FROM VISION TO REALITY

Advancing Public Health in the South-East Asia Region
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Dr Poonam Khetrapal Singh,
WHO Regional Director for South-East Asia
When I assumed leadership of WHO in the South-East Asia Region in February 2014, the need to define the Organization’s trajectory for the coming years was apparent: In public health as in other pursuits, we can only be truly effective when actions are informed by vision and strategy.

An initial ‘1 by 4’ plan was developed as a result of consultations with Member States, which became the Flagship Priority Areas. These have defined the Organization’s programmatic, financial and technical bearings since, and have driven the regional public health agenda. In giving shape to the guiding vision of the Priority Areas and ensuring it has the greatest possible influence, advocacy and outreach has been of critical importance.

At the highest levels, vigorous advocacy has helped increase the visibility and uptake of key technical guidelines and recommendations. As the following pages demonstrate, whether at high-level meetings or among international working groups, public health advocacy is promoting good policy choices across the Region. Making a difference is as much about creating momentum and drive as about providing sound technical advice.

Engaging with the public via popular media has been similarly vital to advancing the public health mission. Targeted messaging has helped increase health literacy, empower the public to avoid health risks, and create greater awareness of public health issues. This not only increases the prominence of public health within social and political discourse, but also results in a more inclusive policymaking process. As economies across the Region develop, public health concerns must be front and center of political and social discussion.

To this end, our online presence is critically important. Live publishing on social media channels and regular website updates mean a steady stream of clear, accurate and actionable information is reaching publics across the Region, with messages being amplified by country offices, UN agencies and other partners. At the same time as serving to inform and educate, these initiatives also promote trust—perhaps the most basic component of any successful public health intervention.

Importantly, advocacy efforts are also oftentimes targeted at audiences beyond the immediate Region. As a number of products in this publication demonstrate, the Organization is a conduit for the concerns of Member States in the Region to be articulated at the global level. Doing so in a responsive and responsible manner is a duty taken seriously, and one that we will continue to exercise with appropriate diligence.

As the world settles into the Sustainable Development Goal era, the need to promote public health policies and concerns remains as strong as ever. WHO South-East Asia Regional Office will continue to advocate for the highest attainable standard of health for every person in the Region, and will continue to do so at all levels of the discussion.
I take charge as Regional Director at an important moment in the history of public health and at a critical time in the evolution of WHO. I do so in all humility, knowing full well the challenges that lie ahead.

The public health arena is changing fast. The paradigm shifts are evident in the agendas of the World Health Assembly and Regional Committee meetings over the past decade. The dominance of communicable diseases, inspite of their continued relevance, stands eroded. Noncommunicable diseases, Millennium Development Goals (MDGs), universal health coverage, intellectual property rights, virus sharing, essential and affordable medical products and the impact of socioeconomic and environmental determinants on health are increasingly engaging the time and attention of our Governing Bodies.

I propose an ambitious ‘1 by 4’ plan. The 1 refers to a more responsive WHO in the Region and the 4 refers to the 4 strategic areas:

1. Addressing the persisting and emerging epidemiological and demographic challenges.
2. Advancing universal health coverage and robust health systems.
4. Articulating a strong Regional voice in the global health agenda.

Addressing the persisting and emerging epidemiological and demographic challenges

Member States in the Region have made spectacular health gains in recent years with concerted national efforts.

The most impressive achievement is the eradication of wild poliovirus. A few months from now, this Region is likely to be certified polio-free. This is certainly a testimony to the capability of the Region. This success must be replicated for other vaccine-preventable childhood killers to fully protect all children from premature morbidity and mortality. We join the United Nations Secretary General in recognizing the achievements of Bangladesh and Nepal in MDGs 4 and 5.

We are progressing steadily in combating diseases enunciated in MDG 6. Since 1990 tuberculosis mortality has declined by 40% and malaria kills 82% fewer people. Maldives continues to be malaria free. The HIV epidemic in most of the high-burden countries has been reversed. However, we need to work together to protect these gains from the menace of drug resistance and coinfections.

Microorganisms continue to surprise us. These caused the influenza pandemic, SARS and avian flu leading to international chaos. The global response against these events is the International Health Regulations (2005). IHR demands substantial scaling-up of national capacity. We must enhance this capacity for ensuring health security in our Region.

While our fight against communicable diseases continues unabated, the escalating epidemic of noncommunicable diseases (NCDs) is stretching health systems. More than half of our mortality is caused by cardiovascular diseases, chronic respiratory diseases, cancers, and diabetes. It is a matter of concern that a third of these deaths occur in people under 60 years of age. Unhealthy lifestyles, unwholesome food, and increasing alcohol and tobacco use are major behavioural risk factors. Sri Lanka has taken the lead in our Region in declaring 2013 as the year of preventing NCDs. Ten countries have adopted legislative and administrative measures to curb the tobacco menace. Health promotion and primary prevention of NCDs is critical. Prevention requires multisectoral action from multiple stakeholders in nonhealth sectors whose policies have adverse health effects.

Mental health is generally neglected. We need to integrate mental health services as part of primary care. Malnutrition in children under five is very high and needs to be addressed through a set of integrated interventions
and multisectoral approaches.

The maternal mortality rate among young women continues to be worrisome. Pregnancies must be made safer than they are today. Gender-based violence needs to be tenaciously addressed. Tobacco consumption among women, including smokeless tobacco, has to be reduced. Our populations are ageing at an unprecedented rate. People aged above 65 will soon outnumber children under the age of five. We are committed to promoting health and wellbeing across the whole life course.

**Advancing on universal health coverage and robust systems**

With its three dimensions of access, affordability and quality, universal health coverage (UHC) is the most important game changer in public health. Thailand has successfully made available to its entire population a health system that provides access to affordable, comprehensive, quality health services. We need to share Thailand’s experience across the Region.

Improving access requires overcoming four main barriers: geographical, technological, social and financial. These are not insurmountable. Efficient implementation of the telemedicine project in Democratic People’s Republic of Korea has demonstrated the reach and utility of technology to far-flung areas of this nation beset with difficult terrain. There is untapped opportunity to improve access to health through new cost-effective technologies. Research, innovation and affordable health technologies need to be encouraged.

The WHO South-East Asia Region has the highest out-of-pocket spending on health and relatively low public investment in health. This is a key cause of overall inequities. In 1978, Alma-Ata showed the importance of primary health care rooted in the community and attuned to its economic, social and cultural aspirations. With escalating NCDs and ageing, health-care costs will spiral upwards. A comprehensive approach is needed to meet people’s expectations. Our health systems must deliver quality preventive, promotive, curative and rehabilitative health services. Public–private partnerships could be a pragmatic way to complement the efforts of the public sector. The Rural Health Insurance Scheme from India holds valuable lessons for public–private partnerships especially those for the poorest.

Increased access to essential, high-quality and affordable medical products remains a major concern. The pharmaceutical industry, regulatory authorities and even the judiciary have roles ensuring universal access to quality medicines. Prices, patents, generic versions and innovation drive pharmaceutical markets. Intellectual property issues carry global sensitivity and complexity requiring deft navigation. While innovative approaches are needed to encourage medical research and development, flexibilities in international agreements provide access to those who cannot afford high prices. The right balance must be sought. In addition, cost-effective procurement mechanisms need to be explored. We must facilitate this especially for countries in greatest need, such as Bhutan, Democratic People’s Republic of Korea, Maldives, and Timor-Leste.

Delivery of quality health services is possible through adequate production, management and training of healthworkforces, backed by appropriate infrastructure and functioning referral systems. Critical shortages, inadequate skill mix, uneven geographical distribution, internal migration from rural to urban areas or public to private sectors are challenges that need to be addressed through renewed approaches regarding their production, education and training as well as their working conditions and remuneration. Health workforce strengthening will be given utmost importance.

**Strengthening emergency risk management**

The WHO South-East Asia Region is extremely disaster prone. The World disaster report 2012 reveals that in the past decade, 41% of global mortality
from natural hazards was in countries of the Region. The tsunami of December 2004 taught us several lessons. Member States were instrumental in establishing the South-East Asia Regional Health Emergency Fund in 2007, which has helped meet immediate financial needs of our countries for a quick response in emergencies. The 12 Benchmarks for Emergency Preparedness and Response have received global recognition and provide a framework for national capacity-building.

Political conflicts have been as challenging. Timor-Leste, during its struggle for independence in 2002, had 70% of its infrastructure destroyed and 70% of its population displaced, which had a significant impact on its health systems and the health status of its people. However, the country has exhibited exceptional progress in its rehabilitation, reconstruction, and rebuilding efforts. We need to take a holistic approach and integrate prevention, risk reduction, preparedness, response, and recovery. We must make disaster risk reduction an integral part of national strategies and sustainable development policy.

A strong voice in the global health agenda

South Asian thinkers have led the international debate on health and development — from Professor Amartya Sen’s seminal work on the human development index that emphasized social development, to the global attention that Bhutan has drawn on gross national happiness as a guiding principle for the post-2015 MDG agenda.

In this era of interdependency and cooperation, stronger voices are generated through alliances and partnerships. The tsunami demonstrated the multisectoral and multicountry coordinated support for immediate response and rapid recovery. We will strengthen existing partnerships and engage in new ones.

To deliver effectively on these four strategic areas, the WHO Regional Office for South-East Asia needs to be more responsive and align with the health needs of Member States. The time-tested ‘honest broker’ role of WHO shall be assiduously augmented through human resources of the highest calibre with proven competence, commitment, and a focus on: providing technical and policy support that is objective and apolitical; mobilizing expertise for institutional and capacity-building in countries; and supporting ministries of health in coordinating all stakeholders including development partners around the national health agenda.

Our diversity is a rich one. We belong to a Region that is blessed with some of the best health experts, state-of-the-art collaborating centres, finest medical facilities and a booming pharmaceutical industry. We will promote inter-country cooperation. We must work to create a common vision that builds incrementally on each and every country’s strengths and capacities, that shares information and best practices, and uses local and regional networks for capacity-building.

“**We will promote intercountry cooperation. We must work to create a common vision that builds incrementally on each and every country’s strengths and capacities.**”

My vision is to partner with you in eliminating gross health inequalities and enhancing human welfare. My vision is to augment the capacities of all Member States so that our Region is recognized for its intellectual vigour and evidence-based decision-making. My vision and determination are to make the WHO South-East Asia Region an excellence-pursuing, responsive, and accountable organization. My vision is to make our Region globally known as a leader in public health.
Fortifying emergency risk management is critical to securing health in the South-East Asia Region, which is especially disaster-prone. Since the 2004 Indian Ocean Tsunami, earthquakes, floods and cyclones have provided public health challenges across the Region, while emerging diseases such as SARS, H1N1 and MERS-CoV have threatened to take root.

Diminishing emergency risk is a core area of WHO South-East Asia Region’s work. As the health sector’s response to the 2015 Nepal Earthquake demonstrates, preparedness and good planning is vital. To this end, WHO South-East Asia Region has been working closely with countries to achieve full compliance with the International Health Regulations as well as to meet the SEAR benchmarks for emergency preparedness. WHO has also engaged with health sector partners to refine emergency preparedness and response capacity, as demonstrated at successive high-level stakeholder meetings on advancing global health security.

By fortifying emergency risk management, health security across the Region is being enhanced.
Speech of Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia Region, at the ‘Advancing Global Health Security: From Commitments to Actions’ meeting held 27-29 June 2016 in Bali, Indonesia

Honourable ministers, distinguished representatives, dignitaries, ladies and gentlemen.

The importance of attaining global health security is more accepted today than at any other time in history.

In recent years, the health security paradigm has broken through the margins of discourse to become a central concern of public health organizations as well as diplomats and foreign policy thinkers. This is a welcome departure from times past.

Since the mid-19th century, when the first set of guidelines to control the international spread of acute diseases were adopted, nation states have often dismissed health security as secondary to other strategic interests. In the post-war era, despite legal obligations to the contrary, disease epidemics were often covered up rather than reported, leading to the punitive use of trade and travel restrictions that could decimate livelihoods and the economies on which they depend. Neither health nor ‘high’ politics benefitted. Within this environment, the role of international organizations in promoting and facilitating health security was, naturally, limited.

The need for this to change has been clear for some time.

In recent years new diseases have emerged at unprecedented rates, while old diseases such as cholera and tuberculosis have made aggressive comebacks. Antimicrobial resistance, meanwhile, is already killing upwards of 700 000 people worldwide every year. Transnational food production means industrial oversights can compromise the health of millions worldwide, while international trade and travel has the capacity to vastly accelerate a pathogen’s spread.

The 2003 SARS pandemic was, after all, initiated by a single infected traveler who stayed overnight at a busy Hong Kong hotel. Alongside these phenomena, climate change and mass urbanization have gathered pace, with significant consequences for the way each one of us lives.

In addressing the challenges of our brave, new, globalized world, more advanced thought-tools were needed. To this end, the health security paradigm proved invaluable.

For the 11 countries of the WHO South-East Asia Region, which comprise 26% of the world’s population, achieving IHR compliance and enhancing health security is vitally important. In recent years these states have faced the full range of emerging health security threats, including from SARS, MERS-CoV, pandemic influenza (including H1N1), and Zika virus. South-East Asia is also uniquely disaster-prone. Since the 2004 Indian Ocean tsunami, which killed an estimated 230 000 people, earthquakes, floods and cyclones have ravaged the Region with varying frequency.

Breakdowns in trust and cooperation in the past demonstrate the urgency with which these values must be pursued in the present.

In 1994, for example, India was isolated and shunned overnight after it reported a suspected outbreak of bubonic plague in Surat, an industrial hub in Gujarat. Despite widespread panic and confusion, authorities controlled the situation within two months. More devastating than the outbreak, however, was the international reaction to it. Cargo transshipments were suspended, exports were embargoed, flights were cancelled and travel bans were implemented. India lost an estimated 1.7 billion dollars and suffered a record trade deficit. The irrational zeal with which states isolated India compromised the foundations of health security and created disincentives to report future epidemics. Wisely, the revised IHR places transparency and trust at the top of its agenda.
Regulatory oversights can prove equally devastating. In 2004, South-East Asia was impacted by the H5N1 avian influenza outbreak that threatened global health and decimated core economic interests. As legitimate fears of the highly pathogenic influenza strain mounted, mass poultry culls were carried out in affected countries in a bid to limit its zoonotic spread. Between the start of the epidemic and 2013 181 people in the Region succumbed to the disease, which also cost billions of dollars in lost revenue. The pathogen’s cross-border transmission underscored mutual vulnerabilities in food production processes that could have been avoided with better cooperation and international regulation. The episode provides a salient example of how weaknesses in one country can threaten all. It has also become a catalyst for greater cross-border regulation between countries in the South-East Asia and Western Pacific Regions.

Despite threats to health security often have little to do with health systems themselves, underscoring the need for a ‘One Health’ approach that promotes multisectoral awareness and action. In South-East Asia, as across the world, major threats to human health emerge from many places. The inappropriate use of antibiotics in the animal and agricultural sector, for example, is diminishing the effectiveness of antimicrobials in humans. To take another example, the criminal manufacturing of counterfeit drugs compromises the wellbeing of patients across the Region as well as the control of life-threatening diseases. Both issues require coordinated, multisectoral solutions, and both require the buy-in of the whole of society. The principles underwriting health security and the ‘One Health’ approach offer a way out.

Though states are, ultimately, responsible for complying with the IHR and strengthening their own preparedness and response capacities, non-state actors must step-up and assume greater responsibility in providing guidance and assistance. Indeed, as global health actors we must go beyond merely setting the rules of the game, and become active participants. That is exactly what we are doing.

As you are all aware, last year’s Cape Town meeting on health security preparedness laid the groundwork for where we are today. That meeting itself was an outcome of the need for a more robust preparedness and response framework demonstrated by the Ebola outbreak in West Africa the previous year. As we gather here today we can be proud of the fact that this constitutes the first international and global meeting organized by the new Outbreak and Health Emergencies program that was adopted at the 69th World Health Assembly. WHO now has the mandate to move forward with the design, results framework and budget that has evolved out of the reform consultation process. The development of the emergencies program is the result of a thorough reform effort that is aimed at providing fast, effective and predictable responses to health emergencies. And it is also aimed at addressing the full risk management cycle of prevention, preparedness, response and early recovery.

Reflecting momentum at the global level, WHO in the South-East Asia Region has built on efforts to help countries strengthen health security and achieve IHR compliance. In the past few years alone this has had tremendous impact.

The retrofitting of hospitals in Nepal, for example, meant that when last year’s earthquake hit the health system was in a position to implement mass casualty management procedures and respond effectively. In similar fashion, efforts to enhance Thailand’s surveillance system have enabled health authorities to identify and halt transmission of incoming cases of MERS-CoV, a highly infectious and oftentimes lethal disease. In the Maldives, Zika preparedness and response plans are ensuring the archipelago nation is ready and able to respond to any outbreak of the
vector-borne pathogen. And right across the Region, national action plans on AMR will prove vital to rolling back the immense problem of antimicrobial resistance.

As WHO leads the push for greater health security via its new emergency program, alongside nation states, regional political and economic groupings are taking note. In the South-East Asia Region, ASEAN, BIMSTEC and SAARC have all, to varying extents, integrated health security concerns within their agendas. This is also happening at the global level, as evidenced by the G-7’s recent Ise Shima Vision for Global Health, which reinforces support for IHR and the commitment of G-7 countries to facilitate international compliance. The Global Health Security Agenda, meanwhile, is leveraging the comparative expertise of developed and developing countries across the world to advance capacities in core areas of health security via the achievement of clear and measurable targets.

As this groundswell builds, multilateral financial institutions such as the ADB and World Bank are creating new avenues for resource mobilization. The Strengthened Support for Regional Health Security initiative and the Pandemic Emergency Financing Facility, for example, will both have a positive impact on health security across the world. The momentum and commitment we are currently seeing will only grow.

Honorable ministers, ladies and gentlemen,

As we work towards greater health security, we must take care to avoid undesirable side-effects. Although health security is concerned with preparing for and responding to fast-evolving threats, this tendency must not distort its proper conception, nor prejudice donor priorities and public health diplomacy. Poor health infrastructure and endemic diseases such as tuberculosis, HIV-AIDS and malaria undermine health security as much as the specter of bioterrorism or the next great pandemic. Their banality must not lead to distraction. Weak health systems were foundational to the 2014 Ebola outbreak in West Africa, for example, and continue to imperil citizens of developing countries across the world. By extension, they imperil all of humanity.

As states move beyond narrow understandings of strategy and interest, approaches to health security must be equally far-sighted. To this end, strengthening health systems and achieving universal health coverage must occur alongside other initiatives to advance cooperation and mutual trust. Strong health systems provide the most effective means to contain and eradicate the infectious diseases of old, and provide the first line of defense against emerging diseases of pandemic potential. They also ensure a rapid and effective response to acute public health events such as natural disasters and environmental emergencies. Stability and growth are similarly well served.

"As states move beyond narrow understandings of strategy and interest, approaches to health security must be equally far-sighted."

This more robust understanding of health security is something that we must all push for. Thankfully, it is gaining traction. The Sustainable Development Goals emphasize the importance of achieving universal health coverage. The 2015 Sendai Framework makes explicit the need for strong and resilient health systems to protect against all hazards. And state-driven emergency preparedness and response frameworks are being complemented by a renewed emphasis on health system strengthening as a core part of public health diplomacy.

