

A Healthier South-East Asia



Years of WHO in the Region

A Healthier South-East Asia: 70 years of WHO in the Region

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A Healthier South-East Asia



Years of WHO in the Region



REGIONAL OFFICE FOR

World Health
Organization
South-East Asia



Conference hall at the Regional Office in Indraprastha Estate, New Delhi. The murals on the walls were painted by internationally renowned Indian artist Maqbool Fida Husain in 1963, entitled 'History of Medicine'



Foreword

by the Regional Director



The World Health Organization's Regional Office for South-East Asia was the first regional office to be established. The year was 1948. Europe was in difficulty. The colonial world was collapsing. The world was being built anew. Naturally, though there must always be a first, it is possible that WHO South-East Asia's 'presence at the creation', so to speak, reflected just how central our Region was – and still is – to global health and humanity's shared future.

As we celebrate the WHO South-East Asia Region's 70th anniversary, that point is worth contemplating. Our Region is home to more than a quarter of the world's population. It has struggled more than many against disease and pestilence and against hunger, want and the many social determinants of health that people across the Region – and the world – encounter every day. And yet through it all we have made remarkable gains.

Indeed, with the commitment and resolve of each of our 11 Member States we have achieved ground-breaking success, changed the course of history, and delivered the kind of results that provide a cogent riposte to those who deny humanity's forward progress.

This is the story the following pages tell. A story of struggle, yes. But also a story of triumph. A story of how gradually and inexorably health systems have been strengthened. A story of how killer diseases have been vanquished and how innovative technologies backed by effective policy have made that possible. A story of ordinary people – their daily struggles and their life-changing experiences. A story of how their health has been transformed for the better. Indeed, a story that covers the breadth of the last seven decades and the effect our Organization has had on the health and well-being of a population that now equates to a staggering 1.8 billion people.

In telling this story, every attempt has been made to ensure both the public health fraternity as well as non-health audiences are provided key takeaways, both compelling and informative. Initial chapters, for instance, focus on our battle against a series of priority diseases, from tuberculosis to yaws, and

to the Organization's attempt to eradicate malaria, even while enhancing the capacity of key training institutions.

Subsequent chapters describe the unyielding – and ultimately successful – quest to eradicate smallpox, as well as the introduction of oral rehydration solution as a standard means of combating diarrhoeal deaths. They also outline the global adoption of the Expanded Programme on Immunization, the Health for All movement, and the Organization's revised strategies to tackle malaria and address HIV/AIDS alongside several noncommunicable diseases.

And in the final chapters, focus is increasingly given to implementing the DOTS strategy to combat TB, efforts to strengthen national immunization programmes and services for maternal, child and newborn health, to enhance tobacco control, and to fortify health security via the International Health Regulations. Notably, they also document how several diseases such as yaws, maternal and neo-natal tetanus, malaria, measles and trachoma among others have been eliminated either Regionwide or from several countries.

In recounting our many and varied achievements, it would of course be remiss of me not to mention our conquering of polio in 2014 – an achievement that is up there with our eradication of smallpox and which was also complemented the following year by being credited with halting and reversing the HIV, tuberculosis and malaria epidemics, all key Millennium Development Goals.

Indeed, while WHO South-East Asia may have been present at the creation, we are also defining the future. In an age where achieving universal health coverage is more than an ambitious slogan, our Region provides a critical test for humanity's resolve to leave no one behind. Our ability to overcome challenges and achieve the dream of health equity is crucial to our collective vision: A vision that is – first and foremost – regional in scope, though unavoidably global in consequence.



Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region

Abbreviations

ASHAs	Accredited Social Health Activists in India	EWARS	Early Warning, Alert and Response Systems
AFP	acute flaccid paralysis	FAO	Food and Agriculture Organization of the United Nations
AMR	antimicrobial resistance	FCHV	female community health volunteer
ARI	acute respiratory infections	FCTC	WHO Framework Convention on Tobacco Control
ART	antiretroviral therapy	FINNIDA	Finnish International Development Agency
ASEAN	Association of Southeast Asian Nations	GDF	Global Drug Facility
AusAID	Australian Agency for International Development (until 2013)	GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria (or simply the Global Fund)
BCG	Bacillus Calmette–Guérin vaccine	GMP	Good Manufacturing Practices
BIRDEM	Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders	GNM	General Nursing & Midwifery
CAPD	continuous ambulatory peritoneal dialysis	HeLLIS	Health Literature, Library and Information Services
CARE	Cooperative for Assistance and Relief Everywhere (to 1993 Cooperative for American Remittances to Europe)	HBV	hepatitis B virus
CCS	Country Cooperation Strategy	HCV	hepatitis C virus
CDC	Centers for Disease Control and Prevention	HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
CDD	control of diarrhoeal diseases	I2I	innovation-to-implementation
CHWs	community health workers	ICRC	International Committee of the Red Cross
CIDA	Canadian International Development Agency (until 2013)	IDD	iodine-deficiency disorder
CRD	chronic respiratory disease	IDP	Internally displaced person
DDS	diaminodiphenyl sulfone (dapson)	IDUs	injecting drug users
DFID	Department for International Development	IHR (2005)	International Health Regulations (2005)
DHF	dengue haemorrhagic fever	IMCI	Integrated Management of Childhood Illness
DPT	diphtheria, pertussis (whooping cough), and tetanus.	IMNCI	Integrated Management of Newborn and Childhood Illness
ESCAP	Economic and Social Council for Asia and the Pacific	IMPO	International Medical Parliamentarians Organization

IPV	inactivated polio vaccine	SEA	WHO South-East Asia Region
JICA	Japan International Cooperation Agency	REGION	
MCH	maternal and child health	SEARO	WHO South-East Asia Regional Office
MDA	mass drug administration	SIDA	Swedish International Development Cooperation Agency
MDGs	Millennium Development Goals	STIs	sexually transmitted infections
MDR-TB	multidrug-resistant tuberculosis	TB	Tuberculosis
MDT	multidrug therapy	TBAs	traditional birth attendants
MMR	maternal mortality ratio	TDR	United Nations Development Programme/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
MSF	Médecins Sans Frontières		
NCDs	noncommunicable diseases	TT	tetanus toxoid
NGOs	nongovernmental organizations	UCI	universal child immunization
NHSO	National Health Security Office (Thailand)	UHC	universal health coverage
NID	national immunization day	UN	United Nations
NORAD	Norwegian Agency for Development Cooperation	UNCAP	UN Consolidated Appeals
NTDs	neglected tropical diseases	UNDAF	United Nations Development Assistance Framework
OIE	World Organisation for Animal Health	UNDP	United Nations Development Programme
OPV	oral polio vaccine	UNFPA	United Nations Population Fund (to 1987: United Nations Fund for Population Activities)
ORS	oral rehydration therapy		
PAS	para-aminosalicylic acid	UNICEF	United Nations Children's Fund (to 1953: United Nations International Children's Emergency Fund)
PEI	Polio Eradication Initiative		
PHC	primary health care	UNTAET	United Nations Transitional Administration in East Timor
Polio	Poliomyelitis	USAID	United States Agency for International Development
PSI	Population Services International	VHWS	Village Health Workers
SAARC	South Asian Association for Regional Cooperation	VRC	Virtual Resource Centre
SARS	Severe Acute Respiratory Syndrome	WHO	World Health Organization
SDGs	Sustainable Development Goals		
SEA-ACMR	South-East Asia Advisory Committee on Medical Research		
SEAPHEIN	South-East Asia Public Health Educational Institutes		

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Introduction

A healthier South-East Asia

The story of human health goes back to the birth of humankind. Since time immemorial, human beings faced the ever-present dangers and emergencies from natural and other causes and established some standardized responses to them, often as a group or community. In the absence of science, they initially relied on prayer. They tried not to get hurt while out hunting or foraging. They learned about medicinal plants, and began to build up a body of health knowledge. Medical systems and curative remedies were developed

in a number of ancient cultures: the ayurvedic medicine practiced on the Indian subcontinent has its roots in the Bronze Age Indus Valley civilizations; while Greek medical lore – referred to in the Region as Unani or “Greek” medicine – with its links to Arab medicine also came to Asia through Persia, bringing with it such concepts as medical diagnosis, prognosis, as well as medical ethics.

