This third volume of selected speeches by Dr Samlee Pliabangchang, WHO Regional Director for South-East Asia, covers the period from March 2008-February 2011. The first two volumes, "A vision for health development in South-East Asia" and "Working towards better health in South-East Asia" covered the period March 2004-February 2008.

Improving health in the South-East Asia Region

Selected speeches by
Dr Samlee Pliabangchang
WHO Regional Director for South-East Asia

Volume III: March 2008 – February 2011
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Preface

This third volume of selected speeches by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, covers the period from March 2008-February 2011. The first two volumes, A vision for health development in South-East Asia and Working towards better health in South-East Asia covered the period March 2004-February 2008.

The speeches included in this volume were delivered by Dr Samlee at various forums and cover a wide range of subjects of priority interest to WHO and the Member States in the Region. The speeches also provide an insight into the achievements of the Member States in health development in collaboration with WHO.

For ease of reference, the speeches have been grouped under four major areas and are presented chronologically. The title, venue and period of the event are indicated in the footnotes.
Communicable Diseases
Malaria is the most widespread tropical disease and continues to be one of the priority communicable diseases. Malaria, which is an ancient disease, may be classified as a “disease of poverty” because it disproportionately affects the poor.

Environmental factors play an important role in the “transmission” and “existence” of the plasmodium parasite. During the 1960s, malaria was brought under control; and almost eradicated in several countries. But its resurgence in the 1970s made the disease a major public health problem in the developing world which continues till this day.

Malaria is endemic in all Member States of the WHO South-East Asia Region except Maldives, where its transmission ceased in 1994. However, during the past many years, there has been significant progress in the Region in its control. This is due to determined and continuous efforts of Member States and WHO as well as other partners. Malaria morbidity and mortality have been significantly reduced in all affected countries during the past decade.

The epidemiological characteristics of malaria in South-East Asia are highly diverse because there are five different malarial parasite species, and there are various species of vectors with different vector bionomics. The disease is highly dynamic and its transmission is unstable. Malaria is a complex vector-borne disease that is affected by changing epidemiological and environmental factors.

The dynamicity of malaria transmission is contributed to by complex changes in the “interaction” between host, agent and environment, in
socioeconomic conditions of the population at risk, as well as in the biology of the parasite and its vector. Several tools for interventions have been developed and deployed for controlling malaria. House-spraying with DDT and efficacious drugs such as chloroquine used to be powerful tools.

Today, there are several newly developed technologies for malaria control, such as:

- new chemical classes of antimalarial drugs;
- rapid diagnostic test;
- new insecticides; and
- long-lasting insecticide-treated mosquito nets.

Newer drugs and their combinations, newer insecticides and improved malaria vaccines are emerging as promising tools. Advancements in the development of these tools is very helpful in malaria treatment and prevention. Several countries in the SEA Region, as well as in other WHO Regions have achieved their targets in malaria control. There are, however, a number of daunting challenges for Member States in their fight against malaria. These include:

- parasite resistance to drugs;
- vector resistance to insecticides;
- high population movement; and
- complex natural events due to global warming or climate change.

To overcome such parasite and vector resistance, attempts are continuing to further develop new drugs and new insecticides. Efforts are continuing in pursuit of the development of newer vaccines against malaria. At the same time, more rational use of antimalarials and insecticides needs due attention. The affected populations and populations at risk should appropriately receive adequate education on these uses.

The malaria control programme is one of the oldest in Member States of the WHO SEA Region. In its long history, several approaches have been applied for malaria control, including the PHC approach. There have been documentations on the best practices in malaria control that used the PHC
approach, such as successful community participation in household insecticide spraying and the establishment of corps of village malaria volunteers.

These volunteers have contributed enormously to the reduction of malaria cases and deaths. The use of insecticide-treated mosquito nets serves as a good example of “appropriate technology”. However, it is difficult to obtain high coverage of its use. More research is needed to help us overcome this difficulty. Despite such successes, there is a need for newer tools to address the emerging problems of malaria control. These emerging problems are due to continued changes in malaria epidemiology and ecology as well as changes in environmental factors, including climate change.

Of utmost importance is the development of innovations in “environmental management”. Interventions through environmental management have been shown to contribute to “longer-term impact”. For the environmental management approach to be adequately realized in malaria control, relevant sectors other than health must also take malaria seriously into account in their development policies and actions. This is the issue of implementing “healthy public policies” in malaria control. It is a difficult strategy to be realized. It needs energetic and long-term advocacy at the policy and decision-making levels. Malaria should be specially included in the environmental health impact assessment of certain sectoral development programmes and projects.

Today, malaria control is much less a vertical programme. It is more an integral part of delivery systems for general health services. “Decentralization” of health services delivery affects the degree of integration of malaria control activities. Like other public health issues malaria is influenced, to a great extent, by social and economic determinants. These determinants have been identified as the root cause of inequity in health, including the malaria burden.

The achievements from the overall national social and economic development perspective are important landmarks on the route to success in malaria control. Global funding for the control of malaria has remarkably increased over the past 4–5 years. This increase is mainly from the national budgets of the affected countries and from the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria. This increase in funding for malaria control provides a great opportunity for Member States to strengthen the capacity of their national malaria control programmes.

Today, malaria control is much less a vertical programme
This programme needs to have adequate capacity to initiate and implement innovative interventions against the emerging problems of malaria control. These interventions suit the locally specific situations in each country in socio-cultural and economic terms. The development of “public health specialists” in malaria should be revisited, and these specialists should be made nationally available in the affected countries. This increase in funding for malaria control will also contribute indirectly to the strengthening of health systems based on the PHC approach and towards the achievement of health-related MDGs.

While searching for more effective ways to fight malaria we need to look at the disease within the broad picture of health. Concerted efforts and a fresh look at malaria from different perspectives will provide us with new ideas in dealing with it. Furthermore, for the national malaria control programme to be optimally effective, active collaboration with the relevant national institutions, especially in research and training, is important indeed.

Among others, operations research seems to be a priority need for today’s malaria control programme to guide us in improving programme development and management in control of the disease.

I would like to congratulate the Ministry of Public Health, Royal Thai Government, and the Faculty of Tropical Medicine, Mahidol University, for organizing this timely Colloquium. This is in view of many prevailing intractable issues in malaria control, and in the context of achieving the target of MDG 6 by the year 2015.
In view of the current worldwide health challenges, the broad topic of the conference is indeed timely. As far as the South-East Asia Region is concerned, the health situation has undergone a remarkable change over the past several decades.

The overall achievements due to socioeconomic development and from the improved capacity of health-care systems have significantly contributed to the longevity and quality of life of people in the Region. The availability of vaccines and antimicrobials has helped to effectively reduce the impact of infectious diseases. Access to quality health services at all levels has substantially improved. Many of the erstwhile “epidemic-prone diseases” have been brought under control.

However, there is still a long way to go to attain the goal of quality health care for all people. The ideal of “equity in health” with due regard to social justice is yet to be universally achieved nationally and internationally. The threat from communicable diseases continues, with new virulent strains or agents. The older menace from infectious agents keeps re-emerging. Recent global experience, such as the H1N1 influenza pandemic, has underlined the need for continued vigilance and preparedness.

Furthermore, demographic transition, with increasing longevity has brought about an epidemiological transition in disease patterns. Diseases due to unhealthy lifestyles already contribute to the majority of morbidity and mortality worldwide. In addition, we have the intractable problem of maternal and newborn mortality.

The SEA Regional Conference on Epidemiology, Regional Office for South-East Asia, New Delhi, India, 8-10 March 2010.
This problem requires urgent action, if we are to achieve Millennium Development Goals 4 and 5 by the target date. In order to ensure an effective response to these very disparate issues, there is a need for a common bond to hold the various diverse elements of health systems together. This challenge requires evidence-based decisions and evidence-based actions for comprehensive and integrated development and strengthening of health systems.

This is where epidemiology comes in; it fills the need for evidence-based knowledge and information as a basis for such decisions and actions. Epidemiology is the study of factors contributing to health and illness of populations. Epidemiology is an environment- and ecology-based body of knowledge about health and disease, which are multifaceted and multifactorial.

More specifically, epidemiology is about the interplay and the interactions between human hosts, disease agents and their environments. It serves as a rationally logical foundation for public health and preventive medicine.

Through the application of epidemiological principles, health systems are provided with evidence-based knowledge, the most important tool for their functioning. Knowledge about the distribution and extent of health problems and health issues enables them to be tackled through public health interventions. Together with the information on health risks and health determinants, this knowledge will lead to the development and implementation of rational policies and strategies for the provision of effective, promotive and preventive health care to the community.

Evidence-based information can certainly help effectively in advocacy and education for health at all levels, in all populations. This information is also extremely important for education and training of all categories of the health workforce.

This Regional Conference on Epidemiology is one in a series of WHO activities in the Region. It aims towards further strengthening of health systems capacity in public health in countries of the Region, so that the countries are able to face today’s health challenges more effectively through public health interventions.
During this consultation, we will review the progress in measles control in the Region; we will examine the challenges in achieving the goal of measles mortality reduction by 2010, and we will explore the feasibility of achieving the goal of measles elimination. If we agree that such an elimination goal is desirable and feasible in the Region, we will outline a roadmap towards this goal.

Despite the progress made by countries in controlling measles, our Region accounts for the largest burden of measles cases and deaths. Measles killed an estimated 136 000 children in the South-East Asia Region in 2007. This number accounts for 69% of the global measles deaths in that year. This was despite an increase in the routine measles immunization coverage from 61% in 2000 to 73% in 2007.

This situation is not very surprising when we look at the reality. The SEA Region is home to about 28% of the world population, or about 1.7 billion people. The fertility rate in the Region is high. Each year, there are about 40 million children born in this Region against 98 million in the rest of the world put together.

However, we are aware that the current global goal for measles control is mortality reduction by 90% by the year 2010 in comparison to year 2000 estimate. And we appreciate that from the successful progress in their efforts to eliminate measles in certain Regions of WHO, there has been an increasing interest in exploring the feasibility of setting a global goal for measles elimination.

Measles elimination is technically and managerially feasible. Since we are familiar with the globally recommended strategies for measles mortality reduction, this can help us greatly in achieving the elimination goal. To achieve measles mortality reduction or measles elimination we need to sustain a high level of measles immunization coverage through routine immunization.

In considering a goal for measles elimination, there may be certain issues requiring particular attention: injection safety and adverse events after immunization; adequacy of funds for long-term sustainability; a rather complex logistics and management in the implementation process; and the size of the entire population and the target population, especially for the South-East Asia Region, which is greater than other regions of WHO.

The South-East Asia Region as a whole, therefore, has much more work to do, and requires more resources in tackling health problems including measles. However, with careful consideration and sound strategic planning, countries of the SEA Region will be able to eliminate measles, as it has been done in some other parts of the world.

To succeed, we need strong political commitment along with a technically sound strategy at the country level. The WHO Regional Committee for South-East Asia will hold its annual Session next month in Nepal. The Committee will deliberate upon the issues relating to measles, including measles elimination. This consultation can help provide strategic inputs for the deliberations and decisions of the Regional Committee on the various issues involved.
This Congress has provided an excellent opportunity to reinforce our total commitment to halting and reversing the HIV epidemic in Asia and the Pacific.

HIV remains one of the most formidable public health challenges of our times. In the Asia Pacific Region, HIV affects mostly vulnerable and difficult-to-reach populations, especially sex workers, men who have sex with men, and injecting drug users. As a result of effective national responses over the past two decades, the overall HIV prevalence has begun to decline or level off in several countries.

However, the epidemic is far from over – thousands of preventable new infections continue to occur. Of particular concern, recent evidence shows an increasing trend of HIV infection especially among men who have sex with men.

For positive and sustained impact, national responses to HIV infection have to be scaled up, particularly “preventive interventions”. As far as antiretroviral therapy (ART) for HIV is concerned, there has been remarkable progress in Asia and the Pacific. Since late 2003, ART coverage has increased nearly tenfold. However, barely one-third of people with HIV in low- and middle-income countries are currently receiving ART. And sadly, a large majority of HIV-positive people do not know that they are infected. There is also evidence that affected people come too late to health-care facilities for treatment.

Poor access for HIV-infected pregnant women to counseling, testing and antiretroviral prophylaxis is also discouraging. To ensure equitable access to

The 9th International Congress on AIDS in Asia and the Pacific, Bali, Indonesia, 13 August 2009.
health services, counseling, testing, care, and treatment need to be urgently expanded. Programmes for antiretroviral therapy need to be implemented with an emphasis on HIV prevention. Sexually active people receiving antiretroviral therapy are more likely to practise safe sex and use contraceptives.

Mounting evidence indicates that viral suppression combined with behavioural intervention reduces HIV transmission. Scientific studies to date suggest that ART should be made a part of a comprehensive and integrated approach to HIV prevention. Antiretroviral therapy should also be included in the analysis of the cost-effectiveness of HIV prevention. This is especially so in low- and middle-income countries.

With technological advances, there has been a gradual change in the epidemiological profile of HIV/AIDS. Therefore, there should be a corresponding change in the evaluation of HIV/AIDS treatment and care. But whatever the situation, national HIV/AIDS programmes should always place their emphasis on prevention.

An HIV vaccine is still not available and thus education and other preventive measures must be our overriding priorities. Effective educational measures would help reduce the disease burden and help ensure long-term sustainability of achievements from control efforts. Therefore, preventive education should be made the key regional strategy for HIV/AIDS control in the long term. This preventive education should be planned and implemented within the sociocultural context of the community.

HIV/AIDS will continue to be an important global public health concern in the foreseeable future. The foremost priority now is to vigorously intensify prevention efforts. By preventing new infections, we will have a better chance to curb the epidemic and mitigate its impact. Sustainable progress in the response to the HIV/AIDS epidemic depends on improving capacity for service delivery. And this response must be aligned with efforts to strengthen health systems based on the primary health care approach.

Implementing HIV/AIDS programming through the PHC approach is the best way forward to achieve a wider commitment to equity and social justice. Equity and social justice are of paramount importance for responding to the HIV/AIDS epidemic.
Halting and reversing the incidence of HIV/AIDS and TB are among the specific targets set for achieving health-related Millennium Development Goals (MDG). To attain these specific goals, more attention is needed for addressing HIV-associated TB. TB programmes and HIV/AIDS programmes must work more closely than ever before. To achieve the MDGs, the programme interventions should be targeted to the most affected and difficult-to-reach populations.

Reaching vulnerable populations is the key to successfully combating the HIV/AIDS epidemic in this Region. HIV/AIDS is likely to stay with us for a long time. WHO’s mission is to provide the required support, to help ensure universal access to HIV/AIDS prevention, treatment and care. WHO support is provided through:

- developing evidence-based guidelines and guidance;
- assisting countries in intensifying the efforts of their national HIV/AIDS programmes;
- mobilizing broad partnerships at all levels;
- contributing to the strengthening of national health systems; and
- assisting countries in monitoring and reporting on programme progress.

Strategic information is critical for tracking the course of the HIV epidemic and for assessing the effectiveness of national response. Strategic information also provides an essential basis for guiding policy development and for improving the delivery of services. The health sector has a key responsibility for generating and promoting the use of strategic information.

While the quest for new knowledge must continue, we have to be aware that there continues to be a wide gap between available know-how and its application. Therefore, researchers should pursue HIV research based on a careful analysis of this gap. Research addressing equity and benefitting marginalized populations should receive high priority.

This Congress is also intended to further strengthen collaboration among all stakeholders. Your effective collaboration will help operationalize the available interventions in bringing much-needed services to all affected people. Only
when we have reached, treated, and cared for every affected man, woman and child can we really think of achieving the MDGs.

Your deliberations during the past few days have provided necessary information and updates. You have gained ideas for further enhancing your efforts to tackle more effectively HIV, TB and STIs. You have reaffirmed your collective commitment to halting and reversing the HIV epidemic. I wish you all the best in your ongoing fight against this scourge.
Communicable Diseases

Freedom from smallpox

It is my pleasure to warmly welcome you all to the Commemoration of Thirty Years of Freedom from Smallpox. It was declared 30 years ago that “The world and all its people had won freedom from smallpox”. We are celebrating the three decades in which humanity has not witnessed suffering and death from smallpox. The combined wisdom, unwavering determination and worldwide united efforts helped eradicate this scourge 30 years ago. We must ensure that the disease will not strike the world population again.

Smallpox is believed to have originated over 3,000 years ago. It was one of the most devastating diseases known to mankind. This highly contagious disease is caused by variola virus. Its massive epidemics decimated populations across the globe for many centuries. With no effective treatment, the disease killed one-third of those affected and left 65% to 80% of the survivors disfigured with deep, pitted scars mostly on their faces.

In the past, smallpox also used to be a major cause of blindness. There was a time in South Asia when the discovery of a few cases was often seen as a prelude to a crisis, a crisis that would result in massive infections and innumerable deaths. When the toll on human life was less dramatic, this was generally celebrated as an instance of good fortune.

For the past 30 years, however, populations all over the world have been able to breathe a sigh of relief, because there has not been a single case of smallpox in their midst. This became possible because of two major breakthroughs in public health. First, Dr Edward Jenner discovered the use of cowpox to immunize against smallpox in 1798. Second, in 1958, the World Health Assembly recommended the worldwide eradication of smallpox.

Commemoration of Thirty Years of Freedom from Smallpox, New Delhi, WHO/SEARO, 31 July 2009.
Responding to this resolution of the World Health Assembly, affected countries drew up national programmes for smallpox eradication. Based on these programmes, the countries planned to achieve 100% smallpox vaccination coverage within three to five years. WHO provided technical assistance to national programmes, and facilitated interregional cooperation.

In 1967, WHO initiated the process to intensify the global eradication efforts. Ten years later, the last case of natural infection of smallpox was recorded in Somalia, Africa. The very last patient of smallpox, from laboratory-acquired infection, died in Birmingham, England, in 1978.

During the 1960s, Asia carried almost 80% of the global burden of smallpox. Because of the frequent and devastating outbreaks in the Region, in 1949, the WHO Regional Committee for South-East Asia recommended coordinated action against smallpox. This recommendation came long before the global resolve by the World Health Assembly.

The strategy to eradicate smallpox in South-East Asia Region was based on some of the basic principles of public health:

• enhanced surveillance;
• case-finding;
• isolation;
• appropriate risk communication to the public, and
• vaccination.

The strategy aimed not only at eradication of smallpox but also aimed at motivating and encouraging those people who were committed to serve in public health. To show them that certain diseases, no matter how severe and disrupting to human beings, could be considered for eradication by applying those basic principles of public health.

As far as SEAR was concerned, eradication of smallpox from India was indeed a remarkable feat. Every house in each village was visited several times by workers of the smallpox eradication programme. Every suspected case became a public health emergency, and triggered immediate investigation. The success of the Indian campaign reflected dedicated and imaginative leadership.
coupled with sound management at all levels – political, bureaucratic and operational.

In this Region, Bangladesh reported the last case on 6 October 1975. In fact, this was also the last case reported from Asia as a whole. The global eradication of smallpox was certified by a commission in 1979 and was endorsed by the World Health Assembly in 1980.

We gather here today to reaffirm the first unequivocal, and total victory of a public health programme — a victory over a major cause of human suffering and death. It was the greatest achievement in public health during the twentieth century. This achievement suggested that through proper application of public health principles, and with unstinted global commitment and solidarity, an available technology could be made equitably beneficial to humankind across in the world.

We have learned from the smallpox eradication campaign that in providing health services, the unreached can be reached through the full participation and involvement of the community, and of all stakeholders at all levels. Achievement of smallpox eradication was certainly due to the total support of the world community.

Our success in smallpox eradication helped us strengthen our belief in the principles of primary health care and health for all put forward in 1978 at Alma-Ata. Our experience with smallpox eradication led us to undertake the next global effort, to eradicate poliomyelitis. Poliomyelitis is one of the most debilitating diseases. We are now at the final push towards a polio-free world. At this point in time, the world may think of further campaigns in the future.

Measles, which is one of the great killers of our children, is under consideration for global eradication. With advances in science and technology, and with strengthened health systems based on primary health care, the eradication of diseases today has a better chance to succeed. The global community of scientists and public health experts may combine their wisdom to identify specific diseases for eradication. The eradication may be achieved within a reasonable time-frame — eradication that is not only technologically, but also financially and managerially feasible. As in the past, the World Health
Assembly may take the leading role in initiating more eradication of diseases. Rich countries and funding agencies should fully support such global efforts.

Above all, we need imaginative and dedicated leadership at all levels throughout the world for disease eradication. Whatever and however the situation is today, our experience with smallpox eradication is always very valuable in guiding us in future disease eradication efforts.

While celebrating our success, we also need to put together our knowledge and ideas to move forward in our fight against infectious diseases through eradication strategies.

We must gratefully thank all those who worked with dedication to bring about a smallpox-free world. With these words, I wish you all productive interactions throughout the course of this gathering. And I also gratefully thank you all for your continued commitment to supporting the work of WHO.
The outbreaks of Influenza A (H1N1) 2009 started in the Western Hemisphere in April this year and spread rapidly to other parts of the world. In responding to the threat of these outbreaks, on 25 April 2009 the Director-General of WHO declared the world’s first ever “public health emergency of international concern”. This was done in accordance with the provisions of the International Health Regulations 2005 or IHR (2005). As on 9 July 2009, there were 135 countries affected worldwide. A total of 94,574 confirmed cases have been reported with 429 deaths.

We are now in Phase 6 of the influenza pandemic alert, it is the maximum phase. However, this H1N1 influenza virus is mainly not causing severe illness. And we hope that the majority of the cases of this H1N1 influenza will continue to be not severe. Unlike seasonal influenza, only less than 1% of the clinical cases of H1N1 viral infections occur among old people. The severe or fatal form of influenza H1N1 confines itself largely to people with underlying chronic diseases. Also, pregnant women and young children appear to be at a higher risk of a more severe form of H1N1 infection.

Our main concern with the H1N1 influenza is its “re-assortment”. If this virus co-infects people with seasonal influenza, there may be a genetic combination, the combination that will result in a new virus of more virulent and more severe form. In this time of seasonal influenza in the WHO South-East Asia Region, we should be aware of the phenomenon to its fullest extent and we should also protect ourselves from becoming infected with the virus.

Furthermore, the AI (H5N1), which has been prevailing in our countries, can complicate the situation. Re-assortment may also take place due to co-

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infection of H1N1 and H5N1 viruses. We have, therefore, to be sure that the endemic AI H5N1 in countries of the Region is properly contained.

Influenza virus, in general, is highly unstable; and easily undergoes genetic mutation, the phenomenon that can turn the virus in a mild form to be more severe. In this regard, the H1N1 virus is no exception. It may turn out to be more severe at any time. This is something important that we need to keep in mind when dealing with the influenza virus.

Past experience shows that the initial situation of influenza pandemics can change. Historically, each influenza pandemic encircled the globe twice or thrice in two to three years. The deadly influenza pandemic which occurred in 1918 was in the mild form first before turning out to be a far more deadly one. The 1957 influenza pandemic began with a mild phase, then was followed by the second wave of a higher fatality; and the influenza pandemic in 1968 remained mild in both its first and second waves. Indeed, the influenza virus is unpredictable. No one can say how the current pandemic influenza H1N1 2009 will evolve. Therefore, in the midst of this scientific uncertainty, it is incumbent upon us:

- To be well prepared, and
- To be adequately prudent in providing advice to the public.

It is certain that the H1N1 influenza is highly communicable, spreading very fast among people. Only that it is not yet severe. Therefore, it is important to be extremely vigilant in closely monitoring its severity. Our experience in dealing with AI (H5N1) outbreaks should be the starting point and this experience should be used as the basis for our efforts to fight against the pandemic influenza H1N1 of 2009. Our influenza pandemic preparedness plans must be strengthened, and vigorously implemented.

We have the International Health Regulations (2005), as the global tool for control of the pandemic. These are the tools for all countries to work in coordination and in solidarity to fight this scourge. With today’s advancement in medical and public health sciences, we should be able to do better than before in our influenza pandemic preparedness and response efforts.

Seriously concerned with the issue, the Ministers of Health from Member States of the WHO South-East Asia Region met in Geneva during the
Sixty-second World Health Assembly. They unanimously called for a unified approach to minimize the impact of influenza pandemic H1N1 2009. In this connection, the Ministers requested the Regional Director of WHO South-East Asia to convene a regional consultation to identify cooperative strategies for coordinated actions in the Region. This consultation, which is in pursuance to that request, will critically review influenza pandemic preparedness and response in the SEA Region. The consultation will discuss, among other matters, issues relating to:

- intensifying action on the surveillance of influenza-like illness (ILI) and severe acute respiratory infections (SARI);
- building capacity of national influenza centres;
- networking of these centres with other laboratories within and between regions;
- regional capacity in the production of antivirals, vaccines and other necessary supplies.

Discussions at the meeting will also touch on matters concerning:
- licensing;
- access; and
- building public-private partnerships.

This influenza pandemic opens several opportunities in public health. These include:

- The opportunity to test our influenza pandemic preparedness plans and our capacity to implement the plans.
- The opportunity for us to assess our core country capacity to participate effectively in implementing IHR (2005).
- And, very importantly, the opportunity for Member States to assess the functioning of IHR (2005), which came into force in June 2007.

Now, we do not know exactly how long this influenza pandemic will last. And we cannot estimate the magnitude of the impact of this influenza pandemic on the world population; the impact on the health, social and economic aspects of societies and populations. However, we can expect to gain valuable lessons from this pandemic, lessons that will be very useful to all of us in our
attempts to strengthen country capability and capacity in influenza pandemic preparedness and response. These lessons will also be very useful for Member States to re-examine and further strengthen IHR (2005).

For now, let us focus on strengthening the existing systems and building effective linkages, the linkages that ensure a consistently coordinated approach, within and among countries, in dealing with the pandemic.

Let me thank all Member States and all partners for their unstinted cooperation. This cooperation enables WHO to maintain the required vigilance as we gear up our response. I thank all participants from Member States, the UN and other partner agencies, civil society organizations, the pharmaceutical industry, laboratories and others for sparing their valuable time to attend the consultation.
Leprosy is one of the few communicable diseases in which the control measures are producing promising progress. In close collaboration with our partners, we are able to make positive changes in leprosy control and elimination. All registered leprosy-affected persons in the world are now getting free Multi-drug Therapy (MDT) drugs for their treatment. World-wide, the number of newly detected cases has been decreasing every year. Around 15 million affected people have been cured with MDT.

It is estimated that globally 2-3 million people have been prevented from becoming disabled due to leprosy. This success is due to our efforts in promoting early case finding and immediate treatment with quality drugs.

We have been able to increase awareness about the value of early case detection and prompt treatment, which together ensure a cure that leaves no residual physical deformity. And this outcome of the treatment helps reduce social stigma and discrimination. People now know that leprosy can be cured, if detected and treated early enough.

Leprosy control activities have now largely been integrated with the general health services. This approach has helped improve service coverage, and ensure sustainability. However, all these achievements will not mean anything unless the affected people can lead a normal life. As we all know, leprosy is a disease of poverty and misery. Its negative social and economic impact on affected persons have been well documented throughout history. The basic activities that most people can do without fear or shame are still a problem for many people affected by leprosy. With the prevalence rate of leprosy declining, we will face challenges that could be more difficult to tackle, such as in getting the remaining cases for prompt treatment. It will become more difficult to reach the remaining cases.

At the same time, we have to maintain the gains made so far in the fight against this disease. We need to reconfirm political will and commitment at both the national and international levels. We have to ensure that complacency does not set in which could undermine commitment. Our collaboration with partners needs to be maintained, and strengthened further. This is to ensure continued advocacy and sustainability of effective leprosy control activities.

In the current economic downturn, special attention needs to be paid to the management of national leprosy control programmes. Because of these financial difficulties, resources will be limited for measures to tackle the leprosy problem. This limitation of resources will also have to be faced in other disease control activities. We will have to carefully prioritize the actions that we would like to take in leprosy control.

We will have to work more efficiently and effectively in utilizing available resources, keeping in mind that it will be difficult for leprosy to gain high priority in the national health agenda. A lot of effort is therefore needed for vigorous advocacy at the country level in order to obtain national attention and commitment. We have to work with all partners more coordinately and cooperatively for synergistic effects and improved outcome. We must always ensure that patients are detected early, properly diagnosed and effectively treated. We need to improve referral systems to ensure that patients are able to get access to required quality services for their treatment. This issue needs to be tackled within the context of comprehensive services for all leprosy patients.

These services must also include effective reconstruction and rehabilitation, addressing both physical and psychosocial aspects. We need to improve our Information, Education and Communication (IEC) activities so that we can reach out to a larger number of communities. As much as possible, the educational messages have to be extended to reach the poor, vulnerable and underprivileged everywhere. Basic and clinical research to find better drugs for more effective treatment of leprosy has to continue. We need drugs and regimens that can shorten the duration of treatment of leprosy.

At the same time, we have to be on the lookout for potential problems of drug resistance. In this regard, we may learn from the experiences of HIV, TB and malaria programmes. These programmes now have to address serious problems of drug-resistant pathogens. Looking forward towards a long-term intervention, we may think of primary prevention of leprosy. For this, we need epidemiological research to help us look at this disease more comprehensively.
We also have to expand the scope of our control interventions beyond the disease agent to give adequate attention to its host and environment at the same time. We need operational research for improvement of programme development and management for leprosy control. Operational research is not less important than other types of research, as far as leprosy control is concerned. Leprosy control programmes need to be developed through a balanced consideration of these three key factors: the agent, the host and the environment. Long term sustainable elimination or eradication of leprosy requires adequate attention to its social and economic facets. This is the principle of treating the whole patient, not just the elimination of the disease agent.

We need an effective strategy for capacity building in national programmes, so that they are able to do all these things in a comprehensive and systematic manner. And we have to make sure that necessary expertise is available in countries to deal with leprosy problems holistically. Country capacity strengthening is therefore really the key issue.

This meeting has been convened with the aim of developing the “Enhanced Global Leprosy Control Strategy” for the next five to six years. This strategy requires an expanded horizon and in-depth actions in all aspects of the problem – medical, psychosocial and economic.

It is time to review our weaknesses and strengths. Our future development efforts should be based on our strengths and success in the implementation of leprosy control programmes in the past. It is time to come up with a really innovative strategy for moving forward to reduce all aspects of the leprosy burden. Let me repeat that, among other things, we have to ensure more effective early case finding, proper diagnosis, and prompt treatment of the remaining cases with more effective drugs.

With this level and scope of intervention, persons suffering from the disease will have a better chance to be really cured, leaving no residual of any physical deformity. Being without physical deformity should lead to a substantial reduction of social stigma and as a consequence, the human rights aspects for the affected people should be improved. All these are our challenges in tackling the remaining problem of leprosy in the years to come. A lot of determination, will, and commitment is needed from all of us. Let us face these challenges squarely.
Taking into account the current global public health situation, the theme of the meeting is indeed timely, relevant and topical. The subject deserves our particular attention.

Over the last century, remarkable improvements have been registered in quality of life and longevity. People today are, in general, healthier than they were and live longer than then they did three decades ago. Among others, positive outcomes have been achieved in combating communicable diseases during the past 30 years.

Advances in several areas in public health, including the development and use of effective antimicrobials and vaccines, have been monumental. Access to quality health care, especially by the underprivileged, has greatly improved. The application of epidemiological principles and tools in public health practice has been crucial for these successes. At the same time, we also have to recognize that the overall socio-economic development has immensely contributed to these achievements. These successes and achievements serve as a source of our inspiration and optimism to constructively pursue further our efforts in the quest for better health.

Despite the progress recorded till date, the threat from, and hence, the fight against, diseases, is far from over. In fact, we are facing new health challenges every day. Previously unknown pathogens keep emerging. Old scourges that were once subdued, in decline, or quiescent, have re-emerged.

Today, infectious diseases are a growing threat to “global health security”; and to socio-economic progress. Indeed, the microbial world remains dynamic and unpredictable. This phenomenon is more prevalent today.

With the rapid changes in lifestyles, and rapidly aging populations, epidemiological transition has taken place in a big way. Chronic noncommunicable diseases are fast emerging as problems of public health importance all over the world. Besides, we have the continuing problem of high maternal and child mortality, which needs to be urgently addressed if we are to achieve the specific health MDGs on target. Through an epidemiological approach, evidence on distribution, as well as on risks and determinants of these health problems, can be generated for health policy and strategy formulation. The evidence is helpful for the purpose of education and advocacy for health; as well as for health programme development and management.

The application of epidemiological principles is equally important in the prevention and control of both communicable and noncommunicable diseases.

The current global concerns with climate change and economic downturn add to the challenges that we face in improving health care and in securing global health. The impact of these occurrences can slow down the momentum, or even reverse some of the public health gains made thus far.

