a number of important measures to mitigate the ill-effects of this crisis. Privatization of state activities and public enterprise has been a major outcome of this development. However, we also know that the uncontrolled use of market-driven policies can have a negative impact, particularly in the social sector and in ensuring equity. The need is for a balanced mix of public and private health care facilities.

**Women, health and development**

Investment in women’s health is now recognized as an essential component of social and economic growth. Investment in women’s health can be argued for on several grounds. First, equity and human rights emphasize the removal of gender disparities; second, the multiple benefits of women’s improved health, which influences increased productivity and the favourable impact of a mother’s health on her offspring and third, the cost-effectiveness of reproductive health interventions compared to other health interventions. An increasingly compelling argument favours policy commitment being complemented by a more participatory approach which involves women in decision-making and implementation. This was the important message of the Population Conference in Cairo and the Women’s Conference in Beijing in 1990 and 1995, respectively. For sustainable population stabilization and overall development, more emphasis must be given to women’s health and empowerment.

**Development of human resources for health and research**

In the context of human resources for health, the concepts of planning, training and utilization have all changed. The insistence on wider coverage, health promotion, disease prevention and community participation is leading to active involvement of the community in the health care process. In consonance with health services in some countries, community-level health workers are trained and supervised by an intermediate level of health personnel, who, in turn, serve as a link with the back-up referral and consultative services of the health system. In these circumstances, the roles of the higher-level, technically-trained health professionals change considerably, particularly to include leadership and management capacities.

**WHO** has developed the concept of Coordinated Health and Human Resources Development (COHHRD). This, in the simplest terms, implies that the three human resources development functions, namely: policy and
planning; production, and management, are carried out in close coordination with the health system. Universities should not merely follow the human resources plans that have been developed, but should actively provide the expertise and the know-how to ministries of health thereby enabling them to actually formulate appropriate human resource plans.

**Relationship between public health and curative medicine**

First of all, it will be useful to recall that curative medicine, which seems to dominate any discussion of health care today, is only a part of health and not the whole of it. So is public health, with all that goes with it – environment and sanitation, promotion and prevention, nutrition, genetics, and behaviour. None of them, nor their sub-specialities, can stand alone. Only when they join and work in harmony can we hope to bring the much-desired holistic care to the people, which includes the promotive, curative and rehabilitative aspects. In many countries, public health is still divorced from clinical medicine and vice versa – and such divorce cannot be justified nor accepted on any reasonable grounds.

The separation has a history and we need to recognize these roots if we are to solve this problem. If one surveys the trend of health care delivery during the last century and a half, one can see how public health came to be divorced from clinical medicine from the days of Edwin Chadwick in the mid-nineteenth century. The two disciplines have gone their separate ways since then, with separate training of physicians for curative practice on the one hand and for public health practice on the other.

I have also maintained that medicine encompasses a much wider area – sanitation, genetics, behaviour, nutrition, hygiene and therapeutics – all in relationship to man and his physical, biological, social, economic and political environment. While each branch of medicine has its distinct role to play, it is only a part of the whole. Often we forget this.

There is yet another negative effect of this artificial division. This is a practical one but is very important. It relates to the recognition and respect accorded to public health specialists. When they work in isolation, without any linkages to clinical medicine, they find it difficult to command the same respect of the community as do their colleagues in the clinical disciplines. Economically, too, there are serious disadvantages. All of this has implications for the choice of public health careers by young students, and the degree to which public health...
specialists can influence health policy and individual and community behaviour.

In the South-East Asia Region, only Indonesia and Thailand have full-fledged faculties of public health. All other countries have higher education in public health located within the faculties of medicine, usually in the departments of Community Medicine or Preventive/Social Medicine as they are usually known. This dichotomy in curative medicine and public health is also reflected in the various training programmes for physicians and other professionals for the two distinct branches of medicine as well as in the organization of curative medicine and public health.

When we look back to the mid-nineteenth century, we can recognize that those who laid the scientific foundations of public health were physicians or surgeons. Southwood Smith, Neil Arnot, John Simon, William Duncan and Burdon-Sanderson, to name a few. In their times, public health did not exist as a field of study; their own research, conscience and efforts created it. Similarly, those who were in the front line in social medicine in the mid-twentieth century were clinicians: like Sir John Rhyle of Oxford, Rene Sand of France and Iago Gladston of New York. They came to observe clinical medicine vis-à-vis public health and extended the concept in the form of social medicine. HFA and PHC are the ideal opportunities to overcome this divergence and to bring back the relevance and integration of education and health care.

The role of universities in health for all

Let me now address the other main theme of my presentation today. The thirty-seventh World Health Assembly in 1984 had, as the subject for Technical Discussions, the “Role of Universities in the Strategies for Health for All”. The Health Assembly recognized that the academic and scientific community represented an enormous potential asset. The problem was to find ways to mobilize that community to use the opportunities that existed. Universities, such as Faculties of Public Health, can play a useful role in bringing decision-makers across disciplines, sectors and national boundaries together to focus on these problems. They can also examine ways to test and disseminate new ideas. The scientific and academic community can also mobilize their counterparts in the developed world to undertake studies on development issues.

The World Health Assembly was convinced that universities could respond positively to the challenges presented by the strategies for health
for all by the year 2000 and primary health care. It took the view that universities could respond in many ways, such as:

- Reordering academic priorities to accord due recognition to primary health care problems, and health promotion and protection;
- Developing broad-based curricula, related to current problems;
- Developing mutually beneficial academic linkages with similar institutions at the national and international levels, and
- Broadening service and research interest in order to address the health concerns of society.

**Education and training needs for the future**

The central challenge to education in relation to health development for the 21st century is to identify the relevant competencies and appropriate attitudes required by health personnel to function effectively in low-cost, wide-coverage health care programmes. These become the guidelines for formulating, and, later for evaluating educational programmes. I can summarize some of the key attributes required in a future public health graduate:

- Understanding the political, social, health and biomedical trends and the realities of today, and anticipating the needs and interventions for the future.
- Advocating equity and social justice, with evidence to support the argument that health is central to development and cannot be left entirely to market forces.
- Providing leadership in the public health arena and mobilizing partners and resources.
- Analysing and applying planning and policy skills to build sustainable health systems.
- Mobilizing people to decide for themselves and paying special attention to the individual, family and community. While doing so, it is important to take serious note of the underprivileged and those at risk, such as children, women and
the elderly, so that they can be self-reliant.

The above, as you will immediately notice, calls for knowledge and skills in many areas, including clinical sciences, public health, behavioural sciences and community development.

Most countries are now applying systematic planning and management processes in health development. WHO pioneered the development of this methodology and provided the necessary technical support to apply it. It began with project system analysis and management in the 1970s, and country health programming in the 1970s. Then, health planning evolved into a broader and policy-based process for national health development during the 1980s. Some countries have developed prospective long-term plans for up to 25 years. The scope of planning seems to have enlarged, but simultaneously, the interactions between economic, environmental and other factors have made it more complicated. New challenges as well as new opportunities have emerged. Staff development and decision-linked health systems research have become crucial to the strengthening of national health programmes.

Health economics is a case in point where national expertise needs to be urgently strengthened. It is interesting to note how health economics has gained a central place in the planning and management of health care in the last 25 years. Alternative ways of health care financing is a subject of utmost concern to all countries, both developing and developed, and various models have been designed and are being experimented with. It has therefore become necessary that health professionals, particularly those at the decision-making level and those involved in planning and management of health services, be well conversant with the basics of health economics. This way the efficiency of our health care systems can be augmented. In order to answer policy questions, there is a need to provide an understanding of major health issues to a sufficient number of health economists.

The training of health teams required for the coming decades cannot begin without first training sufficient numbers of teachers.
Fundamental to this is the recognition that the role of the teacher is not so much as a source of knowledge, but, more importantly, as a facilitator of learning. The role of the teacher and the teaching institute is to educate health teams for health systems.

In this regard most schools of public health, while focusing on training in public health, rarely participate in the preparation of the basic doctor. Here, once again, I return to my original thesis. I strongly believe that schools of public health, as leaders in health care and not merely in public health, should play an active role in reorientation of medical education by technical inputs in the preparation of undergraduate medical curriculum and teacher training, and not be confined to public health. Therefore, my advice to you would be to seek out and participate in the training of health professionals at several interconnected levels – within the basic curriculum, as in-service training for health workers involved in part-time public health activities, at the masters level in public health, and also at the doctorate level for teachers and researchers in public health. Public health should also find a place as part of continuing education programmes.

The reorientation or establishment of new training programmes in public health must be based on appropriate research and information. While such research should direct programmes, research itself must be carried out in realistic field situations drawn from an understanding of the needs and demands of the community. This includes the present and prospective roles of health personnel, which are of priority interest to curriculum planners and health decision-makers.

Health systems research is one of the decisive factors for the attainment of the goal of health for all by the Year 2000 (HFA/2000). WHO’s South-East Asia Advisory Committee for Health Research, developed a comprehensive research agenda for health for all in the early 1980s. It stressed that all countries, whether developed or developing, rich or poor, needed research for development. Even in times of economic difficulties, as currently being experienced in many developing countries, ways of using existing resources more effectively are essential to increase national capabilities for solving priority health problems and for promoting scientific approaches to PHC. Research becomes a useful tool here.

Research needs for the future

Linkages, networks and consortia
One of the objectives of public health in the South-East Asia Region is to develop linkages to foster collaboration in human resources development and research as an effective mode of institutional capability-strengthening. Linkages could bring together academic and research institutions in developed and developing countries, or institutions in developing countries which have common interests but are at varying levels of infrastructural development. A network of institutions, with common academic and research interests can benefit from sharing experiences among participating countries. The Asia Pacific Academic Consortium of Public Health is one such example of productive collaboration between institutions from developed and developing countries in different areas of public health and human resources development and research.

Twinning of institutions is another way of facilitating international cooperation in the health sector. Projects such as the International Clinical Epidemiology Network (INCLEN) and some other WHO-supported projects in schools in Indonesia and Thailand have demonstrated that a crucial element in achieving change has been the establishment of institution-to-institution linkages involving recognized international schools.

Universities such as yours, as centres of excellence and seats of academics, must take the lead role in international collaboration to make it effective and successful. The main function of universities, of course, should be to act as centres of technical expertise, as advisers or consultants, for giving necessary training to all types of health workers, covering such specialties as planning, management, health economics, manpower development, clinical or public health.

The future needs for research, particularly health services research, in developing countries is great, and for this, too, institutional strengthening should be a priority. By virtue of their status and reputation, it is likely that regional and international financial and technical resources can more successfully be attracted by universities for regional and international collaborative programmes.

I know that you have many precedents where your University and its faculties have contributed at the highest policy-making level in Indonesia. My plea to you is to enlarge this role nationally and also prepare to assume a wider responsibility so that we, in WHO, can draw on your expertise to support similar initiatives in the Region. This means that you must help to generate a network among other Universities and their faculties, including schools of
public health which allows for interaction through exchange of staff, information, and collaborative research, so that a rich diversity of ideas can evolve out of this cross-fertilization.

**Improving WHO’s own response**

Now you will probably ask, what is WHO doing to improve the way of working with institutions and countries such as yours in health development? This year we are celebrating our fiftieth anniversary. We, in WHO, consider ourselves also as a technical agency devoted to public health. Therefore, we are constantly looking at ways of playing our role better. Questions are sometimes asked about the efficiency and effectiveness of WHO’s activities and its use of resources. WHO always has to face up to this scrutiny and improve its transparency and accountability to Member States. There are two contexts in which to monitor and evaluate WHO’s work: the first is the world health situation, and the second is WHO’s own work. Monitoring is done every three years and evaluation undertaken every six years of the implementation of the HFA Global Strategy. In future, WHO plans to make even better use of its network of collaborating centres and other national centres of excellence. We hope to use their expertise to undertake research and to rapidly apply research findings at the country level. In fact, building partnerships with all, particularly the nongovernmental sector, including the private sector, is now a priority objective for WHO. The new Director-General of WHO, Dr Gro Harlem Brundtland, is actively pursuing to build global-level partnerships with other UN agencies, development banks and the private sector. Overarching all of these reforms and improvements is the fact that WHO is acknowledged as having a unique access to international technical expertise. We will strengthen our modalities for technical consultation between WHO and institutions such as yours and hope you will participate fully and share your expertise with us to fulfill our mission.

I would like to mention one or two of our recent initiatives. I feel that these lend credibility to our commitment and priorities. Last year, WHO spearheaded the development of a Regional Health Declaration, which was endorsed by
the Ministers of Health of the Region and adopted by the Regional Committee. This outlines WHO’s values, principles and priorities in South-East Asia for the next few decades. We are now working with countries in the Region to identify the specific regional and national applications.

WHO has also developed a set of functional mechanisms to seek advice and guidance in its work. We have, in addition to the Governing Body, the Regional Committee, a Ministers of Health Forum, a Health Secretaries’ Forum and a Parliamentarians’ Forum. These provide ideal platforms for health advocacy and promotion. Regional solidarity and cooperation for health have received an added boost through these high-level political platforms. On the other hand, they also help WHO to sharpen its own concepts, programme priorities and operational mechanisms.

Conclusion
The world today will not permit us to isolate ourselves in a Utopia that we may wish to create for ourselves. Knowledge should know no boundary. Therefore, the challenge we have to meet is to strike the correct balance in our need to work with each other and to promote international understanding and technical collaboration among our countries. In this endeavour, universities such as yours can contribute immensely so that the changing social responsibility of health professionals receives full meaning and expression.

In summary, I can cite at least four major challenges that face universities and their faculties, including schools of public health in our Region today. The first, of course, is how these academic institutions can train health personnel to have a more holistic approach to health care and development.

The second challenge is, how best to promote the team approach to health care and health development. Traditionally, human resources have been organized in an hierarchical fashion and function in compartments. This needs to be recognized as a barrier before team training can become a reality. Among other things, this requires a change of attitudes and a reorientation of the staff, the students and the policy-makers of health personnel training institutions.

The third challenge is, how these centres of excellence, which are held in high esteem by respective governments and have the necessary expertise, can contribute more actively to policy development and programme evaluation. How can you, being sensitive to intersectoral action for health, actually
prepare and collaborate with other sectors meaningfully?

The fourth challenge has been made imperative by the macro-economic development model that we have begun to adopt. That is for academic institutions such as the University of Airlangga to join hands with the private sector and business and industry to harness their resources and expertise in health development. You need to show the way by testing out the best possible partnerships and models of collaboration.

In our efforts to mobilize universities to take an active part in health development, we have to learn from one another, and move into the world of real action. Universities and their faculties including schools of public health must provide the leadership and the know-how and be the vanguard of health development. The Challenges of tomorrow call for persons with breadth and depth of vision, boundless energy and enterprise. I have no doubt that you will accept the challenge and will continue the exemplary work that has been your hallmark. You will no doubt face up to the challenges ahead with courage and commitment. I can assure you that we in WHO are, and will be, with you and will continue to play our catalytic and promotive role in order to achieve our mutually-identified goals.
International Health Development

The work of the World Health Organization, over the last 50 years clearly demonstrates the importance of working together, for health development. This period also witnessed the growth of other inter-governmental and international agencies; within and outside the United Nations System with mandates for working in different areas of health.

With the availability of rapid transportation, there is extensive movement of people and goods across borders in most parts of the world. In a world that is indeed a global village, health problems in one part of the world become the concern of those in other parts.

Diseases have no borders. Today, transnational action for health development is becoming increasingly essential. Governments need to work together to strengthen the process of international cooperation in health to ensure good health of all nations. What happens within borders of one country has significant implications for health development in neighbouring countries. For example, environmental degradation, population growth, efficacy of food safety, availability or lack of critical raw materials for drugs and vaccines affect more than one nation. Cooperation and collaboration among countries is the need of the hour to overcome problems affecting health.

National boundaries should not become barriers to the spread and transfer of scientific and technical knowledge. Sharing lessons and

Regional Consultative Meeting on International Health Development Bangkok, November 1998
experiences in development of health and technology are key strategies for improving capacity and self-reliance at national level. Institutions such as universities, development organizations, NGOs, foundations and government institutions can all play a crucial role in this very important area.

Movement across national boundaries of health care providers, is also playing an important role in increasing transfer of knowledge and technology from country to country and from region to region.

All the above reasons warrant a new focus on cooperation in international health. Indeed, there is an urgent need for developing a regional strategy for international health development.

We, in the South-East Asia Region, perceive international health development as an extension of health development beyond national boundaries. All forces that directly or indirectly act on or affect health within the national boundaries - cultural, demographic, epidemiological and environmental - are of importance to us all. Full understanding of such health and health-related issues requires both a regional and global perspective. We believe that no nation can solve its health problems in isolation.

It is no accident that technical cooperation among countries in our Region has emerged as one of the most important activities in international health development. At their sixteenth meeting, held in September 1998 in New Delhi, India, the Ministers of Health of South-East Asia Region recommended that intercountry collaboration should be intensified in the area of disease control and national capacity-building in primary health care.

Since the recent economic crisis in a few countries of our Region, WHO has taken the lead in helping them to network with other countries, to address emerging issues in health development such as support in the areas of pharmaceutical and drug supplies. WHO has also promoted sharing of knowledge and experiences in the development of social safety net programmes for health to cope with the situation during economic crisis.

Other examples of successful intercountry cooperation in health in our Region are the activities aimed at poliomyelitis eradication, control of malaria and other vector-borne diseases in border areas, and drug action programmes.

In pursuit of this goal, we must count on the growing number of partners in international health
development. We must foster partnerships among governments, international organizations, non-governmental organizations and the private sector. We also need to mobilize the support of academic institutions. Especially, we must bring those in academia into the mainstream of global public health. We must redraw the lines of thinking and activity in the field of international health. We need to mobilize all educational institutions, specifically schools of public health in the Region, to develop effective leadership in international health development.

We all recognize that the attainment of the highest level of health can only be achieved through partnerships, cooperation and joint efforts of various countries. The development of different fields of knowledge, including international health development, is an effort that requires the involvement of all partners. The World Health Organization is ready to play a catalytic role in such activities.
Environmental Sanitation

Poor household and community sanitation poses a major risk to human health. This relationship has long been recognized. The South-East Asia Region made many efforts, especially during the International Decade for Water Supply and Sanitation and after, to improve environmental sanitation, and specifically excreta disposal. But, the ever increasing population has reduced whatever gains were made in some of our countries. A workshop on rural sanitation in India, conducted in July 1998, estimated that the sanitation coverage is probably below that of sub-Saharan Africa. Furthermore, the rural sanitation coverage in some of our countries is among the lowest in the world. Uncontrolled urbanization, particularly resulting from migration into cities, and subsequent growth of slums, are continuously increasing the magnitude of the sanitation problems of the unserved and underserved urban populations.

Although innovative approaches, particularly since the end of the International Drinking Water Supply and Sanitation (IDWSS) Decade, have been tried by many community organizations and NGOs, the main approach to sanitation promotion, to date, has been the direct intervention by the government. In every country, hygiene promotion activities were found to be the weakest aspect during the IDWSS. However, since then, we have witnessed some innovations such as the social mobilization for sanitation launched in Bangladesh, which has produced impressive gains. Thailand’s community-based approach has also registered very impressive gains, and has already resulted in almost universal coverage.

The Regional Consultation on New...
Directions for Hygiene and Sanitation Promotion in May 1993 identified a very pragmatic objective for sanitation promotion summarized as "Hygiene promotion for all and full latrine coverage for high-risk communities".

The objective was based on the realization that with the current and predicted population growth, full sanitation coverage was not feasible over the next few decades even with accelerated efforts. Thus, it had two key elements: (1) incremental improvements to existing local practices affordable by the community, and (2) stress on the interaction between people and technology to prevent transmission of pathogens.

Over the next three days, you will be presented with the WHO Strategy on Sanitation for High-Risk Communities, which has since become part of the Joint UNICEF-WHO Water Supply and Environmental Sanitation Strategy. The Strategy recognizes that current efforts to deal with sanitation deficiencies are grossly inadequate and require a radical change. The Strategy further goes beyond the above-mentioned objective of our 1993 consultation and calls for giving priority to communities where conditions are the worst and the risk of contracting diseases related to unhygienic conditions is the highest.

The Strategy is complemented by the Participatory Hygiene and Sanitation Transformation or the PHAST methodology developed in collaboration with the Water Supply and Sanitation Collaborative Council, which will also be introduced during this Consultation. It represents a new approach to working with communities to control the spread of diarrhoeal diseases. In addition, the Sanitation Promotion Kit, also jointly developed with the Water Supply and Sanitation Collaborative Council, will be introduced as a supporting tool. The kit offers a range of technologies and approaches for communities to choose from and use in their own efforts to improve sanitation.

I am confident that the above documents and case studies presenting success stories from our Region, will assist you in your deliberations. They will also help you to evolve a framework for implementation of sanitation programmes based on the new strategy and PHAST methodology in your individual countries. This should help in improving the present sanitary situation and, with it, the health of our peoples. I believe that this consultation will spur you towards concrete actions at country level, with requisite community participation.
For five decades, WHO has been associated with its Member States and development partners in improving the health of people all over the world. Much progress has been made in increasing life expectancy, in reducing the disease burden and in promoting health. However, as we look towards the next millennium, much remains to be done at national, regional and global levels.

With the rapid development and improvement in biomedical and other scientific technology, the end of the cold war and increasing international trade, the 21st century will present new opportunities as well as challenges in public health. Clearly, new approaches have to be undertaken in the coming millennium. Here, I would like to share my views on the challenges for the future from the global public health perspective, which is the major theme of this Conference. I would also reiterate the changing role of universities and other training institutions to cater to the changing needs in public health.

It may be useful to take a brief look at the evolution of global public health. It is well recognized that improvement in health leads to the well-being of people, and to overall socioeconomic development. During the last two decades, however, progress in health development has been hampered for several reasons. These include, among other things, unequal socioeconomic growth and insufficient political commitment in implementing

national strategies for Health-for-All. There has also been inadequate funding for health and health-related development activities. These factors have been compounded by rapid demographic and epidemiological changes as well as frequent natural and man-made disasters. Yet another important constraint has been the widespread poverty in developing countries.

Despite these formidable hurdles, we have seen some positive developments. For instance, we have seen how primary health care has been successfully used as a public health approach. It has helped in the rapid expansion of essential public health services in all countries. It has been the key factor in accelerating the progress towards "Health for All". Primary health care remains valid as a key factor for achieving successful health development during the next century. It is an important entry point for development of a comprehensive health care system.

The major challenge ahead is how to work with the governments, development partners and the communities at large, in order to sustain essential public health practice and services. What is needed urgently is the creation of a conducive political and social climate to facilitate good governance in health.

All governments have the responsibility to develop sustainable health systems. For this, they must develop a strong capacity in policy-making for public health. Governments must guarantee equity in and access to the highest quality of health care to all people. Such essential functions are indispensable for preventing public health disasters and protecting and promoting the people's health. In order to do this effectively, the management and administrative machinery must be reformed to support organizational culture in the health systems. This would encourage innovative approaches and staff motivation. Collaboration and cooperation of many sectors that have an impact on health could help in the realization of the Health for All vision.

The increasing involvement of civil society, particularly non-governmental organizations, may lead to a situation where all those responsible for health will assume ownership and become accountable for their actions.

In the South-East Asia Region, our efforts over the last few years to promote health advocacy, and place health high on the political and development agenda, have borne fruit. The ministers of health, decision-makers in the health sectors, and the parliamentarians in the Region are committed to work towards the goal of health for all. In August 1997, the
ministers of health of Member Countries of the WHO South-East Asia Region adopted the Declaration on Health Development in the South-East Asia Region in the 21st Century.

In May this year, the World Health Assembly adopted the World Health Declaration for global action. Our Regional Health Declaration provides the necessary policy framework and identifies action points to help steer this region steadily towards the Health-for-All goal. Similarly, the parliamentarians of the Region issued a call for action on women’s health and environment. Regional solidarity and cooperation for health have received an added impetus, through these high-level political platforms.

We all accept that the enjoyment of the highest standard of health is a fundamental right of all human beings. It is important for governments to ensure equity and social justice for all in health development efforts, particularly the vulnerable.

It may be pertinent here to take a look at the health challenges facing us today. The world’s population has been growing rapidly. Our Region, already home to a quarter of the world’s population, will cross the 1.5 billion mark by the year 2000. With an increase in life expectancy, population aging is a worldwide phenomenon. It is estimated that in this Region the elderly would constitute 11 per cent of the total population by 2025.

Recent studies show that the elderly suffer mainly from high blood pressure, arthritis and back pain, heart diseases and stomach ulcers, along with visual and hearing impairments as well as deterioration of the central nervous system. Mortality due to heart diseases, cancer and diabetes has increased recently. Yet, the proportion of elderly people having access to professional care is substantially lower in this region than in developed countries. There is a need to strengthen the traditional family and home-based care for the elderly. At the same time, health personnel need to be trained on health problems of the aged and how to deal with them at home and at the community level. It is also important to undertake social and epidemiological studies on health of the elderly. Research into the aging process will be very relevant to health care development in the next century.
In the next few decades, communicable diseases such as HIV/AIDS and tuberculosis as well as diarrhoeal diseases and acute respiratory infections will continue to contribute substantially to morbidity and mortality. At the same time, changing lifestyles will expose people to diseases such as cancer, diabetes and cardiovascular diseases, as well as accidents, alcohol and other substance abuse, mental illness, and nutrition-related diseases. Pressure of population growth, together with vested interests have led to environmental and social degradation to the detriment of people’s health. Excessive deforestation, uncontrolled construction of irrigation dams and canals and unplanned migration and settlements have further compounded this problem.

However, the world has made gigantic strides in health development. Tremendous advances in biomedical sciences and the application of health technology have enabled the medical and public health professionals to eliminate or eradicate certain communicable diseases, and to control many noncommunicable diseases. From being dependent only on natural immunity to resist infections, it is now possible to induce immunity through a variety of vaccines. Herbs and plants are being utilized to produce the most advanced synthetic drugs and antibiotics. Smallpox has been wiped off from the face of the earth. Leprosy, yaws, trachoma, guineaworm, river blindness, measles, diphtheria, whooping cough, tetanus, poliomyelitis and iodinedeficiency disorders are on the verge of elimination or eradication. Compared to the days of crude surgery, it is possible today to repair and rebuild the human body by using lasers, microsurgery and synthetic components. Genetic engineering will play an important role in medicine in the coming decades.

Since the rapid globalization and liberalization of trade, we find that we are living virtually in a world without borders or boundaries. Advancement in technology, communications and marketing, the global impact of economic forces and policies are influencing national and local decisions, as never before. On one hand, globalization may lead to economic growth and development. On the other, it contributes to the occurrence and spreading of diseases and the aggravation of many other health problems. We have also witnessed the impact of the economic crisis on health, particularly of the poor. To bring national policies in line with the
Striving for Better Health in South-East Asia

global and regional perspective, governments today have to work under pressure from many directions, both within and outside the country.

