Highlights of

The Work of WHO

in the South-East Asia Region

Report of the Regional Director

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This short report on the work of WHO in the South-East Asia Region gives the highlights of the activities carried out during the period 1 July 1999 to 30 June 2000. It only describes some of the projects and programmes, highlighting matters of major interest. However, the many activities not mentioned here are of no less importance than the ones described. A more detailed account of WHO's activities in the Region during 1999-2001 will be given in the Regional Director's report to be presented to the fifty-fourth session of the Regional Committee in 2001.

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Introduction

This report is truly unique, covering as it does, the end of one century and the beginning of another. In highlighting the collaborative efforts of WHO, the report presents a brief overview of the health situation in a Region that is home not only to a fourth of humankind, but also to a host of communicable and noncommunicable diseases.

Conscious of the fact that the South-East Asia Region accounts for 40 per cent of the global disease burden, Member States are making determined efforts to strengthen their health and surveillance systems. The ultimate objective is to ensure equitable accessibility of health care to all their people. Particular attention is being paid to the vulnerable and marginalized groups. It is well recognized that any breakthrough in health in the Region would have a global impact.

Since the larger picture of health is adequately discussed under various sections in the Report, I shall draw attention to a few noteworthy developments.

In the area of prevention and control of communicable diseases, the Roll Back Malaria initiative, the thrust and emphasis on expanding the DOTS (directly observed treatment, short course) strategy, the Stop TB initiative to combat tuberculosis, and the synchronized national immunization days to help eradicate poliomyelitis are making good progress. Similarly, since the Region accounts for 78 per cent of the registered cases of leprosy globally, the twin strategies of leprosy elimination campaigns (LEC) and special action projects (SAPEL) are being pursued vigorously in high-endemic countries.

A landmark in public health was reached when the International Commission for Certification of Dracunculiasis Eradication certified, in February 2000, that guineaworm disease (dracunculiasis) had been

eradicated from India, DPR Korea and Thailand. Thus, the South-East Asia Region became the first WHO region to eradicate this disease.

Though HIV/AIDS came relatively late to the Region, it is estimated that 5.5 million people are already infected with HIV in the Region. This is nearly 18 per cent of the global burden. Apart from the health implications, this is bound to have a serious socioeconomic impact in the years ahead. The emphasis of WHO support is, therefore, on prevention and control of STDs, ensuring blood safety, clinical care and counselling, as well as epidemiological surveillance and research.

As for noncommunicable diseases, an integrated preventive approach, addressing the common risk factors, and promoting healthy lifestyles is being pursued in the Region.

In keeping with its leadership role in international health development, and in order to focus attention on priority health issues, WHO has initiated several international meetings and conferences. These, among others, included the WHO Framework Convention on Tobacco Control, Vision 2020 focusing on the prevention of blindness in the Region, and the Regional Conference on Public Health in the 21st Century.

Maternal and child health, women's health, and integrated management of childhood illness have continued to receive priority attention. Considering that environmental health risks account for one-fifth of the total disease burden in the developing world, greater emphasis is being placed on sustainable development and a healthy environment.

In supporting Member States in their health development efforts, WHO has continued its initiative in organizing meetings of Health Ministers and Health Secretaries, as well as Health Parliamentarians in the Region. Necessary guidance to the countries in their respective health policies and plans of action continue to be provided by the Regional Health Declaration of 1997.

The common thread running through all of WHO's collaborative efforts in the Region has been, and continues to be, better health for the people. In the period under review, the Director-General has sought to give a new direction to the way in which WHO works. Again, the bottom line is to improve overall efficiency and to make the Organization's work meaningful in keeping with the needs of the Member States.

As with the rest of the world, WHO too must learn to do more with less. We have to do better with what we have, and, forever, to strive to make the world a happier and healthier place to live in. It is with these thoughts that I present this report to the fifty-third session of the Regional Committee.

Dr Uton Muchtar Rafei
Regional Director

1
Communicable Diseases

Communicable Disease Surveillance and Response

Emerging and re-emerging communicable diseases remain an important challenge to public health in the Region which bears more than 40 per cent of the global burden. During the past year, epidemics of dengue, cholera, malaria and Japanese encephalitis were reported from some countries. The increasing number of disease outbreaks highlights the need to develop sensitive epidemiological surveillance systems to detect these epidemics early. It is equally important to have adequately trained manpower to respond effectively.

Technical support was provided to the Field Epidemiology Training Programmes (FETPs) in India, Indonesia and Thailand which have continued to function successfully as regional training programmes for developing a core group of skilled epidemiologists. The Regional Office conducted two ten-day intercountry training courses on "Epidemic Preparedness and Response" in Myanmar (July 1999) and in Delhi (April 2000) to develop regional capacity to detect early disease outbreaks and to respond effectively. Training materials were developed by WHO for the training of trainers at the central level and regularly updated incorporating regional case studies. The Regional Office is also developing a five-day training package for district-level staff.

WHO played a proactive role in developing a plan for strengthening the surveillance system in India. A team from WHO headquarters twice visited the country for extensive discussions with national officials and agencies such as USAID

and World Bank. Technical assistance was provided for the development of a strategic paper on assessment of the implementation of the national surveillance programme on communicable diseases (NSPCD) in the pilot districts of identified states before the proposed expansion to other districts; preparing an inventory of laboratories which can assist disease surveillance; and review of training courses for capacity building. To enhance USAID-WHO collaboration in strengthening disease surveillance in India, a Task Force was constituted. Regular meetings were held to identify priority activities for implementation and for mobilizing resources.

During the cyclone in Orissa in October 1999, the state government was supported in devising an emergency surveillance system to get an early warning of impending disease outbreaks. The system is functioning well and has been successful in controlling and preventing epidemics of diarrhoea, cholera, malaria, measles and ARI. WHO staff also regularly participated in the meetings of the UN Disaster Management Committee.

In regard to information sharing, WHO has been assisting the National Institute of Communicable Diseases (NICD), Delhi, in the preparation, printing and distribution of "CD Alert", a monthly newsletter to disseminate information on various aspects of communicable diseases to the medical fraternity and health administrators. The Early Warning Reporting System (EWARS) Bulletin in Nepal shares information on communicable disease outbreak with the national health staff. The information is also available in electronic form. Similarly, Sri Lanka publishes a "Weekly Epidemiological Bulletin", which is shared with the national staff as well as with the Member Countries of the Region.

Cholera

Although cholera is endemic in many countries of the Region, only Bangladesh, India and Sri Lanka report regularly to the Regional Office. Many countries report cholera as acute diarrhoeal disease. While the majority of isolates is Vibrio Cholera 01, serotype Ogawa or Inaba, there is evidence of

sero group O139 in several countries. Mortality from cholera continued to be very low because of prompt and appropriate case management.

All Member Countries have been encouraged to apply the current International Health Regulations (IHR) by notifying cholera or suspected cholera cases to WHO. They have also been requested not to impose inappropriate measures (e.g., trade and travel restrictions) against the affected countries.

Communicable Disease Prevention and Control

Roll Back Malaria

Malaria remains a major economic burden in the endemic countries of the Region and produces a telling effect on the health of the people. Following the acceptance of the Roll Back Malaria (RBM) initiative by Member Countries in 1998, important resolutions were adopted by the Regional Committee and the Health Ministers' Meeting in 1999 relating to advocacy, mainstreaming of RBM into health sector development and ensuring sustainable partnership for effective malaria control. In the Region, mono and multidrug-resistant *P. falciparum* strains are spreading, increasing morbidity, mortality as well as the cost of treatment. The focus of drug-resistant malaria is the international borders around Mekong Basin, e.g., Thailand, Myanmar, China (Yunnan Province), PDR Laos, Vietnam, and Cambodia. These countries have agreed to work jointly for malaria control by investing in capacity building, improving communication on programme implementation and surveillance, and focusing activities on universal access to health care for the poor. RBM Mekong is a partnership project supported by the WHO South-East Asia and Western Pacific Regional Offices, UNICEF, UNDP, EEU, and other bilateral agencies. A UNICEF/WHO RBM project document has been developed for implementation by Member Countries.

In preparation for the implementation of RBM, WHO has developed a protocol on conducting situation analyses in pilot districts. Guidelines for strengthening the district health system, advocacy and community mobilization and diagnosis, and treatment and transmission control at the community

level are being finalized through informal consultations in the Regional Office. Informal consultative meetings between the South-East Asia and Western Pacific Regional Offices on Technical Resource Networks, held at Chiang Mai, Thailand, in March 2000, identified scientists and institutions for three technical support networks viz., transmission risk reduction; surveillance, information management and epidemic preparedness and response; and drug resistance and policy. Priority activities, such as poverty alleviation, ensuring universal access to health care, thrust on capacity building, social mobilization, strengthening of the health system and technical networking of institutions, are focused on the poor and vulnerable groups, especially children, pregnant mothers and the migrant population.

Vector-borne diseases

Vector-borne diseases are important causes of morbidity and mortality in the Region. In the absence of vaccines and specific drugs, vector control assumes greater importance in the prevention and control of these diseases.

The first WHO Regional Training Course on Comprehensive Vector Control, was held at the Vector Control Research Centre (WHO Collaborating Centre for Integrated Method for Vector Control) in Pondicherry, India, in August-September 1999. Problem-based training modules were developed by experts and used at the training. These modules are being further refined. The second regional training course will be held at VCRC, Pondicherry, in August 2000. Following this training course, national training courses will be held in India, Indonesia, and Thailand during this biennium.

Though insecticides are the mainstay of vector-borne disease control activities, most countries do not, as yet, have a national policy and guidelines on the use of insecticides. WHO is assisting in the development of such a policy.

Unfortunately, most countries of the Region, when undertaking development projects, do not give much

consideration to their health impact. An Intercountry Workshop on Adverse Effects of Development Projects on Mosquito-borne Diseases was held in Bangkok in October 1999. The Workshop focused on medium and small-sized projects where health aspects are usually not addressed. Based on case studies presented at this meeting, a working model for incorporating health impact assessment and remedial actions was developed.

Dengue fever/ dengue haemmorhagic fever

Dengue fever/dengue haemorrhagic fever (DF/DHF) is increasingly becoming a leading cause of morbidity and mortality, especially among children. An estimated 20 to 30 million cases of dengue fever with approximately 400 000 cases of DHF occur annually in the Region. To combat this problem, WHO is assisting countries in improving clinical management of cases and in carrying out effective vector control activities.

To reduce case fatality, WHO supported the countries in conducting training in case management. The manual on *Case Management in Small Hospitals,* prepared by the Regional Office, as well as the publication, *Prevention and Control of Dengue Haemorrhagic Fever* was distributed to the countries. Support was provided to the countries in translating the latter document into respective national languages. A video on case management will also be distributed to strengthen training.

WHO continued to assist Thailand in the development of a vaccine. While clinical trials of a live-attenuated tetravalent vaccine are continuing in Thailand, WHO is supporting the development of a recombinant vaccine as well.

Consultants assisted India, Indonesia, Maldives, Myanmar and Sri Lanka in reviewing the dengue/DHF situation and evaluating control activities. The problems identified were: occurrence of cases in epidemic populations, especially in India and Indonesia, high case-fatality rates during outbreaks, and poor participation of communities in control activities.

Following an external evaluation of Thailand's national dengue control programme in March-April 1999, an initiative to control dengue to coincide with the 72nd birthday celebrations of His Majesty the King of Thailand was started. In June 2000, an external evaluation was carried out in Indonesia, which had experienced its largest outbreak of DF/DHF in 1998.

Communicable Disease Eradication and Elimination

Guinea-worm disease (Dracunculiasis)

A landmark in public health was reached when guinea-worm disease (dracunculiasis) was eradicated in India. Following the visit of the International Certification Team to India in November 1999, the International Commission for Certification of Dracunculiasis Eradication (ICCDE), at its fourth meeting, held in Geneva in February 2000, certified that guinea-worm disease was eradicated from India, DPR Korea and Thailand. Thus the South-East Asia Region of WHO became the first WHO region to eradicate this disease.

Leprosy

Of the 11 high leprosy-endemic countries in the world, four are in this Region which accounts for 78 per cent of the registered global cases. India alone has 87 per cent of the total cases in the Region. At present, five countries of the Region (Bangladesh, Bhutan, Maldives, Sri Lanka and Thailand) have achieved the elimination target of less than one case per 10 000 population at the national level and hope to achieve this target at the sub-national level in the next few years. The leprosy situation in Indonesia shows a declining trend and the country is expected to achieve the elimination target by the end of 2000. India, Myanmar and Nepal hope to achieve the elimination goal at the national level by 2003. The highest prevalence rate at the end of 1999 was reported from Myanmar (6.6 cases per 10 000 population) while India and Nepal had prevalence rates of 4.4 and 6 respectively.