Furthermore, to effectively prevent and mitigate health impacts from disasters, there is a need to strengthen preparedness, surveillance and response which have to be developed on an epidemiological basis. The application of an epidemiological approach in an emergency situation, by collecting and using data for action at local level, can effectively prevent disease outbreaks.

In addition, effective implementation of “the revised IHR”, which is intended to ensure global health security, needs epidemiological backup at all levels of intervention.

In order to ensure more efficient and more effective public health interventions, we need to capitalize on our past experiences in the application of epidemiological approaches in responding to public health problems.

We have to be better equipped ourselves with epidemiological tools to meet the current public health challenges, and to prepare for future health threats. We need to prepare ourselves adequately for combating emerging threats to public health, such as climate change.
In view of these mounting challenges, it is necessary, among other things, to strengthen and maximize the application of epidemiological principles in health programme development and management.

Competence to identify public health problems, to analyse and interpret data, as well as design and implement evidence-based interventions is essential for today’s public health action. Skills in investigating and initiating timely response to disease outbreaks, and to other public health emergencies are indispensable indeed, in mitigating the impact and preventing consequences. While expanding the public health workforce for tackling public health problems, we need to strive towards building a critical mass of epidemiologists at various levels of health systems.

The South-East Asia Region has many years of accumulated experience in developing and implementing public health programmes. There are many institutions in the Region excelling in the application of epidemiological principles in public health practice. These institutions should be maximally utilized in the area of epidemiology and public health.

The World Health Organization accords high importance to the networking of public health and epidemiology institutions in the Region. By bringing them to common platforms, and by networking them, WHO promotes coordination and cooperation among these institutions, in sharing the relevant experiences and expertise. The networks of these institutions can effectively contribute to the improvement of quality of work and fostering partnerships in epidemiology and public health. Networking builds trust and collaboration; as well as promotes shared values to advance the noble cause of public health.

We need to seize every opportunity to foster intercountry and inter-institutional cooperation in promoting capacity building in epidemiology; and in promoting the use of epidemiological approaches in public health and health-related action. Such cooperation, with an “enabling policy environment”, is essential for the development of a critical mass of competent epidemiologists. WHO looks forward to working closely with countries and interested partners in strengthening epidemiological capacity in SEAR. We certainly look forward to the effective application of epidemiological know-how and skills to overcome public health challenges in the 21st century.
Before concluding, let me provide some food for thought, as far as epidemiology is concerned. This is from my long experience in public health. Today, epidemiology must be viewed in a much broader context. Epidemiology should not deal with only physical ailments but also with all aspects of social illness. Epidemiology should be viewed within the context of the ecological system. The system that deals with the interaction between man and his environment. The environment that is not only physical, but also psychosocial, cultural, economic and political. We have heard of many other areas that need the application of epidemiological principles: epidemiology of mental illness; epidemiology of malnutrition; epidemiology of accidents and injuries; epidemiology of occupational diseases, and so on.

Equally important, one must recognize that, “economic principles” will not be effectively applied to health without adequate support from “epidemiological principles”. At the individual level, epidemiology helps increase our own analytical capability and capacity; epidemiology helps make us a “good researcher”, a “good planner” and a “good manager” in health. Epidemiology is an indispensable tool for every public health professional and public health practitioner.

Today, the concept of health is very broad indeed. Epidemiology, which is the main thrust of health action, the main thrust of public health action, must encompass all aspects of today’s health concerns. It depends on us how to use this tool, the “epidemiology tool”, in our public health career in our public health work. Epidemiology requires the recognition and appreciation it deserves for its role in the health field. With this recognition and appreciation, it will take us a long way towards the application of epidemiological principles for public health action.

Finally, let me reiterate that “public health interventions” will not be effectively developed or implemented without appropriate application of epidemiological principles.
We all agree that considerable progress in malaria control has been achieved by the Roll Back Malaria (RBM) Partnership Initiative since its inception in 1998. This is especially true in building partnerships, and in resource mobilization, with the aim to reduce the burden of malaria by half by the end of the decade. As far as the South-East Asia Region is concerned, malaria remains one of the major public health problems. The burden of malaria in this part of the world is second only to that in Africa. With a large population at risk of malaria, and the presence of several contributing factors, countries of South-East Asia find it difficult to control malaria effectively without outside support.

Over the past decade, several countries in this Region had reported a perceptible decline in malaria morbidity and mortality. However, the situation remains highly dynamic and diverse. While many countries in South-East Asia still suffer from a high malaria burden and endure frequent outbreaks of the disease, a few are aiming a final thrust towards malaria elimination.

Needless to say, the South-East Asia Region is well known as the epicentre of drug-resistant malaria. There is the potential of this drug-resistant strain of malaria spreading to other parts of the world. A major effort is being made by the countries affected in tackling this global health threat. This effort of the Member States is being backed by several partners including the two WHO Regions of South-East Asia and the Western Pacific. Member States in the South-East Asia Region are palpably concerned about the persistence of the malaria problem; which contributes significantly to the health, social and economic burden in the Region. At last year’s session of the WHO Regional

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The 15th Meeting of Roll Back Malaria Partnership Board, WHO-SEARO, New Delhi, India, 11-12 November 2008.
Committee for South-East Asia in Thimpu, Bhutan, Member States committed themselves to working coordinatedly in their fight against the disease. The Member States also joined in the global observance of the first “World Malaria Day” this year.

I am pleased that the RBM Partnership has chosen New Delhi as the venue for the 15th meeting of its Board, and that India, which is one of the countries affected by the disease, represents the WHO South-East Asia Region as a member of the board. During the past few months, we had witnessed a number of important developments in connection with malaria control. These include:

- the launch of the World Malaria Report 2008,
- the start of the Global Malaria Action Plan, and very importantly,
- the pledge by donors of around US$ 3 billion to fight this pernicious scourge.

This is indeed good news; good news towards a bold step forward in the global endeavour to combat malaria. This meeting of the Board of RBM Partnership is another milestone in the global efforts at malaria control and elimination.
This conference is indeed timely, in view of the fact that dengue and dengue haemorrhagic fever are becoming an increasingly serious public health problem in Asia and the Pacific.

Dengue mortality may not be high, but its morbidity and disease burden are important concerns. In addition to its health impact, the social and economic implications are also significant. Environmental, ecological and demographic changes have brought about a significant epidemiological transition and transmission of dengue. This situation contributes to the increasing difficulty in its prevention and control.

Outbreaks of dengue have become more frequent, more explosive, and sweeping across international borders. Dengue is increasingly a regional and global health concern, which requires national priority attention and stronger international collaboration. It is, therefore, timely indeed to deliberate on the theme of “Global Innovations to Fight Dengue”. I would like to congratulate the organizers for selecting this theme for discussions during this conference.

Almost eight years ago, at the First International Conference, we agreed on a declaration to “Hold Hands together to protect our Children from Dengue”. Today, we are still struggling for effective protection of our children from the disease. To be effective in dengue prevention and control and in light of the current changes, we need “improved tools” and an “improved strategy”. We need better tools for effective control of its vector. And we need an effective vaccine against dengue for protecting our children. Certainly, we still need to further improve tools for case management.

Prevention of dengue, as far as the currently available interventions are concerned, is difficult. Dengue prevention requires community action, with strong community leadership and commitment, and it needs strong multisectoral cooperation, which are usually not easy to come by. This is indeed a challenging task; therefore, more concerted efforts are needed.

What we have been longing for for a long time is an effective dengue vaccine, especially for children. There are several groups of scientists and researchers working hard towards the development of this vaccine. Effective vaccine against dengue is the only tool to ensure protection of our children. I wish those scientists and researchers all the best and all success in their endeavours in accomplishing this scientifically difficult task. We should acknowledge that children in the world will greatly benefit from the noble efforts of the scientific community in this regard.

At present, an estimated 2.5 billion people are at risk of dengue globally. Of these, 1.8 billion people, or about 70%, are in the Asia-Pacific Region. And this Region shoulders nearly 75% of the global disease burden due to dengue. There is no doubt, therefore, that dengue is a serious health and social problem in this part of the world.

As we all know, the epidemiological dynamism of dengue is changing, and its endemicity is expanding more and more to new areas. Many factors are involved in the expansion of dengue endemicity, and these factors contribute to its frequent and explosive outbreaks.

These factors include:

• Globalization and climate change;
• Improper water management at household and community levels;
• Uncontrolled urbanization;
• Unregulated development activities; and
• Ease and increasing frequency of travel.

To repeat, it is clearly evident that dengue can easily spread internationally. Intercountry cooperation is therefore necessary for effective prevention and control of dengue at the regional level.
Yes, for a long time we have been developing effective tools for dengue prevention and control. Several success stories in the use of such tools have been documented. However, it is paradoxical that in spite of those tools, the severity of dengue outbreaks is increasing. It is therefore time to seriously consider that the tools currently in use need a critical review, and improved tools need to be developed. This international conference is the right platform to deliberate on these issues.

At the same time, for effective prevention and control of dengue, the importance of partnerships cannot be underestimated. Partnerships within the health sector, and partnerships with other sectors, such as environment, education, law and tourism, are essential. Certainly, partnerships among countries and among international organizations need to be further strengthened.

Prevention and control of dengue is everyone’s responsibility. And this prevention and control requires unwavering political commitment from the governments. It also needs continuous support from national and local authorities.

To reverse the rising trend of dengue in Asia and the Pacific, WHO developed the Dengue Strategic Plan (2008-2015). This plan was conceived through a series of consultations with national dengue control programme managers in the Region, held in 2007 and 2008. The WHO Regional Committee for South-East Asia, at its Sixty-first Session held last September, reviewed this strategic plan. Among others, the Committee urged Member States to vigorously implement the plan, with particular attention to the use of the PHC approach.

In addition, with close cooperation among concerned agencies and organizations, the Asia-Pacific Dengue Partnerships were established. These partnerships are now playing a vital role in undertaking advocacy. Partnerships are the cornerstone for resource mobilization to support implementation of national and regional dengue control programmes.

The need for innovation for improved tools, on which we are working, is to further strengthen our efforts in dengue prevention and control. Among these efforts are;
• Outbreak prediction;
• Early case detection;
• Preparedness and response to outbreaks; and
• Effective case management.

We also need studies and research in many areas, such as:
• Vaccine development;
• Epidemiology and transmission patterns;
• Vector management;
• Treatment of cases;
• Social and behavioural aspects of prevention and control; and
• Programme development and management.

Results of such studies and research will be very useful in fine-tuning and revising policies, strategies and intervention methods.

A wide range of related subjects are reflected in the programme of work of the conference. This conference is one of the best forums for knowledge and experience sharing, as well as for information exchange. The deliberations during the course of the conference, hopefully, will lead to the development of improved tools and a strategy for dengue prevention and control.

I would like to take this opportunity to urge our financial partners to give favourable consideration to generous support for the implementation of the recommendations derived from these deliberations. These partners include the World Bank, the Asian Development Bank, and the Bill and Melinda Gates Foundation. Support from these and other partners is indispensable indeed to the next steps towards effective prevention and control of dengue and dengue haemorrhagic fever in Asia and the Pacific.
The creation of the National Influenza Centre (NIC) in the National Health Laboratory is a remarkable achievement of the Government of the Union of Myanmar in responding to the current threat of influenza pandemic. We must congratulate the Government of the Union of Myanmar for this commendable effort.

The influenza virus occasionally causes epidemics and pandemics. As far as records are available, there were three major influenza pandemics in the 20th century. The most devastating one was the Spanish flu outbreak in three consecutive waves across the globe in 1918 that killed at least 50 million people. The subsequent pandemics were in 1957 and 1968 respectively. Though milder, the later two pandemics still killed about 2 million people.

The influenza virus is prone to cause a pandemic, because its genetic composition is relatively unstable. So, it frequently undergoes mutation, or combines with the animal virus; the phenomena that can lead to the emergence of a novel virus against which the human population has no immunity. Therefore, the infection with this type of virus can rapidly spread and result in a pandemic.

Currently, we have a threat posed by avian influenza that may emerge as the next pandemic in human beings. To ensure effective preventive and control measures we need a system to monitor and predict the influenza epidemic right at its start.

WHO established a Global Influenza Surveillance Network as early as 1950. This network monitors and characterizes an influenza virus of pandemic

Designation of National Health Laboratory, Yangon, as National Influenza Centre, Yangon, Myanmar, 26 February 2008.
potential. National influenza centres (NIC), like the one we are now inaugurating, form the backbone of this global network.

These centres are national institutions designated to be national influenza centres by the national health authorities.

Since the Government of the Union of Myanmar has formally designated the National Health Laboratory as their National Influenza Centre, WHO now recognizes this Centre as a member of the Global Influenza Surveillance Network.

We welcome the National Influenza Centre of Myanmar to this network, which currently consists of 122 centres in 93 countries around the world. Being a member of the WHO Global Influenza Surveillance Network entails both the right and the responsibility in the prevention of the influenza pandemic.

To jumpstart the functioning of the National Health Laboratory as the National Influenza Centre in Myanmar, WHO has provided reference reagents for the diagnosis of the H5 virus. Every year, WHO will continue providing standardized kits for identification of the current strains of influenza viruses. These reagents cannot be commercially procured; they are exclusively produced for National Influenza Centres by WHO Collaborating Centres.

The information by these Centres on the antigenic characterization of influenza viruses that are globally circulating will be shared. National Influenza Centres will also receive WHO publications on regional and global influenza activities. For this global network to maintain its vigilant monitoring, NIC will need to fulfil its functions, which include, among other things:

- Sharing of viruses for risk assessment;
- Sharing of the relevant information with the global network;
- Collecting clinical specimens and undertaking initial identification of the type of virus; and
- Alerting the Global Network of any influenza virus that cannot be readily identified by using WHO reagents.

Initially, the NICs were primarily involved in the surveillance of seasonal influenza viruses. These viruses had formerly not attracted our attention in
the Region, due to the presence of other competing diseases. However, the scenario has changed because of the endemicity of the H5 Avian Influenza (H5AI) in this part of the world.

These avian influenza viruses which are usually found in poultry have crossed species barriers and caused human infection with a high case fatality rate. Thus, the role of NICs has become increasingly important; their adequate capability and capacity to fully function has become, as expected, indispensable. They must be able to expeditiously collect and ship; and where appropriate, correctly test the samples to identify H5 viruses. Timely and accurate diagnosis of influenza virus by NICs could be very helpful in averting an influenza pandemic.

Last year, the revised International Health Regulations (IHR) 2005 came into force. Under these Regulations, a global system to identify public health threats was created. Among others, human influenza caused by the novel virus needs to be reported to WHO through this system for rapid global response.

To strengthen the regional response to the requirements of IHR, NICs in Bangladesh and DPR Korea have been reactivated and new NICs designated like this one in Myanmar. WHO support has been extended to the Centre and this support will continue. Maintaining the functioning of NICs at the international level depends on networking among the centres around the world. To enhance this partnership in South-East Asia, a strategy for networking of NICs in the Region is being implemented.

The National Health Laboratory in Myanmar is invited to be an active partner in this development process. Such networking will enable the sharing of methods, scientific findings, reagents and expertise.

Once again, I welcome the advent of the NIC in Myanmar and I wish the Centre all success in its contribution to global efforts to prevent influenza pandemics. And once again I sincerely congratulate the Government of the Union of Myanmar for their foresight and initiative in the creation of this National Influenza Centre.
I am indeed privileged to accept the “Honorary Fellowship” awarded by the Indian Society for Malaria and Other Communicable Diseases. I am very thankful to the society for this prestigious award. Let me also express my regret and sincerely apologize that due to pressing commitments, I could not attend the Annual Conference jointly organized by the Society and the Indian Association of Epidemiologists last October. I am very grateful to the organizers of this elegant function arranged in my honour today.

The society is now more than 50 years old. It was formed by past luminaries, when public health in India was still in its formative stage. We must appreciate their vision and foresightedness. Now, the Society has emerged as a leading public health forum in India. It has made a name for itself due to its exemplary work, particularly in the areas of prevention, control and elimination or eradication of certain communicable diseases. Over many years, members of the Society have contributed immensely to the national programmes for elimination and eradication of various diseases, notably smallpox, guineaworm, and yaws. And I foresee a far greater role for the Society in future, especially in preventing, controlling and eliminating or eradicating other priority communicable diseases. Also, the Society’s members are likely to be called upon to respond to the emerging issue of noncommunicable diseases, which represent another formidable task in public health. The Society must be ready to meet these challenges as well.

In the South-East Asia Region, communicable diseases contribute to 40% of the 14 million annual deaths, while noncommunicable diseases are fast emerging as the leading cause of death and disability. This double burden of
disease presents a major public health challenge for all of us in the Region. In the area of communicable diseases alone, age-old scourges, like malaria and tuberculosis will continue to take a heavy toll. The emergence of new pathogens during the past years has further compounded the situation. For example, SARS (Severe Acute Respiratory Syndrome) was the most recent such disease to emerge, and it spread to 31 countries in a short time, causing economic devastation across the globe.

While containment of SARS was an excellent example of international cooperation in communicable disease control, a far greater challenge has been posed by the daunting threat of an influenza pandemic. The entire world appreciated the rapid and effective action by India in containing avian influenza outbreaks in 2006 and 2007. Also, India has been lauded for bringing together health and agriculture sectors to fight avian influenza. The two sectors have committed to work together under the framework of the Delhi Declaration.

In this Region, we are also vulnerable to the other emerging and re-emerging infectious diseases, such as Nipah virus, dengue fever, leptospirosis, Japanese encephalitis, and chikungunya. Chikungunya reappeared in India after 31 years of absence, and swept across several states last year at an amazing speed. It affected a huge number of people, causing pain and disability. The genesis of several communicable diseases can be traced to factors beyond the domain of the health sector; yet, the impact in terms of morbidity and mortality has to be managed primarily within the public health framework. That framework still needs strengthening and development. We need a strong public health infrastructure in our fight against communicable and noncommunicable diseases.

Today in the world there are a multitude of ideal settings for the emergence and spread of infectious diseases, which require multilateral action and interventions. Among the factors implicated in the spread of diseases are globalization, ease of international travel, population movement across borders, poverty, overpopulation, deforestation, urbanization, global warming, ignorance and weak public health infrastructures. Clearly, the health sector alone will not be able to successfully tackle these problems, many of which are characteristic of the developing countries, and of poor countries. With technological advancement, especially in information, communication and transportation,
Improving health in the South-East Asia Region

the world has become smaller and smaller; more and more we are living in a global village. But with its ever-increasing size, the world population has to share many things, including diseases. This scenario is profoundly affecting our being on this planet.

Evidence is fast emerging on the impact of climate change on communicable diseases and on the nutritional status of populations. The struggle of humanity to survive and thrive on earth has led to climate change and global warming and this process can lead ultimately to global catastrophe. Climate change disproportionately affects the developing and poorer nations. It now appears quite likely that the earth will be warmer by 1 to 4 degrees celsius in the 21st century. This phenomenon will change the distribution of disease vectors, enabling them to thrive in areas previously inhospitable to them. At warmer temperatures, pathogens develop more rapidly in mosquitoes, and consequently there will be an increase in the incidence of malaria and dengue fever. Today, 2.5 billion people who live in the tropics and subtropics are at risk for dengue, and of those, 1.3 billion live in South-East Asia. During the past three years, dengue virus has expanded geographically to newer areas, such as Bhutan and Nepal. This is an alarming trend in the area of communicable diseases.

Because of social and economic reasons, human beings have lived closely with animals. This has been the case for as long as we can remember. This co-existence is intense and continuous in our part of the world. This continuously close contact provides frequent exchange of microorganisms between animals and humans, and from time to time, people acquire diseases from the animal. This situation also provides an opportunity for some genetically altered organisms to adopt the human body as their host. Then, there is the initiation of a new cycle of human to human transmission of the agents. SARS and possibly avian influenza, exemplify this phenomenon. More than two-thirds of newly identified pathogens have originated from animals. Unmindful degradation of the environment, especially in developing countries, is the order of the day. The ecological balance all over the world is being upset due to the destruction of ecosystems. Deforestation is altering flora and fauna. This deterioration of the environment provides greater contact between human beings and the hitherto restricted pathogens.

On the positive front, however, there has been a perceptible national desire and political will to address the problem of infectious diseases. It has
yielded commendable results, too. At the international level, there has been a growing realization that emerging diseases can be better fought collectively, through global efforts. Therefore, the International Health Regulations (2005) came into force last year. These regulations will facilitate the containment of the international spread of infectious diseases, with minimal disruption of trade and other human activities across borders. Extensive preparation and advocacy for their implementation are in progress, in order to build national commitment and country core capacity to respond effectively to the challenge of International Health Regulations (2005). The advocacy is yielding positive results. Countries are now more aware of the necessity to ensure international health security through the implementation of the International Health Regulations (2005). There are growing efforts to bring health at the centre of human development.

More investment in health is also forthcoming. The Government of India has made a laudable commitment to enhance public expenditure on health, and has decided to increase health expenditure to at least 2%-3% of gross domestic product by 2010, compared with the current level of 0.9%. The multifaceted dimensions of emerging diseases are also now well recognized. Prevention and control of these diseases will have to be carried out through multidisciplinary and multisectoral endeavours. Active community participation and involvement is the key approach to such prevention and control. The Indian Society for Malaria and Other Communicable Diseases can play a leading role, particularly in providing technical support to the country in policy, strategy development and capacity strengthening. The commendable work done by the Society in the past to popularize public health is widely recognized. Public health interventions will be effective only through multidisciplinary and multisectoral approaches with full participation and involvement of people in the community. In this connection, I would like to mention that more than 1000 life members of the Society from various disciplines, have worked as a strong base for field-level public health initiatives. Also, the Society’s “Journal of Communicable Diseases” has a prominent place in the scientific community. We always look towards this journal for any development regarding communicable disease prevention and control in India. Through the Society’s fellowships programme, scientists and health administrators have been encouraged to take up public health work in earnest.
Following the success of the National Surveillance Programme for Communicable Diseases, the Government of India launched the Integrated Disease Surveillance Project in 2004. WHO has been an active partner in this challenging initiative. I understand that members of the Society have been proactively involved in every sphere of this project as well. This effort will greatly strengthen the surveillance mechanism in the country. Surveillance that leads to timely response is necessary to ensure mitigation of human suffering and the economic burden resulting from epidemics. Recent years have also witnessed major natural disasters followed by disease outbreaks, and members of the Society have played a crucial role here as well, helping to control such outbreaks across the country. To provide timely technical backup to countries in the Region, WHO-SEARO chose to locate a Regional Sub-unit on Communicable Disease Surveillance and Response in NICD. This sub-unit can work closely with the society in this important area.

As you are aware, the Planning Commission of India, in its “Vision 2020”, envisaged this country to be in the club of the upper middle-income group. To achieve this goal, good health for the whole population has to be ensured. In this connection, there is a need to research every aspect of diseases, both communicable and noncommunicable. With the changing spectrum of these maladies, there is a need to look again at the way we deal with them. There is a plan to reorganize NICD to expand its mandate to include noncommunicable diseases as well. This is another challenging area, in which the Society may be interested to get involved. It is very important indeed to ensure capability and capacity of this new organization in prevention and control of NCD. In this connection, there are also other important initiatives, such as the establishment of the South Asian Association for Regional Cooperation Coordination Centres for Disease Surveillance, and the creation of the Public Health Foundation of India. Needless to say, in all these initiatives, WHO shall lend its support. WHO will be happy to work closely with concerned agencies in these challenging undertakings.

I again reiterate my happiness that the Society thought it fit to award its “Honorary Fellowship” to me. I have seen the list of earlier recipients of this award, and it is a great pleasure and privilege for me to be associated with those great names. I can wholeheartedly assure the Society of the unstinting collaboration of WHO in the strengthening of the public health system, public
health infrastructure and public health workforce in India. Members of the Society have a vital role to play along with WHO in the development process. Finally, I wish the society all success in its pursuit of excellence in public health; in its unwavering determination and commitment in serving the country in disease prevention and control; and in its contribution to the attainment of the Millennium Development Goals and Health For All people.
I warmly welcome you all to the Regional Meeting on Strengthening the Deployment of Public Health Nurses in Support of the Millennium Development Goals. We recognize the important role of PHNs in striding forward towards these goals; that is why this meeting. This meeting is also a part of our effort in following up the outcome of the Regional Meeting on “Revisiting Community-based health workers and community health volunteers” held in 2007.

“Public health nurses”, in some countries, are called “Community Health Nurses”. Public health nurses form part and parcel of the Community-based Health Workforce; the workforce that is the backbone of the HFA/PHC movement. The workforce that contributes significantly to equity and social justice in health. In pursuing their functions, public health nurses along with other community health workers always give preferential attention to the poor, the underserved, the vulnerable and the underprivileged.

Substantially, public health nurses help ensure accessibility to health care by all people in the community in the remote areas and therefore they contribute to reaching the “hard-to-reach” or “unreached”.

In health care, it is well known that “prevention” is better than “cure”. And prevention is cheaper than cure. The governments of our countries underline “preventive care” in their national health policies. Preventive interventions, to ensure the protection of people’s health, are carried out by public health nurses as their main functions. We need more effective preventive interventions; and therefore, among other things, we need more public health nurses.

We always have the most rational argument to convince our governments to invest more in preventive interventions, and to invest more in strengthening the capacity of public health nurses in order for them to do much more in “preventive care”; preventive care, among other things, can prevent the high health care cost, the skyrocketing of health care cost. Preventive care is the best health strategy to improve and maintain the quality of the countries’ human resources. The countries need the population/human resources with a strong potential to drive forward effectively the national, social and economic movement.

By the year 2015, all countries in the world are expected to achieve the UN Millennium Development Goals. As far as we are concerned, at least the targets for health-related MDGs must be attained. These goals relate to:

- reducing child mortality;
- improving maternal, newborn and child health; and
- reducing morbidity and mortality from HIV/AIDS, TB, malaria and other tropical diseases.

There is no doubt that to attain these goals, we need robust “public health interventions”; the interventions that need to be implemented through multidisciplinary and multisectoral actions in the community; the interventions that need coordinating and organizing efforts of a community-based health workforce. To achieve the health-related MDGs, all targeted populations must be reached; these populations must have access to the needed health care. There are many obstacles for the poor and marginalized to be reached and to have such an access.

Community-based health workers, including public health nurses, have an important role to play in overcoming those obstacles; in particular, the socio-cultural and psychosocial barriers.

Furthermore, with increasing numbers of people with chronically ill-health conditions, there is a greater need for ambulatory care for these people in the community whereby the services of public health nurses are in greater demand. Public health nurses will have to play a key role in community health care for the people with chronic, noncommunicable diseases.
Through the HFA/PHC movement during more than the past three decades, the overall improvement in people’s health worldwide has been observed globally. However, such an improvement is not uniform, either within or among countries. There is still a wide gap in health prevailing between the “haves” and “have nots”. The poor are still the hardest hit by ill health, they are “hard to reach” or “unreached”. These people continue to face the basic health problems that stem from environmental and socioeconomic determinants. The poor have poor health because they are poor, illiterate, and belong to the underserved section of society. Unless the health of these poor people is adequately taken care of the attainment of health for all people will continue to elude us.

We have to intensify our efforts in implementing the PHC approach through community-based actions; the actions that need to be effectively coordinated and spearheaded; primarily by the community-based health workforce. Public health nurses have an important role to play indeed in such a coordination and spearheading. With the genuine demand for their contribution to the attainment of health for all people and to the achievement of health-related MDGs it is an opportune time to revisit the role and functions of public health nurses with the view to further develop their capacity for maximum contribution to today’s health development; especially at the grassroots level.

Educational institutions can effectively help in further development of public health nurses in adequate number and quality to help ensure that they are adequately equipped with essential knowledge, skills, and tools to work effectively at the grassroots level. National professional bodies, like the Nursing and Midwifery Council, could help set standards of practice.

Associations or societies of nurses and midwives could work with the government and the community to create:

- enabling working environment;
- opportunities for career advancement; and
- appropriate welfare schemes and incentives.

The community and local government are the key partners in supporting the effective deployment of public health nurses.
All countries in the South-East Asia Region have experiences in the deployment of public health nurses. However, their roles and functions vary from country to country, and are not sufficiently documented. Thailand started education of public health nurses at the professional level several decades ago. This is a unique category of nurses in Thailand. This particular meeting is intended also to be a platform for sharing relevant information and experiences from the countries on the development and training of PHNs. WHO urges Member States to pay special attention to the development and deployment of public health nurses. This is to maximally utilize the community-oriented potentials of this category of nurses.

At the end of this meeting, I hope, we would be able to agree on a regional strategic framework that might be useful as our collaborative tool for future cooperation among countries in this important area.

I would like to take this opportunity of thanking all participants and advisers for sparing their valuable time to attend this meeting. I overwhelmingly thank H.E. Dr Aminath Jameel and Professor Prawase Wasi for their precious time; as usual, we can expect to hear their inspiring and thought-provoking key-note addresses. I thank Dr Paijit Warachit for graciously agreeing to inaugurate the meeting.
The principle of primary health care (PHC) has served as an important tool for the Voluntary Health Association of India on its journey to achieve its vision of making health a reality for all the people of India. The primary health care principle encompasses the goals of equity and social justice in health. These goals are to be attained primarily through the mobilization of all available resources in the community. This mobilization and harnessing of resources must be done through effective community “participation” and “involvement”, and this participation and involvement must be encouraged and promoted through “education” and the “empowerment” of people.

Recognizing health as “a fundamental right of everyone”, regardless of social class, is an important requisite in the successful development and implementation of the PHC principle that calls for “social control” of “health knowledge” and “health technology”.

Health for all through the PHC approach requires “unconditional access” to health care by all people everywhere. The hard-to-reach or unreached must be reached and served, with their “human dignity” duly recognized.

The PHC principle has served people of the world very well in their quest for “health for all”. This contribution of PHC was in evidence even before the Alma Ata Declaration on Primary Health Care 32 years ago, when it was globally endorsed as the key to achieve the “social goal of Health For All” at the International Conference on PHC in 1978. Within the context of “the social goal of Health for All”, it is universally accepted that PHC has significantly contributed to health improvement of all people around the world. This contribution has

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36th Annual Meeting of Voluntary Health Association of India, New Delhi, India, 10 November 2010.
been mainly through “overall social and economic development” in countries, in addition to direct contribution from health programmes.

Developing countries have had more health benefits from the implementation of the PHC principle. On average, people today live longer and enjoy a healthier life than they did 30 years ago. However, much remains to be done in our journey towards the social goal of health for all. There is still a large number of poor, underserved, underprivileged and vulnerable people who are yet to be adequately taken care of. These people — the poor, underprivileged, underserved and the vulnerable — are yet to adequately benefit from health systems that are based on PHC principle.

In addition to further pursuance of the “unfinished agenda” of HFA, there is a multitude of emerging challenges that threaten human health security worldwide. These are, climate change, pandemics of new and emerging pathogens, aged populations, lifestyle changes, rapid and unplanned urbanization and adverse effects of globalization. The people in developing countries especially the poor, underprivileged, underserved and vulnerable are disproportionately affected by these challenges and threats.

We understand that health situations worldwide evolve over time according to the environmental and ecological changes. These changes are not only in physical but also in social, economic and political terms. Health systems, within which PHC is playing its role, have to be reoriented to effectively face such changes. Health systems strengthening must be pursued on the basis of the PHC principle of “good health for all people” of a country and the world. Reorientation of the PHC approach is to ensure “continued relevance” of health systems to health needs especially of the poor, underprivileged and vulnerable. With the emerging health challenges today, PHC needs innovations in its approach in order to continue to be relevant and effective. It is necessary in this context to encourage more multidisciplinary and multisectoral involvement.

Achievements in health, in terms of both physical, mental and social well-being, are part of a “social goal” that encompasses all elements of the “quality of life”. This goal cannot be attained only through the health sector or by health programmes alone. The goal calls for incorporating “health in all development policies”.
In 2008, the Regional Conference on Revitalizing PHC was held to review the past and the present of PHC. The conference looked into the future of PHC in terms of its revitalization and its continued relevance to the health and other social needs in the community. It was agreed at the conference that a “development-based rather than service-based approach” should be the basis for revitalizing PHC. The ultimate aim of PHC should be achieving self-reliance in health care by all people, individually and collectively, with emphasis on the poor and the underserved. To fulfill this aim, every individual in the community must be empowered through appropriate educational processes. Health knowledge must be adequately “demystified” to be understood by all people, according to their needs. Health technology must be “appropriately developed” for use by all people at different levels. Local or indigenous technology must be developed for more effective use by people in the community.