The 21st century will herald a new era of public health - we can perhaps term it as a potential era of public health. Many countries have reached the levels, where national processes have been established for consensus building. The ideals of socioeconomic development policies, including health, have been translated into concrete action in many countries. This is an era where continued development and nurturing of dynamic leadership and good governance of health systems is essential. What we also need is the promotion of informed public opinion and participation. This is the time to strengthen national and international partnerships in health development. The multifaceted nature of health and the multisectoral dimensions that influence health are bringing a large number of actors to the health development arena. The overwhelming concern is to find tangible ways of fostering meaningful partnerships with these "new" players.

Irrespective of their nature, scope, purpose or duration, partnerships in health development do not happen easily or by chance. Identifying the opportunities and building and maintaining partnerships is an intricate process involving time, energy and resources. It also requires new skills and adaptability. Extensive consultations are needed to explore the prospective partners and ensure a common understanding and direction. Creating multisectoral linkages at all levels of the government administration, building on existing national structures and mechanisms, establishing networking and fostering international links are vital for the success of effective partnerships.

I would like to take this opportunity to highlight the role of the universities, particularly the medical and public health faculties. I would like to touch upon how they can complement the partnerships in health development and also how they can respond positively to the challenge of public health in the 21st century. To begin with, there have been perceptible advances and improvements in all aspects of human resources for health in the past few years. Policy formulation and planning, education and training, and deployment and managerial skills have received serious attention from managers. Yet, achieving a balance and relevance in human resource development needs
further attention. The globalization and liberalization of trade have led to an expansion of the role of the private and nongovernmental sectors in human resources production and utilization. Consequently, the distribution, behaviour, motivation, productivity and performance of health personnel has been affected. It is, therefore, essential for public health institutions, together with the governments, to develop a long-term vision, remain informed and alert, and pay careful attention to health priorities.

In future, we can expect the client communities to be much better informed, more discriminating and demanding. Over the last few years, WHO, together with major international academic institutions, has organized several consultations and seminars on this issue. We are clear about the route we have to follow. The academic institutions must reorder their priorities to effectively address the health challenges ahead. They need to develop mutually beneficial academic linkages with similar institutions at national and international levels. They also need to broaden their services and research interests to address the health concerns of the people, keeping in mind the scarcity of resources.

The major challenge, however, is how to produce a proper mix of health care personnel, capable of fulfilling effectively the health needs of the people. The health personnel need to be trained using a more holistic approach, including a team approach, in health care and development. Another challenge is to reorient those already in the work force with the new concepts, knowledge and skills. A major task for the schools of public health and medicine today is how to train various categories of personnel to be sensitive to the need for intersectoral action. The success of public health institutions in the future will depend largely on how these institutions prepare health personnel to link meaningfully with other sectors and with decision-makers.

Finally, I would like to reiterate that global action and cooperation is necessary to secure the benefits of globalization for health for all on an equitable basis. This is essential to prevent or minimize threats to health and well being. We need to foster global public health action through the full utilization of international and intergovernmental organizations involved in health and health development. Such global public health action will include active surveillance on the global
burden of disease, support for research on poverty and health, and the development of ethical and scientific norms and standards.

We urgently need to strengthen preventive, promotive, and control activities to tackle the increasing burden of both communicable and noncommunicable diseases. This is particularly so amongst the poorer countries and communities. Concerted efforts are also needed to reduce the major risk factors that constitute transnational threats to health.

Once again, I would like to reiterate that health for all can only be achieved with the active partnership of all concerned. WHO is committed to make a difference by working with countries and their development partners.
Food Safety

NEDLESS to say, the subject of food safety is of crucial importance. The objectives of any national food and food safety programme should be to promote safe and nutritious food. It has been observed that food-borne diseases are widely endemic and large outbreaks are regularly reported. Therefore, food safety programmes must attempt to protect the consumers, particularly in the South-East Asia Region whose populations are already subjected to a heavy burden of disease and malnutrition. In the face of such enormous demands, it is essential that food safety programmes identify and focus on key priority issues. WHO has, over the past few decades, provided substantial technical and financial support to Member States to reverse food and water-borne diseases in the Region by identifying and collaborating on certain priority areas specific to the countries.

Since 1992, WHO has worked with national governments to achieve greater focus on action-oriented themes identified as key issues by the International Conference on Nutrition (ICN) Declaration. Some of the issues related to food safety include:

- incorporating nutritional and food safety objectives and components into development policies and programmes;
- improving household security of safe food;
- protecting consumers through improved food safety;
- preventing and managing infectious diseases;
- promoting breast-feeding,

Both nutritional and food-borne diseases not only have a direct impact on those affected, but can have long-term effects on the individual, health care and economic systems of the community.

Regional Consultation on Development of a Strategic Plan for Food Safety in the South-East Asia Region, New Delhi, October 1998
appropriate and adequate safe complementary foods, and
• promoting appropriate and healthy lifestyle, and assessing, analysing and monitoring nutrition and food safety.

As you are aware, an estimated 3.2 million children die each year from diarrhoeal diseases in developing countries. Hundreds of millions more suffer from frequent episodes of diarrhoea and consequent impairment of nutritional status. Although it has been well documented that food prepared under unhygienic conditions is one of the common causes of diarrhoea, little attention is given to educating care-givers about food safety. Moreover, the increasing use of chemicals in agriculture and in food processing and preservatives resulting in chemical contamination of food, have added new concerns to health.

Despite the importance attached to the need to educate policy makers, health authorities, consumers and industry personnel regarding nutrition, food security and food safety, only limited attention has been given in the plans of Member States to the strengthening of national capacity to implement such broad information, education and communication programmes. Training of administrators, inspectors and analysts is the focus of human resource development within the food control structure.

I would like to emphasize the public health significance of nutritional and food-borne diseases – that persistent hunger, malnutrition and diarrhoeal diseases remain perhaps the major causes of disease and health worldwide. In South-East Asia, many millions suffer each year due to an insufficient supply of nutritionally adequate, safe food and clean water. Both nutritional and food-borne diseases not only have a direct impact on those affected, but can have longer term effects on the individual, health care and economic systems of the community.

It should also be noted that although in a majority of cases the causes of food-borne diseases have been traced to biological contaminants, the harmful effect of chemical contaminants must not be underestimated. Such problems can arise when unscrupulous food processors use non-permitted additives, such as textile dyes instead of permissible food colours, and use non-permitted preservatives, such as boric acid or formaldehyde.

You are aware that almost at any stage of production, food can also be contaminated with foreign material that
could be a physical hazard to the consumer.

Besides human suffering, food-borne diseases cause substantial economic losses. These include loss of income, loss of manpower, loss of food, medical care costs and decrease in tourism and foreign trade. Also, adverse reputation in food safety can severely affect the economy of a country by a restriction of food exports and by reducing the values of exported foods. Such an economic impact has a compounding effect and leads to a vicious cycle of increased poverty and malnutrition.

In conclusion, I would like to emphasize the importance of food legislation in accordance with the Codex Alimentarius Commission, that is, food legislation provides the foundation for national food safety programmes. It plays a pivotal role in directing the food control efforts of food inspectors. It informs producers and processors of requirements regarding production and processing methods and product standards. It meets the expectations of the consumer regarding the quality of food.

Most of the food laws addressing food safety in the Region have not been evaluated for their relevance and effectiveness. As a consequence, in some countries, the basic food laws have not been revised significantly since the 1950s. Food regulations and food standards too have stagnated in some countries of the Region.

It is desirable that Member Countries commit themselves to a comprehensive revision of laws, regulations and standards and improvement of food safety for their populations in accordance with the guidelines of the Codex Alimentarius Commission (CODEX).

Since the regional review on food safety conducted in 1993, new developments in regard to food safety have taken place in the countries as well as globally. It is timely to review the current situation. I hope that on the basis of the ongoing situation analysis and current advanced knowledge on food safety issues, you will be able to revise and restructure your food strategies as appropriate and feasible.
Emergency Preparedness

ASIA suffers frequently from disasters. In the global perspective, it is the region struck by the highest number of disasters. To give you an idea, in 1997, a total of 109 disasters occurred in Asia. This is almost 40% of all global disasters in that period. When viewed globally, the absolute number of people killed or affected by disasters is also very high for Asia. Annually, the number of people affected by disasters in the ten Member States in the South-East Asia Region approximates about 80 million.

We have all heard about the devastating floods a few months ago in Bangladesh and India, leaving millions of people homeless. In Bangladesh alone, 30.6 million people, approximately 38% of the population, have been affected.

We also remember well the cyclone in the Indian state of Gujarat in June this year, affecting thousands of people. The victims were mainly those working in the shallow pits near the shoreline which are highly vulnerable to the extreme windspeeds and the high sea waves.

In 1997 and in 1998, the 'El Nino' phenomenon had a major impact in the world, including in two of our Member States, Indonesia and Thailand. Indonesia suffered because the delay in the monsoon prolonged the forest fires and intensified the health effects due to the haze. Drought in some areas of the country caused food crops to fail, aggravating malnutrition of the population. Moreover, malaria appeared for the first time in high altitude areas in Irian Jaya causing many fatalities.

Another ongoing emergency is the crisis in DPR Korea due to floods and

the economic difficulties being faced by that country. The health system, which was functioning well in the past, has to cope with a shortage in medical supplies and equipment resulting in great human suffering and death.

Besides the loss of human lives caused by disasters, the damage in financial terms is also considerable. The annual average damage has been estimated at approximately US$ 500 000 million in Asia.

The number of emergencies in our region and their impact calls for an increase in the allocation of financial resources. It also calls for mobilization of additional human resources to respond to these emergencies which are a threat to the gains of development. Therefore, an investment in emergency prevention, preparedness, mitigation and emergency management is itself a contribution to development as well as protection of the existing level of development.

In the context of the theme of this Conference, which is the role of policy and legislation for emergency preparedness and management, I would like to remind the participants of the importance of partnerships. When it comes to preparing for and managing emergencies and disasters, the health sector cannot achieve its objectives single-handed. The complexity of the task calls for efforts by many partners working together.

If emergency response is about minimizing injuries, illness, loss of life and damage to property and the environment, then it is essential that authority, responsibility and functions are clearly defined in legislation. This is essential to ensure efficient and effective collaboration, coordination and cooperation within and between agencies, and between agencies and the public.

Emergency response is a multisectoral undertaking, and as in all such undertakings at the national level, true collaboration can only be achieved when there is national legislation underpinning the process. In such cases, absolute clarity about the allocation of authority and division of responsibility is essential if the function is to be carried out properly, if gaps and overlaps are to be identified and if the ill effects are to be minimized. The purpose of legislation is to define roles and to delegate particular authority and responsibility to certain offices and agencies. It serves to protect officials in the exercise of their responsibilities and duties as well as serving to lay norms and procedures for compensating the public for injuries and damage to property.
There is every reason to believe that disasters will remain with us. Natural calamities, civil strife and degradation of the environment, combined with overcrowding of cities and overflow of people into high-risk areas, make the protection of the population from the consequences of these events increasingly difficult.

Tackling the issue of the role of policy development and legislation in emergency preparedness and management is thus an important and challenging task. It merits utmost attention.
Health Care Infrastructure

When WHO came into existence 50 years ago, its Constitution reflected the aspirations of the world's population when it stated that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition. Health was defined in a holistic way as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. When WHO was born in 1948, many developing countries were gaining their independence. WHO was entrusted with the task of directing and coordinating international health.

In the early years of WHO’s collaboration with its Member Countries, priority was given to the prevention and control of epidemic diseases, such as yaws, smallpox and malaria. Vertical disease control programmes were necessary as no adequate infrastructure existed. However, since 1953, WHO has stressed the need to strengthen the basic health services through the establishment of a network of health centres and sub-centres, as close to the people as possible. The concept of auxiliary health workers, to be trained and deployed particularly in rural areas, to provide basic health care was advocated.

During the 1970s, progress in health development did not proceed as anticipated. It became clear that there was widespread dissatisfaction with health services. It was found that the basic health needs of the vast number of people throughout the world had not been met. Investment in health services infrastructure was biased towards the provision of medical care.

Health for All was based on the philosophy of social equity and justice, on the principle of equitable distribution, addressing inequities and pursuing health as an integral component of social and economic development.

Seminar on National Health Care Infrastructure for the Next Millennium, New Delhi, June 1998.
through hospitals in urban centres with concentration of manpower and resources. Appropriate infrastructure for comprehensive promotive, preventive, curative and rehabilitative aspects of health care received less attention. Gaps in health status between and within countries widened.

A new approach to realize the health goals of Member Countries was required. Valuable lessons emerged from the analysis of the experiences of achievers in health in developed and in developing countries. Spectacular improvements in health status in Europe followed the provision of clean water, sanitation and education, which brought the practice of hygiene into the family. A major decline in communicable diseases occurred even before the discovery of antibiotics.

Developing countries, such as, Cuba and Sri Lanka, and within India in states such as Kerala, which skillfully used their resources, achieved major progress in the health of their population even with a modest per capita income. The experiences of various NGOs, such as the Jhamked project in India were documented and analysed. The elements for the successes in providing health for all people became clear.

These findings triggered the 1977 World Health Assembly resolution on Health for All which stated "that the main social targets of governments and WHO should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". Health for All was based on the philosophy of social equity and justice, on the principle of equitable distribution, addressing inequities and pursuing health as an integral component of social and economic development. In the words of Dr Halfdan T. Mahler, former Director-General of WHO, "without health, life has little quality, for even if health is not everything, without it, the rest is nothing".

In 1978, a conference held in Alma-Ata, USSR declared that primary health care is the key strategy for attaining health for all.

The primary health care approach was a departure from the provider-receiver approach of the basic health services. It is a way of planning, organizing and providing health care and is known to yield maximum gains in health. It is a people-focused approach and is based on the principles of:

- Equitable access according to needs, particularly, for the underserved and disadvantaged;
• Affordability to be maintained and sustained, thus promoting self-reliance;
• Appropriate technology - that is scientifically sound and socially acceptable;
• Full involvement of individuals and communities;
• Intersectoral action for health and overall social development, and
• Emphasis on promotive and preventive aspects.

Achieving Health for All (HFA) goals requires the development of a health system infrastructure based on the principles and strategies of HFA. The system starts with individuals, families and communities. They are linked with the first health facility and extend to the first referral level. This is the primary level of health care which is the foundation of health care in a country. It is the first line of health development and is the level where maximum gains in health are realized. Appropriately trained health personnel work closely with personnel from other sectors and with communities for the provision of essential health care as per the local needs and overall community development. Thus, health is pursued as an integral component of socio-economic development. The primary level of health care is supported by secondary and tertiary referral facilities through a referral system for providing more specialized services.

It is already 20 years since the 10 Member Countries of the WHO South-East Asia Region committed themselves to the goals of HFA through primary health care. In the 20 years since Alma Ata, considerable efforts have been made to improve the health system infrastructure and develop and strengthen human resources for health, including various categories of voluntary health workers in both public and private sectors. An extensive network of health services has been established in all SEAR countries. Community participation has been given priority attention in a number of countries. Various community-based schemes for health development have been established. Disease control programmes have been implemented against major communicable diseases. Morbidity and mortality due to these diseases has been reduced. Important health indicators, such as crude death rate, infant mortality rate and under-5 mortality rate, have declined in all countries of the Region. Poliomyelitis, and guineaworm disease are expected to be eradicated and leprosy eliminated by the year 2000.

However, development in all health sectors has not been even. Although maternal mortality rates have declined,
they unfortunately still remain unacceptably high will about 40 percent of the global maternal deaths occurring in the Region. Disaggregated data reflect inequities, and poor health indicators are seen in association with poverty in many communities. Communicable diseases are still deep-rooted in the Region. In addition, diseases of poverty – malaria, plague and kala-azar are re-emerging. New diseases, such as HIV/AIDS are assuming epidemic proportions. With the epidemiological transition, chronic noncommunicable diseases are emerging as an additional burden which need to be addressed. The Region is also witnessing rapid changes in urbanization, economic liberalization and industrialization, which are impacting health development.

The WHO South-East Asia Regional Office conducted extensive consultations with a wide range of experts and policy makers on health development in the 21st Century. Following this, the Declaration on Health Development in the South-East Asia Region in the 21st Century was adopted at the 15th Meeting of Health Ministers of the Countries of the Region in Bangkok, in August 1997. The Declaration was subsequently endorsed by the 50th session of the Regional Committee for South-East Asia held in Thimpu, in September 1997.

All Member Countries of WHO are engaged in a process of reviving and updating their Health-For-All strategies.

The development of an effective health care infrastructure for the 21st century is confronted with many challenges. The foremost challenges as reflected in the Declaration on Health Development in South-East Asia, are:

- Closing the gaps and inequities in health within and between countries;
- Creating conditions that promote health and self-reliance;
- Ensuring basic services for all, especially the poor, women and other vulnerable groups;
- Updating and enforcing health ethics, and
- Placing health at the centre of development.

The vision for HFA in the 21st Century needs to be clearly framed, shared, promoted, communicated and advocated. It needs to be a priority issue on the political agenda of all parties, all heads of State, professional groups, the private sector and NGOs. The principles of health as central to sustainable development and well-
being, as a basic human right founded on the dignity and worth of every human, and the right and obligations of individuals and communities in attaining the highest possible level of health, should be upheld. The ethical principles of equity and social justice and in particular, gender equity is fundamental to the vision of HFA. Health development needs to be pursued through a holistic approach and a broad partnership with various development sectors, civil society, NGOs, the private sector and industry. Poverty, a root cause of ill health, needs to be addressed urgently.

The vision of HFA needs to be translated into action. It needs to be reflected in the national development policy, the national health policy and strategies and in the allocation of resources. The allocation for health needs to be seen as an investment in human capital for the future.

Plans to strengthen, establish, sustain and maintain appropriate health care infrastructure to deliver essential health care, as per the local needs have to be prioritized. The policy for allocating the maximum resources to tertiary level facilities and starving the primary level of health care needs to be reversed. The primary level of health care that provides the maximum volume of promotive, preventive and basic medical services to the total population is the level where maximum gains in health are realized. The cost of interventions at this level is low. However, the returns are high. It is the wisest and the most gainful investment in health.

Extensive networks of health care facilities have already been established as health centres, sub-centres and first referral facilities. Experience shows that when these are manned by an appropriate mix of human resources, supported for maintenance and with essential logistics, supplies and equipment, it makes a great difference. These issues need to be addressed. The health care infrastructure already in place needs to be strengthened so as to make it a vibrant centre for health development.

There has to be a shift in the orientation of the health personnel. Extensive orientation is required through in-service and basic training. The perception of their role as simply delivering government health programmes needs to be changed to being agents of health development. They need to be sensitive to the local needs. In addition to technical skills,
they will need social skills to negotiate with other sectors, and communication skills for organization and empowerment of communities.

In order to operationalize the HFA/PHC approach, WHO adopted the district health system approach in 1986. The district health system is a geographic and administrative unit with a defined population. The approach provides for the development and strengthening of the capabilities needed for decentralized planning and management of programmes. The district health system adapts the national strategies to local needs. Successful decentralization requires local administrative and managerial capacity and mechanisms for accountability and people’s participation.

Experience shows that creative management and real community involvement can be initiated at the district level through devolution of functions and responsibilities. Decentralized planning and management, therefore, becomes essential for empowering the district health system. Successful examples have been documented from Member Countries. These need to be replicated and expanded gradually.

Strengthening current primary care systems is essential, but will not be enough in itself to address the unmet needs of the past and the enormous health challenges of the future. What is imperative is greater understanding of the diverse influences on health, and a reform of the health systems.

Health systems of the future must strike a new balance between health care for the individual and the protection and promotion of the health of whole populations. Primary health care services need strengthening through increased investment and reform to ensure their accessibility to all and focus on the priority health needs of the communities they serve. At the same time, the crucial importance of public health - neglected and under-funded in many places at present - must be reorganized.

Health systems of the future will be characterized by:

- **Broad alliances for health**: a great diversity of groups and individuals at local, national and global levels will be involved in an equally diverse range of complementary activities with an impact on health.
- **Flexibility**, to be able to respond readily to changing health needs, and grasp new opportunities offered by science and technology.
• Radically different health care settings with greater emphasis on home- and community-based services, and relying on a wider range of professional and non-professional providers. Health will be integrated with social and environmental services. And modern information and communications technology will be used increasingly to link activities as well as to deliver "remote" and "interactive" care.

Health systems will take many forms, but the essential elements will include:

• **A life-span approach:** Health systems should provide a continuum of high quality care from conception to death, based on the understanding that a person’s health status at any one time is influenced by events and conditions earlier in life. Ensuring the healthy development of children by meeting their diverse needs in an integrated manner is an excellent investment in the long-term health of populations and in equity.

• **Specific measures to control and prevent disease,** with emphasis on common and endemic diseases, injuries and violence.

• **Laws and regulations** to give guidance, set standards, and create an environment in which collective action for health is facilitated, and activities that threaten health - including trade and industrial practices - are curbed.

• **Health information systems** are able to provide intelligence for rational decision-making and setting of priorities, give early warning of health hazards, and highlight shortcomings in the planning and performance of the health system. Strong links should be developed between national, regional and global information systems.

• **Appropriate, needs-driven research** and increased use of technology for health. Technology's potential for improving the quality of life has never been greater, but barriers to the use of what is available - including cost, and lack of skills and knowledge - need breaking down.

• **A workforce with a wider range of skills.** Skills required by modern health systems to complement traditional medical skills include community development, communications, technology use, and the ability to work in a
multidisciplinary and collaborative set-up. Staff skills should be regularly upgraded and training curricula updated to reflect changing needs.

- **Adequate and sustainable financing.** Measures to ensure the cost-effectiveness of interventions, disciplined spending, universal and equitable access to services, and emphasis on preventive and promotive activities will be priorities. They are most likely to be met when the government has the overall responsibility for health spending, regardless of the source of funds.

National research institutions have an important role to play. The problems in the development and maintenance of infrastructure for health care and the delivery of essential health care programmes need to be identified. Research areas need to be prioritized, jointly with programme managers, and concerned parties. Problem solving and operational research that promotes health care delivery is required. Innovative approaches for enhancing the effectiveness of health care are required.

A broad and strong partnership is required to address the challenges for establishing a health services infrastructure for the 21st century. This is one of the main strategies for health development in the new millennium. A book on "Partnership for Health Development", recently published by WHO/SEARO spells out the many partnerships required to achieving the goal of HFA. It is encouraging to note that this Seminar has been organized by the Federation of Indian Chambers of Commerce and Industry. The private sector has an important role to play, both in technology development and in provision of services. At the same time, countries need an efficient and well-performing public sector. Governments should ensure universal coverage with health services. While there are major challenges for health development in the 21st Century, there are also great opportunities. If we utilize these opportunities wisely, the goals for health development can certainly be attained.
In our search for equity and social justice for all people, reaching the poor and the vulnerable groups has assumed added importance. We have enough evidence to conclude that countries where poverty was reduced faster also achieved higher levels of health status, including sharp reductions in infant and maternal mortality, and rapid increase in life expectancy.

Sound macro-economic policies and stable economic growth are essential for sustained investment in health. Health and economic growth are inherently interlinked. Rising incomes are necessary, but not sufficient for improved health. They have to be accompanied by social development policies focused on the underprivileged. The experiences of many Asian countries have shown that improved health has contributed to economic growth in several ways. Most significantly, the gains from investment in health are relatively much more for the poor, especially the female poor and the indigenous people. The bottom line is that health is a fundamental goal of development as well as a means of accelerating and sustaining it. The World Development Report 1993 - Investing in Health - has stated that appropriate allocation and optimum use of health resources to cover the whole population is essential.

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ADB/WHO Seminar on Health in Developing Asia: Seizing the Opportunities, Reaching Vulnerable Groups: Improving the Health of the Poor, Women and Indigenous People, Geneva, April 1998.
for human development. The challenge that faces us today is: how to improve the health of the marginalized, the poor, the women and the indigenous people. The challenge has far reaching implications for the future of Asia.

Globally, we have noticed significant increases in GNP per capita in most countries as the result of economic growth. Commendable gains in terms of increase in life expectancy and a substantial decline in morbidity and mortality have also been observed during the past two to three decades.

However, disparities of all types still exist between and within countries. Globally, more than half of the population survives on less than two US dollars a day, and about a quarter on less than one dollar a day. South Asia is home to 35 per cent of the developing world’s poor, and with a per capita GNP in 1993 of merely US $ 309, is the poorest part of the world. In many countries of Asia and the Pacific, there are vast disparities in terms of gender, socio-economic conditions and cultural and caste systems. These are major hindrances to development and must be addressed urgently. Narrowing these gaps must be our goal, along with economic growth.

The World Health Report 1995 clearly indicates that most human suffering and premature deaths are poverty-related. Malnutrition is a consequence of poverty: it is also its cause. Globally, nearly 100 million people go hungry everyday.

Women carry a disproportionate burden of poverty, illiteracy, malnutrition and ill-health, particularly in developing countries. A girl born in a developing country is less likely to receive equal opportunities for education, food and health care. A mother in a least developed country has a twenty times higher chance of dying during pregnancy compared to a mother in the developed world. In South Asia, gender bias directly impacts on the health status of women throughout their life span. Childhood mortality rates are considerably higher for girls as compared to boys, and South Asia is the only part of the world where men outnumber women - a complete reversal of biological norms in the rest of the world.

In most countries, ethnic minorities have an infant mortality rate twice that of the general population. This reflects the generally poor socio-economic status of these minority groups, which are often forced to lead a sad existence on the fringes of society.
Thus, despite health gains, we still face formidable challenges. The first task then is to identify and reach out to the vulnerable groups. This is a challenging task, as the existence of some of these groups is not even officially acknowledged. Also, it is not enough to develop the health care infrastructure and services. We have to find the will and the way to make these accessible, acceptable, affordable and sustainable to those who are the most vulnerable.

An ethical and moral dimension to the prevailing inequities in access to health care has now become a dominant concern. Protection and preservation of human dignity in impoverished communities is deeply disturbing. These issues have also come into the domain of human rights as embodied in the International Children's Charter.

It is a simple, yet sad truth that health services in many countries are, by and large, not adequately responsive to the needs of the poor and vulnerable. The emphasis is still on curative services rather than on preventive and promotive care. And yet, the poor and vulnerable are actually more prone to the preventable, poverty-related diseases, which do not need a high level of curative care.

Privatization of health services is on the increase. An appropriate mix of public and private services is welcome. But, we observe a proliferation of private health facilities without effective regulatory mechanisms. Expensive diagnostic and curative technology is becoming increasingly available and health care costs are rising rapidly. The type of health care available to the rich and the poor is fast getting polarized in opposite directions. This is particularly so in the less developed countries. How do we make sure that public resources spent in these countries cover the vulnerable groups? Growth with equity and environmental protection is the direction to take.

WHO has consistently advocated that health is central to development. This has been reinforced by the recent UN Conferences, such as the Social Summit, which highlighted the key role of health in generating productive employment, alleviating poverty and fostering social integration. The inclusion of life expectancy, along with literacy and per capita income, in UNDP’s Human Development Index, also brings out the centrality of health in sustainable human development and well-being. Yet, the health sector is still not accorded due priority in the overall development agenda. It is viewed as a sectoral programme that only “consume” resources. It is not seen by
policy makers as a central pillar in the development process. What is needed is a change in the mind-set and strong political will to assign health its due place in developmental and political agendas.