Civilizations came and went, the pre-scientific age generally yielded to the beginnings of evidence-based medicine, and countries slowly began to improve their health care mechanisms. Nevertheless, many years later, around the time the World Health Organization came



into existence, the public health scenario in most countries in South-East Asia was still very bleak. As the then Regional Director, Dr VTH Gunaratne, put it at the time of the World Health Organization's 25th anniversary¹: "It is sometimes difficult to recall what conditions were like in 1947. Malaria was rampant. India alone had some 75 million cases of malaria, causing some 800 000 deaths a year. Some 2.5 million cases of tuberculosis led to half a million deaths annually. The situation was equally grim in other countries. Smallpox reigned unchecked, scarring, blinding and killing thousands. Plague and other

common communicable diseases were ever-present menaces... yaws ... afflicted millions and millions of people and was particularly serious in Indonesia and Thailand. In most of the newly independent countries, doctors and nurses were particularly scarce, and there were extremely limited facilities for training and preparing them. Finally, many countries were still attempting to deal with their health problems on a day-to-day basis, and there was a dearth of overall planning, often an absence of rational goals, and little attempt to improve training techniques."

¹ 25th Anniversary of the World Health Organization for South-East Asia: 1948–1973

In the early years of WHO, communicable diseases were widely prevalent and contributed to the high mortality and morbidity rates in the countries of the Region. Plague, cholera and diarrhoeal diseases ravaged populations and about 90% of the world's cases of smallpox were to be found in this Region. In addition, endemic diseases such as leprosy, filariasis, and guinea-worm and hookworm diseases, were responsible for considerable morbidity and mortality. Life expectancy was as low as 30 years in some countries, while crude death rates and infant mortality rates were very high. Common environmental problems such as the lack of safe water and poor sanitation also contributed to the high incidence of diseases. Environmental pollution arising out of the rapid urbanization and industrialization in the early years of the 20th century was becoming a new menace. Overarching all was the threat of a population explosion which outstripped the gains from progress and development impeded the success of endeavours to control and combat various diseases through improved medical and public health measures.

At the time of the establishment of the United Nations and the World Health Organization after the Second World War, many of the countries in the Region were emerging from decades of colonial rule. As a consequence their health systems were primarily

directed towards the alleviation of suffering due to sickness, and mostly catered to the needs of a privileged group concentrated in urban areas. Health facilities in rural areas were extremely meagre and often inadequate. Some countries experienced a large exodus of public health workers at the time of their independence, and the shortage of doctors and paramedical personnel became an acute problem. There was an acute shortage of medical schools.

The beginning of the global multilateral system

In the early years of the 20th century most of Europe and many non-European nations were plunged into chaos with the two World Wars. Soon after the Second World War ended in 1945, the colonial system of the previous century was gradually dismantled. The birth of several newly independent nations, the rapidly changing patterns of society and social order, and the beginnings of the inexorable rise of technology all gave rise to new hopes and expectations. The nation state began to realize it could not go alone, and multilateralism was born.

The first of the multilaterals was the League of Nations, a direct product of the Paris Peace Conference – the meeting of the victorious Allied Powers following the end of World



A photograph of World Health House, Indraprastha Estate New Delhi, from the 1960s

War I to set the peace terms for the defeated Central Powers in 1919. The desire of all nations to rebuild from the ashes and create something new gave rise to the idea that society is something that can be constructed: governments were actors in this construction of a “makeable society”. The International Labour Organization, International Telegraph (later Telecommunication) Union, and a number of other global bodies that were precursors to many United Nations Specialized Agencies began to function under the aegis of the League of Nations. It took another world war before the notion was taken up decisively.

The term “United Nations” was coined in 1941 by US President

Franklin D. Roosevelt (in the Declaration of the United Nations), but it took until 24 October 1945 for the world organization to be formally founded, replacing the League of Nations. Specialized agencies were set up almost simultaneously or soon thereafter: the Food and Agriculture Organization of the United Nations (FAO) actually started eight days earlier, on 16 October 1945, and the World Bank Group two months later in December 1945. Others followed in quick succession: notably the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 1946, the International Civil Aviation Organization (ICAO) in 1947, International Maritime Consultative Organization (IMCO) in 1948 (called the International

Maritime Organization, or IMO, since 1982), and the World Health Organization, which was established on 7 April 1948.

WHO in South-East Asia

This commemorative volume covers the history of seven decades of the World Health Organization's work in South-East Asia. It is the story of WHO's collaborative work in support of Member countries to help improve the health and well-being of the people in this Region.

The countries of the WHO South-East Asia Region make up more than a quarter of the world's population, and an even greater percentage of the global disease burden. This is a Region with a huge geographical diversity. It has the world's highest mountains, deep oceans, long and broad rivers and impenetrable forests. It is beset by heavy monsoon rains, floods and tsunamis in some parts, and hit by frequent cyclones, volcanic eruptions, earthquakes, droughts and other natural disasters in others.

In this Region, WHO's collaborative work with the countries to address their challenges in health has evolved: not only is it an integral component of their social and

economic development, but WHO also helps them in the eradication, elimination and control of communicable diseases and public health development, in reducing maternal and child mortality, reversing the epidemic of noncommunicable diseases, combating antimicrobial resistance, improving emergency preparedness and response, and in strengthening the health systems on the road to the goal of universal health coverage (UHC).

WHO's work with its Member countries has been guided by the twin goals of health equity and social justice, both key principles of primary health care as set out in the Alma-Ata Declaration². The focus of WHO's collaboration with countries has been to strengthen public health. This has included capacity-building for the formulation of evidence-based health policies and strategies; strengthening public health education; building the health workforce; developing public health infrastructure; ensuring health system readiness for tackling the outbreaks of disease, emergencies, disasters and radical climate changes; and the generation of research and evidence to build a knowledge base for improving the effectiveness of public health delivery.