We have to pay more attention to and invest more resources in the strengthening and further development of a community-based health workforce: the workforce that consists principally of community-based health workers and community-based health volunteers. This is so that these people can function as effective “change agents” in the community and among the people. These “change agents” are to catalyse and facilitate the changes in people’s attitudes, behaviours and practices in health. This catalysis is to be pursued through “educational and empowerment processes”. This is in addition to the services to be provided by the community-based health workforce in responding to the health-care needs at the grassroots level.

The community-based health workforce, if properly developed and strengthened, will be able to contribute more and better and would be able to shoulder additional responsibility over providing health care in an efficient and effective manner. Development of the community-based health-care process can relieve the burden on health facilities at the secondary and tertiary levels.

Very importantly, through their work in health promotion and disease prevention the community-based health workforce is able, to a large extent, to help keep the population healthy for as long as possible. The community-based health workforce can help reduce the use of expensive medicines and medical equipment. Such development, therefore, can help lessen the investment in secondary and tertiary levels of care. It can also contribute significantly towards stemming any skyrocketing increase in health-care costs.
To be effective, the development of community-based health care on the basis of the PHC principle must go hand in hand with policy change at the national level. National health policies must ensure, among other things, a well balanced allocation of health resources between preventive and curative care. The policies must ensure adequate referral and other institutional support to community-based health-care systems.

Countries in the South-East Asia Region can be justifiably proud that the seeds of the “PHC movement” had been sown long before the Alma-Ata Declaration. Several successful piloting of PHC initiatives in the Region had been achieved in the past. These include:

- “Basic minimum needs” in Thailand;
- “Posayandu scheme” in Indonesia;
- “Ayadaw Health Development Initiative” in Myanmar; and
- “Mongar Health Development Project” in Bhutan.

Now, efforts are being made at further development of PHC innovations, such as:

- “Strategic Road Map” in Thailand;
- “Network of Community Health Clinics” in Bangladesh;
- “Integrated Health Posts” in Indonesia; and
- “Integrated Development of Community Health Services or SISCA” in Timor-Leste.

In India, community participation in health has been further strengthened through the use of Accredited Social Health Activists (ASHAs) under the National Rural Health Mission. This is another example worthy of mention. In Sri Lanka, PHC is being reoriented to ensure effective community-based services for noncommunicable diseases.

The Regional Consultation on Innovations in PHC was held in August 2010 in Chiang Mai, Thailand, to share experiences among countries. The consultation chalked out a roadmap for regional endeavours for the future development of such innovations. Through collaborations among several institutions in the Region, the South-East Asia PHC Innovations Network (SEAPIN) was established. This Network will serve as a mechanism for the
exchange of ideas, experiences and learning among countries. The mechanism will contribute significantly to the PHC revitalization process in the WHO South-East Asia Region. I am pleased to note that VHAI is also a founder member of this Network.

Community education and empowerment is the essence of improving the health of all people. Organizations such as VHAI and others represented in the meeting today are close to the people in the community. They are in the best position to promote and support such education and empowerment that can effectively contribute to the “reality of health for all for the people of India”. This is the crucial role played by the voluntary sector in supporting the government’s initiatives such as the National Rural Health Mission.

I am also happy to note that VHAI and its partner agencies are regularly consulted by the Government of India for health programme-related issues. I highly commend the government for involving civil society organizations in its social sector programmes, including the NRHM initiative. Public-private partnerships of this nature can vastly contribute to the improved efficiency and effectiveness of national health development programmes.
Almost two years ago we met in Jakarta to lay down a roadmap for revitalizing PHC in the WHO South-East Asia Region. And at that meeting, we resolved to redouble our efforts to strengthen health systems based on the primary healthcare approach. We are here now to examine how far we have gone towards the revitalization of PHC. Certainly, a lot more remains to be done to ensure a robust PHC approach in supporting the functioning of health systems. We will be able to achieve the health-related MDGs only when we have health systems that are functioning efficiently and effectively. Only five years are left before the target date for the world to achieve MDGs. Therefore, we need to exert all our efforts to further explore innovative avenues to accelerate progress towards health systems based on primary health care.

There is evidence that countries have gained considerable experience in their efforts to reduce health inequities; and in their endeavours towards universal healthcare coverage.

On the basis of the principles of PHC, different intervention models have been developed to address prevailing health problems. Consequently, substantial improvements in people’s health have been made possible. Life expectancy has increased further. Infant and child mortality has been significantly reduced. Countries in the SEA Region have recorded substantial success in improving access to safe water and sanitation. The coverage of immunization and antenatal care services have increased. Significant progress has been made in controlling and eliminating communicable diseases such as guineaworm, leprosy and tuberculosis. The incidence of vaccine-preventable diseases such as diphtheria,
pertussis and measles has significantly declined. Neonatal tetanus has been eliminated from a large part of the Region and we are very close to eradication of poliomyelitis. These are significant contributions of the PHC approach.

The WHO South-East Asia Region is undergoing demographical and epidemiological transitions. We are facing challenges of a double burden of diseases (communicable and noncommunicable). We are also facing threats from:

- epidemics of new and emerging pathogens;
- the ageing population;
- lifestyle changes;
- rapid urbanization; and
- impact of climate change, etc.

The list is very long indeed.

These and other challenges mandate a fresh examination by countries of strategic options in their health development efforts. We have to believe that revitalization of PHC with innovative actions to address these issues is a vehicle through which health systems can be effectively strengthened to meet the old, new and emerging health challenges in an equitable, efficient and effective manner.

There is widespread consensus on the validity of the overarching principles of PHC, which particularly encompass:

- Equity
- Universal coverage
- Social justice.

The PHC principles need to be applied through multidisciplinary/multisectoral actions. The application of the PHC principles must be done with the full participation and involvement of people in the community. What is needed is a fresh look as to how health problems and issues can be practically addressed through the PHC approach. In the process we need to keep in mind that health outcomes are influenced by a complex interplay among sociocultural, economic, political and environmental factors.

"Health for All" is predicated by actions of multiple players and multiple stakeholders. We all know very well that to address the current health issues effectively, we need to go far beyond the confines of the health sector.
Coordinated multisectoral and multidisciplinary actions are imperative. With these requisites as the background, revitalization of PHC should, therefore, adopt a developmental approach. This approach must incorporate innovative new ideas from evaluation and research. Primary health care must not only focus its activities on the delivery of health services but also has to be research-oriented and research-based.

The international community is committed to achieving the Millennium Development Goals by 2015. We, in South-East Asia, have to think of strategies that can help us reach the goals within the remaining five years. I believe that our Region has sufficient resources to pursue these goals; especially MDGs 4, 5 and 6. These goals relate to:

- reducing child mortality;
- improving maternal health; and
- combating HIV/AIDS, malaria, tuberculosis and other diseases.

What is needed is a strategy to harness the available resources in the most cost-efficient and cost-effective manner. There are several examples from within the Region and elsewhere to demonstrate that adoption of innovative PHC interventions can help accelerate the pace of progress towards MDGs.

This consultation will provide a platform for exchange of such experiences from some countries and will also provide an opportunity to explore how best we can optimize the use of our available resources for the purpose.

On the other hand, some contemporary issues are affecting the functioning of health systems. Among others, health services today have become overwhelmingly commercialized with the increased involvement of the market mechanism. Out-of-pocket expenditure for health care in the Region has skyrocketed. Catastrophic expenditure on health is recognized as a major cause for people to become impoverished.

This phenomenon can be effectively countered through the development of health systems based on the PHC approach whereby equitable access to healthcare services is promoted within the spirit of equity and social justice. Such healthcare places primary emphasis on promoting healthy growth and development, maintaining healthy status and preventing ill health. During the past two years, WHO in the South-East Asia Region has actively collaborated
with countries in their initiatives to revitalize PHC. These include, among others:

- The Strategic Roadmap (SRM) in Thailand.
- Development of community health clinics in Bangladesh.
- ASHA (Accredited Social Health Activists) scheme in India.
- Integrated Development of Community Health Services (SISCA) in Timor-Leste.

A number of regional consultations and meetings were organized to offer suitable platforms for Member States to deliberate upon different aspects of the PHC approach such as:

- Self-care in the context of PHC;
- Use of herbal medicines in PHC;
- Application of sociocultural approaches within the context of PHC to accelerate achievement of MDGs 4 and 5;
- Health Care Reform for the 21st Century with emphasis on strengthening health systems based on PHC;
- Decentralization of health care services delivery to ensure health equity and universal coverage; and
- Most recently, the development of national health policies and strategies in support of strengthening of health systems based on PHC.

Several important recommendations emerged from these meetings. WHO will continue to work with Member States to ensure the implementation of these recommendations. Later this year, WHO plans to organize at least two more important regional meetings on related topics. These are:

- Regional Meeting on PHC Approach in Emergencies; and
- Regional Consultation on Health of the Urban Poor, with particular attention to the application of PHC principles in urban settings.

These regional events will provide further guidance on the use of the PHC approach.

WHO will continue promoting the exchange of experiences that contribute towards the PHC revitalization process. The South-East Asia PHC Innovations Network has been established with the initiative of the Foundation for Quality
of Life. The first meeting of the network will be held immediately after this consultation.

We need to focus our attention, especially on the “thrust areas” that will effectively contribute to revitalize PHC in our countries. It is imperative that people in the community must be educated and empowered to enable them to take informed health decisions. Towards this end, and among others, equipping the community for “self care” assumes great importance. In this connection, we need to redouble our efforts to strengthen the community-based health workforce.

We need to equip community health workers adequately to ensure that they are able to face today’s community health challenges in the most efficient and effective manner. We also need to ensure that these workers are capable to perform as change agents in the community through educating and empowering the people.

Furthermore, innovative approaches to “healthcare financing” need to be explored to ensure that people will not fall into the poverty trap due to the high cost of health care. We need to advocate for the correction of the “imbalance” in health resource allocation at the national level to ensure a fair share of national health resources for promotive and preventive care.

We not only have to ensure that national health policies adequately reflect PHC principles but also that health matters are adequately taken care of in other sectoral development policies. There is a reason why PHC has not succeeded to its full potential. It is due to the relatively weak “referral support” from the “higher levels of care”. Innovative approaches to strengthening referral systems need special attention.

In this connection, the role of a vibrant private sector, which is growing rapidly in our Region, needs urgent attention.

I am sure our deliberations over the next three days will provide further and tangible guidance on the various issues involved. The recommendations from the consultation will provide a blueprint for accelerating action towards the strengthening of health systems based on PHC.
We in the SEA Region are facing a formidable challenge to increase and sustain high coverage of routine immunization. We need to support countries to adopt specific strategies that can achieve and sustain such coverage, especially in countries that are lagging behind.

We need to clearly understand why some countries are not able to achieve higher immunization coverage in certain geographical locations. The underlying reasons for low immunization coverage may be country-specific, but we need to identify them and work towards eliminating the barriers that prevent us from achieving our immunization targets.

More important, we need to revisit the available information on the burden of vaccine-preventable diseases. We need to have information on current and future vaccine availability; including technologies for vaccine delivery.

The vaccines used in our immunization programme need evaluation from time to time in terms of their contribution to the reduction of the disease burden, cost implications and the capacity of national programmes to successfully deliver.

As we all know, immunization is the most cost-effective public health intervention today. Nonetheless, children in developing countries do not have adequate access to life-saving vaccines.

Protecting more people with immunization is a global challenge towards achieving the health-related MDGs, especially when considering the hard-to-reach populations.

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Regional Review Meeting on Immunization, WHO-SEARO, New Delhi, India, 19-23 July 2010.
Improving health in the South-East Asia Region

Immunization acts as a pillar of PHC. The PHC approach will expand its services to cover all children, adolescents and older age groups to increase community demand for immunization and ensure the use of an integrated approach to reach all who are targeted.

Globally, 23.5 million children do not receive DTP3 vaccination during their first year of life. Of these children, 10 million live in the SEA Region. DTP3 coverage in this Region increased only by 7% between 2000 and 2008. Three countries in the Region cannot achieve 80% DTP3 coverage.

As far as polio eradication is concerned; the situation in India has significantly improved during the recent past. However, the country faces a number of challenges on its road towards polio eradication.

The polio-free countries also face challenges in maintaining high-level OPV coverage through routine immunization, and sustaining high-quality AFP surveillance. Measles mortality reduction in the SEA Region is currently at 46% compared with 2002.

However, measles elimination in the Region is still a formidable challenge. We appreciate the funds made available by GAVI, which have helped children in the poor countries to be protected from several common diseases.

Over the last few years, hepatitis B vaccine has emerged as an integral component of routine immunization in most Member States in the Region. Several countries have introduced a vaccine against Japanese encephalitis. Four countries have introduced haemophilus influenza B vaccine. This is an encouraging trend that countries in the Region are adding more vaccines in their national immunization programmes.

This is to encourage countries to move forward towards high and sustainable coverage of routine immunization. To achieve such immunization coverage needs, infrastructure must be improved, including strengthening strategies for implementation of national immunization programmes.

As far as adding more vaccines into the routine immunization programmes is concerned, WHO will continue providing support to countries in deciding on the choice of vaccines. The choice made will be based on a genuine need for vaccines on the basis of the disease burden and on prioritization according to the countries’ ability to afford and sustain.
We also have to keep in mind that a vaccine may be highly efficacious, but the disease it prevents may not necessarily be a public health priority. A vaccine may be highly cost-effective; but it may not be affordable.

The availability of additional vaccines for national immunization programmes has to be sustainable in the long term. As far as side-effects of vaccines are concerned, those traditional vaccines used in EPI have several decades of post-marketing surveillance. There are enough data to prove their safety.

For vaccines that have just been added to the immunization programmes, their possible long-term side-effects in our populations are not yet known. This needs long-term surveillance and evaluation. Therefore, there is a need to strengthen country surveillance and response systems on the adverse events following immunization.

When adding vaccines into immunization programmes, injection safety and vaccine security need to be assured. I believe that this meeting will provide a useful platform where countries can review their needs and agree on strategies to enhance the coverage of their routine immunization.

Regional policy guidance and a rational framework are required for our future actions in the development and management of our immunization programmes.

With many changes in disease prevention since the time EPI started, it is time to revisit in a big way the national, regional and global policies and strategies on “immunization” with a consideration of the vaccine as a part of the exercise. Immunization should be viewed in a much broader context, encompassing not only scientific and technological but also social, economic and political aspects.

Considering that immunization is the most cost-effective public health intervention, we should do everything possible to achieve high and sustained coverage of routine immunization.

Whenever possible and indicated technically and socially, more vaccines should be added into the schedule of national immunization programmes. This is to ensure the maximum health benefit from immunization to various age-groups of our populations, given that the immunization with those vaccines is safe in both the short and long terms, affordable by individuals, communities and countries, and socially acceptable to the people.

Immunization should be viewed in a much broader context
In light of the current efforts worldwide to revitalize PHC, the subject for this symposium is indeed timely. PHC has served as the main strategy for the attainment of health for all over 30 years.

PHC has been the key approach to “equity” and “social justice” in health. PHC is an important tool for public health actions; the actions that help ensure reaching the “hard-to-reach” or reaching the “unreached”.

As we all know, however, the world is yet to attain the goal of health for all. This goal is the attainment of the level of health that can permit all people to lead a socially and economically productive and satisfied life. Substantial progress had been achieved during the past three decades in pursuit of this goal.

In general, people today live longer; life expectancy at birth has increased. Illness and illness-related death have gradually declined; this is especially so in developing countries. People look healthier today than they did 30 years ago. However, with new and emerging health challenges, much more needs to be done to attain the health for all goal.

The principles of HFA/PHC have significantly changed the ways in which health policies are developed and the ways health programmes are planned and implemented. With HFA/PHC principles, health development work has expanded much farther than the realm of the health sector.

The integration of “health concerns” into national development policies in all sectors has been promoted. Based on the PHC approach, health systems have been reformed to take into account the work of other sectors that have

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a bearing on health and well being of people. Worldwide, the success story of PHC implementation has been extensively documented.

In SEAR, there are also several such examples. For instance, the basic minimum needs programme in Thailand, the Posayandu development scheme in Indonesia, the Ayadant health development project in Myanmar, and the Mongar health development initiative in Bhutan.

At the same time, there have been “global changes” in all spheres during the past three decades. There has been a deterioration of the environment and the eco-system worldwide. The global climate has changed, leading to global warming. There have been frequent outbreaks of new and emerging infectious diseases etc.

These events have profoundly affected people’s health, either directly or indirectly. Therefore, in 2008, WHO called for worldwide revitalization of PHC to ensure its continued relevance to the changing health needs of people. This call was made, when the 30th anniversary of the Alma Ata Declaration on PHC was celebrated globally.

In SEAR, a high profile regional meeting on revitalizing PHC was held as part of the celebrations. As far as health of the world’s population is concerned, we may say that this period is the second phase of the PHC movement. During this phase, PHC needs invigoration, innovation and reorientation.

PHC, which is a “social movement”, has to adapt to the dynamics of “social change”. “Social determinants of health” must be the cornerstone of today’s development of PHC. Along these lines of thought, there are a number of ideas in the SEA Region to revitalize PHC; the Strategic Road Map Initiative in Thailand; development of Community Health Clinics in Bangladesh; development and deployment of ASHA (Accredited Social Health Activist) in India; Community-based health development (SISCa) in Timor-Leste; etc.

Among other support to these initiatives, WHO has provided platforms for Member States to share information and to learn from each other in the development process that can lead to effective cooperation between and among Member States. This intercountry cooperation is one way to help nurture PHC development in a uniform and sustained manner to ensure effective information exchange, and successful intercountry cooperation; networking of relevant “institutions”, both within and outside countries, is necessary.
The idea of regional networking in PHC as being initiated by AIHD is commendable indeed. It will help ensure the relevance and effectiveness of PHC development in the Region. At the Regional Meeting on Revitalizing PHC in 2008, an idea to develop a network of “PHC innovations” was broached. That network development involves the Thai Ministry of Public Health and the Quality of Life Foundation (QOLF), Thailand.

WHO has been supporting these efforts. Networking in PHC as initiated by the QoLF and AIHD should be coordinated to ensure complementarity. I understand that this PHC network development, which is being initiated by AIHD will focus attention on PHC “quality improvement” through R&D and experience sharing.

With this perspective in view, I would like to underline the important role of academic and research institutions that can help generate the evidence necessary for innovations in PHC development.

These institutions can also help in assessing or evaluating the impact of PHC interventions. Certainly, community health workers have an indispensable role to play in this R&D process. Important contributions to PHC development also come from people in the community, local government, civil society, voluntary organizations, and others.

Once the PHC network is formed, we have to ensure its sustained functioning. This is a formidable challenge. We have to plan how to organize an effective managerial back-up to the network functioning. Networking requires a spirit of coordination and cooperation among the institutions concerned.

In principle, the networking must be beneficial to all institutions involved; individually and collectively. There must be means and ways to firmly bind these institutions together, in both technical and managerial terms. These institutions need to play their respective roles as equal partners, sharing responsibility, and sharing credit in a fair manner.

Once again, I highly commend AIHD for its effort in organizing this important international symposium on PHC Network Development. The outcome of the symposium will take us a long way towards PHC “quality improvement”. The symposium will significantly contribute to the revitalization of PHC in the SEA Region.
Before I conclude, let me touch on some challenges in PHC. We may say that these challenges are the unfinished agendas, as far as PHC development is concerned. Since the Alma Ata Declaration over 30 years ago, not all aspects of PHC principles have been implemented or successfully implemented.

Therefore, some of the challenges in PHC 30 years ago remain challenges. In this connection, I would like to remind us of the following: PHC is “health care for all people by all people” – health for all through all for health. PHC is “people’s health care systems”, by people for people; PHC is for both rich and poor, for both rural and urban, PHC is not second-grade care or low quality care, but is quality health care for all.

PHC is not exactly the same as primary care. PHC is more than primary care, which is the first level of government health care delivery systems. To remind, PHC is an important tool for public health actions to reach the unreached. We are yet to really achieve universal coverage of health care, through reaching the unreached.

Wide gaps in health among population groups are persisting. PHC should be primarily considered as a development endeavour rather than the provision of health services. Education and empowerment of people are the principal strategy of PHC, which needs change agents – community health workers and community health volunteers.

Demystification of health knowledge, health technology, that is appropriate for use by people in the community, social control of health technology, HFA/PHC movement is considered as a “social reform” in the health area.

These challenges are important areas for education, research and development in PHC. The relevance of PHC to today’s and tomorrow’s health development will continue. However, the word “PHC” may be changed to something else.

A lot remains to be done in the development and implementation of the PHC approach which is the key to equity and social justice in health. These are formidable challenges in today’s changing health scenario and needs. With strong determination and unwavering commitment, let us utilize our full potential in facing these challenges to attain health for all in the South-East Asia Region.
According to cost-effectiveness studies in the 1980s and 1990s, immunization against childhood diseases is one of the most cost-effective public health interventions for prevention of child illness and death. Although the cost of fully vaccinating a child has increased from US$ 15 to US$ 26 over the past 30 years, immunization remains one of the most cost-effective public health interventions. This cost increase has been mostly due to the introduction of additional antigens. There are several implications of introduction of new vaccines in developing countries, e.g., cost, affordability and sustainability, logistics, cold chain, adverse effects, safety, short- and long-term issues.

Prior to the introduction of routine immunization against the six traditional EPI diseases in the 1980s, countries in the South-East Asia Region (SEAR) reported a disease burden of more than 700,000 cases in a population of 1.05 billion. By 2008, as a result of routine immunization, the disease burden decreased by 81% to less than 140 000 cases in a population of 1.76 billion.

WHO estimates that immunization can be linked to a 25% reduction in the under-five child mortality. This is with the condition that a high coverage of 90% with traditional and new vaccines is achieved. There was a global vaccine shortage during the 1990s (1990-2000). Prior to this shortage, UNICEF procured a majority of the vaccines used in the Region. The vaccine shortage was due mainly to changes in the supply and demand for traditional EPI vaccines. These changes affected vaccine supply to a number of countries in the Region.
Some of these "market changes" are as follows: the merger of major pharmaceutical companies with large multinational conglomerates; the change in industry market strategy to stop production of traditional vaccines in favour of more sophisticated technology and more lucrative products, such as combination vaccines, i.e., Hib-pentavalent vaccine, which uses diptheria, tetanus, and pertussis (DTP) as its base.

In order to meet demand for the production of combination vaccines, manufacturers procured a major proportion of the available DTP in the market, particularly from vaccine manufacturers in developing countries.

With a greater variety in the availability of vaccines in the global market, developed and developing countries started using different vaccines. e.g., vaccines produced by the use of more sophisticated technology; more advanced developed countries started using DTP vaccine containing acellular pertussis, which is more expensive; while developing countries continued using DTP containing whole cell pertussis which has less sophisticated technology and is cheaper.

This situation jeopardized the global supply of the affordable vaccines; supply policy, funding policy, the EPI programme in developing countries due to lack of funds to buy vaccines. Due to the demand for different vaccines, developing countries emerged as a distinct and important market for vaccines influenced by large multinational conglomerates; expensive vs cheap vaccines. From 2000 to 2010, 10 of the 14 vaccine manufacturers with long-term agreements with UNICEF, either partially or totally stopped production of the traditional EPI vaccines. At the same time, by 2010, the global market for vaccines had grown annually by 15% in financial terms, reaching US$ 21 billion.

The vaccine demand in developed countries represented 82% of industry revenue, but, this demand is only 12% of its volume. Profitability has risen significantly. This profitability has been driven by proprietary products and technology, targeting the high-income market. Consequently, the investment in R&D rose significantly, comparable with the pharmaceutical industry.

In developing countries which also include some countries in the South-East Asia Region, the vaccines used in national immunization programmes
were non-patented products produced in the private sector (of developing countries). In order to meet the demand, these private companies tried to focus on increasing their capacity for large volume production. There was lack of investment in R&D.

At the same time, they were trying to establish quality assurance systems in compliance with WHO criteria. In 2000, to ensure a consistent supply of affordable quality vaccines, manufacturers in developing countries formed a non-profit public health alliance called the “Developing County Vaccine Manufacturers’ Network” (DCVMN). SEAR with its large population and three vaccine manufacturing countries has become an important focus for global vaccine supply and demand.

SEAR represents a large market; it produces a significant quantity of vaccine; and it provides a centre for clinical trials. Two out of every three children born in the world get immunized with at least one vaccine coming from country members of the DCVMN. This demonstrates the critical role played by vaccine manufacturers in developing countries in ensuring global supply of essential vaccines.

The profit margins for these non-patented vaccines is much less than for patented vaccines; thereby reducing the capacity of DCVMN members to invest in vaccine R&D. Out of 28 members of the DCVMN, 10 are in SEAR, including India, Indonesia and Thailand. India has become a major vaccine producing country, accounting for more than 80% of the DTP group of vaccines produced by DCVMN members.

Since 2000, substantial financial support made by various “international initiatives” has resulted in a focus on clinical trials in developing countries and on technology transfer. Point for consideration – clinical trial vs technology transfer or on importing vaccine in bulk to develop production capacity in developing countries of non-patented vaccines. For example in SEAR, Biofarma – Indonesia, Serum Institute of India, and Biological Evans Limited, India.

These benefited from technology transfer from the National Vaccine Institute (NVI) in the Netherlands in the production of conjugate Haemophilus influenza b vaccine. In 2009, these manufacturers in India and Indonesia...
produced around 53 million doses of Hib containing vaccine. SEAR has increasingly become a centre for clinical trials.

For example, in India, there are vaccines in clinical trials for oral cholera, rotavirus, anthrax, pneumococcal, meningococcal, measles aerosol, and H1N1. In Indonesia, pre-clinical trials have been initiated for H1N1 vaccine. In Thailand, H1N1, dengue and H5N1 vaccines are being tested; as well as phase 3 clinical trials for HIV vaccine.

In this process, there is an issue of interest of governments in technology transfer. SEAR has a large community of well-qualified scientists, particularly in the three vaccine producing countries. These countries have rather sophisticated laboratory facilities. The Region with its recognized vaccine producing countries will become an important player in the field of vaccine development and production if the issue of interest and investment by governments can be overcome.

Vaccines produced in the Region have the potential for global use because of their affordable cost (and assured quality). This potential will provide for regional vaccine security. With this perspective in view, there are challenges that must be overcome for the Region to realize its full potential in achieving self-reliance in the production of affordable vaccines of assured quality.

There are other issues that need to be addressed. For example, the lack of interest, incentive and support from governments for R&D, government, institutes, industry, the private sector. Lack of investment by governments and the lack of full compliance with regulatory requirements. There are also issues relating to IPR. There is lack of coordination and cooperation among stakeholders, universities, research institutes, manufacturers, national regulatory authorities (NRAs) and the national immunization programmes, the lack of fully operational NRAs to provide oversight in all aspects of vaccine development and production.

This is particularly important in considering the number of new vaccines entering the market. There is also lack of public-private partnerships in the area of vaccine regulation. With WHO support, countries in SEAR have made substantial progress in building the capacity of their NRAs. This is particularly through the process of producing WHO pre-qualification vaccines.
WHO will continue working with governments to strengthen NRAs in all 11 Member States. In the three vaccine-producing countries, WHO will continue supporting and assisting in improvements in market authorization and licensing; clinical trial authorization and monitoring; on-site regulatory inspections; establishing and monitoring quality management systems within NRAs; and responding to adverse events following immunization (AEFI).

While in the process of review and revisiting its regional policy on vaccine development, WHO is actively encouraging each Member State to develop a national vaccine policy with goals for the next five to 10 years. As a way forward in fostering regional solidarity, WHO will continue promoting cooperation and coordination among vaccine manufacturers and the regulatory network within the Region.

This is to ensure a fully functioning vaccine regulatory authority in every country. An important part of this endeavour is for WHO to provide mechanisms for sharing information among countries, guidance to harmonize practice procedures across the countries and facilitate agreements on regulatory procedures that could be accepted by countries with limited vaccine regulatory expertise.

With these measures, countries with limited regulatory resources would have better access to high quality vaccines at affordable cost.
I am very happy that India has taken this initiative to bring all WHO Collaborating
Centres (CCs) in the country to a common platform. WHO CCs are national
centres of excellence and are technically prestigious. These centres primarily
serve their own country in various technical areas.

Following certain criteria and conditions, these institutions are designated
by WHO to be Collaborating Centres. The primary purpose of designating a
national centre of excellence to be a WHO Collaborating Centre is to involve
it in the work of WHO. WHO CCs form a world-wide network of expertise for
participating in various WHO programmes at the national, regional and global
levels. This network provides technical support to countries through WHO.

Designation as a WHO CC does not involve WHO financial commitment. However, if a WHO CC is to be involved in the activities of a WHO programme,
a certain type of contract will be raised, such as:

- Agreement for the Performance of Work (APW)
- Technical Service Agreement (TSA)
- Direct Financial Cooperation (DFC).

Involvement in WHO programmes means the WHO CCs will have to work
with WHO technical units at the country office, Regional Office or headquarters
level. Such involvement of WHO CCs is normally in the areas of education and
training, technical services, and research.

WHO technical units utilize expert services from WHO CCs in developing
various technical guidelines and training modules, preparation for meetings
(including preparing workplans), facilitating training programmes and many
other activities.

Meeting of WHO Collaborating Centres in India, New Delhi, India, 12-13 November 2009.
Experts from WHO CCs work as Temporary International Professionals in different programme areas or as Temporary Advisers to the Regional Director or the Director-General. In some cases, experts from CCs may be even absorbed by WHO to become regular staff members to work in various programme areas. WHO will designate a national centre of excellence to be a WHO CC on the basis of its readiness to participate in the relevant technical programme of WHO.

At the same time, WHO is not discouraged from working with other national centres of expertise that are not designated as WHO CCs. Neither are WHO CCs prevented from working with agencies other than WHO. Working with WHO in a country, in many cases, means getting involved in the implementation of WHO country programmes. WHO country programmes are government – WHO collaborative endeavours. The main focal point of WHO in such cooperation is the ministry of health. Therefore, maintaining close working relationships with ministries of health is necessary for the productive functioning of WHO CCs.

As I have said, WHO CCs are national centres of excellence. Therefore, working relationships between the centres and ministries of health should already have been established before their designation as WHO CCs.

In most cases, WHO CCs are specialized institutions working in specific technical areas such as malaria, TB, HIV/AIDS, diabetes and cardiovascular disease.

These centres/institutions are usually coordinating with each other in their respective technical areas. By working together, networks of centres in the same specific technical areas may be formed. Such networks may be created at the national and international levels. Even though WHO CCs are working in specific technical areas, sometimes, they may have issues that are common to most or all of the centres in the country. These include issues relating to designation of centres of excellence to be WHO CCs, or re-designation of CCs when their terms are expiring. In such situations, the CCs may want to tackle their common issues together.

Thus, forming a national network of WHO CCs in the country may be justified. Such a national network should primarily deal with broad areas of concern common to all or most of the centres. The national network of WHO CCs can help facilitate managerial action in working with WHO, especially
those actions relating to communication and coordination between the centres and WHO and among the centres themselves. Dissemination of information among the centres may be done more efficiently through this networking. The network may develop its own website or issue a newsletter to promote such communication and information dissemination.

The national network of WHO CCs is meant to facilitate the provision of “common services”, as mentioned, according to the requirements of the centres.

In order to create a national network of WHO CCs in a comprehensive manner, the networks in specific technical areas may link with the national network. Networking of WHO CCs is a mechanism to ensure effective utilization of expertise available in the centres, either by WHO or by the country. The network can help in aligning the work of CCs with national priorities and challenges. It can facilitate releasing the technical potential of CCs for effective implementation of government–WHO collaborative programmes or other types of technical service.

India has 39 WHO CCs and the number is growing. India has expertise available in a wide range of specific technical areas. Efforts should be intensified to designate more WHO CCs. It is also very clear that networking is required for the effective use of WHO CCs in India. Thailand has experience in networking WHO CCs, and we may learn from the Thai experience how a national network may start and be managed.

WHO CCs are working in specific technical areas, and their interests are rather diverse. Networking them may be a real challenge, especially in the area of management. This challenge may persist even if the centres are put into groups or categories. However, the challenge can be easily overcome if all WHO CCs work together towards national health goals and priorities.

For the national interest, WHO CCs need to match their potential roles with national goals and priorities as much as possible.

I look forward to an excellent outcome from this meeting. This is a good opportunity for technical units to meet with CCs in various technical areas. I hope that, after this meeting, a national network of WHO CCs linked with the networks in specific technical areas will be formed to help maximize the utilization of the expertise in the centres.
The current pandemic A(H1N1) 2009 was announced on 11 June 2009. So far more than 400 000 cases and, at least 4700 deaths, have been attributed to the new pandemic influenza virus worldwide. These figures are conservative estimates. In the South-East Asia Region, India and Thailand report the highest number of cases. The Region has recorded 43 000 cases and more than 600 deaths to date. The pandemic A(H1N1) 2009 virus has never before circulated among humans on a large scale. Most people, therefore, have little or no immunity to the infection.