Although we have been relatively successful in controlling communicable diseases, old scourges such as TB and malaria are re-emerging. At the same time, new diseases such as HIV/AIDS have become formidable problems. It is ironic that the bulk of those affected are the poor and the vulnerable.

Where are we in terms of reaching the vulnerable today? It is obvious that we have a long way to go. To achieve our goal, we need to ensure that macro-economic policies are conducive to health development and that public health becomes the primary responsibility of the government.

The policies and strategies in the social sector, including health, need to focus on poverty reduction, as poverty is one of the main causes of ill-health. Poverty reduction programmes must selectively target women and the vulnerable. The countries which have been successful in reducing poverty and improving the health of their people did so through policies which distributed the economic gains with adequate attention to improvement of human capital. We can conclude that acceleration of economic growth and development of human capital reinforce each other.

We must ensure that women enjoy and benefit from their right to health and health security by promoting the education of girls, by ensuring equity in feeding practices, and by empowering women to make informed choices for themselves and their families. Women must, of course, have access to the health care they need. In particular, the emphasis should be on improving the health of adolescent girls.

Another cardinal requirement is to ensure that our health systems are sustainable and socially relevant. Capacity building must include the target populations. The paradigm must shift from relief and reconstruction to community self-reliance. Knowledge and technology must be directly transferred to the needy populations. We must build on and make the best use of the vast fund of indigenous knowledge and practices. Good governance at all levels is, of course, imperative for sustainable development and for meeting the needs of the poor and vulnerable groups.

In outlining some of the approaches that we need to adopt, both individually and collectively, I shall draw from experiences in the South-East Asia Region. In the past two
decades, we have seen many successful examples of attempts to meet the health needs of vulnerable groups. The innovative work being done by the Bangladesh Rural Advancement Committee and the Grameen Bank, which provide easy credit to the poor in Bangladesh, the Self-employed Women’s Association, and the Maharashtra Employment Guarantee scheme in India, the Samridhi programme in Sri Lanka, the PKK Family Welfare Movement, and Posyandu Integrated Services in Indonesia; the Basic Minimum Needs Programme in Thailand, and the Ayadaw Township Development Programme in Myanmar provide many valuable lessons. A common feature, and the most important lesson of these initiatives, is that they are focused on poverty alleviation in its multi-dimensional aspects.

In other Asian countries, such as Pakistan, Iran and Jordan, the “Basic Development Needs” approach addresses poverty through integrated income generating schemes, which also include a health component. This approach, coupled with advancement of primary health services, is found to be particularly effective in reaching the vulnerable groups and improving their health.

What is equally clear is that the health of the poor and the indigenous people cannot be improved in isolation. What is needed is development of infrastructure such as roads and electricity, and services such as education, water supply and sanitation. Development banks can play a crucial role in this. They might consider devoting an increasing share of their assistance for social development. They may further consider earmarking a portion of such assistance to be targeted at the poor and vulnerable groups.

Governments, the private sector, NGOs and development partners must be prepared to invest in backward and remote areas where the poor live. This would need balanced economic returns from investments in advanced areas. It also needs sustainable human development and social cohesion. Appropriate national policies can promote such a balance.

Because of resource constraints and the recent economic turmoil in East Asia, the time has come for governments to review the priorities with a view to obtain value for money. This could be best done by allocating resources for priority areas and for those who need them most. Economic crises result in unemployment and rising prices of food and other essential items: the worst affected are, inevitably, the poor and women. It is imperative for governments to ensure that health
and other services for the poor are not allowed to be undermined by economic downslides and structural adjustment programmes.

As the consequences of ill-health, disease, poverty and environmental degradation are felt across international borders, major banks like the Asian Development Bank and other partners may consider widening the scope of their assistance to cover regions or a group of countries, as this would be more cost effective.

As we are aware, many Asian countries still do not have well-developed social security or insurance cover for health. Economies in transition are only now taking the initial steps to set up such mechanisms. Therefore, a “health safety net” or the concept of health security must be established to provide access to all the determinants of health to the vulnerable. Developing countries also need to strengthen their response mechanisms to effectively manage outbreaks of epidemics and natural calamities, which strike the poor and vulnerable particularly hard.

Within the framework of integrated development, governments must go to the grassroots, involve the vulnerable groups and forge partnerships to evolve lasting solutions. Ways of bringing these people rapidly into the mainstream of such development must be found. Their voices must be heard.

Experiences from NGOs in many countries in the Region indicate that the poor and the vulnerable are responsible and have good credit records. Even if they are destitute, they can identify their needs and given the opportunity, develop and manage the programmes themselves with support from the governments. They should, therefore, not be seen as only passive recipients of services, but also be involved fully in policy formulation, programme planning and implementation. This would give them a sense of ownership for their community development.

In most developing countries, reforms, including those in the health sector, are taking place partly due to the donors’ influence. WHO, however, is committed to work with countries in accordance with their needs and aspirations. Development partners and others concerned should ensure that the reforms take account of the special needs of the vulnerable groups. Partnership between WHO and development banks in the health sector should be strengthened towards these ends.

WHO has an obligation to serve as the health conscience of the world. Protection of the health of the
vulnerable segments is one of our prime responsibilities. I believe that, at the global level, UN Agencies, the financial and developmental institutions such as the Asian Development Bank and the World Bank, need to reaffirm their commitment to poverty eradication in a visible and practical manner.

The Asian Development Bank and the World Bank are well placed to invest in health, focusing on the vulnerable groups, and to improve the status of women. WHO, for its part, would like to further strengthen technical collaboration with the Banks for developing policies, norms and standards, and in research and development.

Already, WHO and the Asian Development Bank have taken a number of steps to broaden the scope of collaboration between the two organizations and to consolidate the operational arrangements. The areas of collaboration that have been identified include: Health and environment, food and nutrition, integrated disease control, and multipurpose information exchange.

Cooperation among countries is the most appropriate mechanism to ensure regional solidarity and self-reliance. In this regard, ASEAN and SAARC can play a crucial role in strengthening health cooperation in Asia and in the Pacific. The Agenda of SAARC has several elements that focus on health development. WHO would be privileged to facilitate this process.

I have tried to place before you some of the challenges that we face in our quest to reach the vulnerable groups and to meet their health needs. Let us reiterate the key messages, as we set out on this mission.

We need to be convinced that the process of structural reform and allocation of resources must be guided not merely by economic principles, but also by social fundamentals. Improving human resources requires adequate investment in health and education, which, in turn, promote and sustain economic growth.

Governments must ensure that adequate health care is accessible to the vulnerable populations. This should not be left to market forces. Similarly, Ministries of Health must also influence the policies of the other sectors that affect the health of these groups.

To meet the health needs of the vulnerable, special attention must be paid to micro-level interventions, clearly targeted to these population groups. Therefore, macro-level development strategies should provide policy and strategic direction and
ensure adequate resources for such micro interventions.

On our part, I can assure you that WHO will continue to work in close partnership with development institutions and donors. It will strive to ensure, through partnerships, that the most vulnerable groups have access to basic health care.

As the Organization of its Member States, WHO can help ensure global and regional consensus on the health aspects of poverty alleviation and facilitate exchange of information and experiences among countries. As a specialized agency of the United Nations, WHO can help provide a technically sound basis for health development globally.

We should not consider improving the health of the poor, women and indigenous people as just another routine task. We have to decide whether we continue business as usual, making little difference to the lives of the vulnerable and underprivileged. Or, whether we face up to the challenges of meeting their health needs with renewed commitment and innovative strategies. The choice, I feel, is quite clear. We cannot let them down.
Chemical Safety

CHEMICALS have become a part of our daily life. The important role played by chemicals in both industrial and agricultural development in Member States of our Region cannot be under-estimated. The use of chemicals is critical in preventing and controlling diseases, in increasing agricultural productivity and in the storage and preservation of food. It is estimated that worldwide some 100,000 chemicals are in everyday use and that over 40,000 of these are used in commercially significant quantities. The type and extent of chemicals used in countries vary widely depending on the level of industrial development and the extent of agricultural use. Furthermore, the chemical scenario is constantly changing as new chemicals and formulations come into the market in place of the old. While the benefits of chemicals are incalculable, we cannot, however, ignore the fact that many of these chemicals may, especially when misused or mismanaged, endanger our health and poison our environment.

An increasing number of new substances, growing production, storage, handling, transport, use and disposal of chemicals, all add to the potential for harmful exposure to man and the environment through accidents or incidentally at work and in the home. Hardly a day goes by when the media does not report some accident or poisoning from chemicals. While most chemical accidents are minor, these are becoming more frequent. Occasionally, there is a major chemical disaster such as the one which occurred in Bhopal, India, in 1984 when methyl isocyanate was released accidentally. This resulted

Regional Consultation on Promotion of National Chemical Safety, Bangkok, March 1998.
in thousands of deaths and disabled many for life. Then there was the chemical explosion and fire in the Klong Toey Port area of Bangkok. It is not only the workers handling chemicals who are at risk but also the community at large. We may be exposed in our homes through misuse or by accidents and contamination from consumer products, including our food. A few years ago, mislabelling of a chemical product resulted in the death of a number of children in one of the countries of our Region when they ate biscuits containing sodium nitrate instead of baking powder. Such incidents have caused grave public concern and demonstrated the urgent need to protect human health from the adverse effects of chemicals.

Chemical safety, that is to say, the control of chemical hazards and risks, is critical if the growing use of chemicals is to be beneficial and not catastrophic for human beings and the environment. The safe production, storage, use and final disposal of chemicals are often seen, mistakenly, as a problem of highly industrialized countries. Consequently, adequate safeguards to protect health are often neglected. However, with the growing international trade in chemicals and especially the rapid industrialization of countries in the Region there is also an enormous increase in the use of chemicals without adequate knowledge of their effects on human health and the environment.

The problems of controlling chemicals are especially difficult in countries where national laws and regulations are generally inadequate to control the manufacture, importation, registration, labelling, packaging, marketing, transport, storage and use of chemicals. The problem of disposal of obsolete chemicals such as certain pesticides as well as hazardous chemical wastes pose enormous challenges to chemical safety not only in countries of South-East Asia but worldwide. In addition, the growing problem of transboundary movement of hazardous wastes into developing countries of the Region calls for effective management of toxic chemicals and hazardous waste in our countries.

Few countries in the Region have comprehensive chemical safety programmes and the safe use of chemicals is usually given a low priority. The public is generally unaware of the dangers to health and the environment of over-exposure and misuse of chemicals. Few governments have adequate policies and programmes which ensure the sound management of chemicals from ‘cradle to grave’. Nevertheless, the growing number of chemical accidents in the Region have recently brought about a realization in governments that they
need to develop and strengthen their infrastructure and capabilities to effectively deal with health risks posed by chemicals.

Unlike many other health service programmes, the promotion of chemical safety to safeguard human health is a complex endeavour. It requires coordinated interaction and cooperation among a large number of ministries and agencies, the private sector, nongovernmental organizations and others to effectively deal with various facets of chemicals management. This obviously calls for concerted partnerships at different levels to ensure that chemicals are safe and beneficial to human development. As the 21st century approaches rapidly, the effective management of chemicals for health and well-being of all peoples in the Region poses a major challenge that needs to be met urgently.
Health, Environment and Development

The WHO South-East Asia Region is where a quarter of the world's population lives on one-twentieth of the total land mass. Thus, population pressures and the resulting strains are not alien issues to us. Further, more than a third of the world's poor and one-half of the world's total burden of diseases are the unfortunate legacy of my Region. If our estimates are right, given the present urban growth rate of 4-5 per cent, our cities will be home to half our regional population by the year 2010.

In the urban areas of the Region, a third of the population lives in slums, and are subject to insanitary conditions, traffic and industrial pollution which impact seriously on health. Poorly planned and unsustainable development activities have resulted in increased pollution and outbreak of diseases, due primarily to the neglect of proper water and waste management. Most of our cities have less than 10 hours of municipal water supply per day, and in many of our cities hardly 60% of the garbage is regularly collected. Man-made ecological changes and deforestation have exposed large populations to new infections, occupational hazards and serious health risks. The Indonesian forest fires, and the outbreak of plague

in Surat, India, are very real reminders of imminent danger that lurk in the environmental domain. The extent of human deprivation in the Region, and particularly in the South Asian subgroup is colossal. About 260 million people lack access to even the basics of health facilities; 337 million lack safe drinking water; 830 million have no access to basic sanitation facilities; more than 50% of the adults are illiterate; half the children are under weight, and over 400 million people go hungry each day. Some call it the most deprived Region of the world. Indeed, the link between health, environment and development is apparent in no uncertain terms. And as countries pursue their policies of modernization and industrialization, the issues of the environment become the key areas which will have to be tackled forcefully in the next century.

As a task manager of Agenda 21, WHO’s efforts are primarily focused on the protection and promotion of human health. However, other areas of the Agenda are equally important and challenging. For instance, water quality and supply, as specified in Chapter 18, underscores the multisectoral nature of water resources development in the context of overall socioeconomic development. The utilization of water resources by a multitude of development sectors have made planning for programmes a highly complex task. Similarly, the management of the other issues also requires a concerted effort by all development sectors.

As many of the distinguished ministers here would be aware, WHO’s efforts as task manager were initiated in early 1993 with the formulation of the Global Plan of Action for Health and Environment. Subsequently, in the South-East Asia Region, we prepared a Regional Strategic Plan for Health and Environment later that year, and national-level health-and-environment efforts were initiated in 1994. This was the first step to give a new emphasis and adopt a new approach to addressing health issues arising out of the economic development process in the Member Countries. The essential focus was on such health concerns being recognized by other development sectors as critical setbacks for sustainable development, and addressing them in national development plans. The key health-and-environment issues in the Region are water and sanitation, solid and hazardous wastes, indoor and outdoor air pollution, food safety, housing and chemical safety.

Now, four years later, eight countries in the Region, namely Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand have taken the first steps in this process of country initiatives.
Efforts to incorporate health concerns in sustainable development plans have been the focus of health and environment initiatives undertaken in these eight countries. This has involved intersectoral consultative meetings and workshops, preparation of reports on national health concerns by national consultants, setting up of coordinating committees on health-and-environment matters, determining priority action areas to be addressed, and development of action plans. I am happy to state that all these countries have carried out an in-depth situational analysis of their environmental concerns, while five of them have actually drafted their national health-and-environment plans of action.

A recent milestone in our regional efforts at promoting the initiative was a Regional Consultation on Health and Environment held in Maldives just two months ago. The meeting reviewed the progress made so far in the Member Countries and endorsed a "Framework for Action on Health and Environment: The Next Steps". It sets out the key steps that the countries of the Region should take over the next few years. These steps relate to preparing national plans of action, strengthening intersectoral coordination, reviewing and strengthening institutional capacities, updating legislation and promoting action at the local level.

We are aware that formulating national plans of action for health-and-environment is only a small step in a long process. Translating these into working protocols would require more intensely-focused efforts on the part of the health sector to interact with other sectors. We will have to move out of the comfortable confines of our sectoral ministries and agencies. The nature of environmental health concerns is complex and their determinants multi-sectoral. We, in the health sector, must become the advocates for health, venturing out to work in close partnership with others.

The recent adoption by the Health Ministers of our Region of the "Declaration on Health Development in the South-East Asia Region in the 21st Century" would assist our moves in this direction, for it endorses health sector reforms, formulating healthy public policies, and strengthening existing partnerships and forging new ones for health development.

At the operational level, the Healthy Cities concept is a very appropriate application of the health-and-environment principles. It espouses the idea of joint planning and cooperative management. It also emphasizes that health is indeed everybody's business. The Healthy Cities projects, already coming up in Bangladesh, India, Indonesia, Nepal, Sri Lanka and
Thailand, demonstrate the intimate linkages between the health and other sectors like urban development, housing, industry, transport, energy and, social welfare.

These initiatives underscore the need for a more diverse capacity building in ministries of health, as well as for countries to review and adapt their structures and managerial systems to meet the changing needs of society. What steps are we willing to take to accommodate these changes by way of re-designing our systems and managerial mechanisms? What changes in our parochial mindset are we willing to accede? And what structural changes in our governance are we willing to allow? These are only some of the questions that must be answered for us to be truly able to move forward with workable and sustainable solutions.

To my mind, the only way to tackle the multitude of complex issues, which see us, is to work in partnership. This is no easy task, but is essential in an era of growing interdependence and resource sharing. In our Region, I am happy to note the commitment of many enlightened health visionaries who take a holistic view of health as an integral part of development, who have unflinching faith in community participation, and who have the courage of conviction to bring about the necessary political change to make health everybody's business.

Talking of collaboration, I would like to refer to the partnership that we would like to develop with your Region. I am fully aware of the excellent work that your centre, CEHA, is doing in promoting environmental health in this region. SEARO has been collaborating with CEHA over the past couple of years in the exchange of information on various related matters. I would indeed like to strengthen these exchanges so that inter-regional linkages can be further enhanced.

While we do not have a Regional Environmental Health Centre as such in SEAR, we are, however, ready to share with you the field experiences we have in the areas of healthy cities, and promoting the health-and-environment initiative in our Regional countries.

These are just some of the experiences from my Region that I hope might be useful to the deliberations at this meeting. I am indeed very happy that I have got this opportunity to learn from you and take back your wisdom. Our efforts are obviously for the common good of all those who inhabit this global village.
Occupational Health

The issues of occupational health and safety, particularly those pertaining to the informal sector and small-scale enterprises, should be of increasing concern to every government - this is not only for their impact on health but also for the economic loss suffered by countries due to occupational injuries and diseases.

It is estimated that 100 million workers are injured and 200,000 die every year due to occupational accidents throughout the world. Another 68 million to 150 million people contract occupational diseases. Such high figures have a severe impact on the health status of the global population. Furthermore, occupational injuries and diseases are more pronounced in developing countries, which are home to 70 per cent of the working population. They also have a profound impact on national economies and on productivity. According to a recent estimate, the cost of providing health services to those affected range between 10 and 15 per cent of the total gross national product of the countries.

The risk and exposure to work hazards are much higher in the informal sector than in others. The absence of relevant legislative, administrative and technological provisions for this sector in most developing countries seems to be the primary contributory factor.

For many years, WHO, in close collaboration with UN sister agencies and other national and international partners has been advocating promotion of workers' health as one of its mainstream activities. In fact, its global strategy for occupational health for all stipulates that protection and promotion of health of the working population is a fundamental right of
each worker towards achieving the highest attainable standard of economic, physical, mental and social well-being.

With this as its ultimate goal, WHO has been supporting national efforts in formulating national policies and strategies. The development of relevant legislative and administrative provisions and strengthening occupational health services have been the focus of such collaboration. Health manpower development, promotion of research activities, and development of inter-sectoral collaboration and partnership have also been given due attention.

Recently, WHO has supported several important activities in the Region having a direct bearing on occupational health. An international symposium held in Thailand considered research and practical approaches relevant to occupational health in small-scale enterprises. The meeting of the South-East Asia Advisory Committee on Health Research held in Nepal in 1996, also discussed extensively the issue of strengthening occupational health research.

Most recently, the Fourth International Conference on Health Promotion, held in July this year in Jakarta, came out with a far-reaching declaration on health at the worksite. It is recognized as one of the important areas requiring urgent promotional and educational focus in the coming years.

The focus of all these national and regional undertakings has always been on the informal sector and small-scale enterprises where occupational risks and hazards are most prevalent and yet health services are the least developed.

With rapid economic development, globalization and privatization, the informal sector and small-scale enterprises are further expected to grow in almost all countries of the Region. Therefore, there is an urgent need for concerted efforts based on sustainable and transparent partnerships at all levels, to deal with health problems of the fast-growing informal economies, particularly in developing countries of the Region.
Health and Environment

At the United Nations Conference on Environment and Development held in Rio de Janeiro five years ago, world leaders expressed in no uncertain terms that environmental degradation adversely affected health. They also recognized that maintenance and improvement of health must be the primary concern in national development. The Rio Conference's Agenda 21 emphasizes that investment in human health and the living environment is the essence of development action. Since this global event, health has come to be seen in a broader perspective of total human well-being and not merely the absence of disease.

The recent UN Special Session, which met to assess the progress of Agenda 21, highlighted the fact that there was much left to be done to implement actions to attain sustainable development. Environmental deterioration goes on unabated, and so does the neglect of the basic health and well-being of people. Being here today in this beautiful and clean environment, we might tend to forget for a moment the enormous environmental degradation that has taken place and continues in other parts of our Region. Let me, however, mention just a few of the problems which affect a large number of people in our Region.

Despite the efforts made to develop water supply and sanitation during the last 20 years, it is estimated that almost

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Regional Consultation on Health and Environment, Malé, Maldives, October 1997.
a quarter of our Region’s population does not have access to adequate water supply, and over three-quarters of the people lack sanitation facilities. The problem of drinking water quality is becoming a major health concern as water sources are getting increasingly contaminated with chemical as well as microbial pollutants.

Cities in our Region are growing at an alarming rate. At the current average annual growth rate of 3.5 per cent, it is estimated that in about 20 years, close to half of the population will be living in urban areas. Even more alarming is the fact that a quarter of this urban population will be living in unhealthy slums.

Most of our cities are unable to keep pace with the growing population. Today many of our cities cannot provide adequate water supply. Most have less than 10 hours of supply per day, and, worse still, the water is of dubious quality, not entirely suitable for drinking. Garbage is collected and dumped haphazardly, providing excellent opportunities for disease vectors to breed. In some of our cities hardly 60 per cent of the garbage is collected. Sewage, if collected, is untreated and often allowed to flow into streams. In fact, most rivers in our Region are now open sewers, posing enormous health risks, particularly to the poor who are often obliged to use this polluted water source for their domestic needs.

Due to traffic congestion and industrial emissions, the quality of air in our cities is increasingly deteriorating. One only has to breathe the foul air in the capital cities of some of our countries to realize the seriousness of the problem of air pollution. While many of our well-off citizens can get away from the harmful effects of wastewater and garbage, there is no escape from the air pollution in cities which affects the rich and the poor alike. We also know from the recent ecological disaster created by forest fires in Indonesia, that air pollution, like epidemics, does not respect national boundaries and can affect the health and well-being of countless people across borders as well.

In rural areas, rampant deforestation and land degradation have taken a heavy toll, especially among the poor, who have been forced to move into city slums in order to eke out a living. These ecological disturbances have displaced thousands of rural people, exposing them to infections, occupational hazards and other serious health risks.

All this environmental degradation takes an immense toll in human suffering and deaths each year in our Region. In 1995, for instance, some four
millions of deaths were caused by acute respiratory infections, tuberculosis, diarrhoea and malaria. Dengue haemorrhagic fever has become a leading cause of hospitalization and death among children, with 400,000 cases and 8,000 deaths reported in 1995 alone. All these deadly diseases are related, in varying degrees, to environmental degradation which could be controlled through concerted actions by governments, communities and individuals.

I have highlighted the ever-increasing deterioration and indiscriminate destruction of our ecosystem because it poses unprecedented challenges to existing public health concepts, policies, strategies and actions. This not only calls for a new orientation of health and social services but also for new strategies and effective action. Unless the health sector can build up a strong political and social front for orderly and sustainable economic development in our countries, the public health gains achieved so far would go waste.

In 1992, WHO was given the mandate of advising and supporting countries in implementing Chapter 6 of Agenda 21, which deals with the protection and promotion of human health. Consequently, WHO launched a series of Health and Environment Initiatives in the countries of the Region in order to assist the health sector to work together with other sectors in addressing health hazards that arise from the development process. These initiatives strive to generate national health and environment action plans that incorporate this multisectoral responsibility. The ultimate goal, of course, is to reflect these actions in the overall national development plan or, as some may like to call it, the National Agenda 21. This must be further translated into actions in local settings using such approaches as Healthy Cities, Healthy Villages, Healthy Islands and Healthy Tourism, to name a few.

Much progress has been made in the Region towards integrated planning for health and the environment. Detailed analyses of health and environment conditions have been conducted and priority areas of action identified. Despite the uniqueness of individual country situations, a number of issues and concerns emerge which are common to virtually all the countries.

The nature of the environment and development problems which the Region now faces pose a serious threat not only to human health but to the health of the entire ecosystem. The situation has reached crisis levels and urgent solutions and actions are required.
To my mind, the health and environment issues facing the Region, and indeed the world over, can never be resolved without the concerted, active and responsible involvement of all sectors in the development process. I feel that this consultation is indeed very timely to review the progress made so far and share experiences in order to chalk out the next steps for implementing national actions. A framework of actions that will be discussed at this meeting will, I hope, provide the right direction to operationalize these actions to address the health situation at the country level.

A new health perspective has emerged whereby the overarching nature of health in sustainable development requires concerted action by all sectors of society. The coming century calls for a new health system where the health sector must serve as a guide and be a proactive partner in protective actions so that health concerns are represented appropriately at all stages of economic development. It is clear that better health is achievable in all communities and countries burdened with high levels of disease and death. However, better health is not an automatic outcome of economic growth. It requires guiding policies and active contributions from government agencies, commercial enterprises and the communities to secure the highest level of health with the resources available. Protection from environmental health hazards is a key element in such policies and actions.
The intricate and intimate linkages between the three vital constituents of human development, namely Women, Health and Environment are well recognized.

During the past decade, and especially over the last five years, the critical interconnected issues related to these three important areas have been widely discussed and debated at various levels.

At the United Nations Conference on Health and Development, held in Rio de Janeiro in 1992, it was expressed in no uncertain terms that environmental degradation adversely affects health. While we have ample scientific data to substantiate this fact, we only have to look around us as we go by in our daily lives, to realize how true it is.

In urban areas, slums, insanitary conditions, vehicular and industrial pollution, among others, have become permanent features of everyday existence, impacting seriously on health. At the same time, in rural areas, deforestation and land degradation have taken a heavy toll, especially among the poor and the disempowered. Unsustainable development has resulted in pollution and outbreaks of diseases, aided primarily by the neglect of proper water management. The ecological changes and deforestation have exposed people to new infections, occupational hazards and serious health risks.

There is increasing evidence today that those who suffer most from such environmental hazards are women.

Regional Conference of Parliamentarians on Women, Health and Environment
Bangkok, August, 1997.
The harrowing tales of women trapped by poverty, hard labour, disease and disability speak for themselves. And yet it is women, who have proved time and time again that, given the opportunities, they can indeed emerge as the most effective agents of change to make the world a safer, healthier and happier place for all. As the Rio Conference pointed out - women have a vital role in achieving sustainable development.

There are numerous examples at women, equipped with the skills and power to negotiate and act, effecting far-reaching changes benefiting not only themselves and their families but also whole communities. For example, women have been known to take up strong leadership positions in promoting, what could be termed, environmental ethics, in minimizing waste and excessive consumption, and in protecting forests. Their largely untapped energies must, therefore, be harnessed.