As WHO leads international and global efforts to further hone the health security agenda at this conference and the many others taking place in the coming year, we must all keep the overarching goal of attaining universal health coverage uppermost in our minds. Similarly, we must also reflect on the importance of the ‘One Health’ approach and the role effective partnerships can play in fast-tracking its realization.
Honorable ministers, ladies and gentlemen,

As I mentioned at the beginning of this speech, the health security agenda is more important now than it has ever been. We are working on a concept that has truly come of age and which is desired by states and their citizens the world over.

“We have the opportunity to hardwire altruism into the global system and make people’s health central to international affairs.”

We must be conscious of the responsibility which accompanies this and work to ensure that the greatest outcomes for public health are pursued with vigor and clear-headed resolve. Together we have the opportunity to hardwire altruism into the global system and make people’s health central to international affairs. History is on our side, ladies and gentleman, but we must harness its force wisely.

With this in mind, I wish you all a productive and engaging conference.

Thank you very much.
26 April 2015, New Delhi: The World Health Organization this morning handed over four emergency health kits comprising of medicines and medical supplies and US dollars 175,000 as the first tranche of emergency health funds to meet the immediate health needs of the earthquake-affected people in Nepal.

“Within hours of the tragedy, WHO disbursed medical supplies to cover the health needs of 40,000 people for three months. These supplies are in the form of inter-agency emergency health kits and were given to hospitals in Nepal treating the injured,” WHO South-East Asia Regional Director Dr Poonam Khetrapal Singh said.

WHO also immediately made available US dollars 175,000 to the Ministry of Health and Population, Nepal, as the first tranche of South-East Asia Regional Health Emergency Fund (SEARHEF). The SEARHEF funds are aimed at meeting immediate financial needs and to fill critical gaps in the aftermath of a disaster.

Simultaneously, WHO is supporting the Ministry of Health and Population, Nepal, to continue to assess the health needs of the affected people and the damage to health facilities. Senior officials from the WHO Regional office are in Kathmandu to reinforce WHO Nepal Office’s support to the Government of Nepal.

Other than the injured, those rendered homeless by the earthquake are in need of immediate support for regular public health services, water and sanitation and psychosocial support to deal with the trauma caused by the tragedy.

The WHO emergency kits disbursed this morning include medicines, disposables and instruments. Each kit can meet the needs of 10,000 people for three months. Each kit has a basic and supplementary unit. The basic unit is intended for use by primary health care workers with limited training. It contains non-injectable drugs, medical supplies and some essential equipment, accompanied by simple treatment guidelines. Basic equipment also has a complete sterilization set and items to help provide for clean water at the health facility. The supplementary unit contains drugs, renewable supplies and equipment needed by doctors working in first- or second-referral health facilities.

The kits, developed by WHO, can also be used for initial supply of primary health care facilities where the normal system of provision has broken down.

Reiterating all possible support, Dr Singh said WHO stands with the people and the Government of Nepal in this hour of crisis and would do everything to save lives.
Perhaps the greatest challenge of all will be rebuilding Nepal's health system to ensure equitable access.
Crisis presents opportunities to rebuild resilient, equitable health systems in Nepal

Opinion editorial article by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia

Just over a month ago an earthquake tore across the Himalayan country of Nepal, causing injury, death and destruction. The fact that the earthquake was anticipated for some time failed to dim the shock and sorrow it caused. Images of grief-stricken Nepali citizens—from the mountains to the plains—became the clarion call of a global outpouring of solidarity and aid. The 12 May aftershock, read as a footnote to the original quake by much of the media, compounded the tragedy that Nepal’s people suffered.

As with all disasters, the extent of the carnage was dependent on the preparedness, resilience and accessibility of the country’s health care system and its ability to deal with the flood of patients requiring life-saving treatment. In this regard, the Government of Nepal must be given credit.

Since the 2004 Indian Ocean tsunami, disaster preparedness in the countries that fall within the World Health Organization’s South-East Asia Region has been measured by the lessons learned from the shortcomings of the response to that unprecedented crisis. Within living memory no comparable calamity had occurred, meaning little planning had gone into preparing for and responding to its eventuality. Health care systems were caught off guard and rendered largely dysfunctional.

“Perhaps the greatest challenge of all will be rebuilding Nepal’s health system to ensure equitable access.”

Nepal’s recent tragedy, however, had long been foreseen. Nepal is located on a tremulous fault line that experts say is disturbed approximately once every 80 years. Though no quake of a similar magnitude had ravaged the country within the living memory of most of its citizens, the 1934 Nepal-Bihar earthquake left its mark on the national psyche: Each year on 15 January, an estimated 8500 Nepali victims of the tragedy are mourned. This awareness was translated into hard policy in areas of critical importance.

While the scattershot urbanization of the Kathmandu valley was always going to be difficult to temper, major public hospitals were retrofitted to withstand powerful quakes, ensuring that a coordinated health response, when required, would be effective. Essential services such as emergency rooms, operating theatres and maternity wards were prioritized for fortification, while emergency medical supplies were strategically located. Though over 90% of the country’s health infrastructure was destroyed by the quakes, including four district-level hospitals outside Kathmandu, the retention of key health care facilities throughout the country prevented a disaster of much greater magnitude.

Of equal importance is the fact that health workers had been given the basic skills to deal with the unprecedented influx of patients. Educational programs in mass-casualty management ensured that amid the chaos there was reason and efficiency. As Nepal’s health workers performed around the clock, often under torchlight, patients were triaged and resources allocated where they could be most effective. Nepal’s first responders provided critical care when it mattered most, and were later supported by foreign medical teams that provided surge capacity in a coordinated, largely orderly manner.

Still, as the monsoon nears and the provision of immediate relief cedes to long-term planning and reconstruction, the challenges to providing equitable access to quality health care are acute. With approximately 2.8 million people displaced, many of whom live in remote areas, priority must be given to reaching the most vulnerable. Along with temporary health care facilities being rolled out to replace those that have been rendered unserviceable, disease surveillance is currently being conducted in the 14 most affected districts so as to enable a rapid response if an outbreak occurs. In the coming months, priority areas of concern include the continuation of maternal and child health care services; the provision of culturally appropriate, evidence-based mental health care for those that have ongoing trauma as a result of the disaster; and access to rehabilitation for the almost 17 000 people injured in the tragedy.
Perhaps the greatest challenge of all, however, will be rebuilding Nepal's health system to ensure equitable access in a country with multiple topographic zones and varying degrees of urbanization. Though it may seem trite, the opportunities that the crisis presents are significant, and must be taken advantage of.

Health services must be rebuilt and distributed according to needs with respect for equitable access and the public nature of the endeavor, while risk-reduction programs must be disseminated and implemented at the subnational level. Soil testing, the enforcement of health facility-related building codes and investment in design for seismic-proof facilities and homes must be encouraged and enacted across the country. At the regional level, neighbors must continue to coordinate closely to enhance the effectiveness of their responses.

While much of this discussion will take place on a policy level and will be the subject of lengthy revision, the key point to be held sacrosanct by those facilitating Nepal's health system response and its long-term recovery is remarkably straightforward: It's about the people. As we move past the 25 April quake, for Nepal's 5.6 million affected citizens, the health-related challenges are ongoing and demand the unflagging solidarity of those with the capacity to help.
INDIAN EXPRESS
Nepal Quake: WHO set up field offices for unreachable survivors

The WHO has set up field offices to extend health care assistance to survivors of the earthquake who have been unreachable since the natural calamity hit the Himalayan nation on April 25.

The World Health Organization’s field offices, that will start operating Monday onwards, will coordinate efforts to reach medical, health care professionals and other life-saving resources to some of the most remote regions hit by the earthquake.

Gorkha is a 24-hour drive northeast of Kathmandu and has been selected as the first major health hub outside the capital.

"Health care services are being delivered in built-up areas in Gorkha and those that still can be reached by road," said Hojo Jeong Eun, WHO’s emergency operations manager, who was on a two-day field visit to the strife-torn village of Kuleshwor in Gorkha that was devastated by the earthquake.

She said the global health organization has identified seven communities in an area not easily accessible, and where there are around 6,000 people who have not been reached with services since the earthquake struck.

"We saw there was an urgent need to provide medical support to the people and treat them for injuries and infections.

"Morgues are also needed to take grief and access for body collection and ensure that any complicity of burial is firmly addressed," she said.

Who committed to helping Nepal deliver health care to citizens, says Dr Pramod Kharel Singh
doctor-pramod-kharel-singh-35065051-1

The World Health Organization’s field office in Nepal has committed to helping deliver health care to citizens of Nepal. Dr Pramod Kharel Singh, WHO Regional Director for South-East Asia, today.

WHO has committed to helping Nepal deliver health care to citizens, says Dr Pramod Kharel Singh
http://www.indianexpress.com/article/journalism/who-committed-to-helping-nepal-deliver-health-care-to-
citizens-doctor-pramod-kharel-singh-35065051-1

WHO has allocated over US$1.1 million for the emergency operations in Nepal. US$ 1.1 million was released within hours of the earthquake from the South East Asia Regional Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster.

The World Health Organization is committed to supporting Nepal’s healthcare system to deliver life-saving and essential services to the people and build back resilient health facilities that will be safe in emergencies, affirmed Dr Pramod Kharel Singh, WHO Regional Director for South-East Asia, today.

"WHO is committed to helping Nepal deliver health care to citizens. We are working closely with the government, the Ministry of Health and Population, Nepal, to ensure that the needs of the affected people are met and that all necessary support is given to help Nepal in tackling the immediate health needs," WHO South East Asia Regional Director Dr Pramod Kharel Singh said.

Dr Kharel Singh also added that medical equipment is needed to be sent to the affected areas.

"There is need for emergency medical supplies, vaccines, medical equipment, medicines and essential medical supplies, accomplished by simple treatment guidelines. Basic equipment also has a complete sterilization set and items to help provide clean water at the health facility. The supplies needed include items such as: medical supplies, personal health care products, essentials for newborns, and essential medical equipment.

"WHO has allocated over US$1.1 million for the emergency operations in Nepal. US$ 1.1 million was released within hours of the earthquake from the South East Asia Regional Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster. WHO has set up a 24-hour emergency response unit in Nepal and is sending medical and other health supplies to treat tens of thousands of people.

NEW EUROPE
According to Red Cross more than 37,566 people are injured
http://www.neweurope.com/article/nepal-depths-toll-above-30000-urgent-need-fail-

Death toll after the catastrophic Nepal earthquake rose again as according to the Nepal Red Cross Society, more than 8,413 people were killed.

On Thursday, the UN stressed that the threat of disease is increasingly hang over the earthquake-stricken nation as the country’s water, sanitation and hygiene infrastructure struggles to recover.

"We are very concerned about the increased risk of communicable diseases, including diarrhoea, in areas were water and sanitation systems are disrupted," said Dr Pramod Kharel Singh, WHO Regional Director for South-East Asia, said on Thursday during a visit to Nepal’s capital, Kathmandu.

"We have a four-week window to provision medical supplies in affected districts and strengthen the country’s water, sanitation and hygiene systems so as to shield it against the threat of disease outbreaks," Dr. Singh continued. "These include water borne and vector-borne diseases such as dengue and malaria, along with acute respiratory infections."

At the same time, the WHO official stressed that more must be done to protect the health of Nepal’s people including ramping up the country’s disease and response system, providing large quantities of necessary medical supplies, and supporting the recovery of the health system.

OUTLOOK
Nepal earthquake: WHO sends emergency hospitals, free aid

The World Health Organization (WHO) has handed over four emergency health facilities comprising medical and medical supplies and US$ 75,000 to meet the immediate health needs of civilians and health workers in Kathmandu.

"WHO has immediately made available US$ 75,000 to the Ministry of Health and Population, Nepal, as the first installment of the South East Asia Regional Health Emergency Fund (SEARHEF). The SEARHEF funds are aimed at meeting immediate financial needs and to fill critical gaps in the aftermath of a disaster.

"WHO is committed to supporting the Ministry of Health and Population, Nepal, to continue to assess the health needs of affected people and to deliver life-saving health services to the people who endured the terrible earthquake," said Dr Pramod Kharel Singh, WHO Regional Director for South-East Asia, today.

"WHO stands with the Government of Nepal as it strives to overcome this crisis," Dr. Singh said during a visit today to Kathmandu. "I am moved by the terrible human impact of the devastating earthquake. It is important that the evidence of the people of Nepal recovered so bravely and effectively in the face of this earthquake is shared with the world."

WHO has allocated over US$1.1 million for the emergency operations in Nepal. US$ 1.1 million was released within hours of the earthquake from the South East Asia Regional Health Emergency Fund to meet immediate financial needs and fill critical gaps in the aftermath of the 25 April disaster. WHO has set up a 24-hour emergency response unit in Nepal and is sending medical and other health supplies to treat tens of thousands of people.

Jakarta Post
WHO sends emergency health units, free aid

The World Health Organization (WHO) has handed over four emergency health care facilities comprising medical and medical supplies and US$ 75,000 to the Ministry of Health and Population, Nepal, as the first installment of the South East Asia Regional Health Emergency Fund (SEARHEF).

The SEARHEF funds are aimed at meeting immediate financial needs and to fill critical gaps in the aftermath of a disaster.

Simultaneously, WHO’s supporting the Ministry of Health and Population, Nepal, to continue to assess the health needs of the affected people and to deliver life-saving health services, including medical supplies and essential medical equipment, to the people affected by the recent earthquake in Nepal.

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Other than the injured, those rendered homeless by the earthquake are in need of immediate support for regular health care, water sanitation and psychosocial support to deal with the trauma caused by the tragedy. The WHO emergency kits delivered by the government, civilians, and international bodies are needed to support the recovery of the health system.
WHO IN THE MEDIA ON NEPAL EARTHQUAKE

With coverage in
BBC News
The Wall Street Journal
Reuters
Idaho Statesman
canberratimes.com.au
The South Asian Times
news.cn
Vancouveritesi.com
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ABC
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The Globe and Mail
Winnipeg Free Press
The New Indian Express
The Economic Times
The Times of India
The Hindu
Hindustan Times
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New Kerala.com
News Informer
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The Asian Age
Kantipur
Kantipur.com
Delhi.com
The Daily Star
Relief Web
Synergy Online
Business Standard
Zee News
The Himalayan

MCKs to be set up to ensure health services

WHO calls for rebuilding health services in Nepal

Step-down centres for those injured in earthquake

China.org.cn

...
Make food safe from farm to plate: WHO

Safe food, from the farm to the plate

Food safety is critical for public health as food-borne diseases affect people’s well-being, strains health-care systems, and adversely impact national economies, tourism and trade.

Pramod Khempale Singh

In an effort to ensure compliance with the framework of the WHO’s South-East Asia Region’s Food Safety Strategy, many countries have undertaken initiatives to reduce the incidence of food-borne diseases. One of the key issues is the need for strong legislative frameworks and effective enforcement of existing regulations. While some progress has been made in terms of legislation, enforcement remains a challenge in many countries.

The WHO recommends that countries develop comprehensive food safety plans, including food safety strategies. These plans should be implemented across various sectors, with a focus on regulatory, technical and educational interventions. Countries should also work to improve collaboration and information sharing among stakeholders.

The food safety regulations need to be strengthened and enforced to ensure that food is safe for consumption. Improvements need to be made in terms of detection, diagnosis and treatment of food-borne diseases. International cooperation is also crucial in addressing these challenges.

WHO call to make food safety a priority

Jakarta Globe

Commentary: Food Safety Must Become a Southeast Asian Priority

Pramod Khempale Singh

The recent call to make food safety a priority highlights the need for action in Southeast Asia. Food-borne diseases pose a significant threat to public health in the region, and effective policies and regulations are essential to prevent and control these diseases.

The Southeast Asia region has one of the highest incidences of food-borne diseases globally. Countries in the region face challenges in terms of立法 enforcement, surveillance and response capacities.

Countries in the region need to enhance their food safety systems, including legislative frameworks, enforcement mechanisms and public awareness campaigns. International cooperation is crucial in addressing these challenges.

The call for action is timely, and countries in the region should seize this opportunity to strengthen their food safety systems and reduce the burden of food-borne diseases.

Vijayasri Parthasarathy

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WHO in the media on emergency risk management, food safety
With coverage in
- The Times of India
- Hindustan Times
- Mail Today
- Business Standard
- The Statesman
- DNA
- The Indian Express
- The Asian Age
- Mid-Day
- Afternoon Despatch & Courier
- The Sunday Times
- Daily News.lk
- The Malaysian Insider
- Jakarta Globe
- Navbharat Times
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- Dainik Jagran
- Rashtriya Sahara
- Rajasthan Patrika
- Punjab Kesari
- Sakal
- Sandhya Times
- Vir Arjun
- Shah Times
- Absolute India
- Haribhoomi
- Yahoo
- Trinity Mirror
- Millennium Post
- New Kerala
- Net India 123
- Web India 123
- The Health Site
- India Live Today
- Punjab Tribune
- Daily World
- Sify
- Can India
- Window To News
- News X
- News24 Online

How safe is your food?

WHO calls for creating awareness on food safety

WHO confirms MERS CoV in traveler, WHO cautions against continued risk of importation

The Telegraph

Respiratory virus alert after Thailand scare


New Delhi, Jan 24: The World Health Organisation today issued an alert after a 71-year-old man from Oman, who arrived in Bangkok, Thailand on Jan 19, was found infected with the Middle East Respiratory Syndrome (MERS) virus.

The WHO said that the virus was confirmed on a blood sample collected from the man, who arrived at Bangkok's Suvarnabhumi International Airport on Jan 19 and was admitted to a private hospital in Thailand.

The virus is a novel coronavirus that emerged in Saudi Arabia in 2012 and has caused at least 260 cases, killing 93 people.

The WHO said that the virus is thought to be transmitted to humans from dromedary camels and that the risk of transmission from animal to human is a concern.

The virus is spread through close contact with sick animals, and the risk of transmission from animal to human is a concern.

The WHO also said that the virus is a respiratory illness, and that the risk of transmission from animal to human is a concern.

The virus is spread through close contact with sick animals, and the risk of transmission from animal to human is a concern.

Thailand confirmed MERS CoV in traveler, WHO cautions against continued risk of importation

NEW DELHI: Thailand today confirmed that a traveler with Middle East Respiratory Syndrome (MERS) had contracted the virus from Oman in the Middle East. The Ministry of Health and Family Welfare has advised travelers to take precautionary measures to avoid exposure to the virus.

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The government has also advised travelers to take precautionary measures to avoid exposure to the virus.
Battling vaccine-preventable diseases with firm resolve is the only means to free the South-East Asia Region of their burden. Vaccine-preventable diseases represent a public health problem that need no longer exist and which WHO South-East Asia Region has made it a priority to address.

Progress is being made. While the Region has maintained its polio-free status, which was certified in 2014, maternal and neonatal tetanus was eliminated across the Region in early 2016, when remaining areas of Indonesia were validated as having reduced the rate of infection to below one in every thousand live births at the district level. Similar resolve will prove vital to the Region-wide measles and rubella campaign, for which each country has developed a national action plan.

As national routine immunization programs are strengthened, the burden of vaccine-preventable diseases will be further diminished. Public health across the Region will be advanced.
Dr Supamit Chunsuttiwat, Chairperson of the Regional Certification Commission for Polio, felicitates WHO Regional Director, Dr Poonam Khetrapal Singh for the South-East Asia Region’s polio-free status.
Redouble efforts to reach every child with lifesaving vaccines

Opinion editorial article by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia

Vaccines save lives. Every year vaccination averts 2 to 3 million infant deaths globally from deadly diseases such as diphtheria, hepatitis B, measles, mumps, pertussis, polio and tetanus. However, at the same time, 1 in 5 children—an estimated 21.8 million infants worldwide—are still missing out on basic vaccines. Of them, 9 million infants —more than one-third—live in WHO’s South-East Asia Region.