The pandemic virus is highly contagious. However, the severity of the disease ranges from very mild symptoms to severe illness and death. More than half of all hospitalized people already had underlying health conditions or weak immune systems. One of the strategies likely to be effective in combating the pandemic is the use of safe and efficacious vaccines in vulnerable populations. Existing seasonal influenza vaccines are not effective against the pandemic strain. And there is, therefore, a need to develop and produce a new vaccine that is both safe and effective for pandemic influenza.

While the Region awaits production of an adequate quantity of the pandemic influenza vaccine, Member States need to rely upon other public health interventions such as:

- an efficient mechanism for coordination;
- effective surveillance and monitoring of acute respiratory illnesses in the community and at health facilities;
- to implement relevant non-pharmaceutical measures; and,
- the judicious use of antiviral agents to control the severe disease.

Informal Meeting on Regional Production of Pandemic Influenza Vaccine, WHO-SEARO, New Delhi, India, 29-30 October 2009.
The vaccination as a countermeasure in cases such as this raises issues of “access” and “equity”; as the bulk of global production is within Europe and North America.

As I said, this meeting is about regional production of pandemic influenza vaccine: how to expedite the process of production, licensing and distribution. While we are striving for maximum cost-effectiveness and safety, we have also learnt from past experience that:

- influenza pandemics have a tendency to attack populations in periodic waves; and,
- the second or third waves may cause more severe morbidity and mortality than the first.

We are approaching the time when we would expect to see a second wave. Some countries have already licensed the vaccine for use, and the United Kingdom commenced vaccinating its people from the third week of October. There is, therefore, the need to accelerate the process while keeping an eye on the safety issue. Member States in the SEA Region have large populations living under difficult socioeconomic conditions; which make them vulnerable to the effects of the pandemic. Vaccines for the SEA Region need to be produced in large quantities.

This meeting needs to discuss the capacity of the Region to produce the required amount of vaccine within certain timeframes. We are fortunate, however, that three Member States, India, Indonesia and Thailand, are capable of producing the vaccine. It is also encouraging to note that a fourth country, Bangladesh, has expressed a keen interest in producing the vaccine.

During the Sixty-second World Health Assembly in May 2009, one of the main issues discussed was pandemic influenza H1N1 preparedness and access to the vaccine. During the Health Assembly, the Health Ministers of this Region also committed to foster collaboration in pandemic influenza vaccine production within the Region. The issue of pandemic influenza vaccine was also raised at the Regional H1N1 consultation held in July 2009 in Bangkok, Thailand.

We are pleased to have with us today representatives from:
• vaccine-manufacturing companies;
• ministries of health; and,
• national regulatory authorities.

The vaccine production chain includes a number of steps. The average lead time for new vaccine production is about five months. Once the vaccine is made available, national regulatory authorities (NRAs) need to ensure its safety. The NRAs are responsible for examining the “risks” and “benefits” of any vaccine before granting its “license”. The results of clinical trials have to show the evidence that the vaccine is “safe”. NRAs may need to put in place the processes that can help accelerate the approval while ensuring that quality and safety are not compromised. When the vaccine has received approval from the NRA, the government of that country needs to implement their distribution plan.

Countries, therefore, need to have a “vaccine prioritization” and “deployment strategy” in place well in advance. The Strategic Advisory Group of Experts on Immunization or SAGE was established in 1999 as the principal advisory group to WHO for vaccines and immunization. SAGE noted that countries should employ a strategy that:

• reflects their epidemiological situation,
• takes into consideration the need to ensure access to the vaccine by those at risk; and the ability to deploy the vaccine alongside “non-vaccine measures”.

WHO recommends that health-care workers who are most vulnerable should be vaccinated first to protect the overall health-care infrastructure. Countries, therefore, need a deployment strategy which should include “post-marketing surveillance” to detect any adverse events following immunization.

A regional workshop on vaccine deployment was held in SEARO in September 2009 with representatives from the countries. The workshop highlighted the need for countries to:

• develop pandemic influenza vaccine deployment plans;
• train the required workforce; and,
• explore the legal requirements for licensing the vaccine prior to deployment.

We have the presence at this meeting of:
• key persons who can inform us about the vaccine production capacity within the Region,
• persons from NRAs who can advise us on the processes that the countries need to follow; and,
• persons from ministries of health who will be involved in the prioritization and deployment of the vaccine.

We also have with us experts whose advice and technical inputs will be invaluable.

At the end of this meeting we should have a clear understanding of:
• the regional vaccine production capacity; and
• the regulatory processes involved.

We will share the information during this meeting with all Member States in order to help them plan their procurement, prioritization and distribution strategies. Furthermore, the SEA Region needs a considerable amount of vaccine for its large population. Combined efforts between the governments and the private sector are critical, indeed. I hope the meeting will also mull the issue of strengthening public-private partnerships in vaccine production.
Health services are technology-intensive. Research is indispensable for the development and application of health technology to make such modern health services possible. Strengthening research capacity in Member States is, therefore, an important role of WHO. And in this capacity strengthening, “ethics in research” is one of our overriding concerns. This is especially the work of “Ethical Review Committees”, to ensure, among other things, physical and psychosocial safety of “research participants” or “research subjects”. In the broader context, the work safeguards the human rights of those participants or subjects.

Research projects involving human participants demand sound “ethical practice” to ensure such safety, and to safeguard such rights. Donor agencies require “ethical clearance” for research involving human subjects before they can make decisions on funding. Journals of international standing will not publish the results of research projects involving human subjects, that have not been cleared by creditable “Ethical Review Committees” (ERC). Not less important, clearance by ERCs certainly provides important safeguards for researchers themselves. We recognize the critical role of ERCs in the research process. This is particularly research in the area of health sciences. To ensure a high standard of practice in the work of ERCs is a challenging task. WHO has been providing support to improve the performance of ERCs, especially those in developing countries.

To achieve such improvement satisfactorily requires a lot of efforts and patience. Despite many guidelines and standard operating procedures having been developed for use, and several training workshops organized in countries and at the regional level, still, in general, there are gaps, lacunae and shortfalls in the work of ERCs in ensuring a high standard of practice in research ethics.

Regional Workshop on Capacity-Building for Ethical Review Committee of Health Sciences Research, Bangkok, Thailand, 19-22 October 2009.
However, we should not, actually we cannot, be discouraged from continuing our efforts to further enhancing the capacity of ERCs. This is to further improve the performance of these Committees in ensuring “safety” and safeguarding human rights of research subjects. And we have to continue enhancing the quality of ethical practice of researchers. On the other hand, research managers and research administrators also need to be always “research-ethics minded”.

There are many issues involved in research ethics. Let me mention a few from my experience in dealing with this important area. Among other factors, is the “conflict of interest” involved in the research process and research work makes the situation more complicated for improving research ethics. And this conflict of interest usually leads to difficulty in ensuring “transparency” in management of research work. At the institutional level, a clear policy on research ethics is a prerequisite for successful functioning of ERCs. Administrators of research institutes need to promote a high standard of ethical practice in their research work. We have to promote positive attitudes of researchers towards “ethics in research”; and towards the work of ERCs. Role models need to be developed for researchers to emulate to be good practitioners of research ethics. “Ethical review” of research projects is delicate work; it needs adequate time and it should not, and cannot be done hurriedly.

At the same time, in certain cases, there are a lot of demands for ethical review of research proposals involving human subjects. Then, the ERCs become too burdened and become “bottlenecks” that delay processing of research projects. This is one of the reasons that turn away researchers from cooperating effectively with ERCs.

For ERCs to be really effective such bottlenecks must be eliminated. Means and ways have to be found to ensure that ERCs will not be too burdened to compromise the quality of their work.

Another problem area that affects the work of ERCs is the conflict between researchers and ERCs about “research methodology”. This research methodology may significantly affect the safety of research participants in the implementation process.

Often researchers are reluctant to accept recommendations of ERCs, especially recommendations to effect change in research methodology for
safeguarding research participants. In this connection, a proper mechanism is needed to help reconcile the difference between researchers and ERCs keeping in view the “overriding consideration” to be given to the safety of research subjects.

Another delicate issue in research ethics is how to obtain consent from research participants in a strictly objective manner. The decision of research participants to cooperate in a study must not be influenced by any kind of incentive. The decision of research participants should be based solely on their valuable contribution to the improvement of people’s health through the concerned research projects, that they are involved in. It is customary practice in research involving human participants that certain kind of material incentives are built into proposals. This is to attract the interest of research subjects beyond the ultimate objective of the research projects. How do we ensure that the research subjects correctly understand the research procedures that may potentially be harmful to them? How do we ensure that the decision of the subjects to participate in research will not be affected by any incentive? I hope that the workshop will dwell on this important issue during the course of its deliberations. This is with the view to improve the situation in regard to obtaining consent from research participants without “prejudice” that is outside the realm of the primary purpose of research projects.

I agree that we need to teach research ethics to the students training in health sciences. This teaching should start as early as possible in their professional training and in their professional career. We need to prepare our researchers in research ethics as early as possible. As part of “hands-on-training”, we may consider involving students in the process of ethical review but not as “members” of ERCs. This is especially true for graduate students. Yes, there are many ethical issues involved in “health systems research” and research on health services delivery systems. The issues involved are generally in the area of “technology application” for health benefits of people in the community. This area involves the development and management of “public health programmes”. This area also touches on socio-cultural and even political dimensions of the community to be served. Certainly, research in this area needs ethical consideration; and also consideration of human rights aspects in a broader context. It is the area that requires more efforts in the development of effective guidelines for ethical review — the guidelines that may be substantially different from those used for clinical or basic research.
In addition to capacity building, this workshop also aims to create networking of ERCs in countries of the South-East Asia Region. This is commendable indeed. Our practical experiences, especially from our own countries, are most important in an exercise such as this. We should bring up the issues from our practices for discussion and deliberations during this workshop. Working on our own experiences will ensure practical solutions for the problems that we are facing in our countries. We have with us “generic guidelines”, and “training modules” to help improve our performance in research ethics. These guidelines and training modules are for adaptation and application to help solve our local problems.

Our local problems, in many cases, may relate to our own socio-cultural and even political environments at home which need to be taken into account adequately in this exercise. However safeguarding research participants is our overriding consideration. And we have to ensure it.

We are talking about “research ethics” or “ethics in research” in reference to the ERCs. In my view, “ethics of researchers” is also very important indeed. If we have researchers who are ethical, most problems that we face in this connection would be solved. Researchers are essentially the key players in research ethics.

I also feel that we should have a separate “ethical code of practice” for researchers. We should deal with “research ethics or ethics in research” in a broader context, encompassing the issues more than safeguarding research subjects. We may already have such a code in place, but if we do not, it is time to consider the same. Ethical issues in research are, more or less, inter-related, and interlinked. To tackle these issues effectively, a holistic approach is needed. Safeguarding research participants, even though extremely important, is only a part of the whole gamut of ethical problems in research.

I am talking from the public health perspective. I hope that it would be useful in your deliberations during the course of this workshop. And I hope however that the outcome of this workshop would contribute significantly to capacity building for Ethical Review Committees in health sciences research in our countries.
Every year, more than half a million women in the world die due to pregnancy-related conditions. And every year, more than 9 million children die before their fifth birthday. The situation is particularly serious in Asia and the Pacific.

More than 44% of maternal, 56% of newborn and 41% of under-five global deaths occur in this Region. Most of these deaths could have been prevented if the currently available technological interventions were appropriately applied, within the socio-cultural context of family and community. If the present trend of maternal and newborn mortality continues, the related Millennium Development Goals (MDGs) are unlikely to be achieved by many low-income countries in Asia and the Pacific.

To achieve the targets of MDG4, for example, it is necessary to reduce neonatal mortality by 50%. As we are well aware, neonatal mortality is inherently tied to maternal health. Effective care during childbirth and during the first week of life is very crucial to reduce neonatal mortality. Indicators of maternal and neonatal health are also the markers, not only for health development but also for economic and other aspects of social development. These indicators also reflect cultural practices, as far as health, especially in the rural areas, is concerned.

With this in mind, a SEA Regional High-level Consultation was held in Ahmedabad, India last year, to deliberate upon the issues relating to maternal, newborn and child health. The consultation highlighted, among others, the important role of the primary health care approach in ensuring the achievements of MDGs 4 and 5. The consultation underlined that our efforts to improve maternal and child health should focus on strengthening health systems based

Biregional Consultation on Sociocultural Aspects of Maternal, Newborn and Child Health, Bali, Indonesia, 11-13 August 2009.
on PHC, taking into account social, cultural and economic determinants of health. If we are to speed up our endeavours to reduce maternal and neonatal mortality, innovative strategies need to be designed and implemented.

This biregional consultation spotlights the importance of socio-cultural and economic dimensions of maternal, newborn and child health and focuses attention on the way that these dimensions are incorporated in the programming process to benefit the health of the mother, newborn and child. The recommendations of the Global Commission on Macroeconomics and Health (CMH) and the recommendations of the Commission on Social Determinants of Health (CSDH) have provided us with adequate policy guidance in this regard. However, the guidance needs to be tailored to suit the situations and needs in the individual countries in their attempts to improve health in general, and health of the mother, newborn and child, in particular.

The PHC approach provides us with a tool to address inequity in health to ensure reaching the unreached. PHC is also an important tool to cover the areas of social, cultural and economic dimensions of health. Just to remind us, PHC is to be implemented through:

- Community participation and involvement;
- Education and empowerment of people in the community;
- Multidisciplinary and multisectoral collaboration and actions; and
- Development and use of appropriate technology.

While CMH recommended a cost-effective service package of interventions the CSDH suggested tackling the issues of education, income, dwelling, and cultural factors.

To date, our interventions for improving health in general and health of the mother, newborn, and child in particular are heavily oriented to the “supply side”. The “supply side” is what the service providers offer. Public health interventions related to the “demand side” are not yet sufficiently addressed, but the “demand side” is what people need.

Effective interactions between providers and clients, which also involve sociocultural and economic dimensions, are not given adequate attention. We need to address this issue by critically reorienting our approaches to the
development and implementation of public health programmes to ensure that such programmes are planned to better serve and improve the health of the mother, newborn and child. Special attention must be given to community-based health promotion and disease prevention, and programmes that take into account social, cultural, and economic aspects of each individual, family and community.

Family planning, nutrition, and immunization are among the important preventive measures in public health. If implemented with recognition of social and cultural dimensions, these measures are expected to contribute significantly to the achievement of MDGs 4 and 5. In improving maternal, newborn and child health, we all recognize the importance of access to quality care, which includes antenatal care, care during childbirth, and postpartum and newborn care, the care that is significantly influenced by social and cultural factors.

Have we done enough in these areas? Have we taken into account adequately the social, cultural and economic environments in which the care is delivered? Have we provided responsive care to the entire population, the needs that are also socially and culturally based, particularly of the poor, vulnerable, underprivileged, and marginalized?

Currently, we limit our attention mostly to individuals or families who come to health facilities with a complaint of ill-health and seek medical attention from service providers. Actually, this is only a small part of the entire range of health problems of the whole community. It represents only the tip of the iceberg that appears above the surface of water, it is the part that we can easily see, it is the part of “declared morbidities”: hidden from view are those people who, for several reasons, do not have access to health-care facilities or who are even unwilling to come to health care facilities, and those who escape our attention, especially the attention of the formal health-care system. These are what we may call “undeclared morbidities”.

There are also people who are without symptoms but already harbouring diseases, silent diseases. These may be in the early stages, and could include HIV infection, diabetes, hypertension, and cancer.

At the same time, there are people who expose themselves to various types of “health risks” and “vulnerability”. These may be known, or may not
be known to them. They are yet to get access to health care and they deserve attention as well. These groups of people represent the major part of health needs. This part of the iceberg represents health problems and potential health problems that are normally invisible.

With this perspective in view, there is a growing need to revisit the reform of health-care systems; such reform can ensure an adequate response to the neglected health needs of the mother, newborn and child, while also improving the overall efficiency and effectiveness of health-care systems in general.

I have planned to convene a regional meeting on Health Care Reform later this year. Its purpose will be to encourage people to think and focus attention more on the development of primary health care in the community. A revitalized PHC can ensure adequate quality health care for all people and also address undeclared morbidities, silent diseases, health risks and vulnerability.

It is necessary to recognize in this connection that community health work must be backed up adequately by an efficient referral system and professional support. The referral system ensures adequate institutional care at the primary, secondary and tertiary levels, for all those people who are referred up from the community for services.

Professional support is needed for supervision and training of staff who provide services in the community, and for monitoring and evaluation of community health work.

We must pursue our best efforts to strengthen community-based health workforce. This workforce includes, among others, community health workers and community health volunteers. It is adequately equipped with sociocultural tools to work effectively in and with the community, and must take on a major operational role for providing effective health care for all people at the grassroots level.

I hope this biregional consultation will focus its deliberations on innovative interventions that can lead to the desired changes in community health care and services. This care must take into account all aspects of the health needs of the entire population, including the health needs of the mother, newborn and child, in particular.
Last, but very importantly, while emphasizing the role of the social and cultural dimensions in tackling health problems of the mother, newborn and child, we must also emphasize the involvement of social scientists in training and research relating to this area; and in programme development and management relating to the mother, newborn and child health.

I thank all participants for their interest in this consultation. I also thank you for your continued collaboration and contribution to the improvement of maternal, newborn and child health, the contribution to the achievement of MDGs 4 and 5.
Two years ago, when the thirtieth session of the ACHR was held, our main concern at that time was in the area of emerging infectious diseases. And this is still an important concern today. We would very much have liked to see our regional research capability and capacity in this area adequately strengthened. This is especially true for capability and capacity in “research and development” in “pharmaceuticals” and “biologicals”.

The Region needs to be more self-reliant in the areas of drugs and vaccines for combating emerging infectious diseases. In this connection, we realize that, to succeed in these efforts, building partnerships among all stakeholders was necessary, i.e. partnerships among research institutions, funding agencies, health services provider organizations and the private industry. We were also particularly concerned with the persistent endemicity of AI(H5N1) in the Region. And, at that session of the ACHR, we specially deliberated upon research aspects on the control of AI(H5N1). This was to find practical and workable solutions for fighting AI. We were also very concerned with countries’ capacity in the management of their research and research-related activities. We paid particular attention to the management of “research resources” both human and financial. We underlined the importance of efficient and effective utilization of available funds, especially WHO funds. These were among other important matters discussed at the thirtieth session of the ACHR two years ago.

Particular efforts were made by the Regional Office during the past two years in taking follow-up actions on the conclusions and recommendations derived from that session of the ACHR. During this session, we will review those follow-up actions with special attention to three important areas:

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Thirty-first Session of WHO South-East Asia Advisory Committee on Health Research, Kathmandu, Nepal, 21-23 July 2009.
• Avian influenza research;
• research management in countries; and
• promotion of research and development in the areas of drugs and vaccines.

As far as our Regional Research Policy and Strategy are concerned, we have not reviewed them for some time. We will do it this time. At the same time, we will have the opportunity to learn about current developments in various areas of global health research. We will hear about the global health research activities as well as the recent developments in “tropical disease research” and “research in human reproduction”.

The purpose of such a policy and strategy review is to refine our health research agenda for action during the next medium-term period in order to finetune our regional research activities with the current global public health challenges.

In order to ensure efficient use of WHO research funds, the management of research in WHO is also very important. As far as the utilization of WHO research funds is concerned, the management of research in WHO and the management of health research in countries are equally important. We should therefore deal with these two areas of research management inclusively. However, for better clarity, at this meeting, we will present the subjects separately.

As far as WHO research funds are concerned, I would like to repeat what I said at the thirtieth ACHR session two years ago. A sizable amount of “WHO resources” was available, at both country and regional levels. That was spent on research. But, the impact of utilization of such resources on research had not been really palpable. Had a systematic study on this issue been undertaken, we would have been surprised by the sizeable amount of wastage occurring in the utilization of WHO funds.

I would again like to underline that efficient management of research and research-related activities is extremely important. It is important to help ensure rational and optimal utilization of research resources. Such management can help ensure positive achievements of research.

Some time ago this year, the WHO Regional Office for South-East Asia organized a regional meeting on research priorities in communicable diseases.
We will present the outcome of that meeting for review and discussions by the ACHR. This is in order to develop a strategic roadmap for implementation of the recommendations arising from that meeting.

On communicable diseases, I would like to remind ourselves of the research needs for addressing the current public health concerns, such as the influenza pandemic H1N1 2009, and the outbreaks of dengue and chikungunya. Also, we are yet to pursue research to find solutions for effective interventions against the endemic AI(H5N1). In addition, during this session, the ACHR will deliberate upon the research priorities in noncommunicable diseases.

In the case of both communicable and noncommunicable diseases, I would urge that we pay special attention to epidemiological and operational research—research that can help ensure effective interventions through evidence-based programme development and management. This aspect of research includes, among others, appropriate application of available technology in disease prevention and control. This is urgently needed in the areas of health services and health systems research.

In disease prevention and control, we need greater research that can help promote “primary prevention”: research that backs up community-based public health interventions. These are interventions that take into account the related risks and determinants. Certainly, we need health systems research to support the implementation of the primary health care approach in the community. Certainly, “basic and clinical research” are also very important. And WHO will support these research efforts, whenever there is a need. And whenever there is a funding opportunity.

The ACHR is an advisory body to WHO on research policies and strategies, in particular. Our deliberations on various subjects of the agenda may need to focus on policy and strategy issues. We need help from the ACHR in developing regional research policies and strategies for various areas. And we need help from the ACHR in developing roadmaps for the implementation of such policies and strategies.

Our own experiences from professional practices form a very important basis for the development of such policies, strategies, and roadmaps. It will help ensure that the ground realities in our countries are clearly reflected in our research work.
At this meeting, we will also touch on the idea of “research for health”. Research for Health implies multidimensional research that has a bearing on health. It implies research efforts of various disciplines and sectors that are required for improvement of the health of all people. Research for health expands the horizon of research needs for health development. The idea of research for health fits very well with today’s health concept, the concept that extends the scope of health far beyond the medical arena.

Very importantly, research for health must also be designed to support our efforts towards equitable distribution of health resources and to help facilitate the closing of the gap between the “haves” and the “have-nots” in health. The evidence from research for health will help us better in our attempt to reach the unreached: the poor, marginalized, vulnerable and the underprivileged.

The policies, strategies and roadmaps developed at this meeting will be operationalized through timebound action plans. These plans will be developed after this meeting through joint efforts of the Member States and WHO.
With the remarkable epidemiological transitions presently taking place, it is time to revisit the subject of “Research Priorities in Communicable Diseases”. This is, in particular to review the related issues against the backdrop of “emerging and re-emerging infectious diseases”.

Scientific and technological progress through research and development in the past has led to a dramatic improvement worldwide in the control of communicable diseases. Yet, these diseases continue taking their toll. In the South-East Asia Region, people suffer a disproportionate burden of communicable diseases, compared to the rest of the world. Of the 14 million deaths that occur annually in the Region, 40% are due to communicable diseases, compared with the global average of 28%. With its large and dense population, the South-East Asia Region is at high risk for new and emerging infectious diseases.

As we have witnessed, this Region has become the epicentre of Avian Influenza. The disease is very intractable to current public health interventions. The impact of rapid urbanization and climate change on vector-borne diseases is also a matter of public health concern. Drug-resistant malaria is emerging as a potential threat to international health security. Malaria is a medical manifestation with remarkable contributions from environmental and ecological factors. chikungunya has re-emerged after 30 years of quiescence. Dengue is spreading to newer geographical areas, and we do not yet have effective preventive measures. The increasing morbidity of dengue and chikungunya is creating a serious public concern with political impact.

Regional Workshop on Research Priorities in Communicable Diseases, WHO-SEARO, New Delhi, India, 4-6 March 2009.
The Region bears one-third of the global burden of tuberculosis. Tuberculosis is a disease of poverty. For effective control of this disease, more social and economic research, as well as health systems research is needed. And the Region has the second highest HIV burden in the world. Effective preventive interventions against HIV infection been found, but not a vaccine.

Tropical diseases, like lymphatic filariasis, that are targeted for elimination still cause enormous morbidity. Other vector-borne diseases are also rampant. Each year in this Region, there is sporadic occurrence of “mysterious diseases”. The pathogens of many of these mysterious diseases could not be identified by our laboratories. There is therefore a need to strengthen our capability and capacity in the Region for their effective investigations and studies.

We have to keep in mind in this connection that during the past few decades, more than 30 new pathogens have been found worldwide. There are many environmental and ecological factors that contribute to the occurrence of these new pathogens. Diseases of animals are transmitted to man; animal pathogens find a host in man. These are some of the challenges for today’s research in communicable diseases.

We know which priority diseases have to be tackled in the South-East Asia Region. At the same time, we also need to know what types of research capacity we have to help us in tackling these diseases. We, in the Region, may not be able to afford much of the sophisticated and expensive research. Very importantly, this research of “sophistication”, in most cases, needs capital investment beyond our capacity. This type of research may be initiated and carried out with support from institutions in rich countries; or through public-private partnerships.

Our attention to research in communicable diseases may therefore be firstly focused on the application of available “know-how” and technology. This is a matter of exploitation and utilization of available know-how. It is to narrow or close the gap between knowledge and application. Certainly, at the same time, we should think of research for the development of new tools, the development that is within our means, our capability and capacity.

Furthermore, research to increase the efficiency and effectiveness of programme development and management in disease prevention and control
is indeed crucially important. To increase efficiency and effectiveness of disease control, we need, among others, operational research, social and economic research, as well as health systems research.

Now, let me touch on some issues relating to “research systems”, which are equally important in our pursuit of research priorities in communicable diseases. In the light of the “current financial crises”, we need to be cost-efficient and cost-effective, in pursuing any research. It is of overriding importance in communicable disease control, as in other areas that research needs to be geared towards the development of evidence-based policies and interventions.

Unfortunately, research has remained a neglected portfolio in the national health policy and programmes in developing countries. And research is still considered as a “luxurious” item in their government budgets. Therefore, research in these countries, is, to a large extent, dependent on outside funding and is donor-driven. This trend diverts research to areas that are not adequately geared to priority health problems of the local populations.

To be effective, research must be strictly guided by the needs and priorities of the concerned countries, and by the local health situation. The countries must take the lead in identifying and prioritizing research needs; the needs that are context-specific to address the local health problems. We need research of high quality to successfully convince national authorities of priority requirements for effective control of communicable diseases.

To have quality research, we basically need competent staff and adequate funds. This implies institutional strengthening and building country capacity in research infrastructure, in both human and financial terms. Funds should be made available as a pre-requisite for investment in strengthening human and institutional capacities for research. Certainly, it would be useful to have more funds; but, at the same time, the available funds must be optimally utilized.

In order to ensure benefits to people, the “practice of research” for health should reach out beyond academic institutions. The “practice of research” should closely involve service providers, policy makers, planners, the public and civil society. One constraint in this regard is that, due to their different interests, policy makers / planners and researchers hardly talk to each other.
Therefore, priority problems of health programmes that require investigation and research do not always get adequate attention of scientists or researchers. On the other hand, relevant and useful research findings are not always brought into national health policy and programme planning. Indeed, closing the gap between research findings and their application is a long-standing issue.

Research on priority health problems should be considered to be the primary responsibility of scientists and academicians; national health programme managers cannot afford to isolate themselves from research institutions. There is a lot of scope to integrate the research agenda of academic institutions into national health policies and programmes. These are particularly health systems research or health services research, operational research and evaluative research. To fulfill this desire energetic advocacy at policy- and decision-making level is needed.

The producers and users of research findings should work more closely to ensure application of such findings for further improvement of health outcomes. On a national scale, progress in health research can often be hindered by insufficient coordination. The success of research relies, to a large extent, on effective networking and partnerships between researchers and health programme planners/implementers. With this perspective in view, particular attention should be paid to identifying research priorities based on the needs of the specific targeted groups of populations. These are especially the poor, vulnerable, marginalized and underprivileged.

In the South-East Asia Region, these groups of populations are disproportionately affected by several communicable diseases. However, the fruits of available scientific know-how often do not benefit these people. Additionally, studies are needed to understand the unique barriers faced by the poor and vulnerable in getting access to health services, including disease control services. And studies are needed to understand how these barriers can be overcome, and health services can be made readily available to those who need them the most.

Please be convinced that we gather here now for an important and timely workshop. Let us spend this valuable time together to appreciate the contribution of priority research in the prevention and control of communicable diseases. We have to face several system challenges in our pursuit of priority
research for the benefit of affected populations. However, with unwavering determination and commitment, we can face these challenges successfully.

Before concluding, allow me also to mention the following. In research, we should look at a disease beyond its disease agent or pathogen. A disease should be viewed as a multifactorial phenomenon. A disease should be viewed from its epidemiological and ecological perspective. Such research must take into account, as much as possible, the disease risks and determinants – physical, socio-cultural, and economic, at least. To tackle communicable diseases holistically, research to support such efforts has also to be holistically designed and implemented.

In disease control, we can no longer afford to look at a disease only from the point of view of its agent or pathogen, without thorough consideration of its host and environment. I hope that, at the end of this meeting, we would have a set of recommendations on concrete actions to carry on. And, we would have a suggested road map to move towards more effective research on communicable diseases.

I am confident that the deliberations during the course of the meeting will significantly contribute to advancing, improving and enhancing national responses to the prevention and control of these diseases in the South-East Asia Region.
As we all know, primary health care (PHC) is the key to the attainment of the social goal of Health for All. It has been realized in this context that Health for All will not be attained without contribution by people from all walks of life. Very important in this context is the contribution at individual, family and community levels. This is what we call “Health for All” through “All for Health”.

This regional consultation is an attempt to highlight the importance of the contribution by individuals to health care. This is in particular to emphasize one key aspect of the contribution made by individuals. That is “self care” which is practiced by individuals.

Good self-care or effective self-care depends on knowledge and understanding of the individuals. And, very importantly, it depends on the ability of individuals to be in control of their own selves.

Effective self-care by the individuals can certainly lead to good health in the family and in the community. And self-care on a wide scale can ultimately lead to better health of the country’s entire population. For this amplifying effect of self-care to take place, a country-wide system is required for supporting its promotion at various stages. And the promotion of self-care should be carried out within the context of the country’s PHC scheme.

Self-care should be viewed as an important intervention in PHC. PHC as we know, is an integral part of a country’s health systems. Self-care, if systematically promoted, can contribute significantly to equity in health status of the population.

Regional Consultation on Self-Care in the Context of PHC, Bangkok, Thailand, 7-9 January 2009.
Promotion of self-care needs policy direction and professional support. And promotion of self-care is best pursued within the social and cultural contexts of the community.

Good self-care depends on individuals having access to the right information. The information that can enable people to make informed decisions on the care of their own health. The right information is vital for promotion of self-care.

Promotion of self-care is an educational and empowering process. The process that ensures that people with the right information can make the right decision as far as their own health is concerned. Skills in education and communication are indispensable indeed for effective promotion of self-care. Access to information, the quality of information, the ability to interpret and apply information are important to a self-care promotion process.

Self-care in a broad sense should be considered as an integral component of the continuum that runs through all levels of health care. Self-care in a broad sense goes far beyond self medication. Self-care is a matter for individuals to do things for themselves in order to stay healthy, without or with medicines. Self-care has to be seen as an integral part of promotive, preventive, curative and rehabilitative care.

One key issue for health professionals in this connection is to help people have free access to health information. The health staff has to play a key role in helping people to be able to choose the right information for their correct understanding, judgement and decision on their own health.

With professional back-up, community health workers and community health volunteers need to play this supporting role actively at community and grassroots levels. These workers and volunteers should also act as change agents to help effect necessary change in the way people practise self-care. This is to help ensure that people at those levels are doing the right things for their own health.

In such a process, health information may need demystification to make it easily understood by all people, especially those at the ground level. As far as information is concerned, there is another side of the coin that needs to be mentioned.
Health is considered to be an industry. The industry within which health related goods and services are being marketed. People also receive information through commercial channels of this market. More often than not, in such a situation, people have difficulty in differentiating between the right and not the right information. People, in general, tend to believe in what they see and what they hear through the media. The media that conveys information to them at home, at the workplace, and everywhere they go.

With advancement in information and communication technology, health messages to people have become increasingly complex. This complexity is in both the content and the process. It is the duty of health professionals therefore to help people choose and select the right information.

We may have to accept, in this connection, that not all available information is the right information for effective self-care.

And, on the other hand, advancement in ICT, if properly harnessed, can also greatly contribute to the efficiency and effectiveness of self-care promotion.