The participants at the Fourth World Conference on Women, held in Beijing in 1996, proposed that governments at all levels ensure that opportunities be provided for women "to participate in environmental decision-making at all levels, including as managers, designers and planners, and as, implementers and evaluators of environmental projects." This recommendation is particularly relevant for the South-East Asia Region. Women In our Region, I am pained to say, suffer greatly from the gross inequities in access to health and well-being. They also have low participation in environment-related programmes. At the recent Regional Conference on Health Development in the South-East Asia Region held in this city, a declaration was drafted by the participants, who included some ministers of health. It underscored the close linkage between women's status and the development process. It is evident, therefore, that a foremost challenge is reducing gender inequalities and mobilizing efforts to involve women for sustainable development.

As parliamentarians, I am sure, you feel as strongly about these issues as I do. But there is no room for despair. I have seen and heard of some heartening reports and stories about women of our Region. In the pursuit of sustainable development, they have increasingly displayed exemplary courage and innovative action to fight against all odds, including powerful commercial interests and culturally suppressive elements. What we must do now is to promote and support such efforts.

Let us be honest and ask ourselves if we have systematically examined this
Striving for Better Health in South-East Asia

opportunity? Or have we continued to accept the old myth that a woman’s role as wife, mother, daughter and sister cannot be compatible with that of a nation builder?

To my mind, the environment issues facing the Region, indeed the world, can never be resolved without the active involvement of women, comprising nearly one-half of the total population. I would, thus, go to the extent of saying that women have an equal, if not a greater, role in development. But women must be empowered to play that role effectively.

As parliamentarians, I have no doubt, that you are sensitive about this. And as women parliamentarians, even more so.

This is not the first time I am addressing a meeting of parliamentarians of this Region. In this very city one year ago, I had, in collaboration with the International Medical Parliamentarians Organization, the privilege and honour of addressing parliamentarians on Health and Development. It was with great pride that I realized that we have some of the finest parliamentarians of the world in our Region. Your vision and determination were most aptly reflected in the Bangkok Call to Action delivered at the end of that meeting. I was most impressed with your deep understanding of the issues involved and your commitment to resolving them. I know some of you have already initiated some of the actions that you planned after that meeting. The present conference will, I trust, help take your initiative further.

The Framework of Action that will be proposed at this meeting will, I hope, provide the right direction. It must take into account, the fact that gender issues cannot be completely addressed unless they are brought into the mainstream of all development programmes, whether they relate to the health, education, the environment or any other sector.

We do not have much time. The world, as you know, seems to be moving faster every day. Soon, the next century will dawn upon us. We cannot afford to be complacent - every day counts, even every minute.

At the same time, however, I do realize that now policies are not easy to formulate. Nor are new laws easy to frame. These cannot take place overnight. But what can take place almost right away is the translation of your deep concern into expeditious action. The success of this meeting will be measured by how much and how well the adopted framework is put into action in the countries. I am sure we will not let each other down. Let us,
then, use our renewed sense of concern and commitment to forge ahead.

I hope we are able to share the experiences of our success very soon. Even a prompt and sound beginning is an important measure of success. I am confident you can do it.

The issue of Women, Health and Environment is all about intersectoral partnerships. And this implies the involvement of all government sectors, nongovernmental organizations, private enterprises, and the people.
ABOUT one-fourth of the world's population, i.e. 1.4 billion people, lives in the ten Member States of the WHO South-East Asia Region, which have only 5 per cent of the total land area. In just 15 years (1980-1995), the Region's population increased by 35 per cent. Despite the actual decline in population growth rates in most SEAR countries, during the next 15 years (1995-2010) another 380 million people are expected to be added to the total. The decline in the crude birth and fertility rates, along with the increase in life expectancy, have also resulted in demographic changes such as the progressive increase in the number of the elderly.

The pace of health development in the countries of the South-East Asia Region varies. However, the overall health scenario has changed for the better in recent years. The infant mortality rates have decreased in some countries, life expectancy has increased, and some headway has been made in reducing death and disability from some communicable diseases. A few of the age-old diseases like poliomyelitis, neonatal tetanus and leprosy are on the verge of eradication or elimination.

We are on the verge of eradicating polio from our Region in the next few years. In this context, we recorded an achievement which is unprecedented in human history: by forging partnerships with several health and related sectors and institutions, nearly 250 million children were immunized during the

Health Development in South-East Asia Region: A New Vision for a New Century, Bangkok, June 1997
National Immunization Days at the end of last year. This unique event confirmed our belief that virtually nothing is impossible in health development if we are determined and make earnest efforts to mobilize all our resources.

Despite these achievements we still face many health challenges. Acute respiratory infections continue to be the leading cause of mortality in young children, accounting for more than 30 per cent of the deaths among children under five years of age. The burden of tuberculosis in the Region is immense; it still kills more adults than any other single infectious disease. Malaria, which had almost disappeared in the 1970s, has reappeared. In addition, new diseases such as cholera, caused by the 0139 strain, and HIV/AIDS have emerged.

As countries in the Region witness rapid industrialization and urbanization, diseases prevalent in more developed countries are now taking hold. Noncommunicable diseases like cardiovascular and cerebrovascular ailments, cancer and diabetes are becoming major causes of morbidity and mortality. Accidents, injuries and domestic violence are rapidly increasing. Substance abuse and mental disorders continue to be of serious public health concern in several countries. Compounding the problem is the spread of the HIV infection through drug injections and unsafe sexual practices.

Thus, the process of epidemiological transition and the resulting double burden of noncommunicable and communicable diseases are stretching the resources of the countries in our Region. Poverty, malnutrition, population increase, environmental problems and unhygienic living conditions need to be addressed strategically. Equity in health, health security and accountability and partnership for health need to be enhanced. Women's status, which has not improved significantly in most countries, and maternal mortality rates, which are still unacceptably high, need to be addressed appropriately.

As we stand on the threshold a new century, rapid changes are sweeping across the world in all spheres of life. There are widespread economic reforms and political, social, and cultural changes which will certainly have a bearing, both positive and negative, on the health and quality of life of the people of our Region. The unfinished health agenda, the double burden of diseases, the emergence of new infectious diseases, compounded by the changing lifestyles, threaten to undermine the health gains achieved so far. The consequences may seriously
impede both economic and social development.

These profound complexities face us as we move into the 21st Century. They force us to look more broadly, create a wider base for appropriate health policies, strategies and actions keeping in mind our regional priorities. Indeed, the very essence of this conference is to examine ways and means of responding to all these challenges.

While health for all and the primary health care approach has remained the mainstay of health development, we have learnt many lessons during the past twenty years. To translate those lessons into action, we need to examine the issues from a wider perspective and in the context of the emerging scenarios. Prior to this conference, WHO convened a series of meetings on the following themes: Regional Health Scenarios, Now and By the Year 2025; Challenges to Health Development in the South-East Asia Region; Developing Partnerships for Health, and Health Development in the South-East Asia Region in the 21st Century. A meeting was also organized to draft a declaration on Health Development in the South-East Asia Region in the 21st Century. We appreciate the valuable contributions made by some of you who participated in these meetings.

Before concluding I wish to share with you some of the cardinal principles on which the vision of WHO is based:

• We are committed to equity, ethics and social justice and hold them as fundamental to the pursuit of health for all.

• We recognize access to quality health care and services as a human right and we commit ourselves to that principle in spite of the economic uncertainties.

• We visualize that health should be seen as a public concern, which requires public spirit and private initiative to complement government endeavours so that the common goal of health for all can be reached.

• Finally, we also accept that while governments and NGOs are playing their part, it is time to mobilise people’s participation and forge new partnerships for health. We see no other choice but to join and work together for health development.

I hope that this conference will be able to arrive at a consensus on re-affirming our commitment to health development and the attainment of better health by our peoples. I also hope that we will be able to suggest
the ways and directions which the Member States and WHO may follow in the future.

We expect that the regional health declaration will be endorsed by the Ministers of Health of the countries of the Region when they meet in August this year. It will act as beacon to guide us in developing a health policy and strategy in the next century. It will also serve as a significant input from our Region to the formulation of a Global Health Policy and Strategy.
Arsenic Contamination of Groundwater

The media has described the recent arsenic contamination of groundwater in large parts of the Indian state of West Bengal and the adjacent Bangladesh as “the biggest arsenic calamity in the world”.

Arsenic is a common chemical element in the earth’s crust. It is also one of the oldest poisons known to mankind. Through man’s exploitation of nature such as the extraction of groundwater for irrigation of crops, geothermal powerplants and mining operations, arsenic is being brought up to the earth’s surface where it has created serious contamination of the environment and has caused many mass poisonings throughout the world.

The present outbreaks of poisoning in West Bengal and Bangladesh, as those in several places in China, Taiwan and Thailand are the result of contaminated groundwater used for drinking. In other locations, such as Guizhou Province in China, the poisoning has resulted from the burning of coal with high arsenic content; in Japan from mining operations, and in the Philippines, from geothermal plant operations.

Besides these outbreaks in Asia, many more examples can be quoted from other parts of the world. All of them present lessons for mankind, underscoring the need for increased consciousness about health and environment in the utilization of natural resources for sustainable development.

While arsenic toxicity in India and Bangladesh does not appear to be a

Consultation on Arsenic in Drinking Water and Resulting Arsenic Toxicity in India & Bangladesh, New Delhi, April-May 1997
A typical case of pollution created by rapid industrialization, investigations to-date point to the overuse of groundwater for irrigation without regard for health and environmental consequences. No exploitation of nature’s resources should be allowed without proper planning based on sound scientific information. If, for instance, the surveillance of drinking water quality, which is being implemented now in some districts of West Bengal, with the assistance of the All India Institute of Hygiene and Public Health and UNICEF, had been in place earlier, it could have provided a warning much sooner.

To combat the present problems in India and Bangladesh as well as other locations, it is necessary that governments take the lead in undertaking timely action. Action is required not only by governments, but also by citizens’ groups, NGOs, medical doctors, scientists, engineers, etc. Everyone must join hands and work towards a solution as soon as possible.

A considerable amount of work has been done in India since the problem was identified in 1978. The Rajiv Gandhi Drinking Water Mission, under the Indian Ministry of Rural Development and Employment, completed a number of investigations and compiled water data. Investigations are still going on both in Bangladesh and India and will continue for some more time before a clear scientific basis is established for long-term comprehensive solutions to the arsenic problem.

There is as yet no known remedy for arsenic poisoning, but arresting further arsenic ingestion can prevent more people suffering from it. Although arsenic can be gradually removed from the systems of those who have been exposed to it, there is no guarantee that they will not develop cancer, later. Concurrently, with the immediate remedial measures to identify and treat the affected populations, access to safe, uncontaminated drinking water should be provided to those affected in both countries at the earliest.
New Medical Dimensions in the Next Decade

Science and technology are universally recognized as the basic factors influencing national development and prosperity. In our Region, for example, we can see that those countries which have accorded science and technology a high priority have achieved commendable standards of health and living. One of the main challenges facing us is how to make available the benefits of science and technology to the maximum number of people and thus improve the quality of their lives.

Scientific and technological advances, industrialization, socio-economic development, improved communication, better hygiene and increased food intake have helped in increasing life expectancy and in reducing mortality rates. This is related to control of communicable diseases and improvement in nutritional status. Even though these problems are declining in many countries, noncommunicable diseases, traffic accidents, substance abuse and problems of ageing are becoming a serious concern. Thus the countries are suffering from a double burden of diseases as a result of epidemiological transition.

In the next decade, the current problems facing countries in the Region will increase. This will be as a result of...

result of the rapid population growth and substantial migration of people from less developed to more developed parts of the respective countries. The burden of disease will increase as a result of increasing environmental degradation. The threat of the emergence, re-emergence and spread of communicable diseases will continue as a result of increased travel and migration of people within countries and across international borders.

The three perspectives of Science
There are three perspectives with regard to the use of science. The first is to use science as the engine of social and economic development on the basis of research that creates knowledge and technology, and also supports the educational system. The second is the imperative of linking science to the development of public policy. Science must be used as the very basis for policy formulation, priority setting and formulating cost-effective approaches. Thirdly, science should be used to serve the needs of the underprivileged, remote and helpless population groups.

Technological Advances
Many technological advances have led to new diagnostic and therapeutic possibilities in medicine. Imaging technologies, new materials for internal or external prosthesis, laser technology, biosensors and silicon chips are some examples. Rapid developments have also taken place in information and communication technology. This allows effective gathering and utilization of public health information and the use of computational logic. Telemedicine is yet another advancement which is the result of these developments.

Today, many state-of-the-art technologies such as genetic engineering, microsurgery, medical imaging and custom designed drugs are becoming increasingly available. Highly sensitive and specific diagnostic tests have been developed as a result of breakthroughs in DNA technologies. The development of pocket-size test kits and dipsticks for field use in tropical countries for diseases like Cholera, STDs and other disease control programmes has been possible as a result of these advances.

In the therapeutic field, new drugs include those for leprosy and onchocerciasis. Genetic manipulation of plants has increased the yield and food production to meet the growing demands resulting from population increase. It is expected that the nutritional quality of food will also be improved through genetic engineering.
Collecting and collating comprehensive information about the need for health care provisions in different geographic, demographic or social sections of a community is difficult even in developed countries. Organizing the information in a form that makes it readily interpretable by the health system planners in developing countries is even more difficult. Advances in computer/human compatibility in analysis procedures in information displays and in methods of collaborative work are generally reducing the cost and improving the usability of computerized systems. This is also helping in extending the support that they can offer to the planners and other public health personnel. In combination with diagnostic software and other decision-support procedures, silicon chip technology may provide powerful hand-held devices to help paramedical personnel with primary care activities in the field. Utilizing satellite communication technology, it would become easy for field workers to transmit relevant data and to receive advice from experts in distant places.

New materials offer considerable potential in producing light-weight, external prostheses and other equipment as well as improved laboratory and diagnostic equipment. Also, rugs made from electrically charged fibres using electrets seem to have the ability to trap mites and dust particles that are thought to be responsible for chronic asthma. This can also be utilized for vector control. It will be possible to diagnose heart, brain, visual and audiological problems through the use of superconducting quantum interference devices also known as "squids". There are indications that robot technology will help make surgical procedures simpler, faster and more accurate.

Vaccine Research

Vaccine research has made great strides and many exciting developments are on the horizon. Vaccines for Hepatitis B, Haemophilus influenza B and other influenza viruses are some examples of success stories. Vaccines for cholera, malaria, TB and AIDS are under development. Research is ongoing for development of a cancer vaccine.

Technology development and use

In technology development, the expanded concept of essential health technology, including biotechnology; food and pharmaceuticals; telecommunications and information systems; and environmental technology are important factors deserving attention. The use of existing, cost-effective and appropriate technology; identification of interventions which are
promising but not used or which are just beginning to be used also need to be carefully reviewed. WHO recommends the adoption of the primary health care approach which includes the wide use of appropriate technology applied through people's cooperation.

While developed countries should be responsible for supporting the development and standardization of technology, the developing countries must mainly assume the responsibility for adaptation.

Capacity building for more effective partnerships in the transfer and use of such advances are a central feature of national development. WHO will continue to support developing countries through more effective partnership in the generation and utilization of advances that are relevant to the health of the people.

Role of National Governments and International Agencies

In most developing countries, a major part of the health services and resources are provided by the government. Until recently, there was no pressure to redefine the precise role of the Ministry of Health in the health care of the general population. In a climate demanding services of greater complexity and quality, questions are being raised as to the appropriateness of the government being the sole provider of health services. The entry of the private sector in health care is expected to lead to greater efficiency. This would make the consumer also more cost-conscious, thereby resulting in a better use of limited resources. However, this has the risk of inequitable distribution of essential public health services. There are also the issues relating to the escalation of costs and marginalization of the poor and the needy. Even with privatization the role of the government is not diminished. The role, in fact, shifts towards monitoring and regulation.

Health for All, Primary Health Care

The role of primary health care in achieving the goal of health for all is fully acknowledged and widely endorsed. This has accelerated the pace of implementation and also helped greatly in the achievement of various targets set by the Member countries. However, there are many shortcomings as well. These need to be addressed with greater vigour during the remaining years of the century. The renewal of the health for all strategy, revision of primary health care approaches, identification of essential public health functions and health sector reform, recommended by
WHO, are likely to yield even better results during the next decade.

Equity and ethical Issues
While taking full advantage of the developments and breakthroughs in science and technology, WHO and national governments should ensure equity in access to health care services through vigorous advocacy at policy and operational levels. In the advocacy for equity, it is important to take into consideration the issue of gender bias which is clearly seen in some countries of our Region. Sustainable human development must take into account all relevant factors, including environmental issues.

With the increasing capacity to diagnose disease, even at the preclinical stage, and the tools available for predictive testing, we are faced with a serious ethical, social and economic dilemma. With the conceptual boundaries between disease and non-disease getting blurred, there is an urgent need to develop a common language and arrive at a consensus, for example, on operational definitions of impairments, disabilities and handicaps and in distinguishing disease from health. Also, keeping in mind this scenario, it is important to ensure that the rich help the poor and that the healthy support the sick.

The ethical dimensions of research and science also require closer scrutiny. In this context, equity, fair distribution of health resources and health care deserve much greater attention. In a nutshell, health policies and health care must be ethics-linked.

Partnerships in Health and Development
Stronger links with sectors like education, agriculture and industry and with those concerned with environmental issues need to be established. Science can add significantly to the quality of life by providing an integrated life-cycle approach rather than an individual disease-centered intervention.
Similarly, a broader strategy will be required to bring about a shift from institution-based research and health care towards self-care and family care.

The importance of the interaction between the natural and the social environment is crucial and requires particular attention. Increasing industrial expansion and concentration, population growth and migration as well as environmental pollution are formidable challenges which need to be addressed collectively by the policy makers, scientists and WHO.

To face these challenges effectively during the next decade, the health sector needs to create a wider base for appropriate health action. Putting health on the agenda for intersectoral action will lead to better participation and a greater momentum for achieving societal goals based on equity and social justice. WHO will continue to provide technical support to the Member States in strengthening intersectoral coordination. These involve public and private enterprise, industry and NGOs, universities and academia. Examples of such partnerships are becoming commonplace and are best illustrated by the recent experience with National Immunization Days (NIDs), in several countries in an effort to eradicate poliomyelitis. The control of HIV/AIDS through the involvement of the education sector and NGOs is another example of effective partnerships. Yet another example is the proposal to encourage the healthy city initiative through cooperation between the ministries of Health, Environment, Home Affairs and Industry in collaboration with academia. In all these endeavours, WHO has played a key advocacy role.

The need for partnership in health policy development is vital. In the past, policy makers and researchers worked in separate worlds which led to suboptimal or even undesirable results. In a partnership between researchers and the government policy makers, both work together in formulating the questions, considering research approaches, examining the results and in formulating and implementing the policies. Further studies to examine how the policies are formulated, implemented and evaluated should be encouraged.

**Future Directions**

During the next decade, science and health policy will jointly have to address the issues regarding clean drinking water, sewage disposal and the need to control environmental pollution. Control of industrial ly-linked diseases, support devices for the disabled and the elderly; and reduction of traffic accidents are some other
areas where science and technology will play an increasingly important role. The issues relating to the development of better health indicators and for improved methods of screening sample populations for early signs of disease and/or incapacity will also need to be addressed.

Today, many state-of-the-art technologies are flooding the health care market. These are expensive and virtually inaccessible to those living under deprived conditions. The scientists and laboratories need therefore to show greater interest in developing appropriate and low-cost, high volume products, keeping in mind the very limited paying capacity of this under-privileged segment of the population.

It is important to realize that advances in science that are particularly relevant to health and social development can rarely be directly implanted in recipient countries. They need to be adapted, applied, absorbed and modified. In this regard, the local people and organizations, including NGOs, must be fully involved to ensure effective utilization of such advances. An example, is the polio vaccine, which is so successful in developed countries with a temperate climate but which requires an elaborate cold chain mechanism in tropical climates. The recommendation of administering several doses is clearly inappropriate in developing countries with weak infrastructures and poor accessibility. Research should be focused to evolve a heat-stable vaccine that will provide protection and require the least number of revaccinations.

The interaction between man-made and social/behavioural environments needs to be better understood through research and development. The purpose of this exercise would be to encourage people to live a healthy life despite all the negative, man-made and induced changes in the environment. Public health will need to be seriously concerned with the issues of environmental health. To combat such high risk complexities, it will be necessary to mobilize the entire scientific community and to urge governments to support and fully participate in the application of science to the global health and development problems. This will call for the utilization of all available and relevant scientific tools and intellectual resources to develop new mechanisms to effectively cope with the, dramatic developments. In this regard, I would like to assure you of WHO's continued support in strengthening trans-disciplinary programmes and actions on human health and development. Together, I am sure, we will be able to achieve our goal of health for all in the foreseeable future.
Looking back in history, one can see that a major shift is taking place in the impact on humanity’s health of the main factors, such as poor diet and ill-health, that have traditionally accounted for most of malnutrition. Over the centuries, the human species survived a hand-to-mouth existence on whatever it could manage to gather. The diet which fuelled most of human evolution was low in fat and very low in sugar, but high in fibre and other complex carbohydrates which constituted a natural balance of healthy eating.

Only in recent decades, as people benefitted from greater control of infectious diseases and better access to food, have research findings confirmed the well-founded suspicion that faulty dietary practices may promote the onset of several major chronic noncommunicable diseases (NCDs). Health problems such as coronary heart disease, various forms of cancers, diabetes mellitus, gastrointestinal disorders, and various diseases of the bones and the joints are diet-related.

Although many dietary and other factors have been investigated, those most frequently linked to such diseases are high consumption of energy-dense foods of animal origin and of foods processed or prepared with added fat, sugar and salt. As a result, on the eve of the 21st Century, moderate to severe overweight which warrants close attention, is becoming

According to WHO estimates, major non-communicable diseases today are responsible for at least 40 per cent of all deaths in developing countries and 75 per cent of all deaths in industrialized countries.

Symposia on Nutrition-Related Chronic Diseases, New Delhi, February 1997.
relatively common in industrialized as well as in many developing countries.

As we are all aware, obesity or overweight, together with smoking, stressful environment, excessive alcohol consumption and lack of physical activity form a group of lifestyle risk factors associated with increased morbidity and mortality from NCDs. Most NCDs are associated with economic development and the resultant lifestyles - particularly inappropriate diets and aging. In many cases, they are largely preventable.

According to WHO estimates, major NCDs today are responsible for at least 40 per cent of all deaths in developing countries and 75 per cent of all deaths in industrialized countries, with cardiovascular diseases (CVDs) being the leading cause of mortality, and cancer being the third. In addition, the increasing prevalence of diabetes has led to a large increase in related mortality. It is predicted that the number of people with diabetes may exceed 100 million by the end of the century. Thus, by 2020, NCDs are expected to account for about three-quarters of all deaths in the developing world.

In many South-East Asian countries data on diet-related NCDs are often incomplete and patchy, and may not be entirely reliable because of under-reporting coupled with deficiencies in case detection and recording. Despite these limitations, available data indicate that NCDs are emerging as the major cause of death in some Asian countries. For example, in India alone, nearly 800,000 people die from ischaemic heart disease and more than 600,000 from stroke each year.

In Indonesia, a 1992 household survey showed cardiovascular disease as the leading cause of death in 17.8 per cent of all deaths attributed to NCDs. While in Thailand, liver cancer is the most frequent malignancy among males with 8,000 new cases every year, lung cancer ranks second with 4,700 cases per year. Furthermore, diabetes mellitus has a prevalence of about 2 per cent and 3 per cent or more in rural and urban populations respectively.

Let me mention some paradoxical facts as well. While over 800 million people still cannot meet their daily basic needs of energy and protein, more than 2,000 million people are deficient in essential micronutrients such as iodine, vitamin A and iron. Further, an estimated 174 million under-five children in developing countries are malnourished, as indicated by low weight-for-age statistics. In addition, 230 million are stunted.

These different forms of malnutrition result in poor physical and cognitive
development as well as in lower resistance to illness, brain damage, blindness and death. More than half of the estimated 12 million deaths occurring annually among under-five children in developing countries are associated with malnutrition.

In addition to these preventable deaths and ill health, we cannot overlook the burden that diet-related chronic NCDs place on the health service delivery system. These emerging diet-related chronic NCDs are generally far more expensive to treat, require much longer treatment and carry highly costly implications for the health systems and economic development of countries.

Recognizing the existing as well as the expected magnitude of the problem of NCDs, WHO, at International Conference on Nutrition, held in Rome in 1992 identified diet-related chronic diseases as one of the priority areas for prevention activities. Therefore, there is an urgent need for vigorous implementation of appropriate cost-effective preventive measures aimed at controlling dietary errors and excesses, and the promotion of healthy lifestyles.

This is an opportune time to draw on the expert technical advice available, to develop strategies and activities for the prevention and management of these diseases as well as to provide Member States with up-to-date technical guidance.

I hope that the participants will review the current epidemiological information and make recommendations for developing public health policies for the prevention and management of these emerging regional public health problems. I also hope that they will examine the impact of health consequences on development and identify the issues which need further research.

Diet-related chronic noncommunicable diseases put a severe burden on health services and are already the leading cause of death and disability in several countries of the South-East Asia Region. With increasing life expectancy, urbanization, and changing lifestyles, this alarming situation is bound to become even more severe in the years to come. It is for these reasons that it is necessary for us to take comprehensive and multi-faceted preventive actions in order to promote healthy nutrition for all people. These preventive activities, in order to be effective, should be based on scientific evidence and must be feasible, cost-effective and sustainable.
Science and Health

SCIENCE and technology are universally recognized as the basic constituents of national development and prosperity. Countries which placed science and technology on their development agenda have achieved very high standards of living. As we stand on the threshold of a new century, one of the main challenges is how to make full use of science for improving the health situation of our people.

While we have been trying to find ways and approaches to lessen the burden of disease in our Region, I believe that we have not yet taken full advantage of all the resources that applied science has to offer. Diseases linked to poverty and poor nutrition, as well as communicable diseases are cases in point. The optimal harnessing of appropriate technology, the development of human resources, health promotion and the building of infrastructure for science and technology, also remain part of our unfinished agenda.

I visualise three perspectives with regard to the use of science. The first and the most obvious is the use of science as the engine of social and economic development, using the research base that creates knowledge and technology, and also supports the education systems.

The second is the imperative of linking science to the development of public policy. The main thrust of our advocacy with decision-makers in the countries would be to emphasize the need to use science and technology as the very basis for policy formulation, priority setting and for formulating cost-effective approaches.

The third perspective is the most forgotten, but to my mind, critically

Most importantly, we need to find ways of making the fruits of scientific developments available and accessible to all people, at an affordable cost.

important - and that is, the use of science as an instrument to serve the needs of the less privileged, remote and helpless groups of the population.

Most importantly, we need to find ways of making the fruits of scientific developments available and accessible to all people, at an affordable cost. The moral, particularly for health, is that science has to be an active partner at all levels of health development. It is time that science came out of the laboratories and the classrooms to where the people are and helped them improve their lives. It is unfortunate, but true, that many of the more marginalised populations are the last to benefit from the answers to health problems that science has given us.

Today, many state-of-the-art technologies, such as genetic engineering, micro-surgery, medical imaging, and custom-designed drugs are invading the health care market. These are expensive and inaccessible to most of our people who live under deprived conditions. Too often, those who have access to such technology pay little attention to its selection and rational use. I feel concerned that often scientists and technologists frequently show little interest in developing appropriate, low cost, high volume products.