Nearly 40 million children are born in the Region every year. Only about 75% of them get all three doses of the diphtheria-pertussis-tetanus vaccine which protects against infectious diseases that can cause serious illness and disability or even be fatal. Children also miss out on the vaccine for measles, a highly infectious viral disease that can cause serious complications, including blindness, encephalitis and pneumonia. In 2013 about 26% of the global measles deaths, almost 38 000, occurred in South-East Asian countries, with 27 500 in India alone. These grim statistics underscore the need to intensify efforts to protect children with lifesaving vaccines. Why should children continue to die of diseases that can be prevented? We must close these vaccination gaps.

Our success against smallpox historically and more recently in stopping poliovirus transmission in the Region has demonstrated that we have the capacity to reach a large majority of children with vaccines. Lessons learnt from these major public health wins, especially polio, need to be emulated in routine immunization to reach the unreached—the underserved children living in remote areas and in deprived urban and other settings—to ensure equity with vaccines.

Disparities in vaccination coverage usually result from resource crunch, competing health priorities, poor management of health systems, inadequate monitoring and supervision and low awareness levels among parents on the benefits of immunization. Addressing these to continuously improve the quality and reach of immunization services is a must to enable all children to benefit from vaccines.

It is encouraging to see the efforts being made by Member States. India, with the biggest birth cohort of 26 million, has been applying lessons and best practices from the polio eradication programme to strengthen routine immunization. It has launched a campaign focusing on 201 districts that have the highest number of partially vaccinated and unvaccinated children, for intensified efforts to increase immunization coverage in these districts. Bangladesh is focusing efforts in 32 priority districts. Bhutan has mapped its hard-to-reach pockets with floating populations across the country for targeted interventions. Indonesia is prioritizing immunization activities in 36 districts across seven provinces, and Thailand is focusing on three southern provinces.

Member States are also adding more vaccines to the immunization schedule such as rubella vaccine and the pneumococcal conjugate vaccine (PCV). The Inactivated Polio Vaccine (IPV), which is injectable, is being included in routine immunization as part of the Polio Eradication & Endgame Strategic Plan.

While introduction of new vaccines is an opportunity to improve immunization services, increasing vaccination coverage is critical for meaningful introduction of any new vaccine.

However, not only should coverage be increased, it needs to be sustained to reap the benefits of immunization. Linking vaccines to delivery of other health interventions can ensure sustainability. At the core, however, is the strengthening of health systems to increase and sustain immunization coverage. We know from our recent experience from Ebola and other public health emergencies in the past the role strong health systems play in rolling out a timely and adequate response is important.

Vaccination is a known cost-effective health intervention. Increasing vaccination coverage will accelerate control of vaccine-preventable diseases and reduce death and diseases among children.
Vaccination is also a shared responsibility. Collective efforts are needed by government, partner agencies, health professionals, academia, civil society, media, the private sector and community itself. And all of the above should be steered by continued political commitment and backed with resources.

With concerted efforts, WHO South-East Asia Region aims at maternal and neonatal tetanus elimination this year; measles elimination and rubella and congenital rubella syndrome (CRS) control by 2020; sustaining the victory over polio until the disease is eradicated globally; and increasing immunization coverage to > 90% at the national level and to > 80% at the district level with the three doses of diphtheria-pertussis-tetanus vaccines. Every child has the right to lead a healthy life, and vaccination is a vital step. The World Immunization Week—celebrated in the last week of April—aims at promoting the use of vaccines to protect against diseases. This year the focus is on closing the immunization gap and reaching equity in immunization levels with renewed efforts.
Implementing a monumental change in vaccination that is expected to bring the world closer to eradicating all types of polio, all 11 countries in the WHO South-East Asia Region have ‘switched’ from using the traditionally used trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) that protects against the remaining wild poliovirus strains.

The vaccine switch removing the ‘type 2’ component of the oral polio vaccine follows global certification of eradication of type 2 wild poliovirus last year. The switch aims at drastically reducing the rare risk of children getting paralysis by oral polio vaccine.

The world is closer than ever before to ending polio. The switch is a critical step in the Polio Endgame Strategy towards achieving a world free of all types of polioviruses.

The polio vaccine switch, which is complemented with introduction of injectable inactivated polio vaccine (IPV), will boost the Region’s efforts to protect children against polio until the crippling disease is eradicated globally. The Region was certified polio-free in March 2014 and continues to maintain polio-free status, despite the risk of importation from polio-endemic countries. Efforts are ongoing to protect children with the polio vaccine, increase routine immunization coverage, focus on the most vulnerable and hard-to-reach populations and step-up vigil against poliovirus importation.

I would like to congratulate all countries in the Region for successfully implementing the polio vaccine switch, which is the biggest globally coordinated project of its kind in the history of vaccines involving over 150 countries. Countries in the Region made extensive preparations, meticulously planned and implemented the switch in the childhood immunization program which reaches out to an estimated 37 million children in the 11 countries of the Region annually.

Timely completion of the vaccine switch process is another strong indication of the Region’s commitment to remain polio-free and contribute to a polio-free world.
Maternal and neonatal tetanus elimination: A step toward better health of newborns and mothers

Opinion editorial article by Dr Poonam Khetrapal Singh, Regional Director of WHO South-East Asia Region

The WHO South-East Asia Region has eliminated maternal and neonatal tetanus as a major public health problem. As immunization coverage and access to maternal and newborn health care has increased, the number of mothers and newborns suffering agonizing deaths on account of the disease has declined to below one in every 1000 live births at district level.

This is a major achievement. In 1989, when the fight against neonatal tetanus (and, consequently, maternal tetanus) began, approximately 787 000 newborns across the world were being killed by tetanus toxins each year. As a result of unhygienic conditions at the time of delivery and inadequate umbilical cord care, these toxins can infect mother and child, causing muscle spasms, lockjaw, and more often than not, death.

With recent elimination successes in India and Indonesia, the South-East Asia Region reached an important milestone. Though elimination took longer than expected, it is a victory that must be savored. At the same time, however, it is a victory that is by no means final.

Unlike with diseases such as polio and smallpox, the risk of maternal and neonatal tetanus will always exist. Tetanus spores are a permanent part of the environment, meaning public health setbacks could once again compromise mothers and their newborns. In relation to maternal and neonatal tetanus, then, ‘elimination’ must be seen as an enduring pursuit. Strengthening measures that facilitated elimination in the first instance can best guarantee the ongoing safety of mothers and their newborns.

Sustaining and enhancing access to quality maternal and newborn health care is critical. By providing expectant mothers the ability to access quality antenatal and safe-birthing services, health systems throughout the Region diminish the risk of tetanus infection, as well as other potentially lethal complications. Though countries in the Region have made important gains in this respect, momentum must be accelerated. Innovative strategies must be deployed to reach the unreached, such as increased training of skilled birth attendants at community-level facilities, or providing cash transfers to every mother that has an institutional delivery, for example.

Immunization coverage must likewise be maintained and enhanced. Expectant mothers must receive the necessary tetanus toxoid vaccine, or combination vaccine, as a matter of priority and at the appropriate stages of pregnancy. As Indonesia’s campaign to vaccinate brides-to-be demonstrates, however, positive initiatives need not be confined to the pregnancy or neonatal periods. Just as newborns receive tetanus immunizations as part of their routine immunization schedule, children must receive booster doses as and when appropriate. A good place for this to happen is at school. Despite the Region’s newly validated status, health authorities must ensure that maternal and neonatal tetanus remains prominent on the list of vaccine-preventable diseases, and that opportunities to immunize against tetanus are grasped.

Effective engagement with communities is similarly essential. Communities that have difficulties accessing care or lack experience doing so must be further encouraged to avail themselves of the benefits maternal and newborn health care brings. Messages related to tetanus immunization and safe-birthing must remain integrated with other outreach activities, and disseminated among the most vulnerable. Harmful traditional practices should be discouraged, while at the same time continuing to build relationships that promote trust, respect and inclusiveness. A positive experience with health care providers can have far-ranging effect, not only for an individual but also a community.

A robust and effective surveillance system is vital to tracking progress in these key areas. After all, the failure of any one of them can mean the death of a mother or newborn through tetanus infection. By closely monitoring incidences of maternal and neonatal tetanus authorities can evaluate the impact of their efforts, and, if found lacking, better calibrate them in future. In-depth knowledge of the causes of every case

“Immunization coverage must be maintained. Expectant mothers must receive the necessary tetanus toxoid vaccine, as a matter of priority and at the appropriate stages of pregnancy.”
of maternal or neonatal tetanus, combined with a resolve to ensure it is not repeated, can be the only appropriate response. However great the recent achievement is, it remains unacceptable that any woman or child should suffer the devastating disease.

Along with conducting routine vaccine-preventable disease surveillance, WHO is committed to realizing the unfinished Millennium Development Goal agenda as it relates to maternal and newborn health, which will in turn help allay tetanus’ menace. Efforts to achieve universal health coverage—a priority area of WHO in the South-East Asia Region—will similarly enhance health equity, ensuring that tetanus’ tendency to prey on the most vulnerable is rebuffed. It is no coincidence that the first countries in the Region to eliminate the problem also had the strongest health systems.

That maternal and neonatal tetanus has been eliminated as a major public health problem in the South-East Asia Region is reason to celebrate. Newborns across the Region are now safer from the disease than at any other time in history. But we must not be misled by our successes. Maternal and neonatal tetanus remains a burden, and could make a comeback in significant numbers in future. By enhancing the reach and quality of maternal and newborn health care, increasing immunization coverage, leveraging greater community buy-in, and ensuring detailed surveillance, we can avert this possibility.
THE HINDU

THE TIMES OF INDIA

The Daily Star

Building on the polio success

Bangladesh

22 million kids miss out basic vaccines: WHO

29 April 2014

The New York Times

WHO urges on the need to close immunisation gap

14 April 2014

22 million children are out of reach of vaccines, WHO says

25 April 2014

Express Healthcare

Sertifikasi Bebas Polio Asia Tenggara


Kepakar Aino-Alla


Banati Tur Iha Susesu Polio Nian

WHO officially declares India ‘polio-free’

WHO

India gets WHO certificate for its polio-free status

India among 11 nations formally declared polio-free

India and 10 other Asian countries were formally declared polio-free (WHO) Thursday.

Apart from India, the other countries which were given polio-free status are North Korea, Indonesia, the Maldives, Myanmar, Nepal, Sri Lanka, Indonesia, Afghanistan, Pakistan and Egypt.

The certificates were handed over to the health ministers of the Southeast Asian Poonam Khetrapal Singh at a ceremony here.

‘Polio-eradication alone is not enough — we need to do a lot more’

Narayani Ganesan

http://blogs.timesofindiatimes.com/treatsurehunt/entry/polio-eradication-alone-is-not-enough-we-need-to-do-a-lot-more

The World Health Organisation’s South East Asia regional director Poonam Khetrapal Singh, the first woman to hold this position, had a proud moment when she declared the region polio-free on March 27. But, this is just the beginning; we need to deal with tuberculosis and measles as well, Singh points out to Narayani Ganesan.

India is a large country with more than a billion people, with 170 million children under the age of five. There is a lot of moving population and an estimated eight million children too are on the move at any given time, so you can imagine how difficult it is to sustain the immunisation process. At one time we thought it might not happen! So it is no mean achievement, and we waited for the mandatory three year period before making the declaration. The last polio case in India was detected in 2011.
**Fight hepatitis on war-footing**

The global focus is on the prevention of hepatitis B and C. We have a vaccine for the treatment of hepatitis B and a cure for hepatitis C. Eliminating both may be an ambitious goal but it is definitely achievable.

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**Elimination of Rubella, Measles possible by 2020: WHO**

New Delhi 18 September 2016 News


The World Health Organization is looking at innovative surveillance and complete immunization approaches as an effective tool for eradicating rubella.

“WHO’s robust disease burden for surveillance and control of measles and rubella is an essential component of the overall approach to achieving universal health coverage,” said WHO Regional Director for South-East Asia. "The WHO Regional Officer for South-East Asia region in the release of the report on measles 2016."

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**Elimination of Rubella, Measles possible by 2020: WHO**

New Delhi, Nov. 14


“WHO’s Southeast Asia region is committed to the elimination of measles and control of rubella/congenital rubella syndrome by 2020. Countries are scaling up efforts to protect children against these deadly diseases by targeting 95 percent coverage with each of the two doses of measles vaccines and rubella containing vaccine to the childhood immunization schedule,” mentioned Dr. Poornima Khetrapal Singh, WHO Regional Director for South-East Asia Region on the release of the report on measles 2016.”
WHO hails India for yaws, maternal and neonatal tetanus elimination

India was declared free from maternal and neonatal tetanus (MNT) in 2015, a major public health achievement. The achievement was announced by Dr. Poonam Khetrapal Singh, Regional Director, World Health Organization–South-East Asia Region, on behalf of the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), on the occasion of the International Day for Elimination of School-related Violence (IDERSV) on 16th November 2020.

India joins the global community in congratulating India for this remarkable achievement and for its continued efforts in achieving the Sustainable Development Goals (SDGs).

The World Health Organization (WHO) on Thursday presented India with the certificate declaring elimination of maternal and neonatal tetanus (MNT) in the country. The certificate was presented by Dr. Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region.

India has achieved the global target of eliminating maternal and neonatal tetanus (MNT) by 2030, as set by the United Nations General Assembly in 2019. The achievement was validated by the World Health Organization and the United Nations Children’s Fund (UNICEF).

India is the first country in the world to be declared free from maternal and neonatal tetanus, joining a growing list of countries that have achieved this milestone.

India has made significant progress in eliminating MNT over the years. In 1997, the maternal and neonatal tetanus burden was estimated to be 70 deaths per 100,000 live births. By 2015, the burden had reduced to 5.5 deaths per 100,000 live births.

The success in eliminating MNT is the result of sustained efforts by the Indian government, supported by international agencies such as WHO and UNICEF, to provide timely and effective tetanus immunization to all women of childbearing age.

India’s achievement is a testament to the country’s commitment to maternal and child health. It is hoped that the achievements made by India can inspire other countries to work towards eliminating MNT and improving the health outcomes of women and children globally.

WHO: India free from maternal, neonatal tetanus

Pioneer news service

NEW DELHI

The World Health Organization (WHO) on Thursday presented India with the certificate declaring elimination of maternal and neonatal tetanus (MNT), caused mainly by unclean deliveries and umbilical cord care practices.

India has been working towards eliminating MNT for several years. The World Health Organization (WHO) has been supporting India in its efforts to eliminate MNT.

India’s achievement in eliminating MNT is significant as it has a major impact on maternal and child health. MNT is a preventable and treatable condition that occurs when a woman gives birth to a baby and there is no access to clean delivery facilities or tetanus immunization.

India has made significant progress in eliminating MNT over the years. In 2011, the maternal and neonatal tetanus burden was estimated to be 10 deaths per 100,000 live births. By 2015, the burden had reduced to 5 deaths per 100,000 live births.

India’s achievement in eliminating MNT is a testament to the country’s commitment to maternal and child health. It is hoped that the achievements made by India can inspire other countries to work towards eliminating MNT and improving the health outcomes of women and children globally.

WHO certifies India as maternal and neonatal tetanus free

The World Health Organization (WHO) on Thursday presented India with the certificates declaring elimination of yaws, maternal and neonatal tetanus, and elimination of neonatal tetanus.

The certificates were presented by the Health Minister JP Nadda, who said that India has made tremendous progress in improving maternal and child health, and has been able to achieve remarkable success in eliminating these diseases.

India has made significant progress in eliminating yaws over the years. In 1997, the burden of yaws was estimated to be 100 cases per 100,000 people. By 2015, the burden had reduced to 1 case per 100,000 people.

India’s achievement in eliminating yaws is a testament to the country’s commitment to maternal and child health. It is hoped that the achievements made by India can inspire other countries to work towards eliminating yaws and improving the health outcomes of women and children globally.

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India has made significant progress in eliminating yaws over the years. In 1997, the burden of yaws was estimated to be 100 cases per 100,000 people. By 2015, the burden had reduced to 1 case per 100,000 people.

India’s achievement in eliminating yaws is a testament to the country’s commitment to maternal and child health. It is hoped that the achievements made by India can inspire other countries to work towards eliminating yaws and improving the health outcomes of women and children globally.

WHO certifies India as maternal and neonatal tetanus free

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India’s achievement in eliminating yaws is a testament to the country’s commitment to maternal and child health. It is hoped that the achievements made by India can inspire other countries to work towards eliminating yaws and improving the health outcomes of women and children globally.
Reversing rising rates of non-communicable diseases such as diabetes and cancer is critical to meeting the South-East Asia Region’s emerging health needs. As economies develop and lifestyles change, the burden of non-communicable diseases across the Region is increasing rapidly, and will continue to do so for the foreseeable future.

Efforts to reverse this trend are underway. Nine of the Region’s 11 countries have now developed multisectoral action plans that emphasize the importance of healthy lifestyle promotion, enhancing diagnostic capacities and increasing access to treatment. Similarly, as a means to combat tobacco use across the Region—which still accounts for around 1.3 million deaths annually—WHO South-East Asia Region has been working with countries to enhance the size of graphic health warnings and to increase and simplify tobacco taxation systems. The next frontier of tobacco control in the Region is the introduction of plain packaging of tobacco products.

Containing non-communicable diseases means securing a healthier future for the countries of the South-East Asia Region. Given the changes the Region is undergoing, this could not be more urgent.
Get ready for the plain packaging of tobacco products

Opinion editorial article by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia

The tobacco epidemic continues to rage across the WHO South-East Asia Region. Nearly 246 million adults Region-wide smoke the cancer-causing agent, while just below 290 million consume it in a variety of smokeless forms. This results in approximately 1.3 million deaths across South-East Asia every year. That’s 150 deaths per hour.

Change is needed, and now. One of the most powerful ways to curb tobacco use is to regulate the advertising of tobacco products. And one of the most powerful ways tobacco companies promote their products is via packaging. In the struggle to free our countries of the tragic, costly and unnecessary burden of tobacco use, the plain packaging of tobacco products is an important weapon.

Plain packaging, also known as ‘standardized packaging’, means that logos, colors, brand images or promotional information is removed from tobacco packaging. Instead, tobacco packaging features black-and-white or other contrasting color combinations, and a brand name, a product name and/or a manufacturer’s name. Astride the package’s drab exterior are graphic health warnings documenting tobacco’s adverse effects, including desiccated, cancerous lungs; gangrenous limbs; and asthmatic children. The net result is a product that is significantly less appealing.

Australia is the pioneer of the plain packaging initiative, and has been enforcing it since December 2012. Research shows that plain tobacco packages are of diminished appeal to a substantial proportion of smokers, and have resulted in declining rates of tobacco use. Plain packaging, in tandem with other tobacco control initiatives, has meant that Australia’s daily smoking rate among persons 14 years and older declined from 15.1% to 12.8% between 2010 and 2013. Many countries now aspire to pass similar legislation and make the plain packaging of tobacco products mandatory. At present, three other countries have done this – France, the United Kingdom and Ireland. Many more are expected to follow.

Importantly, the passage of plain-packaging legislation to date has been limited to high-income countries. This needs to change. While tobacco consumption is on a downward trend among these countries, the opposite is true in low- and middle-income countries. The developing economies of the South-East Asia Region remain key markets for Big Tobacco, who will fight tooth-and-nail to retain influence and brand loyalty to maintain and expand their markets. The cost of allowing this to happen is immense, and will be borne society-wide. Economies will be less productive; health care costs will increase; and the tobacco-poverty cycle will be entrenched.