² The Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care, Alma-Ata (now Almaty), former Kazakh Soviet Socialist Republic, 6–12 September 1978



Till the turn of the 20th century, most doctors in countries of the Region were trained in indigenous schools of medicine such as Ayurveda, Unani, Siddha and others that were prevalent in South-East Asia. There were very few Asian doctors with a Western medical education. Seen here are perhaps the first few doctors from Asian countries who had secured a Western medical degree: Anandibai Joshee (left) of India, who graduated from the Women's Medical College of Pennsylvania, United States of America, with Kei Okami (centre) of Japan, and Tabat Islambooly of Syria. Each of the three was most likely the first woman in their respective countries to have secured a degree in medicine

However, the attainment of health for all cannot be achieved in isolation by the health sector working alone. Health outcomes are affected by a complex interplay of sociocultural, economic, political and environmental factors, and so progress in health requires dedicated, concerted and coordinated action by multiple players from many sectors. Consequently, WHO's work with

countries continues to advocate for and adopt a multisectoral approach for addressing current and emerging health issues. The principle adopted is to strengthen "health in all policies".

The geographical entity of "South-East Asia" has unparalleled cultural variety, which is mirrored in the WHO South East Asia (SEA) Region. The SEA Region was the first of the

INTRODUCTION

WHO Regions to be established, if the WHO Region of the Americas (whose parent body, the Pan American Health Organization, was founded in 1902) is excluded.

Five countries originally joined the South-East Asia Region in 1948: Afghanistan, Burma (later Myanmar), Ceylon (Sri Lanka), India, and Siam (Thailand). These were later joined by Indonesia (in 1950), Nepal (1953), Mongolia (1962), and Maldives (1965). Afghanistan subsequently left the Region to join WHO's Eastern Mediterranean Region in 1969. East Pakistan acquired independence as Bangladesh in December 1971, and joined the Region in 1972. The Democratic People's Republic of Korea joined the SEA Region in 1973, and Bhutan in 1982. Mongolia left to join the Western Pacific Region in 1995. Timor-Leste was the last Member State to join the Region in 2002 and formally signed the WHO Constitution on 28 May 2003.

Thus WHO's South-East Asia Region now comprises 11 countries: Bangladesh, Bhutan, the Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. For ease of comprehension, these and other contemporary names for the countries will be used throughout this book, irrespective of the name that was in use in the given decade.

Commemorative books have been published in the past on the occasions

of the 20th, 25th, 40th, 50th and 60th anniversaries of the Organization, along with other publications on similar lines. These served as excellent references for drafting this book. Compared with them, the focus of this publication is on the major achievements of WHO in the Region, their impact on people's health, success stories, lessons learnt, as well as the persistent challenges that remain.

Data from various publications have been used to indicate the progress in health status and health system development across different decades. However, it is to be acknowledged here that the data were obtained by different methods during different periods and, as a result, comparisons between the countries should be made with caution, particularly in the early decades. The main publications referred to in drafting this volume have been listed separately.

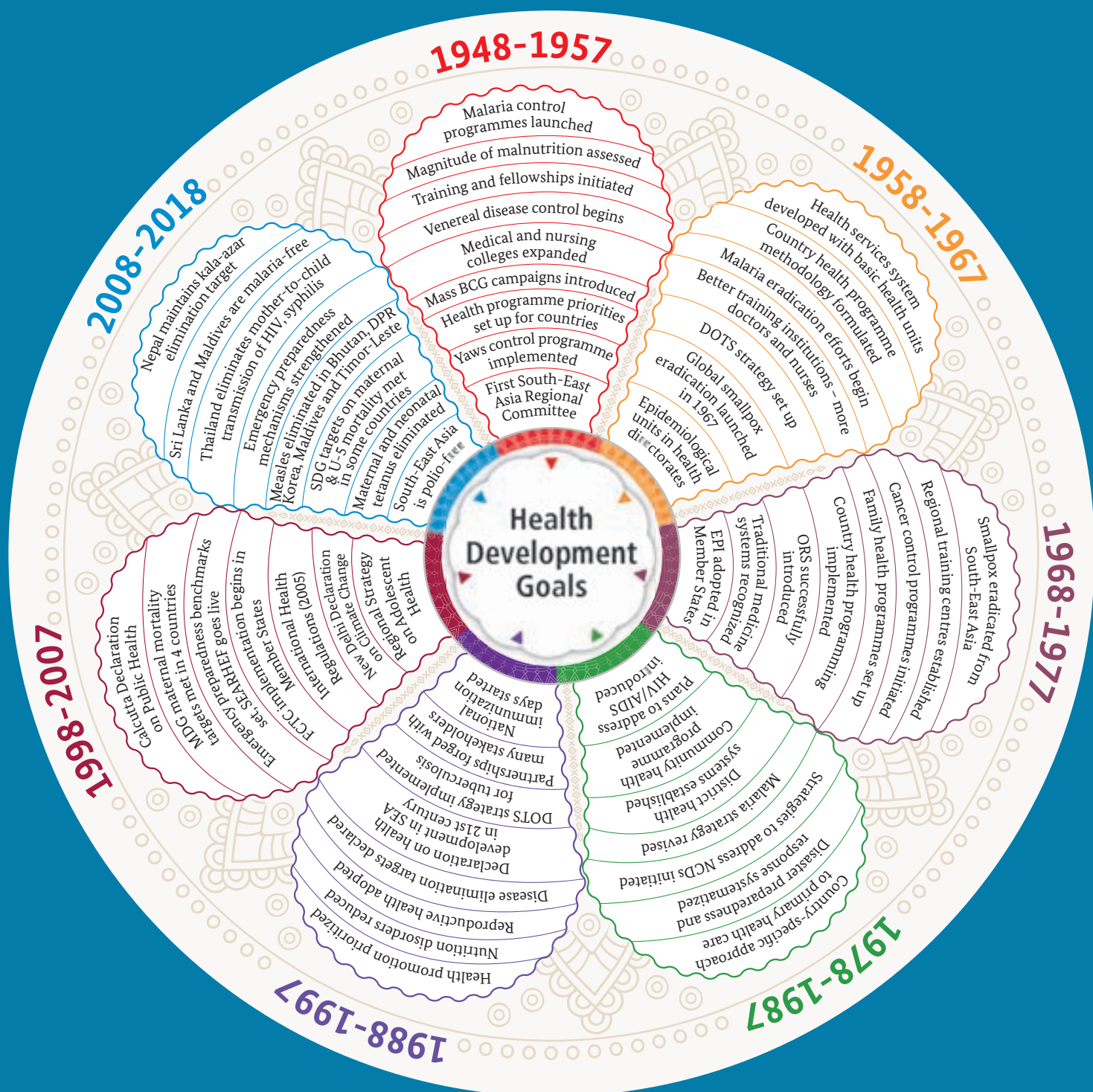
This commemorative publication is designed to serve as a reference volume for those interested in the progress of health development in South-East Asia over the last 70 years. The many public health achievements in the Member States since the founding of the Region in 1948 are described in the book. These achievements are the result of the ceaseless, untiring efforts of many players and stakeholders, led by the national governments. WHO in the South-East Asia Region has been collaborating with Member countries on the long haul to achieve the Sustainable Development Goals and ensure universal health coverage for all.