Furthermore, information on self-care may come from peers, friends and relatives. This type of information is influential for individuals in their decision-making. Therefore, when educating the individuals on self-care, we need also to think of their peers, friends and relatives. The process for today’s information flow to individuals and families needs to be well understood by health professionals in their efforts to promote self-care. Self-care, if properly promoted, can contribute significantly to a longer life. The life that has increased social and economic productivity, and the life that has more mental and social well-being.

Self-care can have a positive impact on the economy, at least, at the individual and family levels. There is anecdotal evidence that self-care has led to reduction in health expenditure. Self-care, if well managed on a large scale, can substantially contribute to poverty alleviation, especially in the poor communities. Self-care, if correctly practised, can contribute greatly to the rational use of medicines and/or to less use of medicines. It should be underlined that the use of medicines in self-care is an important subject. This aspect of self-care was also touched upon during our Regional Meeting on the Role of Education in Rational Use of Medicines held in Bangkok last year.
Furthermore, “Social control of health technology” can greatly facilitate the development of effective self-care practice. The technology in this context is the technology which is technically and operationally appropriate for use by people in the community. And it is the technology which is socially and culturally acceptable by individuals, the family and the community. For all this to happen, people must be in control of the technology which is made available for their use.

It should also be underlined that promotion of self-care needs multidisciplinary and multisectoral efforts. On a large scale, health staff alone will not be enough to achieve the objective of self-care promotion.

The role of the education sector in promotion of self-care is important indeed; this is especially when people of the entire community and the entire country are targeted. Promotion of self-care needs understanding and support from all levels of the health care systems — from the primary to the tertiary.

If the promotion of self-care is to be pursued on a national scale, government policy and commitment are the prerequisites. This is particularly so when self-care is seen as an integral part of PHC, which is practised nationwide.

Self-care is actually not new, however, its active promotion on a large scale is yet to be systematically planned and implemented. Self-care seems to be simple, but the process of its promotion is complex. Self-care may sometime seem to be a matter of common sense, but it needs a lot of professional thinking and insight.

First and foremost, understanding and appreciation by health professionals are the important starting points for effective self-care promotion. In this process, we need to gain more of such professional understanding and appreciation. And we have to understand that the right practice of self-care will not be in competition with the care provided by health professionals. Instead, self-care will undoubtedly complement in a big way the care provided by health professionals. Professional care, or care provided by health professionals, should be considered the most important contribution to the promotion of effective self-care. And, self-care should be considered and used as an important means for health promotion and disease prevention.
Various aspects of research are needed to generate the evidence necessary for self-care promotion. These aspects are:

- Identification of the socio-cultural determinants which influence self-care practice;
- The use of information and communication technology in educating and empowering people to practise effective self-care; and
- Collection and compilation of success stories of self-care in the family and community for further promotion.

Several aspects of what I have said are researchable subjects, which may be interesting to researchers and health care practitioners to pursue.

Very importantly, we have to do research to assess and evaluate the efficacy, benefit and safety of every self-care practice. And we have to pursue research to assess the contribution from self-care practice to health improvement of the population.

We still need a lot of experiences, lessons and evidence to learn and accumulate in our pursuit of health care promotion on a wide scale.

This consultation will start with the very basic question, “What is self-care?” The Secretariat will present a broad connotation of self-care for consideration of the distinguished participants.

Some aspects of self-care will be brought up for deliberation during the consultation. And the consultation will end with strategies, best practices and main activities for promoting self-care in the context of PHC.

We call this meeting a consultation. However, it is more of a seminar. I hope, however, that the distinguished participants would find this meeting interesting and useful to their work. The work that can lead to better health for all people through the promotion of self-care within the PHC context.

The WHO Regional Office for South-East Asia will do its best in supporting Member States in their efforts to promote effective self-care practice.
I specially welcome two of our eminent invitees. I warmly welcome Dr Halfdan T. Mahler, who had served WHO in the capacity of Director-General for 15 years during the 1970s and 1980s. Dr Mahler had been “the father” of Global “HFA/PHC Movement” during that period. Dr Mahler, it is indeed our privilege to have you with us at this important conference. We look forward to listening to your inspiring and thought-provoking keynote address.

I welcome Dr Amorn Nondasuta, former Permanent Secretary for Public Health of Thailand. Dr Amorn was the prime mover who extraordinarily spear-headed PHC development in his country. His work on PHC was well-known and applied not only in South-East Asia but also other Regions of WHO. Dr Amorn, we look forward to learning from your rich experience.

All of us are aware that this year is the 30th anniversary of the Alma-Ata Declaration on Primary Health Care (PHC). PHC, as we know, is the key to the attainment of the social goal of Health for All (HFA). The widening gap between “haves” and “have nots” in health has been a serious concern all over the world. It is the impediment preventing us from reaching this social goal, the goal of HFA. During the past 30 years, countries around the world had attempted to close this gap, the gap between “haves” and “have nots”, by developing and implementing their national HFA/PHC strategies. Countries in the SEA Region had been among the pioneers in the successful development and implementation of the PHC approach. Experiences of these countries will be shared during the course of this meeting.

Since we are here in Indonesia, a country which also successfully implemented the PHC approach, let me briefly mention their PHC work.
Indonesia had pursued untiring efforts in strengthening health systems based on PHC concept, even before the Alma-Alta Declaration was adopted in 1978. Through community empowerment, applying the PHC concept, the country launched the Village Community Health Development scheme during the 1960s. Following the Alma-Ata Declaration, a system of Integrated Health Post (POSYANDU) was launched. This system provided the community with integrated services of immunization, diarrhoeal disease control, weighing of under-fives, health education and several others. Today, every village in Indonesia has on an average, five Integrated Health Posts.

Recently, other innovations in community-based health care programmes have been added, such as Village Maternity Huts and Alert Village. We must congratulate the Government of the Republic of Indonesia for its success in the development of community-based health services schemes through the PHC approach. I hope we will have an opportunity during the course of this conference to learn more from Indonesia’s experience on PHC implementation.

The Alma-Ata Declaration has broadened the medical model of health to include social and economic dimensions. The Declaration acknowledged that activities of multiple sectors shaped the prospects for better health. PHC, as defined in the Alma-Ata Declaration, forms an integral part of the country’s health systems, of which it is the nucleus. PHC cannot be developed and implemented in isolation, without the support of national health systems. PHC is designed to be an important part of the overall social and economic development of the community. The application of the PHC concept has been carried out in ways that suit the local socio-cultural, economic and political context of the countries concerned. The concept of PHC has been adapted, applied and extended progressively in the process of its implementation to satisfy the dynamic health needs, both short-and long-term, in individual countries.

In reality, many different forms of PHC exist throughout the world. What forms PHC will take depend on the ground reality in countries, and on the interpretation of its concept by concerned parties and authorities. Nevertheless, experiences from the implementation of PHC in countries for the past 30 years can provide very useful lessons today, especially by the development authorities and professionals. If properly developed and implemented, PHC will be a powerful tool for public health interventions. The interventions that can help
ensure reaching the unreached, and help ensure equity and social justice in health. The unreached can be anywhere; rural or urban, and in any social class. The HFA goal will not be attained if the unreached are not reached.

It is universally accepted that during the past 30 years, PHC significantly contributed to positive changes. The changes in the ways that health systems in countries had been developed and managed. And certainly, PHC had contributed significantly to the positive impact on health of people around the world. Health-wise in general, we can agree that peoples of the world today are better off than they were 30 years ago. The application of the PHC concept has far-reaching consequences. The consequences that not only pervade throughout the health sector, but also impact on other aspects of social and economic development.

Whatever positive changes or positive consequences have taken place, these are not enough to achieve HFA. Good health for all people is still to be realized. Today, the social goal of HFA exists as an aspirational target, towards which all countries should strive in their quest for good health for all their citizens. And PHC is still considered to be the key to the attainment of this social goal. It is realized that during the past three decades, there have been many changes in all spheres; socially, economically, politically and technologically. And there have been significant transitions; environmentally, ecologically, demographically and epidemiologically. These changes and transitions have profoundly affected the ways we plan and manage our health policy and programmes today.

It is a fact that, through the application of the PHC principle to achieve the HFA goal, health has gone far beyond the confines of the health sector. Roles of other sectors are considered indispensable indeed for the attainment of HFA. More and more now, health issues are becoming the concern of the general public; and subject for public debate. The reflection of health issues in the political agenda for social and economic development is very clear today. Health is becoming more prominent on the international development agenda. With the rapid global changes and the prevailing formidable health challenges, it is now time to revisit PHC. We revisit PHC to ensure the continued relevance and effectiveness of its concept and operational modalities, in responding to the current health development needs. We must ensure that PHC will continue to
be firmly embedded as an indispensable element of public health interventions at all levels. The interventions can also help ensure timely achievement of health and health-related MDGs. These goals are important milestones in the national development agenda, particularly in the area of human resources.

This is the year of revitalization of PHC. In this process of revitalization, we have to take into account the changing scenarios not only of global health, but also global politics and the global economy. We have to take advantage, as much as possible, of the proliferation of “global health initiatives” and “international health partnerships”, in our health development efforts. These initiatives and partnerships have an important role to play in shaping global health action in support of national health development in the developing world. In the development process, social and economic determinants of health must be adequately taken into consideration when health care services are planned and delivered at various levels of health systems. Consideration of these determinants is indeed required, when health programmes are developed and implemented based on the PHC approach.

All stakeholders have to be taken on board with “strong leadership” and “fair governance”. The leadership and governance that fully recognize and respect health as a fundamental right of everyone. We have to work much harder to achieve universal coverage of health services across socio-economic groups. This is the centre stage of PHC. We have to understand that PHC is “quality care” for everyone; rich and poor; not only for the poor: urban and rural; not only for the rural. It is the care that places emphasis on protecting people from becoming sick or disabled, and promoting people to lead a socially and economically satisfied and productive life. It is an integral element of total health care for the individual, family and community. It is not second grade care as one may perceive.

At this important conference, let us once again reaffirm our unwavering determination and commitment to the attainment of the social goal of health for all through the PHC approach. Let us continue pursuing our untiring efforts to advocate for more political commitment to the development of national health systems based on PHC. Let us continue our endeavours to ensure quality care and quality services organized and delivered through the PHC approach. WHO will continue to work tirelessly in supporting the efforts of Member States towards these ends.
This meeting is one in a series of regional consultations to prepare for the Bamako Global Ministerial Forum on “Research for Health”, to be held in Bamako, Mali, in November this year. This forum is another milestone in the global efforts to ensure effective research for health.

The Bamako Global Ministerial Forum aims to review progress following the previous global health research activities, such as the International Conference on Health Research for Development, held in Bangkok in 2000, and the Ministerial Summit on Health Research, held in Mexico in 2004. The Bamako Forum intends to place “research for health” within the wider context of “research for development”. This is to ensure effective coordination of global efforts in research in tackling today’s health challenges. Within a broad context of research for health, the Bamako Global Ministerial Forum will pay particular attention to:

- Leadership improvement;
- Engagement of all relevant constituencies; and
- Increasing accountability of various stakeholders.

To contribute to the Bamako Global Ministerial Forum, this Asia-Pacific Preparatory Meeting will review the current situation of national health research. Among others, special attention will be paid to:

- Health research policy, legislation and political environment;
- Human resources for health research;
- Financing of health research;

• Research management;
• Networking of stakeholders; and
• Translation of research findings into policy and practice.

The preparatory meeting will then make recommendations on priority issues and needs for further strengthening of national health research.

The theme of the Bamako Global Ministerial Forum, “Research for Health”, is very timely. It broadens the scope and role of research in health development within today’s health concept. Research needs to go beyond traditional “health research”, which has focused heavily on health and medical sciences. Instead, “research for health” should include research efforts in any area that can have a direct or indirect bearing on health. These areas include social science, population science, veterinary science, agricultural science, meteorological science and others. “Research for health” really requires coordinated actions of various disciplines and sectors. For example, we need multipronged research that can help ensure international health security by contributing to the development of effective strategies for reducing global health threats such as:

• Climate change;
• Outbreak and spread of highly pathogenic infectious diseases, like Avian Influenza; and
• Disasters of various kinds, whether natural or man-made.

All countries in the world have committed to achieve the Millennium Development Goals. These goals are a means towards poverty alleviation and sustainable development, which are prerequisites for good health. But it is apparent now that the achievement of these goals is at risk in many parts of the world. Research support to ensure attainment of health-related MDGs, especially MDGs 4, 5 and 6, by the year 2015 is urgently required.

This year is the thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care, or PHC. We are revitalizing PHC to improve our future strategy for ensuring equity and social justice in health. For this, evidence from multidisciplinary research is needed to make PHC more effective. Additionally, the report of the Global Commission on Social Determinants of Health is being released this year. The report will help reorient health development towards a promotive and preventive strategy. Such a strategy can contribute significantly
to the development and maintenance of positive health for all. We also need multidisciplinary research to guide us in taking forward the recommendations of the Commission. Health systems strengthening is now a worldwide priority.

Without strong health systems, health programmes will not be able to produce long-term sustainable health impacts. A successful approach to health systems strengthening really needs to be backed up by health systems research. Furthermore, we badly need multidisciplinary and multisectoral research to support the development and management of public health programmes in such areas as environmental health, disease prevention and control, nutrition and health promotion. Last, but very important for “today’s global health”, we need research into the critical issue of how to ensure more efficient and effective utilization of donors’ resource inputs to support health development in developing countries.

WHO headquarters and Regional Offices, especially those for the Western Pacific Region and the South-East Asia Region, are working together to ensure the success of this meeting. On behalf of WHO, I thank the Health System Research Institute for the excellent arrangements made for the meeting.
The Task Force on Health Research and Capacity Building has been created in pursuance of a recommendation of the Thirtieth session of the WHO South-East Asia Advisory Committee on Health Research. The ACHR has always underlined the undisputed importance of research management in ensuring the relevance, quality and effectiveness of health research programmes and health research projects. The Task Force is expected to make recommendations, among other things, on building and strengthening the research management capability and capacity in countries, and on what to do and how to do so in such procedures.

For this meeting, the Task Force will help identify key issues and challenges in health research management, and help develop a framework and strategy for capability and capacity building in health research management in the Region.

At the same time, the Task Force will also help review and improve research management training modules, which are tools for strengthening such capability and capacity at the regional and country levels. Actually, most of the time of the Task Force will be spent on reviewing and improving of the 10 training modules.

Research management is a very broad area, encompassing many issues and challenges. Research management deals with, among other things, research policy and strategy at the global, regional, national and institutional levels, as well as research communication, coordination, networking and partnerships at international and national levels.

First Meeting of the Task Force on Health Research Management and Capacity Building, WHO-SEARO, New Delhi, India, 6-7 March 2008.
Management of research resources includes funds (distribution among agencies and institutions); budget allocation in countries; investment by governments in health research; management of human resources; development and retention of researchers; research support staff; and, not less important, research managers.

Some of the prominent issues in dealing with research management are:

- Management of research funds within the institutions to ensure their growth and development.
- Management of research findings, and the promotion of collection, maintenance, dissemination and utilization of research results and data.
- Research capability and capacity.
- The ability of managers and researchers to develop and implement research programmes and projects efficiently and effectively.
- Mechanism and process for research project review to ensure relevance and technical and scientific merit.
- Technically sound research methodology.
- Mechanism and process to ensure adequate ethics in research.
- Ethics committee dealing with ethical aspects of research projects and ensuring that researchers are adequately ethical in the pursuance of their research.

These are only some of the issues and challenges in research management. More are included in the training modules 1-10, to be reviewed by the Task Force during the course of this meeting.

We have many things to do in strengthening our research management capability and capacity. We do not have the capacity to do everything at the same time. We have to prioritize what we should do first, and what we might do later.

This is an issue with research planning which is an important function of research managers. However, research managers need to have competence in all aspects of research management. They should be able to manage efficiently
and effectively the research resources and facilities: financial, human, knowledge and information; and research facilities.

Activities to strengthen research management capability and capacity in countries should be accorded the highest priority. Training activities should be organized in countries, targeting primarily the research managers.

In this connection, it may be a good idea to define who are research managers. This definition, if any, may be just for our own practical operational use and may not be the same as the international standard definition, keeping in mind in the process that not all people working in research are research managers.

To develop a research institute into a full-fledged centre of excellence requires capable research managers. The managers who can efficiently and effectively mobilize, coordinate, and utilize all resources for the steady growth and development of the institution.

The structured training course we are now developing is good. It will be more effective if it is in tandem with on-the-job training, learning by doing and learning from experience.

Research managers are usually mature people; they do not actually need a detailed and structured training course. They may rather need orientation in the form of study visits to the institutions in other countries and in other regions. Coaching on the job by experienced persons is very important indeed.

I hope that at the end of the meeting we would have a framework, strategy and tool to move forward to strengthen capability and capacity in health research management in the South-East Asia Region.
The theme of the Conference, “New Frontiers in Primary Health Care: Role of Nursing and Other Professions”, is timely indeed. The topic for my talk today is “Primary Health Care towards Health for All”.

In this connection, all of us must be aware that this year is the 30th anniversary of the Alma-Ata Declaration on Primary Health Care. This Declaration was the outcome of the International Conference on Primary Health Care held at Alma-Ata, USSR, in September 1978. The Conference defined how “Health for All” could be achieved.

A year prior to the Alma-Ata Conference, the Thirtieth World Health Assembly in 1977 decided, among other things, that the social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

As far as health is concerned, this decision of the World Health Assembly was really historic. The decision has been popularly known as “Health for All by the year 2000”.

The overriding consideration underlying this decision was the increasing magnitude and severity of the world’s health problems, and the global concern with the unjust and unbalanced distribution of health resources throughout the world. The decision was based also on the consideration that health is a basic human right and a worldwide social goal. And that health is essential to the satisfaction of basic human needs, and to the quality of life of all people.

International Conference on Primary Health Care, “Primary Health Care towards Health for All”, Chiang Mai University, Thailand, 4 February 2008.
According to the Alma-Ata Declaration, Primary Health Care (PHC) is the key to achieving an acceptable level of health for all people throughout the world. PHC is an integral part of social development in the spirit of equity and social justice. PHC is the key to health for all, anywhere and world-wide.

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

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

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

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

In reality, many different forms and modalities of PHC exist throughout the world. The lessons from the use of those forms and modalities of PHC can be usefully learned today. The lessons that can lead us a long way in our quest for health for all.

It has been evident that the proper application of PHC concepts has far-reaching consequences. The consequences that not only penetrate throughout the health sector, but also impact other aspects of social and economic development, particularly at community level.
During the past 30 years, PHC has significantly contributed to positive changes in the ways that health systems in countries are developed and managed. And certainly, it has contributed significantly to the positive impact on health of people around the world.

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

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

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

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

If we are to achieve Health For All, we need the strategies and technological tools that can help us tackle today’s health problems in a much more efficient and effective manner. And these strategies and tools have to be suitable for implementation through PHC.

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

After 30 years, it is now time, however, to revisit PHC, its principles and operational modalities. This is with the view to ensuring continued appropriateness in the application, utilization, improvement and innovation of these principles and modalities of PHC.
We must recognize that adoption of the decision on HFA/2000 by the World Health Assembly in 1977 contributed to profound changes in the concepts and scope of health development. Two years after the inception of the HFA movement, the UN General Assembly adopted a resolution underpinning health as an integral part of overall development. This was an important augmentation of the expansion of health development concepts and scope. Since then, health has gone much beyond the health sector.

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

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

To ensure health for all people, multisectoral involvement in health development, either individually or collectively, is critically needed. This is “health for all by all sectors”.

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

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

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

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

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

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

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

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

The role of public health nurses may need reorientation in the light of the changing scenario in the health field, particularly in public health. It is without doubt that nurses who are performing health work right in and with the community continue their excellent contribution to health development at that level. And these nurses continue to form an important part of the team for overall community development.
PHC cannot function in isolation. PHC needs support from other levels of the health system; primary, secondary and tertiary care; this is for referral of sick people, when needed. This is necessary in order to ensure that people in the community will have an opportunity to enjoy the benefits of valid and useful technical know-how; the benefits in the advancement of health sciences and technology; and for the people to enjoy the benefits from technologies which are too complex, or too costly to be applied through PHC in the community, especially in the rural areas.

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

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

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

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

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

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

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

With this in view, while pursuing the HFA goal, we cannot expect all people to be free of disease or infirmity. The goal of health for all is actually calling for “a socially and economically productive life for all people”, not for all people to be without any suffering or ailments; physically, mentally or socially. The people may still continue harbouring diseases, silently or with a certain degree of declared morbidity. Very importantly in this context, the people should have longevity of life that is healthy enough to permit them to live independently and be socio-economically productive.

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

We all must ensure that PHC will continue to be firmly embedded as an indispensable element of any public health interventions to promote and support equity and social justice in health around the world.
Role of primary health care

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

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

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

As far as health information is concerned, we will continue using morbidity and mortality data as the main proxy indicators for indirect measurement of the level of health of the population. The efforts to identify practical parameters for directly measuring health will also gain momentum. By then, we will have more concrete evidence to develop an effective strategy for promoting positive health. While fighting illnesses and disabilities through curative and rehabilitative care, we will also have to invest more in primary prevention. This is the strategy that needs to be implemented through public health interventions with specific focus on health promotion and disease prevention.

Prince Mahidol Award Conference 2008, Commemoration Ceremony of 30 Years of Health For All / Primary Health Care on “Health in the Next Three Decades and the Role of PHC”, Bangkok, Thailand, 1 February 2008.
We understand that Health for All can be achieved through the primary health care (PHC) approach. And we have observed that PHC has significantly produced a positive impact on the health of the people around the world during the past 30 years. PHC has profoundly influenced the ways in which national health policies and strategies are developed and implemented. The reform of health systems in many countries has also been undertaken on the basis of the Health for All (HFA) principle and the PHC concept. PHC has become an indispensable component of the public health system, and functions as a system that calls for equity and social justice in health.

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

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

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

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

We are pursuing this endeavour to ensure the effectiveness of PHC in tackling current and future health threats such as climate change. We will use the PHC approach on a large scale to ensure health security in all communities around the world; and, we will use the PHC approach to ensure reaching the MDGs by the year 2015. This Prince Mahidol Award Conference is one in a series. At this meeting we reviewed various aspects of PHC, its past achievements and current challenges. We have made a series of recommendations on policies and actions for achieving a functioning PHC approach for HFA. Certainly, these recommendations will significantly contribute to the global efforts in revitalizing PHC.
Sustainable Development and Healthy Environments and Noncommunicable Diseases
At the outset, I would like to thank the Government of the People’s Republic of Bangladesh for jointly organizing this high-level preparatory meeting with WHO. And I would like to thank His Excellency Dr. AFM Ruhal Haque, Honourable Minister of Health and Family Welfare, for graciously agreeing to inaugurate the meeting. This meeting is to provide an opportunity for Member States to collectively prepare themselves to voice their concerns at the COP16. These concerns are on the health impact of climate change. The meeting will also prepare Member States for the negotiations to include these concerns in the new agreement on climate change that will benefit human health.

Bangladesh is an appropriate venue for this meeting, because the country is one of the nations “most vulnerable” to extreme weather events that are now being aggravated by climate change.

Furthermore, Bangladesh provides a good example of a successful adaptation programme against natural disasters. Climate change contributes to the frequency and severity of natural disasters.

The reality of global warming due to climate change is now universally accepted. Climate change is the result of human actions and activities. According to the 4th Assessment Report of the Intergovernmental Panel on Climate Change, there is a remarkable increase in global atmospheric concentrations of greenhouse gases. Global warming due to these greenhouse gases is undisputed. And this global warming will continue even if the concentrations of greenhouse gases are stabilized. Some effects of global warming are already
felt: more frequent and more intense heatwaves and cyclones, unusual pattern of rain and floods, and unpredictable droughts at certain places.

According to the latest report of the U.S. National Oceanic and Atmospheric Administration, the average levels of annual global temperature have continued to rise and set new records. Last June was the hottest month ever. And 2010 is the hottest year ever. In the SEA Region, about 82 000 deaths in 2002 were due mainly to malnutrition and diarrhoea. These deaths could be attributed to climate change. Rising global temperature, if not properly addressed now, will jeopardize the achievements in the field of “health-related MDGs”. Developing countries contribute the least to climate change. But, they are disproportionately affected by it. Climate change will significantly impact on all countries in South-East Asia.

An article of the United Nations Framework Convention on Climate Change (UNFCCC) emphasizes minimizing the health effects of climate change; and another article of the same document defines the adverse effects of climate change on health along with other concerns. However, this fundamental concern on health that was envisaged at the beginning has not received due consideration in the ensuing years.

The preparatory submissions to COP15 in Copenhagen focused mainly on “emission targets” and “trading”; only 4 out of 47 nations at the conference in Copenhagen mentioned “human health” as a consideration.

The report of the “Stern Review” on the “Economics of Climate Change” mentions the adverse effects of climate change on food yields, water shortages, weather disasters and species losses, but nothing directly on human health. This absence of a reference to health indicates a serious blind spot in the deliberations on climate change. Nearly all the adverse environmental, social and economic effects of climate change will ultimately threaten human health. Human biology is absolutely dependent on the stability, resilience and productivity of the environment and ecosystems; therefore, human health has to be a central criterion in the development of policies and strategies on climate change.

To make other sectors understand this reality, the health sector needs to closely engage with others in the planning process to respond to foreseeable crises related to climate change. Energy policies, for example, need to be guided
by an assessment of the impact of climate change on vulnerable populations. Carbon emissions must be reduced to avoid the worst outcome of climate change. Developing countries need rapid economic growth so that no country is too poor to successfully pursue adaptation to the impact of climate change. The principle of contraction and convergence needs to be implemented. In order to reduce global carbon emissions by industrialized nations, and simultaneously ensure accelerated economic development of under-developed countries, the health sector needs to send positive messages on health gains from well-conceived “adaptation” and “mitigation” policies. Very important among others in such adaptation and mitigation are strong health systems based on primary health care and strong public health infrastructures and programmes.

At the COP16 in Mexico, among others, I would like to suggest that the following messages from the health sector be conveyed:

- Climate change is a fundamental threat to human health that requires urgent attention and action.
- Strengthening public health programmes to control diseases of poverty such as malnutrition, diarrhoea and malaria is essential to protect the most vulnerable populations.
- Cutting greenhouse gas emissions can represent a mutually reinforcing opportunity to reduce climate change and improve human health.

I am confident that this meeting will provide useful information for Member States in preparing themselves effectively for COP16, and especially for the successful negotiations at the conference.
Human health and climate change

At the outset, I would like to thank the Royal Government of Bhutan for agreeing to host this conference in the peaceful city of Thimphu. My thanks are extended to the Honourable Prime Minister, His Excellency Lyonchen Jigmi Y. Thinley, for graciously agreeing to inaugurate this conference.

Without any doubt, the health impact from climate change is real. In order to protect human health from the adverse impacts of climate change, appropriate measures must be urgently be taken. These measures require multidisciplinary and multisectoral actions, and demand the involvement of all stakeholders and partners at both national and international levels in the most coordinated manner.

The parliamentarians’ forum can provide a suitable platform for discussing the measures to be taken against the adverse health impact from climate change and can help facilitate the required collaboration both in countries and among countries, especially at the policy level. More importantly, we are here to make our voice heard about the formidable threat to human health posed by climate change. We are here to create more political awareness, to gain more political will and commitment. The threat from climate change is steadily increasing. But worldwide, there is still an obvious lack of adequate political decisiveness and action to seriously tackle the related issues.

Several international conferences on climate change have been held during the recent past, but the health impact has not had a very high profile, and the health issues involved were only minimally discussed at such forums. Developing

Regional Conference of Parliamentarians on “Protecting Human Health from Climate Change”, Thimphu, Bhutan, 5-7 October 2010.
countries contribute the least to climate change but they are disproportionately affected by it. Even in developed countries, we still need more political will and commitment to deal with health problems contributed by climate change.

The reality of global warming due to climate change is now universally accepted. The effects of global warming are already felt in many forms:

- More frequent and more intense heat waves;
- More cyclones with more devastation; and
- Unusual patterns of rain and floods in some places, and droughts in others.

Sea levels are rising, and the snow and glaciers that supply fresh water to many of our populations are receding. Climate as an important “determinant of health” is historically established. Changes in climate certainly affect human health. The change of climate alters the equilibrium of the human ecosystem. Climate change threatens the basic elements of health security and human existence. As an example, in 2000 about 82,000 deaths, mainly from malnutrition and diarrhoea, could be attributed to climate change in the South-East Asia Region.

Rising global temperatures and resulting changes in the climate, if not promptly and properly addressed, will jeopardize the achievements of the Millennium Development Goals. This will be among several other development drawbacks due to climate change. Rapid glacier melt, as projected, will initially increase flooding and rock avalanches. The shrinkage of glaciers will ultimately result in reduced water supply and food sources in the larger river basins. Rising sea levels will result in large-scale migration of populations who live in low-lying coastal areas and small islands. The situation will certainly bring about social disruption, mental health problems and political turmoil.

Scarcity of water or too much water or floods will affect agriculture and sanitation. This situation will lead to health problems due to malnutrition, diarrhoea and other water- and food-borne diseases.

Recent observations indicate that species of mosquitoes transmitting malaria, dengue and encephalitis are now found at higher altitudes in the Himalayas. Nepal and Bhutan started reporting cases of dengue for the first
time in 2004 and 2006, respectively. Climate change is thus aggravating the problems of vector-borne diseases. It will increasingly exacerbate public health problems in the populations.

Responding to the health impact of climate change does not mean, at least at this stage, creating new public health programmes. Rather, the available public health interventions must be urgently strengthened to ensure their effective implementation. None of the health outcomes due to climate change is inevitable. It can be modulated by appropriate policies and programmes of the relevant sectors, developed and implemented through efficient coordination and cooperation.

Health is everyone’s concern; all stakeholders must get involved urgently in a synchronized manner. Health should be at the core of all responses to climate change. Awareness generation is an important first step in planning for action in this regard. In this connection, Member States need to reaffirm their commitment to the World Health Assembly resolution on “climate change and health”, adopted in 2008, and to reconfirm their commitment to the New Delhi Declaration on the impacts of climate change on human health, adopted by the Health Ministers of the Region in the same year. Research is needed to assess vulnerability, envisaged migration, adaptation options and health impact. It will have to be multidisciplinary and action-oriented research. Health infrastructure, both public health programmes and public health workforce, need reorientation, strengthening and effective back-up support.

The adaptive capacity of vulnerable populations must be ensured through the implementation of priority public health interventions, which may vary according to specific situations in countries. The most vulnerable populations are the poor, small farmers, urban slum dwellers, tribal people and those living in coastal areas, on small islands and mountains.

There is also a need to develop an integrated strategy for incorporating current and projected risks of climate change into existing policies, legislation, and measures of key development sectors.

This is in order to ensure effective control and containment of the adverse health outcomes. For immediate action, we need to facilitate the participation of our health sector in preparing national representation at the 16th Conference
of Parties of the UN Framework Convention on Climate Change known as COP16. This conference is to take place in November in Mexico. And, in this connection, we have to ensure adequate inclusion of health issues as the core elements in the negotiation process at COP16. There will be a Regional High-Level Preparatory Meeting for COP16 in Bangladesh from 19-21 October 2010.

WHO is firmly committed to providing technical guidance and support to the Member States in building their capacity to be able to effectively carry out the health impact and vulnerability assessment. This is particularly within the health arena as well as between concerned disciplines. WHO will facilitate knowledge-sharing and networking on “climate change and human health”. Internationally, WHO is not the only agency to support Member States in dealing with the health impact from climate change; there are other international organizations, both within and outside the UN system. This Regional Conference of Parliamentarians aims primarily to increase awareness and understanding of health-related issues due to climate change, and to identify collaborative actions for the effective protection of human health from climate change in the South-East Asia Region.

Tackling health problems relating to climate change demands world-wide efforts, with contributions from many countries and regions. We now need to take collective action for the SEA Region, which will contribute to global endeavours.
It is timely to discuss this topic in view of our efforts to revitalize primary health care (PHC) in the South-East Asia (SEA) Region and in view of the increasing frequency and severity of emergencies due to disasters.

A number of regional meetings in the area of PHC have been organized during the past two years, and “innovations” in the PHC approach have been developed in several countries.

In Bangladesh, the government’s scheme on “community health clinics”, aiming at universal access to health services, especially in rural areas, has been a laudable development. At this gathering, we will capitalize on what has come out from our experiences in revitalizing PHC. We will also see how the PHC approach can help protect the affected population when disasters strike and how it can help ensure availability of necessary health services; before, during, and after any emergency. Not only do they cause death, disasters also threaten lives by increasing the risk for disease; decreasing food security; diminishing access to basic services; and endangering water safety.