To be sure, important steps have been taken to control tobacco use across the South-East Asia Region. Ten of the Region’s 11 Member States are Parties to the WHO Framework Convention on Tobacco Control. And each country has passed and implemented tobacco control legislation in line with the Convention’s provisions. Nepal, for example, has decided to have health warnings cover 90% of the principal display area of tobacco packs, while in Thailand health warnings cover 85% of cigarette packs on both sides. India has recently increased the size of warnings from 40% on the front to 85% on both sides of all tobacco products packs.

“Important steps have been taken to control tobacco use across the South-East Asia Region. Ten of the Region’s 11 Member States are Parties to the WHO Framework Convention on Tobacco Control.”

Despite these and other advances, there is considerable room for improvement. Children, youth and adults in countries across the Region continue to be subjected to pro-tobacco messages in media. They also often encounter product advertising at outlets where tobacco is sold. Our commitment to addressing the tobacco epidemic must be renewed. New initiatives must be considered.

The Seventh Session of the Conference of Parties to the WHO Framework Convention on Tobacco Control (COP7), hosted by India in November 2016, will be an opportunity to do just that. The conference provides an
important forum to help fine-tune and enhance tobacco control measures across the Region, as well as to discuss and emphasize the utility of plain packaging. Plain packaging is already being considered by lawmakers in India, and will become a key tool for tobacco control partners and stakeholders from across the Region. It is an initiative that will only gain momentum.

Beyond a desire to protect the profit margins of Big Tobacco, there can be no reason to oppose plain packaging. With plain packaging in place individuals will remain as free as ever to consume tobacco products, but will be more empowered to decide otherwise. The psychology of consumption will be disrupted and new patterns of behavior will emerge. This will help our friends and family live longer, healthier and happier lives. It will also increase economic productivity and lessen the substantial burden tobacco-related illnesses represent to health care services and taxpayers.

On World No Tobacco Day we must all reflect on the harm tobacco causes and open ourselves to new and innovative ways to challenge its grip over individuals, communities and countries. We must all get ready for plain packaging.
The greatest threats to public health are far from shocking or contagious. They are familiar and common.

Globally, non-communicable diseases such as cancer, hypertension and asthma account for 38 million deaths per year. Of these diseases, diabetes—a condition often the result of excess bodyweight and physical inactivity—is expected to increase rapidly to become the world’s seventh largest killer by 2030. Though this seldom makes headlines, and is as confronting to our vanity as it is our health, the implications are alarming. By preventing and managing diabetes, we can, however, defy expectations and chart a different reality. This is a life and death battle that we must all sign up to.

In the WHO South-East Asia Region the stakes are particularly high. In SEA countries, diabetes, which can cause serious damage to every major organ system in the body, resulting in heart attacks, strokes, kidney disease and nerve damage, is a major public health issue. More than one out of every four diabetes-related deaths globally occurs in the Region, while its prevalence exacerbates difficulties in the control of major infectious diseases such as tuberculosis. Though Type 1 diabetes is thought to be caused by genetic or environmental factors, Type 2, or ‘adult-onset’ diabetes, is primarily the consequence of lifestyle factors. Type 2 diabetes accounts for 90% of all cases.

The negative by-products of the Region’s vast social and economic changes are culpable. Sedentary lifestyles coupled with sugary, salty and fatty diets that are also rich in starchy carbs—including those from white rice and refined flours—are driving the epidemic, which in the Region affects primarily those who are in their productive prime.

Rather than being a disease solely of the middle classes of high-income countries—as is often imagined—it affects all classes and countries, leading to adverse economic consequences in the developing world, including in the Region. Diabetes not only affects a person’s ability to work and earn income, but also limits the wider economy by creating an unhealthy workforce while consuming limited health budget resources. If the diabetes epidemic is exacerbated, so too will be its harm to the health and economies of the SEA Region. Charting a different course is vital.

There are individual steps that we must all take. Eating healthily and avoiding sugary drinks is a good place to start, and can be done by taking simple measures such as avoiding fatty snacks that are rich in calories though offer little in the way of nutrition, and choosing to drink tea without sugar and opt for water instead of soft drink. Vegetables, fruits and foods high in complex carbohydrates provide the fiber and nutrients necessary for taxing work schedules, while drinking water rather than soft drink aids hydration at the same time as avoiding unnecessary calories.

Controlling portion sizes is also important. This can be achieved by better understanding the needs of our bodies and the caloric density of the foods that we eat, as well as revising how we should feel when we are ‘full’. Instead of portion-sizes that match the size of our plates, our portion sizes should match our energy needs.

Committing to regular exercise, which helps control weight, is also necessary. Adults aged 18–64 should do 30 minutes of moderate-intensity aerobic activity at least five times a week. This does not have to be a regimented process. Swimming, hiking, playing football and dancing, for example, are all great for aerobic fitness, and are best enjoyed in the company of others.

For those with children, family-based activities are an excellent way to get exercise and promote healthy habits in kids. Physical activity, however, does not always need to be planned. Simple changes of habit, such as
Athletic champion Milkha Singh promotes healthy lifestyle choices alongside Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia Region.
taking the stairs or walking to work, are also useful in burning calories and helping to mitigate the risk of diabetes.

Still, preventing the disease requires much more than individual action: It requires society-wide awareness and behavioral change. Community groups such as those managing school or work canteens can facilitate positive decision-making by offering healthy options on their menus and by promoting the benefits that these provide. Schools and workplaces can similarly promote exercise by factoring physical activity into the workday and by providing the resources to facilitate it, as well as organizing social sporting competitions and events.

Governments, meanwhile, should work with consumer groups and the private sector to regulate the marketing of food to children and to explore innovative partnerships for transmitting positive health messages. They can also insist on accurate food labeling to help consumers make decisions that will be positive for their health, and can tax sugary beverages and re-invest the revenue in health promotion activities.

However successful prevention efforts are, diabetes will, to some extent, continue to afflict public health due to non-modifiable risk factors such as ageing and genetics. Early detection of the disease is vital to limiting its impact. We can all facilitate this by regularly visiting health care services for assessing diabetes risk.

For those that already have diabetes, strict adherence to diet and exercise regimes and timely medication is essential to limiting complications. Governments, meanwhile, must increase access to health care and promote educational campaigns regarding self-care, as well as making treatment less costly. Diabetes can be managed successfully. It does not have to lead to complications or be fatal.

Diabetes rarely makes headlines, despite its appalling impact on public health and the wider damage this causes. On World Health Day 2016, we have the potential to re-calibrate our priorities, recognize the public health threat diabetes poses, and do something about it. We can defy expectations and beat the epidemic. The battle must begin.
NEW DELHI: The World Health Organization (WHO) urged governments in southeast Asia to tackle the issue of “urgent” pollution, in the region as 14 of the world’s 20 polluted cities, and 35 lakh people in India succumbed to cancer every year, the Indian Society for Clinical Research (ISCR) added referring to the WHO World Cancer Report 2015.

WHO said that every year, 8.2 million people die from the disease, across the world, and two-thirds of these deaths occur in low- and middle-income countries.

It also said tobacco use, both in smoke and smokeless forms accounts for 22 percent of cancer deaths globally and is a “leading cause of the disease in the region.” WHO’s South-East Asia region comprises Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Lao PDR, Malaysia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

“Outdoor air pollution increases the risk of cancer, WHO today urged governments of Southeast Asian region to tackle the issue with urgency,” said WHO Regional Director for South-East Asia on the eve of World Cancer Day.

NEW DELHI: on the eve of World Cancer Day, the World Health Organisation warned that tobacco and alcohol abuse, unhealthy diets and physical inactivity significantly increase the risks of cancer.

The WHO said that in South-East Asia, occupational hazards and exposure to environmental substances continue to be a source of cancer and premature death.

Dr. Poornam Khetrapal Singh, regional director of WHO South-East Asia region, said: “Tobacco use accounts for 22 percent of cancer deaths globally. In southeast Asia, Alcoholic use, unhealthy diets and physical inactivity contribute to a burden that has profound negative social, economic and developmental impact.”

“WHO for urgent preventive measures to check pollution”

New Delhi: With the Southeast Asian region being home to 14 of the world’s top 20 polluted cities, the WHO on Wednesday called for urgent preventive steps to check pollution which can increase the risk of cancer.

WHO said that every year, 8.2 million people die from the disease across the world, and two-thirds of these deaths occur in low- and middle-income countries. It also said tobacco use, both in smoke and smokeless forms accounts for 22 percent of cancer deaths globally and is a “leading cause of the disease in the region.”

WHO’s South-East Asian region comprises Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Lao PDR, Malaysia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. "Outdoor air pollution, meanwhile, increases the risk of cancer for all. The region has 14 of the world’s top 20 polluted cities, making the need for governments to tackle the issue with urgency," said Poornam Khetrapal Singh, WHO Regional Director for South-East Asia on the eve of World Cancer Day.

How safe is your food?

By Dr. Poornam Khetrapal Singh

"How often do we ask ourselves if the food we are eating is free from parasites, chemicals, other contaminants and additives? Every year, diabetics from 18 million people, including 1.8 million children, globally. Untreated childhood diabetes is a disease for life and gives rise to serious complications. At least 14 percent of the population worldwide lives with diabetes, and 90% of these cases are in developing countries. Food safety is critical for public health as food-borne diseases create a vicious cycle of disease and malnutrition, particularly affecting elderly and the sick. Food-borne diseases impede socio-economic development systems and adversely impacting national economies, tourism and trade. Since food passes through multiple hands from the farm to reach our plate, multi-sectoral collaboration is a must. The approach needs to be preventive – to identify and reduce the risks to the food supply chain. But the need for a preventive approach is becoming more urgent as climate change and the growing population are increasing the vulnerability of global food systems.

It is estimated that 5.1 million deaths occurred globally last year as a result of diabetes.

Khetrapal Singh said enabling environments must be created for people to adapt these lifestyle changes, with improved access to areas for walking, cycling, sports and other physical activities.

"Healthy food should be made available at affordable rates to make healthy choices easy choices. This requires a holistic approach and must include the private sector and engagement of sectors beyond health," she said.

She said that while governments have a role in prevention and control of diabetes, individuals also make a difference by taking responsibility for their own health. "Eating right and undertaking regular physical activity to maintain a healthy weight can cut the risk of diabetes or delay its onset."

Deal with outdoor air pollution: WHO urges SE Asian region


INIAN EXPRESS

India Needs to Revisit Health Strategy: WHO

Published: 12th November 2014 1:37 PM


India needs to revisit its health promotion strategy for non-communicable diseases to increase awareness about simple and effective lifestyle changes to control diabetes, the World Health Organisation Wednesday said.

"The number of people in the world suffering from diabetes is increasing. Nearly 377 million people with diabetes live in the WHO South-East Asia Region," Poornam Khetrapal Singh, regional director for WHO South-East Asia Region said.

"We must act quickly to arrest this trend. Governments need to revisit their health promotion strategies for non-communicable diseases to increase awareness about simple and effective lifestyle changes, such as physical activity and healthy diets,” she said in a statement.

It is estimated that 5.1 million deaths occurred globally last year as a result of diabetes.

Khetrapal Singh said enabling environments must be created for people to adapt these lifestyle changes, with improved access to areas for walking, cycling, sports and other physical activities.

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The Economic Times

Deal with outdoor air pollution: WHO urges SE Asian region

Diabetes kills slowly and silently

Considered a rich man’s common disease, diabetes rarely makes headlines, despite its debilitating impact on public health and the economy at large. We must re-calibrate our fight against this epidemic.

Dr. Pravesh Khetrapal Singh, regional director, WHO South-East Asia Region, said in a statement.

Global estimates are that 150 million people have diabetes and 240 million are prediabetic, with diabetes expected to kill 5 million people a year around the world by 2030, bringing the total number of deaths to 50 million a year.

WHO estimates that 90% of deaths from diabetes are in low- and middle-income countries.

In the South-East Asia Region, occupational hazards and exposure to environmental substances continue to be a source of cancer and premature death.

Every year across the world, 8.2 million people die from cancer. The fact that two-thirds of these deaths occur in low and middle income countries, and that more than 10% of deaths could have been prevented, is a cause for reflection and action.

“Alcohol use, unhealthy diets and physical inactivity significantly contribute to a burden that has profoundly negative social, economic and developmental implications,” said Dr. Pravesh Khetrapal Singh.

WHO warns of onslaught of diabetes

The global threat to public health is far from over. While the region has made slow and steady progress in terms of tobacco control and prevention, tobacco-related diseases continue to be a major public health issue.

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Plain packaging a way out to curb tobacco epidemic: WHO

New Delhi

In a bid to help cut down the perils associated with tobacco, the World Health Organisation (WHO) on Monday urged the various stakeholders to make plain packaging of tobacco products mandatory across the world.

In plain packaging, the tobacco product package will have no branding or promotional information. Rather, it will sport graphic health warnings, dull colour combinations, and a product and manufacturer’s name in standardized font.

The Uniform Implementation of Plain Packaging (WHO) regional director for the South East Asia Region, Dr. Poonam Khetrapal Singh, in a statement said: ‘WHO promotes plain packaging to curb tobacco epidemic.


In a bid to help cut down the perils associated with tobacco, the World Health Organisation (WHO) on Monday urged the various stakeholders to make plain packaging of tobacco products mandatory across the world. In plain packaging, the tobacco product package will have no branding or promotional information. Rather, it will sport graphic health warnings, dull colour combinations, and a product and manufacturer’s name in standardized font.

With a decline in smoking levels, the high-income countries, tobacco companies are increasingly relying on developing economies, especially in the south-east Asia region – with nearly 260 million people in 11 countries continuing to smoke tobacco and nearly 250 million using it a smokeless forms -- to bolster to market presence’, said Dr. Poonam Khetrapal Singh, WHO regional director for South East Asia, in a statement.

The Plain and Simple packaging is expected to help in reducing the number of smokers and reducing the revenue that tobacco companies earn from different countries.

The WHO recommended that the government should implement plain packaging to prevent tobacco companies from misleading consumers.

Plain packs can save lives: WHO

Additi Tandon

New Delhi

With tobacco-related fatalities in Southeast Asia reaching the 150 per hour mark, the World Health Organisation today urged governments of the region to make plain packaging of tobacco products mandatory to reduce their appeal and make anti-smoking products more noticeable.

Of the 1.3 million deaths, SE Asia witnesses annually on account of tobacco consumption, India makes up around 10 lakh. The Indian Council of Medical Research has now shown that 30 per cent of all 14.5 lakh new cancer cases in the country this year were tobacco-related. New cases would climb to 173 lakh by 2020 with tobacco contributing India, continues to be a major public health issue across the Southeast Asia with nearly 266 million people in the region’s 11 countries, including India continuing to be the leading cause of deaths of 13.5 million people across the region every year – the equivalent of 180 fatalities per hour,” the WHO SE Asia Director Poonam Khetrapal Singh said.

The WHO argued that plain packaging was not getting through and plain packaging can also change the perception of tobacco products.

The WHO called for plain packaging, saying the message that tobacco kills is not getting through and plain packaging can also change the perception of tobacco products.

Coinciding with the launch of plain packaging, the WHO also launched a new campaign titled ‘Tobacco Free’, which aims to raise awareness about the dangers of tobacco use and promote healthy lifestyles.

The campaign which is expected to run for six months, will be supported by a range of activities including media campaigns, public events, and workshops.
WHO IN THE MEDIA
ON DIABETES
AND TOBACCO

With coverage in
The Times of India
ET Healthworld.com
The Hindu
The Health Site
Bio Spectrum
bdnews24.com
The Samaya
New Telegraph
Indian24News
New Indian Express
DNA
The Pioneer
National Duniya
Shah Times
Navbharat Times
Business Standard
NDTV Food
India Today
ANI
Health CNN
Sify
Yahoo
Bio Spectrum
Herald Globe
The Asia News
Web India 123
Myanmar News
SocialNews.xyz
Tell Me Boss
India Forums
NRI Press
Indian Bloom
News Reporter
New Delhi News
Idaho Indian
The Health Site
Yuvashare
The Times of India
Mint
Absolute India
The Asian Age
Free Press Journal
Deccan Chronicle
Absolute India-Hindi
Dabang Duniya
Virat Valbhav
Sakal Times
Free Press Journal

WHO warns against diabetes epidemic

NEW DELHI—Stating that immediate action has to be taken to control the onslaught of diabetes, Poonam Khetrapal Singh, Regional Director of WHO South-East Asia, said on the World Diabetes Day (November 14) that diabetes is a global epidemic which kills one person every six seconds and over five million people every year.

Diabetes makes people prone to heart disease, kidney failure and infectious diseases like tuberculosis, malaria, and HIV/AIDS, among others. According to WHO, the number of people with diabetes is projected to increase from 467 million in 2014 to 722 million by 2035.

“WHO has warned that there is an urgent need to act against diabetes, which has selected diabetes as the theme for the World Diabetes Day, to focus on ‘Healthy Living and Diabetes’ as the theme for 2014 to 2016, and the importance of prevention in diabetes. To put the spotlight on the urgent need to act against diabetes, WHO has selected diabetes as the theme for the World Diabetes Day,” said the Regional Director.

WHO also emphasized the importance of health promotion strategies for non-commensurable diseases to increase awareness about simple and effective lifestyle changes, such as physical activity and healthy diet. Healthy food should be made available at affordable rates to make healthy choice an easy choice.

The medical community has warned against serious financial implications from diabetes if the country does not act fast to tackle the spread of the disease. At about 65 million, India has the highest number of patients in the world, after China.

Previously considered a disease of affluent-class, diabetes has spread fast among the rural poor too thanks to unhealthy diet and reduced physical activity. On the eve World Diabetes Day which is on November 14, experts say it is important to create awareness about the preventive measures and provide support for regular screening of persons at risk to develop the condition.

“The government needs to revisit its health promotion strategies for non-commensurable diseases to increase awareness about simple and effective lifestyle changes, such as physical activity and healthy diet. Healthy food should be made available at affordable rates to make healthy choice an easy choice,” WHO regional director Poonam Khetrapal Singh said in a statement. She said creating easy access to

‘Diabetes to turn world’s 7th largest killer by ’30’

NEW DELHI—With diabetes, a potentially fatal disease, reaching epidemic proportions and ominously surging towards becoming the world’s seventh largest killer by 2030, the World Health Organisation (WHO) on Saturday cautioned South Asian countries including India to take vigorous and concerted action to prevent and treat the disease.

The global health agency, also said governments “must regulate the marketing of food to children as well as ensure accurate food labelling to help the consumers make decisions that can help them avoid diabetes.”

“Diabetes rarely makes headlines, and yet it will be the world’s seventh largest killer by 2030 unless intense and focused efforts are made by governments, communities and individuals,” said Poonam Khetrapal Singh, Regional Director, WHO South-East Asia ahead of World Health Day which falls on April 7. World Health Day this year focuses on diabetes and calls for scaling up efforts to prevent, care for and detect the disease to arrest the global epidemic which is hitting the low and middle income countries the most. “Diabetes is of particular concern in region. More than one out of every four of the 3.7 million diabetes-related deaths globally occur in region, while its prevalence exacerbates difficulties in the control of major infectious diseases such as tuberculosis.”
Achieving universal health coverage is vital to building a healthier South-East Asia Region. Ensuring that all people everywhere have access to the services they need without facing financial hardship is the sine qua non of public health, and one of WHO South-East Asia Region’s core aims.

The progressive realization of this goal is gathering pace across the Region. National action plans to strengthen the health workforce have been developed, with special emphasis on retention of rural staff and ongoing staff training, while joint assessments of medicines systems have been completed in a majority of countries in the Region. Resolutions concerning the importance of community-based health services have meanwhile been made, and all countries have put in place systems to monitor progress.

