Introductory remarks

By
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At

The 61st Session of the Regional Committee

"*The RD's Annual Report on the Work of WHO in South-East Asia Region covering the period 1 July 2007 to 30 June 2008*"

New Delhi
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REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA

- Honourable Chairman;
- Distinguished country representatives;
- Honorable guests;
- Ladies and gentlemen:

I have great pleasure to present my annual report on the work of WHO in South-East Asia Region; covering the period 1 July 2007 to 30 June 2008.

Since the report has already been distributed as the document SEA/RC61/2, I will confine my introduction only to some salient features.

During the period under review, the Member States continued making steady progress in their health development efforts. This was, in particular, the strengthening of health systems for more effective public health interventions in disease prevention and control. WHO had invested more resources to further strengthen its direct support to national health and health-related programmes; focusing on country capacity building.

Let me now take up Communicable Disease Prevention and Control. The majority of countries in the Region had achieved the global targets for tuberculosis control. These targets are 70% case detection and 85% treatment success.

However, in the Region, there were more than 1.3 million people who suffered from co-infection of TB and HIV. Attempts had been made through intensified training of concerned national staff, to improve the management of multidrug resistant TB, and TB/HIV co-infection.

Leprosy prevalence in South-East Asia continued declining. Only two countries were yet to achieve the global target of leprosy elimination. That is to bring down the prevalence rate to less than 1/10,000 population. To sustain leprosy control activities, a post-elimination strategy was developed and its implementation in countries promoted.

With regard to lymphatic filariasis, the South-East Asia Region accounted for 82% of the global Mass Drug Administration (MDA). Sri Lanka had already achieved the goal of lymphatic filariasis elimination for the entire country, in bringing down the microfilaria rate to less than 1% .

For kala-azar, with the availability of Recombinant Kinatoplast 39 for diagnosis, and miltefosine for treatment; case management was much improved. Cooperation among affected countries was further strengthened through an Intercountry Collaborative Programme for kala-azar Elimination.

In South-East Asia, diarrhoeal and respiratory diseases, contributed to 48% of the 3 million annual deaths among children below five years of age. A technical unit was reconstituted at the Regional Office to ensure effective support to countries in this important area.

Concerning dengue and chikungunya, in spite of vigorous control efforts in countries, the diseases still continued to emerge as a major public health concern. Even though seasonal, the outbreaks of dengue and chikungunya occurred in massive events, sweeping across countries, and expanding geographically. All out efforts were continued by affected countries in their prevention and control. In coordination with the relevant institutions in the Region, the Regional Office initiated a development project on Dengue Vaccine for Children.

Out of 385 cases of human Avian Influenza reported globally, 42% were in South-East Asia. And its case-fatality rate in Region is the highest. High level multisectoral task forces and coordinating bodies on Avian Influenza control were formed in several countries. An intercountry consultation was organized to promote intercountry cooperation in prevention of cross-border spread of Avian Influenza.

Seven countries of the Region had developed national influenza centres, which were linked to the Global Influenza Surveillance Network. The South-East Asia/Western Pacific Bi-regional Influenza Laboratory Network was established during the period under review.

The National Institute of Virology, in Pune, India was designated by WHO as the first Regional Influenza Referral Laboratory in South-East Asia.

Concerning HIV/AIDS, the total estimate of HIV infections in the Region was 3.6 million. The HIV/AIDS situation in general seemed stable. However, due to the prevailing risk factors, the situation could worsen. Since 2002, almost one billion US Dollars had been mobilized from the Global Fund for prevention and Control of HIV/AIDS in countries.

Intensified actions had been taken to build country core capacity, necessary for effective implementation of International Health Regulations. More than 2,000

health workers had been trained in rapid response to public health emergency of international concern. The table-top exercises to test influenza pandemic preparedness plans were conducted in most countries of the Region.

As far as Vaccine Preventable Diseases are concerned, Polio Eradication is still another unfinished agenda. Vigorous efforts by concerned countries were intensified to ensure reaching the eradication target as soon as possible. Prevention of cross-border importation of polio virus was coordinated through intercountry collaboration facilitated by WHO.

As for measles, its incidence continued declining under the progressive development and implementation of the immunization programme. The expansion of its laboratory network last year resulted in the addition of four new labs, which increased the network capacity from 16 to 20.

Vaccine manufacturers in three countries were identified for the development of seasonal influenza vaccine, which had never been done in the Region before.

Chronic noncommunicable diseases accounted for 44% of the total disease burden and 54% of the total deaths in our Region. Risk factors of noncommunicable diseases were well known and prevailing in South-East Asia. The situation provided an opportunity for the development of an effective and integrated NCD prevention and control strategy in the Region.

Tobacco use kills more than a million people annually in South-East Asia. During the past year, several tobacco use surveys were conducted in the Region. A Regional strategy was prepared to guide the development and implementation of evidence-based programmes for prevention and control of tobacco use.

In the area of mental health, village-based workers were trained to identify determinants of mental health and mental disorders. Community-based programmes for mental health services were further expanded in countries through the application of those determinants. Mental health promotion as a part of general health promotion strategy was encouraged at family and community levels.

In the area of Family and Community Health, the majority of Member States in the Region were on track towards achieving the MDG to reduce under-five mortality.