Therefore, it is fundamental that we examine the relevance of the breakthroughs of modern science and technology in terms of costs, and the real benefits that these could bring to the majority of the population.

I would now touch on another but somewhat related aspect of science which I consider crucial - its ethical implications.

We have long been familiar with the ethical dimension of research involving human subjects. Today, all countries in our Region have established mechanisms for ethical oversight of their research. But we need to extend this to other areas of public health too, such as equity, fair distribution of health resources and health care. We need to adopt measures that would lend leverage for ethics-linked health policies and health care. I recognize that all this is not easy to achieve in the market and technology-oriented world of today but if we undertake it with the seriousness it deserves I am confident that we will succeed. In this regard, we recognize WHO’s responsibility to promote a genuinely open dialogue involving all partners concerned to foster health development in a spirit of respect, equity and solidarity.

Given these possibilities, let me re-emphasize my concern that we are still not making the best use of the potential of available science for health
development in our Region. We are sometimes also getting bogged down by unclear goals and strategies. We are not managing our Research and Design institutions imaginatively and efficiently to advance and utilise science and technology for health development in the best possible manner. We must recognize the critical role of science, respect it, support it and use it for the common good. We must constantly remind ourselves that science is an essential instrument for health development in an environment of uncertainty and hope.

I hope this Conference will generate the commitment to draw appropriately from the remarkable developments in science and technology so as to improve the health status and the quality of life of the peoples of our Region. I am confident that out of these deliberations will emerge the agenda for the judicious application of the fruits of science for health development in the 21st Century.

As always, we at WHO stand ready and committed to work with all of you to achieve our common goal. Let us consider the challenges of the 21st Century as real opportunities for better application of science towards achievement of better health in the Region.
Social Change and Mental Health
MORE than a decade ago, in Ottawa, the public health community opted for an alternative approach to health delivery. This was in the face of ever-increasing health costs when better ways to create, maintain and protect health were being sought. Public health practitioners were looking for new ways to support healthy lifestyles and create supportive environments for health. The outcome of the First International Conference on Health Promotion widely known as the Ottawa Charter for Health Promotion, carried forward the spirit of the Alma-Ata Declaration and set the direction for health promotion.

The era of health promotion has notably developed since the First International Conference on Health Promotion. This Conference was followed by others which explored the major themes of the Ottawa Charter. In 1988, the Adelaide Conference focussed on healthy public policies; and the Sundsvall Conference held in 1991, was on supportive environments for health. The Fourth International Conference on Health Promotion, held in Jakarta in 1997, was on the theme of “New Players for a New Era: Leading Health Promotion into the 21st Century”. Health promotion is one of the most viable processes to ensure equitable health development. It can be a very effective preventive measure for a large number of human illnesses, whether it is mental health, cancers or others.

Keynote Address at the International Union For Health Promotion and Education: SEARB Conference on “Health Promotion and Education: Meeting Millennium Challenges”, Mysore, April 2000.
human illnesses, whether it is mental health, cancers or others.

In 1977, the world set for itself the visionary goal of Health for All by the year 2000. Through the Primary Health Care approach, coupled with a strong determination, the ten Member Countries of the South-East Asia Region have made significant progress towards sustainable development. Today, from its rudimentary form in the 1950s, the Region can boast of a public health service network reaching even the remotest parts in some countries. Access to water and sanitation facilities has improved considerably while health literacy has seen a marked improvement.

As a result, the infant mortality rate has decreased significantly, from an average of 125 in the late 1960s and the early 1970s to 57.8 in the late 1990s. Although the levels of maternal mortality in some countries are still undesirably high, there has been remarkable improvement in most countries. Life expectancy at birth has risen from 41.1 years in the 1950s to 61.6 years in the 1990s.

In the United States of America, the prevalence of cigarette smoking among adults decreased from 40 per cent in 1964 to 23 per cent by 1997 due to strong promotional activities to combat tobacco use by various stakeholders. Not to mention all success stories of health promotion in the past and the current activities in our Region, tremendous progress has been made towards the eradication of poliomyelitis, guineaworm and yaws, and elimination of leprosy and neonatal tetanus; nevertheless, we still face formidable health challenges. I shall mention only a few. Despite the significant achievements in the control of communicable diseases, countries of the Region are faced with an unparalleled challenge of new and emerging infectious diseases. HIV/AIDS, drug-resistant malaria and tuberculosis are major causes for concern. The steady spread of HIV/AIDS, in particular, has the potential to offset the hard-won gains in child survival and life expectancy.

The second challenge concerns noncommunicable diseases and the upsurge in cancer and cardiovascular diseases and other lifestyle-related diseases, such as diabetes, high blood pressure, mental depression and suicide. For the emerging market economies in the Region, these diseases are already a major cause of morbidity and mortality. In this context, the increase in tobacco consumption is a cause for added concern. The link between tobacco use and cardiovascular diseases and cancer is well established.
Currently, tobacco consumption rates in the countries of this Region range between 50 and 80 per cent for men and between 1 and 71 per cent for women. There is thus an urgency to contain the tobacco epidemic before it is too late.

The other challenge is to respond effectively to the various social, economic and environmental factors which harm the health of the people. Widespread malnutrition, poverty and illiteracy as well as the generally low status of women impede equitable health development in the Region.

Further, the ever-increasing population as well as environmental degradation and unplanned urbanization are putting additional stress on the already overstretched social amenities. Another important issue is related to demographic transition - the increasing ageing population in our Member Countries. It is estimated that India alone would have 142 million elderly people, constituting 11 per cent of the country’s population, by 2020. This increasing number of the elderly would require special care and welfare services, which are not yet available in many countries.

The critical link between health development and the pace of social and economic development in the Region cannot be ignored. The recent economic crisis, which affected some countries in the Region, clearly underscored this relationship. In such a situation, the resources for the health sector are among the first to be reduced. Such policies, however, could further widen the gap between the health haves and have-nots.

The economic status of Member Countries is also influenced by external factors and technology advances. For example, rapid globalization and revolutionary advances in telecommunication technology have brought countries and continents closer than ever before. The ever-increasing interdependence between local, national and transnational policies and actions has implications for health development. Today no country is an island and no country can afford to live in isolation. The operational market forces have the potential to rapidly take us towards extensive privatization and commercialization, including privatization of health services, a widening economic gap and consequently poor accessibility of health services for the marginalized population.

While economic growth has an important role in improving health, we also need to recognize the critical role of healthy public policies. In his address to the Fifty-second World Health Assembly, the Nobel laureate, Dr Amartya Sen, asserted that even
with low income levels, health and life expectancy could be improved through appropriate social support, such as health care, education, etc. This, as I said earlier, highlights the importance of healthy public policies—policies which emphasize social support systems and development sectors and create a supportive environment for health action; policies that empower the most vulnerable to take control of their health determinants and thereby improve their health. This is where the role of health promoters becomes vital.

In keeping with the concept of health promotion, as it existed in 1986, of health being a fundamental human right, the Ottawa Charter highlighted the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to a holistic understanding of health which is central to the definition of health promotion.

Health promotion represents a comprehensive social and political process. It not only embraces actions directed at obtaining knowledge, strengthening skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health.

The Ottawa Charter identifies three basic strategies for health promotion, viz. advocacy for health to promote the essential conditions for health, enabling all people to achieve the final health potential and mediating between the different interests in society in the pursuit of health. These three strategies are supported by five priority action areas for health promotion, i.e., building healthy public policy, creating supportive environments for health, strengthening community action for health, developing personal skills and reorienting health services.

There is clear evidence that comprehensive approaches to health development are the most effective. Healthy settings approaches offer practical opportunities for the implementation of comprehensive strategies.
People have to be at the centre of health promotion action, and access to education and information is critical to achieving effective participation and the empowerment of people and communities.

The Jakarta Declaration identifies five priority areas for health promotion in the 21st Century, i.e., promoting social responsibility for health; increasing investments for health development; expanding partnerships for health promotion; increasing community capacity and empowering the individual and securing an infrastructure for health promotion.

At this point, I would like to mention a few areas where, I am sure, the Regional Bureau of the International Union of Health Promotion and Education could put its comparative advantage to best use. The first is advocacy. We are all aware that the role and actions of a number of national developmental sectors, particularly housing, education, industry, agriculture, transport and local government, can break or make health. This means that such sectors need to understand their role and, in response, undertake policies that enhance health development. But, healthy public policies do not happen on their own. One has to work hard for them. For example, strong advocacy with high-level policymakers is indispensable if we are to obtain their understanding and secure their commitment to healthy public policies. We need to advocate the centrality of health and, as such, the critical importance of increased investment in health. I believe that health promoters are in a much better position to make this happen.

This brings me to the second area, that of partnerships. We should be under no illusion that national governments alone can improve health. Institutions, the private sector, NGOs and sectors other than health can and should play a critical role in health development. Partnerships with all sectors of society and at all levels are imperative if we are to bridge the equity gap.

In this connection, one needs to look at the resources available for health promotion - health promotion financing. While there has been some improvement in budgetary allocations for health promotion in absolute terms, health promotion is the least resourced programme in most countries. Thus, effective strategies for resource mobilization need to be evolved and widely disseminated to strengthen national capacities.

It is also important to evolve innovative ways of forging sustainable partnerships which will help not only to mainstream health promotion but also to make its impact more visible.
Another area that merits the urgent attention of health promoters is research. In the face of increasing resource cuts, health promoters would be called upon to demonstrate the efficacy and effectiveness of health promotion interventions. Such evidence-based demonstration can only be provided through research. In this context, formative research plays an important role as it can help establish the critical link between health and psychosocial and environmental factors as well as validate and strengthen health promotion strategies.

Responding to these health challenges and needs of health promotion in the Region, it is urgent to review the situation regarding human resources for health promotion. Our challenge is not merely to change unhealthy lifestyles – we have to promote psychosocial and political environments that favour health. Health promoters need to develop new horizons of understanding on their tasks and responsibilities. We learn that many training institutions in the Member Countries have taken the initiative to review the training curriculum in this area.

During the last few years, WHO has placed increasing emphasis on promoting healthy public policies in the context of the healthy settings approach. Healthy cities, health promoting schools, workplaces and hospitals are gradually taking root in this Region. Advocacy to strengthen commitment for the elimination and control of diseases, such as polio, tuberculosis, leprosy and HIV/AIDS, has become a critical component of the regular functioning of my Organization.

As you may be aware, WHO has launched special projects, such as Roll Back Malaria and Tobacco Free Initiative, to mobilize global, regional and national efforts in these important areas. At the regional level, we are continuing to explore innovative ways to work with regional institutions, such as ASEAN and SAARC, in health development. Efforts are also being made to work closely with other UN and bilateral agencies to maximize resources for health.

While Member Countries are steadily responding to the complex demands of health promotion, we recognize the magnitude of health promotion needs in the Region. We, on our part, look forward to our continued partnership with the South-East Asia Regional Bureau of the International Union of Health Promotion and Education in responding to these needs. Together, I am sure, we can make health a resource for and the centrepiece of socioeconomic development in the Region.
Prevention of Injuries

INJURIES have become a major public health problem throughout the world. The number of injuries is continuously on the rise and so are the disabilities associated with them. Injuries are also becoming more serious for individuals and for society at large.

An analysis of the leading causes of death shows that in most countries, irrespective of their level of development, accidents are among the top five leading causes of death. According to WHO's Global Burden of Disease estimates, accidents as the cause of death and disability adjusted life years (DALY) will dramatically rise in the next 20 years.

Injuries may be caused by accidents (unintentionally) or by violence (intentionally). Traffic accidents are a major cause of severe injuries, which result in death and disability in most countries. Drowning, falls, burns and poisoning are other common causes of injuries. In the developing world, where safety precautions are not maintained, there will be a more rapid increase in the incidence of accidents than in the developed world. On an average, one out of ten hospital beds is occupied by an accident victim in countries of the South-East Asia Region. Accidents are already ranked as the leading cause of death in Sri Lanka, as the third cause in Thailand and the fourth in Bangladesh and DPR Korea.

According to WHO, violence claims at least 3.5 million lives per year. The cost of medical care and loss of productivity due to injuries of all kinds globally, resulting from violence is almost US$ 500 billion annually.
Women and children are severely affected by violence. Recently, there has been growing awareness of the impact of violence on women's physical and mental health. Numerous studies have shown that the most pervasive form of gender violence is violence against women, often by male relations, including physical, mental and sexual abuse of children and adolescents. The consequences of accidents and violence extend far beyond physical injury. They include profound psychological implications for their victims.

During the past decade, major changes have taken place in the pattern of injury – from individual victims to mass injury. Developed countries have long recognized the extent of the problem of injuries and have made significant improvements, particularly in the prevention of traffic accidents, burns and their sequelae.

In 1966, the World Health Assembly, through a resolution (WHA19.36), requested the Director-General of WHO to play a more active role in the prevention of traffic accidents with the focus on human and medical aspects. In 1974, the Assembly called upon WHO resolution WHA27.59 to encourage and assist in the development of improved programmes in the field of traffic safety. WHO's Eighth General Programme of Work, (1990-1995) gave emphasis to the development of national and regional preventive strategies within the overall efforts of the Global Strategy for Health for All 2000.

In 1996, the Forty-ninth World Health Assembly, declared violence as a public health priority (WHA49.25). This resolution requested the Director-General to present a report to the Executive Board in January 1997. WHO thus set up a Task Force on violence and Health to develop an operational framework for public health involvement in the prevention and control of violence. The WHO Plan of Action on Violence Prevention is the result of collaborative efforts of several technical programmes in WHO headquarters, Regional Offices as well as WHO Collaborating Centres on Injury Prevention and Control. The Fiftieth World Health Assembly, in May 1997, endorsed the Plan of Action (WHA50.19).

The plan contains four major objectives ranging from describing the problem to programme implementation and dissemination. Given the many forms, circumstances and consequences of accidents and violence, measuring of the magnitude of the problem, until now, has not been satisfactory. The first priority is, therefore, to characterize different types of violence, define their magnitude and
assess their public health consequences. Unlike communicable diseases, there is no vaccine or effective drug for prevention and control of injuries. The best strategy to prevent injury is to prevent or minimize the risk factors. The next priority is therefore to support studies to identify risk factors of accident, violence and injuries.

During the Informal Technical Consultation on Violence and Injury Prevention, organized by the Indian Institute of Technology in New Delhi, supported by WHO/SEARO in September 1999, the following issues were identified:

- Injuries are low in priority for policy makers.
- Only a few countries have developed plans for injury prevention.
- The impact of socio-economic loss to individuals, families, society and infrastructure is very high.
- There is a universal lack of reliable data for analysis of injury problems.

The Consultation also recommended that ministries of health of Member countries should establish long-term plans for injury prevention and control.

I am very pleased that the Global Conference on Prevention of Injuries is being organized in Delhi. This is the first time that such a conference has been organized in a developing country. I am confident that the recommendations of this Conference will help create greater awareness among policy makers in the countries of the Region and lead to a higher priority and commitment to the health aspects of accidents and violence.
Tobacco Control

In the century that just ended, humanity has, without doubt, witnessed tremendous achievements. Unprecedented scientific advances have greatly enriched human life. The discovery of antibiotics has made a significant difference in the treatment of diseases and in enhancing longevity of life. New frontiers have been explored. Formidable health and economic problems have been surmounted. Global barriers have been broken and nations have come much closer to one another and have become interdependent.

Yet, in the midst of all these achievements, there are a few dark spots. For example, mankind is yet to take concrete steps to negate the severe health and socio-economic impact of tobacco. As we welcome the dawn of the new millennium, the world faces a formidable public health challenge posed by tobacco.

Already, 800 million of the estimated 12 billion smokers in the world live in developing countries. In 25 years, 75% of the world’s smokers will live in these countries. They will account for seven million of the global 10 million tobacco-related deaths by the third decade of this century.

Today, 80% of the global tobacco production comes from developing countries. Four countries, including India, account for two-thirds of the world’s production.

In fact, developing countries, are virtually sitting on a time bomb! The
question is: can we afford such a man-made calamity in the 21st Century? The answer is an obvious NO.

The South-East Asia Region contains one fourth of the world’s population, and carries an even larger percentage of its disease burden and the poor. Yet, the Region has the unenviable distinction of having the second highest annual per capita growth in tobacco consumption among the six WHO Regions.

The large populations and rapid economic growth in some countries are an irresistible magnet for the tobacco industry. Multinational companies and national tobacco monopolies are expanding their business in India, Indonesia and Thailand.

As a result of the powerful advertising and marketing strategies of these companies, over one million children in India and Thailand alone take to smoking every year. The Region also reports not only one of the highest smoking rates among women but also oral cancers caused by tobacco. Cardiovascular diseases, chronic obstructive lung diseases and lung cancers are already major killers. Every year, tobacco kills an estimated 580,000 people in the Region.

We must adopt legal instruments to control tobacco or our children will accuse us of having wasted the opportunity. This is one epidemic of several illnesses which we can control and we must take action now.

For many decades, the tobacco industry has used the argument that tobacco control will lead to unemployment and revenue loss for governments. But this is not true. The World Bank reports clearly state that most countries will not face any significant economic repercussions or job losses if tobacco consumption is reduced or eliminated. For example, in Bangladesh, which is a net tobacco importer, elimination of tobacco consumption will increase employment by over 18%. Also, enhancing tobacco taxes, in fact, increases, rather than diminishes government revenue.

In the South-East Asia Region, tobacco disproportionately affects the poor and the most vulnerable. Over 80% of the workforce in the tobacco industry comprises women, the poor and children. It is they who till the land, pluck the tobacco leaves, cure thousands of metric tonnes of leaves in smoke-filled curing units, and spend hours in bidi rolling and gutka packaging cottage industries.

It is they who suffer from numerous occupational hazards. Their vulner-
ability is accentuated by the very low wages they earn from tobacco. Working in tobacco production, keeps the poor in poverty.

In many countries of the Region, about 25-30% of a poor man’s income is spent on tobacco. The expenditure on diagnosis and treatment, travel for treatment, and loss of income due to absenteeism goes far beyond the means of most families.

Poverty alleviation programmes are being eroded as beneficiaries spend larger proportions of their income on tobacco products than on food, shelter, education and health. In fact, the government spends more on tobacco than it receives as revenue.

In the final analysis, it is the tobacco industry which grows richer, leaving the poor poorer.

Today, the link between TB and tobacco needs no elaboration. Already, this region accounts for about 40% of the world’s reported tuberculosis cases. The danger facing a majority of communities exposed to the TB bacilli and now to smoking or chewing tobacco is too serious to be ignored.

The time has come for us to respond to the urgent call to disinvest tobacco in order to enhance the future welfare of our nations. Today is the hour, tomorrow will be too late.

The litigation against the tobacco industry in the USA holds valuable lessons for all of us. The industry cannot be allowed to continue to sell hazardous and addictive products. Nor should it be permitted to continue to lure millions of innocent children into tobacco use under the garb of trade liberalization and the right to freedom of speech. The tobacco industry knows the health hazards of tobacco and skillfully markets death. With the power of this information, we must ensure our children understand the dangers they face.

We also need international laws and regulations to curb this deception, particularly in developing countries. Laws that will protect the most vulnerable and ensure that what is not allowed in developed countries is not allowed in developing countries either.

This Conference presents a unique and timely opportunity for developing countries to shape the elements of a Global Tobacco Control Law. A law that will not only protect their economic interests but also save the lives of millions WHO are, and will be, enslaved by tobacco.

The challenge is obviously daunting, but it is definitely not
unsurmountable. With focused commitment and the determination of all governments, the world can become tobacco-free.

Let us enter the new millennium with the determination and vision to liberate society from the bondage of tobacco. We owe this to posterity. Together, we can make a difference. Together, we can make it happen.
GLOBAL demographic and epidemiological changes have led to the emergence of noncommunicable diseases as important causes of morbidity and mortality. The countries of the South-East Asia Region are also undergoing similar changes. One can see increased industrialization, rapid urbanization, rising incomes, expanded education, including education for girls, and improved health care. Improved medical and public health measures have resulted in the control of many infectious diseases, and reduction in mortality and fertility. On the other hand, noncommunicable diseases have emerged as major public health problems. It is estimated that the global burden of noncommunicable diseases will rise from 43 per cent in 1998 to 78 per cent in 2020. In developing countries, six out of ten leading causes of death will be due to noncommunicable diseases.

Along with the social and demographic changes, living standards have improved, resulting in changes in lifestyle. There has been a significant change in consumption of high-fat diets and increased use of alcohol and tobacco. It is estimated that 800 million out of the world's 1.2 billion smokers live in developing countries. By 2025, 75 per cent of the world's estimated 1.6 billion smokers will live in developing countries and seven million of the ten million deaths globally each year will

- There is convincing evidence that lack of exercise, a diet high in fat and cholesterol, stress, smoking, obesity, alcohol and drug abuse, and exposure to chemical pollutants cause serious health problems.
- As lifestyles reflect both individual choice and the norms and values of a particular group or community, promotion of healthy lifestyles should be directed to both the individual and the community.

Second International Conference on Lifestyle and Health, New Delhi, November 1999
occur in these countries. An added cause for concern is the rapid increase in tobacco consumption among women in the Region. WHO recently convened an international conference in Kobe, Japan, to address the tobacco epidemic among women and youth. The outcome of this conference will be gainfully used in developing the WHO Framework Convention on Tobacco Control.

In the mid-twentieth century, epidemiological research clearly established the relationship between unhealthy lifestyles and ill health. There is convincing evidence that lack of exercise, a diet high in fat and cholesterol, stress, smoking, obesity, alcohol and drug abuse, and exposure to chemical pollutants cause serious health problems. These include psychosomatic diseases and cause early deaths. It has been shown that even a 10% increase in serum cholesterol, which occurs with the consumption of high-fat diets, can result in a 50% increase in the risk of coronary heart diseases. Smoking is linked to lung cancer, alcoholism to cirrhosis, heart disease, violence, suicide and mental ill health. Furthermore, low family incomes are diverted to tobacco, alcohol and drugs, resulting in increased poverty and other social implications. Unsafe sexual practices and intravenous drug use have increased the risk of HIV/AIDS. Unfortunately, there is very little public awareness of the link between health and our own lifestyles. Many are unaware that a change in lifestyle is an important reason for the emergence of non-communicable diseases as causes of increased morbidity and mortality.

Lifestyle is generally considered a personal issue. However, lifestyles are social practices and ways of living adopted by individuals that reflect personal, group and socio-economic identities. Although lifestyles reflect individual identity, they are primarily a reflection of the norms and values of the group to which individuals belong.

In recent times, the terms “western lifestyle” or “modern lifestyle” have become popular. These refer to forms of consumerism, involving particular choices in dress and appearance, food, housing, automobiles, work habits, forms of leisure and other types of status-oriented behaviour.

Healthy lifestyles can be defined as collective patterns of health-related behaviour, based on choices made from available options. This suggests that health is related to choice of lifestyle.

Health professionals and the media now repeatedly carry the message that to remain healthy, people need to adopt healthy behaviour. There is
scientific evidence to show that pursuing a healthy lifestyle can enhance health and life expectancy. Exercise, cessation of tobacco consumption, eating a high-fibre, low-fat diet, controlling body weight, and learning to cope with stress, reduce the risk of heart disease. In the context of increasing life expectancy, it is important to note that this would lead to problems like osteoporosis in post-menopausal women. This, in turn, would need lifestyle intervention among others.

Today, globalization is an important factor in the lives of communities. It brings both opportunities and disadvantages. To some, globalization has brought economic prosperity. To many, particularly in developing countries, it has brought social hardship. Most importantly, it has brought external influences which change lifestyles. Children in developing countries are increasingly taking to junk foods with little nutritious value. The young are exposed to drugs, alcohol and cigarettes. Cigarette multinationals, driven out of western countries are expanding their business in developing countries, including those in South-East Asia, where regulations are less strict. It is time for all of us to take up the challenges and promote healthy lifestyles among our population.

As lifestyles reflect both individual choice and the norms and values of a particular group or community, promotion of healthy lifestyles should be directed to both the individual and the community. The focus should be more on the community to provide a favourable structural and social environment, which offers healthy alternatives.

During the last decade, WHO has given high priority to health promotion and protection. These efforts emphasize social, economic and environmental factors that influence health and enable individuals, families and communities to have control over their health.

At the regional and country levels, WHO advocates several strategies.

First, promotion of healthy lifestyles should be concrete and tangible and be linked with specific health problems. It should not be done in isolation. Therefore, integrated control of a group of risk factors in regard to many diseases should be adopted. For example, proper nutrition can reduce the risk of hypertension, heart attacks, stroke, diabetes and even selected cancers.

Second, at the individual level, life skill education should be stressed, especially in schools. Decision-making,
problem solving, creative and critical thinking, building up a positive self-image, expressing empathy and coping with peer pressure are of critical importance.

Third, in the immediate environment such as the family, schools, peer-group and community, it is important to provide a range of alternative positive behavioural choices for individuals to select from, and to support the individual with positive reinforcement.

Fourth, the population approach and the high-risk group approach should be combined. Healthy lifestyles should be promoted, addressing the whole population and also focusing on high-risk groups.

Finally, at the national level, it is critical to advocate the development of strong policies and clear strategies on national health programmes. These should include measures by the government to provide socio-economic, cultural and legal environments that favour positive support for the adoption of healthy lifestyles by individuals. For example, under the Tobacco Free Initiative (TFI), some Member Countries have increased the tax on tobacco, banned the advertisement of tobacco products on the electronic media and smoking at public places, and established tobacco-free schools. These are supportive environments, which could help keep children away from tobacco use.

I appreciate the organizer’s initiative in introducing the new approach in health care provision by combining modern medical technology with indigenous healthy practices. This is an effective way of demonstrating the benefits of a healthy lifestyle. The objective of this conference is also very much in line with one of the major WHO strategic directions, that is, to reduce health risk factors.

I would like to assure you that I remain firmly committed to improving the health of the people in our Region. Besides providing technical support for the implementation of noncommunicable disease control programmes, WHO also calls for an innovative mechanism to ensure joint work within the UN system, as well as with major international agencies, NGOs, professional associations, research institutions and the private sector.
Tobacco, Women and Youth

It seems rather strange that we are here to discuss a critical issue that everyone understands. But it is even stranger that so few seem willing to take strong action.

Though most Governments will immediately spend billions of dollars on armaments, the same decisiveness seems lacking when it comes to saving the lives of millions dying or suffering every year from a ruthless killer. Yes, a killer called tobacco. And, if unchecked, tobacco use will cripple or kill almost 10 million persons by the year 2030.

Unlike dangerous vehicles, there are no skid marks for people to link today’s cancer, heart disease and prenatal damage to unborn babies to what had been regarded as a harmless personal indulgence. An indulgence, that also affects many more innocent passive inhalers.

Unfortunately, tobacco use has generated hardly any sense of outrage or urgency to tackle the problem. Few realize that tobacco is, in fact, a dangerous monster. A monster hiding behind the friendly masks of the macho actors and glamorous actresses adorning all its product publicity.