The two control strategies of WHO, leprosy elimination campaigns (LEC) and special action projects (SAPEL), have

been carried out in high endemic countries. Leprosy elimination campaigns (LEC) were evaluated in India, Indonesia, Myanmar and Nepal. Based on these reviews, modified LECs (MLECs) in high endemic provinces and states were organized. To improve case detection, MLEC was coordinated with media campaigns in India and Nepal with WHO and BBC collaboration. These campaigns were organized successfully in Nepal in 1999 and in India in the five endemic states during 1999-2000.

The Government of Myanmar, supported by WHO and NGOs, produced two videos on leprosy and its elimination activities, to increase awareness and to motivate the patients and the community.

To enlist political commitment, WHO, the Nippon Foundation, Novartis and the International Federation of Anti-Leprosy Associations (ILEP) launched the Global Alliance for Leprosy Elimination at the Third International Conference on the Elimination of Leprosy, held in Abidjan, Ivory Coast, in November 1999. The Government of India has agreed to chair the first year of the Global Alliance. Resource mobilization for providing the last push is thus critical to success. This requires further strengthening of existing partnerships (Sasakawa Memorial Health Foundation, Nippon Foundation, ILEP, Novartis, DANIDA, World Bank) and the active involvement of both national and international NGOs.

Lymphatic filariasis

Filariasis is a disease that is targeted for elimination as a public health problem globally. This infection is widespread in eight countries of the Region. It is estimated that over 600 million people are living in filaria-endemic areas with approximately 60 million persons infected. This represents 60 per cent of the global burden of this disease. A global strategic plan for the elimination of filariasis was developed in September 1999. The two main strategies are: (1) checking the spread of infection by interrupting transmission –through mass drug administration (diethyl carbamazine and

albendazole) to 'at-risk' populations, and (2) relieving and preventing suffering and disability – through intensive local hygiene.

An informal Consultation on New Initiatives on Lymphatic Filariasis Elimination was held in Bhubaneshwar, India, in February 2000. Following this meeting, a regional strategic plan to eliminate filariasis was developed with the identification of milestones, key indicators and establishing targets for the next five years (2000-2004). Elimination plans have been developed for Bangladesh, Maldives and Nepal. Other countries will complete this exercise during this year. The elaboration of these plans of action will help the countries to obtain assistance for the necessary drugs and resources for implementation of the planned activities.

Communicable Disease Research and Development, including TDR

TDR is a special programme co-sponsored by the United Nations Development Programme (UNDP) and the World Bank, with WHO as the executing agency. TDR is financed almost entirely by voluntary contributions from governments, intergovernmental and nongovernmental agencies, foundations and other external sources. It was established in 1975 with two interdependent objectives: (1) to undertake research and development of new and improved tools for the control of major groups of tropical diseases (malaria, schistosomiasis, lymphatic filariasis, onchocerciasis, leishmaniasis, Chagas disease, African trypanosomiasis, leprosy), and (2) to strengthen research capabilities where these diseases are endemic.

In the SEA Region, the TDR programme continued to support activities and research which focused on malaria (Bangladesh, India, Myanmar, Nepal, Sri Lanka, Thailand); lymphatic filariasis (India, Myanmar, Nepal, Sri Lanka); Leprosy (India), and kala-azar (Bangladesh, India, Nepal).

Studies on lymphatic filariasis emphasized the impact of mass chemotherapy with DEC or albendazole (India,

Myanmar and Sri Lanka); filariasis endemicity (Myanmar, Sri Lanka); and insecticide impregnated curtains (Sri Lanka).

Research activities on malaria focused on studies on drug resistance (Myanmar, Thailand), vaccine development (India, Thailand); vector control (Sri Lanka); and monitoring of drug efficacy (Indonesia, Myanmar, Sri Lanka); and new drug regimen (Thailand).

Studies on kala-azar focused on the development of an animal model (India); clinical study with aminosidine and miltefosine (India); impregnated bednets (Bangladesh); field evaluation of test kit (Nepal), and epidemiology and control (Nepal).

HIV/AIDS and STD

In the South-East Asia Region, the human immunodeficiency virus (HIV), which causes AIDS, is a serious public health and developmental problem. The epidemic is highly dynamic and evolving and requires continuous updating and sharing of information and experiences at various levels.

As of March 2000, a total of 136 870 cases of AIDS were reported in the Region, as compared to 5 700 in March 1994. Thailand, India and Myanmar continue to report the largest number of cases, accounting for over 95 per cent of cases in the Region.

Based on sentinel surveillance data, WHO and UNAIDS estimate that 5.5 million people in the South-East Asia Region are already infected with HIV. This represents nearly 18 per cent of the global burden of HIV infections. Based on the latency period of 7-10 years between HIV infection and actual development of AIDS, it can be concluded that AIDS cases in the Region will continue to increase in the new millennium.

During the past year, the Regional Office continued to assist the Member Countries in the prevention and control of sexually transmitted diseases, including HIV/AIDS. The emphasis of WHO support was more on prevention and control of STD; ensuring blood safety; clinical care and counselling, and epidemiological surveillance and research.

Some of the highlights of the collaborative activities are as follows:

The Regional Office organized an informal Consultation on HIV/AIDS Surveillance in May 1999 and developed guidelines on surveillance, including on sexually transmitted infections and on behavioural surveillance. The need for strategies to further improve surveillance activities in the Region was discussed at an intercountry meeting of national programme managers and surveillance officers in Bali in July 1999. The meeting stressed the need to expand surveillance to include STI and risk behaviours. In September 1999, Technical Discussions on Intensification of HIV/AIDS were held during the 36th meeting of CCPDM, which was followed by the fifty-second session of the Regional Committee adopting a resolution on the subject. The Committee called for enhanced financial and human support and logistic supplies to improve and further expand HIV/AIDS surveillance. Support was provided to India to develop a consensus on HIV estimates in the country based on HIV sentinel surveillance data, which are updated and revised periodically using a standard methodology.

A Consultation on Regional Priorities in HIV/AIDS Research was organized by the Regional Office in December 1999. Among the priority areas for research, the expert group recommended research in HIV vaccine development, development of new drugs and diagnostics, identification of behavioural and social risk factors, approaches to community and home care for people with HIV/AIDS, including the use of alternative systems of medicine, etc. The need to mobilize additional resources, approaches for use/application of research for programme purposes, and networking of institutions was highlighted. HIV/AIDS research was also discussed at the meeting of the Advisory Committee on Health Research, held in Bali, in April 2000.

WHO continues to collaborate actively with UNAIDS and other co-sponsors in the area of advocacy, sharing of technical information and addressing the problems relating to

drug trafficking, cross-border migration, etc. At the request of UNAIDS, WHO assisted the Government of Sri Lanka in conducting an external review of the National AIDS Programme in February 2000.

Stop TB Initiative

The South-East Asia Region accounts for 40 per cent of the world's burden of TB. The incidence of the disease is highest in the 20-45 age group, thus seriously affecting economic development. The loss sustained in the Region is estimated at US$ 4 billion per year. The rapid spread of HIV in the Region and the emergence in recent years of multidrug-resistant strains of tuberculosis pose additional threats. Till date, nearly 500 000 TB patients have been treated with 80 per cent success rate regionwide.

WHO has continued to provide technical support to all Member Countries in the planning, implementation and monitoring of national TB control programmes. During 1998-2000, assistance was provided for joint programme reviews in India, Nepal and Thailand, and monitoring missions to strengthen TB control in Myanmar, DPR Korea and Indonesia. Several training courses on the technical and operational aspects of TB control were held. These include: (1) an annual regional training course on TB in Nepal; (2) laboratory methods for TB control in Indonesia; (3) epidemiological basis of TB control in India. A monograph was prepared and field-tested at Bangalore; (4) leadership and strategic management, India. Modules for this were developed and pre-tested and include case studies and interactive learning techniques, and (5) training on EPICENTRE, a software programme to facilitate recording and reporting at the country level.

Technical and advocacy materials were developed and distributed widely. To advocate for enhanced support for TB control, WHO organized a meeting of Directors-General of Health and managers of national TB control programmes on the Stop TB initiative in Myanmar in August 1999. This was followed by a review of the progress made at the meeting of

Health Ministers, also in Myanmar in October 1999, where it was agreed that high-level government commitment would be ensured to provide adequate resources, both human and financial, in order to achieve nationwide coverage with DOTS in all countries by 2005. In February 2000, the meeting of Health Secretaries, held at New Delhi, recommended the strengthening of TB control efforts through building national capacities and by forming sustainable partnerships with other government departments, such as finance and development, medical schools, the private sector, NGOs, donors and others within and outside the Region. This global partnership effort gained additional momentum from the Ministerial Conference on Tuberculosis and Sustainable Development, held at Amsterdam in March 2000.

Expansion of the DOTS strategy remains a top priority for the Region. Crucial issues needing active consideration include continued mobilization of political commitment in terms of resources, forging and sustaining partnerships with NGOs and the private sector, and ensuring uninterrupted and regular supply of good quality drugs. While mid-to-low burden countries have agreed and are planning to achieve the global targets before the end of 2000, all the high burden countries are expected to do so before 2005.

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Noncommunicable Diseases

The current global epidemiological transition has seen a shift in a number of noncommunicable diseases (NCDs) from their previous category of disorders of elderly and wealthy people of western countries to that of a global pandemic affecting millions of disadvantaged and increasingly younger people throughout the world. In the South-East Asia Region, this group of diseases has emerged as an important health issue.

With continued increase in life expectancy, combined with profound changes in lifestyle, NCDs have become one of the main causes of mortality and morbidity in a majority of the countries in the Region. The need for suitable and timely action for controlling NCDs is recognized as one of the regional priorities in health development.

WHO continues to promote an integrated preventive approach, which addresses common risk factors of major NCDs, namely cardiovascular diseases, diabetes mellitus and cancers. The aim is to reduce morbidity and mortality due to major NCDs by strengthening prevention, early detection and effective treatment.

Non-communicable Disease Surveillance

In most of the Member Countries, reliable data on major NCDs are inadequate. This hampers advocacy, prevention and control efforts.

A project to collect basic epidemiological information on cardiovascular diseases, cancer, diabetes and local specific NCDs was initiated by the Regional Office during the last

quarter of 1999. A questionnaire was sent to the designated principal investigator in each country and the information obtained is being consolidated. Based on this information, a regional NCD profile will be prepared and utilized for future planning and monitoring of programme implementation.

Indonesia has produced a report of 500 abstracts on major NCDs and related issues based on articles collected from libraries and institutions in the country. This report will be used to identify research areas and to plan a national agenda for NCD research.

Non-communicable Disease Prevention

Strengthening of the NCD programme as an integral part of national health development is being pursued by Member Countries. India, Myanmar and Thailand are currently implementing an integrated approach in selected areas while Indonesia is testing comprehensive community-based CVD control.

Prevention is the most important aspect of reducing premature deaths and disability due to NCDs. In order to bring about increased awareness among the public with regard to prevention and control of NCDs, Sri Lanka is preparing a health education booklet on ischaemic heart disease for school children.

Efforts have been made to strengthen programme management capabilities of PHC personnel. Bangladesh, India, Myanmar and Sri Lanka conducted training courses on prevention and management of NCDs for medical and paramedical staff. DPR Korea continues to improve the technical capability of manpower for intensive care of cardiovascular diseases, neuro-surgery and for diagnosis and management of cancer through local training and fellowship programmes. In Bangladesh, senior doctors were trained in the clinical aspects of cardiovascular diseases through local fellowships.

In addition to the major NCDs, Member Countries are paying specific attention to other high prevalence NCDs. To

increase awareness and improve early diagnosis for the prevention of thalassemia, Maldives has produced educational material, procured laboratory diagnostic instruments and trained health personnel in programme management.

In Myanmar, snake-bites account annually for 10 000 cases and approximately 2000 deaths, which afflict mostly young people between ages 15 and 45 years. WHO has been supporting health education efforts and enhancing the skills of health providers in emergency care of snake-bites.

In March 2000, in collaboration with EMRO, the Regional Office supported the participation of nationals from Bangladesh, India, Indonesia, Myanmar, Sri Lanka and Thailand at a training-cum-technical Workshop on International Networking on Control of Gynaecological Cancers in Pakistan. The Regional Office also supported University Hospital, Geneva, a WHO collaborating centre, in organizing and conducting this Workshop.

Non-communicable Disease Management

While most of the Member Countries recognize NCDs as a public health problem, there is overall inadequacy of health care infrastructure and of human resources for coping with the rising burden of cardiovascular diseases, cancer and diabetes mellitus in the Region. With WHO support, an improvement in diagnosis and treatment facilities for CVD has been reported by Bhutan and DPR Korea.

As a follow-up to the Intercountry Workshop on Prevention and Control of Diabetes Mellitus, held in Dhaka in April 1998, several other countries have attempted to strengthen their national diabetes control programmes, including management of the disease, using PHC facilities. National programmes for control of diabetes mellitus have been developed in Bangladesh, Myanmar and Thailand while activities for the same have recently been initiated in Indonesia and Sri Lanka. In view of the growing demand for information on treatment, the Regional Office has recently developed a regional guide for self-care of diabetes mellitus.