Achieving universal health coverage will not only contribute to public health across the Region, but will also enhance wider development efforts. It is a goal that must inform all that we do.
Speech of Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia Region, at the Regional Consultation on ‘Health, the SDGs and role of Universal Health Coverage: next steps in South East Asia’, held 30 March-1 April 2016 in New Delhi, India

Distinguished participants, ladies and gentlemen,

A very good morning to you, and welcome to this important meeting about what the SDGs, and within that universal health coverage, are going to mean for health in the South-East Asia Region.

On 25 September last year, the 193 Member States of the United Nations adopted a resolution, which begins like this:

“We resolve, between now and 2030, to end poverty and hunger everywhere; to combat inequalities within and among countries; to build peaceful, just and inclusive societies; to protect human rights and promote gender equality and the empowerment of women and girls; and to ensure the lasting protection of the planet and its natural resources. We resolve also to create conditions for sustainable, inclusive and sustained economic growth, shared prosperity and decent work for all, taking into account different levels of national development.”

You will agree that with an opening paragraph like that, no one is going to accuse the UN of undue modesty.

This, as the Declaration goes on to say, “is a supremely ambitious and transformational vision”. Put more bluntly, it is a huge amount to achieve in 15 years.

I want to address two big questions.

First, how did we succeed in getting the heads of state and government of virtually every country on the planet to agree to commit themselves to achieving 17 ambitious goals and 169 associated targets in the name of sustainable development?

Second, setting goals and targets is one thing. Achieving them is altogether something different. Is it really going to be possible to get even close to this level of ambition in such a short period of time?

So, question one: how did we get here?

To celebrate the beginning of a new century the UN General Assembly passed the Millennium Resolution, which made reference to a number of development goals that had been agreed at a series of UN conferences over the course of the 1990s.

We would all agree that the Millennium Development Goals—the MDGs—have been an outstanding success.

It took some time to get the ball rolling. But a combination of skillful advocacy and some powerful champions made a difference. It also helped that the MDGs were few in number—just eight—and they dealt with subjects that people understood and could relate to: decreasing hunger, increasing the number of children in school, reducing maternal and child deaths, conquering major pandemics of AIDS, TB and malaria and improving water, sanitation and the environment.

There has been remarkable progress in health outcomes over the last 15 years.

Development funding for health has tripled since 2000 and domestic budgets in many parts of the world have grown rapidly. In our Region, the regional MDG targets for HIV, tuberculosis and malaria have been met or are on track. Child mortality has fallen by over 60% and maternal mortality by over 40%. Even though these figures fall short of the two-thirds and three-quarters declines that were targeted, they are still cause for celebration.

In addition, and this is a key point, because the targets were quantitative the MDGs have had a huge influence on promoting measurement and monitoring systems. Without them the world would not be in a position to track progress with the degree of confidence that is now possible.

Measurement also has a political spin off. Commitments made by national...
leaders not only put pressure on ministries of health, but also provide a way for civil society, parliament and the media to hold health providers accountable for their performance.

As I am sure you are aware, the MDGs have not been without their critics. Let me give you a few examples. We hear that...

Their scope is too narrow—they focus on a few human development outcomes and overlook the broader determinants of poverty.

They say nothing about the role of economic growth.

They say little about the need to address inequity and inequality. They are silent on the issue of gender.

They are a top-down instrument, loved by donors but are of less consequence to national governments. They have influenced aid more than they have national budgets.

And in health, that they focus on a limited set of outcomes; they overlook new priorities like noncommunicable diseases and health security; they say little about the role of health systems. They have created silos, vertical delivery and financing systems and distorted national planning and budgeting.

And, of course, there is a huge unfinished agenda of global targets that have yet to be met, and countries that lag far behind in their achievements.

Listening to that list might tempt you to think that global goal setting has had its day. You would however be completely wrong.

As the world approached 2015, there was unequivocal support for a new generation of goals. Rather than acting as a disincentive, the critique of the MDGs merely fuelled the desire to do things better next time around.

So part of the answer to our first question (how did we get here?) is that the MDGs have been more influential and achieved wider public recognition than any other attempt at international target setting in the field of development. Their influence in attracting financial and political support for the goals and targets included has been unprecedented.

Indeed, the legacy of the MDGs was such that succession was inevitable.

The question we now turn to is how did we end up with the current agenda and a daunting total of 17 goals and 169 targets?

The SDGs are different, and the transition from MDGs to SDGs is not just a question of a longer list of goals and targets.

The SDGs are designed to be relevant to all countries. They are about development as a shared global concern not just about developing countries.

Their scope is much greater, and a key theme is the creation of an integrated agenda, where the links between goals are as important as the goals themselves.

The SDGs cover the three pillars of sustainable development: economic, environmental and social, with a strong focus on equity—leaving no-one behind. They therefore better reflect the full range of real-world issues that keep all politicians awake at night.

The Declaration states clearly, “Each country has primary responsibility for its own economic and social development”. This means that if the SDG...
agenda is genuinely universal and relevant to all countries, then the close link between development goals and financing from donors will be less important.

In contrast to the MDGs, which were developed out of the glare of political debate, the SDGs are the product of extensive consultation and negotiation.

Once the starting gun was fired some four years ago, the number of global, national, regional, grass-roots, thematic, governmental, civil society, online, and off-line discussions, debates and consultations that took place reached almost epidemic proportions. Indeed, for many of those involved in the process, it is a minor miracle that the result was only 17 goals.

On a more serious note, though, throughout the negotiations a veritable army of interest groups lobbied intensely to ensure that their priorities found a place; sadly, with little concern for the coherence of the agenda as a whole.

So where have we arrived as we try to answer the two questions?

On one hand, the SDGs have been welcomed for their comprehensiveness, universal applicability and breadth of ambition. But equally they have been criticized for trying to do too much and proposing an unattainable utopia.

On the plus side: We have a set of goals that have been endorsed by the world’s governments, (even if the signatories will be long out of office by 2030) and which reflect a commitment to address—albeit at a level of intent—an agenda of undeniable importance to our troubled world.

But the response from the critics is that goal setting should stick to what is actually doable and forget idealism and political correctness. They say it is absurd to try “to eradicate extreme poverty for all people everywhere” in 15 years, or to “end all forms of discrimination against all women and girls everywhere” in the same time frame.

So, a house divided.

Let us therefore move on to our second challenge. We now have a new set of goals, what can we do to make sure they are achieved?

At this point in our discussion, I am going to be more parochial and focus on health.

I also want to come off the fence.

While the debate on the merits and the faults of the SDGs will continue, in the second half of this talk I want to make the case that the new agenda provides us with a great opportunity to accelerate progress in health, to make universal health coverage a reality, and to improve the lives of millions of our fellow citizens.

This is an agenda of vital importance for this country and our Region.

Let me start by pulling some of the strands of the argument together.

First of all, health is in a prominent place in the new agenda. Goal 3 is broadly drafted: Ensure healthy lives and promote well-being for all at all ages. It is followed by 13 more specific targets. Several of these follow on from the unfinished MDG agenda. Indeed, much of the critique about feasibility and measurement directed at the SDGs can be easily countered when it comes to the health goal, even though the agenda is now more ambitious.
In this meeting we will begin by reflecting on ‘who is still being left behind’ in terms of access to care and financial protection in our Region. Despite considerable progress on the MDGs, a recent report on tracking universal health coverage by WHO and the World Bank found that globally, 400 million people still lack access to one or more of seven essential health services. One hundred and thirty million of those people are in our Region. And around 50 million people are pushed into poverty each year in our Region because of the costs of health care.

From the perspective of the health SDGs, UHC helps to bring together three elements. First, the unfinished agenda of the MDGs: reducing maternal, newborn and child deaths; ending the epidemics of AIDS, TB and malaria as well as hepatitis and other communicable diseases; and ensuring access to sexual and reproductive health care services.

The second element brings in new priorities: NCDs and mental health; prevention and treatment of substance abuse; road traffic accidents and deaths from hazardous chemicals, air, water and soil pollution.

The third element emphasizes the means for achieving these targets: ensuring access to medicines and vaccines; increasing health financing and strengthening the health workforce; strengthening capacity for early warning, risk reduction and management of health risks; and implementing the framework convention on tobacco control.

My third point is that when the SDG text was published the health professionals scoured it to see what was missing. The answer is that the targets under Goal 3 actually cover a great deal of ground. In addition, as we have already noted, many health issues such as sexual and reproductive rights, water and sanitation or the health impacts of climate change are also covered under Goal 3.

The key idea of universal health coverage is that all people have access to the services they need without facing financial hardship when they fall ill.

Second, it brings in new priorities: NCDs and mental health; prevention and treatment of substance abuse; road traffic accidents and deaths from hazardous chemicals, air, water and soil pollution.

The third element emphasizes the means for achieving these targets: ensuring access to medicines and vaccines; increasing health financing and strengthening the health workforce; strengthening capacity for early warning, risk reduction and management of health risks; and implementing the framework convention on tobacco control.

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change are found under other goals.

Two points that should, in my view, have been given more prominence are anti-microbial resistance (AMR) and the impacts of population ageing on health systems and health financing. Anti-microbial resistance, which as you know, is one of the greatest threats facing modern health care, managed to find a place in the preamble of the declaration, but is absent from the goals and targets.

Ageing gets a mention under nutrition and healthy cities, but as a factor that will seriously impact the way we think about health care over the next two or three decades it is noticeable by its omission.

These missing issues take me on to my fourth point about health and the SDGs: They prompt us to think about new ways of doing business. What the missing issues have in common is that neither population ageing nor AMR fit neatly into sectoral boxes. They require high-level political support and coordinated responses across government and society. The strength of the new agenda is that it provides unprecedented legitimacy for those in the health community to work across conventional boundaries. However, the fact that two of the most important challenges in global health are missing from the new agenda should give us pause for thought.

Breaking down the institutional barriers that too often exist between medical and social care are essential elements in helping prepare for a society in which those over 60 will soon make up 20% of the population.

New ways of working that establish coordinated regulatory regimes and responses between the agricultural and health sector to combat AMR require action on the part of each and every government.

As we have learnt to our cost when it comes to the detection and response to disease outbreaks, it is the weakest link in the chain that determines the effectiveness of global and regional systems.

The health SDGs therefore will influence not just how health services work in each country, but have major implications for the broader role of our governments in relation to their own people and to the global community as a whole.

Ladies and gentlemen,

I have pointed to some of the key challenges implicit in the new SDG agenda. I strongly believe we can meet these challenges. But there will still be those who will ask: Are the SDGs affordable?

Critics point to the UN’s estimate that the SDGs will cost between US dollars 3.3 and US dollars 4.5 trillion a year to achieve as evidence of their unaffordability.

My sense is that the anxiety generated by figures like this is misplaced. First, like any normative framework the aim is for progressive realization. Countries will proceed at their own pace given the availability of resources—a point that is reinforced by the emphasis on national target setting. Second, even though estimating the costs of some of the more aspirational targets will remain highly imprecise, some goals, including Goal 3, can and will be costed more accurately.

“The health SDGs therefore will influence not just how health services work in each country, but have major implications for the broader role of our governments in relation to their own people and to the global community as a whole.”
The affordability and rate of progress in implementing the SDGs is a question—in the majority of countries—for the national government, far more than it is for their development partners.

Which brings me to my last point on the health SDGs.

Yes, it is a new agenda, and yes, it will require new ways of working, but at the same time we must not forget the basics. Good health creates wealth. But good health requires adequate financial and human resources.

In our Region, economic growth is expected to continue. We stand well placed to pull millions more out of poverty, though the inclusiveness of that growth will be a common challenge.

As you know, much health care expenditure in our Region is still out-of-pocket, though it varies across countries from as low as 10% to a high 70%. This is a tremendous financial burden for individuals and their families, often resulting in financial ruin.

But let me not belabour these issues: The fundamental point I want to make is that the SDG health agenda is relevant to all countries. And part of that agenda is attending to the basic issues of resources, management, measurement and accountability.

As we conclude, it seems clear to me that the success of the MDGs has created a global environment in which there remains a voracious appetite for setting goals and targets.

Whether the SDG agenda, in its entirety, is over-ambitious with the risk that the momentum created by its predecessor may be lost, is uncertain. My sense is that it is not—with at least one proviso.

That is why we must keep our focus on the big picture—are we really getting to grips with the big challenges of our day? Accountability is key, but monitoring must not get drowned in the detail of every single target and indicator. Let’s keep our eye on the prize.

In the field of health, I am convinced we are in a good place.

We have a solid and comprehensive agenda, and the idea of universal health coverage helps pull what might otherwise be a rather disparate list of programmes into a powerful concept that promotes both equity and rights.

We need new ways of working that will require governments to think hard about the issues that do not fit neatly into sectoral boxes. And we must not, ever, forget the basics and the people we serve.

Thank you.
Leave no one behind, make universal health coverage a reality: WHO

Press Release on the occasion of the Regional consultation on ‘Health, the SDGs and role of Universal Health Coverage: Next steps in South-East Asia’, held 30 March-1 April 2016 in New Delhi, India

30 March 2016, New Delhi: An estimated 130 million people in WHO South-East Asia Region lack access to essential health services and over 50 million people are pushed into poverty every year because of health care costs. Countries in the Region need to take urgent and concerted efforts to make universal health coverage a reality and thereby promote wellbeing for all at all ages.

“Universal health coverage (UHC) means that all people, however rich or poor, and wherever they live, are able to access the health care they need without incurring financial hardship. We must make UHC a reality and ensure that no one is left behind,” Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia said at the beginning of a three-day meeting on ‘Health, the SDGs and the role of universal health coverage’. At the meeting, health ministers and experts from across the Region are discussing ways to accelerate health coverage and attain the Sustainable Development Goal (SDG) of ensuring healthy lives and promoting wellbeing for all at all ages.

Dr Khetrapal Singh emphasized four ways that countries can increase health coverage and progress in their journey toward achieving UHC. “First, access to quality frontline health care is essential. Quality frontline services enhance equity. Second, a well-trained, highly motivated health workforce must be created.”

“Third, we must reduce out-of-pocket payments. At present out-of-pocket expenditures in the Region account for as much as 70% of all health care spending. This represents a tremendous financial burden for individuals and their families. For many of the poorest it means health care is simply inaccessible.”

“And fourth, countries must monitor who is not getting access to care and who is being impoverished as a result of health care costs. Enhancing coverage requires reliable information and an in-depth understanding of such gaps and challenges,” Dr Khetrapal Singh said.

Universal health coverage underpins the other SDG health targets and is the means by which they can be attained. Enhancing coverage will help reduce maternal, newborn and child deaths; help end the epidemics of AIDS, TB and malaria as well as hepatitis and other communicable diseases; and enhance access to sexual and reproductive health care services. It will also help tackle new areas of focus in the Region, including alarming rises in non-communicable diseases such as diabetes and hypertension, along with multi-sectoral issues such as antimicrobial resistance.

“The SDGs provide an opportunity—and an obligation—to make further gains in our public health mission. The goals will not be achieved if everyone relies on ‘business as usual,’” said Dr Khetrapal Singh. In September 2015, following extensive global consultation, the 193 Member States of the United Nations adopted the SDGs. The SDGs aim to encourage an integrated approach to sustainable development, with a focus on the most vulnerable.
WHO to seek Universal Health Coverage in Southeast Asia

Out-of-pocket payments for health are the highest among all WHO regions and one-third of new annual poverty is health care related.


The World Health Organization (WHO) will seek to provide access to health services for all in Southeast Asia and put in place robust healthcare systems in the region, the agency’s regional director for the region, Hifza Akhter Rehman, said in a speech at a conference on Wednesday in Phnom Penh.

Public health experts, development agencies and academics are attending the conference to share their experiences and identify ways to bring about universal health coverage (UHC) in Southeast Asia, which aims to ensure that people get health services without experiencing financial hardship in paying for them. WHO’s Southeast Asia Region covers 13 countries—Bangladesh, Bhutan, North Korea, India, Indonesia, Malaysia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

In Southeast Asia, out-of-pocket payments for health are the highest among all the WHO regions and one-third of new annual poverty is health care related. The World Bank has set a goal to reach UHC by 2020, which is considered central to their objective of ending extreme poverty and the need to step up public support to health because the out-of-pocket expenditure in the country is one of the highest in the world, the director said in an interview last month. "However, putting more resources in health doesn’t always translate into better health outcomes," she said.

Prevent, provide timely care for birth defects

Message from the Regional Director, WHO South-East Asia Region on the occasion of the first World Birth Defects Day, observed on 3 March 2015

Dr. Prasanna Khetrapal Singh, Regional Director, WHO South-East Asia Regional Office

WHO would like to congratulate the Ministry of Health, Bhutan for having established Birth Defects Control Guidelines and having established Birth Defect surveillance in three Regional Hospitals.

A n estimated 70000 newborns die in WHO’s South-East Asia Region in 2015 due to birth defects which also account for an unknown number of spontaneous abortions and stillborns. Birth defects are among the leading causes of perinatal mortality, and account for up to 20% of deaths in children younger than 5 years. Nearly 70% of birth defects can be prevented through maternal health interventions before and after conception.

The most common birth defects are heart defects, neural tube defects and Down’s syndrome, with 94% of the severe cases occurring in middle and low income settings. The socio-economic conditions, where mothers are more susceptible to malnutrition, under nutrition, poverty, obesity, diabetes play a major role. Interventions such as vitamin A supplementation, iodine, micronutrient-rich foods, reduce exposure to pesticides, medications, alcohol, tobacco and other environmental risk factors. Advanced maternal age, smoking, maternal illness, birth defects in family history and congenital infections have an important role in causing birth defects.

The existing primary health services need to be strengthened to provide treatment and management of birth defects effectively. Adequate health personnel, surgical treatments and community-based rehabilitation can help improve the health and quality of life of children born with birth defects, and their families. Early detection of birth defects is important to start timely intervention to achieve reasonable functionality.

First World Birth Defects Day

Prevent, provide timely care for birth defects

March 3

The birth defect of environmental origin can be addressed by prevention approaches and legislation controlling management of toxic chemicals.

Birth defects like thalassemia and sickle cell diseases need a combination approach of care screening, counselling and personal diagnosis.

The timely primary health services need to be strengthened to make treatment and management of birth defects available. This largely depends on the level of healthcare available, significant improvements can be made even with limited resources. Affordable medications, surgical treatments and community-based rehabilitation can help improve the health and quality of life of children born with birth defects, and their families. Early detection of birth defects is important to start timely intervention to achieve reasonable functionality.

The need to prevent and control birth defects, countries of the South East Asia Region have developed their national plans. Efforts are being made to develop and strengthen registration and surveillance systems, build capacity and infrastructure of birth defects and strengthen research.

Despite the many health and wellbeing of people in a big way, birth defects have so far received less recognition. The first ever World Birth Defects Day observed on March 3, is an effort to raise awareness about the occurrence of birth defects and advocate for development and implementation of strong prevention programs and expansion of services for all people around the world.

The initiatives led by WHO and partners have included activities such as the U.S. Centers for Disease Control and Prevention, the International Union of Women for a New World, the International Birth Defects Innovation Network and the Bureau of National Affairs.

Addressing birth defects is important to achieve Millennium Development Goal 4 of reducing child mortality, to which all countries are committed. Significant achievements have been made in reducing under-five deaths, but the progress has not been the same in reducing maternal mortality rate. The under-five mortality rate in the region has declined from 75.1 to 36.0 deaths per 1000 live births in 2013, but the neonatal mortality rate has not declined as predicted. The per live birth to 26 per 1000 live births in the same period with deaths caused by birth defects remaining static.