In this connection, we can easily identify our main adversaries. They are Attraction, Addiction, Apathy.

- The young are attracted to cigarettes, seen as magic wands, that they believe can instantly make them feel older and more sophisticated. The poor and hungry

WHO International Conference on Tobacco and Health - "Making a Difference to Tobacco and Health: Avoiding the Tobacco Epidemic in Women and Youth", Kobe, Japan, November 1999
feel that cigarettes and other tobacco products can also dull their sorrows.

- However, nicotine is so powerfully addictive that a seemingly innocent indulgence soon becomes a pervasive habit.

- The long gap between cause and effect also generates apathy to address the problem at personal, social and governmental levels.

Commercial interests, advertising and deliberate misinformation are dangerous enemies too. Cigarettes, “bidis” and various chewing tobaccos are big businesses. The manufacturers know that their survival depends on aggressive marketing. They have added subtle persuasion, manipulation and management of the political environment to their arsenal.

There is no apathy in their camp. They have constantly propagated widely believed myths that curbs on tobacco use will cost many thousand jobs, stifle economic growth, reduce export earnings and hurt farmers WHO grow tobacco. These myths need to be exposed.

One also needs to measure the costs of tobacco to national economies, the man-days lost to sickness, and the costs of treatment, insurance and environmental degradation. It is estimated that the world pays $200 billion, every year in such costs due to tobacco use. These, surely, make a mockery of the falsely propagated benefits of tobacco.

The South-East Asia Region contains one-fourth of the world's population and an even larger percentage of its poor. This has led to some very specific problems. The huge and growing South-East Asian market is naturally an irresistible magnet for the tobacco companies, especially as tobacco consumption in developed countries is declining. A sizeable number of today's 1.1 billion smokers live in the South-East Asia Region.

Consumption rates in the Region are growing alarmingly, particularly among the most vulnerable – children and women. The habit of chewing tobacco is most prevalent among women in most countries. The Region reports not only one of the world's highest smoking rates among women but also tobacco-related oral cancers. Not surprisingly, studies in some countries show that up to one-third of a poor family's income is spent on tobacco products.

The link between tobacco and poverty is becoming increasingly clear. Yet, for most countries of the Region which produce and export tobacco, the economic considerations seem to take
preference over this major public health interest.

The relatively low ratio of women smokers should not, however, lull us into a false sense of complacency. Though family traditions remain strong, there is a rapidly growing and dangerous trend for women and young children to smoke or chew tobacco. The high illiteracy levels often make women most vulnerable to clever marketing by the tobacco industry. Eventually, their indulgence cuts into their scarce incomes. It deprives them and their children of better food, medicines, education and other life sustaining needs.

Low-paid women workers are also important to the tobacco industry. Women constitute half the working population in the tobacco industry. They do most of the interculture, plucking and curing in the smoke-filled tobacco curing units. They form the backbone of the bidi industries in the South-East Asia Region. Yet, they are the lowest paid workers in poor regions. A high percentage of them, therefore, suffer from allergies, skin disorders, nausea, dizziness and other ailments. These factors severely impact poor households further.

However, as with protecting trees in the Himalayas or fighting against alcohol in parts of India, women have emerged as formidable agents of change. Many women have shown how effective they can be when stirred to fight for their causes. This brings us to the challenge of empowering women. This has to be seen in the context of enhancing the total socio-cultural status of women.

Educating women is one of the strongest weapons in the war against poverty and disease. Denial of education keeps women in a state of permanent servitude and poverty. Yet, the striking examples of many areas like Kerala in India demonstrate how effectively education can energise women into a huge resource for the benefit of their communities.

Education, employment and health are crucial pillars of poverty alleviation programmes. The excellent example of Sri Lanka shows how effectively poverty can be alleviated particularly, with women playing a lead role. Improved economic means and sustainable environments need to be addressed if we are to effectively respond to women’s needs.

The South-East Asia Region has seen many distinguished women holding high political and official positions. This has often resulted in higher priority to women’s empowerment and related issues. As more women assume high decision-making positions and are brought into the
mainstream of the family decision-making process as well, the chances of their influencing policies which affect their lives become brighter. Thus, while the situation of women and tobacco is grave, it is not hopeless.

Effective action needs concerted networking with non-health Government departments, NGOs and other agencies to multiply effectiveness. Cooperation with other countries and partnerships with organizations with common goals can provide a valuable platform for sharing manpower and experience. Tobacco is not just a health issue concerning the health ministries and departments. It is a socio-economic development issue and for women, this is most critical.

We have seen the success of proactive campaigns in several countries in increasing awareness of the dangers of tobacco. These show that the benign mask can be stripped off to reveal the corrupting and corrosive monster that tobacco actually is.

We all know that action is important. We now have to make it urgent. We have to mobilize the people of the world, the local communities, women’s groups and organizations and also governments. But, most importantly, we have to mobilize ourselves, the health professionals, to act and act decisively.
Health Promoting Hospitals

In 1980, the First International Conference on Health Promotion held in Ottawa, Canada, set the benchmark for the development of health promotion; a process of enabling people to have control over and to improve their health. Reorienting health services to enable hospitals to play a proactive role in health promotion was one of the five main areas for action for health promotion outlined by the Ottawa Charter. Since then, the Adelaide and Sundsvall Conferences on Health Promotion and, recently, the Jakarta Declaration, have legitimized the concept and practice of health promotion.

In particular, the Sundsvall statement underscored the importance and advantages of the “healthy settings” approach. It stated clearly that it is where people live, work and play that health is made or destroyed. In this context, hospitals, as a setting for creating health, are of critical importance. Settings provide exceptional entry points for health promotion, reaching specific target groups with special health needs and different response requirements.

In the South-East Asia Region, hospitals form an important component of the health system network. They provide the necessary technical back-up for health centres and primary health care clinics. They also have the responsibility of dealing with threatening diseases. To the public, hospitals are places providing healing and relief from pain. The need for hospitals to be role models for healthy

Hospitals are being challenged to go beyond their traditional roles of diagnosis, treatment and rehabilitation. They are being called upon to place more emphasis on the social, physical and environmental determinants that support healing while promoting health.
settings in every aspect is, therefore, very relevant.

Rapid technological developments, the emerging epidemiological and demographic patterns and changing lifestyles call for a holistic response to health. As we enter the next millennium, the need to improve and broaden the functions of hospitals becomes even more urgent.

Hospitals are being challenged to go beyond their traditional roles of diagnosis, treatment and rehabilitation. They are being called upon to place more emphasis on the social, physical and environmental determinants that support healing while promoting health. Not only the health of patients, but of staff, the management, relatives of patients and the communities in which they are situated. They are thus required to be health promoting organizations in addition to being providers of medical care.

This leads us to the question, what is a health promoting hospital? Hospitals perform four key roles which can be the focus of health promotion. Not only do they serve patients, they are workplaces for various categories of hospital workers. They serve as a repository of health knowledge and skills and are encompassed by their own policies, rules, management styles and communication channels. Their influence extends far beyond their walls, affecting positively or negatively the health of communities and societies.

Yet, for most hospitals in our Region, the main function is limited to patient care. Even here, patients’ rights to professional and support services are not met due to lack of proper skills and knowledge coupled with poor management.

As a workplace, hospitals need to maintain optimum levels of required occupational health standards that enhance the working environment for their staff and management. Effective precautionary measures, clean and safe physical and psychosocial environments, and good nutrition and food safety for both staff and patients, need to be maintained. In this regard, high standards of waste management and adequate supply of sanitation facilities, and safe water are critical.

Hospitals take root in the communities in which they are situated. To enable them to respond effectively, the communities have to be their critical allies. Hospitals, therefore, need to focus on the health of communities and beyond individual patients. Supporting existing community-based health promotion efforts; providing health education services; strengthening advocacy for holistic community...
health, and reaching out to disadvantaged and special groups, such as the elderly, are some of the essential characteristics of a health promoting hospital.

Salient to the effective partnerships between hospitals and communities is the necessary link between the private and public sector hospitals. There is need for hospitals operating in communities to build a strong network to maximize each other’s strengths and compensate for the weaknesses. This would help their collective efforts at serving the health needs of communities. In this regard, the Hospital Accreditation Programme, initiated by some countries in the Region needs to be commended. It should become a unifying force to improve the level of care, technology and health knowledge for the benefit of our communities, patients, staff and the management of hospitals.

In recent years, WHO has put a lot of emphasis on the “settings” approach. The healthy cities concept is gaining momentum in many countries. Health promoting schools are becoming effective entry points for maximizing the organizational and educational capacities of schools and thereby improving the health of students and school personnel. I believe we can also turn our hospitals into health promoting hospitals. This is our collective challenge. I sincerely hope that this meeting would come up with strategies to develop health promoting hospitals in our Region.
Health of the Elderly

On the threshold of the twenty-first century, the world is witnessing a rapidly-changing demography, particularly in the developing countries. When India got independence, the life expectancy at birth was around 30 years. In the last five decades, the life expectancy has doubled. The absolute number of elderly persons has more than tripled. By the year 2001, India will be inhabited by about 76 million elderly people, WHO would constitute 7.7 per cent of the country’s population.

This demographic transition effectively transforms India from a “mature society”, to an “ageing” one, that is, one with an ageing population of more than 7 per cent, by the turn of this century.

It is projected that the elderly population of the world will cross the one billion mark by the year 2020. By that time, over 700 million old people will be living in developing countries. In India, around 11 per cent of its population will be 60 years and above.

The economic, social and health status of the fast-growing elderly population poses a great challenge to all sectors. Studies conducted in India and other countries of the Region show that a majority of the elderly population are not in a position to lead an economically-independent life after their retirement. In the absence of pension benefits, many old persons have to work for their livelihood until they are physically exhausted.

healthy Ageing – Agenda for the Coming Century, Public function on International Year of Older Persons, New Delhi, January 1999
On the other hand, the joint family system and family values are gradually eroding. We find that more than 12 per cent of the rural elderly males live alone in India. The number of the elderly living alone will increase with urbanization and migration of young people coupled with decreased cohesiveness in family bond.

With regard to the health status, around 6 per cent of the aged in India are immobile due to various disabling conditions. Approximately 50 per cent of the elderly suffer from chronic diseases. Visual and hearing impairments are highly prevalent. At the same time, the availability of health services for the elderly are lacking. Knowledge among health workers on the specific needs of the elderly are also minimal.

National health services are still preoccupied with the centuries-old scourge of communicable diseases, maternal and child care, etc. Little attention is paid to the enormous needs of the elderly population.

Over the years, WHO has been taking action to improve the health care of the elderly. The principal focus of WHO’s actions has been on community participation and family care. Promotion of traditional family ties has, therefore, been emphasized instead of institutional care. Making optimal use of the available PHC services is the cornerstone for supporting the traditional family care.

In collaboration with its Member States, the WHO Regional Office for South-East Asia has been concentrating its efforts in several areas of elderly care. These include:

- identification of special needs of the elderly;
- creation of awareness among policy makers and the general population;
- supporting the formulation of appropriate national policies, strategies and programmes, and
- establishment of institutions or centres of excellence for health care of the elderly.

As a top priority, training of health workers and studies on the determinants of healthy ageing have been receiving continued support under the WHO programme.

In 1992, the United Nations declared 1999 as the International Year of Older Persons. In response to this, WHO launched activities relating to this International Year on 1 October 1998. At the launching ceremony, Dr Gro Harlem Brundtland, Director-General of the World Health Organization, called upon policy makers to recognize the importance of
population ageing, and take concrete action. With a view to promoting national actions, “Active Ageing” has been selected as the theme for this year’s World Health Day.

The Director-General pointed out that the great challenge of the 21st century is to improve the quality of life of people of all ages. In order to meet this challenge, it is essential to bring the issue of “ageing” into the development agenda of all countries. For this, a three-pronged approach; namely, income security, health security, and emotional or spiritual security is required.

Income security is a fundamental right of elderly people. Every society owes this to its senior citizens. We should strongly advocate that the coverage of pension benefits be expanded to all elderly people. Appropriate mechanisms, such as income-saving schemes and allowances, need to be evolved. Other supplementary benefits, such as travel subsidies, incentives for care-givers in the family and for housing schemes, will also have to be strengthened. All these require multisectoral action as a top priority.

Health security is one of the basic prerequisites of an enjoyable life for elderly people. But health in old age depends on people’s lifestyle and behaviour during their life-span. Tomorrow’s elderly are today’s adults and yesterday’s children. That is why WHO emphasizes a life-span approach for the health of the elderly. Here, health promotion at all ages comes ahead of geriatric care. Thus, we have to advocate that people consider preparing for their health when they are old.

Emotional security is another essential aspect for the wellbeing of elderly persons. Mere physical health would not be indicative of a person’s happiness. People, particularly in old age, need continued social interaction, due respect, affection and spiritual satisfaction.

It is important that elderly people are not taken as a burden on society, but rather as an asset. Their wisdom and experience have to be fully utilized. For this, an inter-generation approach should be pursued an with increased role for the mass media, education and religious organizations. At the same time, activities of self-help and social involvement will have to be widely publicized and promoted. Appropriate mechanisms are needed for engaging senior citizens in social activities which require strong support from both governmental and non-governmental organizations.
WHO will continue its efforts to promote the concept of “active ageing” in a spirit of broad partnership with all the actors, including governments, professional organizations, the mass media, the education sector, and international and national NGOs.
Health Promoting Schools

SCHOOL health has a long and chequered history in our Region. Some very innovative approaches have been tried and initiated. The mid-day meal programme in schools in India the Little Doctors’ programme in Indonesia and the child-to-child activities in many other countries have received worldwide recognition. Medical examination of schoolchildren has been a routine activity in many countries, as has been health instruction. However, unfortunately, school health has largely focused on schools in urban areas.

After all these efforts, there are a number of questions that must be asked: Have these school health programmes equipped children with skills to practise healthy living? Have they motivated a child to value health, to seek and promote it? Have they empowered children to take decisions regarding their own health? Have they helped children to carry health beyond their classrooms - to their families and communities?

Over the past few years, many committees, conferences and consultations have examined these questions. They have concluded that it is not enough to merely impart to children knowledge on health. Children must be equipped with the skills needed to promote health.

Children also need a supportive environment that will develop as well as sustain action for health promotion. In short, health education in schools must become more comprehensive if

Health education in schools must become more comprehensive if children are to be empowered to pursue a healthy lifestyle and to work as agents of change.

Health promotion in and by schools cannot be carried out by one sector alone. The health and education sectors must work together as equal partners.

Intercountry Consultation on Health Promoting Schools, Bangkok, December 1997
Striving for Better Health in South-East Asia

children are to be empowered to pursue a healthy lifestyle and to work as agents of change.

Never has this been more necessary than at present. The socioeconomic changes and technological advances during the past few years have influenced most of us. But these changes have made a much stronger impact on the lives of young people.

In addition to facing the age-old health problems resulting from nutritional deficiencies and unhygienic living conditions, the young today are confronted with problems related to lifestyle changes. A significant increase in tobacco prevalence in some countries has been mainly due to the increase in the smoking habit by the youth.

The strong and overwhelming linkage between alcohol use and the initiation of many young people into the career of street gangs has also been documented in some countries of the Region. In almost all countries, drug use has been associated with high crime and suicide rates. Further, alcohol is estimated to account for almost 50% of all deaths from traffic accidents in some countries with adolescents and the age groups 19-29 years being the worst affected.

We cannot close our eyes to the immense suffering caused by tobacco, alcohol and drug abuse as well as by irresponsible sexual behaviour and violence.

Schools have an important role to play to ensure that the young are equipped to overcome negative forces. Schools must inspire and influence the young to grow into happy and productive citizens and to enhance common well-being, harmony and peace.

In 1991, a case for comprehensive school health education was made at a global consultation held at WHO headquarters. The consultation emphasized that health education in schools must include other components of school health such as school health services and promotion of a healthy school environment. Suggested guidelines for action prepared by this consultation were further examined by health and education experts from the countries of the South-East Asia Region at an intercountry consultation held in Sri Lanka in the same year.

Since then, some initiatives have been taken. For example, in Sri Lanka, a joint committee on health and education has revised the health curriculum in schools. At the secondary school level, new subjects such as adolescent health, reproductive health and HIV/AIDS have been introduced. A
guide for programme monitoring and evaluation has also been developed.

Today, there is considerable emphasis, and rightly so, on making the school a starting point to promote health in children as well as their families and communities through comprehensive school health education.

In 1995, a WHO Expert Committee on Comprehensive School Health Education and Promotion recommended the need to make schools "health promoting schools". Such schools not only provide health education, they also offer multiple opportunities for promoting health in school-children and the teaching staff. Healthy school environments and services, counselling and social support as well as outreach services through school community projects are some of the characteristics of health promoting schools.

In other words, health promoting schools create a healthy setting for living, learning and working. This concept was clearly expressed at the First International Conference on Health Promotion in Ottawa in 1986 and has been reinforced at the Fourth International Conference on Health Promotion in Jakarta this year.

I am very pleased to note that Thailand has taken an important step in this direction. A Health Promoting School Pilot Project, I am informed, has been initiated in selected schools in Bangkok, with encouraging results.

I have studied with great interest the objectives listed for this consultation. With the highly experienced participants present, I am confident that very practical guidelines for health promoting schools in the Region will be formulated.

I also hope that you will be able to give some thought to the education of out-of-school youth belonging to the not-so-privileged section of society. They are the ones WHO are exposed to health risks at every stage of their lives, but have neither the knowledge nor the power to face them.

The plight of the girl child and the female adolescent is of special concern. Female literacy rates are unfortunately still very low in some countries of the Region. We know that one of the most important determinants of a child's health is the educational status of the mother as well as her health status. Efforts must therefore be made to increase school attendance and improve the health education of girls.

The ten countries of the South-East Asia Region display diverse cultures,
political systems and socioeconomic conditions. However, despite this diversity, the health promoting school concept is applicable to all countries. Each country, however, will have to carefully work out its operational aspects so as to make it relevant to its specific needs. Even within a country, the health education needs of urban and rural schoolchildren may differ.

You must also remember that our Region has over 40% of the world’s poor. There are schools that have no rooms, no walls, no latrines, no running water and sometimes not more than just one teacher.

This clearly indicates that health promotion in and by schools cannot be carried out by one sector alone. The health and education sectors must work together as equal partners. Teachers will need fresh training, school administrators will need reorientation, and parents and communities will need to get more actively involved.

This implies fostering close partnerships between several players like health and education planners and implementers, environmentalists, NGOs, teachers, parents and community leaders.

WHO, as you may be aware, has developed and implemented a Global School Health Initiative. The goal of this Initiative is to increase the number of health promoting schools all over the world. Regional networks of health promoting schools are being developed in different regions of WHO. I am confident that the South-East Asia Region will soon join the other regions in establishing such networks.
Health Promotion in the 21st Century

The theme of the conference, “New Players for a New Era: Leading Health Promotion into the 21st Century”, is as reflective as it is visionary. Providing a unique opportunity for a meeting of eminent minds, it is as timely as it is urgent.

In less than a thousand days we shall usher in the year 2000. The year 2000 is special for all of us. It has, in fact, been an inspirational goal since the Declaration of Alma Ata in 1978.

Dictating the course of our thinking, the pace of action and definition of our strategies, the year 2000 has been an emotive magnet over the past decade. Sometimes it may have seemed like a distant horizon - a mirage that never really got closer. Now it is upon us. The New Era has already begun.

For many of us the year 2000 is viewed with mixed feelings. There is a sense of achievement. There is also a sense of anxiety.

Yes, we have made progress! Science and technological breakthroughs have helped to improve the health status of nations. Now information can reach more people more quickly and accurately than ever before.

Life expectancy has risen in the countries of our Region. Infant mortality has fallen. The prospect of eliminating leprosy and that of eradicating polio is

The 4th International Conference on Health Promotion Jakarta, July 1997
unbelievably brighter than ever before.

However, the goal we set ourselves for Health for All is far from fully achieved. Our South-East Asia Region is home to one quarter of the world’s population. Half the world’s poor live in this Region. Millions of people are still caught in an inextricable trap of malnutrition, illiteracy and gender inequalities.

Uncontrolled migration coupled with large scale industrialization have contributed in a large measure to the rapid urbanization and the deteriorating environment in many countries of the Region.

Further, diseases such as malaria continue to threaten the lives of millions. At the same time, we face new challenges like HIV/AIDS, or re-emerging diseases like tuberculosis and plague - once thought to be well under control. Lifestyle changes as a result of economic prosperity have brought about an increase in heart diseases, cancer and diabetes.

Contributing to this complex situation is the growing use of tobacco and alcohol, more importantly among the youth and women. Our Region thus bears a double burden of diseases. The old and the new, communicable and non-communicable. And there lies the cause for anxiety.

The system of health care available today and developing for tomorrow may provide the means to effectively deal with most of the health problems we now face. It may provide the means to communicate as never before to communicate about health with all. But the effective use of these systems requires wisdom. It is up to us to develop that wisdom, and translate it into effective practical policies, well resourced strategies and imaginative partnerships for health.

Over a decade ago, the foundations of a worldwide movement for health promotion for the late twentieth century were set in Ottawa. And many of us were there, just as we are here today. The conferences in Adelaide in 1988 and Sundsvall in 1991, reinforced this important process.

Today we are in Jakarta, on the threshold of the 21st century for which a new course of health promotion needs to be chartered. The question is, how far have we come since the Ottawa Charter? Now is the time to take stock!

In our Region we can say that health issues have gained better recognition than a decade ago. However, it is yet to reach the top of the political agenda. Healthy public policies and supportive environments in the area of tobacco and alcohol
control need to be pursued more vigorously.

Successes achieved in promoting the health of the school going child have to be concretized in the broader context of health promoting schools. At the same time, the promotion of a wider adoption of the healthy city concept has to be intensified. This underscores the urgent need to formulate a new vision for health development in this Region.

Next month the Health Ministers of the South-East Asia Region will meet to endorse a Declaration on Health Development in the 21st Century. A Declaration based on the cardinal principles of health as a fundamental right, on equity and social justice. It recognizes the centrality of health to successful socio-economic development.

The Declaration advocates steps towards the eradication of poverty, gender inequalities and discrimination. The empowerment of communities for their health development is also given due recognition. It seeks the commitment of all sectors: public and private, the media, nongovernmental organizations, organized groups as well as communities.

The Declaration seeks nothing less than the achievement of health for all by mobilizing all for health in the true spirit of partnerships. We need to build support where it counts, where maximum benefit would be realized!

Our past experiences in health development speak of success stories, of collective efforts built on the principles of partnerships. Classical examples include the historic eradication of smallpox. Strong partnerships between the scientific world, dedicated health workers and willing communities made all the difference.

Last January we achieved a world record of immunizing 127 million children in a single day, in India alone. This was the result of constant advocacy and imaginative intersectoral action: state and private sectors, NGOs, the community, volunteers and health workers working together towards a common goal. Building trust nurtured on the confidence that people can have a direct effect on their own health and that of their children. Yes, in the recognition that they can make a difference in shaping their future health status!

In all of these efforts and in many others, we recognize that our eventual success lies increasingly in our ability to create and manage partnerships - between and among a wide spectrum of "new players". Our collective thinking on partnerships is expressed in

Among other issues, the publication underscores the need to utilize more fully the rich opportunities that science and technology offer. To help conquer the formidable diseases and ill-health burdening our Region. To harness and nurture the inherent power of the best and vast resource we have human beings. To live and work with all groups of people as true partners at all levels for health. Through partnerships, to break the stranglehold of poverty which holds millions of our people in its tight grip. To strengthen our efforts to bridge the gaps created by inequities and inequalities. To put a human face to our health services, which many times seem devoid of this essential ingredient. And, ultimately, to aspire for a healthier world whose building blocks are moulded by everyone – the young and old, the rich and the poor, the learned and the unlearned.

Health is more than a medical or scientific issue. Its content, delivery and outcomes extend far beyond the confines of the ministries of health. But we still need the humility to accept our inability to succeed alone.

The complexities and far reaching consequences of ill-health and disease should compel us to acknowledge the abilities of others. We need to build trust and leadership skills within and outside the boundaries of the ministries of health. We need to demonstrate our willingness to meet our partners halfway if we are to engage people in sustainable
partnerships. Be it among institutions, men and women, individuals, private or public, great or small.

Our critical duty here is to bring our technical expertise into a sharper focus for the benefit of all. At the same time, we should do our utmost to convince people of their vital role in improving their own health and that of their neighbours.

As we move into the next millennium, we need to constantly remind ourselves of our responsibility for transparency and accountability. We have to shed past habits of exclusivity and sell our ideas and successes more forcefully and openly - devoid of the sense of self righteousness.

We have to address people at their own level and in a language that responds effectively to their sensitivities. We need to master the art of good listening.

While insisting on health as a fundamental right, while positioning health at the centre of socio economic development, while promoting equity and gender equalities, while creating public policy and supportive environments, and while doing all we can to promote healthy lifestyles in a fast changing world, we must not forget that our authority is further legitimized through building partnerships.

The new players we seek for our new era are at all levels, waiting. They are waiting for us to demonstrate our readiness for true partnerships. How our legitimate ideas can be translated into action, how abstractions can become practicalities, and how the noble goal of Health for All can finally become a reality.

We are on the threshold not only of a new century, but of a great opportunity! The time is now. To capture the beckoning heights of partnerships to build a healthy world for tomorrow. A world with less pain and anxiety, illhealth and disease.

The extent to which we successfully achieve this would be the acid test of our strength and abilities. Let this conference, therefore, be the beginning of partnerships of many eminent and focused minds, seeking together ways to reach out across the world.

Let this conference, above all, be a path-breaking one as we strive for sustainable partnerships for health promotion. I wish you success in this partnership of minds and action.
Health Technology and Pharmaceuticals
Opportunistic Infections in HIV/AIDS

HIV/AIDS has assumed a major, almost overwhelming, public health importance in our Region. In many parts of the world, the curve of new infections is beginning to level off. In our Region, HIV is still increasing sharply. As on 1 October 1999, 164 671 cases of AIDS have been reported in SEAR countries and around 5.6 million people are estimated to be infected with HIV. It has also been estimated that by the year 2000 there will be 8 to 10 million infected persons in Asia alone. WHO has identified HIV/AIDS as a disease of priority importance.

AIDS is characterized by a number of opportunistic infections which are responsible for high morbidity and mortality. In fact, even before the discovery of the causative virus, cases of AIDS were defined as those having certain opportunistic infections. The spectrum and distribution of opportunistic infections in AIDS patients is ever-expanding. This spectrum varies from continent to continent as also between children and adults. There are differences in the pattern of opportunistic infections in AIDS patients depending upon the risk group. From the limited studies conducted, it is quite apparent that tuberculosis is the single most important opportunistic infection associated with AIDS in our Region. It is estimated that an HIV-infected individual is six times at higher risk of acquiring tuberculosis than an HIV-negative individual. In AIDS patients, the incidence of extrapulmonary tuberculosis increases and that of smear positive pulmonary tuberculosis decreases -

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Intercountry Training on Laboratory Diagnosis of HIV-Opportunistic Infections, Bangkok, December 1999
making the diagnosis of the disease that much more difficult, unless good diagnostic tools are available.