We all know that the SEA Region is prone to disasters and we know that climate change is further increasing the possibility of disasters. All countries in the Region are affected by climate change. During 1999 to 2008, about 62% of the total global deaths from natural disasters took place in the SEA Region.

During the same period, the number of disasters in Asia represented around 44% of the reported events worldwide. Some examples in the recent

Regional Meeting on Primary Health Care Approach in Emergencies, Dhaka, Bangladesh, 28-30 September 2010.
past show that several major disasters in the SEA Region impacted country development.

For example, the devastating Tsunami of 26 December 2004 left an estimated 230,000 dead or missing, and contributed to losses estimated at several billion US dollars.

In 2007, cyclone Sidr hit Bangladesh, resulting in an estimated 3,000 deaths and losses totaling about 1.7 billion US dollars.

In 2008, cyclone Nargis struck Myanmar, and resulted in about 134,000 deaths or “missings” and losses of about 10 billion US dollars. In these crises, the existing “inequities” in both social and economic terms were amplified. New social and public health problems emerged. The prevailing health problems were aggravated. Sadly, the people who are hit the hardest are the vulnerable, including the poor, women, children, those with disability and the elderly. This is an important humanitarian issue.

Universal coverage in humanitarian health action during crises is needed. This action includes the provision of a package of necessary services that are extended to all affected areas in an equitable manner. Adopting the “primary health care approach” means putting people at the core of humanitarian action – action that can ensure effective health protection through promotion of community participation and intersectoral collaboration; “community-enhanced resilience” during emergencies; and the ability of people in the community to take appropriate action.

Protecting health, livelihoods and assets during the response phase of an emergency and addressing the root causes of crisis in the recovery phase provide a better chance for sustainable impact from emergency management efforts. With limited external help during the first week of the crisis, a coordinated response from the community and local government determines the positive outcome of the efforts.

The health of affected people during crises depends on the capacities of health systems to effectively address emergency health needs. Applying the PHC approach has proven to be the best strategy, and cost-effective investment in health in any situation. This is not only to ensure “equitable access” of the
population to essential quality health care but also to reduce vulnerabilities and enhance resilience of communities.

Additionally, the PHC approach will eventually promote and ensure self-determination and self-reliance of people in community and as a consequence, it will reduce dependence on external assistance. Humanitarian health action is not just meeting the basic needs in the short term but rather a means to promote “social justice in health”, and to fulfil the fundamental right to health in the long term.

The success of humanitarian health action depends on effective implementation of the PHC approach. Preventive measures through primary health care with well-planned preparedness are more cost-effective than action in response to damage that is already done.

The cost generated by the increasingly frequent natural disasters is one of the most important lessons that warrant more investments in PHC as it emphasizes prevention while maintaining a good balance with treatment.

Several examples of commendable results from implementation of the PHC approach during an emergency have been demonstrated; in the 2004 Tsunami – effective and urgent interventions during the first hours of emergency by trained health volunteers in Thailand and Indonesia; and in Cyclone Sidr in Bangladesh where community-based actions took place in response to “early warning” and evacuation.

In these events we saw the strength of combined efforts of various sectors with civil society, NGOs and the private sector; the coordinated and synchronized actions on the ground multiply “community capacities” in preparedness and response. Although these sound simple, the challenges are immense, and it takes time to turn such thoughts into action.

There are several fundamental constraints like inappropriate policy that focuses mainly on response rather than preparedness; change that drives focus away from community involvement and actions; unavailability of “community-based workers” or volunteers; lack of capacity in the community to respond effectively to an emergency situation; inadequacy of information systems relating to “early warning” and “surveillance”; and inefficient coordination at both national and subnational (field) levels.
These are some of the main challenges that are faced in adopting the PHC approach in emergencies. However, it is important also to look at the positive aspects for our future endeavours. The disasters that occurred during the recent past have actually brought about greater awareness at various levels; awareness of how community resilience can be improved through strengthening of “health systems based on the PHC approach”, through empowering people in the affected community to mobilize the local resources, especially human resources, for helping themselves during the first 24 hours of an emergency.

In several countries in the Region, individual sectors take emergency action during crises according to their respective responsibilities. “Disaster risk reduction” and “emergency health preparedness” are considered integral parts of health systems. “Health systems based on PHC” are used to build community resilience and resistance to devastation and “health systems based on primary health care” are providing a concrete foundation for effective emergency preparedness and response.

Planning for health in disaster management needs to aim at inclusive and participatory involvement; and key preparedness strategy also includes development of “self-care”; especially at individual, family and community levels. The preparedness strategy includes the important component of improvement of knowledge and communication skills of community-based health workforce.

The issue of equity is fundamental to the development of disaster preparedness and response plans. With this perspective in view, we can see that there are numerous opportunities to achieve our aim in this challenging area.

Through sharing of our experiences, we will be able to help each other find effective means and ways to move forward. This meeting is a platform for exchange of information and learning together so that the “best practices” can be applied and adapted within our own countries’ social, cultural and governance systems.

Let us also work tirelessly in empowering our people through the PHC approach, to enable them to help themselves effectively during the first hours of crisis.
The World Health Organization is very happy to collaborate with UNESCAP, the Royal Thai Government, and others in organizing the First Community-Based Rehabilitation Congress in the Asia Pacific Region.

This Congress will take us a long way in furthering our partnerships and strengthening our bond of working together. For the approximately 650 million persons around the world living with disabilities, their exclusion from the mainstream of development efforts has been permitted for too long.

We need to work together more effectively to change this scenario. The year 2008 was a watershed for us to have an international instrument to make a difference for persons with disabilities.

It was the year that the UN Convention on the Rights of Persons with Disabilities (CRPD) came into force; it is a concrete framework for all concerned to move towards further improving welfare of the disabled.

The Convention is guiding us in our efforts to promote and protect human rights and fundamental freedoms of all persons with disabilities; it promotes respect for their inherent dignity as human beings.

WHO started Community-Based Rehabilitation (CBR) following the Alma-Ata Declaration on Primary Health Care (PHC) in 1978 through the community-based approach, which is enshrined in the PHC principle; the right to health of all people, including those with disabilities, has been actively promoted.

The First Asia Pacific Community-Based Rehabilitation Congress, Bangkok, Thailand, 18 February 2009.
CBR provides persons with disabilities an opportunity to get access to rehabilitative care and services in their own communities. As a result of a 25-year review of CBR work in 2004, ILO, UNESCO and WHO repositioned CBR to be the key strategy for rehabilitation. Community-based rehabilitation also helps to ensure equalization of opportunity, poverty alleviation and social inclusion of people with disabilities.

In a broader context, PHC contributes to health equity, social justice; and ultimately to the well-being of all people in communities. Therefore, CRPD, primary health care and CBR, are reinforcing each other; and WHO is committed to their implementation.

In 2005, the World Health Assembly through Resolution WHA 58.23 made a global appeal, urging Member States to increase attention, commitment and actions in the area of disability. These include prevention and management of disability, and rehabilitation of the disabled in both physical and psychosocial domains.

WHO strongly advocates for the removal of health and social barriers against people with disabilities; in this or other contexts, WHO focuses its contribution on the areas where it has a comparative advantage, where it can make a difference. This is specially with regard to the strengthening and further development of community-based rehabilitation.

Among others, assistive medical devices are provided as an important part of CBR services. In addition, CBR improves the collection of data to support policy development within the context of CRPD. Both CRPD and CBR are about accessibility and inclusion.

Inclusion means inclusive schools, inclusive health care and inclusive workplaces in communities. In this connection, a Taskforce on Disability has been set up in WHO to ensure the inclusiveness of people with disabilities.

Attempts have been made to ensure that these people are fully involved in all spheres of the development process taking place in the Organization. Efforts will continue to be made to increase awareness of CRPD and its implications on the work of WHO.
Next year, a world evidence-based “Report on Disability and Rehabilitation”, developed jointly by WHO and the World Bank will be released. The report will provide information on the global status of disability, rehabilitation and life experiences of the affected persons. The report is also intended to enhance collaboration across sectors and disciplines.

In bringing about the necessary change that can benefit persons with disabilities, the report can be used to promote full participation of those persons in every facet of daily life.

Support to Member States on the development and management of rehabilitative services has been an important part of WHO’s work.

WHO is moving forward to ensure that these services, which are provided within the CBR framework, are evidence-based and scaled up on a technically sound basis.

Furthermore, a set of Guidelines on Wheelchair Production in Less Resource Settings was launched last year. These guidelines were developed with support from Prosthetics and Orthotics International Society and USAID. This set of guidelines is an important tool for Member States to develop a system for provision of wheelchairs.

No less important, WHO, in partnership with ILO and UNESCO, is facilitating the preparation of operational guidelines on community-based rehabilitation. These guidelines will provide hands-on direction on how development initiatives can work at community level to ensure the rights of persons with disabilities.

The focus of this Congress is community-based inclusive development for people with disabilities and their families. To achieve inclusive development, CBR cannot be solely delivered by one ministry or one sector; CBR needs multisectoral and multidisciplinary actions.

People with disabilities and their representative organizations must be centrally placed in the process of CBR development and implementation. WHO will continue to work with all stakeholders and partners in scaling up CBR activities, and thereby contributing to the building up of inclusive communities for people with disabilities.
CBR is a multisectoral, bottom-up strategy that contributes to the objective of CRPD; this is particularly so in effecting a positive change at the grassroots level. The change that ensures accessibility and inclusiveness of persons with disabilities.

CBR requires participation of a broad range of stakeholders and partners in order to meet the basic needs of the disabled; CBR addresses social determinants that ensure access to health care, education and livelihood.

One of the expected outcomes of this Congress is the formation of the CBR Asia-Pacific Network; the network that will promote progressive and steady development of CBR in the Region. WHO is looking forward to working closely with the network.

In order to ensure that people with disabilities and their families can live in harmony with communities, all concerned parties must work together in coordination and cooperation to make this vision a reality.

This Congress is a necessary step to provide an opportunity for practitioners and researchers to chalk out their roles in effecting a paradigm shift. The shift from a charity to a rights-based approach to disability and the roles that can ensure a prominent place for community-based rehabilitation that builds up inclusive communities for persons with disabilities.
First, I would like to congratulate the World Diabetes Foundation for taking an important initiative in organizing this Summit. The Summit will highlight, among other things, the growing epidemics of diabetes and other related noncommunicable diseases in the South-East Asia Region. It will provide a platform for multiple partners to discuss and initiate coordinated actions to address this public health challenge. Only united action can lead to long-lasting results in the fight against these diseases. Acting in partnership and applying multisectoral approaches are the best ways to tackle these scourges.

Morbidity and mortality due to diabetes and other major lifestyle-related noncommunicable diseases are increasing across all social and economic strata in this part of the world. Middle-aged adults in the SEA Region show disproportionately high death rates due to NCDs compared with those living in more developed countries. Premature death in the productive phase of life poses a serious challenge to societies and to their economies. If appropriate and timely public health actions are not initiated, disability and death from diabetes and other NCDs in this Region will grow by more than 21% over the next ten years.

According to 2007 estimates, there were 54 million diabetes-affected people in the South-East Asia Region. This number is anticipated to increase by 71% by 2025. India, due to its very large population, has the highest number of people with diabetes in the world, nearly 41 million. The prevalence rates of diabetes in adults in countries of the Region range from 2% to 8%. High rates between 7% and 8% are reported from India, Maldives, Sri Lanka and Thailand.

Diabetes Summit – South-East Asia, Chennai, India, 28-30 November 2008.
Information from available studies indicates that 30% to 80% of people with diabetes are not aware of their diabetic status. In this Region, the mortality attributable to diabetes is estimated at 1 million annually. Most people with diabetes die of late vascular complications such as ischaemic heart disease, stroke and renal failure. These deaths, though directly attributed to diabetes, are often not counted as diabetes-related deaths. As a result, the health impact of diabetes is substantially underestimated.

If the related factors are properly adjusted, diabetes-attributed death may be as high as 12% of the total mortality due to all causes. At this rate, the disease will be placed among the top five leading causes of death. There is however a contradiction in this connection. Only 20% of global expenditure on diabetes is spent in low- and middle-income countries, where up to 80% of people with diabetes live. The cost of medical care for diabetic persons goes mainly towards treatment of high blood sugar (hyperglycaemia).

“Primary prevention” of diabetes needs much more attention at all levels. Available evidence points to the central role of common risk factors of diabetes and other major NCDs. These include imbalanced diet, physical inactivity, obesity, tobacco use and harmful consumption of alcohol. These risk factors are highly prevalent in countries of South-East Asia. There is also a remarkable variation in the prevalence of individual risk factors, which reflects the complexity of the situation. Hence, there is a need for targeted public health interventions to suit specific national, subnational and local settings.

The current threat from diabetes and other major NCDs can be overcome with the use of available know-how. Interventions that are comprehensive, population-based and risk factor-centered can ensure effective reduction in the occurrence of these diseases. When these interventions are applied in an integrated manner, they can prevent at least 80% of diabetes, heart diseases and stroke.

The main strategy of the WHO programme on prevention and control of NCDs targets major risk factors. The strategy that is pursued through risk factor surveillance; and management of these factors through integrated population-based interventions. The strategic direction of WHO programme development is to move towards a well-defined package of integrated interventions, which are based on primary prevention through health promotion and disease prevention.
These interventions must be integrated operationally into the general health service systems.

This strategy will ensure that such interventions, with risk factors as the entry points, will reach the entire population, in both urban and rural areas. The strategy will enhance a “positive health approach” that ensures long-term sustainability of health gains from prevention and control efforts.

It is now recognized that the environments in which we live, work and rest are the genuine sources of chronic NCDs. Unhealthy human behaviours and lifestyles are to blame for diabetes and other major NCDs. These behaviours and lifestyles stem from specific socioeconomic, physical, cultural and political environments in the individual countries. Modification of these underlying determinants requires multidisciplinary and multisectoral approaches. These approaches involve all relevant sectors, public and private partners, as well as civil society groups.

A modest investment to modify or improve environments can go a long way in yielding significant public health and economic benefits. The interventions that are targeted at unhealthy environments are less expensive. Furthermore, these interventions can ensure more sustainable gains in the long term than an individual lifestyle approach.

Over the last six years, the World Diabetes Foundation has been an important advocate of actions against diabetes and other NCDs that aim at improving the quality of life of people with diabetes around the world. With support from the World Diabetes Foundation, over 49 projects have been developed and implemented, involving most countries of the SEA Region. WHO-SEARO is really proud to be a cosponsor of this important Summit along with the International Diabetes Federation and the World Bank.

The Summit will certainly provide an excellent opportunity and platform for us all to review the lessons learned from our past experience accumulated during the long course of our collaboration. The Summit will also help refine our priority directions and further strengthen our future collaborative actions as well as our firm determination and commitment to effective coordination of all partners and stakeholders. Indeed, the Summit has a crucial role to play in the prevention and control of diabetes in this Region and in other parts of the world.
Illicit trade in tobacco products

World-wide, tobacco use is one of the most pernicious public health threats today. Developing countries are generally the main target for expanding the market for the deadly tobacco products. Out of over five million annual deaths from tobacco consumption worldwide, 1.2 million occur in this Region alone. Illicit trade in tobacco products has contributed very significantly to the global problems of tobacco use and is emerging as one of the biggest obstacles to the control of tobacco use in developing countries. Illicit trade adversely affects health as well as socioeconomic development. It creates easy access to tobacco products at lower price, fuelling their spread.

This situation has important public health implications that lead to a number of debilitating illnesses. It also results in loss of revenue for countries. It adversely affects the implementation of demand reduction strategies for the control of tobacco use, such as raising prices and taxes. The desired impact of these strategies depends, to a great extent, on how successfully illicit trade is suppressed.

Many countries in the South-East Asia Region are losing millions of dollars in revenue due to smuggling, illicit manufacturing and counterfeiting of cigarettes and other tobacco products. Data from the South-East Asia Region reveal a significant degree of illicit trade in a number of countries, and the extent of the industry’s involvement in this illegal act. Illicit trade has really become a serious concern in our efforts to control tobacco use in this part of the world. This damaging illicit trade is a result of the unlimited desire for profits of the industry, and the involvement of industry.

Regional Workshop on Illicit Trade in Tobacco Products, New Delhi, India, 15-16 September 2008.
The control of illicit trade in tobacco products is a supply-reduction strategy in the WHO Framework Convention on Tobacco Control (FCTC). The second session of the Conference of Parties requested a Protocol to the Convention on Illicit Trade in Tobacco Products. An Intergovernmental Negotiation Body to negotiate the Protocol (INB) was formed. Its first session took place in February 2008 and its next session will be in October 2008. Countries in the SEA Region are now being given an opportunity at this workshop to consider the “Text of the Chair of INB”, which was drafted at its February session.

This workshop is intended to make a preliminary assessment of the issues involved in the Text of the Chair, and the issues that concern the South-East Asia Region in particular. The discussions and debates on these issues also need to take place at the country level, involving all concerned sectors. Illicit trade is complex indeed; a number of stakeholders are involved, domestically and internationally. We need to deal with this issue in the right perspective. Given the ground realities in the South-East Asia Region, the issues may be dealt with in three broad areas: control of the supply chain, capacity-building for enforcement of laws and regulations, and international cooperation. Details will be elaborated during the course of this meeting.

From the point of view of public finance, developing countries are faced with the fact that taxation is an important part of the revenue system. Strengthening revenue through taxation is essential for them. The health of people must be taken into serious consideration when building a strong revenue system. However, many times health issues become peripheral, and are considered subsidiary to those of public finance. It needs to be made clear to the countries that protecting the health of the public from the epidemic of tobacco use is no less important. In fact, this health protection will lead to better economic productivity from a better quality, healthier workforce.

There is an urgent need for effective collaboration among concerned sectors in dealing with the issues involved in illicit trade. For effective control of illicit trade, it is critical to enhance knowledge, and create appropriate understanding among policy- and decision- makers in the government. This workshop provides an opportunity for concerned stakeholders to take part in a dialogue and to enhance their effective cooperation in this important area.
Health Systems Development
In view of the prevailing situation in the area of medical care services in several countries of the Region, it is timely to revisit the issue of “Doctor-Patient Relationship”.

The doctor-patient relationship is an important determinant of quality health care, especially medical care. Doctor-patient relationship is built on a solid foundation of “trust” and “empathy”. Trust and empathy that comes from effective communication and interaction between doctors and patients. Patients, as human beings, come to health facilities with their own expectation for care. Care of not only their body, but also their “mind” and “soul”. They (the patients) expect fair treatment from the health care systems.

We (the health-care providers) need to recognize health of everyone as a “fundamental right”. We should treat the patients with the principle of equity and social justice in mind. The patients also expect us to respect their dignity as human beings.

The breakdown of the doctor-patient relationship, due to any reasons, will lead to mistrust between them. This mistrust can lead to patient dissatisfaction and resentment that may cause medical litigation against doctors. In this situation, it is natural that doctors have to protect themselves; among other things they do is to secure “malpractice insurance”. Doctors become more careful in their practice. Doctors may not rely much on “clinical approach” in dealing with patients — the approach that can strengthen and maintain good relationship between doctor and patient. Doctors will use more sophisticated

Meeting of Experts on Doctor-Patient Relationship, WHO/SEARO, New Delhi, India, 15-16 February 2011
tools for investigating the causes of illness. Doctors use newer medicines to ensure full expectation of cure of the disease. This phenomenon certainly will lead to, among other things, high, and eventually skyrocketing health care costs. The situation whereby a vicious cycle is formed between patient dissatisfaction; mistrust; medical litigation; over-investigation as well as over treatment; and high health care cost.

Doctor-patient relationship has a critical role to play in this vicious cycle. Communication between doctors and patients must be adequately effective. Interaction between doctor and patient must be appropriate enough to create better understanding on both sides.

To ensure such a communication and such an interaction, doctors need to have and spend enough time with patients. It is difficult indeed for doctors to have enough time for all these aspects. Doctors today are overburdened with the huge number of patients coming for care. This situation will never end – people will continue getting sick and they will keep coming to get help from doctors. One of the important contributions to this situation is the design of our health-care services delivery systems, the systems that are mainly designed to wait for people to get sick and come for treatment inspite of the prevailing national health policy on “health promotion” and “disease prevention”, whereby people can be kept healthy as much as possible, not to fall sick easily or often; and not to overburden the treatment facilities.

The governments’ investment is still too heavy in the development of infrastructure that is in favour of “treatment” at the cost of “prevention”. Furthermore, the failure of referral systems of health care leads to bypassing of patients in particular, to secondary and tertiary levels without proper reasons. And also, the lack of appropriate task shifting – delegating some simple medical procedures to other relevant professions at various levels of health-care systems. These shortfalls contribute significantly to the overburn of doctors that jeopardize doctor-patient relationship.

We have to continue our efforts in convincing the governments to pay more attention to promotive and preventive care, the care that can reduce the burden of curative services institutions. We like to see the development of health services delivery that really keeps the right balance between promotive, preventive, curative and rehabilitative care.
These are system issues or problems of the system that need long-term efforts from all of us to tackle. On the other hand, our immediate attention is now required in helping doctors and patients strengthen their relationship, the relationship that can create the climate and environment that is conducive to positive interaction between doctors and patients, the interaction that can contribute to effective curative services and to the quality of medical treatment.

The subject of the doctor-patient relationship needs to be attentively revisited in the development and implementation of medical education programmes. These programmes can be important entry points for strengthening the doctor-patient relationship. This is primarily the role of medical schools, medical colleges.

Attention also needs to be paid to the ethical code of medical practice. We may need to see how this ethical code is implemented to ensure positive relationship between doctors and patients. This is primarily the role of medical councils and medical professional bodies, such as medical associations. Fairness for all in medical practice must be ensured by medical/health care service facilities. As much as it can be done, it has to be ensured that doctors have enough time with their patients by reducing doctors’ workload; promoting preventive care by other professions; and delegating simple medical treatments to others.

On the other hand, for the patients, they need to be adequately educated to clearly understand the functioning of health-care systems; to understand the roles of various professions, including doctors, who provide public health and medical services; to understand when and where to go for care, and at what level of the health services delivery system.

And, very importantly, the patients or people in general have to be educated and empowered to be able to take effective care of their own health. This is self-care – self-care at individual, family and community levels. Educating people to be functionally literate in self-care is an essential element for strengthening the doctor-patient relationship.

With today’s advancement in IT, patients can receive information about health from various sources, and from various directions. They, the patients are
flooded with information, and often they are confused and misled. The patients may not need to be more informed, but they need to be better informed to better understand their doctors and medical practice.

We need to keep in mind also that all patients basically love, and highly respect their doctors. And they expect doctors to love them and respect them also. Doctors too need to better understand their patients, to understand not only the patients’ sickness; but also their social, cultural and economic profiles, not less important, to understand the patients’ expectations. And, if needed, try to help reconcile such expectations, expectations of patients and expectations of doctors.

We all know well that the patients need to be treated holistically: their physical, mental, and social health, and treated with sympathy and empathy. However, this holistic treatment cannot happen perfectly because of many reasons. I am sure all of us are aware of those reasons.

It will take us a long way in further strengthening the doctor-patient relationship if the principle of PHC is effectively applied at all levels of health-care systems. If there is more investment in promotive and preventive care, if medical workforce is more rationally utilized, if primary care with the addition of “family doctor” is developed and is fully functioning in all villages of countries, and so on.

These are some of my thoughts relating to today’s doctor-patient relationship. The Secretariat has developed a draft strategic framework for addressing the issues. This draft reflects our primary thinking about what may need to be done to further strengthen the doctor-patient relationship. We look forward to your guidance in improving and refining this framework. Your experiences and your combined wisdom will be most useful in guiding us in further development of the framework, the framework that is suitable for application within the social and cultural context of countries in the South-East Asia Region.
Irrational use of medicines continues to be a very serious public health problem worldwide. Less than half of all medicines prescribed at the primary-care level are in compliance with standard guidelines. We have spent a lot of effort to promote the rational use of medicines through the education of health-care providers. It is very difficult to change their behaviour and practices.

However, we will continue our efforts in educating the health-care providers. At the same time, we have also to do more in educating the consumers, the community and the public at large. These people are at the receiving end of the impact of irrational use of medicines. This education should start at as early an age as possible, irrespective of whether they are currently using the health-care facilities. To get better results, people themselves must be empowered to be able to decide and do things themselves, for their own health.

In countries, there needs to be awareness and strong advocacy at the policy and decision-making levels. There must be complete political understanding, strong political will, and sustained political commitment in promoting rational use of medicines. In addition to doctors, pharmacists and nurses, many different groups of people must be involved in the process of this promotion, for example:

- teachers, schools.
- women’s groups or representatives.
- NGOs, civil society.
- consumers groups.

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Intercountry Meeting on Promoting Rational use of Medicines, SEARO, New Delhi, India, 13-15 July 2010.
Promotion of rational use of medicines requires multidisciplinary/multisectoral inputs and actions. This education of people must aim for functional literacy whereby everyone understands that while medicines can cure very effectively they can also cause much harm to health if taken incorrectly or inappropriately.

Now, I separate medicines from dietary supplements. And everyone should be made to understand that with proper health care, and emphasizing health promotive and preventive care, one would be able to stay healthy without the unnecessary use of medicines.

To emphasize the importance of education, a regional meeting on the Role of Education in Rational Use of Medicines was held in 2007. At the meeting, a regional strategic framework was developed to promote such a role of education, particularly for consumers and the public at large. Following the meeting, a number of small projects in this area were undertaken in various countries. The results from the projects will be shared during this meeting.

I hope that you would be able to draw from these results valuable lessons on what works and what does not work in promoting the rational use of medicines. However, all the projects undertaken were only small-scale; we need to think about how to scale up these projects to obtain more accurate results.

At the regional meeting in 2007, it was also concluded that irrational use of medicines is hazardous and wasteful. The current efforts to control it are not adequate. There is a need to further strengthen the rational use of medicines component of the national medicine policy in countries. We all agree that much more needs to be done to educate consumers and people in general on promoting the rational use of medicines.

At the regional level:

- The regional strategy and plans of action will need further strengthening, and their implementation intensified;
- More WHO Collaborating Centres for rational use of medicines need to be designated;
- Generic protocol for situational analysis needs to be reviewed and
updated for country use, in preparing national plans of action to promote rational use of medicines;

- Resource mobilization needs particular attention, to secure funds for supporting activities related to rational use of medicines;
- WHO will continue advocacy, awareness building, and providing technical and financial back-up to country activities; and
- WHO will continue organizing regional meetings to encourage information sharing and intercountry collaboration.

At the country level:

- There is a need for “high-level multidisciplinary/multisectoral mechanisms” for monitoring and evaluation of activities related to rational use of medicines;
- There must be multidisciplinary/multisectoral involvement in the implementation of national plans of action on rational use of medicines;
- Country situational analysis need to be regularly undertaken as the basis for updating national plans of action;
- “Medicine Information Centres” have to be established in each country; and
- “National formularies” and “lists of essential medicines” need to be regularly reviewed and updated. These formularies and lists can significantly contribute to the proper use of medicines.

At the consumer level:

- To develop structured educational programmes, targeting all members of the community/society through a coalition of stakeholders;
- To undertake a variety of different activities using “persuasive” and “participatory” approaches to providing information to consumers, including:
  - face-to-face sessions;
  - group discussions;
  - public campaigns;
– dissemination of printed materials;
– curricula development for education in schools; and
– advocacy through the media and lobbying.

• To develop/update certain tools for education, including:
  – standard treatment guidelines;
  – programmes for “training of trainers” within communities; and
  – education programme involving mothers’ and women’s groups.

Adequate funds must be made available to sustain rational use of medicines activities at the consumer level. The means and ways must be found for mobilization of funds at this level. These are among the other areas to be discussed during this meeting. We have many things, maybe too many things, to do in promoting the rational use of medicines. However, our capacity is finite; therefore these areas need to be prioritized.

We need to identify and select the areas that can be best taken forward within the Strategic Framework developed in 2007 for the SEA Region, and within our current capacity. Work in promoting rational use of medicines is difficult. However, with our unwavering determination and continued commitment, good results can be achieved through our combined wisdom and joint efforts.
Decentralization of health-care services

It is indeed timely to review and discuss the issues relating to this important subject. It is timely because all countries worldwide are now attempting to achieve several time-bound health targets. Most important among these are the targets for the achievement of the health-related Millennium Development Goals (MDGs).

Decentralization of health-care services is an essential element of health systems strengthening (HSS). This is to ensure improved effectiveness of public health interventions that can lead to the achievement of those goals. The aims of decentralization of health-care services are to improve the “efficiency” of their delivery and the “equity” of their outcomes.

Decentralization helps ensure availability and accessibility of the services to all people in need. Globally, such decentralization has been launched in various forms. However, its achievement and success varies from country to country. Unfortunately, in developing countries, decentralization of health-care services is rarely evaluated.

During the past many years, decentralization has become one of the common government policy measures. Much of decentralization has been motivated by political concerns. Decentralization is an important tool to improve governance. It is a dynamic political process, a learning process, a mix with centralization. Decentralization should not be seen in isolation as a separate entity. It is an integral part of the country’s governance system.

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Regional Seminar on Decentralization of Health Care Services in the South-East Asia Region: Perspectives and Challenges, Bandung, Indonesia, 6-8 July 2010.
Decentralization is very much context-specific. The contexts are:

- Political
- Geographical
- Social and economic.

Though the countries can effectively learn from the experiences of each other on decentralization, comparing decentralization “outcomes” between countries is not easy. This regional seminar is a continuation of the:

- Regional Meeting on Revitalizing PHC in 2008, and the
- Regional Meeting on Health Care Reform in 2009.

The primary intention of the seminar is to look at decentralization of health-care services within the context of health systems based on PHC and within the context of health-care reform. Among others, certain important components of decentralized health care systems may be particularly examined in this connection. These are:

- Referral systems to ensure effective back-up to health-care services in the community;
- The essential role of local governments in the management of health-care services;
- The indispensable role of community health workforce at the grassroots level;
- Policy direction, supervision and oversight from the centre;
- Health policy reform; and
- HR reform.

Decentralization in health needs to be made a part of the total government decentralization system. The capacity of the local government is a prerequisite for successful decentralization. This capacity can be built through the processes that permit learning by doing on the ground. This capacity building requires institutional support from both local and central levels. Universities have an important role to play in building management and planning capacities of the local governments. Also, it may be kept in mind that successful decentralization depends on the strength at the centre.

Decentralization will not successfully take place if the centre is weak. Various disease-specific programmes, even though initiated from the centre,
should be implemented through decentralized health-care systems in an integrated fashion.

The role of stakeholders other than the local governments must also be clearly defined for their effective involvement. These stakeholders include:

- The private sector
- NGOs
- Civil society, community
- Others.

This seminar is meant to provide an opportunity for sharing experiences among countries as to:

- what works;
- what does not work; and
- how to make such decentralization happen more efficiently and effectively.

Decentralization is a means to an end. It is an important process of national health services management. The process that has to be operated within multidisciplinary and multisectoral environments. With accumulated experiences in countries, we should be optimistic that future endeavours in this area in the SEA Region will be more promising. There has been considerable debate on the various issues involved. However, decentralization is an essential measure towards the achievement of equity and social justice in health. With our rich experience and the lessons learnt, the challenges in front of us should be faced squarely in forging ahead.

We need to be very pragmatic in our approach in dealing with decentralization issues. And we have to use a systems approach in an integrated manner in tackling the issues involved. When it comes to action, we need to be adequately realistic and practical.

To be successful in providing health-care services to all people, especially in the countries with resource constraints, decentralization is a must. WHO will continue providing a platform for information exchange in this important area. WHO will continue supporting countries that pursue decentralization within the context of health systems based on PHC and health-care reform.
In the health area, Bhutan has been extraordinarily successful over the last few decades. The country’s crude death rate had declined from 9 per 1000 population in 1994 to 7 in 2005. Life expectancy at birth increased from 47.5 years in 1984 to 66.1 in 2005. The infant mortality rate decreased from 70.7 per 1000 live births in 1994 to 40 in 2005. The maternal mortality ratio reduced from 380 per 100 000 live births in 1994 to 255 in 2000. The current coverage of PHC is more than 90% of all health services. These are reflected in some of the important health indicators of the country.

With the launch of the national initiative on “Gross National Happiness”, the health status of the Bhutanese people has been further elevated. The philosophy of Gross National Happiness was propounded by His Majesty King Jigme Singye Wangchuk in the late 1980s.

As far as health infrastructure in Bhutan is concerned, among others, the Basic Health Units were developed to be the cornerstone of community health services throughout the country. Primary health care has been firmly established in the rural community country-wide; and referral systems have been well defined and strengthened from the primary to secondary and tertiary levels of care. In general, Bhutanese people look healthier and happier today than they did at least 30 years ago.