The guide will be distributed to the countries for appropriate adaptation.

With a view to developing a profile of the diabetic services available, a questionnaire aimed at ascertaining the current burden of diabetes mellitus was developed by the Regional Office and distributed to the Member Countries. Based on this information, a descriptive profile of each country and of the Region as a whole will be developed and used to identify priorities for programme development.

Following an intercountry training course on palliative care for the management of terminal cancer patients, held in Calicut, India, Indonesia has produced guidelines on palliative care in the local language and organized training for health providers in cancer hospitals.

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Family and Community Health

Child and Adolescent Health and Development

Though there has been a significant decline in infant and childhood mortality in all countries of the Region during the last decade, the rates are still high in some. Therefore, the focus has been on the reduction of the prevailing high level of mortality and promotion of child health through integrated management of childhood illness (IMCI).

Adolescence has been recognized as a transition period between childhood and adulthood. Common health problems associated with this phase of life include malnutrition, unwanted pregnancy, STD/HIV, substance abuse, etc. A regional strategy for ADH has been developed. With this in view, the Regional Office supported an in-depth assessment of the adolescent health (ADH) situation in Bangladesh, Bhutan India, Maldives, Myanmar and Nepal. The assessment report was presented to a Joint Intercountry Meeting of Child and Adolescent Health Programme Managers in Bali in March 2000. The meeting discussed various aspects of the programme and identified steps to be taken to develop national programmes on ADH at the country level and priority activities to be undertaken.

Integrated Management of Childhood Illness

Every year, nearly 5 million children die before five years of age in the countries of the Region. About 70 per cent of these deaths are caused by pneumonia, diarrhoea, malaria, measles and malnutrition. Integrated Management of Childhood Illness (IMCI) is an effective, low-cost strategy to prevent death and improve child health. Due to their high

infant and childhood mortality rates, Bangladesh, Bhutan, India, Indonesia, Myanmar and Nepal have been identified as IMCI target countries.

To build regional capacity, four intercountry and two national-level courses were organized and 644 trainers trained. In Bangladesh and Bhutan, the adaptation of technical guidelines and training materials has been completed. In India and Myanmar, the process of adaptation has been initiated. In Nepal and Indonesia, IMCI activities have been expanded to cover more districts. IMCI has also been introduced in 16 medical schools in the two countries.

Previously, most activities in the Region were focused on improvement of skills. Now there is added focus on strengthening the health system. A regional consultation on review of drug supply management course for its application in IMCI was held in Bali, Indonesia, in March 2000. The South-East Asia Region was the first region to organize such a consultation.

To extend implementation to the community level, the IMCI package for Basic Health Workers (BHWs) was developed and field-tested in partnership with CARE and the Government of India. Indonesia, Myanmar and Nepal have adapted the package and 2 738 BHWs and their trainers have been trained. In Nepal, 715 female community health volunteers have been trained in partnership with John Snow International (JSI) and USAID. These efforts are likely to improve family and community practices for better child health and development.

IMCI has been jointly implemented in many countries with technical support from WHO and in partnership with donors and developmental partners. There is good inter-agency collaboration and several partners are supporting IMCI activities in different countries. These include USAID, BASICS (Basic Support for Institutionalizing Child Survival), JSI, DFID (Department for International Development, British High Commission), ADB, the World Bank and UNICEF.

Reproductive Health and Research (excluding HIV/AIDS/STI)

The activities at the regional level focused on the development of a reproductive health programme profile, capacity building, operations research, development of guidelines, etc.

The reproductive health (RH) programme profile provides comprehensive information on the reproductive health situation, programmatic details, training, research and funding. This is a very good resource for governments, donors and WHO for providing coordinated support to the countries.

In the area of capacity building, a regional training programme on reproductive health was held in collaboration with the Indian Institute of Health and Family Welfare, and Mahidol University, Thailand, at Hyderabad, in which 20 persons from various states in India participated. Training and exchange visits for peripheral health workers, e.g., MCH workers, working in disadvantaged to better developed areas, were organized in Nepal, when they had the opportunity to see and learn from better developed programmes within the country itself.

A global meeting on finalizing guidelines for qualitative approaches for investigating maternal deaths was jointly organized by headquarters and the Regional Office in Bangkok in March 2000. These guidelines will be field-tested in the countries.

Women's Health

Mainstreaming gender as an integral dimension in the designing, implementation, monitoring and evaluation of health policies, plans and programmes has become a priority concern in recent years. Strategies for gender mainstreaming have been promoted in accordance with the resolution adopted by the fifty-first session of the Regional Committee. The Women's Health programme has continued to develop resource materials for supporting the integration of a gender perspective in WHO and national health programmes. Technical assistance was provided to Bangladesh for the

development of a gender strategy in the Health and Population Sector Programme.

Violence against women is being increasingly recognized as a public health issue in many countries of the Region. Country-level activities have been initiated to promote the role of the health sector in both prevention and management of violence against women as a follow-up to the regional consultation on the same topic, held in 1999. Support was provided for a workshop in Nepal to improve coordination between the legal and medical communities and for a national seminar on awareness-raising in Myanmar.

Country profiles on Women, Health and Development have been completed in nearly all countries of the Region and are being used to provide policy and programme direction. *Women of South-East Asia: A Health Profile,* a comprehensive regional analysis of women's health issues, determinants and responses, has been widely distributed.

Organization of Health Services Delivery

District health systems

The Regional Office assisted Member Countries in developing district health system (DHS) models. Efforts are under way to utilize these models in focusing WHO resources through integrated implementation of various priority programmes, such as Making Pregnancy Safer, Roll Back Malaria, Stop TB and Healthy Settings. Successful implementation of this new method of working should improve the outcome of WHO collaborative programmes.

The 7th Round of the International Practical Training Course on DHS based on PHC was held in July-August 1999 in India, Myanmar and Thailand with a revised curriculum to keep up with the needs of the Member Countries. Twenty-one participants from six countries of the Region attended the course.

To improve access to health care, particularly by the poor and marginalized groups, baseline health and anthropological surveys were organized and training of community health workers and TBAs conducted for tribal groups in six states of India.

Development of Human Resources for Health

Human resources planning is being strengthened by the development of a computer model for HRH planning. An appropriate methodology for creating strategic HR plans for national health systems, using this model has been identified.

Quality assurance in medical education is being strengthened. In this context, meetings of the Task Force on Accreditation of Institutions of Higher Education of Health Personnel and national follow-up meetings have been held.

WHO and the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) jointly held a Workshop on Medical Education and Medical Practice More Relevant to People's Needs in Chennai, India, in October 1999. Among others, the issue of making medical education and medical practice more relevant to people's needs was addressed.

An Intercountry Consultation on Strengthening Paramedical Services and Education was held in Bangkok in March 2000 which highlighted the issues in services and education of allied health personnel.

A pilot project on HR performance indicators with a manual for introducing the use of the performance indicators was completed in two countries.

In many countries of the Region, policy statements on HRH have been made but implementation lags behind. The balance and relevance of human resources for health will be reviewed in the light of demographic and epidemiological changes and health sector reform. Multilateral trade agreements, such as GATS, also have implications for human resources for health.

Nursing and Midwifery

Greater attention has been paid to improving the quality of nursing and midwifery services. The Regional Office supported Member States in implementing the newly-developed Standards of Midwifery Practice for Safe Motherhood for quality improvement in midwifery and to

address the problem of high maternal morbidity and mortality. Support was also provided to further develop standards for nursing practice to ensure the quality of nursing services.

To prepare competent nurses and midwives to meet the challenges in the 21st century, a regional consultation was held in Bangkok in December 1999 to identify strategies to provide education relevant to the changing needs and context of countries. A strategy document is under preparation to help countries determine how best they can provide education for nursing and midwifery personnel.

Continued attention is being paid to enhance the productivity of nursing and midwifery personnel. This is with particular reference to community health, in support of national health development, and to enhance the roles of nurses in health promotion and protection.

Despite these developments, much remains to be done to improve the quality of nursing and midwifery services. The problem of the continuing shortage of nursing and midwifery personnel and maldistribution in many countries of the Region needs to be urgently addressed. Educational resources as well as nursing service management need to be further strengthened to promote cost-effectiveness.

Education and Training Support

Training is a major component of WHO assistance for strengthening human resources for health. Presently, this consists of fellowships, study tours and inter- and intra-country training in all the countries of the Region. There has been an increasing trend of short-term fellowships for practical training in specialized fields with greater use of regional and in-country training facilities. Currently, such training is in the areas of primary health care, field epidemiology, malaria control and nursing. While the number of extra-regional fellowships for both short-term and long-term programmes

has considerably decreased, there is an upward trend in regional training. Efforts are under way to assess in-country training needs of the Region in terms of the number, duration and areas of study, under the WHO collaborative programmes.

During the period 1 July 1999 to 30 June 2000, 285 fellowship applications from the countries of the Region and 57 requests from the Western Pacific and Eastern Mediterranean regions for placements in the SEA Region were received. Against this, 424 fellowships were awarded, including 264 awards pertaining to the applications received prior to the reporting period. Placements for 82 fellows from the above regions were arranged during the reporting period, out of which 25 pertained to the twelve-month period ending 30 June 1999.

Two hundred Study Tour Application Forms (STAF) in respect of study tours up to a duration of four weeks were processed and programmes facilitated.

Consequent to the introduction of the system of release of fellowship termination allowance to fellows being conditional to the receipt of Fellowship Termination of Studies Report (FTSR), there has been an appreciable increase in the number of FTSR. While during the period 1 July 1998 to 30 June 1999, 265 FTSRs were received, the figure stood at 294 for the reporting period. Analytically speaking, for the previous one year, against 450 awards issued, 339 FTSRs were received, constituting 75.3 per cent in terms of compliance. This should facilitate better evaluation of the fellowships in the future.

The development of Allied Fellowship Information System could not be pursued due to resource constraints. However, in order to streamline and strengthen the fellowship operations in the Regional Office, a Document Management System (DMS) has been taken up for implementation. While

the ultimate goal of this initiative would be a 'paperless' office, the main benefits and features would include electronic storage, retrieval, access, speedy action, indexing, and CD back-up.

During the period, 61 meetings were held of which 5 were policy meetings, 8 were advisory meetings and 48 were intercountry technical meetings.

4
Sustainable Development and Healthy Environment

Health in Sustainable Development

Most countries in the Region face an increasing threat to health from exposure to urban, industrial and agro-chemical pollution in addition to the traditional environmental risks which continue to play a large role. To mitigate traditional environmental risks, better infrastructure and energy services for households and communities are needed, together with improved housing and vector control interventions. To reduce environmental risks, pollution prevention and enforcement of environmental standards as well as development of the culture of environmental compliance and provision of effective incentives are urgently needed. Most environmental interventions are very cost-effective in achieving health outcomes.

It is well recognized that premature death and illness due to environmental factors account for one-fifth of the total burden of disease in the developing world. The lack of clean water and sanitation and indoor air pollution are the two principal causes of illness and death that predominantly affect children and women in poor families. In the South-East Asia Region, it is the poor who suffer disproportionately from unsafe environment conditions in the household and in the community.

Health Impact Assessment is gaining prominence as an effective methodology for minimizing the adverse impact and maximizing the beneficial impact of the policies and

programmes of other sectors on health. This methodology has been shared with the Member Countries. Through the Health-and-Environment (H&E) initiatives, WHO assisted the countries in identifying and assessing health hazards and issues in such sectors as agriculture, industry and environment. Nine countries have initiated H&E programmes and six have either adopted or drafted plans of action involving intersectoral partnerships. The constraints have been the absence of a national coordinating mechanism to monitor the progress of implementation and the lack of H&E programme implementation capacities in ministries of health and other sectoral ministries. A regional publication, entitled *Sustainable Development and Health for All: Building the Capacity of National Health Authorities,* was published and disseminated to all the Member Countries.

Renewing the health-for-all strategy

The World Health Assembly, in May 1998, adopted the World Health Declaration and recognized Health For All in the 21st Century as the framework for future development of health policies.

Member Countries, in accordance with their planning cycles, have been reviewing their health policies and plans and incorporating/adapting the principles and policy guidance of the Regional Health Declaration therein.

Health Ministers' meeting

The seventeenth meeting of Ministers of Health was held in Yangon, Myanmar, in October 1999. It was inaugurated by H.E. Lt. General Khin Nyunt, Chairman of the National Health Committee and Secretary (I) of the State Peace and Development Council of the Government of the Union of Myanmar. General Khin Nyunt highlighted the double burden of communicable and noncommunicable diseases faced by the countries of the South-East Asia Region, and underlined the need to provide quality health care equitably.

Besides reviewing the actions taken on the recommendations of their sixteenth meeting, the Ministers

deliberated upon global health projects on Roll Back Malaria, Stop TB initiative and Tobacco-Free Initiative. They also discussed the importance of traditional medicine in the health care system.