But, to achieve the MDG relating to maternal mortality reduction was difficult indeed. This was in spite of available evidence-based interventions, and the untiring efforts of Member States. More operation-based research is needed, especially in social, cultural and economic dimensions of maternal deaths.

Efforts to reduce child mortality through Integrated Management of Childhood Illnesses (IMCI) were expanded in most countries during the period under review. It was evident that IMCI was an effective strategy that contributed significantly to the reduction of child mortality.

Accelerated efforts had been made on the development of community-based health workers and health volunteers for more effective maternal and newborn care. The integration of essential post-natal and newborn care into primary health care was promoted in all countries.

As far as health of mothers is concerned, new guidelines on preventing and managing reproductive tract infections were pilot-tested in several countries. Attempts had been made in the Region to eliminate congenital syphilis.

In the area of adolescents' health, efforts were continued to increase sensitivity to the health needs of this population group. Development of national quality standards of health services for adolescents was further promoted.

In the context of health and environment, access to safe water supply had increased from 80% in 2004 to 85% at present. Plans for water safety, including water quality standards, were reviewed and updated in several countries. However, nine hundred million people in South-East Asia still lacked access to proper sanitation. An ecology-based approach to sanitation was conceived and launched through pilot-testing in a few countries with promising results.

With regard to natural disasters, more than half of the global deaths occurred in South-East Asia. During last year, floods and cyclones killed tens of thousands and affected millions. The South-East Asia Regional Health Emergency Fund was established and was functional. Funds were released within hours following cyclone Nargis in Myanmar. Also, funds were used for relief operations after floods in Sri Lanka this year. Now, Nepal and Bihar State of India are facing unprecedented devastation from floods, affecting millions of people. WHO is working closely with other international agencies in supporting the governments in relief operations.

Concerning food safety, its surveillance in the Region was very weak; and public awareness of food hygiene was limited. Several countries developed, reviewed or updated their national regulations to ensure better safety of food. Public health authorities in countries were better empowered for more effective enforcement of food safety standards.

Climate change created a formidable challenge with long term health implications to all countries in South-East Asia. A regional framework for action to protect human health from the effects of climate change was prepared through coordinated efforts of countries. A special emphasis of this framework was on strengthening the existing public health programmes and emergency preparedness.

In the area of health systems development, Member States continue to face many challenges. Outstanding among these challenges was the development of human resources for health. Strengthening of public health workforce at all levels continued receiving priority attention in the Region.

Several public health education programmes were developed in countries to ensure effective implementation of disease prevention and control strategies. The South-East Asia Public Health Education Institutions Network continued promoting inter-institutional and intercountry cooperation.

As far as health research is concerned, a Task Force on Avian Influenza research was formed to identify priority research areas. Social and behavioural research in Avian Influenza control was launched in Indonesia; the result is now being applied.

With cooperation of the Indian Council of Medical Research, steps had been taken to improve research ethics in WHO SEAR.

In the area of Essential Medicines; with the view to a wide-range involvement of the public; an advocacy Meeting on Role of Education in Rational Use of Medicines was held last year. As a result, several proposals for community-based actions were received from countries and the same were supported.

In regard to national health information systems, generic format and guidelines for improving data collection and management were disseminated for use by countries. Attempts were also made to help ensure availability of reliable information for monitoring progress towards Health MDGs. A regional repository of WHO information was made available on line to promote widespread access by countries to health information.

To improve accessibility and quality of community health services; a high profile Regional Meeting on Community-based Health Workers and Community Health Volunteers was held last year. As a consequence, regional strategic guidelines for strengthening community-based health workforce and community health volunteers were prepared and disseminated.

In the area of resource mobilization, 183 agreements were concluded with 45 donors and partners. A 33% increase of Voluntary Contributions over the planned target of the last biennium was achieved. This was a commendable achievement in resource mobilization for the Region.

The WHO Global Management System (GSM) was gradually put in place in the Organization. It is really a very complex system; its development and implementation are difficult and complicated. It is expected to be functional for South-East Asia Region next year. This system is supposed to enhance management efficiency of the Organization; particularly the management of WHO collaboration with Member States.

As far as financial resources for WHO in SEAR were concerned, more than 70% of expenditure during the past biennium was funded from voluntary contributions. This percentage is likely to increase further in future.

With this trend in view, the management of WHO's budget within the framework of WHO collectively agreed policy becomes very challenging indeed.

Our main collaboration strategy with Member States remains country focus and country specific approach. This is to ensure that WHO can respond effectively to the changing needs for national health development; within the context of the country specific socioeconomic environment and the governance system.

WHO's efforts are geared towards strengthening country capability and capacity; to help ensure long-term sustainable health development and self-reliance. While pursuing these efforts, we are also well aware that there are many stakeholders and players contributing to this desirable outcome. WHO will continue to coordinate and cooperate closely with those stakeholders and players.

WHO will further enhance extraordinarily close and productive collaboration with ministries of health of the Member States; keeping in view the indispensable role of other sectors in overall national health development.

With these words, I have great pleasure in submitting to the Regional Committee my report on the work of WHO in South-East Asia Region for the period 1 July 2007 to 30 June 2008.

Thank you.