In recognition of the achievements in health development in Bhutan:

- The Mongar Health Service Development Project won the WHO Sasakawa Health Prize and Award in 1993;

Launch of Bhutan Bachelor of Public Health Programme, Thimphu, Bhutan, 13 April 2010.
Many districts in the country have been awarded by the WHO Tobacco Free Initiative on a number of occasions;

The Royal Institute of Health Sciences received the WHO Award for PHC Development in 1998.

These are among the notable recognitions received by the Royal Government of Bhutan for its health development efforts. Certainly, these achievements are due to selfless dedication and hard work of all Bhutanese health staff and other players at all levels; these achievements have been built on the concrete foundation of a well-conceived development strategy, which has been followed since the beginning of national development endeavours. This strategy reflects national determination to work towards long-term sustainable development and national self-reliance; the main pillar to realize this development strategy is human resource development (HRD) to ensure efficient and effective implementation of national development plan.

In spite of the past success, today, Bhutan faces many challenges in the health area such as:

- Ensuring the achievement of universal coverage through reaching the unreached in the remote areas;
- Ensuring the attainment of heath and health-related MDGs in the year 2015;
- Mitigating the prevailing health impact of “climate change”; and
- Combating emerging infectious diseases, such as influenza H1N1, among others.

To tackle these challenges successfully, “institutional health care” must first be well developed. This is the care that is provided primarily at health facilities – hospitals and health centres. In addition to institutional care, priority attention is urgently needed for further strengthening and further developing “community and population-based” health services that can be extended beyond the “walls” of health facilities, the walls of hospitals or health centres. The services that can be made available to families and at workplaces, in the community and in villages.

To do this effectively, we may need to start firstly, with revisiting the “community-based health workforce”. Community-based health workers,
who are an important part of public health workforce, are the vanguards of national health services delivery systems, especially in rural areas. Bhutan has been successful in the development of its community-based health workforce. A basic cadre of rural community-based health staff has been developed to run the BHUs, and their satellite out-reach units in the remote areas. These health staff are:

- Health Assistant (HA),
- Auxiliary Nurse Midwife (ANM), and
- Basic Health Workers (BHW).

For decades, hundreds of these health staff have been trained and are in service with the government. These staff members have contributed greatly to the successful development and implementation of community-based health services in the country. They have been the mainstay of PHC development. They provide primary care and services to rural people. And they play a critical role in education and empowerment of the rural population, as far as health is concerned. They have contributed significantly to the upliftment of the health of the people, especially in rural areas.

In this connection, I must also mention that such effective contribution from community health staff cannot go alone. Effective community health services must be supported by functional referral systems for higher levels of care. And community health staff must be provided with effective institutional support for their education, training and supervision. In Bhutan, many health assistants have moved up to become District Health Officers, and as other categories of health staff at the district level. Some of them have also taken up service at the headquarters of the Ministry of Health in Thimphu, in various capacities.

It is now an opportune time to further strengthen the education and career opportunities of these community health staff so that they will be encouraged to perform their functions with more enthusiasm and commitment. Raising the level of education of community-based health workforce will be an important step in strengthening community-based health services. They will be more energetic in improving their competence and skills; and they will be willing to dedicate more energy and efforts to serve the rural people. Their pride and morale as members of the community-based health workforce will also be reinforced.
Therefore, the decision to launch the Bachelor’s Degree Programme in Public Health in Bhutan is indeed highly commendable. It is a very timely decision as far as health development in Bhutan is concerned. The status of the community-based health workforce will be raised to a “professional level”. Certainly, this educational programme will further strengthen the overall health system capability in the country, particularly at the district level and below.

At the community level, health systems will be able to deliver a better quality health care and services. Among others, the community will be better prepared to deal with local health challenges. This is especially true in responding appropriately to disease outbreaks and disasters. Planning, implementation, monitoring and supervision of community health services will be improved.

As we are aware, Bhutan is also prone to several natural disasters. This public health education programme should also be carefully designed to contribute effectively to capacity building in disaster preparedness and response. The programme should be involved in training of community health workforce, including community health volunteers who have a critical role to play in promoting the building of community capacity and resilience in an emergency.

I am pleased to note that the Royal Government of Bhutan is according top priority to this important area. And I am sure that the subject of “disaster management”, will be prominently incorporated as a part of the course content of this BPH programme.

In running this public health education programme, I would like to underline the crucial importance of “faculty development”. We need a faculty development plan that is realistic, practical and flexible in its implementation. A plan that leads to the development of a core faculty, who can effectively manage and coordinate the course contents, and activities of teaching-learning process of the programme. It is necessary that “local expertise” is maximally mobilized for running the course.

I also earnestly encourage other international agencies/organizations operating in the country to participate fully in this important exercise. As far as collaboration with institutions in other countries is concerned, working
through the South-East Asia Public Health Education Institutions Network (SEAPHEIN) will take Bhutan a long way in collaborating with other institutions in the Region. WHO has been playing a supporting role in the development of this public health education programme. And WHO and other partners are more than willing to continue this supporting role in future.

I would like to take this opportunity to thank the Faculty of Public Health, Mahidol University and other members of SEAPHEIN for their encouragement and support in the development of this educational programme.

I would like to express my sincere appreciation to all dignitaries and honourable guests, for their presence at this launch ceremony. I deeply appreciate the contribution of various committees, groups and technical advisers who have been involved in bringing the BPH programme to this stage of development.

And again, I would like to sincerely congratulate the Royal Government of Bhutan for this important development in health. Let us also hope that this educational programme would significantly contribute to the strengthening of the required leaderships and stewardship of Bhutan’s health sector. The programme has already started. Let us hope that it would stay, continue, grow and grow further, in order to ensure meeting the requirements for public health workforce of the country.
Teaching of public health in medical schools

The importance of teaching of public health in medical schools has long been recognized. Such teaching may be in the form of:

- preventive and social medicine; or
- community medicine; or
- community health.

In medical schools, there is usually a department devoted to teaching one of these subjects. The main purpose of this meeting is to review the situation and to see whether there is anything in such a teaching that may need further orientation. This is especially in light of the changing paradigm in public health today. We have to ensure that our medical graduates have adequate proficiency in today’s public health.

During the recent past, there have been significant changes in public health scenarios worldwide. Among others, the macroeconomics principle is playing an important role in today’s health development. Planning and managing public health programmes are influenced by modern thinking in macroeconomics. Macroeconomics is influencing governments’ decisions; on strategy to achieve “universal coverage” of health care and services, and decisions on strategy to ensure unlimited access to such care and services by all people. At the same time, social determinants are becoming an essence for development of public health programmes.

The programmes that are needed to attain the level of health that will permit all people to lead a socially and economically productive and satisfied
Improving health in the South-East Asia Region

life. The PHC approach as we all know well, is the principal tool of public health endeavours towards this goal in health, that is, the goal of HFA. PHC, through public health interventions will help ensure reaching the hard-to-reach, or reaching the unreached.

As all are well aware, we are facing a multitude of problems in health today. We have the double burden of diseases – communicable and noncommunicable. We have to take the best care of the sick. We have to devote all our time to prolong the life of sick people through the application of medical sciences and technology; and we have to pursue improvement in the quality of life of those sick people through "medical rehabilitation", to enable them to return to normal life, socially and economically. At the same time, the health of the people, who are not sick, must be protected, maintained and even further improved. This health protection, maintenance and improvement must be pursued through public health interventions, the interventions that are especially at primary level of health care, the interventions that focus on health promotion and disease prevention, taking into consideration in these processes health determinants and health risks. Indeed, today’s emerging health challenges stem from various crises, such as: global economic downturn; global food crisis; global warming or climate change; and not the least, the pandemic influenza A(H1N1). These environmental and ecological factors are inter-linked and inter-related, forming vicious cycles in many aspects of human life, including health.

We need strong public health systems, we need robust public health programmes to face these formidable challenges. Among others in this perspective, there is an urgent need to strengthen public health workforce in our countries. We have to review, and we have to improve education and training of our public health professionals and practitioners. In this connection, we believe that teaching of public health in medical schools can also take us a long way towards strengthening of the public health workforce in our countries.

We need to ensure that our medical graduates are adequately proficient in public health. We need them to be able to tackle public health problems of the entire community; the problems that stem primarily from environmental and ecological degradation. We would like to see our medical graduates being able to work effectively in the multisectoral and multidisciplinary environments. Our medical graduates should join the public health workforce in efforts to
reduce the disease burden, particularly, through health promotion and disease prevention strategies.

Medical graduates need to effectively adapt to the constant change in the health paradigm, the change that is due to the dynamics of the environment and the ecosystem. Public health competence is also needed for those who work in medical institutions, the institutions that are also the referral facilities for continuum of care for people in the community.

Public health can help ensure a reasonable balance of care, the balance between preventive and curative services. The role of medical doctors is more than providing curative care in institutions. But, they have also to get involved in public health education and research; they have to get involved in training and supervising community-based health workforce. Medical doctors have to support the functioning of public health facilities, such as public health laboratory and disease surveillance and many more areas in public health that need the involvement of medical graduates. Medical graduates will have to get involved in health activities, beyond the boundary of medical institutions.

The responsibility for teaching public health in medical schools should go much beyond the department of preventive and social medicine. This teaching, the teaching of public health in medical schools, is a multi-departmental responsibility, all other departments should also abide by this responsibility. And this teaching should be considered an obligation in today’s medical education. Public health can help medical personnel look at their clients in a more holistic manner, help medical staff better understand clients’ life, both before and after institutional care. Public health can help improve interdepartmental collaboration among various specialities in medical schools. Rather than a discipline, public health is a field of multiple disciplines and multiple sectors. Public health programmes need an application of a range of scientific know-how in their development and implementation.

We have a diverse group of participants who can express their views on the subjects from different perspectives. We will hear the opinions of people, from both inside and outside medical schools. I hope we would also hear about the expectation of the public, on what medical graduates can effectively contribute to the total well-being of people in society.
Let me also thank Professor Adisorn Patradul, Dean, Faculty of Medicine, Chulalongkorn University, for agreeing to co-host the meeting. My sincere thanks are extended to Dr Sathaporn Wongjaroen the Deputy Permanent Secretary of Public Health, the Royal Thai Government for agreeing to inaugurate the meeting.

I thank Professor Pirom Kamol-ratanakul, President, Chulalongkorn University for graciously welcoming the participants. I most sincerely thank the two internationally known figures for agreeing to deliver keynote speeches – Professor Prawase Wasi and Dr Amorn Nondasuta. We look forward to hearing their inspired and thought-provoking speeches.
I am very pleased to welcome you all to the Regional Meeting on Health Care Reform for the 21st Century. This is one of our high-profile regional meetings on the current topics of our priority concerns in health care. The primary purpose of these meetings is to advocate for policy and strategy changes in the health care systems.

I specially welcome our distinguished keynote speakers H.E. Lyonpo Zangley Dupka, Minister of Health, the Royal Government of Bhutan. Lyonpo Zangley Dupka has been in the mainstream of the “Gross National Happiness” movement in Bhutan since its inception. The movement is now internationally known and followed; H.E. Dr Fernando S. Antezana, former Deputy Director-General of WHO, former Chairman of WHO Executive Board and former Minister of Health of Bolivia. Dr Antezana was Deputy Director-General of WHO when the Organization underwent a reform process in the light of the global changes during the 1990s, a process that inspired the new paradigm of public health today. Dr Amorn Nondasuta, President, Foundation for Quality of Life, and former Permanent Secretary for Public Health, the Royal Thai Government. Dr Amorn was the pioneer of PHC development of public health care in Thailand during 1980s which had been a lesson for many countries in Asia. He has also been a key supporter of the health care reform in Thailand.

I sincerely thank them for their interest, time and valuable contribution to this meeting. We look forward to their inspiring and thought-provoking keynote speeches.

It is time to revisit “health-care reform” to identify necessary changes in our health care systems that are needed to ensure universal coverage of health
services for all people and to chalk out a roadmap for effecting those changes in countries of the South-East Asia Region during this century. This is with the view to accelerating progress towards:

- better equity and social justice in health; and
- a universal coverage of, and unlimited accessibility to, health services for all people in all countries.

We can appreciate that these broad objectives of health care development need to be achieved, among others, through:

- full community participation and involvement, and
- multisectoral and multidisciplinary actions.

We need this reform because several important public health problems persist in countries of the Region and we are currently facing a multitude of new challenges that need to be tackled with more robust health care systems. These challenges stem from the various crises of our times, such as:

- climate change,
- the global economic downturn,
- emerging infectious diseases, including pandemic Influenza A(H1N1), and
- rapid emergence of noncommunicable diseases.

We should take these crises as another opportunity, to move one more step to strengthen our health care systems, make our health services delivery stronger, more relevant, and more responsive to the changing health problems and needs of the entire population in the community.

We are now at another milestone in a long road to secure improved health for all people, for which the achievements of equity and social justice in health need critical re-examination. Attempts to reach the hard-to-reach, or to reach the unreachable, must be intensified through innovative strategies. Overriding priority has to be accorded to health care reform in the national political agenda—the agenda that ensures substantial change in the health care system through innovative strategies; changes in the way health care and services are planned and provided. We need strategies that call for country-wide application of the PHC principle to ensure adequate health care for all, including the poor, underprivileged, vulnerable and marginalized. These strategies must ensure a balanced development of health care, with the right mix of preventive and curative services.
PHC should be made the cornerstone for reorientation of national health care systems, the systems that take into account the entire range of health problems and health needs.

Major health problems include:

- mortality or deaths,
- morbidity, declared or undeclared by suffering people,
- silent diseases, diseases at early stage, and
- health risks and vulnerability, both known and unknown.

We need health care systems that adequately recognize the role of sociocultural, economic and environmental determinants of health that prevail in a particular community. These determinants profoundly impact the health of people of all strata. We need health care strategies that:

- recognize the important role of local governments and civil society; in the management of decentralized health services delivery systems,
- adequately recognize the important role of community health workers and community health volunteers; who serve the majority of the population at the grassroots levels.

Attempts to reform the health care system are not new. The reforms have been conceived and pursued worldwide in various forms for decades. During the recent past, there have been strategic developments in countries of the Region, in strengthening health care systems based on the PHC principle. These experiences will be shared during the course of this meeting. However, a lot more needs to be done in these reform processes to ensure health for all people everywhere, regardless of their social or economic status. Big gaps in health status and in health situations are still prevalent everywhere.

The reforms have to continue to ensure health care systems that are robust enough to effectively face emerging health challenges. More combined efforts of all sectors and disciplines are needed for successful health care reform for the 21st century.

To effectively harness these combined efforts, able leadership is indispensable. Such leadership can coordinate the work of various sectors across disciplinary lines, and is without professional prejudice, neutral and balanced enough to pursue the reform process successfully.
In this reform process, we should expect changes, among others, in:

- health policy development, with emphasis on balanced care between preventive and curative;
- the care that enables people to stay healthy, to lead a socially and economically productive life;
- health systems infrastructure and its governance, with emphasis on decentralized health services delivery to ensure reaching the hard-to-reach or to reach the unreached population; and
- the development of human resources for health, with the emphasis on workforce in the area of public health, primary care and primary health care.

And even more important is the fact that the reforms should lead to significant changes in allocation of health resources, changes that ensures their equitable distribution, at both national and sub-national levels.

The reforms should lead to effective protection of health consumers through:

- improvement in ensuring the “people’s right” to unlimited access to quality health care, and
- better recognition of “pride” and “dignity” of consumers in the process of health services delivery.

Healthy public policies should be further promoted in the reform process. These are policies whereby individual sectors seriously take into account health concerns in their development activities. Public-private partnership should be another important area for our attention in any discussion on health care reform. Public-private partnership is not new. But its realization is yet to be achieved. The private sector should be motivated to take more responsibility in areas of public health and primary health care. In managing health care systems, there should be clearly defined roles of:

- governments at all levels,
- service providers – either public or private, and
- consumers of health services.

To achieve all these and others in the health care reform process, what is essential is unwavering political commitment and support. Untiring efforts are needed for advocacy at policy level for strategic change; and for actions at the operational level.
This is the fifth meeting of the South-East Asia Public Health Education Institutions Network (SEAPHEIN). It is also another important step in the work of SEAPHEIN. This meeting will deliberate on three important areas:

- Inequities in health;
- ICT in public health education; and
- Networking and collaboration.

Regarding inequities in health, the subject will also be discussed at the Regional Meeting on Health Care Reform for the 21st Century which will take place at this venue from 20th to 22nd October. Also, in this connection we should keep in mind that the PHC approach is a public health tool to reduce inequities in health, and to improve social justice in health care. Social justice is an important pre-requisite for ensuring equity in health.

As far as ICT is concerned, if appropriately applied, it can make an important difference, and significantly contribute to positive changes in the development and management of public health education and training programmes. It will greatly facilitate the improvement of the quality of public health education and practice. Late or reluctant application of ICT will slow down the progress of the development of our public health education programmes. As for networking and collaboration, this can bring us a long way in improving our inter-institutional cooperation and joint actions, within and among countries. This cooperation can play an important role in improving the quality of public health education and training.

The Fifth Annual Meeting of SEAPHEIN, Bangkok, Thailand, 18-19 October 2009.
I am glad to see that we have, among us colleagues from three countries outside the SEA Region: Cambodia, Japan and Laos.

I would very much like to see more countries outside the South-East Asia Region joining or participating in the activities of SEAPHEIN. In this connection, we have to look at the South-East Asia Region in a context broader than merely a Region of WHO. Let us consider this and try to get more like-minded people to work as part of SEAPHEIN to improve the quality of public health education and practice.

WHO-SEARO will continue full support to the work of SEAPHEIN. I hope that SEAPHEIN would emerge even stronger, and its work would be more beneficial to its member institutes anywhere.

The aim of public health is to keep people, as individuals or groups, always healthy and with the least disability dependence. In this connection, we need public health programmes to solve health problems of people; with special attention to health risks and health determinants – physical, social and economic. We need public health programmes that are developed and managed through multidisciplinary and multisectoral efforts. Such programmes are implemented through community action, in close collaboration with the local governments, with full participation and involvement of all other partners and various social organizations.

The primary function of public health is the prevention of disease; physical, mental and social. Public health prevents dependence of people in the community and ensures optimum social and economic productivity. And public health is to ensure that such social and economic productivity will contribute significantly to the prosperity of countries.

Despite these important roles, public health is yet to find an appropriate place in national development agendas. Public health is yet to receive a reasonable share of national resources for its development. And public health is yet to receive the social recognition it deserves. That is why we have the “SEAR Public Health Initiative”; and “SEAPHEIN”. Both were launched in 2004.

We are well aware that these are modest efforts to contribute to public health in SEAR. Both of these movements started in 2004. Our mission in this
connection, among other things, is to further improve public health and elevate it to its proper status in national health development plans.

With the prevalent global crises such as emerging diseases and climate change, public health is more recognized. But, it is not yet enough and not yet satisfactory. A lot more needs to be done to advocate for better public health. While working to improve the quality of public health education and practice, we have also to actively try to convince people about the value of public health work.

In particular, we have to convince politicians who make the key decisions on national health policy. Not less important, we need to convince our peers in the health community to appreciate preventive interventions in health care. Our aim in this advocacy is, at least, to achieve the right balance between prevention and cure, the balance that can benefit both healthy and sick people.

Ultimately, we should look forward to a day when we will have all people well, healthy, and socially and economically productive. And, at the same time, we will have the least number of people who are sick, disabled; or socially and economically dependent.
I would like to recall the global social goal of health for all (HFA); as resolved by the World Health Assembly in 1977. The goal, if universally achieved, will lead to the attainment of a level of health that will permit all people in the world to lead “a socially and economically productive life.” This goal can be achieved through the implementation of the PHC approach with which we all are very familiar. The PHC approach calls for full community participation and involvement in health development.

The goal of HFA will be achieved through improved equity and social justice in health. Equity in health calls for multidisciplinary and multisectoral actions for health, which can lead to universal coverage of health care. Universal coverage promotes unlimited accessibility to health services by all people.

To achieve these broad objectives of health services development, there have been attempts to effect changes in the health care systems. The changes can produce efficient and effective management of health services delivery. It is believed today that the PHC approach can greatly contribute to the efficiency and effectiveness of health services delivery at any level of the health care system.

During the past over 30 years, the PHC approach has been applied globally with positive results. Compared with the situation more than three decades ago; people in the world today, on average, live longer, and look healthier and happier. However, a wide gap in health exists between different population
groups, within and among countries.

The distribution of world resources for health, at both national and international levels remains unjust and unfair. There is a long way to go for the world to achieve uniform universal coverage and for all people everywhere to have unlimited access to quality health services which are required for the attainment of the social goal of health for all.

We are now at another crossroads on the long path towards the social goal of HFA through which all people would be enabled to lead a productive and satisfying life, socially and economically. The achievements of equity and social justice in health need to be critically re-examined and re-assured. Our efforts to reach the hard-to-reach, or to reach the unreached must be intensified. This intensification of efforts has to be done through a substantial change in the management of the health care system. Such change must ensure effective delivery of health services to the entire population in the community regardless of their socio-economic status. It is the management change that requires combined wisdom and combined efforts of all disciplines and sectors.

Such combined efforts demand strong leadership that can ensure effective coordination of the work of different sectors across disciplinary lines. Only with such leadership can the reform process be pursued successfully, without professional prejudice and in a balanced manner. This leadership must be developed first in the health sector. We need this leadership to ensure that health services management can address all spectrums of health problems and needs of the population.

As far as health needs of the entire population in a community are concerned, I would like to remind everyone of their various facets. Understanding health problems and needs is the first requirement for effective development and management of the health services programmes that are relevant and responsive to those problems and needs.

Now, I will use a simple illustration. This simple illustration depicts a range of health problems in the population.
Death or mortality is on the top of our concern. When people die, we can easily see they die because of health problems due to various causes. Next to death, our attention is paid to individual persons, who come to health facilities with a complaint of ill-health. They come for medical attention and care from service providers, and this is what is termed “declared morbidity”. But death and declared morbidity represent only the tip of an iceberg, the part that appears above the surface of the water. This is the part that is easily seen by service providers, and that attracts most of the attention of the public.

At the same time, there are people with symptoms, with signs of illnesses but, for several reasons, they do not, or they cannot access health care facilities and may even be unwilling to come to health facilities for care. The reasons may be financial, logistical, or psychosocial, among other things. Whatever the reason, these people mostly escape the attention of service providers, especially service providers in the formal health care institutions. This class of health problems falls under the category of “undeclared morbidity”, and it lies unseen just beneath the surface of the water as shown in the diagram. There are still other people, who are already diseased but without signs or symptoms. These are “silent diseases” or diseases mostly at their early stages, such as HIV infection, diabetes, hypertension, and carcinoma in situ.
There are also people who expose themselves or are exposed to various types of health risks and vulnerability that may be known, or may not be known to them.

The health problems that lie under the surface of water represent the significant part of the health needs of the population. Normally invisible, these health problems are not easily seen by service providers. These are the problems that need public health interventions through the PHC approach, among other social and economic interventions. Such problems need community-based interventions, for which certain population groups are targets. Health care and services need to be provided right in the community to ensure coverage of the entire population. And such interventions need to adequately take into account social, cultural, economic and environmental determinants of health that prevail in a community.

With this perspective in view, management of health services delivery may need a change. Health service providers need to pay more attention to the entire range of health problems and needs in the community. We need management that can ensure a balance in health care at all levels, maintaining the balance between preventive and curative care. We need a health services delivery system that can lead to comprehensive care provided through a multidisciplinary team.

The health-care system should recognize the important roles of local governments and civil society in managing decentralized health care delivery systems. The system needs to be able to appropriately shift tasks, and reprofile roles of health workers at various levels of care in order to ensure a reasonable division of responsibilities to maximize the efficiency of health services. We need a system that recognizes the important role of community health workers and community health volunteers who are already in the forefront of health-care delivery and serve the majority of the population at the grassroots level.

PHC is an important tool for public health interventions. The interventions certainly need to ensure:

- universal coverage,
- unlimited access to care and services by all people.
We need public health interventions to ensure that health care and services are provided with adequate recognition of fundamental rights to health of individuals; and with adequate recognition of dignity of clients. This is the recognition by service institutions and service providers.

The management of health services delivery has also to build understanding that PHC is quality care for all people, rich and poor, urban and rural.

PHC should be practised, both in the community and in health care institutions including referral facilities. The health services delivery system has to ensure both that there will be adequate professional back-up support to community health work for effective supervision and training, and also that there will be functional referral systems that provide continuum of care in service delivery.

The management of the national health care system must recognize the important role of education and research institutions. These institutions help ensure at least the availability of socially responsible health workforce, and ensure the availability of quality health care services. As already mentioned, the adequacy of quality health care for all people depends on appropriate application of PHC principles. The concept has been broadly defined to allow flexibility in its application in all health care settings, institutional or otherwise, in a manner suited to specific situations in the world. The PHC approach should be used as the basis for management reform in the health care system in any country. Reform should recognize the essence of educational and empowerment processes the processes that are considered to be important tools of public health interventions, wherein PHC approach can play a key role.

To reiterate, PHC approach can ensure adequate attention of service providers to “the entire range” of health problems and needs of the population. The ultimate aim of PHC is to educate and empower all people in the community to be able to look after their own health and the health of their community and also for them to be able to make the right decision regarding when to seek help from service providers. This ultimate aim of PHC is what we call HFA through the PHC approach.
Improvement in the management of national health services delivery needs reforms among others, in:

- health policy development to ensure decentralized services delivery;
- development of health workforce to ensure socially responsible health workers; and to ensure a unified multidisciplinary health team in the community; and
- development of health infrastructure to ensure availability of out-reach health care facilities to cover the poor, vulnerable, marginalized and underprivileged people.

And even more important, reform is needed in effecting change in the allocation of health resources, to ensure their equitable distribution among population groups as well as between preventive and curative care. All these reforms need strong political will and commitment. To be successful, these reforms need untiring advocacy through evidence-based messages to convince politicians and policy makers. All these challenges for the improvement of health services delivery management are formidable indeed, and hence our united efforts towards this common goal must be ensured. Let us pledge our unwavering commitment to the desirable changes towards more efficient and more effective health services delivery management in our countries.
The prevailing public health problems in the WHO South-East Asia Region, both old and new or emerging, call for robust public health systems to tackle them. WHO in this Region accords high priority to supporting Member States in strengthening their public health infrastructure and workforce. Our collaboration with countries in this important area has been carried out through our ongoing public health programmes, and through the special programme of Public Health Initiative launched in the Region in 2004.

The initiative is aimed to ensure our focused attention on strengthening public health systems in the Region. The emphasis of our efforts in this connection has been on the development of education and training programmes in public health. This seems to have a very broad purview. However, our attention is drawn to certain specific aspects of public health education and training. We advocate the development of public health professionals, who acquire a broad vision in health policy formulation and in health programme planning.

Intercountry and inter-institutional cooperation has been promoted through the network of public health education institutions, SEAPHEIN. This network was created to facilitate WHO’s collaboration with institutions concerned in Member States to pursue the development of public health education and training programmes. The network holds its annual assembly in conjunction with a high-profile regional meeting on a topical subject.

Our high-profile regional meeting last year was on Revitalizing Primary Health Care. The meeting was held as a part of our celebrations to commemorate

National Consultation on Public Health Workforce in India, New Delhi, India, 24-25 June 2009.
the 30th anniversary of the Alma Ata Declaration on PHC in 1978. For this year, the subject for our high-profile regional meeting will be Health Care Reform in the 21st Century.

We intend for this year’s meeting, to revisit our health care systems with the view to promote the balanced development of health-care services, secure an optimum balance between promotive, preventive, curative and rehabilitative care, and, most importantly, promote the development of health care for all people — urban and rural, rich and poor — through public health actions and the PHC movement.

Allow me to say a few words on the development of public health in this country. Beginning with the Bhore Committee Report on Health Survey and Development in 1946, India formulated a national health plan that was considered a model for health planning and for public health development in the country.

The concept of a primary health centre, as enshrined in the plan, had been a cornerstone for the development of community and primary health care in India. The success of this development, certainly, depended on the wisdom of national public health experts at that time. Even though there were not many public health schools in the country, India had greatly contributed to the development of public health specialists in many fields.

The institutions involved in such a development included:

- National Institute of Communicable Diseases (NICD) in Delhi.
- National Institute of Nutrition in Hyderabad.
- National Institute of Virology in Pune.
- National Institute of Tuberculosis in Bangalore.
- All India Institute of Hygiene and Public Health in Kolkata.

Today, there are many more such institutions which contribute significantly to the development of a public health workforce in India and in other countries. WHO has been collaborating closely with these institutes in the past, and at present. These institutes have formed an important part of the WHO global expertise network. The international health community always appreciates valuable contributions from these institutes. It will be very useful if a more
formal national network is formed to ensure more efficient coordination among these public health institutes.

It is also heartening to learn about the attempts made by the Government of India to develop new schools of public health. This development will go a long way towards ensuring a more robust public health workforce and infrastructure in the country.

Another important contribution to the development of a public health workforce in India is the public health education imparted in various medical colleges. This may be in the form of preventive and social medicine, community health or community medicine.

WHO in the South-East Asia Region is interested in the teaching of public health in medical schools. We plan to hold a regional meeting on this subject at the end of this year. This is in order to review the situation and to see whether there is any need to effect changes in such teaching in medical schools. This review will focus, in particular, on the prevailing dynamic situation with regard to global public health. These situations include persisting trends with new, emerging and re-emerging diseases, health impacts from climate change, and the impact on health from the global economic downturn.

Today, there are several postgraduate programmes in public health education in India. Many of these programmes aim to produce a public health workforce at the professional level. Public health professionals are those who are able to effectively undertake the development and management of public health programmes. Public health programmes are involved particularly in areas such as maternal and child health, disease prevention and control, nutrition, and environmental health, including water and sanitation. It is indeed a commendable endeavour of the Government of India to ensure the presence of an adequate number of such professionals in the public health workforce.

While developing a public health workforce it needs to be kept in mind that public health work requires multidisciplinary and multisectoral action. This is even more important in areas of health promotion and health protection as well as disease prevention and control in the community. Therefore, the opportunity for public health education and training should also be extended to several related disciplines and to staff of other sectors.
Other related sectors also need a public health workforce for their contribution to health development. The involvement of other disciplines in public health work will certainly spare the time and efforts of medical professionals for more important tasks in institutional settings.

Community Health Workers (CHWs) and Community Health Volunteers (CHVs) are doing public health work within the community and they should be recognized as a part of the public health workforce. In reality, these people have already formed an important part of this workforce. They should be given the opportunity for appropriate orientation and training in public health, the orientation and training that is relevant to their community work. CHWs and CHVs also need special attention from the government at all levels for their development and training as well as their retention, welfare and career advancement.

Public health problems lie heavily on the poor, underprivileged, marginalized and the vulnerable. In designing the delivery of public health services to the community, priority attention should be paid to the health needs of these people.

Furthermore, in accepting the importance of health risks and health determinants in health development, public health programmes should also be planned and managed within the sociocultural, economic and governance context of countries. Public health education and training programmes should be developed on the basis of the ground realities within such a sociocultural, economic and governance context. Community settings with their prevailing health problems are the best training ground for the public health workforce.

With rapid changes in all spheres, locally and internationally, it may be time to revisit the public health education curricula and programmes. Even though the basic principle of public health remains the same, with the current global changes today we are working on a changing paradigm of public health.

Public health professionals need to be aware of the emerging trends and their impact on the health of the people. As already said, these include climate change, the global economic downturn, and persisting trends in new, emerging and re-emerging diseases, both communicable and noncommunicable.
Primary health care is an important tool of public health interventions and should find a prominent place in public health education and training.

Furthermore, the launch of the National Rural Health Mission by the Government of India in 2005 has laid a concrete basis for the further development of public health workforce in the country.

Therefore, this national consultation is timely indeed in providing a significant contribution to the effective implementation of the NRHM. WHO stands ready to collaborate with the Government of India in pursuing this challenging mission in the years to come.
Keeping in mind the wide gap between “haves” and “have-nots” in health and with the rapid increase in the cost of medical treatment worldwide, the theme of this meeting is timely and relevant indeed. This is particularly so for countries in the South-East Asia Region.

It is an opportune time for us to think of returning to our natural resources for health care. These are especially traditional medicines, and herbal medicines in particular.

Traditional systems of medicines, including herbal medicines, have been used for several centuries for health care by people in Asia, as well as in other parts of the world. Traditional medicine continues to be a valuable source of remedies that have been used by millions of people around the world to secure their health. As we know, traditional systems of medicine have been developed from empirical experiences and from observations by people who use them. It embodies age-old wisdom, and forms an integral part of the social and cultural heritage of peoples and countries. The system has been inherited and handed down from one generation to the next.