Health Secretaries' meeting

The fifth meeting of Health Secretaries was held in New Delhi in February 2000. Besides reviewing the progress of polio eradication and control of TB in South-East Asia, the meeting deliberated on public health in the Region in the 21st Century. It also discussed relevant aspects of traditional medicine in the South-East Asia Region. The WHO collaborative programme and a report on Intercountry Cooperation in Health Development in the 21st Century were also reviewed.

Leadership for health

Leadership for health was widened by the Regional Conference of Parliamentarians on Health of the Vulnerable Populations, held in November 1999. The parliamentarians emphasized that poverty is the prime cause of vulnerability of the people. They underlined the need for intersectoral efforts to improve the health status of the poor, which is essential to achieve the global target of reducing the number of people living in poverty by 50 per cent by 2015. Another landmark was the Calcutta Declaration on Public Health, which was adopted at the Regional Conference on Public Health in the 21st Century, held in December 1999. The Declaration, *inter alia,* highlighted how public health could fuel the engine of health development.

Nutrition for Health and Development and Food Safety

Nutrition

South-East Asia is currently among the most populated regions in the world. It is home to over 1.4 billion people or one-fourth of the global population. Despite these population pressures as well as the financial constraints, notable progress has been made in the area of health and nutrition through the development of health and nutrition programmes and policies as well as national plans of action. All countries of the Region except DPR Korea have developed national plans of action for nutrition with a multisectoral approach following the

declaration at the International Conference on Nutrition (ICN). At present, implementation of these plans is receiving due attention from the highest level in the respective governments. National nutrition and food policies have been adopted in most countries and interventions are being redesigned keeping in view past experiences and future needs.

A regional nutrition profile has been prepared which highlights nutritional achievements and future challenges. Importantly, a significant decrease has been registered in regional mortality figures during the last two decades as life expectancy has simultaneously increased. Moreover, the per capita energy supply in the Region has risen in the last 20 years.

Severe forms of protein-energy malnutrition (PEM) and nutritional blindness have declined substantially but progress with regard to reduction in mild and moderate degrees of malnutrition is negligible in most countries. Household food insecurity is a major concern in all countries. While several nutritional disorders, such as beriberi and pellagra, have virtually disappeared, nutritional disorders of public health concern are PEM and deficiencies of micronutrients, such as iron, iodine and vitamin A. These conditions, afflicting a large section of the vulnerable groups, pose a challenge to health care. On the other hand, diet-related chronic noncommunicable diseases (NCDs) are causing death and disability in several countries of the Region. With increasing urbanization, changing dietary habits and changing lifestyles, this situation is bound to become even more severe in the years to come.

The Regional Office organized, in December 1999, a WHO/FAO joint intercountry workshop to review: (a) the progress and experiences of countries in developing and implementing national nutrition plans and policies; (b) the strategies adopted by the countries in pursuance of the ICN Declaration; (c) the constraints faced by the countries; (d) the key elements for successful implementation, and (e) the lessons learned and the way forward. Additional actions and support required by the countries to revise and reprioritize their national plans of action for nutrition on the basis of

successes and failures of programme implementation were also discussed.

In February 2000, the first informal inter-agency meeting of the South-East Asian Iodine Deficiency Disorder Elimination Action (SEA IDDEA) Group was held in the Regional Office in collaboration with UNICEF, the Micronutrient Initiative (MI) and the International Coordination Council for Elimination of Iodine Deficiency Disorders (ICCIDD). The meeting provided an opportunity to share participants 'experiences of progress in achieving Universal Salt Iodisation (USI) and IDD elimination, and begin a process of planning regional collaborative approaches to make achievements sustainable in the South-East Asian countries.

Support was extended to countries in the area of capacity building and human resource development and in reviewing nutritional activities at the health centres.

The following nutritional research activities are being undertaken:

Vitamin A supplementation with intensified pulse polio immunization (IPPI) on National Immunization Days (NIDs) in Orissa. Orissa is the only state in India that included vitamin A supplementation with the IPPI campaigns. It is important to provide evidence of feasibility, safety and impact that this intervention has on the vitamin A status of children in this population. The study was undertaken in collaboration with the National Institute of Nutrition and UNICEF.

WHO multicentric growth reference study for children 0-5 years. This is an international mutlicentric study aimed at constructing new growth reference curves for children aged 0 to 5 years of age by pooling data from seven sites in different geographical regions. India is included from this Region with other sites, which are the United States of America, Brazil, Norway, Ghana, Oman, and China. Data collected at each of these sites will be compared with respect to selection of the study population, reliability of measurements, compliance with the recommendations on breast-feeding and absence of constraints on growth.

Food safety

Foodborne diseases are common in most countries of the Region. A large proportion of mortality and morbidity due to diarrhoea can be prevented if microbial contamination of food and water is controlled. The increasing use of chemicals in agriculture and in food processing has added a new dimension pertaining to chemical contamination of food. A number of countries in the Region export and/or import food, but while several countries have food legislation, well-defined national food safety policies and strategies have yet to be developed in many.

As a follow-up of the ten-point regional strategy developed by the Regional Office last year, inputs were provided by way of a rapid assessment of selected state food laboratories in India, leading to recommendations on the minimum requirements for a well-equipped microbiology laboratory. A brief review has been made of the Indian food law, and discussions have been held with concerned government officials on food safety legislation. Advice and examples of well-designed food safety legislation from other countries were provided. Technical assistance was provided to Maldives in the areas of (a) training in general food safety, (b) hazard analysis critical control point (HACCP), and (c) inspections and strengthening laboratory capabilities.

Food aid

Technical support was provided through the World Food Programme (WFP) in the school feeding and deworming programme, in selected districts in Nepal. Also, technical support was extended in collaboration with WHO headquarters and WFP in Orissa, India, and DPR Korea.

Protection of Human Environment

Water supply and sanitation in human settlements

During the reporting period, the focus was on gathering data for global assessment of the progress in the sector as a basis for the UN Secretary-General's report to the General Assembly in 2000. All countries of the Region submitted reports and subsequently provided clarifications. The data and information collected were processed by the London School of Hygiene and Tropical Medicine (a WHO

collaborating centre) and UNICEF. The results, format and preparation of the report were discussed at a meeting of representatives from all WHO regions and UNICEF at WHO headquarters in September 1999.

In preparation for the March 2000 World Water Forum, the Water Supply and Sanitation Colaborative Council held a series of regional meetings in Bangkok (for South Asia) and subsequently a global meeting in Ahmedabad, India, designed to finalize the "Vision 21" document representing the sector strategy for the first part of the new millenium. The strategy was presented to the World Water Forum Conference, held in The Hague in March 2000.

Support is continuing to the national drinking water and sanitation programmes in the Member Countries and to address arsenic contamination of drinking water in Bangladesh and India. The meeting on preparation of the monograph on arsenic poisoning was held in Dhaka in November 1999 with the participation of WHO, UNICEF, the World Bank and other contributors. The document, summarizing the current knowledge of various aspects of arsenic poisoning and mitigation approaches and technologies was put on the internet at the end of January 2000 for peer review and subsequent finalization and publishing by the end of 2000. Work has started on the preparation of Guidelines for Monitoring, Surveillance and Control of Water Supplies in Medium Sized Towns, initiated in Bangladesh with HQ support. The plan of action for 2000-2001 includes a review of the progress in the development of drinking water quality surveillance programmes in the Member Countries.

Environmental health in urban development

Efforts continued on further expansion and promotion of the Healthy City approach in the countries. Support was extended to communities that already have Healthy City programmes. To assist these communities as well as those interested in initiating such projects, a regional publication in two volumes summarizing the regional experiences is being issued. The

first is based on a questionnaire survey of various practitioners of Healthy City projects as well as those administrators responsible for promoting the approach. The second volume summarizes the successes and constraints and draws conclusions based on regional experiences.

Assessment of environmental health hazards

Work has continued on reviewing the capacity of Member Countries in the area of hazardous waste management. A questionnaire survey was carried out to develop country hazardous waste profiles to help in formulating proposals to strengthen national hazardous waste management programmes. In addition, countries were supported for developing capacity in the area of hospital waste management. A similar exercise is being carried out in the area of air quality. A survey of Member Countries 'capacity in the area of ambient air quality control focusing on the main cities was carried out. The survey results are expected to provide a base for drawing up national air quality country profiles and later proposals for capacity development.

Promotion of chemical safety

In this programme area, support was continued mainly in strengthening poison control capacity. In India, Indonesia, Thailand and Nepal, pilot projects for developing procedures for data collection and developing a database on pesticide poisoning are under way. In addition, a regional meeting was organized for representatives from poison control centres and key persons from countries which still did not have poison control centres to discuss programmes for the development and strengthening of poison control centres, through the TCDC approach.

A retrospective study of organophosphorous pesticide poisoning has been undertaken in cooperation with the Medical Toxicology Unit of Guy's and St. Thomas Hospital, London, UK, leading to a prospective study in four countries of the Region. These studies are essential to gather more

information on pesticide poisoning which is emerging as one of the leading causes of morbidity in the Region.

A national Workshop on Chemicals and Women's Health was held in Ahmedabad, India, in March 2000 to raise awareness and to develop a plan of action.

Occupational and environmental health

The South-East Asia Region has an estimated work force of 580 million. Eighty per cent of this work force is in the informal sectors, including small-scale industries and home industries, self-employed, services, farms and fisheries.

A Regional Training Workshop in Environmental Epidemiology was held in New Delhi in November-December 1999 to impart the basic skills and knowledge on methods for surveillance, monitoring and response to environmental health problems. The Workshop also discussed, among other issues, the burden of diseases and injury related to environmental and occupational hazards. It recommended that Member Countries should adapt the WHO workshop materials to develop environmental epidemiology curricula compatible with national needs and priorities.

Support for the training of nationals in occupational health, industrial toxicology and environmental health was extended to some countries.

Essential supplies and equipment were provided to the National Institute of Occupational Health, Ahmedabad, which is in the process of being redesignated as a WHO Collaborating Centre in Occupational Health in India.

Emergency and Humanitarian Action

Because of its geographical location and characteristics, the Region is vulnerable to an increasing number of natural as well as man-made emergency and disaster situations. According to the International Federation of Red Cross and Red Crescent Societies (IFRC), 38 per cent of the people affected by natural disasters and 57 per cent of the people killed by natural disasters are in the SEA Region. Besides natural disasters (cyclones, floods, landslides, volcanic

eruptions, earthquakes and drought), complex emergencies leading to internally displaced population (IDP) are now on the increase in some Member Countries.

The second Workshop on Health as a Bridge (HBP) for Peace was held in Sri Lanka in February 2000. It was attended by people from the south of the country, Jaffna and from the border areas. During the Workshop, an Active Learning Package (ALP) was used to train the participants in the HBP concept. The subjects included: Medical Ethics, the Framework of Humanitarian Assistance, International Human Rights Law (HRL), International Humanitarian Law (IHL), and Conflict Resolution and Negotiation. Similar workshops are planned to be held in Indonesia and in Thailand.

Financial and technical support from the Regional Office has been initiated to develop a country EHA profile for Bangladesh, India, Indonesia, Myanmar and Nepal. This is the first step in developing an EHA information system. Geographical information system software has been purchased and provided to Indonesia for pilot-testing.

Floods in Bangladesh during June-August 1999 affected approximately one million people in 21 of the 64 districts. No deaths were reported. A film to promote flood preparedness is being produced in Bangladesh.

In DPR Korea, the emergency programmes continued to focus on the control of tuberculosis and implementation of DOTS, strengthening of the early warning system, control of epidemics and improvement of the quality of community-based health services. The support emphasizes local capacity building and training as well as provision of essential equipment and supplies. The EHA WHO office in DPR Korea, set up in 1997, provides technical advice on health policies and practices in relation to humanitarian assistance to the government and international agencies.

In October 1999, five districts in Orissa, India, were hit by a severe cyclone, which devastated a large area. Severe damage was caused to 14 of the 30 districts. It was estimated

that nearly 15 million people were seriously affected, with nearly 10 000 deaths reported officially. Outbreaks and eventual epidemics of communicable diseases with a potential public health threat were the major concern. A staff member from the Regional Office participated in the UNDMT response mechanism from the beginning. She also joined the UNDAC assessment team to Orissa and conducted the initial rapid health sector assessment and provided inputs to the UN appeal.

Three priority areas were identified for support to the local authorities:

(1) Coordination, along with UNICEF, of health assistance between local authorities and local and international NGOs.

(2) Establishment of an emergency surveillance system in coordination with the health authorities, other UN agencies, and local and international NGOs. Aid was prioritised according to geographical distribution and the epidemiological pattern of diseases.

(3) Ensuring that the humanitarian health assistance is implemented according to international standards by providing advice and WHO guidelines.

In East Timor, following the violence that erupted in August 1999, the health system totally collapsed as a result of the emigration of doctors and core health professionals. The Regional Office deputed its Regional Epidemiologist to East and West Timor, who assessed the state of epidemic-prone diseases; assisted in strengthening disease surveillance among the residents and internally displaced persons of East and West Timor, and provided interim technical assistance for other WHO-related activities.