Fungal agents such as Candida, Histoplasma and Cryptococcus also are important opportunistic pathogens in AIDS patients. Protozoal infections such as Cryptosporidium, Toxoplasma and Isospora also contribute significantly towards morbidity and mortality in such patients. While an organism of low or no pathogenicity becomes an opportunistic pathogen in HIV/AIDS patients, known pathogens can also present in an abnormal fashion; either in the form of increased virulence, atypical clinical presentation, repeated infections or in drug-resistant form. Hence, it may not always be possible to suspect or identify these infections on clinical presentation alone.

Laboratories, thus, play a key role in the diagnosis and management of these infections. Fortunately, many of these opportunistic infections can be effectively prevented and treated if timely diagnosis is made. Although the tests required to diagnose these infections are simple and feasible at most places, not many laboratories are carrying them out in Member Countries. The reasons for this could be lack of awareness, or lack of infrastructure and training. The major objective of this meeting is to improve the capacity of laboratory personnel to diagnose and manage such infections which can otherwise assume life-threatening proportions.

Thus the present meeting aims at training the participants in the diagnosis of opportunistic infections and thereby help in the establishment of laboratory-based surveillance on a sentinel basis. The data generated should be promptly analyzed and relevant information disseminated to all concerned for taking appropriate action. While doing so, however, we should take care to generate quality data on the principles of quality assurance.

I am very happy that this consultative meeting is being organized in Thailand, because this country has a very rich experience in handling these infections. I have been given to understand that this workshop shall mainly focus on hands-on, bench-level techniques so that participants can replicate the same at their respective work places. And, I sincerely hope that they benefit a lot from this training and are successful in establishing laboratory-based surveillance in their countries.
Blood Safety

BLOOD transfusion services have now become an integral part of the health care system throughout the world. Provision of safe blood in an efficient, coordinated and cost-effective manner to all those who need it, is recognized as an essential function of health providers. In recent years, the issue of blood transfusion has become urgent particularly due to the HIV/AIDS pandemic, which has emerged in the past decade and a half as the most devastating public health and developmental crisis globally, and in this Region as well. The epidemic is at an early stage and prevention of HIV still remains the cornerstone of all national AIDS control programmes.

Blood transfusion is the most efficient mode of transmission of many infectious agents. These include HIV and hepatitis B and C. Syphilis and malaria are also transmissible through blood. It must be stressed that infections transmitted through this route are also the most easily preventable. This can be achieved by establishing a comprehensive and well-organized blood safety programme. A three-pronged prevention strategy includes careful selection of blood donors, screening of donated blood for infectious agents, such as HIV, hepatitis B and C, and restricting transfusion only to those who really need it.

Transfusion of blood and blood products presently account for approximately 5-10% of the global HIV infections. In some countries of South-East Asia, blood transfusion contributes substantially to HIV infection and AIDS. For example, nearly 7% of AIDS patients as reported to the National AIDS Control Organization in India, acquired infection following transfusion

A greater degree of national commitment at all levels and financial support are needed to further strengthen blood transfusion services.

of blood and blood products. In Thailand, on the other hand, less than 1% of AIDS cases are attributed to blood transfusion.

Considerable progress has been made in the South-East Asia Region towards the provision of safe blood. Nearly all donated blood is screened for HIV and hepatitis B in many countries, including Thailand, Indonesia, Nepal, Sri Lanka and Maldives. However, in some other countries of the Region, despite excellent progress being made in recent years, provision of safe blood transfusion still remains an important issue to be tackled. A greater degree of national commitment at all levels and financial support are needed to further strengthen blood transfusion services in these countries.

As you are aware, blood transfusion programmes are faced with many constraints. Voluntary blood donation is often unpopular for cultural reasons. In some countries, the number of blood units collected is far less than the demand. The lack of personnel and equipment makes it difficult to test all the blood collected by the public and private sectors for transmissible agents. Moreover, many blood banks are run by private agencies, which have little or no collaboration with the government sector.

It is important to remember that blood is precious; hence it must be used appropriately and rationally. I am happy that many countries in our Region are making efforts to optimize the use of blood by encouraging usage of blood components and alternatives, such as plasma expanders, wherever possible. Still, in many countries, twice as many people get blood transfusion than are really warranted. We, in WHO, are aware of the efforts being made in the Member Countries, including India, to improve the situation, and we strongly support and encourage this. It is unacceptable that people should be infected with HIV through a procedure designed to save lives.

Many lessons can be learnt from our experience in implementing safe blood programmes. In a big country like India, there are many examples of excellent blood transfusion services being provided at the local level. The ban on professional donation of blood, which came into force in India from 1 January 1998, is testament to the government's commitment to the provision of safe blood to its citizens. The Ministry of Health has intensified a campaign to motivate voluntary blood donations and to remove myths, misinformation and inhibitions from the minds of people. The experience in Myanmar shows a considerable decline in the amount of blood transfused.
following the education and training of health care workers. Even a resource-constrained country, such as Nepal, has achieved 100% blood safety, mainly through the efforts of the Red Cross.

The overall responsibility for the provision of safe blood to the community lies with the government. As an essential component of the health care system, this service must be made available wherever and whenever it is required. The primary objective is to ensure safety, adequacy, accessibility and efficiency of blood supply in an efficient, cost-effective and coordinated manner. The onus for fully discharging their role of coordinating, supporting, mobilizing and facilitating safe blood transfusion services in the country lies with the governments.

Nevertheless, governments alone cannot do everything. Therefore, a need for forging partnerships to ensure the safety of blood is of paramount importance. The public and private sectors, including the national and state governments, academia and industry can bring into focus complementary skills and perspectives. The role of NGOs, like the Red Cross and Red Crescent and community level NGOs, in advocacy and mobilizing voluntary donations, is crucial. Clinicians working in government hospitals and health centres and those in private practice must prescribe whole blood donations only as a life-saving measure. Closer collaboration with other relevant programmes, such as National AIDS Control Programme, Nutrition, Laboratory Services and Reproductive Health, must be forged for the use of scarce resources and for ensuring a sustainable programme.

Community involvement can play an important role. People can be motivated to donate blood, by assuring them that it is life saving. Communities can also mobilize groups and organizations working for social causes.

WHO has consistently advocated for national commitment in establishing a National Blood Transfusion Policy and its implementation through a sustainable, well-coordinated, adequately-funded and efficiently-managed blood safety programme. In 1985, blood safety as an issue was discussed in the World Health Assembly which adopted a resolution urging all Member States to develop and strengthen their national blood transfusion services. Since then WHO has been providing the necessary support and information on blood transfusion safety issues. This has been done by developing blood safety strategies, guidelines and advocacy materials for policy makers. Technical support has been provided in three
different areas: promotion of voluntary remunerative donors, screening of donated blood, and appropriate and rational use of blood. WHO’s Distance Learning Materials are used by Member Countries in training their staff. The global database for blood safety helps Member Countries to identify priority areas for developing strategies for safe blood transfusion. Pre-transfusion certification of blood for its infection-free status has been made mandatory. This requires reliable laboratory support. In this regard, the need for quality assurance in laboratory testing of blood remains a crucial area for WHO technical assistance to all Member Countries.

One can visualize that blood safety will remain with us as an issue in the 21st century. With the advances in medical and surgical specialties and the rapid expansion of health services to the periphery, the demand for blood and blood components is expected to increase throughout the South-East Asia Region. It is even possible that the demand-and-supply ratio may even worsen. Therefore, in the absence of a coordinated national transfusion programme, some countries may find it difficult to meet their requirements and ensure sustainability of the programme.

In order to address these challenges adequately in the next millennium, a new vision and a set of actions to strengthen national blood transfusion services will be needed.

First of all, blood safety should be accorded a high priority in all countries. It is essential to recognize that improving the health status of the population is integral and basic to socio-economic development. Blood safety should be fully integrated into the broad national policy framework and as part of the overall infrastructure of the health services. Adequate resources, both financial and human, should be mobilized to run a comprehensive blood safety programme. For this, advocacy at all levels would be required.

Secondly, each country must formulate and implement a national blood policy and programme. Such a policy would provide a strategy framework and directions for the management of blood transfusion services integrated into the national health programme. The national policy would address issues, such as political
commitment, organization and management of services and funding for the programme. Policies relating to HIV testing, notification, confidentiality, legal implications and compensation, as well as guidelines on technical aspects are important issues to be addressed at the country level. In countries where the system of blood banking is fragmented and services not properly organized, the constraints and priority activities can be addressed through implementation of the national policy framework. Moreover, the strengthening of the health infrastructure particularly with regard to safe blood transfusion must be a priority. The government will have to assume a greater role in policy formulation, facilitating action and governance. Equity should be the foundation on which the government policy framework and strategies should be built.

Thirdly, partnerships for safe blood are of crucial importance. As already stated, the role of the public and private sectors and the community is extremely important in ensuring blood safety. In countries and areas where the private sector is strong, the role of the government in monitoring quality assurance assumes even greater importance.

The safety of blood and the credibility of national blood programmes will depend on several factors. Crucial among these are: laws and regulations relating to paid donors, the testing of blood for HIV through informed consent, and maintaining confidentiality of test results.

Fourthly, monitoring and evaluation of the blood safety programme must be carried out regularly. Monitoring and evaluation are important to assess the accessibility, safety and affordability of blood for transfusion, the quality and pattern of blood usage, and the impact of national programmes in improving appropriate use of blood. This requires systematic data collection and analysis at all levels of the health system. The responsibility for monitoring the availability and quality of service lies with the national blood programme, the national committee and all relevant disciplines participating in blood transfusion services.

Finally, global and regional solidarity is needed to ensure safe blood transfusion in all regions and in all countries. The urgency to strengthen blood transfusion programmes requires cooperation among countries to exchange experiences and to learn from one another. International agencies, multilateral donors and UN agencies also must support safe blood initiatives in the developing world to make the world a safer place to live in.
Countries in need, on the other hand, must first prepare sound projects based on concrete evidence and research taking into consideration public health and epidemiological aspects. Ultimately, the success of the blood transfusion programme does not depend merely on finances. Indeed, organizational and management aspects, which are the theme of this international Conference, play a most crucial role.

In conclusion, the challenges posed by unsafe blood are formidable. Tackling these challenges requires national commitment and resources, sound and rational policies, and programmes that are effective, affordable and sustainable. Certain minimum essentials would be needed to address the key issues. These include enhanced support from governments, ensuring equity for the poor and the underprivileged, fostering partnerships across sectors, and greater community involvement.

WHO continues to address global blood safety issues by improving collaboration with national and international partners, including the International Society of Blood Transfusion, the Council of Europe, the American Association of Blood Banks, the World Federation of Haemophilia, the International Federation of Red Cross and Red Crescent Societies and a host of other such organizations. We are committed to supporting Member Countries in their endeavours to strengthen national blood transfusion services.
Vaccine Development

We are aware that the main objective of the International Vaccine Institute (IVI), is to strengthen basic vaccine research, which is vital for health programmes in general and for our Expanded Programme on Immunization in particular. Basic research is needed for updating and improving the present knowledge about vaccines as well as for developing the future health policies and strategies for the use of new vaccines. I have no doubt that the research at the IVI will also result in finding quality vaccines which are potent and effective at ambient temperatures, contain more than one antigen with minimal side-effects, and are affordable and easy to deliver to our children.

In this endeavour, IVI may wish to collaborate with WHO’s Children’s Vaccine Initiative (CVI), in which the United Nations Development Programme is also participating since 1990. In the South-East Asia Region, some of the research institutes, WHO collaborating centres and public and private vaccine producers may wish to collaborate with you on strengthening vaccine development in order to achieve the above-mentioned objectives. Member States in the Region might also be interested in exploring the possibility of having joint vaccine research programmes with IVI.

May I further suggest that before entering into technical partnership with a country, IVI may wish to consult WHO Headquarters on existing internationally approved standards of vaccine production, research and development, including research protocols, vaccine standards, staff training and group educational activities. In order to bring about fruitful partnership

Meeting of the governing board of trustees of the International Vaccine Institute, Seoul, October, 1997
between WHO and the IVI, this collaboration would be useful in order to have a technical consensus on vaccine production. This would also avoid duplication of efforts in vaccine development.

The activities of IVI are in line with the recommendation of the Ministers of Health of the countries of the WHO South-East Asia Region as well as the Declaration on Health Development in the South-East Asia Region in the 21st Century, which call for Member States' self-sufficiency in vaccine production and procurement.

We are now actively strengthening national control authorities (or NCA) in our countries. These authorities will monitor and assess locally-produced and imported vaccines in the areas of licensing, clinical trials, lot release, laboratory testing, inspection and post-licensing activities. Thus, we feel that for any vaccine produced within a country, the concerned NCA should be consulted for further guidance. In addition, the performance of vaccine-producing laboratories within the South-East Asia regional network of national control laboratories (or NCL) is being regularly improved to check and assess the potency of both EPI and non-EPI vaccines. The skills of our vaccine producers in applying good vaccine manufacturing practices and other technical and management techniques are being improved. This is being done through bilateral cooperation among countries and by collaborating with the WHO/CVI global network of vaccine development training.

In the context of global resource constraints, we highly appreciate the support of IVI, UNDP and other partners in mobilizing resources for basic vaccine research activities. We, in WHO, look forward to your continued support in providing adequate, safe and affordable vaccines for children everywhere to protect them from avoidable suffering and death.
MEMBER Countries of WHO are strengthening primary health care in the context of the goal of Health for All. One of the eight elements of primary health care, as identified at Alma-Ata is the provision of essential drugs.

In this context, a major realization during the last decade has been that the public sector alone cannot achieve equitable health services coverage. Limitations on the part of the public sector to adequately finance health care have resulted in the restructuring of health policies and strategies in some Member Countries of our Region. These include decentralization of health care and its managerial infrastructures, introduction of cost-sharing schemes, and allowing the development of the private sector for providing and financing health care.

In each and every instance of health care reform, pharmaceuticals in general, and essential drugs and vaccines in particular, have a vital role to play. This is because re-emerging diseases, such as plague, drug-resistant tuberculosis, and malaria and dengue haemorrhagic fever, among others, continue to proliferate in our Region. This is despite vigorous efforts in their prevention, control and treatment undertaken by the public health services.

The public sector has traditionally been providing health care services for which effective fund-generating mechanisms are usually not well...
established. This, in turn, affects the availability and distribution of resources in spite of efforts made by national health departments and international organizations to promote equity. Hence, in the area of essential drugs, economic strategies have become an important component which merit serious consideration and inclusion in national drug policies.

The World Health Organization has been collaborating with Member Countries in the South-East Asia Region in the development, strengthening and revamping, where necessary, of national drug policies. These activities have been based on the essential drugs concept and the Revised Drug Strategy of WHO as adopted by the World Health Assembly.

As a result of active collaboration between Member Countries and WHO, the implementation of national drug policies has progressed in various aspects. This includes the selection and supply of essential drugs, drug quality assurance, rational use of drugs, drug regulatory control, human resource development and technical cooperation among countries.

In this regard, the first meeting of the WHO/SEARO Working Group on Drug Financing was held in Nikorn Ratchasima, Thailand, in November 1996. The meeting identified country-specific priority issues and recommended, among others, strengthening of national and local drug financing schemes in order to ensure equity and access to essential drugs.

It is important to measure the progress of national drug policies in terms of their achievements, particularly with respect to the accessibility of essential drugs, both in physical and financial terms. It is also important to plan for meeting the future health care needs of Member Countries and evaluate the relevance of national drug policies against these needs within the countries' priorities as we enter the 21st century. In this regard, WHO has published and distributed a manual on indicators for measuring the progress of national drug policies.

Several countries in the Region are moving towards an alternative mechanism to effectively deal with drug shortages by allowing the development of an appropriate public-private mix in the pharmaceutical sector. The public and private sectors constituting this mix should complement, rather than compete with each other. The trend, therefore, is likely to be an increase in the role of the private sector which would also include the involvement of private-for-profit as well as private-not-for-profit mechanisms. It is important that governments harmonize these mechanisms in order to achieve equity.
in the provision of essential drugs to satisfy health services' needs to the maximum extent possible.

Access to essential drugs is a priority issue in our Region. The supply of essential drugs varies from mostly public to mostly private funding, with varying proportions of the two systems working in combination. In order to effectively promote equity in access to drug, it is most appropriate to evaluate and improve our existing strategies for the supply and distribution of essential drugs as they form integral parts of an equitable health care system.

The key factors in promoting universal access to essential drugs continue to be equity, efficiency, economic sustainability and alternative financing.

In this regard, equity in accessibility to essential drugs has been a major and long-standing goal of WHO. It is an important goal since every citizen has the basic right to health care and, thus, to needed drugs. The goal becomes even more important in situations involving a high percentage of people living below the poverty line. Inequity becomes more prominent when the drug supply coverage by the public sector is insufficient compared to the total requirement.

One of the ways of promoting equity is for the public sector to look after those who are unable to pay for themselves. The private sector, on the other hand, can meet the needs of those who are able to pay.

Economic efficiency through obtaining essential drugs with the lowest possible cost is another goal that we must pursue relentlessly. The Ministries of Health, despite their attempts to increase the allocation for the drug budget often, in fact, have decreased the budget in real terms. Hence, there is a great need for making the best use of available resources in the procurement of drugs.

Economic sustainability in the context of drug management is also a critical issue. This has led, in some instances, to privatization which is an attempt at improving the availability of essential drugs. In this context, it is important that governments set forth national drug policy directions to enable tangible benefits to accrue from the public as well as private pharmaceutical sectors.

The alternative financing mechanisms, such as the user-charge system, social health insurance and health card schemes have proved to be feasible in providing health care as well as drugs. Hence, the process of privatization as a means to satisfy the increasing demands and offset the rising costs in the health sector should complement the efforts of the public sector to bring
about equity. In a situation where the market forces may diminish the quality of the health and pharmaceutical services provided, the good quality of drugs and health services need to be ensured, both in the rural as well as urban communities.

Finally, I wish to highlight the issue of sustainable access to essential drugs within the context of the overall health services. This inevitably raises the question of financial sustainability since funds within the public health facilities are generally inadequate for procuring the required drugs. Among the various strategies aimed at supplementing the national budget, cost-sharing has been shown to be crucial if its implementation is monitored and regulated effectively. It is necessary in this case that all practical mechanisms that would promote and ensure universal access to essential drugs are put into operation.

I would therefore urge you to examine the various issues related to improving access to essential drugs, and to recommend innovative ways of improving the existing drug financing schemes. In undertaking this task, let us re-dedicate ourselves to attaining the goal of universal access by all people to necessary medicines at prices which they can afford.

Priority must be accorded to drugs which meet the real health needs of the majority of the population. There must be equitable distribution of health services and essential drugs between cities and rural communities. Quality assurance mechanisms for drugs must be further developed and strengthened to ensure their quality, efficacy and safety.

The rational use of drugs should be vigorously promoted as everyone, at one time or another, needs medicines. In order to achieve and sustain these goals, innovative approaches need to be identified for promoting and sustaining the progress achieved in these areas.

I wish you every success in your efforts at promoting the availability of essential drugs. I am sure you will strive not only to facilitate the improvement of access to essential drugs but also to formulate practical guidelines and recommendations towards achieving this goal. This, in turn, would improve and strengthen health services at all levels of health care.
Health Sector Reforms

All countries, whether developed, developing, or least developed, are in various stages of health sector reforms. But what are health sector reforms? Using a simple definition, health sector reforms are “sustained processes of fundamental change in the policy and institutional arrangements in the health sector.”

These processes are usually guided by the respective governments on a technical and political basis. They are designed to improve the functioning and performance of the health sector and, ultimately, the health status of the population.

A question normally asked is, why do we have to undertake such reforms? The main reason for such reforms flows from the changes in political processes. These changes are more evident in countries which had previously adopted central planning systems. Another reason is pressure from outside, leading to what are often called “donor-driven reforms”. These pressures are more evident in the countries with heavy external investment programmes, especially those funded by multilateral financial institutions, such as the IMF, the World Bank, the Asian Development Bank or aid consortiums.

As part of economic structural reforms, several preconditions, including the reshaping of social sectors, are laid by these institutions. The term, “health sector reforms”, became popular after the World Bank issued a report in 1987 on “Financing health services in developing countries: an agenda for reforms”.

The ongoing socioeconomic changes taking place globally are another major reason for reforms. Poverty and underdevelopment, cost-containment and privatization efforts are resulting in social change. In

Regional Consultative Meeting on Research on Health Sector Reforms, Bangkok, February 1997
addition, epidemiological and demographic transitions also play a role. However, in practice, reforms in the health sector are likely to be influenced by external changes and pressures rather than epidemiological and demographic factors.

Whatever reforms are undertaken, the underlying objectives are to deal with issues related to equity, efficiency and quality of health systems. They are meant to ensure that the needs of the poor and the underprivileged are met.

The reform processes involve a clear definition of priorities, the strengthening of policies and the reshaping of the organization and management of health systems. Health sector reforms in countries of the South-East Asia Region, or elsewhere, are generally characterized by a number of changes.

Firstly, most countries undertake reforms in the organization and management of the health system. This includes changes in the organizational structure at various levels; as well as in management style. Also, changes in the type of health care facilities and staffing patterns, and the introduction of market mechanisms for running public facilities are undertaken.

Secondly, reforms are undertaken in the area of health care financing. These, for example include, a shift in the sources of finance and introduction of user fees, cost-containment measures, social insurance and reallocation of resources.

Thirdly, reforms deal with health care delivery, such as the use of a large number of health volunteers and nongovernmental organizations; the introduction of public-private mix, including the increased role of private profit/non-profit facilities as well as of community facilities.

Fourthly, reforms take place as part of changes in civil service structure and administration, such as decentralization, deconcentration and devolution.

Recently, an increasing number of countries have been rethinking their health policies and strategies and have initiated the reorientation and restructuring of health systems. Such processes of change are proceeding rapidly. Thus, health sector reforms demand an explicit link between planners, decision-makers and researchers.

Thus, the subjects of health sector reforms, health policy research, health systems research, and research on public policies have featured prominently on the agendas of recent country and intercountry meetings organized by WHO in our Region.
Most recently, at the meetings of the Regional Advisory Committee on Health Research (ACHR) and the Medical Research Councils (MRC) the subject of “Health Sector Reform” was also discussed. The same will again be the subject of the technical discussions at the session of the Regional Committee for South-East Asia, in September this year.

Despite this emphasis, there is a conspicuous lack of evaluation of such reforms in our Region. Research on the development of health policy and health systems lags far behind epidemiological and economic research. There is therefore an urgent need to undertake continuous and simultaneous monitoring and review of health systems development, in order to keep reforms on track and to facilitate timely and necessary improvements.

Scientific studies are required to find alternative ways to minimize the possible negative impact of reform initiatives. There is a need for better systems analysis and methodologies to enable planners to analyze different approaches to policy and institutional changes in the health sector.

The success of the reforms however, lies in the commitment of the stake-holders to the extent that they are involved in the processes of changes.

Another important issue is information sharing. A few related questions are: “Do we have enough information on various research efforts undertaken under health sector reforms?”, “Do we have an inventory of research studies on health sector reforms?”; “Do we have an inventory of health and health-related public policies?”; “Have the stake-holders identified their own research agenda?”; “Are there mechanisms to promote information sharing?”; and “Do focal points exist?”

In many countries, “capacity building” is another major issue. Very few countries have established special institutions or technical focal points for undertaking research in health sector reforms. Some of these institutions are the Centre for Health Economics at Chulalongkorn University; the Health Research Institute, and the Health Systems Research Institute, all in Thailand. In Indonesia there is a Centre of Health Service Research and Development under the National Institute of Health Research and Development, and in India, there is the National Institute of Health and Family Welfare.

Furthermore, only a few countries have identified a unit as a focal point. For example, the Department of Planning and Statistics in Myanmar; the Nepal Medical Research Council and the Division of Planning of the Ministry
of Health in Sri Lanka. Thus, the following questions still remain: “Do these institutions have the capacity to undertake research on health sector reforms on a national scale?”; “How should a network be formed and operated?”, and, “Do other actors have the same capacity?”

Against the backdrop of these concerns, the WHO Regional Office for South-East Asia has developed a regional plan of action for promotion of research on health sector reforms. The first activity under this plan relates to capacity building. There is a need to support the development of a critical mass of human resources and institutions that could ably respond to the various research needs of the countries.

Research promotion and development also need to be undertaken as part of other development in health systems, including health economics, policy analysis and research.

Information exchange, at both national and international levels, is also needed. Networking among national and international institutions and individuals should be promoted.

I expect that at the end of the Consultation, a list of major issues as well as a broad framework for areas of research on health sector reforms will be developed. I am confident that, with your expertise and experience, we will achieve our objectives.
Evidence and Information for Policy
WHO Collaborating Centres

The practice of utilizing national institutions, for international collaborative activities, goes back to the days of the League of Nations. At that time, some national laboratories were designated as reference centres for standardization of biological products. With the founding of the United Nations, and of the World Health Organization in particular, additional reference centres were designated. For example, 50 years ago, in 1947, the World Influenza Centre in London became a reference centre for worldwide epidemiological surveillance.

In the South-East Asia Region, the first WHO collaborating centre was designated in 1953. Since then, WHO collaborating centres have come to play, an important role in the Organization’s functions, as the leading technical agency in global health development. In 1989, the Regional Office organized a meeting of WHO collaborating centres in the Region which discussed the role of centres vis-à-vis WHO.

This included maintaining effective contact, for technical collaboration, information exchange, and developing mechanisms for monitoring and evaluation of collaborative activities. It is increasingly recognized, that every effort needs to be made to create the broadest possible network of partners for health.

In May 1997, the Fiftieth World Health Assembly passed a significant resolution on the subject of WHO collaborating centres. A series of recommendations were made, some of which are clearly relevant for this

Consultative Meeting of WHO Collaborating Centres and Centres of Expertise in the Areas of Reproductive Health and Emerging/Re-Emerging Infectious Diseases, WHO-SEARO, September 1997
meeting. The WHA resolution urged Member States to develop and support national centres of expertise so that they may meet the criteria to become a WHO collaborating centre. It also urged Member States to inform WHO of the existence of these centres of expertise.

The resolution also called for reviewing the arrangements between WHO and its collaborating centres and examining the option of working through contracts. The resolution urged that skills available at country level should be used fully. Steps should also be taken to encourage the identification of new resources and using them optimally to fulfill our tasks in the 21st century within the framework of the new strategy of health for all. The resolution recommended the promotion of a larger number of collaborating centres concerned with WHO’s priorities.

Two weeks ago, the 32nd WHO Consultative Committee for Programme Development and Management and the 50th Session of the WHO Regional Committee for South-East Asia, also discussed this subject. The Regional Committee passed a resolution, focussing on the need to improve the involvement of WHO Collaborating Centres in support of national health development.

Member States were urged to support national centres of expertise, and to optimize the use of WHO’s resources by involving such centers as well as WHO Collaborating Centres in the development and management of WHO-supported programmes.

In designating centres, a balance by area of speciality and geographic representation should be aspired to.