Therefore, to a large extent, traditional systems of medicine, including herbal medicines, are country- and locality-specific. These systems have long been a part of life of people in communities, especially in rural areas.

Herbal medicines are widely used by people as a primary source for their health care. Today, herbal medicines are used not only by people of the country where they originated but by people of other countries as well. The traditional systems of medicine that have been practiced in countries of the

Regional Meeting on the Use of Herbal Medicines in Primary Health Care, Yangon, Myanmar, 10-12 March 2009.
SEA Region contain herbal remedies that can protect and promote health. These medicines can be used to cure common ailments, and are especially useful in rural communities.

It is important to draw a line distinguishing between traditional medicines and modern medicines. The domain of traditional medicines comprises preparations from parts of herbal plants, such as the bark, leaves, roots, flowers, and so on. It involves direct use of parts of the herbal plants for medical purposes. Once the active ingredient is isolated from the herbal and natural raw materials and purified into chemical forms, we enter the domain of modern medicines.

Modern medicines are developed from scientific discovery and research. In the case of traditional medicines, the active ingredients of most herbal raw materials are still not known.

In this meeting, our attention is confined within the domain of traditional medicines, and our emphasis is on promotion of the use of herbal remedies in primary health care.

Isolation of active ingredients to find the chemical forms of “modern” medicines has to go through the process of research and development, which requires capital investment and is time-consuming.

As we know, herbal medicines that are prepared by traditional methods are cheap. They are mainly used by people in rural areas. But when the preparation of these medicines is done through “modern methods”, they become expensive. Modernization of production of herbal medicines can lead to the increased cost of medicines. Since the 1990s, there has been a resurgence in the use of herbal products. It is likely that this trend will continue in future as well, for a number of reasons. I shall mention three of them. First, there is a desire of people to return to nature and to use natural products for taking care of their own health. Second, there is a perception that herbal medicines that are derived from natural raw materials are relatively safe. Third, herbal medicines are almost always available, and they are affordable in their traditional dosage forms, especially in rural areas.

WHO promotes the use of traditional medicines in primary health care, particularly the use of herbal products. As part of this promotion, WHO helps
assure the quality, efficacy and safety of herbal remedies, as well as the availability of herbal plants in the community.

This meeting aims to promote sharing of information and experiences among institutions in the Region on the use of herbal medicines in PHC. The meeting is meant to initiate the networking of interested groups that can lead to inter-institutional and intercountry cooperation.

During recent years, there have been a number of important developments in the area of traditional and herbal medicines. In 2007, a WHO Interregional Workshop on the Use of Traditional Medicine in Primary Health Care was held in Mongolia. In 2008, a WHO Congress on traditional medicine was held in Beijing. In January this year, the WHO Executive Board passed a resolution on traditional medicine, which will be discussed at the forthcoming World Health Assembly. All these developments put an emphasis on the promotion of the use of traditional medicines in primary health care. These efforts all aim to promote inter-institutional, intercountry and interagency coordination and cooperation in the area of traditional medicines.

The time has come to meticulously examine the role of traditional and herbal medicines in securing and promoting good health. The use of herbal medicines in PHC can help improve health care coverage, and help reduce inequity in access to health-care services. It should be kept in mind that herbal medicines are for everyone — rich or poor, urban or rural. And the consumption of these preparations is equally relevant in both developed and developing countries.

The use of herbal medicines in PHC reflects the application of appropriate technology that is socially and culturally acceptable to people in a community. To reiterate, herbal medicines are affordable and people can get easy access to them. They also help to promote the rational use of medicines.

Countries in the South-East Asia Region have vast resources of medicinal plants, and thus these countries are custodians of a huge repository of knowledge in traditional medicines. They must be protected from exploitation or misuse. If not adequately protected, there is a possibility that the custodians of this knowledge would end up paying a high price, the price for commercial products that are prepared from their own medicinal plants by other countries with the capacity to invest in modern production methods.
However, traditional and herbal medicines can certainly be developed and made commercially available by our own countries and, therefore, the production of herbal medicines can significantly contribute to economic gains for our countries. Herbal medicines provide a sound basis for countries to embark on a long-term plan for ensuring better health for all their people. Through modernization of their production, and through commercialization, herbal medicines can contribute significantly to economic and health gains for our countries.

To achieve this goal, among other things, biodiversity needs to be promoted and protected for the sustainable use of medicinal plants in the Region. There is a lurking danger that over-exploitation, especially by outsiders, may lead to the depletion of these fragile natural resources. Let us move forward together in protecting our herbal plants, our natural resources, and promoting the production of herbal medicines for use by all population groups. This will contribute to the self-reliance of our countries in the provision of “essential medicines”.

Let us try to advocate for herbal medicines to be on the “national list” of essential drugs. This meeting is an appropriate vehicle to create opportunities for intercountry cooperation. This is the place where partnerships and networks among institutions can be initiated.

Networking is an efficient mechanism for addressing various related issues through combined wisdom and concerted action among institutions and countries. Networking is also an appropriate way to implement “consensus-based” activities aimed at achieving mutual objectives and mutual benefits. Furthermore, institutional capacity in traditional systems of medicine can be strengthened through this process.

Since traditional systems of medicine are, to a large extent, country- and locality-specific, the scope as well as limits of intercountry and inter-institutional cooperation need to be clearly defined. This is to prevent “misconception” and “misunderstanding” as far as traditional systems of medicines is concerned. The feasibility of such cooperation depends mainly on the recognition and acceptance of ground realities and the uniqueness of traditional systems of medicines in their social and cultural context.
It is indeed an honour for me to address this distinguished audience at the launching of the Course on Economic Principles for Health Policy and Planning. The course is jointly organized by Chulalongkorn University and the WHO Regional Office for South-East Asia.

The Centre of Health Economics at Chulalongkong University has served as a WHO Collaborating for the past 15 years. During these years, the Centre has contributed significantly to training and research in health economics in countries in the South-East Asia Region. I expect that work of this collaborating centre will continue in the years to come, with unwavering support from the University. I am also very grateful to Chulalongkorn University for agreeing to host this Course at the Centre of Health Economics.

WHO has always recognized the importance of economic contribution to health development. Health, as defined in the WHO Constitution, is not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being. Health problems are basically the consequences of an interplay among a wide variety of factors, which may be categorized into three main areas which are well known to us: disease, ignorance and poverty. These groups of factors are enhanced and perpetuated in a vicious cycle. Efforts in the education and economic sectors, among others, are therefore necessary to tackle the root causes of ill health. Health development requires actions beyond those of the health sector and is considered to be an area that needs strong multisectoral coordination and cooperation.

My focus in this connection is on the contribution of other sectors to health development, with the economic domain playing a crucial role, and the

Launching of the Joint Course on Economic Principles in Health Policy and Planning, Chulalongkorn University, Thailand, 3-8 November 2008.
efforts to develop country capacity in national health planning and management during the 1960s to the 1980s. WHO had systematically brought about the application of economic principles in national health policy and programme formulation during these decades. During that period, WHO had developed, introduced and supported several training programmes in this area worldwide. Since the advent of the Health For All (HFA) goal which was collectively adopted in the World Health Assembly in 1977, health has gone much beyond the “medical domain” and the scope of health development has expanded further. The scope of health development now encompasses those elements which are considered to be the essential contributions to health from the economic and other sectors.

The United Nations General Assembly (UNGA) in 1978 resolved to endorse “health” as the core of development. This resolution of UNGA highlighted the important contribution of health to “social and economic progress”. As part of the WHO Global Strategy for HFA, health systems are defined to incorporate health-related activities of several sectors other than health. Thus, health systems have become a multisectoral system; and go beyond the scope and meaning of the health sector, with which we are familiar. It should also be mentioned here that during the 1980s WHO introduced and promoted the concept of healthy public policies. This concept defines the role and responsibility of various sectors in protecting the health of the people/population in the pursuit of their individual development activities.

In 2002 WHO established the Global Commission on Macroeconomics and Health. Work of the Commission renewed attention to the role of economic principles in national health policy planning and management. The Commission’s work highlighted the two-way contribution by health and economic sectors in the overall development endeavours. Not less importantly, the Commission emphasized the role of health in poverty alleviation. Recently, the Global Commission on Social Determinants of Health – which was established by WHO a few years ago – underlined the importance of accounting for “social environment”, the environment within which health policy is formulated and managed.

As a consequence of the work of the Commission on Social Determinants of Health, economic determinants also emerged as an essential consideration
for health policy formulation and management. Today, no one can deny the multisectorality of health development, with economic contribution as its essence. Health has now gone far beyond the health sector; health issues have more and more become public concerns. And these concerns have become subjects for public debate. Nowadays, health features prominently on political agendas for social and economic development at both national and international levels. It is also universally accepted that health is an indispensable element for human resource development and that health development efforts improve the quality of “human capital”. These efforts also improve the quality of the workforce, which leads to improved economic productivity.

This course brings together these and other related issues on a common platform. This platform allows us to review and discuss the role of economic principles in health policy planning and management. These principles are in tandem with equity and efficiency considerations in health and other development endeavours. These considerations provide decision-makers with the opportunity to pursue their efforts in health development planning in a more effectively.

Economic principles are the basis of evaluation tools; the tools that assist in assessing the potential and actual impact of investment in health. This is considered to be a critical role of economic principles in health policy. This course on economic principles in health policy and planning covers three main areas for our review and discussions:

- Health and development
- Social protection for health
- Evaluation of health investment.

These areas will be thoroughly elaborated during the proceedings of the course. On many occasions “health”, especially its “human element”, and its concern with the quality of being human may go beyond the issue of monetary value or numerical domain. However, economic thinking has grown to include these elements today. Health planners can now move forward with full confidence in the application of economic principles in health planning and management.

Last but not the least, with the current global financial crisis the role of economic principles has become more crucial in helping us find appropriate
solutions to the adverse impact of this crisis on health. We need the right solutions now to tackle the associated health impact of the current financial crisis, in both the short and long term, and at both macro and micro levels. This financial crisis, which is expected to continue can lead to social and political unrest at both national and international levels.

Coming back to this course, it aims to strengthen country capacity in the application of economic principles in health planning and management. We start with this short course. If found successful or perceived to be a useful exercise, a longer course of more detailed and in-depth content may be considered for the future. WHO intends to organize such training in interested countries of the South-East Asia Region. This is with the expectation that a more promising application of economic principles will improve health outcomes, especially of the poor. Certainly, WHO stands ready to provide necessary support to countries which are interested in pursuing this type of training programme.

I am urging the Centre of Health Economics, Faculty of Economics, Chulalongkorn University, to continue working with WHO in this useful exercise. I once again thank the President of Chulalongkorn University for his special interest in the course. I also expect that the course will continue to receive favourable attention from the Office of the National Economic and Social Development Board and from the Ministry of Public Health of the Royal Thai Government.
First and foremost, allow me to convey greetings and congratulations from WHO to people of Bhutan and the Royal Government of Bhutan for systematic and smooth transition of governance to democratic rule under constitutional monarchy. Also, WHO is happy to see that Gross National Happiness has been adopted by the Royal Government of Bhutan as the principal basis for national development.

This can be a model that other countries can learn from on how governments can gear their national development strategies more directly towards social development, particularly people’s happiness and well-being as the overriding priority of the countries.

This annual health conference coincides with the thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care, and also, this year is the Sixtieth anniversary of WHO. As we all know, PHC is the key to the attainment of the social goal of Health for All (HFA), the goal that will permit all citizens of the world to lead a socially and economically satisfying and productive life. PHC is considered an integral part of overall development in the spirit of equity and social justice in health. Indeed, the worldwide efforts to reach HFA through PHC during the past three decades have had far-reaching consequences. These consequences not only pervade the health sector, they also impact other aspects of social and economic development. This is particularly true of development at the community level, especially in developing countries.

The HFA/PHC movement has highlighted the central role of health in overall national development and in contributing to economic development in particular. During the past 30 years, the principle of HFA/PHC has significantly

Improving health in the South-East Asia Region

contributed to positive changes in the ways that health systems in countries all over the world are developed and managed. Certainly, the HFA/PHC principle has had a positive impact on the health of people around the world. As far as health is concerned, people in the world today, in general, are better off than they were 30 years ago. Worldwide, there have been numerous, documented success stories in the implementation of HFA/PHC strategies at national level.

In the recent past, a number of international conferences have been convened wherein the positive impacts of HFA/PHC strategies were reviewed. Since the adoption of HFA/PHC by the World Health Assembly 30 years ago, health has expanded far beyond the responsibility of the health sector. Health has become more multisectoral, requiring efforts across all sectors in its development. Increasingly, health issues are becoming public concerns and subjects for public debate. Health issues are reflected more and more on political agendas for national social and economic development. Health is becoming more prominent on both national and international development agendas as well.

The special focus of HFA/PHC strategies is on positive health outcomes for all people, in both social and economic terms. These outcomes can lead to a real reduction in the disease burden and to the alleviation of poverty. But to be really effective, the implementation of HFA/PHC strategies has to be carried out through the integration of technological interventions into social and economic measures. In the process of such implementation, there must also be an effort to ensure a balance in the provision of the entire range of health services - promotive, preventive, curative and rehabilitative - in the community.

The global movement for HFA through PHC has also significantly influenced health development in Bhutan. Bhutan had been closely collaborating with the World Health Organization, whereby the HFA/PHC principle was introduced to the country 30 years ago. However, I must say that a health development concept similar to PHC had been practised in this country even before the inception of the Alma-Ata Declaration.

Strong community participation and the prevailing multisectoral actions in health development at the village level greatly contributed to the successful
application of such a concept in Bhutan. The unwavering determination of the government, as reflected in the national development policy effectively supported the development and implementation of the PHC approach in the country.

Strong political will and commitment are prerequisites for successful efforts in PHC. This was particularly true of the national development strategy of the Royal Government of Bhutan which emphasized human resource development, building country capacity for national self-reliance and special efforts towards long-term sustainable development. Bhutan’s health development has moved forward very fast indeed during the past 30 years. Starting almost from scratch, Bhutan’s health infrastructure is now robust enough to adequately serve the basic health needs of the population.

In 1984, the year I first came to Bhutan, there were not more than 20 hospitals altogether, 64 basic health units (BHUs), and 40 dispensaries, with not more than 100 supporting outreach clinics. Today, the country health services delivery is carried out through a network of 29 hospitals and 176 BHUs, supplemented by 485 outreach clinics. The capacity of district hospitals has been strengthened to ensure better quality medical care and more effective referral services. The National Medical Centre in the capital has been further developed to ensure availability of tertiary care with specialized services of higher quality. Health training institutions have been expanded to meet health manpower needs for competent and skilled health professionals and health workers to serve the entire population.

Very remarkably, the national health expenditure of Bhutan has increased significantly from a small proportion to 10% of the overall national expenditure for development today. This clearly shows that the Government has a strong commitment to health development that can lead to happiness and well-being for all Bhutanese people. Not many countries can afford to raise the level of allocation for health to this level.

These are some of the things that show the progress in the development of the health system in Bhutan. Certainly, Bhutanese people today also look healthier and happier than they did 30 years ago. Life expectancy at birth increased from 47 years in 1984 to 66 in 1994. The infant mortality rate declined from 102.8/1000 live births in 1984 to 60.5 in 2000. The maternal
mortality rate decreased from 7.7/1000 live births in 1984 to 2.55 in 2000. This maternal mortality rate is calculated according to the old method of estimation. I am sure that if we had more recent and accurate data, these statistical health profiles of Bhutan would be significantly different.

Furthermore, Bhutan achieved the target of universal childhood immunization (UCI) in 1991; and that achievement has been successfully maintained. Very few countries in the Region could have reached this achievement at that time. And Bhutan was the only country in the SEA Region that reached the elimination goal of IDD in 2003, and that gain has also been maintained. As mentioned by H.E. the Minister of Health, the global targets for polio eradication and leprosy elimination have also been achieved.

The strength of the entire health system in Bhutan has been greatly influenced by health development from the grassroots level. The grassroots is where the PHC concept has been successfully developed and implemented, with strong national policy commitment and support. An operational plan for PHC implementation had been well prepared within the socio-cultural, economic and political context of the country.

Technical competence, unwavering determination and commitment, selfless dedication, and hard work of the Bhutanese health staff and people at all levels have no doubt been the cornerstone of all these successes. I sincerely congratulate the Royal Government of Bhutan for their very high quality health workforce and for their committed communities.

The world is now celebrating the thirtieth anniversary of PHC. Operational modalities of PHC throughout the world are being reviewed with a view to further innovation and revitalization. We have to look forward to the continued relevance and effectiveness of PHC in facing today’s health challenges, and in responding to dynamic health needs of the entire population. Today’s health challenges are really not the same as those we faced 30 years ago. We, therefore, must be innovative enough to be able to tackle the new health challenges with full confidence. The success story of PHC in Bhutan can be a valuable lesson for other countries to learn from especially those in the developing world.

WHO will certainly continue close collaboration with the Royal Government of Bhutan in further strengthening the country’s health system based on HFA/
PHC principles. With a complete and functional health infrastructure, Bhutan may now pay due attention to qualitative aspects of health development. Particular attention may be given to the quality of health care, especially in the rural areas. Ways and means may be thought of for the development of a realistic and practical strategy for effective delivery of services in the areas of health promotion and disease prevention. The reduction of the disease burden and alleviation of the economic burden due to disease depend on health promotion and disease prevention. These are indeed important public health interventions for positive health.

More efforts may be needed in further developing and strengthening various categories of health workforce to adequately satisfy the need for health services of all people, at all levels. With adequate qualified and skilled health staff, Bhutan will go a long way in improving the health status of the entire population, rural and urban, in the twenty-first century. In this connection, special attention may need to be paid to further development and strengthening of community/village-based health workforce. This is the workforce that can help reach the unreached, and enhance services in the areas of health promotion and disease prevention. WHO will spare no effort in supporting the country in the development of human resources for health, which should be a high priority in the national health development plan.

Finally, I sincerely congratulate the Royal Government of Bhutan for convening this important annual conference. It is the best platform for taking stock of health issues of national concern; outcomes from the conference can be an important basis for further planning for a more effective national health system to serve the entire population. I gratefully thank the Royal Government of Bhutan for conferring on me this special honour and privilege. I wish Bhutan continued successful endeavours towards good health for all their people in the coming decades. WHO will certainly continue to be an intimate partner in this endeavour of the Government.
Human resource in the context of a national HIV/AIDS programme is a broad subject. This is especially so when HIV/AIDS is considered to be not only a health, but also a social and economic problem. And in particular, when health is not only an issue of a physical but also of mental and social well-being. HIV/AIDS considerably affects mental and social well-being because of the nature of the disease. The national HIV/AIDS programmes need to be multisectoral and multidisciplinary, involving a wide range of players and stakeholders in its prevention and control.

An understanding of various dimensions of the disease is necessary for the development of human resource in the context of national HIV/AIDS programmes. For effective prevention and control of HIV/AIDS, competent planners and administrators are required to undertake effective programme development and management. The HIV/AIDS programme needs capable professionals and specialists to pursue research, training, and supervision. And very importantly, the programme needs well-trained staff with the required skills to deliver quality services to HIV/AIDS-affected people.

The delivery of HIV/AIDS services involve providers beyond health-care workers. The service providers for HIV/AIDS also include social workers and several others working in the community. The programme needs staff and volunteers who can render required assistance as needed by the HIV/AIDS-affected persons. On the other hand and to a large extent, HIV/AIDS service-providers themselves also become the victims of the disease. They too need professional help and care. While providing services for HIV/AIDS, the providers also need to know how to protect themselves from the infection.

All who are involved in planning management and delivery systems for the population at risk, and for affected persons are considered the human resource in the context of the national HIV/AIDS programme. To be effective in service delivery, service-providers need appropriate education and training. The content of such education and training should no doubt include knowledge and evidence on the natural history of the disease; and not less important, such content should encompass its sociocultural, economic, and political dimensions.

Human resource development within the context of the national HIV/AIDS programme, in a way, has its own distinct features. However, services of the programme should be integrated into the general health-care services and into other social services. In this particular exercise, I hope that we would not create a new category of workers who can serve exclusively only HIV/AIDS-affected persons. Services for HIV/AIDS-affected people should be a function of all general health-care and social service-providers.

Let me also touch on certain aspects of HIV/AIDS which may be useful in the development of human resources within the context of the national HIV/AIDS programme. These are not new to any one of us, but I would like to mention them because I think they are important for such development of human resource.

Let me touch on the social dimension of HIV/AIDS which is very strong indeed; the aspects of social stigma and discrimination. These are also linked with the natural history or epidemiology of the disease. We know that the incubation period of the disease takes time; and AIDS cases come insidiously, not in any acute or sudden development. This situation allows time for the affected persons to go underground and hide from society. Therefore, it is very difficult to estimate accurately the number of HIV-infected people in the population.

We do not know exactly how many people are affected with HIV/AIDS in the community. Therefore, it is very difficult to get every affected person to come for treatment and care. Attempts have been made to estimate the number of the HIV-infected by various methods; and we know something about the estimates. However, this may be only be tip of an iceberg; much about the HIV/AIDS-affected population may still be unknown. This not only in terms of the actual number of those infected, but also in terms of the social and
economic dimensions of the disease. While they are underground and hiding, the HIV-infected persons also spread the dangerous virus to other people. Due to social stigma, the people who are exposed to HIV risks are afraid to come for counselling and blood tests. Therefore, they do not even know that they are infected with the virus and they may not also know that they are spreading the virus to other people.

This situation is serious indeed in terms of prevention and control of HIV/AIDS in the community and in the population. The situation prevents us from reaching the unreached, even in the urban or the upper social classes. Social stigma and discrimination create psychosocial barriers between the infected and the service-providers that are very difficult to overcome. The social dimension of HIV/AIDS really needs more attention of the national programmes.

One other aspect also relates to treatment. With advancement in pharmaceutical sciences, the industry can produce more effective drugs for treating HIV/AIDS. HIV-infected persons can now live much longer. One day in the future, HIV infection may become something like a chronic disease with which affected people may be able to live a longer life under extensive treatment. The infected person, to a certain extent, may be able to pursue a reasonably happy, socially and economically productive life. For this, it is necessary for effective drugs to be freely accessible to HIV-infected persons at an affordable cost.

This technology advancement may significantly change the epidemiological profile of HIV/AIDS in future; and the paradigm for HIV/AIDS treatment and care may not be the same. Whatever the situation is, the national HIV/AIDS programmes should always place emphasis on prevention. Till the vaccine is not available, education to go along with other preventive measures should be the overriding priority in the national HIV/AIDS programme. This is to help reduce the disease burden and ensure a long-term sustainability of the programme’s achievements. However, we have to keep in mind that the ultimate impact of education is a long-term goal.

HIV/AIDS will continue to be a grave concern globally, and for how long we do not exactly know. It will continue to be a global public health problem with high priority. All of us know well that HIV/AIDS is a great health threat for people in the SEA Region, and in the world. I am sure the exact magnitude
of the problem in countries of the South-East Asia Region is still not clear. Therefore, preventive education should be the key regional strategy for HIV/AIDS control in the long term. The development of human resources in the context of a national HIV/AIDS programme is indeed relevant to our public health needs today in our fight against this scourge. Only with an efficient and effective workforce will we be able to bring HIV/AIDS successfully under control in the Region.
The theme of the conference, “Healthy People for a Healthy World”, is very timely indeed. The topic of my talk today is “Thirty Years of WHO’s Health For All Goal”.

With increasing magnitude and severity of health problems in the world, and with the worldwide concern regarding to the unjust and unbalanced distribution of health resources throughout the world, the Thirtieth World Health Assembly in 1977 resolved, among other things, that the social target of governments and WHO in the coming decades should be the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life. This decision of the World Health Assembly was really historic. It was the starting point of the global movement for “Health For All”. The overriding consideration behind this decision was also based on the principle that health is a basic human right and a worldwide social goal; and that health is essential for the satisfaction of basic human needs, and for the quality of life of all people.

A year later in 1978, the International Conference on Primary Health Care held at Alma Ata, in the then Union of Soviet Socialist Republics, defined ways and means to attain the “Health For All” goal. It was agreed at the Conference that the primary health care approach was the key to the attainment of this social goal. PHC, as defined at that International Conference, was considered as an integral part of social development in the spirit of equity and social justice.

We all know that the Health For All goal is yet to be realized. Today, Health For All exists as an aspirational goal, towards which all countries should strive in their quest for good health for all people. And PHC is still considered to be the key approach to achieving this social goal. The worldwide efforts to

reach Health For All through the PHC approach during the past three decades have had far-reaching consequences. These consequences not only pervade throughout the health sector but also impact other aspects of social and economic development. This is particularly so at the community level; and in particular, in developing countries.

During the past 30 years the HFA/PHC principle has significantly contributed to positive changes in the ways that health systems in countries are developed and managed. And certainly, the HFA/PHC principle has contributed significantly to the positive impact on health of the people around the globe. Apparently, people in the world today, in general, look healthier, have an improved well being than 30 years ago. However, when looking at the global averages of the changes in certain vital statistics during the past three decades, one may have mixed feelings.

- Life expectancy at birth increased by only 5 years.
- Maternal mortality ratio decreased by only 30 per 100000 live births.
- Infant mortality rate decreased only by 29 per 1000 live births.
- And under-5 mortality rate decreased by 43 per 1000 live births.

Undoubtedly, these global changes had been effected through the combined efforts of the health sector and other sectors. A wide variety of stakeholders and partners have been involved at all levels of health development, which is an integral component of social and economic development. Numerous documents have been published on the success stories in the implementation of HFA/PHC strategies during the past three decades. During the recent past, a number of international conferences were convened, where the positive impacts of HFA/PHC strategies were presented and reviewed. And at those conferences the future course of action towards the attainment of HFA through the PHC approach were chalked out.

The adoption of HFA goal by the World Health Assembly in 1977 had contributed to a profound change in the concept and scope of health development. In 1979, the United Nations General Assembly passed a resolution underpinning health as an integral part of overall development. Since then, health has gone much beyond the responsibility of the health sector. More and more health issues have now become public concerns and subjects of public debate. And health issues are reflected more and more on the political
agenda for national social and economic development. Health is becoming more prominent on both national and international development agendas.

The social goal of HFA is yet to be realized in the world. To stride towards this social goal, we have to face a number of formidable challenges. We certainly have a hugely unfinished agenda in the health area. The age-old scourges such as malaria, tuberculosis, encephalitis and dengue are still rampant. The spread of HIV/AIDS is still continuing, especially in the developing world. There are added health challenges due to environmental, ecological, demographic and epidemiological transitions. There are new and emerging diseases, communicable and noncommunicable. Over 30 new pathogens have been identified during the past 30 years. Chronic noncommunicable diseases have emerged as problems of public health importance in developing countries.

Climate change poses a real health threat for the whole world. Global warming is real and already with us. We have to squarely face the consequences of climate change. We have to be ready to protect the health of our people from this daunting global change. And, undoubtedly, the changes in social, economic and political arenas have profoundly affected the way we plan and manage our health programmes today.

Technological advancement and globalization have a significant impact on the development and delivery of health services around the world. These factors and attributes are part of the environment within which we are pursuing our quest for HFA. To achieve the HFA goal, we need innovative strategies and tools for tackling today’s health problems much more efficiently and effectively. To ensure HFA, it is necessary that all sectors get involved in health development, individually or collectively. Even more importantly, people from all walks of life must be educated and empowered, in order for them to get fully engaged in their health matters. This is “Health for All” through “All for Health”.

To achieve Health For All, the vicious cycle of illness, ignorance and poverty has to be broken through the combined endeavours of all stakeholders at all levels. Governments must ensure well-balanced national development that can lead to equity in health, education and wealth. Adding to these determinants are peace and security that need to prevail locally and internationally. Peace and security are indispensable requisites for worldwide progress towards the Health For All goal.
There is an important consideration that needs to be clearly understood in connection with Health For All. The HFA goal does not envisage all people to be completely free from any ailments; physical, mental or social. With HFA, people may still continue harbouring certain illnesses; silent or with a certain degree of declared morbidity. Very importantly within this context, all people should live long and be able to live independently and enjoy a socially and economically satisfying and productive life. With HFA, we will continue fighting diseases and disabilities while, at the same time, intensifying our investment in health promotion and disease prevention. Health promotion and disease prevention are the strategies that focus their interventions on health risks and health determinants. The strategy that can ensure the reduction of disease burden and the alleviation of poverty. It is the strategy that has to be implemented through complete integration between social measures and technological tools. The strategy that can ensure the balanced provision of promotive, preventive, curative and rehabilitative services. The strategy that can ensure the balance between health services that are provided institutionally and those that are planned and provided directly by the community.

This important international conference is being convened by nurse leaders. During the past decades, nurses have played an important role in contributing to the progress towards the HFA goal. Certainly, this profession will have an increasing role to play in our future endeavours towards this social goal. In a big way, nurses can help ensure reaching the unreached, who are usually the poor, underprivileged, marginalized and vulnerable. The nurses, thereby, will contribute significantly to equity and social justice in health.

With proper orientation, the nursing profession can form a critical mass of workforce that spearheads the efforts towards the achievement of good health for all people. This will help promote the constitutional principle of WHO that calls for health to be a fundamental right of everyone. At this important international conference, let us once again reaffirm our unwavering determination and commitment to the attainment of the social goal of HFA through the PHC approach.

Let us continue our untiring efforts to advocate for more political will, and for decisive political commitment to the development of national health systems based on the HFA/PHC principle.
I congratulate the Ministry of Healthcare and Nutrition of the Government of Sri Lanka and the College of Community Physicians for taking another significant step in the strengthening of public health in the country. This Public Health Lounge will help take us a long way forward in promoting the development of more public health professionals in Sri Lanka.

Public health is not new. Its principle and practice back to over a century. Today, we need to revisit public health, to re-examine its principle and practice. There are many reasons for doing so.

There has indeed been a remarkable change in the concept of and approach to health development. Along with this change, there has been an evolution in the principle and practice of public health. Health issues have increasingly become public concerns and the subject of public debates; and health concerns have been increasingly reflected on the political agenda for development at all levels. More and more health development needs the combined force of multisectoral and multidisciplinary actions. Nowadays, we increasingly talk about using health to reduce poverty and to spearhead the thrust for peace.

Health development is gradually moving towards primary prevention to reduce disease burden, the primary prevention that bases its interventions on health risks and health determinants. Today, we are not only concerned with survival, but also with a socially and economically productive life.

Changes in the world necessitate new measures and new interventions to ensure human well-being in all spheres, including health. In health, we need
public health with its new paradigm, new outlook. We need public health interventions that can effectively ensure equity and social justice in health. We need public health interventions that promote health as a fundamental right of everyone. Public health interventions that ensure reaching the unreached.

In this new public health paradigm, essential functions of public health, which are country-specific, need to be defined in the local socio-cultural, economic and political context.

Primary health care is an indispensable tool of public health towards the achievement of national health goals, including the Millenium Development Goals. PHC encompasses social and economic productivity of all citizens in all countries. This is the composite of today’s health landscape, one which has many stakeholders and partners.

The goal of health for all has indeed become a social goal; and has transcended the traditional parameters of health. We need to revisit public health in order to keep pace with the global changes today.

Certainly, there is a need to strengthen our public health infrastructure and public health workforce. More attention is needed for the public health workforce, especially those who are working at the community and grassroots level. These people are community-based workers and community volunteers. These people can effectively help ensure reaching the unreached, the poor, the under-privileged, the marginalized and the vulnerable.

We, public health professionals, should fully support these dedicated people in all aspects of their work. At the same time we have to train and equip our public health professionals in order to move forward more effectively in the new public health paradigm, the paradigm that can help ensure good health for all through the primary health care approach. The paradigm that brings out quality health services beyond the institutional boundary to the entire community and the whole population. These services are reaching out to all people everywhere, regardless of physical and psychosocial barriers.

Strengthening public health infrastructure and the public health workforce is accorded highest priority in the WHO South-East Asia Region. We promote and support the development and strengthening of public health education
institutions. The South-East Asia Public Health Education Institutions Network (SEAPHEIN) has been in existence for such promotion and support. The network convenes an annual meeting for promoting intercountry cooperation in public health education. This year the meeting will be held in Bali, Indonesia, in June. All of us here are cordially invited to attend.

I also would like to take this opportunity to place on record our deep appreciation for the valuable support from Dr. Palitha Abeykoon, to the work of “Public Health Initiative” of SEA Region, and to the work of SEAPHEIN in particular. We hope for his continued contribution to this priority work of WHO in the Region. WHO’s former staff members in Sri Lanka are also valuable assets to help in this endeavour.
This third volume of selected speeches by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, covers the period from March 2008-February 2011. The first two volumes, "A vision for health development in South-East Asia" and "Working towards better health in South-East Asia" covered the period March 2004-February 2008.