Jointly with Medical Relief International (Merlin) and the International Rescue Committee, WHO is implementing the Roll Back Malaria strategy in East Timor. The activities are being extended to wider areas. Significant progress has been

made in the establishment of a national TB programme based on the DOTS strategy.

WHO is also assisting the health authorities in responding to the crisis in some areas in Indonesia, especially in the Maluku islands.

Funds were raised by the US Foreign Disaster Assistance (OFDA) in order to carry out planned activities in earthquake disaster preparedness and mitigation in Nepal. The following four events were organized in 1999 with technical input from PAHO: Hospital disaster mitigation training; Mass casualty management training; Simulation exercise, and Strategic planning workshop. An awareness-raising advocacy and training video, based on these events, is being prepared for regional and global use. Further training activities in line with the above have been requested by Nepal. Indonesia was invited to participate in these exercises and is interested in similar projects.

5
Social Change and Mental Health

Health Promotion

The Healthy Settings approach has been the focus of interventions during the period of reporting. An advocacy package on settings aimed at policy-makers was developed and distributed. The period also saw a systematic effort to move forward in the areas of health promoting schools, workplaces and hospitals. The second phase of Rapid Assessment and Action Planning Process (RAAPP) on School Health in Indonesia, started in 1998, was conducted. This involved data collection at various levels in five provinces in the country. Support was provided to Maldives in the development and expansion of health promoting schools while a consultant assisted Bhutan in strengthening health promoting schools, with particular emphasis on reviewing school health curriculum.

Guidelines for the development of health promoting schools have been developed. An intercountry Consultation on Incorporation of Life-skill Education on Adolescents in School Education was attended by participants from all countries. The critical output of the Consultation was a life - skill education package for adaptation by the countries.

Advocacy for health promotion at the workplace was initiated in some countries immediately after the Fourth International Conference on Health Promotion, held in Jakarta in 1997. Partnerships, mainly with the private sector, have been established to further improve the health of workers, management and communities in some countries. A regional advocacy brochure on health promoting workplace,

to be used by programme implementors, has been developed and distributed.

Health promoting hospitals was the focus of an intercountry meeting in Bangkok in November 1999. The consultation not only created a better understanding of the health promoting concept, but also motivated participants to pay attention to other health determinants at the hospital setting which influence the health of patients and their relatives, management and staff. A regional concept and strategic paper was the main outcome of the consultation. Participants are following through with activities towards developing health promoting hospitals in their respective countries.

A healthy lifestyle is critical to the quality of life. It can also help prevent some communicable diseases which are increasingly becoming a public health problem in the Region. Advocacy publications on healthy lifestyles and prevention and management of noncommunicable diseases were issued. An in-service training module on the promotion of healthy lifestyles in the country is in the process of development for health personnel.

A five-year (2000-2005) strategic plan has been developed, highlighting concrete actions for health promotion infrastructure and technology development, advocacy, research capacity and networking, monitoring and evaluation of health promotion outcomes in the Region. This will provide regional direction for health promotion in the next five years.

At its fifty-second session, the Regional Committee adopted a Regional Policy Framework and a Regional Action Plan 2000-2004 for tobacco control. The Action Plan highlights time-bound critical demand reduction policies and activities to be adopted by all countries in a comprehensive manner. The Policy Framework and Action Plan would serve as blueprints for collective intercountry tobacco control action in the coming years.

Adding its voice to the urgent need for intercountry action on tobacco, the seventeenth meeting of Health Ministers recommended further action, including research and innovative demand reduction interventions by Member Countries. Most countries have evolved national plans with technical and financial support from WHO. Studies on the prevalence of tobacco use and the economics of tobacco have been initiated in selected countries and regional- and country-level advocacy intensified.

The International Conference on Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control, organized and co-hosted by the Regional Office was held in New Delhi in January 2000. It brought together over 100 participants from all over the world, particularly from the developing countries. The focus of the meeting was on the development of country perspectives in the formulation of the WHO Framework Convention on Tobacco Control. Critical outcomes of the Conference, including the New Delhi Declaration, are an important milestone for the countries in their march towards a tobacco-free Region.

The Region hosted the Global Launch of World No-Tobacco Day in Bangkok on 31 May 2000. Activities, including the national launch of the South-East Asia Anti-Tobacco (SEAAT) Flame, the start of the advocacy clock on tobacco by the WHO Director-General, press conferences by the Prime Minister of Thailand and the Director-General and an audience of the Director-General with His Majesty the King of Thailand heightened advocacy for political as well as social movement for tobacco control in the country. The Crown Prince of Thailand chaired the function relating to the national launching of the SEAAT Flame.

To enhance regionwide social mobilization for action, the South-East Asia Anti-Tobacco Flame Campaign was launched on 7 January 2000. The flame symbolizes, in many cultures of the Region, energy, life, youthfulness and victory of good over evil. The aim of the campaign is to stimulate and increase the momentum of societal action against tobacco.

Disability/Injury Prevention and Rehabilitation

The incidence of injuries has continuously increased in most countries of the Region. Traffic accidents and violence are the most common causes of injuries. There is however a universal lack of reliable information in these areas, which explains the absence of a clear national policy in the prevention and control of injuries.

In September 1999, the Regional Office supported a Pre-conference Workshop on Injury Prevention at the Indian Institute of Technology, New Delhi. Recommendations were brought up at the Round Table Discussion during the Fifth Global Conference on Injury Prevention in New Delhi in March 2000. Member Countries were called upon to identify a national focal person for initiating and coordinating the programme. WHO was also urged to support Member Countries in the area of advocacy and establishment of a regional network in injury prevention.

Prevention of blindness and deafness

Prevention of blindness and deafness is considered the most important regional priority among all disability prevention programmes.

Sustained advocacy on the part of WHO has helped to create, within WHO and in other countries a great deal of awareness and interest in Vision 2020. Following the Global Vision 2020, launched by the Director-General in February 1999, the Regional Office organized a SEARO/IAPB meeting and launched Regional Vision 2020 in September of the same year. Nepal was the first country in the Region to launch the National Vision 2020, at the VI Congress of SAARC Ophthalmologists, held in November 1999. The recommendations of the Congress led to the Intercountry Consultation on Development of Regional Vision 2020, in Jakarta, in February 2000. Indonesia took the opportunity of this Consultation to launch National Vision 2020, by the Vice-President of Indonesia.

The most important outcome of this Consultation was the high priority that the prevention of blindness programme

started to receive. The Consultation endorsed the Regional Strategy on Vision 2020, which would serve as a road map for developing National Vision 2020 programmes. Two countries, viz., Bangladesh and Indonesia, were identified as priority countries for implementing the Vision 2020 programme.

Information on deafness and hearing loss is still very scanty and incomparable among most countries of the Region. In 1998, the Regional Office supported a survey on the etiology of deafness and hearing impairments in India, Indonesia, Myanmar and Sri Lanka. A meeting of all principal investigators is being planned to finalize the survey results.

Rehabilitation

The main emphasis of WHO's support to countries on rehabilitation is the community-based rehabilitation (CBR) approach. Integration of CBR into PHC services has been initiated in Bangladesh, Bhutan, India, Indonesia, Myanmar, Sri Lanka and Thailand. The outcomes of these projects have yet to be followed up. It is planned to evaluate, in collaboration with WHO headquarters, the impact of CBR in 2001.

An Intercountry Consultation on Strengthening Training of Health Workers on CBR was held in Bangkok in May 1999. The recommendations of the Consultation have helped to improve CBR training in Member Countries.

Ageing and health

Since the last decade, countries in the Region have been facing the double burden of communicable and noncommunicable diseases. Many of them occur among the ageing population causing high mortality and disability. Realizing these problems, many countries have included 'Elderly Health' in their national health programmes.

A Workshop on Active and Healthy Ageing for Mega-countries was held in the Regional Office in September-October 1999. The objective was to develop regional strategic directions for intercountry collaboration on strengthening active and healthy ageing programmes,

particularly in the mega-countries (Bangladesh, India and Indonesia). Based on the recommendations of the Workshop, a WHO intercountry programme was developed for initiating a situation analysis and establishing an integrated home-based care programme.

Mental Health

Mental and neurological conditions account for 10 per cent of the burden from noncommunicable diseases in the Region, measured according to Disability Adjusted Life Years (DALYs).

Basic mental health care coverage has been increasing steadily over the last decade in all countries of the Region, including Bhutan and Maldives, where such care was previously virtually absent. This effort was supported by the Regional Office. Bhutan was assisted in the training of a group of physicians in basic psychiatric skills and psychosocial rehabilitation and in finalizing details of the second phase of a mental health project.

A study on dementia and its prevention was conducted by the Department of Psychiatry, Lady Hardinge Medical College, New Delhi, from April to October 1999. The results of the study will be used for India's National Mental Health Programme.

An agreement was signed with the Faculty of Medicine, University of Colombo, Sri Lanka, to study the feelings/motivational patterns in persons who identify themselves as having had ideations of self-harm or of seriously harming others, or attempted suicide or seriously harmed or assaulted others, during the preceding six months. The study is continuing.

Mental Health policies of Member Countries are being reviewed and feedback will be provided to each country. A regional policy on community mental health, including plans of action for 2000-2005, has been developed.

Substance abuse

The Region is seriously affected by increased substance abuse. Innovative programmes (e.g. combining treatment of substance abuse with social support to the family and

providing traditional spiritual support to the victims) need to be introduced in the Member Countries.

The second phase of the ethnographic study on the intervention strategies of street gangs, their alcohol and drug use is being conducted in Jakarta by the collaborating researcher, Police Science College, Jakarta, Indonesia.

A project document on Strengthening Selected Demand Reduction Programmes was signed by the Government of Sri Lanka and the Executive Director of UNDCP in September 1999. WHO has been appointed the executing agency for this project.

A regional policy on the control of substance dependence and prevention of harm from alcohol, including plans of action for 2000-2005, has been developed.

6
Health Technology and Pharmaceuticals

Essential Drugs and Medicines Policy

Action programme on essential drugs

Essential drugs are indispensable for the prevention, control, treatment or amelioration of diseases and maladies. In order to improve the availability, accessibility and affordability of essential drugs, WHO has been collaborating with all Member Countries in the development and implementation of national essential drugs programmes.

A thrust of WHO activities is on strengthening human resources and improving national capabilities in the area of pharmaceuticals. In this context, training courses have been held under the ASEAN Pharmaceuticals Programme and Bi-regional Technical Cooperation. The areas covered were: quality control of pharmaceuticals, good manufacturing practices and good laboratory practices. Training workshops on the assessment of applications for marketing authorizations and on monitoring, detection and control of counterfeit drugs for drug regulatory officials were also held.

At the country level, national essential drugs programmes are being supported according to national priorities. The areas of collaboration cover: quality assurance of essential drugs (Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal), production according to good manufacturing practices (Bangladesh, Sri Lanka), availability and accessibility of essential drugs (Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar), rational use of drugs (Bhutan, Indonesia, Sri Lanka) and drug information (Indonesia). Strengthening of national pharmaceutical regulations and drug policy in

Maldives and technical support for the development of local production of artemisinin derivatives in Myanmar was also provided.

Traditional medicine

A Regional Consultative Meeting on Development of Traditional Medicine in the South-East Asia Region was held in the Regional Office in September 1999. The meeting brought together experts in traditional medicine (TRM) from the public as well as private sectors from within and outside the Region. The meeting reviewed three important aspects of traditional medicine; viz., development of national TRM programmes; involvement of WHO collaborating centres and national centres of expertise in TRM and PHC in improving district health systems; and identification of areas for operational research in TRM and PHC.

The seventeenth meeting of Ministers of Health of the countries of the Region, held in Yangon in October 1999, discussed the use of traditional medicine in the health care system. The meeting recognized the need for developing and strengthening national policies on TRM. In the context of this policy, the use of TRM in the national health care system, improving the efficacy and safety of TRM, strengthening TRM legislation and regulation, among others, can be carried out. Protection of the rich heritage of medicinal plants and judicious export of their products can be undertaken within the interpretation of the TRIPS agreement.

Vaccines and other Biologicals (VAB)

Poliomyelitis eradication

The large number of births and low routine OPV3 immunization coverage as well as crowded urban slums can facilitate the resurgence of polio between the rounds of National Immunization Days (NIDs) in Bangladesh, India and other polio-endemic countries. Recognizing this, the Fifty-second World Health Assembly, in May 1999, called for acceleration and intensification of polio eradication strategies. Accordingly, India completed four rounds of intensified NIDs from October 1999 to January 2000, to be followed by intensified Sub-NIDs (SNIDs) in eight high-risk

states in February and March 2000. Nepal synchronized its NIDs and SNIDs with those of India. Bangladesh completed its intensified NIDs in November and December 1999 and additional intensified NIDs in April and May 2000.