Child mortality and long term disabilities caused by birth defects are preventable to a large extent. Adequate attention to this public health issue is unacceptable. It is time that the national governments, health programmes and families individuals pledge to act against birth defects.
Enhancing health coverage will help reduce maternal, newborn and child deaths.

Dr. Deepak Singh said the ministry is also considering a new approach to universal health coverage.

"The new approach aims to address the gaps in the current system by focusing on improving access to quality healthcare services, especially in rural and remote areas," he said.

The proposal includes measures such as increasing the number of health facilities, strengthening the insurance system, and improving the quality of healthcare services.

Litmus test of health system

From Fig. 1, WHO-SEARO officials state that universal health coverage (UHC) has not been achieved in the region. The report highlights that only 30% of the population in South-East Asia has access to essential health services.

"This highlights the need for a comprehensive approach to UHC," said Dr. Deepak Singh.

The report also points out that there are significant regional disparities in access to health services, with some countries having rates as low as 10%.

Bhutan has made progress in child health

Bhutan has made significant progress in reducing child mortality rates.

"The Bhutanese government has been making significant efforts to improve child health outcomes," said Dr. Deepak Singh.

The report highlights that the country has reduced child mortality rates by 50% since 1990.

However, the report also notes that there are still significant challenges to be addressed, particularly in remote and rural areas.

Bhutan has made progress in universal health coverage

While Bhutan remains a challenge due to its geographic isolation and remote areas, the country has made significant progress in implementing universal health coverage.

"The Bhutanese government has been making significant efforts to improve access to healthcare services," said Dr. Deepak Singh.

The report highlights that the country has made significant progress in implementing universal health coverage, with nearly 80% of the population having access to at least basic healthcare services.

However, the report also notes that there are significant challenges to be addressed, particularly in remote and rural areas.
Finishing off the task of eliminating key neglected tropical diseases demands vigorous pursuit. Lymphatic filariasis, visceral leishmaniasis, leprosy and schistomiasis are all due to be eliminated in coming years, while yaws is targeted for eradication by 2020.

WHO South-East Asia Region is working with countries to make this happen. Besides high-level advocacy, resources are being mobilized and innovative strategies rolled out. Notable milestones achieved recently include the elimination of lymphatic filariasis in Maldives and Sri Lanka, the verification of India as ‘yaws-free’, and the elimination of kala-azar in approximately 96% of endemic areas in Bangladesh and 80% of endemic areas in India. This momentum must continue.

Finishing off key neglected tropical diseases is part of ensuring that all sectors of the population enjoy the right to the highest attainable standard of health. This goal is foundational to WHO’s mission.
Excellencies, distinguished guests, ladies and gentlemen,

It is a pleasure to be in Maldives once again and to celebrate with you yet another public health achievement. That achievement, of course, is Maldives’ elimination of lymphatic filariasis as a public health problem.

Given the Maldives’ campaign against lymphatic filariasis began in 1951, and was the first time Maldives and WHO worked together, it is an extraordinary pleasure to be here today to celebrate the success of this collaboration. For that I am most grateful.

But beyond the benefits this achievement brings to vulnerable communities, not to mention what it says about the strength of WHO and Maldives’ ongoing partnership, what makes it even more special is that Maldives is the first country in the South-East Asia Region to have accomplished it. In this regard, Maldives provides a shining example to other countries in the Region and right across the world. It is an example we cannot afford to ignore.

Worldwide, 1.1 billion people in 55 countries are threatened by lymphatic filariasis and require preventive chemotherapy to stop the spread of infection. Over 120 million people are estimated to be suffering from chronic forms of lymphatic filariasis, with about 40 million of them disfigured and incapacitated as a result. Lymphatic filariasis is endemic to seven of the Region’s 11 Member States.

Maldives’ achievement demonstrates that the elimination of this disease is indeed possible. Maldives achieved this by initially focusing on vector control, identification of cases and patient treatment, and later adopting the current strategy of providing mass drug administration to the entire at-risk population.

Maldives has demonstrated success through a robust surveillance system and a number of surveys undertaken since 2008. And for more than 200 chronically infected patients who require lifelong care, the government has developed a strong plan to provide morbidity management and disability prevention services that will help ease their suffering.

Of fundamental importance in all of this is the sustained commitment and long-term vision that Maldives’ health authorities and political leaders have demonstrated. It is this commitment that I believe will allow authorities to maintain the achievement and continue to provide robust surveillance and effective vector control.

At the same time as acknowledging high-level commitment, though, I also wish to highlight the efforts of all involved. As such, I congratulate the generations of health workers who have worked tirelessly over the years to help eliminate the disease. Indeed, I can see a few of these frontline heroes among us today and hope they savor this opportunity to celebrate and reflect on the immense value of their work.

On a more general note, I also take this opportunity to congratulate His Excellency, the President, and the Government for their wider achievements across Maldives’ health sector. Alongside socio-economic development, improved health has led to poverty alleviation, the achievement of universal primary and secondary education, prolonged life expectancy and a host of other benefits concomitant to the rising health and wellbeing of the people of Maldives.

Your Excellency and Honorable Minister, distinguished guests, ladies and gentlemen,

The Republic of Maldives’ recent success is no surprise given that the country has long dared to dream big. Over its history Maldives has eradicated smallpox and eliminated polio and maternal and neonatal tetanus. Maldives became the first country in the region to achieve malaria-free status when WHO certified the country as such in December 2015. And with no reported cases of measles and rubella since 2010 Maldives is suitably positioned to eliminate measles by 2018—earlier than...
the regional deadline.

On my way to the Maldives, I had the opportunity to read a book on the success of malaria elimination in Maldives. I was extremely impressed to see that Maldives achieved tremendous success on effective vector and malaria control while the country was still very poor, newly independent, and lacking sufficient human resources. It was also a time when the rest of the world was giving up on its efforts to eliminate malaria.

Maldives achieved their goal through strong political commitment and effective engagement and participation of the community. We see a very close association with malaria elimination and economic growth in the country, a link that has been made by Jeffery Sachs and others. Maldives is an inspiration to other countries in the Region and is one of two countries in the Region to become an upper-middle income economy.

Maldives is in many ways setting the standard for the Region on issues of health, environment and disease elimination. So we look to Maldives to demonstrate ways to control dengue that would also prevent Zika through effective control of the Aedes mosquito.

In all of this WHO has been, and continues to be, immensely proud to be a credible and trusted partner of the Government and people of Maldives. Under the vision and leadership of His Excellency, the President, and with the professional insight and execution of the Honorable Health Minister, I am confident that Maldives’ ongoing health reforms will meet the country’s emerging needs.

In today’s globalized world, for example, we face emerging threats such as from Zika virus, MERS Corona Virus and yellow fever to name a few. To meet these threats it is critical that countries prioritize and invest in complying with the International Health Regulations (IHR) and achieve the core IHR capacities.

I appreciate the progress that Maldives has made in this regard but there is still a long way to go. I assure Maldives of our fullest support in achieving IHR compliance and enhancing the country’s health security.

Similarly, as we enter the SDG era, let me emphasize the importance of achieving universal health coverage. Universal health coverage means that all people have access to the services they need, without facing financial hardship when they fall ill. To date, Maldives has led by example through expanding service coverage and increasing access to essential medicines.

“The Republic of Maldives’ recent success is no surprise given that the country has long dared to dream big. Over its history Maldives has eradicated smallpox and eliminated polio and maternal and neonatal tetanus. Maldives became the first country in the region to achieve malaria-free status when WHO certified the country as such in December 2015.”

In essence, Maldives’ significant health sector gains in recent years can be reinforced by better preparing the health system to meet emerging threats and increasing its already significant coverage.

Against the backdrop of Maldives’ significant historical achievements and its ongoing quest to strengthen the country’s health system, it is my great pleasure, ladies and gentlemen, to announce the Maldives to have eliminated lymphatic filariasis as a public health problem, and to note that Maldives is the first country in our Region to achieve this.

Let me take this moment again to express my heartfelt congratulations to His Excellency, the President, to the Minister of Health, to the thousands of frontline workers who toiled relentlessly in remote and difficult areas, and to the people of Maldives for making such achievements possible.

Lastly, I would like to thank His Excellency, the President, Vice President,
The Republic of Maldives’ recent success is no surprise given that the country has long dared to dream big. Over its history Maldives has eradicated smallpox and eliminated polio and maternal and neonatal tetanus. Maldives became the first country in the region to achieve malaria-free status when WHO certified the country as such in December 2015.

Cabinet Ministers, and especially the Honorable Health Minister for the kind invitation extended to me to be part of this august gathering.

I thank you all sincerely and hope you enjoy the rest of the program.
**India’s triumph over yaws adds momentum to global eradication**

Press release on the occasion of the felicitation of India for yaws elimination held 14 July 2016 in New Delhi, India

14 July 2016, Geneva: WHO has urged 13 countries that remain endemic for yaws to accelerate efforts to implement the new global strategy and achieve interruption of transmission by 2020. The call followed the official celebration of India’s yaws-free status.

“Highly targeted awareness and early treatment campaigns in vulnerable communities enabled treatment of yaws cases and interruption of disease transmission” said Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, while commending India’s capacity and commitment to eliminating neglected tropical diseases, which serves as an example to other countries.

India eliminated yaws after years of sustained campaign using injectable benzathine penicillin to treat affected individuals and their close contacts in the community.

“This is yet another impressive public health achievement for India” said Dr Dirk Engels, Director of the WHO Department of Control of Neglected Tropical Diseases. “It demonstrates how sustained control, awareness, surveillance and, most importantly, community involvement can work to defeat the disease in the remaining 13 endemic countries.”

Today’s event at the National Media Centre in New Delhi also celebrated the elimination of maternal and neonatal tetanus (MNTE) as a public health problem in India. This means that MNTE has been reduced to less than one case per 1000 live births in all 675 districts across the country. A few decades ago, India reported 150 000–200 000 neonatal tetanus cases annually.

According to Dr Khetrapal Singh, the lessons learnt from the elimination of yaws and MNT in India should inform the design and implementation of future disease control programmes in the country.

**WHO recognition**

In May 2016, WHO officially recognized India for being the first Member State to “achieve this important milestone” under the 2012 WHO roadmap on neglected tropical diseases.

Over the past 15 years, India has witnessed unprecedented improvement in health systems, both in terms of infrastructure and human resources. Prior to becoming yaws-free, India was declared polio-free in 2014.

**Timeline of India’s triumph over yaws**

In 2004, the Ministry of Health and Family Welfare reported interruption of indigenous yaws transmission after 7 years of intensive implementation of eradication activities.

On 19 September 2006 – and after 3 consecutive years of reporting of zero cases – the Government of India declared yaws elimination in the country.

Active case searches and serosurveys were maintained with no new cases or evidence of transmission. Following a formal request by the Government of India in March 2015, an independent International Verification Team confirmed interruption of transmission in October 2015.

Elimination of both yaws and MNTE was achieved using the existing health system, national resources and health workforce.

India’s sustained political commitment and clear public health policies, unified strategies, close supervision and monitoring, tireless efforts of the frontline workers, and invaluable support of partners, particularly for MNTE, were key factors for these public health achievements.

**New tool, new thrust for global eradication**

The finding in 2012 that a single-dose of azithromycin is as effective as injectable benzathine penicillin has improved prospects for accelerated eradication of yaws. Oral administration of azithromycin on a large-scale to entire eligible populations is feasible and obviates the need for injections, which require administration by trained health-care workers.
Earlier this week (12 July 2016), as part of the high-level political forum on the Sustainable Development Goals – Leaving no-one behind – the United Nations Department of Public Information screened Where the roads end, a documentary that recounts the discovery, success and potential of oral treatment against yaws. During the panel discussions that followed, the lead researcher Dr Oriol Mitjà appealed to governments, philanthropic organizations and pharmaceutical companies to make azithromycin tablets available free of charge to affected populations so that the world can finally triumph over yaws.

Yaws – a neglected disease of poverty
Yaws is a chronic skin disease that mostly affects poor children who have inadequate or no access to health care and live in unhygienic conditions. Transmission is from person to person. There is no vaccine against yaws. Prevention is based on interruption of transmission through early diagnosis and treatment of individuals and their contacts. Health education and improvement in personal hygiene are essential components of prevention.
Neglected tropical diseases have no place in today’s world. As the name suggests, their persistence is the outcome of inattention and omission, and their burden the harbinger of poverty and stigma.

It is of immense joy, therefore, that Maldives and Sri Lanka have now eliminated lymphatic filariasis, a painful and disfiguring disease transmitted by mosquitos. Vulnerable communities in both countries need no longer fear the swollen extremities, disability and mental anguish caused by the disease, which is more commonly known as elephantiasis.

The technical ability both countries demonstrated in their campaigns is laudable. But it is only half the story. Of equal importance is the political will and commitment shown by health authorities and political leaders at the highest levels. Though lymphatic filariasis is slated for global elimination by 2020, both Maldives and Sri Lanka were able to achieve and certify their filariasis-free status four years before the deadline. This is a remarkable feat, and demonstrates how firm resolve can make real change possible.

Countries across the Region should take note. Though progress against lymphatic filariasis and other neglected tropical diseases (NTDs) has been steady, it must be scaled-up to protect vulnerable communities and meet global targets. Conveniently, the strategies central to tackling lymphatic filariasis can help address other problems.

Mass drug administration campaigns can be employed to target soil transmitted helminthiasis, trachoma and schistosomiasis, for example. Mosquito and other vector control measures can help diminish the transmission of kala-azar, dengue and Japanese encephalitis. And a greater emphasis on case finding can also hone-in on remaining cases of
leprosy and yaws. Better surveillance systems will inform and guide all of these efforts.

Importantly, advances in the battle against lymphatic filariasis and other NTDs must be driven by the principles underpinning the Sustainable Development Goals. Goal 3 outlines the need to “Ensure healthy lives and promote wellbeing for all at all ages,” with a special emphasis on leaving no one behind. Given that lymphatic filariasis and other NTDs are often the product of marginalization and inadequate access to services, a focus on equity and access will be critical to progress. It is no coincidence that Maldives and Sri Lanka both have well-developed health systems with high levels of coverage.

To be sure, the certification of Maldives and Sri Lanka as having eliminated lymphatic filariasis should be relished. The health of vulnerable communities in their respective countries will be enhanced, while efforts to tackle other NTDs can be reinforced. But unless other countries in the Region emulate their drive and success, an opportunity will be lost.

All countries must learn from Maldives’ and Sri Lanka’s achievements and fortify resolve accordingly. All countries must prove that lymphatic filariasis and other NTDs have no place in today’s South-East Asia Region.
Maldives, Sri Lanka eliminate elephantiasis, India yet to achieve target

http://www.liverpoolstar.com/index.php/id/244967250

New Delhi, June 3 (IANS) India’s close neighbours, Maldives and Sri Lanka have eliminated filariasis (LF), a disease commonly known as elephantiasis that has been crippling the World Health Organization’s (WHO) South-East Asia Region office said in a statement.

However, India is still far away from achieving the target of total elimination, with people still suffering from the disease, spread through mosquito bites.

“The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people,” said Prasun Khetrapal Singh, Regional Director, WHO South-East Asia Region.

Commonly known as elephantiasis, LF occurs when filarial parasites are transmitted to humans through mosquito bites.

Infection is usually acquired in childhood which often causes permanent disability later in life.

In India, the disease is endemic in 15 States and five Union territories with approximating populations at risk, according to India’s Health Ministry data.

Indian LF cases were reported from Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh, West Bengal, Puducherry, Andamans and Nicobar Islands, Daman and Diu, Dadra and Nagar Haveli.

From these States/UTs, a total of 250 districts have been identified by the National Vector Control Programme to be endemic for filariasis.

Maldives, Sri Lanka eliminate lymphatic filariasis, India yet to achieve target


New Delhi, Jun 3 (IANS) World Health Organization today said Maldives and Sri Lanka in the South-East Asian region have eliminated lymphatic filariasis, a disease that was crippling people for decades, though India is yet to achieve this feat.

WHO termed it as a “significant” progress against neglected tropical diseases (NTDs) in its South-East Asia Region which also includes India.

“The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people,” said Prasun Khetrapal Singh, Regional Director, WHO South-East Asia Region.

Lymphatic filariasis (LF) is believed to have been endemic in Maldives since 12th and 13th century and is traced back to much earlier in Sri Lanka, with the mosquitoes transmitting the bug found in abundance across the two countries.

Commonly known as elephantiasis, LF occurs when filarial parasites are transmitted to humans through mosquito bites.

These parasites suffer the disease and also suffer mental, social and financial losses contributing to stigma and poverty.

“NTD is typically of the neglected population, the poor and the marginalised. By eliminating this NTD as a public health problem, Maldives and Sri Lanka have shown the way for reaching these populations with other health interventions, much needed to improve their overall health,” Singh added, India is yet to eliminate the disease.

Following Maldives and Sri Lanka’s success, LF endemic countries working towards elimination is now reduced to seven in the Region.

WHO’s South-East Asia Region comprises of Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

The disease is transmitted to humans through mosquito bites. The infection is acquired during childhood and as it progresses, it may lead to permanent disability. Financial losses, mental problems and poverty are the other effects of this neglected disease.

WHO emphasized lymphatic filariasis as a public health problem and developed key strategies to eliminate the disease by 2020. One of the strategies was to stop the spread of the infection and other way to increase disease management and disability prevention measures.

Now, the effective elimination of the disease in Maldives and Sri Lanka was due to intensive mosquito control efforts, effective treatment of the infected population, strengthening of surveillance and close monitoring of prevention and control measures.

“Maldives is committed to enhancing health and wellbeing of its population. Achieving the goal of eliminating lymphatic filariasis as a public health problem, has been possible with our strong commitment, dedication of our health workers and active participation and support of the community,” said Dr. Rajitha Senaratne, Minister of Health, Maldives.

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India behind Maldives, Lanka in filariasis elimination: WHO

http://www.adaderana.lk/news.php?id=43539

World Health Organisation today said Maldives and Sri Lanka in the South-East Asian region have eliminated lymphatic filariasis, a disease that was crippling people for decades, though India is yet to achieve this feat. WHO termed it as a "significant" progress in its South-East Asia Region which also includes India. "The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people," said Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region.

Sri Lanka, Maldives free of elephantiasis - WHO

http://www.ansnewsilanka.co.lk/7h

Sri Lanka and Maldives have eliminated elephantiasis, also called lymphatic filariasis (LF), according to the World Health Organisation (WHO). The WHO termed LF a disease "that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty." A statement posted on the website of the WHO's regional office for South-East Asia said the success in Maldives and Sri Lanka followed intensified mosquito control efforts; treatment of the infected population, disability prevention and control; strengthening of surveillance and closely monitoring and evaluating these efforts which together helped eliminate LF as a public health problem. "The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people," Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, said. "Eliminating LF is also critical to sustainable development goals which emphasises on 'no one being left behind'," the WHO release added.

ColomboPage

Sri Lanka, Maldives Eliminate Lymphatic Filariasis


In a significant progress against neglected tropical diseases in WHO South-East Asia Region, Maldives and Sri Lanka have eliminated lymphatic filariasis, a disease that was crippling people for decades, forcing them to lead a life of stigma, discrimination and poverty.

"The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases, which have no reason to continue and mar the lives of people," Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, said.

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Sri Lanka, Maldives eliminate lymphatic filariasis: India still crippled by disease


New Delhi: India’s close neighbours, Maldives and Sri Lanka have eliminated lymphatic filariasis (LF), a disease commonly known as elephantiasis that has been crippling people for decades, the recent regional Organisation’s (WHO) South-East Asia Region office said in a statement on Friday.