The 11 Member States of the WHO South-East Asia Region as of 2018

Country		Became a party to WHO Constitution
Thailand (Siam until 1949)		26 September 1947
India		12 January 1948
Myanmar (Burma until 1989)		1 July 1948
Sri Lanka (Ceylon until 1972)		7 July 1948
Indonesia		23 May 1950
Nepal		2 September 1953
Maldives		5 November 1965
Bangladesh (East Pakistan until 1971)		19 May 1972
Democratic People's Republic of Korea		19 May 1973
Bhutan		8 March 1982
Timor-Leste		28 May 2003

Afghanistan (1948–1969) and Mongolia (1962–1995) were also part of the Region in earlier years

Highlights of 70 years of WHO's work in South-East Asia







1

THE FIRST DECADE

1948–1957

Setting up health
agendas and
tackling priority
diseases

THE FIRST DECADE: 1948–1957

MAJOR ACHIEVEMENTS IN THE FIRST DECADE: 1948–1957

1

A rural health strategy was developed, including a focus on community participation in health services, and model rural health centres. Countries prioritized the development of community health services

2

Medical and nursing colleges were set up or expanded, and fellowships were awarded. A number of nurses, doctors and auxiliaries were trained

3

Malaria control programmes were started in India, Indonesia, Myanmar, Sri Lanka and Thailand. In 1955, malaria eradication was adopted as a goal of all national malaria control programmes in the Region (in response to the development of resistance of the vector to DDT). The death rate from malaria was reduced

4

A mass BCG vaccination campaign was introduced in the Region as a part of tuberculosis control programmes. Domiciliary TB therapy trials were initiated and they proved to be successful

5

A yaws control programme was implemented through well-planned mass penicillin treatment

6

The first WHO venereal disease control demonstration and training projects were established in India, Myanmar and Sri Lanka

7

The magnitude of the malnutrition problem was assessed, and training programmes and fellowships supported

8

Training of national sanitary inspectors and sanitary engineers was initiated

According to a UN Review of South-East Asia in the first post-War decade of 1945–1955, the economic and social situation was improving rapidly: “Production has doubled over the pre-War level. The evolution of social climate (is) favourable to economic development; (a) virtual revolution

in public health had lifted life expectancy and a striking advance in public education has made marked inroads upon illiteracy...”.³ According to the review, the improvement in the economic conditions of the countries of South-East Asia had also led to increased allocations to the health sector during that period.

³ World Health Organization, Regional Office for South-East Asia. Sixty Years of WHO in South-East Asia 1948–2008. World Health Organization 2008.

The newly-independent countries were all publicly committed to improving the general social conditions and welfare of their citizens. The charters and Constitutions of the emerging countries spoke of social welfare in all forms. In the 1950s and 1960s, social development was accepted as being synonymous with economic development. Despite patchy health services infrastructure and a health workforce that was low in numbers and poorly trained, all countries included in their respective covenants the objective of serving their own people to their best of their abilities. WHO accordingly encouraged each Member State to develop a good and efficient health system and to train an appropriate health workforce that was competent and skilled and evenly distributed in the country, balancing between urban and rural needs.

However, the positive developments had to confront the fact that the prevailing diseases in the Region were caused by poverty, illiteracy, unsanitary environments and lack of safe drinking water, and that the problems were particularly dominant in the rural areas where almost 80% of the population lived at that time.

Accordingly, the World Health Assembly and the Regional Committee for South-East Asia began to support Member countries

in addressing the major health issues. Given the very high morbidity and mortality resulting from malaria, particularly in the South-East Asia Region, top priority was given to this disease in the work of WHO. Then came tuberculosis. Despite the lack of reliable regional data on its morbidity and mortality, it was well known that there was high prevalence of tuberculosis in India, Sri Lanka and Thailand. Leprosy was also highly prevalent in the Region and action was taken at the global level, led by the WHO Regional Office for South-East Asia. The prevalence of venereal diseases was also high and documented in some countries of the Region. Plague was a serious health problem and occurred as an endemic disease in a few countries. Nutritional deficiency diseases were considerably aggravated by simultaneous public health problems such as hookworm disease and chronic malaria, which were also widespread. All this contributed to the prevailing high morbidity and mortality in this Region at that time.

Thus, the main focus of WHO's work in the Region during the first decade of its existence was the gradual establishment of a health agenda at the national and international levels and building the capacities of Member States to tackle the priority health problems.

Historical milestones:

Enforced isolation/
quarantine (the
word literally
means “40 days”)
for ships in the
Mediterranean
and Adriatic
seaports of
Alexandria and
Ragusa

**14th-15th
century**

Health
Organization
of the
League of
Nations
formed

1920

United
Nations
founded,
UN Charter
adopted

1945

**Mid-19th
century to the
beginning of
the 20th century**

International
Sanitary
Conferences held in
Europe

1943

UN Relief and
Rehabilitation
Agency
established

1946

International
Health
Conference
in New York:
First meeting
of the Interim
Commission
for WHO;
Constitution of
WHO signed

Road to global public health before the SEA Region is founded

Article on health incorporated into the UN Charter of Human Rights

1947

First World Health Assembly held in Geneva, Switzerland

June-July 1948

First meeting of the Regional Committee for South-East Asia held in New Delhi

October 1948

April 1948

WHO Constitution comes into effect

July 1948

World Health Assembly approves the establishment of the WHO South-East Asia Regional Office

November 1948

WHO Regional Office for South-East Asia (SEARO) established in New Delhi

Creating WHO's regional organizations

The World Health Organization is unique among international organizations and agencies of the United Nations in that it has a very strong regional character. A major contributing factor to this was the prior existence of the Pan American Sanitary Bureau, which was a strong and functional regional organization for health in the Americas.

There were many discussions before and during the First World Health Assembly in 1948 as to the desirability of regionalization. India and China pushed particularly hard for regionalization from the beginning. They were supported by the United States of America and the Latin American countries, which did not wish to see the Pan American Sanitary Bureau dissolved.

Accordingly, the International Health Conference – held in New York from 19 June to 22 July 1946 to establish the World Health Organization and draft its Constitution – agreed to define geographical areas for the establishment of regional organizations within WHO, with the approval of a majority of the Member States in each area, to meet their special needs.

The First World Health Assembly set up a “Main Committee on Headquarters and Regional

Organization”, which, in turn, formed working parties to consider the delimitation of geographical areas and to study the possible structures of regional organizations of WHO for Europe, the Middle East and Near East, South-East Asia, the Far East, and the rest of Africa.

When the formation of the World Health Organization was being discussed, the Interim Commission for WHO made preliminary inquiries among governments about their views in the delineation of areas for the regional organization of WHO. After much debate, the Main Committee set up to consider the delimitation of the geographical areas at the First World Health Assembly in 1948 recommended the following specific regions: Europe; Middle East, Near East and parts of North-East Africa; South-East Asia; the Far East; and Africa. The area for the Americas was included later. After much debate and considering all the options, the World Health Assembly resolved to define six geographical areas for setting up regional entities of WHO. These six were: Eastern Mediterranean, Western Pacific, South-East Asia, Europe, Africa (south of the Sahara), and the Americas.

The World Health Assembly in its recommendations for regional



Reduction of the present heavy morbidity due to communicable diseases will not be possible in South-East Asian countries until basic health services are strengthened and adequately supervised so as to be able to play their part. Let there be no mistake about this

Dr C. Mani, Regional Director, WHO South-East Asia, 1948–1968

groupings had considered several factors and established specific criteria for their designation. However, in the end, all these criteria could not be, and were not, applied consistently, and no uniform method was employed to delineate the WHO Regions. The American and European Regions included whole continents; the African Region was based partly on political frontiers and partly on geographical frontiers; for the Eastern Mediterranean, South-East Asia and the Western Pacific Regions, the states and territories that would be included in them were enumerated. Later, countries that were not included in this enumeration and new Member States were assigned to the various Regions by the Health Assembly.