Reported polio cases in the Region decreased 14-fold from 25 711 in 1988 to 1 160 laboratory-confirmed cases accounting for 94 per cent of the cases. Of the global total, India accounted for 41 per cent of the cases. Indigenous wild polio virus was isolated in Bangladesh, India and Nepal in 1999. Bhutan, Maldives and Sri Lanka have had no wild polio virus isolates for more than six years and Thailand and Indonesia for more than three. Data from DPR Korea are inadequate to determine the progress in 1999.

Of the 17 laboratories comprising the Region's polio laboratory network, 14 were WHO-accredited, one provisionally accredited, and two pending accreditation. India, Nepal, Sri Lanka and Thailand achieved the non-polio AFP reporting rate of at least 1 per 100 000 children aged less than 15 years. Bangladesh, Indonesia and Myanmar have rates below 1 but above 0.71. Indonesia, Sri Lanka and Thailand had adequate stools collected from >80 per cent of the AFP cases and India, Myanmar and Nepal from >60 per cent of the cases.

Polio-free since 1997, Myanmar isolated wild polio virus along its border with Bangladesh. This highlights the vulnerability of polio-free countries to resurgence of polio unless they sustain high quality AFP surveillance and conduct appropriate supplementary immunization campaigns. Myanmar responded by conducting mopping-up operations in the infected province and in other high-risk areas.

WHO assisted the Government of India in strengthening the capacity of the National Regulatory Authority for vaccines and local vaccine producers. Technical support and guidance was also provided to the World Bank in the development of the project for strengthening routine immunization in India.

Measles

Measles continues to be a major cause of morbidity and mortality in the Region, with 65 208 cases reported in 1998. The true incidence is likely to be several million cases. Improving surveillance is key to better target immunization activities. Myanmar, Sri Lanka and Thailand have linked measles and neonatal surveillance to AFP surveillance.

Neonatal tetanus

Bhutan, DPR Korea, Sri Lanka, Maldives and Thailand are considered as having eliminated neonatal tetanus (less than 1 NT case per 1 000 live births). Bangladesh, India and Myanmar conducted TT immunization campaigns for all women of child-bearing age in high-risk areas.

EPI coverage

Regional coverage for OPV3, DPT3, BCG and measles declined from the 1995-1997 rate of over 80 per cent of children in their first year of life to about 70 per cent in 1998. Therefore, in 2000, the Regional Office will attempt to increase and maintain high coverage by improving the routine immunization programme.

Introduction of new vaccines

New priorities in respect of vaccines in the Region are hepatitis B and Hib. Hepatitis B vaccine is routinely given in four countries: Bhutan (81 per cent coverage in 1998), Indonesia, Maldives (45 per cent coverage in 1998), and Thailand. Reliable data on the burden of invasive Hib disease in the Region are not available. A study of the effect of Hib vaccination on pneumonia incidence among children under 5 is now ongoing in India, Indonesia and Thailand.

Vaccine supply and quality

In 1999, WHO supported the Government of India in ensuring timely supply of oral polio vaccine (OPV) of assured quality that was required for the six rounds of NIDs/ SNIDs. WHO also coordinated and supported activities to establish and strengthen the National Regulatory Authority (NRA) and National Controlling Laboratory (NCL) in the Member Countries. A cold chain review was conducted in parts of

India and a crash maintenance programme implemented in a priority state. A vaccine vial monitoring study was conducted in Bhutan and a correlation study in India. A GMP review was undertaken of local producers of OPV in India. A feasibility study of hepatitis B vaccine production in Myanmar was completed. The staff of NRAs and NCLs were trained under the Global Training Network scheme.

Blood Safety and Clinical Technology

Technology for health care

The main thrust of WHO has been in the field of quality assurance in various disciplines of laboratory medicine, blood transfusion services, antimicrobial resistance monitoring, analytical chemistry as well as radition medicine. Various group educational activities, guidelines and training workshops have been organized in the recent past to strengthen quality assurance in various countries. A steady increase in the number of participating laboratories in external quality assessment schemes for a large number of parameters is a broad indicator of improvement in quality assurance. Nevertheless, a systematic evaluation is called for and is accordingly being planned. The information about success achieved in various countries is being disseminated through the publication of a half-yearly QA Newsletter.

In addition to quality assurance, capacity building has been accorded priority under the blood safety programmes of various Member Countries, including India, Myanmar, Sri Lanka, and DPR Korea. Efforts have been initiated in India and Myanmar to educate clinicians about the rational use of blood. These activities will be replicated in other Member Countries. In keeping with the World Health Day slogan for 2000, 'Safe blood starts with me", a number of advocacy and promotional activities were supported.

Services of the WHO Collaborating Centre in India were utilized to establish quality assurance in diagnostic imaging services in different countries, notably Bangladesh, DPR Korea and Myanmar.

Antimicrobial resistance has emerged as a major problem in the Region. WHO has been actively involved in the training of trainers in uniform methodology for antimicrobial susceptibility testing and utilization of WHO developed software (WHONET 4 and 5) in rapid analysis of data. Bangladesh, Myanmar and Nepal were provided technical support to strengthen their resistance monitoring. Networking of laboratories in different countries is being proposed for quality assurance as well as for analysis of data at national and regional levels.

Technical support through a training workshop in analytical toxicology was provided to participants from India and Nepal in collaboration with the Medical Toxicology Unit, London.

7
Evidence and Information for Policy

Evidence for Health Policy

Countries of the Region have been active in collecting, validating and disseminating information on health situation and trends in health status. To support country efforts to improve national health information systems (HISs), a number of intercountry activities have been initiated. These have provided substantive points of entry for more in-depth and focused efforts within the countries.

As an entry point for strengthening morbidity and mortality data, a training course on the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) was developed by the National Centre for Classification in Health (NCCH), a WHO collaborating centre in Australia, in cooperation with the Regional Office. A curriculum for a short course in basic medical records practice was also developed by the same collaborating centre in cooperation with the Regional Office. Both of the above-mentioned courses have been institutionalized in Sri Lanka. In mid-1999, the National Institute of Health Sciences (NIHS), Kalutara, Sri Lanka, carried out a 12-week national course for medical records personnel according to the curriculum developed by NCCH and adapted in Sri Lanka. During this course, staff from NCCH conducted the two-week ICD-10 training so that more people from Sri Lanka could become trainers and facilitators for intercountry courses of this nature.

In November-December 1999, Sri Lanka organized a two-week intercountry ICD-10 training course as well as a four-week intercountry medical records/health information management training course for participants from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. The evaluations by NCCH staff and experts from the Region were extremely positive reflecting the competence of NIHS to carry out these courses in future.

In order to strengthen HISs and their contribution to national planning processes, the Regional Office is using the application of health futures methodologies as another point of entry to better focus efforts within Member Countries. A number of health futures studies are being carried out in Thailand. A handbook, *Health Futures,* has recently been published by WHO headquarters. Another innovative approach recently being promoted in the Region is the DALY methodology for measuring the burden of disease.

During the year under review, the following activities were supported by the intercountry GPE/HST programme:

- Inter-regional Consultation on WHO Support to Health Information System Development in August 1999 in Malaysia (jointly organized by WHO headquarters and the Western Pacific Regional Office) to review the status of national health information systems development and to prepare updates of national/regional PoAs.

- Workshop on Mortality Statistics in September 1999 in Myanmar to support countries of the Region in their efforts to strengthen vital registration and cause of death certification.

- Joint workshop on using burden of disease and cost-effectiveness to define national health priorities in November 1999 in Australia. Twelve public health professionals from the Region, four from WHO country offices and two persons from the Regional Office were trained in this methodology in Australia in 1999 and in the USA in 1998.

- A publication, South-East Asia: Progress Towards Health for All: 1977-2000 has been issued.

Health Information Management and Disseminatio

As in the past, the focus of activities during the period was on the improvement of scientific communication, production and distribution of documents and dissemination of information.

Seven new titles were issued under the SEARO Publications series. Among the non-serial publications, one issue of the Regional Health Forum and Volume 22 of the Dengue Bulletin were issued. Non-priced documents, including reports of various kinds, were produced and distributed. Documentation of the 52nd session of the Regional Committee was issued. The loose-leaf list of technical documents issued since 1979 was updated. Lists of documents received from WHO headquarters and other regions and distributed by the Regional Office were issued periodically.

In the area of development of electronic document database, action was initiated to include WHO publications on the web site for potential Internet users.

The Regional Office distributed documents received from WHO headquarters and other regions to staff and the general public. Documents relating to meetings of the governing bodies, received from WHO headquarters, were distributed to the staff in the Region. Translation of WHO publications into regional/local languages was arranged with a view to making them easily accessible to public health workers. The languages included Bahasa Indonesia, Bengali, Hindi, Kannada, Korean, Nepalese, Tamil, Telugu and Thai.

The Regional Office participated in two book fairs and one scientific meeting. Twelve books were selected for publishing low-cost local editions for sale in the Region as well as in the neighbouring countries and in Africa.

The Regional Office Library continued to provide comprehensive technical information and current awareness

services to WHO staff, WHO country offices and Member Countries.

New initiatives in collaboration between the library and departments/units within the Regional Office were undertaken to facilitate the management and exchange of in-house information resources with a view to providing better services to the Member Countries. A digital photo library database of over 5 000 photographic images and slides was developed. A full text database of research abstracts, funded by the Regional Office was also developed. Assistance was provided in information management by developing an electronic document archival system for the Programme Coordination Unit and in the development of an information system for the Operations Room.

With a view to providing better information services by taking advantage of current information technologies, the library was expanding its digital information resources and services. The bibliographic database of WHO SEARO publications, SEALIS, was being upgraded to a full text database. Several international journals subscribed by the library in paper format were substituted by the electronic format. The library also started the table of content services via personal e-mail alert.

The library continued to provide technical assistance to the Member Countries through the HELLIS (Health Literature, Library and Information Services) Network. An intercountry meeting on HELLIS, organized in June 1999, laid down activity guidelines to strengthen libraries and information services in the Region. Activities to manage national health information resources using current information technologies were started in Bhutan, Maldives and Myanmar and action plans were drawn up for other Member Countries to achieve the objectives recommended at the said meeting.

Research Policy and Cooperation

The regional research programme focused on integrated work in several interlinked areas: health research promotion and development, health research management practices,

research capability strengthening, health systems research promotion, and utilization of research findings. Improvement of health research management in the countries of South-East Asia remains the overall goal. A set of strategies was adopted to contribute to this key objective.

One important strategy is to bring together health research scientists, research policy advisers and health policy-makers. Following the first joint session of the SEA Advisory Committee on Health Research (SEA-ACHR) and the Medical Research Councils (MRCs), held in Sri Lanka in 1998, and the 24th session of SEA-ACHR, held in Yangon in 1999, SEA-ACHR was reconstituted with new terms of reference. This also took cognizance of the changing global scenario in health research policy and cooperation. The 25th session of SEA-ACHR, held in Bali, Indonesia, in April 2000, reflected this new role with its enlarged membership drawn from all the countries of the Region and its greater diversity of disciplines and expertise. To help ensure implementation of the health research agenda in the countries, members of the new SEA-ACHR comprise health policy-makers, research policy advisers, heads of health research councils or research institutions and senior research scientists.

Adding to this strategy, in 1999, four scientific working groups were established in important areas of health research management, viz. (1) Management and coordination of health research activities in the countries; (2) Criteria for setting health research priorities; (3) Formulation of national health research policies and strategies, and (4) Management of health research information. This was in keeping with the recommendations of the first joint session of SEA-ACHR and MRCs. The purpose of these groups was not only to deliberate on important issues and ideas, but also to develop guidelines and suggest strategies in health research management and related issues that are important to this Region. The 25th session of SEA-ACHR reviewed the progress of the scientific working groups and commended the initiative. The contribution to current thinking on a range of issues was

welcomed, for example, reform of the health or medical research councils, strengthening ethical review mechanisms, priority setting for health research and health problems.

The recommendations of the 24th session of SEA-ACHR were followed up closely. A compendium of the Committee's recommendations for the period 1976-1999, categorized by technical areas as well as by WHO's current programme classification, was compiled.

Furthermore, the second meeting of the scientific working group on operational research in reproductive health was organized in the Regional Office in November 1999. This meeting reviewed the progress in the field since its first meeting, held in 1996.

An expert group meeting on HIV-AIDS research, with emphasis on social and behavioural aspects, was held in the Regional Office in December 1999. The meeting generated a substantive agenda for further work in this field.

A core group was constituted in the area of vaccination research. It met in Bangkok in October 1999 and formulated guiding principles for the development of a regional vaccine policy. It comprised such aspects as vaccine development, vaccine mix, and sustainability of expanded programmes of immunization in the Region in the 21st century. Equity, self-reliance and regional solidarity would be its guiding principles.

A further strategy sought to initiate studies concerning specific aspects of health research management in the countries of the Region. For instance, assessment of the complementarity between the national health research policy and actual health research projects was conducted in Bangladesh, Myanmar and Nepal. Such a study represents an important facet of research management.

Emphasizing the training aspect in health research and medical education, a review of curricula on research methods and research-related issues used in medical and paramedical

institutes was started in Bangladesh, Indonesia, Myanmar, Nepal and Sri Lanka.