However, India is still far from achieving the target of total elimination, with around six million people still suffering from the disease, spread through mosquito bites.

"The achievement by Maldives and Sri Lanka demonstrates the resolve of these countries and the region as a whole to eliminate all neglected tropical diseases," Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, said.

"Commonly known as elephantiasis, LF occurs when filarial parasites are transmitted to humans through mosquito bites. The infection is usually acquired in childhood and the painful and profoundly disfiguring visible manifestations appear much later in life, often in the form of elephantiasis which causes permanent disability. These patients suffer the disease and also suffer mental, social and financial losses contributing to stigma and poverty.

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Leprosy needs renewed efforts, greater push
By: Dr. Poonam Khetrapal Singh,
Regional Director for WHO South-East Asia Region

WHO launches new strategy to end leprosy

World Health Organization (WHO) launched a new global strategy for leprosy control in South-East Asia, calling for stronger commitments and accelerated efforts to stop disease transmission and end associated discrimination and stigma.

The strategy aims to, by 2020, reduce to zero the number of children diagnosed with leprosy and related physical deformities, reduce the rate of newly diagnosed leprosy patients with visible deformities to less than one per 10,000 population; and ensure that all legislation that allows for discrimination on the basis of leprosy is overturned.

A strategy can only be as good as its implementation.” Poonam Khetrapal Singh, Regional Director of the World Health Organization (WHO) South-East Asia, said in New Delhi at the launch of the global strategy for 2015-2020: “Accelerating towards a leprosy-free world.

WHO launched an efficient treatment protocol in early 2013. There is no reason why a person should suffer the deformities and stigma of leprosy today. The WHO South-East Asia region, which includes India, is now treating 5,651 cases. 72% per cent of the global leprosy cases are treated.

Leprosy affected persons, providing a unique and unrepeatable opportunity for the education of the lay public about the dangers of not seeking early diagnosis and treatment for leprosy. This strategy is not only an educational tool but also a means to promote social inclusion and respect.

WHO launches new strategy to end leprosy by 2020

WHO, in a global strategy entitled “End Leprosy Now: A Call to Action”, has outlined a new approach to address the challenges of leprosy elimination. The strategy focuses on equity and universal health coverage, which will contribute to reaching sustainable development goals in health.

The strategy aims to reduce the number of children diagnosed with leprosy and related physical deformities, reduce the rate of newly diagnosed leprosy patients with visible deformities to less than one per 10,000 population; and ensure that all legislation that allows for discrimination on the basis of leprosy is overturned.

The key intervention need is to reduce the number of children diagnosed with leprosy and related physical deformities. The strategy aims to, by 2020, reduce to zero the number of children diagnosed with leprosy and related physical deformities, reduce the rate of newly diagnosed leprosy patients with visible deformities to less than one per 10,000 population; and ensure that all legislation that allows for discrimination on the basis of leprosy is overturned.

The new strategy is guided by the principle of initiating action, ensuring accountability and promoting inclusivity. These principles must be embedded in all aspects of leprosy control efforts.

Leprosy was eliminated globally in the year 2000 with the disease prevalence rate dropping to below five per 10,000 population. Though all countries have achieved this rate at the national level, at the sub-national level, it remains an unfinished agenda. Of the 313,899 new cases in 2014, 94 per cent were reported from 13 countries: Bangladesh, Brazil, Democratic Republic of Congo, Ethiopia, India, Indonesia, Madagascar, Myanmar, Nepal, Nigeria, the Philippines, Sri Lanka and Tanzania. India, Brazil and Indonesia account for 51 per cent of the newly diagnosed and reported cases globally.

Main challenges

The main and continuing challenges to leprosy control have been the delay in detection of new patients and persisting discrimination against people affected by leprosy which has ensured continued transmission of the disease.

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The main and continuing challenges to leprosy control have been the delay in detection of new patients and persisting discrimination against people affected by leprosy which has ensured continued transmission of the disease.
WHO aims for ‘world free of leprosy’ by 2020

The World Health Organization (WHO) has set a goal to eliminate leprosy by 2020. This means that the disease should no longer be present in any country, and that all cases should be detected and treated. The goal is to be achieved through a combination of strategies, including early detection and treatment of cases, education and advocacy, and the use of effective chemotherapy.

WHO launches global strategy to end leprosy

The World Health Organization (WHO) launched the Global Strategy to End Leprosy and Reactions in 2015. The strategy is designed to help countries achieve the goal of eliminating leprosy as a public health problem by 2020. The strategy focuses on improving access to diagnosis and treatment, reducing the incidence of leprosy, and addressing the needs of people affected by leprosy.

WHO launches plan to fight leprosy

The WHO launches a new plan to fight leprosy, aiming to eliminate the disease by 2020. The plan includes a focus on early detection, effective treatment, and improved access to care. It also emphasizes the importance of community engagement and the involvement of local organizations.

Global strategy to make world free of leprosy by 2022

The WHO has set a new goal to eliminate leprosy worldwide by 2022. This will be achieved through a combination of strategies, including early detection and treatment of cases, education and advocacy, and the use of effective chemotherapy.

Leprosy vaccine: a step closer

Scientists are making progress toward developing a vaccine for leprosy. A recent study showed that a vaccine candidate was able to protect monkeys from infection with the leprosy bacteria. This is an important step toward developing a vaccine for human use.

Leprosy eliminated in India

India has eliminated leprosy as a public health problem. This means that the disease is no longer considered a major threat to public health in the country. The achievement is the result of a long-term commitment to eliminating leprosy, including early detection and treatment, as well as community engagement.

India’s response to leprosy

India has been a leader in the global effort to eliminate leprosy. The country has made significant progress in reducing the incidence of the disease, and has been recognized for its efforts by the WHO. The success in India is a testament to the power of community engagement and collaboration in achieving public health goals.
Rolling back the burden of communicable diseases is a task of ongoing attention. Communicable diseases such as HIV/AIDS, tuberculosis and viral hepatitis continue to be a major health concern in the South-East Asia Region, and must be tackled accordingly.

Registering a remarkable achievement in early 2016, Thailand was certified as having eliminated mother-to-child transmission of HIV/AIDS, meaning that an entire generation will now be born HIV-free. Thailand’s achievement sets a powerful example as the Region strives to end the HIV epidemic by 2030. In similar fashion, countries across the Region are now gearing up to tackle the viral hepatitis epidemic. Diminishing the disease’s burden means strengthening proven methods of infection control and treatment, as well as ensuring every newborn receives the birth dose vaccine. The 2016-2020 Regional Strategic Plan to End TB, meanwhile, is being rolled out, and will prove vital to controlling tuberculosis across the Region.

Rolling back the burden of communicable diseases means preventing and treating a range of potentially life-threatening conditions. It is an imperative that is being pursued with vigor.
Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia congratulates Thailand’s Health Minister Dr Piyasakol Saholsatayadorn on his country’s elimination of mother-to-child transmission of HIV and syphilis.
Excellencies, distinguished guests, ladies and gentlemen,

We are gathered here today to mark an important moment in the global effort to eliminate new HIV infections among children.

On the 7th of June, Thailand became the first country in Asia to be certified as having eliminated mother-to-child transmission of HIV and syphilis. It was also the first time that a country with a large HIV epidemic achieved this feat.

In Thailand today more than 95% of all pregnant women living with HIV receive antiretroviral therapy, and the rate of mother-to-child HIV transmission is less than 2%. Whereas at the turn of the millennium an estimated 1000 children in the country were newly infected with HIV, in 2015 the number of children who become infected was 85. This is a remarkable achievement in a country where an estimated 440 000 people live with the disease.

For far too long it was assumed that only the wealthiest countries could obtain immediate access to biomedical breakthroughs, and that everyone else would have to wait years or even decades to benefit from the lifesaving technologies. Beginning with AIDS, though, non-OECD countries have attempted to guarantee the same standard of care as is available in their wealthier peers. This represents a tectonic shift in the history of global health.

In acknowledging the significance of Thailand’s achievement, we must now build on it to further protect the health and wellbeing of future generations across the South-East Asia Region and the world. But if we hope to emulate Thailand’s success in preventing new HIV infections among children, we need to understand how this achievement was possible.

First, Thailand’s success in preventing new HIV infections across all demographics reduced the burden of HIV among women of childbearing age. From 2000 to 2014, the annual number of women newly infected with HIV in Thailand fell from 15 000 to 1900—an 87% reduction. We would not be celebrating today had Thailand not made HIV prevention a major national priority.

Second, Thailand has been steadfast in its pursuit of universal health coverage. In Thailand, essential health services are available to both rich and poor, making the country’s health system a model to be followed the world over. Though limited AIDs budgets are often unable to sustain the costs of essential screening and treatment programs, Thailand has demonstrated that with a sound, well-designed health system that includes the participation of diverse sectors, public health goals can be achieved.

This is all the more noteworthy as we go about pursuing the Sustainable Development Goals, a core part of which requires the attainment of universal health coverage.

Finally, Thailand has demonstrated a visionary commitment to providing equitable access. Like all Thai citizens, immigrants are also covered for HIV treatment. In our increasingly connected and mobile world, withholding lifesaving health services based on one’s country of origin is inhumane and contrary to basic principles of public health and human rights.

Thailand’s achievement similarly offers inspiration as we work towards the SDG goal of ending the AIDs epidemic as a public health threat by 2030. Political commitment, community engagement, and evidence-based interventions have been central to what Thailand and other countries around the world have achieved thus far.

These achievements have also been facilitated by transformative international partnerships, not only between the North and South but also South-South partnerships. Thailand has not only benefited from such partnerships, but has also served as a critical source of knowledge, learning and best practices in relation to AIDS.

Speech of Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia Region, at the event for Elimination of mother-to-child transmission of HIV and Syphilis by Thailand, held on 20 June 2016 in Bangkok, Thailand
Thailand has been home to some of the most important HIV clinical trials and implementation studies, including with respect to prevention of mother-to-child transmission. Thailand’s early pioneering of condom promotion for sex workers has inspired effective HIV prevention measures across the world, in both rich and not-so-rich countries. And as Thailand’s investments in health have placed it on track to achieve the 90-90-90 target before the 2020 deadline, it is showing the entire world what it takes to fully leverage antiretroviral therapy to reduce new HIV infections and AIDS-related deaths.

Having eliminated mother-to-child HIV transmission, Thailand’s efforts to end AIDS can now be focused on the MSM community, among whom the epidemic is increasing. It also has the opportunity to address HIV’s continuing prevalence among drug users. Given Thailand’s successes and commitment, I am confident that the country will go from strength-to-strength in its battle to control the disease.

Keeping in mind the ambitious Agenda for Sustainable Development, let us also take a moment today to do two things. Let us congratulate and celebrate Thailand for its extraordinary achievement in eliminating new HIV infections among children. But let us also renew our determination to ensure that this achievement is the first of many. We must use this milestone as a springboard for other health gains.

We look forward, for example, to Thailand fast-tracking efforts to eliminate malaria ahead of the 2026 target and reinforcing the worldwide struggle against artemisinin resistance. We also look ahead to Thailand’s approach to eliminating TB, which could prove instructive for the wider Region. And we anticipate keenly the expansion of Thailand’s path-breaking work on health promotion to address the rising toll of non-communicable diseases.

At WHO we are immensely proud to have worked with and supported Thailand in its efforts to safeguard the health of all, and look forward to making many more public health gains in the future.

Thank you all very much.
The hepatitis B vaccine is impressively effective when provided within 24 hours of birth. When followed up with at least two more doses of the vaccine during the first year of life, the birth dose protects newborns from mother-to-child transmission of the liver-wasting disease, and also guards against infection during a period when the virus is most damaging to future health.

That newborns across the WHO South-East Asia Region are going without the birth dose represents a missed opportunity. Hepatitis B kills around 350 000 people in the Region every year. That’s more than AIDS and malaria combined, and second only to tuberculosis among life-threatening communicable diseases. Approximately 100 million people across the Region, meanwhile, suffer from the disease’s chronic form, which can cause debilitating fatigue, jaundice and abdominal pain. It also results in increased health costs and limits workforce participation.

Though many newborns are deprived of the birth dose due to lack of attendance by a skilled health worker at birth, even in institutional settings it is estimated that up to half of neonates go without. This is due primarily to a shortfall in skills, knowledge, resources and regulation. For some countries in the Region, the hepatitis B birth dose has no place at all in standard early post-natal care, meaning the benefits are missed entirely.

There are several ways we can turn this around and ensure every newborn receives the birth dose and is given the best chance possible to avoid hepatitis B.

First, every country in the Region should make the birth dose an essential component of its early post-natal care regime. By aligning national practice with international guidelines, health service providers will know what is expected, meaning there can be no excuse for a lapse in coverage.

Second, where the birth dose is part of the immunization schedule, health care providers must be adequately trained and educated on the importance of the vaccine’s early delivery. Well-structured training backed by frequent follow-up support will increase confidence among health workers administering the dose, and will also enhance the likelihood of it becoming a routine part of post-natal care.

Third, technologies vital to the dose’s provision must be made available at all levels of the health system, including at the community level. Though all efforts to encourage institutional delivery must be made, in hard-to-reach areas novel storage systems can allow health workers to provide the dose outside of a health care setting. As in all aspects of public health, advancing equity and access must be a priority.

Finally, health systems and those working in them must engage with communities to advance knowledge of the birth dose and emphasize its benefits. Fear of adverse effects remains a source of resistance to the vaccine among parents, while traditional practices—such as the custom of sequestering a newborn—provide their own challenges. Health workers must deal with these barriers sensitively and in a way that empowers parents. Just as health workers must be trained to provide the vaccine, so too must parents be given the information necessary to drive demand.

Still, as vital as the birth dose and completing the vaccination schedule is, interrupting the disease’s transmission will require complementary public health interventions. These interventions can help interrupt other forms of viral hepatitis, including hepatitis A, C, D and E.

Alongside efforts to increase early childhood and adult vaccination, for example, harm-reduction programs such as needle exchanges can help halt the spread of hepatitis B and C, as well as other blood-borne diseases among injecting drug users. Safe practices related to injections, blood transfusions and other medical procedures can similarly diminish the spread of hepatitis B and C among health care consumers, and will also promote better health facility management. Stronger enforcement of food safety regulations, safe water, sanitation and hygiene can also aid in reducing the risk of hepatitis A and E among the general public.
For those already suffering chronic hepatitis B and C, access to high-quality, safe and affordable treatment must be guaranteed at all levels of the health system.

While political commitment to the birth dose and other means of combating viral hepatitis is growing, resolve must be fortified. Countries across the Region must now devise and implement national hepatitis action plans built on sound strategic and financial principles. And they must do so as a matter of priority: If delayed, the global goal of ending hepatitis as a public health problem by 2030 will be unfulfilled. Millions of people across the Region will continue to suffer needlessly.

Not always in public health do we have the tools, knowledge and resources to rout a disease effectively. But when it comes to tackling hepatitis B we are well-positioned. The vaccine, and especially its birth dose, is an exceptionally efficient method of interrupting transmission and keeping millions of people safe from the life-threatening disease. We just need to use it. Countries across the Region must no longer fight hepatitis with one arm tied. Every newborn should receive the hepatitis B birth dose.
**95% of hepatitis patients don't notice infection**

New Delhi: Viral hepatitis has been ranked among the world's most serious public health problems. In India, the World Health Organization (WHO), with an estimated 50 million people infected with chronic hepatitis, is driving a multi-faceted national strategy to control the disease. According to the WHO, 180 million people are infected with hepatitis B and C, and over 40 million people in India are aware of having hepatitis C.

**Rise in cases**

The rise in cases of hepatitis B and C has been attributed to several factors, including increased awareness and screening programs. However, a significant number of cases remain undiagnosed, leading to delayed treatment and complications.

**Lack of awareness**

Despite the progress made in recent years, there continues to be a lack of awareness and understanding of the disease among the general population. This has led to a delay in seeking healthcare and treatment, which in turn increases the risk of complications such as liver failure, cirrhosis, and hepatocellular carcinoma.

**Way forward**

To address this issue, there is a need for increased awareness and education programs. These initiatives should be targeted at all levels of society, including schools, workplaces, and communities, to ensure that people are informed about the signs, symptoms, and prevention of hepatitis.

**World AIDS Day being celebrated, but lack of awareness still exists**

**WHO warns India over hepatitis incidence**

India alone has 50 million people living with chronic hepatitis B and C, which are major public health problems in the country. The World Health Organization (WHO) has warned that the incidence of chronic hepatitis B and C is rising in India, and that action must be taken to address this growing public health crisis.

**Chronic hepatitis**

Chronic hepatitis B and C are serious and often asymptomatic conditions that can lead to liver disease, cirrhosis, and even liver cancer. The WHO estimates that there are 2.5 million people living with chronic hepatitis B and C in India, and that this number is likely to increase in the coming years.

**Prevention and treatment**

Effective prevention and treatment measures are available, but they require increased awareness and access to healthcare services. The WHO recommends regular screening, early detection, and prompt treatment to prevent the progression of chronic hepatitis B and C to more severe conditions.

**Government action**

Governments have a role to play in addressing this public health crisis. They need to invest in initiatives that promote awareness, increase access to screening and treatment, and develop strategies to prevent the spread of the virus. This includes funding research, training healthcare workers, and implementing policies that support viral hepatitis control programs.

**Conclusion**

The fight against viral hepatitis is an ongoing battle, and much remains to be done. By increasing awareness, improving access to care, and investing in research, we can make progress towards eliminating this deadly disease. It is crucial that we act now to ensure that no one is left behind in the fight against hepatitis B and C.
WHO: Thailand eliminates mother-to-baby HIV

Bangkok, June 8

Thailand has become the first Asian country to eliminate mother-to-child transmission of HIV, the World Health Organization said on Wednesday, a milestone in the fight against the disease.

The announcement is a boost for a generation of Thai health workers who have transformed the nation from one of Asia’s most HIV-affected societies to a leader in how to effectively tackle the crisis. Describing the elimination as a “remarkable achievement,” the WHO said Thailand was “the first country in the world with a high HIV epidemic to reduce maternal-to-child transmission by 99 percent.”

Thailand became the first country to eliminate mother-to-child transmission of HIV in 2015, marking a major milestone in the global fight against the disease. Since then, the country has maintained its commitment to reducing mother-to-child transmission, and today it can claim to have eliminated it altogether.

Thais beat mom-to-kid HIV; 1st in Asia

Routine Screening, Universal Free Meds For Pregnant Women Fuel Turnaround

Bangkok: Thailand has become the first Asian country to eliminate mother-to-child transmission of HIV, the World Health Organisation said on Wednesday, a milestone in the fight against the disease.

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WHO urges South-East Asia to taper hepatitis cases

DISEASE CONTROL

NEW DELHI: The World Health Organization on Wednesday urged the South-East Asian nations to increase access to hepatitis testing, treatment and care. The WHO said it will release its first hepatitis testing guidelines in 2016 which will provide guidance on who should be tested, and recommends simple testing strategies to help scale up hepatitis testing, treatment and care. The WHO said that national strategies should use hepatitis testing tools and step up efforts at all levels to address the growing threat of hepatitis. At the launch of the guidelines, the WHO launched the Global Health Sector Strategy for Hepatitis that aims to reduce the number of deaths from hepatitis B and C by 2030.

WHO urged South-East Asia to taper hepatitis cases

CHEAPER HEPATITIS TREATMENT IN INDIA ATTRACTS FOREIGN PATIENTS

Kamal Math, Times of India

Chennai: It is a fact that treatment for hepatitis C costs much less in India than in many other developed nations and city transplant surgeons say they see a lot more overseas patients flying to Chennai for treatment.