The States could also request to be transferred from one Region to another.

Key steps in defining the evolving membership of the WHO South-East Asia Region were:

- At the First World Health Assembly in 1948, the original five members of the South-East Asia Region had signified their consent to join the Region when it was established. They were Afghanistan, India, Myanmar, Sri Lanka and Thailand.
- By a resolution of the Second World Health Assembly, representatives of Member States of WHO that did not have their seat of government

within a particular Region but were responsible for the conduct of international relations for territories that were within that Region, were allowed to attend the Regional Committee concerned. Thus, in the South-East Asia Region, France (representing French possessions in India), Portugal (representing the territory of Goa, Daman and Diu in India) and the United Kingdom (representing Maldives) attended the sessions of the Regional Committee for South-East Asia in the early years. This representation continued from the second to the sixteenth sessions of the Regional Committee. French and Portuguese territories in India became part of India in 1954 and 1961 respectively. Maldives became an independent country in 1965.

- The original World Health Assembly resolution in 1948 had placed Indonesia in the Western Pacific Region. But in 1950, when Indonesia joined WHO, it was transferred, at its own request, to the South-East Asian Region.
- Cambodia, the Lao People's Democratic Republic and Viet Nam were also originally included in the South-East Asia Region by a resolution of the Third World Health Assembly, but when the Regional Office for the Western

Pacific was established in 1951, these three countries opted to join that Region.

- Nepal became a member of the World Health Organization on 2 September 1953 and was formally included in the South-East Asia Region by a resolution of the World Health Assembly that year.
- The next country to join the South-East Asia Region was Mongolia. It became a member of WHO on 18 April 1962 and, although not belonging geographically to South or South-East Asia, it requested to be allowed to join this Region. This was formally approved by the Fifteenth World Health Assembly. However, from 1 July 1995, Mongolia separated from the South-East Asia Region and joined the Western Pacific Region.
- Maldives became independent on 26 July 1965. It became a member of WHO on 5 November 1965 and joined the South-East Asia Region.
- In 1969, Afghanistan, one of the original members of the South-East Asia Region, was transferred at its request and the approval of the Health Assembly to the Eastern Mediterranean Region because of geographical contiguity as well as political reasons.

- Bangladesh was “East Pakistan” at the time of the independence of India and Pakistan in 1947. In December 1971, it gained independence. Bangladesh became a member of WHO on 19 May 1972 and joined the South-East Asia Region.
- The Democratic People’s Republic of Korea became a member of WHO – the first UN agency that the country joined – on 19 May 1973. It opted to join the South-East Asia Region.
- Bhutan joined WHO on 8 March 1982.
- The most recent Member State to be included in the Region was Timor-Leste which joined WHO on 27 September 2002, and opted for joining the South-East Asia Region on 28 May 2003.

At the meeting of the working party for WHO South-East Asia on 2 July 1948, delegates from Australia, France, India, Myanmar, the Netherlands, New Zealand, Pakistan, Portugal, Sri Lanka, Thailand and the United Kingdom agreed unanimously that a regional organization should be set up “as a first priority”, with India as its headquarters. This decision was reported to the Main Committee which submitted it to the World Health Assembly. The First World Health Assembly approved this recommendation at its eleventh plenary session on 10 July 1948.



Cobra mask (above) and the disease devil-bird mask (below).
Gifted by Sri Lanka

The beginnings of WHO-SEARO

The stage was now set for holding the first Regional Committee session and the establishment of the first regional office of the World Health Organization, both in South-East Asia. The nomination by the Regional Committee for South-East Asia of Dr Chandra Mani as the Regional Director was approved by the WHO Executive Board at its meeting in November 1948. The South-East Asia Regional Office – or SEARO – was now ready to start functioning. The Regional Office began operations on 15 November 1948 from one small room located in the North Block of the Secretariat of the Government of India in New Delhi. Those were humble beginnings indeed: there were only two staff members – the Regional Director and one messenger loaned from the Government of India.

Chapter 8 provides an account of the long journey made by the Regional Office from a one-room set-up to finding its own permanent home in New Delhi.

In October 1948, the first session of the Regional Committee for WHO South-East Asia was inaugurated by H.E. Jawaharlal Nehru, Prime Minister of India. The session was attended by the first Director-General of WHO, Dr Brock Chisholm. It recommended that the Regional Office be located in New Delhi. The Committee confirmed the appointment of Dr Chandra Mani as the first Regional Director for South-East Asia. The session was attended by representatives from Afghanistan, India, Myanmar, Sri Lanka and Thailand, with Nepal as an Observer.

The ‘Big Six’ and other regional priorities

In the technical field, the “Big Six” priorities – malaria, tuberculosis, venereal diseases, maternal and child health, nutrition, environmental health and sanitation – were identified for international work by the First World Health Assembly in July 1948. At the first WHO Regional Committee for

South-East Asia, there was an agreement that WHO’s initial programmes in the Region should be as follows:

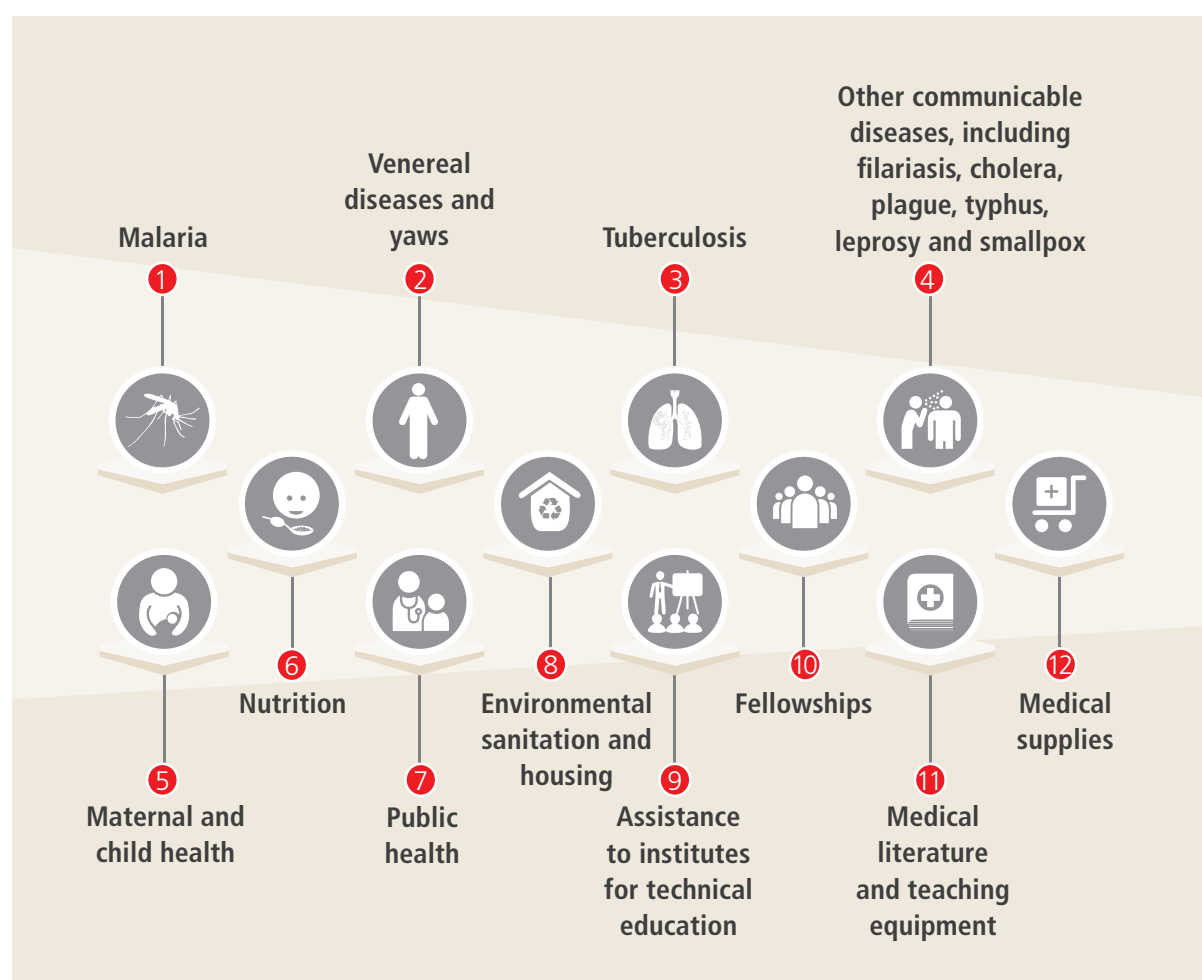
- **India:** tuberculosis, malaria, maternal and child health, venereal diseases, nutrition, health education, fellowships