Considering the importance of the infrastructure for health research in the context of research management, an assessment of health research infrastructure and health research scenario was commissioned in Thailand. Representing a further facet of managerial relevance, a study has commenced concerning the development of a generic monitoring system for health research projects in Myanmar. In addition, separate studies have been commissioned dealing with the development of a national system of health research information in India, Indonesia and Thailand.

WHO works closely with its collaborating centres in various disciplines. Following World Health Assembly resolution WHA50.2 and discussions at the 101st session of the Executive Board in January 1999, a review of the rules and regulations of WHO collaborating centres was carried out. Proposals for change were reviewed in July 1999 by the Director-General and Regional Directors. The WHO Executive Board, at its 105th session held in January 2000, approved the recommendations and the new rules and regulations came into effect immediately thereafter. The new rules enunciate the criteria for the selection of WHO collaborating centres; procedure for designating WHO collaborating centres; title and use of WHO's name and emblem on letterheads; management; and evaluation and monitoring.

As of 1 June 2000, there were 31 active collaborating centres in the Region while 50 were under redesignation. The new rules and regulations were being forwarded to all the WHO collaborating centres.

Health Sector Reform and Health Economics

Considerable emphasis on health systems, their management, performance and the resources utilized to enhance health status is being laid by the WHO Director-General. National Health Accounts are a key foundation for such an analysis. In fact, the theme of the World Health Report 2000 is *Health*

Systems: Improving Performance. WHO organized an Inter-regional Workshop on Health Systems Performance Assessment in Harare, Zimbabwe, in April 2000, with a view to understanding the concept and use of health systems performance indicators and arriving at a consensus to derive such indicators.

General information about the magnitude of selected financing and expenditure trends, including worksheets for individual countries, prepared by WHO headquarters, was disseminated to all the Member Countries. In this context, the document on *Estimates of national health accounts: Aggregates for 191 countries in* 1997 *(GPE discussions, page No. 26 GAFO Geneva 2000)* would help the national focal points to critically review the existing data on National Health Accounts in order to report more accurately.

WHO also supported a study to analyse equity in three national health systems, viz., Bangladesh, Nepal and Sri Lanka, aimed at documenting the overall equity in the delivery of health care services using the National Health Account Framework. The study would also attempt to compare the performance of the existing health care systems and policies in achieving equity in health care in these countries. The study is continuing and the outcome will be shared with the Member Countries.

In order to have a comprehensive resource, the WHO Regional Office assisted Member Countries in preparing country profiles on health systems and health sector reforms. Seven countries, viz., Bangladesh, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, have already prepared the first drafts of such profiles and the remaining three countries have initiated the process. A regional expert has been contracted to coordinate and technically edit the profiles.

The Regional Office had taken the initiative to establish the Asia-Pacific Network on Health Policy and Health Systems Research within the framework of intercountry cooperation for health development in the Region. An agreement was

concluded with the Health Systems Research Institute, Thailand, for strengthening research collaboration and stimulating the generation of knowledge and information to facilitate policy analysis with a view to improving understanding of the health systems and policy processes in the countries of the Region. The first meeting of the network participants was held in Bangkok in May 2000.

In the area of health insurance, WHO supported Member Countries in updating the profiles on various health insurance schemes, including establishment of a database on health insurance in the non-formal sector.

The Organization also supported the participation of nationals from SEAR countries in a workshop on creating and using National Health Accounts for Health Finance Reform in Lower Income Countries, organized by the Harvard School of Public Health in Vermont, USA. Similarly, support was provided for participation in a course on health sector reform, held in Bangkok in September 1999. WHO supported study tours for officials from the Member Countries in the field of health policy formulation process, to study programme planning and planning strategy, and in the field of health economics, within and outside the Region.

8
External Relations and Governing Bodies

Governing Bodies

World Health Assembly

The Fifty-third World Health Assembly was held in Geneva from 15 to 20 May 2000. The Assembly elected Dr Libertina Amathila (Namibia) as President. Mr N.T. Shanmugham (India) was elected as one of the Vice-Presidents, Prof S.M. Ali (Bangladesh) as Chairman of Committee A and Dr Suwit Wibulpolprasert (Thailand) as Rapporteur of Committee B.

DPR Korea was elected to designate a person to serve as a Member of the Executive Board for a term of three years, to fill the vacancy created by Sri Lanka completing its term. The Assembly adopted 17 resolutions.

Discussions on technical and health matters included the subjects of: Stop TB initiative; HIV/AIDS; food safety: the role of WHO; infant and young child nutrition; technical cooperation among developing countries; strengthening health systems in developing countries; revised drug strategy; eradication of poliomyelitis; WHO Framework Convention on Tobacco Control; global strategy for the prevention and control of noncommunicable diseases; cloning in human health; and health promotion.

In addition to routine management and finance matters, the Assembly also proposed amendments to the Financial Regulations; the most important changes relating to applicability and delegation of authority, financial period,

budget, Regular budget appropriations, assessed contributions, investment of funds, and internal control.

Executive Board

The 105th session of the Executive Board was held in Geneva from 24 to 28 January 2000. Among the important issues discussed were: the WHO corporate strategy; poverty and health: evidence and information for policy including an important presentation on trends and challenges in world health; working in and with countries; public-private partnerships for health; draft policy on extrabudgetary resources; and programme budget priorities for 2002-2003, terms of reference of the audit committee; amendments to the Financial Regulations; and use of languages in WHO.

The technical and health matters discussed related to: food safety: the role of WHO; WHO Framework Convention on Tobacco Control; HIV/AIDS: confronting the epidemic; Stop TB initiative; and global alliance for vaccines and immunization.

The 106th session of the Executive Board was held in Geneva on 21-22 May 2000 and considered a number of mostly procedural issues. The session also reviewed smallpox eradication: destruction of variola virus stocks, and Roll Back Malaria.

Regional Committee

The 52nd session of the WHO Regional Committee for South-East Asia was held in Dhaka, Bangladesh, from 6-9 September 1999. Besides representatives from all the ten Member Countries of the Region, it was also attended by the Director-General of WHO, representatives from UNICEF, UNESCO and a number of nongovernmental organizations. The Prime Minister of Bangladesh delivered the inaugural address, which highlighted her government's commitment to socioeconomic development, particularly health sector programmes.

The Committee discussed the Regional Director's report on the work of WHO and noted the progress made in the

implementation of the WHO collaborative programmes in the Region. The report highlighted WHO's intensified efforts and initiatives in collaboration with countries, such as intercountry cooperation for health development, joint planning initiative, synchronization of National Immunization Days (NIDs), coordination of border meetings for prevention and control of communicable diseases, addressing of women's health issues, and health research and training.

The Committee, among other things, discussed programme budget issues, Roll Back Malaria (RBM), intercountry cooperation on essential drugs, and strengthening poison control centres in the Region. The Committee considered the recommendations arising out of the Technical Discussions on "Tobacco or Health: Action for 21st Century" and "Intensification of HIV/AIDS Surveillance", held during the 36th meeting of the Consultative Committee on Programme Development and Management (CCPDM).

Member Countries were urged to promote and support the Roll Back Malaria initiative by integrating its activities with those of prevention and control programmes of other communicable diseases within the existing primary health care settings and district health system. The Committee urged the Member Countries to establish and strengthen poison control initiatives for chemical safety and control of environmental health hazards like arsenic and fluoride contamination in ground water. The Committee, following review of the report of CCPDM on tobacco control, urged the countries to constitute a multisectoral national council, strengthen policies to control this serious health hazard and promote advocacy for policy changes through intercountry activities, such as the South-East Asia Anti-tobacco (SEAAT) Flame.

Resource Mobilization

WHO has established new policy guidelines for resource mobilization, which focus, among others, on broadening the resource base, including involvement of the private sector, improving intra-organization coordination and increasing complementarity with partners. It also emphasizes the need

for improved capacity at the country level concentrating on WHO priority programmes and for joint planning of regular and extrabudgetary funds.

The WHO extrabudgetary resources used in the South-East Asia Region had shown an increasing trend during the last biennium. A positive development has been the increased health sector financing by a number of newly-established large foundations in the private sector, such as the UN Foundation (Turner) and the Bill and Melinda Gates Foundation. Programmes such as children's health, polio eradication, tobacco control, reproductive health, prevention and control of AIDS, etc. received substantial contributions from these foundations. In addition, the Nippon Foundation continued its support to the leprosy elimination programme in the Region.

Significant contributions to the health programmes in the Region also resulted from WHO's collaboration with other NGOs. Notable among these were Rotary International, Lions Club International, American Leprosy Mission, Medecins du Monde, and International Planned Parenthood Federation (IPPF). Polio eradication, prevention of blindness, leprosy elimination, HIV/AIDS prevention and control, and reproductive health were among the major programmes supported by these organizations. Within the framework of WHO's new strategy on renewed relations with NGOs, the Regional Office is currently exploring the feasibility of setting up a regular regional WHO-NGO consultation forum with a view to promoting collaboration between governments, NGOs and WHO at regional and country levels.

The Regional Office continued to maintain close collaboration with the World Bank and the Asian Development Bank in respect of various health sector programmes and projects financed by these institutions. WHO technically supported the national authorities as well as the banks in various appraisal and programme formulation missions, in programme monitoring and evaluation and, in

some instances, implementation of selected technical assistance components.

The Government of Sri Lanka negotiated with the Japan Bank for International Cooperation (JBIC) a credit of US$20 million for improving blood transfusion services. WHO participated in programme development as well as in the negotiation process as a technical adviser and will continue its support through technical supervision.

The Netherlands, DANIDA, USAID, NORAD, SIDA, FINIDA, UK, Australia, Italy and Germany continued to be among the major bilateral donors who substantially contributed to the priority health programmes in the countries of the Region.

WHO organized the second Intercountry Workshop on Negotiation Process for Health Resource Mobilization in Jakarta in November 1999. This was part of its continuing efforts at strengthening national capacity to negotiate more effectively mobilization of resources for the health sector.

External Cooperation and Partnership

WHO, with other UN partners, actively participated in the process of UN Development Assistance Framework (UNDAF) in the countries to increase the effectiveness and efficiency of UN operations by bringing synergy and developing a clear vision of cooperation among UN agencies. At the end of 1999, the UN Country Team and the Government of India completed the preparation of UNDAF, as a pilot exercise, focusing on two strategic areas, namely, reducing gender inequality and strengthening decentralization.

Collaboration with UNICEF in the area of immunization was further strengthened by convening the WHO-UNICEF meeting of Secretaries of SAARC and Border Countries on Cross-Border Management of Poliomyelitis Eradication, held in Nepal in March 2000. This joint meeting initiated a number of actions to achieve a high level of national commitment, financial support, micro planning and management, and local-level activities.

The Regional Office organized a Regional Consultation on the Implications of WTO Multilateral Trade Agreements on Health – TRIPS – in Bangkok in August 1999. There was wide-ranging participation of different sectors, e.g. ministries of health and trade, national institutions, civil society groups, national and international NGOs and UN and intergovernmental agencies, such as WTO. The Consultation extensively considered a number of potential health implications resulting from the protection of intellectual property rights (IPR) under the TRIPS agreement and recommended actions to be taken at regional and country levels to safeguard health in the process of IPR reform. This Consultation helped increase awareness among various sectors and stimulated further discussion at country and regional levels.

Continuous efforts were made to strengthen cooperation, collaboration and coordination with regional bodies of the UN system and other regional inter-governmental organizations. WHO attended a number of ESCAP meetings of relevance to health and social development and participated in the Regional Coordinating Meeting, specially convened by the Deputy Secretary-General of the United Nations. At this meeting, WHO presented a position paper on inter-agency collaboration with ESCAP and other UN agencies and highlighted, among others, regional health priorities and a need for social equity and for a social safety net. WHO contributed, within the framework of ESCAP, to the follow-up of the World Summit for Social Development and the review of regional implementation of the Beijing Platform for Action. It also provided technical support in the preparations for the 4th ESCAP Ministerial Conference on Environment and Development, to be held in Japan in September 2000. A mid-term review of the WHO-ASEAN Memorandum of Understanding, held in November 1999, recommended future strategic directions as well as new areas of priorities, such as health sector reform, Tobacco Free Initiative and health impact of globalization and trade liberalization for intensified collaboration between the two organizations.

WHO also provided technical support to the 5th ASEAN Health Ministers Meeting in Yogyakarta, Indonesia, in April 2000. A Memorandum of Understanding between WHO and SAARC for collaboration in health development is in the final stage of processing and is expected to be signed soon.

WHO supported a follow-up Integrated Meeting of the Process and Subject Area Coordinators for Intercountry Cooperation for Health Development (ICHD), held in Manila in December 1999. The meeting adopted the Manila Declaration, identified seven priority subject areas and a framework for intercountry cooperation and also formulated a Plan of Action for each area. The process of ICHD was also discussed at the 5th Meeting of Health Secretaries of the WHO South-East Asia Region. Continued commitment of the participating countries to ICHD at the highest political and administrative levels remains a prerequisite to the sustainability of the initiative. The College of Public Health, Chulalongkorn University, Thailand, developed a comprehensive curriculum and training module for capacity strengthening in international health development with WHO support. WHO also assisted the College in conducting short training courses for policy-makers and senior managers based on these modules.