LIVER KILLER

Liver transplant surgeon Dr. Diwakar, says “We have a lot of patients flying in from other countries who are looking for liver transplants. Many of them come from countries where the cost is much higher.”

Viral hepatitis kills over 3 lakh people every year in South Asia: WHO

NEW DELHI: The World Health Organization on Wednesday urged the South-East Asian nations to increase access to hepatitis testing, treatment and care. The WHO said it will release its first hepatitis testing guidelines in 2016 which will provide guidance on who should be tested, and recommends simple testing strategies to help scale up hepatitis testing, treatment and care. The WHO said that national strategies should use hepatitis testing tools and step up efforts at all levels to address the growing threat of hepatitis. At the launch of the guidelines, the WHO launched the Global Health Sector Strategy for Hepatitis that aims to reduce the number of deaths from hepatitis B and C by 2030.
Combating antimicrobial resistance means taking on one of the greatest threats to the health and wellbeing of people across the South-East Asia Region. The inappropriate use of antibiotics is leading to bacterial infections that cannot be treated and which are already killing approximately 700,000 people worldwide every year.

Tackling the problem is a key priority. Building on the consensus established in the 2011 Jaipur Declaration on Antimicrobial Resistance, in February this year ministers of health from across the South-East Asia Region convened in New Delhi and charted a Roadmap for Action. The Roadmap, which is aligned with the 2014 Global Action Plan on Antimicrobial Resistance, lays out priority areas of action with the aim of achieving compliant national action plans by May 2017. The event was followed in June with a bi-regional meeting in Tokyo that sought to further enhance multisectoral coordination and awareness around AMR.

As the deadline for compliance with the Global Action Plan approaches, WHO is supporting countries to draft and implement national action plans capable of stemming the threat AMR poses. The efficacy of antimicrobial drugs must be safeguarded.
Your Excellencies, distinguished participants, ladies and gentlemen,

When in 1928 a Scottish scientist chanced upon the discovery of penicillin, public health changed dramatically. Once-fatal bacterial infections became curable, and infection-risks associated with surgical procedures, too, diminished greatly. Health systems became not only more effective, but also more equitable, as rich and poor alike accessed the medication needed to treat many infections and stay healthy and productive.

As is often the case, too much of a good thing is proving to be harmful. We are now in a world where the efficacy of antibiotics is under threat. Inappropriate use of antibiotics has led to resistance, resulting in approximately 700,000 people dying each year from conditions that were once easily curable.

Already resistance to HIV drugs is rising: More than 100 countries report extensively drug-resistant tuberculosis, and resistance against artemisinin-based combination therapies for falciparum malaria is a serious issue. Hospital acquired infections with highly resistant infective organisms are now becoming daily realities.

If present trends continue, by 2050 AMR will contribute to more than 10 million deaths worldwide. In the looming post-antibiotic era, skin sores and diarrhea could be untreatable; life-saving surgeries more risky.

Though the discovery of antibiotics may have been accidental, their demise will be of our own making. Urgent action is needed.

Countries in the South-East Asia Region have been proactive in addressing antimicrobial resistance. Since 2010, several Regional Committee resolutions on prevention and containment of AMR have been adopted, the last being resolution SEA/RC68/R3 adopted by the RC held in Timor-Leste in September 2015. That resolution emphasized that “combating antimicrobial resistance shall require political commitments, multisectoral coordination, sustained investment and technical assistance,” and it called on Member States to put AMR as one of the top priorities on their national agenda.

Further, as early as 2011, the honorable health ministers of this Region recognized the seriousness of AMR and adopted the Jaipur Declaration on Antimicrobial Resistance. It was an important step to promote, at the highest level, awareness about the problem of AMR and to stimulate concerted efforts to tackle it. The Jaipur Declaration on Antimicrobial Resistance recognized the irrational use of antibiotics as the key driver of the emergence of resistance and advocated for a holistic and multidisciplinary approach to the control and prevention of resistance to antimicrobials.

When I assumed my responsibilities as the new Regional Director for WHO South-East Asia in 2014, I made AMR one of my flagship priorities for the Region. Identifying flagship priorities allows us to focus our resources to achieve clear deliverables, and to support countries.

At the international level, too, strong and sustained actions have been taken, and the momentum continues.

In May 2015, the 68th World Health Assembly endorsed a resolution making it mandatory for member countries to align national action plans with the global standard by May 2017. WHO published the Global Action Plan on Antimicrobial Resistance to guide countries in the development of their national action plans.

At the UN General Assembly later this year a resolution on AMR is expected to be passed that will further mainstream the issue. Concurrently, the commitment by G7 countries in Berlin, Germany in 2015 to promote the
AMR agenda will likely be cemented at the G7 summit in 2016 in Tokyo, Japan.

So, ladies and gentlemen, we know the problem. We have committed ourselves to deal with it. International attention to AMR has crystallized and global commitment is at its highest. And now, more than ever, is the time to start taking concrete actions on the ground; to walk the talk, to repeat a cliché.

That means we must turn words into action. It means we must battle AMR with all the means we have at our disposal. In this context, I applaud India’s leadership in combating AMR. This meeting on AMR-related public health challenges and priorities will contribute to the development and implementation of national action plans in the Region—plans that will assess risks associated with AMR, as well as our response capacities.

Since we cannot anticipate what pathogens may evolve, and on what scale they could harm, this planning will be vital. The meeting also provides an opportunity to renew commitments to the global agenda outlined in the World Health Assembly Resolution. From here on, vigilance, risk assessment and risk management must be ongoing.

Excellencies, ladies and gentlemen,

In all discussions around AMR the key strategy is to have a holistic and multisectoral ‘One Health’ approach. AMR cannot be dealt with by the health sector alone. In addition to easy access to medicines and over prescription, antibiotic use is on the rise in the animal and agriculture sectors. A future rise in demand for more animal-origin food products threatens to raise demand for antibiotics even more. Therefore, one of the key strategies in the Global Action Plan is to “optimize the use of antimicrobial medicines in human and animal health.” To do this, strong coordination is needed among all sectors, including veterinary medicine, and agriculture.

Given the multi-sectoral nature of AMR, the attendance of the Ministry of Agriculture and the FAO and OIE agencies is vital and welcomed; without a multisectoral approach, the emergence of AMR cannot be halted. To that end I am encouraged by the fact that we have the presence of honorable ministers of several Member States which speaks volumes about the seriousness of our countries to tackle AMR. I am also greatly pleased to see many experts and high-level officials from countries beyond our Region, including from France, Japan, the Netherlands, the UK and the US.

It is indeed an opportunity to collectively develop meaningful and practical next steps in the fight against AMR. And I have no doubt that we will succeed in this endeavor. I urge you all to work together to take forward the momentum against AMR, both at this meeting and thereafter.

The stakes are high. We must guard our health security and fight antimicrobial resistance together.

I wish the meeting all success.

Thank You.
Aggressive superbugs that have the power to kill are a reality. Inappropriate use of antibiotics has led to the evolution of illness-causing microbes, resulting in approximately 700,000 people dying each year from conditions that were once straightforward to manage—from seemingly benign cuts and abrasions to diarrhea and skin sores.

By 2050, if present trends continue, that figure is expected to rise to 10 million. The reduced effectiveness of antibiotics, an outcome of antimicrobial resistance, is real, and constitutes a mortal threat to health security. It must be arrested now.

Countries in the WHO South-East Asia Region are particularly vulnerable. Alongside gaps in health care services, dense populations and often poor sanitation contributes to a breeding ground for superbugs that kill with impunity. In Jaipur, India, in 2011, countries in the Region recognized the imperative of prioritizing measures to prevent and contain the problem, and acknowledged that the most significant driving factor is irrational use of antibiotics from over-the-counter availability and over prescription. They also recognized that while the problem could lead to an epidemic, it is already leading to loss of lives, long-term suffering, disability, and reduced productivity and earnings.

While concrete measures have been taken, more must be done. With a dearth of new antibiotics being developed, we must closely guard the efficacy of those that we already have. Now is the time to turn the pledges into action.

Government must also promote changes in the prescription habits of doctors by emphasizing the diminishing returns of antibiotics. This will help medical professionals feel confident in the treatments they recommend and will enhance their ability to resist pressure—whether from industry or patients—to prescribe powerful antibiotics as an easy fix. And governments must take urgent action to regulate the use of antibiotics for purposes that have no relation to health. In the South-East Asia Region, this means ensuring that the livestock and fisheries industries desist from using life-saving antibiotics for ‘growth promotion’ in animals.

Unless these and other steps are taken, we face a return to the dark, pre-antibiotic era of public health.

**Stop antimicrobial resistance now**

Opinion editorial article by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia

Advances in the quality of health care across the Region are already being reversed. Resistance to first-line antibiotics means treating once-basic illnesses is more difficult, costly and time-consuming. In resource-poor settings, this matters. Not only is a farmer in Nepal, a fisherman in Sri Lanka, or a factory worker in Indonesia biologically imperiled by antimicrobial resistance, as we all are, but they must also deal with the potentially ruinous burden of having to pay more for care while taking a greater amount of time off of work in order to get well.

The wider economic implications of this are troubling. If present trends continue, it has been estimated that by 2050 antimicrobial resistance will result in a 2% to 3.5% reduction in Gross Domestic Product, representing a significant opportunity cost for the Region’s developing economies.

The good news is that commitment to tackle the problem is crystallizing. Governments, pharmaceutical companies and multilateral organizations have recognized that concerted action is needed, and that adhering...
to WHO’s Global Action Plan on Antimicrobial Resistance is the surest way to fight back. At a meeting of SEA Region Member Countries in New Delhi this week, governments are working on a roadmap to achieve the Global Action Plan’s targets, including drafting and implementing national action plans with clear outcome-based protocols for measuring, documenting and reporting progress. What can’t be measured, after all, can’t be achieved. WHO will work closely with Member States to monitor their progress and help them reach these goals, thereby making the Region a leader in the global fight-back.

As with all public health interventions, the push to reverse antimicrobial resistance and the menace it represents to health security requires intelligent policymaking backed by keen and effective enforcement. It also demands more than a little old-fashioned grit and a society-wide resolve to see these efforts through. If words aren’t transformed into meaningful, multi-sector action, antimicrobial resistance’s future consequences will be many times more catastrophic than they already are.
Govt draws thin red line to curb antibiotics misuse

New Delhi: To check irrational use of antibiotics, packs of certain medicines will soon carry a ‘red line’ differentiating them from other drugs. The move is aimed at discouraging unnecessary prescription and over-the-counter sale of antibiotics causing drug resistance for several critical diseases including TB, malaria, urinary tract infection and even HIV.

The Centre is set to kick-start an awareness campaign ‘Medicines with the Red Line’ to increase awareness on rational use of antibiotics. “India is committed to combating antimicrobial resistance (AMR). However, a collective action is required by all stakeholders within a comprehensive and multi-sectoral framework,” said a press release.

India, which has the highest number of TB patients in the world with over 2.5 million new cases and 0.75 million deaths every year, has already prepared a standard treatment protocol to restrict overprescription and sale of antibiotics. However, the government has so far failed to enforce the protocol strictly because of an absence of monitoring mechanism. It is crucial to India is a hub of multi-drug resistant TB. Estimates show over 1.1 lakh MDR tuberculosis cases are notified in India every year. This is significant when compared to Brazil and South Africa which reported around 15-20,000 MDR TB annually.

Inappropriate use of antibiotics makes bacterial infections immune to them. Over 7 lakh deaths occur every year as a result of drug resistance. In India, an additional 1.5 lakh cases can be attributed to drug resistance.

In a communiqué issued by the Tokyo Meeting of Health Ministers on Antimicrobial Resistance, health ministers from 13 countries is the region agreed to improve the way information on antimicrobial resistance is collected and shared to guide effective policies and actions.

They also agreed to strengthen and harmonize how their nations regulate the production, sale and use of antibiotics and other antimicrobial medicines. They said they were ready to take innovative approaches to stimulate research and development of new antibiotics, diagnostic tests, vaccines and other technologies.

World Health Organization (WHO) regional director for South-East Asia Poonam Khetrapal Singh said antimicrobial resistance was a threat to global security and economic stability.

“It is a looming health and economic crisis that requires global and local solutions. Since drug-resistant genes can travel, countries with higher levels of economic and social organization have a stake in the success of measures taken by less developed countries. In the fight against antimicrobial resistance, we are only as strong as the weakest link,” she told ministers during the meeting.

Khetrapal Singh further said antibiotic resistance was one of the biggest threats to human health today. “Having effective antimicrobials is also critical to the social and economic development of nations. We have a limited window of opportunity to take action and avoid a post-antibiotic era,” she said.

WHO is supporting countries across the Asia Pacific region to take critical steps to preserve the effectiveness of these life-saving medicines.

Big Worry

- Globally, over 700,000 deaths each year are attributed to drug resistance.
- In India, an additional two million lives can be lost by 2050 due to drug resistance.
- Antibiotics are the most sold drugs segment in India with sales over Rs. 1,000 cr.

Antibiotics. The UN agency has cautioned the government and public health experts that “if enough was not done now, common bacterial infections such as skin, sore or diarrhea would become untreatable and fatal.”

The Jakarta Post


18.04.2016

Asia Pacific countries vow to jointly tackle antimicrobial resistance

Countries in the Asia Pacific region on Saturday pledged to jointly combat the increasing threat of antimicrobial resistance, which transgresses borders and endangers global health by making life-saving antibiotics ineffective.

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BERITA SATU.COM

Menekan Asia Pasifik Bahaya Ancaman Resistensi Antibiotik


Pada pertemuan ini para delegasi berbagi pengalaman mengenai usaha dan penggunaan AMR di sebagian mancanegara. Pihak KKD di WHO, Badan Pangan dan Pertanian (FAO), Kementerian Kesehatan, dan WHO-Regional Pasifik Barat (MPRC) memberikan usulan bersama dengan praktik yang telah dilakukan terkait, mengenai tindakan kesehatan global yang harus dilakukan agar AMR tidak menjadi isu serius yang terjadi di masyarakat.

Resistensi antibiotik tidak hanya terbatas pada manusia, namun juga pada keberlanjutan tanaman. Untuk memperkuat tindakan WHO, yang melibatkan sektor kesehatan, pertanian (termasuk peternakan dan kehutanan) secara berganda dan menjadi bentuk kepemimpinan bagi negara-negara yang ada dalam pertemuan ini.

Curb non-rational use of antibiotics: Centre

AGE CORRESPONDENT
NEW DELHI, FEB 23

Terming antimicrobial resistance as the number one public health challenge before the world today, the government on Thursday made it a fight against non-rational use of antibiotics.

"ARM has emerged as the number one public health challenge before the world today. The first step in addressing the problem of ARM is to avoid the need for antibiotics at all in the first place," Union health minister J.P. Nadda said while inaugurating a three-day international conference on combating ARM.

"This is best done through improved water and sanitation, in the absence of which proliferation of diarrhoeal diseases results in inappropriate antibiotic use," the Union health minister said.

The Union health minister said that the WHO (90 on 216) had recommended strong measures by the governments to stop the availability of antibiotics over the counters. Governments must take strong measures to stop the over-counter availability of antibiotics, while strengthening and enforcing legislation to prevent the manufacture, sale and distribution of substandard antibiotics.

"These measures must be accompanied by campaigns to make behavioural and cultural changes in prescribers and patients so that antibiotics are no longer considered the first treatment option," he said.

The minister added that evidence from the world had shown that antibiotic resistance, if left unchecked, would become unmanageable and fatal.

"Global estimates state that 700,000 people die every year due to once-treatable health conditions. In South-East Asia region, the situation is grim in public health. Public confidence gaps, coupled with dense populations and sub-optimal sanitation, contribute to a breeding ground for bacterial infections," Dr. Poonam Khutrapal Singh said.

Health ministers from 12 countries of the region agreed to improve the way information on antimicrobial resistance is collected and shared to guide effective policies and actions. The meeting also stressed on the need to harmonise approaches to stimulate research and development of new antibiotics, diagnostic tests, in vitro screening of new drugs, and meeting of Health Ministers on April 24.

"Antimicrobial resistance is a threat to our economic development as countries with higher levels of education by far developed countries suffer the burden," Dr. Poonam Khutrapal Singh said.

WHO IN THE MEDIA

WHO IN THE MEDIA ON ANTIMICROBIAL RESISTANCE

With coverage in DNA
- India Today
- The Times of India
- Business Standard
- Zee News
- The Himalayan
- Financial Express
- The NewsToday
- Bangladesh News
- The Asian Age
- The Pioneer
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- Sangstha (BSS)
- Yahoo! News
- Sify News
- HT Media Syndication
- Live Uttar Pradesh
- Odisha Sun Times
- Express Pharma
- BDnews24.com

The Himalayan

https://www.thehindu.com/opinion/columns/asia-pacific-countries-pledge-end-antimicrobial-resistance/article15624804.ece

17.04.2015
Asia Pacific countries pledge to end antimicrobial resistance, the biggest threat to global security

Countries in the Asia Pacific region today pledged to collaborate in combating the increasing threat of antibiotic resistance which transcends borders and endangers global health by making the use of antibiotics ineffective.

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"The mission of the guidelines is to provide a platform to move Health Organizations (WHO) region-wide," said Dr. Poonam Khutrapal Singh.

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Menkes se-Asia Pasifik Bahas Ancaman Resisten Antimikroba


17.04.2016

Jakarta- Para menenti kesehatan Se-Asia Pasifik pose bersama usia membagi resistenti antimikroba global di Tokyo, Sabtu 16 April 2016. (Humus Kemenkes)

HARMABIZ.COM

September 2015


O calls for action on indiscriminate use of antibiotics to prevent return to pre-antibiotic era

All Health Organisation (WHO) has urged member nations in South East Asia Region to urgently stop the indiscriminate use of antibiotics and other drugs which are increasingly leading to resistance to medicines, persistence of infections, and treatment failure.

"A threat to public health and immediate action is required to stop the world from heading back to a pre-antibiotic era in which all achievements made in prevention and control of communicable diseases will be reversed. Common infections and minor injuries which have been treatable for decades will again kill millions. Resistance to antibiotics will make complex surgeries and management of even common diseases like cancer, extremely difficult," Dr Asmau Rameswari Singh, regional director, South East Asia Region, said at a regional meeting in Dhaka, capital of Bangladesh.

"Today, without effective antimicrobial medicines, a number of common infections such as hospital and catheter associated pneumonia, urinary tract infections, bacteraemia, tuberculosis, meningitis, etc. are becoming harder to treat. The problem is compounding, and unless we act now, the consequences might be irreversible," said Dr Singh.

The forecast of the potential human and economic cost indicates 10 million deaths per year and 2 to 3.5 per cent global gross domestic product by 2050 if antimicrobial resistance goes unchecked. Reduced productivity from persisting illness, and its cost of treatment, adds to the economic burden.

The regional director was addressing health ministers and senior health ministry officials from the 11 member countries of WHO South East Asia Region, at the six-day meeting of the regional ministers which meets annually to discuss health priorities and health agenda for the region.

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एटीवायकॉटिक प्रतिरोध से लड़ने के लिए जल्द से जल्द कारावास करना जरूरी: डक्टर यू.एस.ओ।

हमारे संवाददाता

‘दूसरी दिनियमें विशेष अवसर संबंधित’

नई दिनियमें विशेष अवसर संबंधित नई दिनियमें विशेष अवसर संबंधित नई दिनियमें विशेष अवसर संबंधित

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