- **Myanmar:** tuberculosis, venereal diseases, maternal and child health, nutrition
- **Sri Lanka:** malaria, tuberculosis, maternal and child health, venereal diseases, filariasis
- **Thailand:** tuberculosis, malaria, venereal diseases, maternal and child health, nutrition.

The countries were also encouraged to have a national public health

organization staffed adequately by trained public health officers. Areas such as Fellowships, assistance to technical institutions, medical literature and teaching equipment, and medical supplies were added to the list of priorities for all countries.

The programme activities for the South-East Asia Region in 1950 and 1951 ranged over a wider field than the priorities identified by the Health Assembly and covered the following:



Over the next two decades, WHO's assistance programme in the South-East Asia Region generally covered these fields

WHO Area/Country Representatives: A pioneering idea



Dr R. L. Tuli (to Sri Lanka)
(file photo)



Dr T.C. Puri (to Myanmar)
(file photo)



Dr N. K. Jungalwalla (to Indonesia)
(file photo)

The first three WHO Area Representatives in the world

When the work of the WHO Regional Office for South-East Asia started in 1948, there was no plan or provision to appoint WHO Representatives in Member countries. The deployment of WHO Representatives in the countries was pioneered by the South-East Asia Region. Starting in 1948 when WHO appointed long-term programme staff in the countries, each project had a senior staff in charge. With several individual projects at the country level, there were three or four senior advisers, each acting as WHO project leaders and exercising the function of liaison officers in their particular field. However, it was found that there was no cohesive force to keep all these WHO advisers and their programmes together at the country level and to liaise with other United Nations agencies and various bilateral and multilateral health organizations.

On 24 December 1951, a proposal was made by the Regional Office for South-East Asia to the Director-General on the

subject of “Health Programmes and their Coordination”. It was proposed to appoint and place in each country an experienced public health officer to act as “WHO Area Representative” on all matters, under the general supervision of the Regional Director. This was approved by the Director-General. Five posts of “Area Representatives” were established in 1952, and the posts in Sri Lanka (then Ceylon), Myanmar (then Burma) and Indonesia were filled immediately.

The very first WHO Area Representative in a Member country was Dr Ram Lal Tuli in Sri Lanka. He was followed by Dr T.C. Puri, who was assigned to Myanmar, and Dr N.K. Jungalwalla, who went to Indonesia. The posts for India and Thailand were filled in September 1953 and May 1955 respectively. In Nepal, the WHO Public Health Adviser continued to carry out the function till January 1962, when he was re-designated as the Area Representative.

From time to time – in 1953, 1957, 1959 and 1962 – the functions of the Area Representatives were reviewed. While these developments were taking place in the South-East Asia Region, the principle of appointing country or area representatives was also being adopted in some of the other regions, and headquarters was gradually assuming the role of coordinator with respect to their post descriptions and overall functions. By June 1961, it was felt that the advantage of having a WHO Representative in developing countries for the purpose of providing advice and, if

necessary, actually assisting the government in planning and day-to-day coordination, had been amply demonstrated.

After further discussions, it was decided at the meeting of the Regional Director with the Area Representatives in May 1962 that officers appointed to carry out such functions should in future be designated as “WHO Representatives”. On 1 February 1963 WHO headquarters issued a Manual Circular No. 75 on WHO Representatives containing the policies which were followed for the next 15 years.

Demonstration projects and long-term assistance

The technical assistance of and approaches adopted by the Regional Office for South-East Asia in the initial years focused on developing short-term (two-year) demonstration projects with the assistance of WHO experts. The aim was to train national staff in the new approaches and techniques used in the control of malaria, venereal diseases, tuberculosis, yaws, and maternal and child health, and later to replicate these projects nationally. Early assistance to the countries was in the form of supporting mass campaigns using mobile health teams and mobile clinics to extend coverage to their most remote geographical areas.

Owing to a lack of resources, and in the absence of a strong health infrastructure, the improvements achieved by the small demonstration projects were not sustainable. The solution adopted by the

Regional Committee in 1951 was to expand the programmes: the Regional Office redirected its policies towards long-term assistance, which included strengthening public health administration and the training of health personnel.



Carrying supplies for a demonstration project on malaria

Supporting medical and nursing education

There was an acute shortage of skilled and experienced health personnel in the Region in the 1940s. The doctor-population ratio at that time ranged from 5700 people per physician in India to 66 000 people per physician in Indonesia, and to even 72 000 people per physician in Nepal. Furthermore, most of the doctors were concentrated in the urban areas, leaving the rural areas without adequate medical care. The situation with nursing personnel was similar.

These shortages were addressed by medical and nursing education and the training of health auxiliaries. The WHO programme on nursing aimed at assisting and expanding the process of training of nurses, midwives and auxiliary nursing personnel in large numbers and the management of an expanding nursing component within the

health services. WHO assisted in setting up or expanding medical and nursing colleges and other schools for auxiliaries, strengthening teaching programmes, training of teachers, and providing Fellowships for training abroad in special fields. The result of this work was a significant improvement in human resources for health that was gradually observed over the following decades.

The Regional Office for South-East Asia launched a comprehensive system of WHO Fellowships in 1948. These Fellowships focused on health services, communicable diseases control, clinical and basic medical sciences and medical and nursing education. The Fellowships programme accounted for about 20% of WHO's regular Budget. The number of Fellowships steadily increased during the decade.