9
General Management

Budget an Managemer Reform

The regional programme budget 2000-2001 was developed in collaboration with the Member Countries. It duly incorporated reforms undertaken in the Organization. The programme budget thus developed, with 19 major programmes, was more strategic to cater to the needs of the Organization's constituent functions. It was revised later to include 35 areas of work in line with the strategic approach of 'One WHO'. Major thrusts of the budget were in the areas of high level advocacy to support a sound health policy, eradication of specific communicable diseases like poliomyelitis and guinea-worm disease, malaria, tuberculosis, HIV/AIDS and acute respiratory tract infections. It also incorporated priority areas like Tobacco Free Initiative, women's health and development and strengthening of health systems development.

The Organization undertook an efficiency savings exercise to shift 2 per cent resources to priority areas underlined by its governing bodies. Reductions were effected in the areas of fellowships and study tours, supplies and equipment, travel etc. Casual income was allocated to five priority programmes, namely, Roll Back Malaria, tuberculosis, HIV/AIDS, Tobacco Free Initiative and polio eradication.

In order to speed up implementation and use the resources optimally, the Regional Office advised countries to advance their implementation plans. Instructions were issued to implement 75 per cent of the total allotted budget of the biennium by December 2000 and the remaining 25 per cent

by September 2001. Emphasis was given to the implementation of programme activities rather than utilization of funds. The Regional Office also undertook an internal review of obligation proposals to ensure preparation and implementation of good and technically sound proposals. A separate unit under the office of the Regional Director was established to catalyse and coordinate with the WRs' offices and technical units. The Unit, known as Internal Review Unit, will support the review of obligation proposals and final reports of completed activities.

Monitoring and evaluation of the WHO collaborative programmes continued. The six-monthly monitoring format was revised. Progress reports and regular updates were submitted to the meetings of CCPDM, RD's meeting with WRs and the Health Secretaries' meeting. The reports incorporated more of the technical aspects of programme implementation with the emphasis on the achievement of planned expected results. Country programme evaluations were undertaken in Maldives and Nepal, which provided a better insight to the processes and mechanisms of evaluation.

Human Resource Services

As of 30 June 2000, the Regional Office had 125 established professional posts in the Region as compared to 132 posts as of 30 June 1999. Of these, 94 were funded from the Regular budget, compared with 98 one year earlier. A total of 5 professional posts have been abolished as a result of efficiency measures.

Recruitment efforts were focused on the need to increase women's participation in the work of WHO. World Health Assembly resolution WHA50.16 set a target for new appointments of women at 50 per cent by the year 2002. During the reporting period, 8 out of 14 new appointees for professional posts were women, which constituted 57 per cent as against 50 per cent during the preceding year. As of 30 June 2000, 25 women, representing 26.9 per cent of the professional staff, were in position in the Region.

With regard to nationalities to be encouraged for appointment to professional posts, 6 out of 14 new appointees were from unrepresented and under-represented countries, or 43 per cent against the target set of 60 per cent (WHA resolution WHA50.15). Four exceptions to the geographical distribution were made in favour of two women and two appointments to the polio programme.

One hundred and one consultants and 28 short-term professionals were employed in various projects. Of these, women constituted 27.9 per cent, the same as during the previous year.

Of the consultants and short-term professionals 57.3 per cent were represented by SEAR nationalities as against 63 per cent during the period July 1997 – June 1999.

Ten posts of National Professional Officer were established, of which nine were filled. Within the context of enhancing the role of nationals in the planned WHO programme activities, 399 Special Services Agreement holders were in position on 30 June 2000.

Financial Services

During the 1998-1999 biennium, financial implementation targets were set and actively monitored to ensure speedy obligation of funds. This enabled the South-East Asia Region to move from being one of the regions with very low implementation in the previous biennia to being the region with the second highest implementation in the last six months of 1999. This active follow-up also allowed enhanced technical quality monitoring, a decrease in end-of-the-biennium spending, more planning time and better preparation for starting the activities in 2000-2001. Full implementation of the 1998-1999 released Regular Budget of $ 96 379 700 was accomplished for the third biennium running. During the same period, $ 53 030 100 in extrabudgetary funds were also obligated.

During the last six months of 1999, exhaustive financial planning was undertaken to ensure that headquarters 'budget

targets and the Regional Director's budget initiatives were appropriately reflected in the 2000-2001 budget. The regional Regular budget allocation of $ 94 639 000 released by the Director-General for implementation beginning 1 January 2000 represents 99 per cent of the approved regional budget, and is a 3.68 per cent reduction from 1998-1999 due to the implementation of World Health Assembly resolution WHA51.31. Within the released budget, efficiency shifts and cost absorption targets of $ 5.2 million were identified, with $ 500 000 shifting to priority areas. These targets include setting regional caps on travel, study tours, fellowships and procurement as well as Regional Office restructuring through mutually-agreed separation agreements.

Total Regular budget obligations for the first six months of the current biennium amounted to $ 38 077 153 representing 40 per cent of the regional working allocation for the biennium 2000-2001.

The external auditors visited the Regional Office in July 1999 in order to facilitate the issuance of an audit report on the financial statements of WHO for the 1998-1999 biennium. Within the same time-frame, they visited the country office in Thailand. They performed an overall evaluation of key operational controls and an assessment of the practices and performance measures facilitating the successful attainment of the WHO objectives.

The internal auditors increased their individual country reviews with three country office visits in September/October and November 1999. They visited DPR Korea and the country offices in India and Nepal to review internal control systems, test compliance and assess effectiveness, efficiency and economy of WHO activities. Their annual visit to the Regional Office in March 2000 concentrated on programme implementation and financial control issues. Recommendations of the auditors have been or are being actively followed up to ensure compliance.

Informatics ar Infrastructur Services

A new high-speed LAN was installed in the Re gional Office to meet increased infrastructure requirements envisaged in the first decade of the 21st century. The Intranet was restructured and redesigned. Technical and administrative units were provided informatics support for the development of departmental web sites and programme web sites, such as Roll Back Malaria, Tobacco Free Initiative, and Blood Safety. Ongoing web infrastructure support is provided for global dissemination of health-related technical information through the SEARO Homepage. To improve communication with the outside world, the Internet capacity of the Regional Office and some WRs 'offices was enhanced.

A systematic approach was adopted to combat the anticipated Year 2000 (Y2K) problem. Computer hardware, network components and office automation software were made compliant through cost-effective software solutions and, where necessary, hardware was replaced. Country offices were supported for Y2K bug resolution through country visits, Y2K web site and CD-ROMs to provide customized solutions for each office. All WHO offices in the Region made a smooth transition to the year 2000.

A user-friendly interface to the Activity Management System (AMS) was developed for technical monitoring of WHO programme implementation based on agreed business rules and user requirements. Training on the use of AMS was provided to the Regional Office staff and some WRs 'offices and one department, together with one country office. AMS was introduced in five country offices as a tool to improve the monitoring of WHO programmes. The Personnel Information System was developed for further improving information management in the Personnel Unit. Other applications developed include an inventory of short-term consultants, library management system, and enhancemen ts to the publication sales system.

Training in the use of office automation software, data protection and security, web browsing and time and meeting management was provided to the Regional Office staff and a

few country offices. Support was provided for building informatics infrastructure for health telematics pilot projects in Bhutan and Myanmar, targeted respectively to improve health care delivery and tele-education.

Procurement Services

Procurement by the medical supply services during the reporting period amounted to US$ 13.5 million.

A major part of the work has been in support of the WHO programme for the eradication of poliomyelitis. Equipment and supplies for surveillance laboratories were provided to Bangladesh, India and Indonesia. In India, WHO supplied equipment to support field surveillance officers. Cold-chain equipment required for conducting national immunization days was provided to Bangladesh and DPR Korea.

Emergency procurement was in two main areas: emergency health kits to help meet the needs of displaced people in several provinces of Indonesia; and material as part of WHO's response to the continuing emergency in DPR Korea.

The setting of an earlier biennial deadline for the submission of requisitions for supplies and equipment helped to ensure orderly and timely execution of procurement activities.

General Support Services

Renovation of the Regional Office has been completed. A new archives room and several store rooms have been built. A new PBX was installed and is being connected to a global private network which will allow instantaneous and cheaper communication between the South-East Asia Regional Office, other regional offices and WHO headquarters. Renovation of the electrical distribution system was completed; a low tension panel board and a new bank of capacitors were provided.

A critical study of the existing Registry procedures is under way. Pilot projects for computerization of the Registry as well as a new computer-based inventory and meeting room reservation system are being tested.

10
Regional Director's Programme Initiatives

Liaison with Country Offices

Under the "liaison" umbrella, the Regional Office initiated a series of proactive and constructive measures aimed at responding effectively and promptly to the needs of the Member Countries. Through such measures the Regional Office endeavoured to make the WHO collaborative programmes more effective. It also developed decentralized ways of working with country offices, in keeping with local specificity as well as the regional perspective. Such decentralization was based on the principle of complementarity, recognizing the respective strengths of country offices and the Regional Office.

The strengthening of WHO's work in the country offices has been a long-standing concern of WHO's governing bodies. This concern led to the formulation of the WHO Country Cooperation Strategy (CCS) as a means of critically reviewing and refining WHO's work in the countries by identifying key issues with regard to working in and with countries. CCS provides a framework that encompasses the entirety of WHO support ensuring that different levels of the Organization complement and support one another.

During the period of reporting, the Regional Office successfully organized and arranged country visits by CCS support teams (missions). The teams analysed: country-specific developmental challenges and health needs, the activities and approaches of other developmental partners,

and WHO's relative strengths and weaknesses in the countries concerned. While being responsive to country needs, the support teams also ensured that strategic directions, positions and values encapsulated in WHO's corporate and regional strategies were duly respected.

The experiences gained through country visits were exhaustively shared and discussed by the concerned country representatives at the Programme Development and Management Meeting, held in the Regional Office in March 2000. Furthermore, a number of "retreats" were organized with the WHO Representatives and senior Regional Office staff where several issues having an impact on WHO's work in the countries were discussed extensively.

In order to enhance effective liaison with the country offices, an Operations Room (OR) was established in the Regional Office. The new facility will help in reviewing, assessing and synthesizing the available data, with a view to crystallizing critical information with regard to country needs and requirements, especially in emergencies. It will also help in coordinating responses to all emergency situations involving disasters and epidemics, as well as the resultant health needs of displaced populations.

Public and Media Relations

The frequency as well as the quality of interaction with the media continued to improve during the period under review. Overall, the Information Unit worked closely with all technical units to provide ongoing information to the media about health issues, and to best utilize the information and advocacy potential of the media.

During the reporting period, the Region was the venue of important health-related global events, which provided opportunities for important media outreach. The Director-General's visit to New Delhi in January provided the focus on tobacco control and the final push against polio. Both events received unprecedented interest from international and national media; the Director-General's visit to the Regional Committee in Dhaka helped focus media attention on polio

and tobacco; President Clinton's visit to a health centre in India provided global media attention on the polio and tuberculosis control programmes; the special meeting of the WHO-SEAR Technical Consultative Group on Poliomyelitis Eradication and Other Vaccine Preventable Diseases, held in August 1999 in India, was supported with two press conferences. Support was also extended for the development of advocacy materials, including a film *Mission on polio,* prepared by WHO headquarters. The global launch of the World No-Tobacco Day in Thailand served as an advocacy event to obtain policy and media attention on the subject.

Public information focused on Vision 2020 through a media launch in the Region and the Information Unit supported media coverage of its national launch in Indonesia. Special media training was provided to tuberculosis technical coordinators. Media strategies were focused at the leprosy country coordinators meeting in Myanmar. Extensive media support was also provided to the Meeting of Parliamentarians, held in Nepal.

The Information Unit continued to play a coordinating role between the media and the technical experts and helped the technical units in the preparation and dissemination of advocacy materials. Numerous nursing groups and social welfare students were routinely briefed on WHO's role in health.

Regional Director's Development Programme and Initiatives

Urgent help was provided under this programme to countries of the Region faced with emergency situations. Furthermore, seed funding was also provided for innovative health initiatives at both country and intercountry levels.

During the reporting period, support was provided to: Myanmar for the establishment of an electronic library and electronic connection among teaching institutes, and for curriculum development and hands-on training in traditional medicine; Indonesia for strengthening smoking control programmes; for epidemic preparedness in West Timor in the form of mosquito nets, and for administrative support for East

Timor operations in Dili, Darwin and Jakarta; India for the establishment of a surveillance system and for emergency supplies and equipment to Orissa state in the wake of the severe cyclone, and Thailand for airport rodent control research, and for the establishment of a centre for combating counterfeit drugs.