In the prevailing climate of diminishing resources, it will be difficult to match available resources with needs. WHO is thus vigorously continuing its reform process which includes making more effective use of WHO collaborating centres and of national centres of expertise.

It is in this context that this meeting assumes added significance in terms of technical and functional aspects.

The research and training functions of WHO collaborating centres have acquired considerable importance. While limited resources might become available from WHO and other agencies for specific tasks, they are likely to be rather nominal. However, one aspect needs to be emphasized even without direct financial support, collaborating centres and national centres of expertise can benefit much from working with WHO as partners for health. Scientific and technical exchange, as well as networking, are obvious examples. Whether at the
bench, in the field, or through consultations, an exchange of ideas and skills is important for strengthening collaborative work, to plan activities, to gain wider experience and recognition, and to mobilize additional resources.

Furthermore, the development, application and promotion of guidelines and standards will become increasingly important in the 21st century. Collaborating centres and national centres of expertise could play a vital role in that effort. As partners for health you could become partners in advocacy as well, to help shape national policy and practice.

As you know, a national institution which possesses a high standard of technical and scientific expertise can be designated as a national centre of expertise by its government. Later, collaborative activities can develop in scope and nature so as to suggest designation as a WHO collaborating centre.

In either case, centres represent an accessible pool of scientific and technical expertise. When properly utilized, they can contribute effectively to the work of WHO in providing support to the mainstream of health development in Member States.

While these aspirations are fine, we need to be realistic as well. Today, there are 78 WHO collaborating centres in our Region. However, effective utilization has not always kept pace with their numerical growth. While some collaborating centres are being well utilized, this is not the case with others.

The possible reasons for under-utilization are many. They range from inadequate communication between concerned parties, poor coordination of technical resources at country and regional levels, imperfect planning or reporting, and, to some extent, lack of resources. We need to tackle such weaknesses, and I am confident that this meeting can provide us with the possible solutions.

I would now briefly like to refer to the technical areas selected for this meeting: reproductive health and new, emerging and re-emerging infectious diseases. These represent two of the five priority areas identified by the World Health Assembly. Both areas pose complex health challenges. It is therefore vital that we strengthen our collaborative activities in these fields.

The scope of reproductive health has widened considerably. This was clearly underlined by the International Conference on Population and Development in 1994. There is an urgent need to activate existing collaborating centres in this area with
the changing demands of national programmes as well as WHO’s priorities. These priorities include family planning, safe motherhood, newborn care, prevention and management of complications arising from abortions, reproductive tract infections, sexually transmitted diseases, HIV/AIDS and adolescent health.

These demands indicate the need to review the existing terms of reference of collaborating centres. Any revision should allow WHO collaborating centres to be involved actively in the development and implementation of national reproductive health programmes. They should also enable collaborating centres to provide technical backstopping to WHO collaborative programmes both nationally and internationally.

The prevention and control of new, emerging and re-emerging infectious diseases is, as we all know, of crucial relevance worldwide. The important role of WHO collaborating centres was clearly demonstrated, during the outbreak of plague in India (in 1994) and of ebola in Africa (in 1995).

The involvement of WHO collaborating centres is therefore essential in strengthening epidemiological surveillance and laboratory diagnosis; and in establishing rapid outbreak investigations and response mechanisms. The involvement of collaborating centres is also necessary in monitoring antimicrobial resistance patterns and in implementing the revised International Health Regulations.

It would therefore be very useful to develop regional collaborative plans of action in these two priority areas, and to strengthen networking and linkages. While this meeting will be followed by others covering different programme areas, your deliberations and collective wisdom will provide the necessary direction and guidance. We will have similar mechanisms for other priority areas as well.

I firmly believe that WHO collaborating centres and national centres of expertise are important partners in pursuing our goal of achieving health for all.
Health Implications of Trade Agreements

We are all aware of the formidable challenges faced by our Member Countries in the pursuit of their health development goals. Recently, these challenges have assumed a bigger dimension with globalization and international trade liberalization. Today, the health sector is facing not only its own systemic problems but also those imposed by the external environment. During the last two years, we have seen the adverse impact on health of the Asian economic crisis. We have also learnt that without appropriate and timely action, the progress made in health development may also be hampered.

There seem to be many potential challenges emanating from multilateral trade agreements under WTO. This is very obvious, especially in the case of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). As you are aware, our Region has ten countries, both developing and least developed. Except for DPR Korea, all are either full members or observers of WTO. Under TRIPS, some countries have to ensure full implementation of the Agreement from next year, whereas others have a longer time-frame.

The TRIPS Agreement envisages a

- The message of the World Health Assembly is clear. Public health interest is of paramount consideration. The access to essential drugs must be safeguarded in the implementation of the trade agreements.
- In order to develop new drugs and vaccines, we need industries with appropriate incentives for innovation, including patent rights. However, their final aim should be to secure human health and not merely economic profit.

Regional Consultation on WTO Multilateral Trade Agreements and their Implications on Health-TRIPS, Bangkok, August 1999
globally harmonized framework for the protection of patents in a limited, transitional period. This framework is based on the high standards applied in the economically and technologically advanced countries. Some of them have introduced such standards only recently. The current TRIPS standards, it is apprehended, may considerably restrict countries in adopting a national patent system suitable to their level of health development, especially in the area of pharmaceuticals.

In the past few years, WHO has noted a number of concerns expressed by many countries on the potential implications of this Agreement on the availability of and accessibility to drugs. The concern is more serious in countries where a large section of the population is living in absolute poverty with minimal access to basic health care, including essential drugs. In most of our countries, 30-40% of the expenditure on health care is on drugs; some may spend even more. The aim of the national health policy must be to ensure equitable access to essential drugs, their rational use and quality. This is in keeping with the fundamental right of people to health care. Now, the question arises: how can the issue of equitable access be addressed within the context of globalization?

Trade, health and intellectual property rights are areas with complicated interactions. At times, they pursue different objectives with cross-cutting interests. Some of you may recall the debate at the Fifty-second World Health Assembly in May this year on the resolution relating to the WHO Revised Drug Strategy. This was one of the most lively discussions in the recent history of the Assembly. The main issue was related to TRIPS. However, a compromise was found and a consensus arrived at.

The message of the World Health Assembly is very clear. Public health interest is of paramount consideration. The access to essential drugs must be safeguarded in the implementation of the trade agreements. We consider that in the negotiations on multilateral trade agreements and their implementation, public health concerns must be heard and weighed appropriately. Many of these multilateral trade agreements affect health and health development. We believe that the health sector must be involved in the discussions and decision-making on trade agreements.

However, experience in our Region shows that the health sector is, in fact, not fully aware of the implications of such multilateral international trade agreements. Also, they have not been involved in the negotiation process of these agreements. We, in the South-East Asia Region, however, took the initiative to deal with this challenge.
We did a situation analysis of the countries’ experiences on a few multilateral trade agreements. We produced advocacy papers and information booklets and distributed them to ministries of health to create awareness of the problems and issues. We had discussions on the subject at the meetings of health ministers in 1998 and of the health secretaries in 1999. However, greater sharing of information on country experiences and discussions on multilateral trade agreements is required.

We need more dialogue and interaction with various sectors. I believe that the health sector must fully understand the implications of international trade agreements. They should enhance their partnership with others, such as trade, industries, intellectual property agencies, legal and consumer institutions. WHO suggests that countries establish appropriate processes and mechanisms to secure better coordination and cooperation among the many players involved. At the global level, WHO has initiated a dialogue with WTO. WHO has also included the private sector and the pharmaceutical industry in its new global initiatives, such as Roll Back Malaria and Tobacco Free Initiative.

We are all aware that with recent progress in research, HIV/AIDS patients can prolong their lives. The cost, however, is very high - nearly US $ 18,000 per year. As is well known, 90 per cent of the 30 million people affected with HIV/AIDS live in developing countries. Most of these people spend less than US $ 10 annually on health. Thus, even though new drugs and interventions exist for HIV/AIDS patients, their availability remains but a dream for many.

The vaccine against Hepatitis B virus infection has been in use for more than a decade in the developed countries. But it is becoming widely available only now in the developing countries. You will appreciate that the delay has been largely because of the exclusive intellectual property rights.

World experience shows that the patent system stimulates research and contributes to economic growth. It can also make enormous contributions to health development. In order to develop new drugs and vaccines, we need industries with appropriate incentives for innovation, including patent rights. However, their final aim should be to secure human health and not merely economic profit.

Many people are asking: Isn’t there any room in the intellectual property rights or TRIPS Agreement to accommodate public health interests? The fundamental questions are: whether
the prices of drugs will increase; whether availability of essential drugs will be affected, and whether research and development will enhance production and availability of drugs for priority public health problems. Suitable answers must be found to these questions.

WHO considers that in the process of globalization, one objective should be clearly kept in mind. It is to ensure that the health status of the population improves as the economy grows. WHO is ready to help Member Countries in ensuring equity and social justice in health. WHO will also monitor the implications of the TRIPS Agreement on the health sector, as mandated by its governing body.
Evidence and Information for Policy

Health and Biomedical Information

Dissemination of health and biomedical information is crucial to WHO’s work. Article 2, paragraphs (q) and (r) of WHO’s Constitution specifically entrust the Organization with the task of providing information in the field of health and to assist in developing an informed public opinion among all peoples on matters of health. In accordance with this mandate, WHO headquarters, the Global Advisory Committee on Health Research and the regional offices have taken various initiatives. These include the supply of medical textbooks and literature, the initiation of the WHO Revolving Fund for the purchase of books and journals, and the establishment of WHO Depository Libraries in the countries.

In WHO’s American Region, a Regional Library of Medicine and Health Sciences (BIREME) has been established at the Paulista Medicine School in Sao Paulo, Brazil. This meets the scientific information needs of the countries in Latin America.

The South-East Asia Region has taken a different approach. Rather than putting all its resources in one Regional Library, it has formed a network for sharing resources. Based on a cooperative and partnership agreement, medical and health libraries of the countries of the Region are strengthening each other.

Based on this approach, the very first meeting on health information and literature was held 20 years ago, almost to the day. Librarians, heads of research institutions and administrators from the countries of the Region met in New Delhi to discuss various issues.

It is important for us to remember that valid and relevant information is essential for decision-makers.

Intercountry Meeting on Strengthening the HELLIS Network, Bangkok, July 1999.
related to biomedical research and health information and literature. It was at this meeting, held in August 1979, that the “Health Literature, Library and Information Services or (HELLIS)” Network of the South-East Asia Region was born. Since then, the WHO South-East Asia Regional Office has been supporting various activities aimed at achieving the objectives of the HELLIS Network. This has been done by supporting meetings, training courses, and through production of information management tools, such as National Union Lists of Serials, and the Index Medicus for the South-East Asia Region (IMSEAR). The HELLIS Network has also successfully collaborated with the Health Systems Research (HSR) Network to provide countries with the required HSR reports. Similarly, links have been established with the ESCAP-POPIN Network.

The budget for these activities was originally from intercountry funds. Later, countries allocated funds from their country budgets for national HELLIS activities. It is unfortunate that, in recent years, many Member Countries have dropped national HELLIS activities from their country budgets. Does it mean that the countries no longer regard provision of health literature, library and information services to their decision-makers, health administrators and researchers as important?

It is important for us to remember that valid and relevant information is essential for decision-makers. This has been recognized in the "Declaration on Health Development in the South-East Asia Region in the 21st Century". I would like to quote some relevant parts of the Declaration:

“The rapid advancements in information technology and communication systems sweeping across the world today have made us irrevocably a part of the global village...”,

“There should not be any hesitation in sharing knowledge and skill through transfer of technology...”.

“Intercountry partnerships to share experiences on development processes, collaboration in research activities and sharing of their findings would indeed prove to be a cost-saving exercise for health development in the Region”.

I need not remind you that we are now in the information age and the information revolution will be accelerated in the next millenium. Electronic libraries and networks will be at the hub of the information society. What we therefore need is more efficient access to the world’s literature and information sources, not less. We need to invest more into information networks, such as the HELLIS Network, rather than starve it of funds. The
HELLIS Network Libraries too need to move into the electronic age, to better enable them to serve their national clients through the resource-sharing network.

This brings me to the present “Intercountry Meeting on Strengthening HELис Network”. There has been a gap of ten years since the last Intercountry HELис meeting. During this period many changes have taken place.

First of all, there have been changes in staff, both in the libraries in the countries as also in the WHO/SEARO library. Many pioneer librarians of the HELис Network have retired making way for a younger breed of high-tech librarians, infusing new blood into the network. This is as it should be and we must take advantage of the situation. But the librarians of today should keep in mind the words of the great Indian leader, Mrs Indira Gandhi, when she said:

"Electronics cannot create comradeship, Computers cannot generate compassion, Satellites cannot communicate tolerance."

Therefore, even while moving towards a virtually electronic library, librarians would still need to retain the human touch.

Secondly, since the last HELис meeting, many advances have taken place in the field of information technology. The HELис Network and its libraries must take advantage of these advances if it is to continue to fulfil its main objective, which is “to ensure easy access to relevant health information for health personnel and other potential users”.

It is therefore an opportune moment for the WHO South-East Asia Regional Office to hold this intercountry meeting. This will enable librarians, health administrators, decision-makers and researchers to come together again to discuss and formulate strategies to strengthen the HELис Network. While doing so, the group should consider ways and means of taking full advantage of the advances in information technology.

I would, however, add a word of caution here. In discussing the introduction and use of the latest technology, never lose sight of the ultimate aim of the Network. This is to provide health and biomedical information services not only to clinicians, academicians and research workers but also to health administrators and decision-makers, and all other health and health-related personnel, to enable them to meet the
health challenges of the next millennium.

I conclude with a well-known quotation from John Donne: “No man is an island, Entire of itself”

This can apply equally to libraries these days. You must network and build partnerships.
Health Impact of Economic Crisis

The recent economic crisis in some countries of South-East Asia took the international community by surprise. Massive devaluation of currencies led to adverse economic and social implications. To mention just a few: rise in prices, shortage of commodities, closing down of many small and medium-size businesses and scaling down of large enterprises. The result? Increased unemployment, shortage of food, social unrest and, at times, even political turmoil.

The economic crisis also affected the health sector. For example, shortages of pharmaceutical and drug supplies, and consequently an increase in the price of drugs in most countries. There is evidence to show that people who utilized private health care facilities are switching back to public health institutions, thereby increasing the pressure on the already strained public health facilities. This has weakened the public sector’s ability to protect the poor and vulnerable segments of the population.

The challenge of the economic crisis however, is not just financial and economic. It is social and political, and even includes issues of governance. Solving a complex socioeconomic situation such as this requires national and international solidarity. Cooperation and coordination among various ministries, community organizations, national and international NGOs and, most important, with peoples’ representatives, such as you. The affected countries need to work together in a spirit of partnership. Let us turn this challenge
into an opportunity for strengthening partnerships and solidarity, among ourselves.

The World Health Organization, from the very beginning, has played a catalytic role in helping Member countries to face the economic crisis. First, a Regional Consultative Meeting on health implications of the economic crisis in the South-East Asia Region held in Thailand, in March 1998, identified four major areas to be addressed. These were (1) pharmaceutical production and management; (2) health status and safety net for the poor; (3) financial risk protection, and (4) management of human resources for health. The meeting also called for strengthening intercountry cooperation mechanisms to address these issues.

As a follow-up to these recommendations, WHO initiated activities to accelerate intercountry technical cooperation among countries in the Region in the area of production of pharmaceuticals and vaccines. As a result, India is now working closely with Indonesia, in providing raw materials for essential drugs. I firmly believe that such partnerships among countries are the most appropriate mechanisms to ensure regional solidarity and self-reliance in health.

Many countries in our Region are yet to develop sound financial risk protection programmes for the poor, especially in the area of health care. A social safety net programme is needed by all countries in order to cover the weaker segments of the population. The U.S. President, Mr Bill Clinton, while addressing the meeting of the Board of Governors of the World Bank and International Monetary Fund in October 1998, said that a significant amount of the US contribution to the World Bank should be used to develop social safety nets for developing countries. President Clinton’s firm commitment to the social well-being of the poor and marginalized people of the world should inspire us in our work to further dedicate ourselves towards improving the health care system in this part of the world.

WHO has consistently advocated that health is central to development. This has been reinforced at many national and international fora. The Global Social Summit had also highlighted the key role of health in generating productive employment, alleviating poverty and fostering social integration. Yet, the health sector is still not accorded due priority in the overall development agenda. Politicians and policy-makers do not see it adequately as a central pillar in the developmental process.

I would, therefore, urge the honourable parliamentarians to take
this message to the Parliaments of your countries. Advocate forcefully for the development of health and social safety net programmes aimed at the poor and vulnerable. Use your influence during budget debates and in the formulation of short and long-term plans in your countries. Ensure that the social sector, including health, gets its fair share. Convince others, especially your Finance Ministers, that investment in health is an investment for the future.
Epidemiological Surveillance

There is a growing concern worldwide about the spread of infectious diseases. This is because problems associated with socio-economic and ecological changes, such as rapid population growth and unplanned urbanization, which facilitate the transmission of these diseases, are expected to increase. As we move into the 21st century, the need to develop comprehensive strategies for controlling infectious diseases has become more urgent than ever before.

For almost 50 years, WHO and its Member States have waged a relentless battle against infectious diseases. The most dreaded scourge, smallpox, has been eradicated. Notable success has also been achieved in controlling infectious diseases, such as guinea-worm disease, poliomyelitis and leprosy. However, diseases such as malaria and tuberculosis, once thought to have been brought under control, still threaten the lives of millions of people in Asia. Plague and kala-azar, once on the verge of eradication, have re-emerged. And new diseases, such as a new strain of cholera, and HIV infections coupled with antimicrobial drug resistance, are spreading rapidly in the Region.

A well-functioning surveillance system is therefore essential if a country is to respond rapidly and effectively to any threat of disease outbreaks.

Intercountry Consultative Meeting on Epidemiological Surveillance and International Health Regulations, Colombo, December 1998
In order to improve the quality of surveillance reports of communicable diseases, WHO decided to develop usable case definitions for health workers at all levels. At an Intercountry consultation, held in Colombo in May 1997, case definitions for eleven communicable diseases with epidemic potential were developed. These case definitions are being field-tested in Indonesia, Myanmar and Nepal.

However, countries are being encouraged to start using these case definitions even before the results of the field tests are available. Depending on the existing epidemiological situation, each country should identify the diseases, that need to be reported.

Given the changing international environment, the emergence of new diseases and resurgence of old diseases, in May 1995 the World Health Assembly adopted a resolution calling upon WHO to undertake a revision of the International Health Regulations. The current Regulations, which have been in effect since 1969, require reporting of only three communicable diseases, viz., cholera, plague and yellow fever. Most countries under-report on these diseases by name for fear of adverse consequences to tourism and trade.

The revised International Health Regulations require immediate reporting of a number of well-defined disease syndromes that are of international importance. This will facilitate timely notification for implementation of effective control measures. These regulations will also provide for the reporting of disease outbreaks of unknown origin where a potential hazard to international travel and trade is identified.

A pilot study is under way in 21 selected countries in the six WHO regions, with the objective of evaluating the notification of these proposed clinical syndromes within the existing national disease surveillance systems. The results of this study in this Region will help to identify the constraints in implementing these new regulations and help in the final revision of the International Health Regulations. Three countries namely, India, Sri Lanka and Thailand, were selected in this Region for the pilot study. It is of vital importance that the revised International Health regulations should be implemented in all countries with the least possible delay. This will help to prevent the rapid spread of diseases across international borders. Until such time as the revised International Health regulations come into effect, Member States have been requested to comply with the current International Health Regulations.
I would like to emphasize that, with the advanced communication technology available, surveillance information can be rapidly and easily disseminated. At the same time, in the absence of reliable information, rumours and unconfirmed reports will lead to a sense of panic, both within and outside a country, resulting in adverse effects on trade and travel. Therefore, there is an urgent need to develop an effective epidemiological surveillance and epidemic response in all countries of the Region. This would ensure rapid dissemination of reliable information as well as rapid implementation of effective control measures.
Equity in Health

EQUITY in access to and use of health services is a common goal for all of us. Recently, WHO has been in the forefront in emphasizing the importance of equity as a policy criterion when reforming health care systems. The World Health Report 1995, which was focused on bridging the gaps, is a vivid example of WHO's commitment to equity, quality and social justice. From the perspective of improving overall health status, equity is an important objective itself. There is considerable evidence that inequalities in such access have an adverse impact on the overall level of health status in a national population.

Equity is increasingly becoming an important issue especially when attention is focused on efficiency considerations. Health sector reforms are taking place in many countries globally and in our Region as well. These will have serious implications if proper attention is not given to the poor, marginalized and vulnerable groups. There have therefore been efforts in many countries to assess the performance of health care systems from an equity perspective.

In the context of least developed countries, equity in access to public health services has become a more important objective from the poverty alleviation perspective. Evidence from Sri Lanka and Malaysia indicate that provision of basic health services has indeed been an important mechanism for mitigating the impact of poverty in rural areas. This very important issue should therefore be given adequate attention, particularly in the least developed countries.

Regional Consultative Meeting on Equity in Health in South-East Asia: Trends, Challenges and Future Strategies, Thimpu, November 1998
WHO has done a lot of work on this subject in terms of organizing technical meetings, collecting available information and developing strategies for monitoring and evaluation of inequalities in health. Much more needs to be done, however, for a better understanding of the implications of inequalities in improving the health status of all.
Health Economics

It is an undeniable fact that countries in Asia and the Pacific have achieved considerable gains in the field of health. The incidence of communicable diseases has declined significantly. Diseases such as smallpox and yaws have been eradicated, and some diseases like poliomyelitis, measles, tetanus and leprosy are on the verge of eradication or elimination. The under-five mortality rate has declined remarkably. There has also been a substantial decline in the total fertility rate. Life expectancy has improved in most countries. However, there is no room for complacency. In certain parts of Asia, infant and maternal mortality is still unacceptably high. This Region accounts for a major proportion of the global disease burden. While the rate of population growth has declined appreciably in most countries, the population continues to grow rapidly in absolute numbers, especially in urban areas. Gaps in the health status between and within countries have further widened. Noncommunicable and chronic diseases are rising creating an increasing demand for health care.

In light of the scarcity of resources, the role of economics in the health sector is becoming increasingly important. While the need to prioritise health care in terms of equity and social justice is crucial, it is nonetheless difficult.

The problem of resource constraints is further compounded by the recent economic turmoil in the Region. At the same time, the increase in health care coverage and improvement in the quality of health care require additional resources. Urgent efforts are therefore needed to make optimal use of available resources through cost-containment and efficient resource management.

Academic institutions dealing with the training of health professionals should formally include health economics in their teaching curriculum.

If we look at the pattern of socio-economic development in Asia and the Pacific, we notice that health and human development have preceded overall economic growth. Health, therefore, has to be an integral part of macro- and micro-economic policies to ensure healthy public policies.

The use of economic principles in the health sector has been evident for some time in both developed and developing countries. The growth in health economics literature, the increasing number of health economists, and the growing interest of policy makers in health economics all bear testimony to the importance of health economics in health development in the Region. We must therefore realize that a clear understanding and appropriate application of economic concepts and principles in health require continuous orientation and education among health professionals, planners and managers. Economists who work in the health sector or other social sectors need to understand issues in health development. Social responsibility for public health measures has to be taken into account in health interventions in order to protect the poor and vulnerable who cannot afford to compete in the market.

During the past few years, various forms of health care financing, such as community financing, cost-recovery, user fees, social health insurance, privatization of health facilities and services, including private health insurance, have been tested and adopted by many countries. However, the results have been mixed, particularly in developing and least developed countries. Revenue generation and the expansion of coverage have not been as expected. Ultimately, the most affected persons are the poor and other vulnerable groups.

While countries are striving hard to increase resources for health through internal and external finances, efforts have to be made to improve efficiency in resource utilization. A major challenge has been to find a proper balance in the financing of health care that will ensure sustainability of quality health services to all, particularly the poor and other vulnerable groups. Economists, planners, policy analysts and managers working in the health or health-related sectors, have to play their roles in guiding the countries to meet this challenge. The role of health economists is vital during the current economic crisis in the Region.

The theme of this forum, "The role of health economics in health policy analysis and evaluation" is timely and relevant. I notice that eminent economists, health planners and managers will be speaking on the role of health economics for health
development in the 21st century. This is very pertinent, as WHO is preparing, for adoption by its Member States, of the "World Health Declaration", which affirms a policy intention and framework for health development in the next millennium. I am sure there will be an intense debate on the various aspects of health care financing undertaken in the countries of Asia as well as in other parts of the world. The debate on the health implications of the economic crisis in this region will be useful and relevant to all of us.

I have noticed that the list of participants includes eminent persons from academic and research institutions, health ministries, donor agencies and international financial institutions. Their valuable contributions, I am sure, will lead to a consensus on future developments in health economics. I do hope that such a debate and analysis of the global and regional situations will also lead to strengthening national capacity. In addition, if possible, agreement could be reached on research priorities in health economics and other information needed for health policy development initiatives.

This forum, as I understand, will serve as an initial step for the formation of a regional network on health economics, linking economists, policy makers, planners, academia and researchers in Asia and the Pacific. This networking, I hope, will provide a good opportunity to countries for exchange of information and ideas, and for sharing the lessons learned globally and regionally.

I am glad that WHO has been involved in this development right from the beginning. The purpose of supporting a forum such as this is to bring health professionals and economists to work together for a more rational approach in health planning and management. That will provide Member States the necessary knowledge and skills in analyzing public policies to ensure equity in health care; feasible alternative health care financing; additional resources, particularly for essential health care; and better approaches in formulating a sound national health development policy.

The Centre for Health Economics, the Faculty of Economics, Chulalongkorn University, is the only institution designated as a WHO Collaborating Centre in Health Economics. The Centre has been involved in postgraduate training and in conducting short courses as well as in research studies and sharing information on health economics. I am sure that there are other national and international centres of expertise similar to this Centre. National governments and WHO need to work closely in
strengthening the capacity of such centres to help them become regional and global centres of excellence.

Today, there are not many economists or professionals in health economics to work in the health sector of the developing countries. In general, health planners and managers do not have adequate knowledge of health economics. Even though many health research institutes have taken up studies in health economics, the results have not been used in policy- and decision-making processes. Academic institutions dealing with the training of health professionals should formally include health economics in their teaching curriculum.

Some countries have strengthened the planning and management capability of their ministries of health by establishing separate departments, units and divisions manned by trained health economists. In others, they use economists from other sectors and academic institutions. A health economist is an indispensable member of today’s health planning and management team.

The role of the World Health Organization is to support national, regional and international institutions in their efforts to strengthen their respective capacity in health economics. This support should also enable them to disseminate information related to health economics through various mechanisms, such as a forum of this type. The purpose is to influence health systems development, and to encourage Member States to promote and advocate the concept of health economics for application in policy development, planning and management of the health programmes.

I hope this forum will become a regular platform for the development of the skills and knowledge in health economics, which will lead to a sound health policy analysis and health systems development in the Region. I sincerely trust that this forum will further strengthen cooperation and solidarity among Member States in the area of health economics.