Comprehensive rural health

Concentration of medical professionals and health services in the cities had left the rural populations deprived in the countries of the Region. The Regional Committee stressed the importance of setting up pilot rural health centres. These would

serve as models in the provision of comprehensive health services to the rural community. The first model rural health centres were established, with WHO's assistance, in Kalutara in Sri Lanka, Singur near Calcutta (now Kolkata) in India, and Najafgarh near New Delhi, India.

The first Rural Health Conference in the region, held in Delhi in October 1957, was sponsored by WHO. The major focus of the conference was on multipurpose village health workers, community participation in health services and village improvement, and intersectoral collaboration between health services and other social welfare sectors. These issues were very similar to those elaborated 20 years later at the Alma-Ata Conference on Primary Health Care.

Following on from the 1957 Rural Health Conference, WHO supported developing rural health services through the training of auxiliary health workers in India, Indonesia, Myanmar, Sri Lanka and Thailand. The Regional Office provided direct assistance to schools in Myanmar and Nepal to administer a two-year training course for health assistants working at rural health centres. The course focused on sanitation, smallpox vaccination, health education, and the prevention and control of diarrhoeal diseases.



A set of two gold coloured statues in a small glass case. Gifted by Thailand

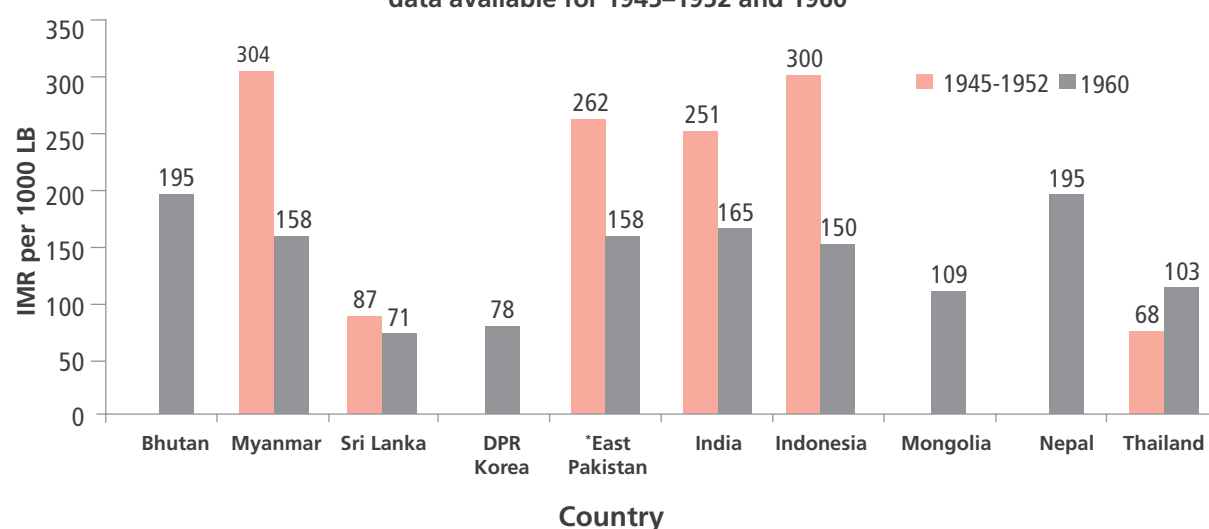
Developing maternal and child health services

The mortality rate statistics available in some countries in the Region revealed the magnitude of the problems in maternal and child health (MCH) services (Figure 1). Apart from Sri Lanka, no other Member State had an administrative authority for maternal and child health at the governmental level. MCH work was limited to services in special centres, and to home and hospital child delivery services. Much of the work was directed to the treatment of children's illnesses.

WHO assisted in developing MCH services in India, Indonesia, Myanmar, Sri Lanka and Thailand, through pilot projects for the training of doctors in paediatric medicine, nurses in child care, as well as auxiliary midwives, and through the establishment

of a network of MCH centres. It was usual to combine MCH and nursing education in one project. These projects were carried out in India, Indonesia, Myanmar and Thailand. However, it was noted that these centres were not linked with the general health facilities, and WHO recommended the integration of MCH services with general health services to enable more comprehensive and effective care. The consensus was that to serve a community best in the field of MCH – which includes antenatal care, deliveries, postnatal care, and the health supervision of infants, children and mothers – a community health programme paying special attention to the vulnerable sections of society (the mother and the child) was the need of the hour.

Figure 1: Infant mortality in selected countries of the SEA Region, data available for 1945–1952 and 1960



Reference: *Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992*

* Before 1971, East Pakistan (now Bangladesh) was part of the Republic of Pakistan, a member of the WHO Eastern Mediterranean Region

Addressing environmental health, sanitation and water supply

WHO's field programmes in the Region for the improvement of environmental health and sanitation, including the provision of safe water supply, began initially as a part of other projects. For example, WHO sanitary engineers and those attached to malaria control and rural health demonstration teams began to train national sanitary inspectors and sanitary workers in Afghanistan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. This work evolved during the decade to take its place among the health priorities.

WHO's environmental health programme was originally concerned mainly with the provision of safe water and the training of environmental health personnel.

Although some good results were achieved, progress was slow. The lack of efficient environmental health organizations and programmes, the scarcity of trained personnel, and the insufficiency of funds for major investments were the primary constraints. Most of the countries launched community water supply programmes, but their development could not keep pace with the needs of the increasing populations.

Many urban areas remained underserved in respect of waste disposal. In rural areas, poor sanitation continued to contribute to the indiscriminate pollution of water, food and soil, and all this was responsible for the high incidence of water-related diseases.



WHO's environmental health programme was initially concerned mainly with the provision of safe water supply

Developing a systematic nutrition programme

Malnutrition was widespread in the Region; this was clear from several one-off nutritional surveys conducted in India, Myanmar, Sri Lanka and Thailand. What was badly needed was an accurate baseline to assess the true extent of the problem of malnutrition. As a beginning towards this objective, the Regional Office for South-East Asia assisted countries in carrying out a number of nutrition-related studies: on blood disorders and anaemia in India, on endemic goitre in Sri Lanka, protein-energy malnutrition and vitamin deficiency in Indonesia, and endemic goitre and beriberi in Thailand.

To deal with the acute shortage of health personnel trained in nutrition at that time, one of the major activities of WHO was to support training programmes and provide Fellowships. Since most countries did not have the mechanism to coordinate nutritional health programmes, the Regional Office for South-East Asia assisted in setting up nutrition units within their ministries of health. Field work started to address protein-energy malnutrition and endemic goitre, particularly when compounded by improper infant-feeding practices. The Regional Office assisted in conducting a survey on the incidence



The Regional Office assisted countries in conducting studies on the nutritional status of children

First Regional Committee: Country priorities and budgetary allocation

(from the Regional Committee report)

'The Committee proceeded to discuss the programme they wished to see carried out in the first year in South-East Asia as part of the over-all activities of WHO, keeping in mind the six top priority programmes to which the First World Health Assembly had decided that major attention should be devoted... The delegations from India and Ceylon had brought with them detailed proposals for WHO assistance to their countries in respect of malaria, tuberculosis, venereal diseases and maternal and child health. In addition, India asked for help with a nutrition programme and Ceylon (for) advice on filariasis control. Burma requested six Fellowships and a BCG team, and Thailand eight Fellowships and a malaria advisory team. Afghanistan did not at that time make any specific request. After discussion, the Committee recommended to the Director-General and Executive Board the following allocation for field programmes for 1949:

Afghanistan	US\$ 50 000
Burma (Myanmar)	US\$ 94 000
Ceylon (Sri Lanka)	US\$ 78 000
India	US\$ 300 000
Thailand	US\$ 56 000
Total	US\$ 578 000

For the financing of the Regional Office, the Committee recommended a budget of US\$ 93 040, of which US\$ 65 230 was to cover the salaries and allowances estimated for the Secretariat, to consist of a Director, a Deputy Director, a Category I officer and two Category II officers, with 24 clerical and custodial staff members at local rates of pay.

The Committee also decided that the Regional Director should be authorized to correspond directly with the ministries of health of governments in the Region, and the Director-General was requested to make the necessary arrangements with Member Governments to that effect...'

of protein-energy malnutrition in Indonesia, and in national efforts to control endemic goitre by iodizing crude, sun-dried salt in India. The assistance included education in the proper feeding of infants and children, and in improving the roles of the public health nurses and the functioning of the MCH programme.

As the decade began, recently acquired knowledge and technologies provided new tools to combat and control priority communicable diseases. The bacille Calmette–Guérin (BCG) vaccine against tuberculosis was first used medically in the 1920s; DDT was developed in the 1940s and was used against vectors of malaria, typhus and plague; and long-acting penicillin (discovered in 1928) began to be used for yaws and other infections in the 1940s.

The evolving regional nutrition programme took up priorities proposed by the countries. For instance, India proposed including a "Health education and propaganda" component, while Sri Lanka wanted to include assistance for their filariasis programme.

On another note, the Second session of the Regional Committee in 1949 decided to retain the six priority programme areas, beginning with the intensification of malaria control activities. There was major emphasis on WHO assistance in establishing or strengthening national training centres for the training of health personnel.

Adopting malaria eradication as a goal

Malaria was a major public health problem with high morbidity and mortality in all countries of the Region. The success of the demonstration projects encouraged countries to consider largescale malaria control operations and national campaigns. Accordingly, they created vertical structures to combat the disease. By 1954, malaria control programmes started in India, Indonesia, Myanmar, Sri Lanka and

Thailand. In 1955, in response to the development of vector resistance to DDT, malaria eradication was adopted as a goal of all national malaria control programmes in the Region. WHO assisted in the development of national campaigns and creation of national malaria institutes. These would give technical directions to national programmes and become training centres for staff.



Some demonstration projects on malaria control helped stop transmission of the malarial parasite



Malaria was a major public health problem with high morbidity and mortality in all countries of the Region, particularly among children

Swift launch of tuberculosis programmes

Pulmonary tuberculosis was reported as one of the leading causes of death in the Region. At its Second session, the Regional Committee recognized tuberculosis as a major public health problem. WHO's initial support focused on the development of standard methods and techniques, including the tuberculin test, direct sputum examination and mass radiography of the general population.

The first "chest clinic" was established at the Bir Hospital in Kathmandu, Nepal, in 1951. By 1952, tuberculosis campaigns had begun in India, Indonesia, Myanmar, Sri Lanka and Thailand. Model tuberculosis centres were established, and in these case-finding, diagnosis and treatment were demonstrated and national staff trained. Four tuberculosis demonstration projects (two in India and one each in Myanmar and Thailand) were started. Biomedical technology was vital here as well, providing the new anti-tuberculosis drugs streptomycin (discovered in 1943) and isoniazid (first made in 1952). A mass BCG vaccination campaign was launched in the Region as part of the tuberculosis control programme.

In 1955, the Tuberculosis Chemotherapy Centre was

established in Madras (present-day Chennai) in India. Controlled trials were initiated, with WHO's co-sponsorship, to find simple, effective and inexpensive methods of tuberculosis control through domiciliary therapy. The results of the controlled trials showed that domiciliary treatment was just as effective as sanatorium treatment. They also showed that such home treatment did not expose close family contacts to any special risk of infection. Domiciliary treatment was much cheaper, and could be done without any drastic dislocation of the family. It opened the door to a new understanding of the national tuberculosis control programme.

The focus on tackling malaria and tuberculosis and also other communicable diseases revealed to the countries the benefits of enhancing their health services infrastructure and training their health workforces. Accordingly, WHO encouraged Member countries to develop efficient health systems and train a health workforce that was appropriate to the needs, had the requisite competence and skills, distributed evenly in the country, and responding to both urban and rural needs.

Projects on venereal diseases

Unstable social conditions during and after the Second World War associated with extreme population movements led to a considerable increase in the prevalence of venereal diseases. The incidence of syphilis, and infant mortality due to syphilis, rose steeply. Some studies showed that, in some areas of India and Sri Lanka, venereal diseases affected from 10% to 60% of the

population. The first WHO venereal disease control demonstration and training projects were established in India in 1949, Sri Lanka in 1950 and Myanmar in 1951. Thanks to the widespread use of penicillin promoted by these projects, a dramatic decline in the reported incidence of new syphilis infections was observed between 1950 and 1957.

A systematic approach to leprosy control

Leprosy was highly prevalent in the Region. Consequently an international effort for leprosy control was prepared, similar to those mounted for malaria and tuberculosis. The Regional Office for South-East Asia took the lead and initiated global actions – convening an expert committee, sending experts to the countries, and providing antileprosy drugs.

The work began in Myanmar and Sri Lanka. Surveys showed that the magnitude of leprosy in Myanmar was enormous, with 50% of cases being infectious. After subsequent

surveys in the countries affected had found high prevalence rates, the Regional Office began to provide support for national leprosy control programmes, particularly in Myanmar (1952), Sri Lanka (1954), Thailand (1955) and Indonesia (1955). This support comprised long-term staff or consultants, some supplies and equipment, and Fellowships and training for local staff. The compulsory isolation of patients was abolished and replaced by effective control of foci through treatment of those affected and surveillance of their contacts.

Regional Directors of the World Health Organization South-East Asia Region



Dr Chandra Mani
1948–1968



Dr VTH Gunaratne
1968–1981



Dr U Ko Ko
1981–1994



Dr Uton
Muchtar Rafei
1994–2004



Dr Samlee
Plianbangchang
2004–2014



Dr Poonam
Khetrpal Singh
2014–Present

Reducing yaws

Yaws had been endemic in a number of countries in the Region for centuries. In 1949, WHO and the then United Nations Children's Emergency Fund (UNICEF) launched a global yaws control programme, with the objective of achieving a significant reduction in prevalence through a well-planned campaign of mass penicillin treatment, followed by case detection and treatment of new or missed cases.

This programme was first implemented in India, Indonesia and Thailand. In Indonesia, the treponematoses control project started in 1950. The strategy was of elimination of all sources of infection by systematic detection and proper treatment of cases with penicillin aluminium monostearate (PAM). In India, mass campaigns were undertaken by the governments of the states together with the Union Government, WHO and UNICEF during 1952–1964. Anti-yaws teams were set up in the endemic states. These teams conducted surveys and provided treatment with long-acting penicillin to all detected cases and their contacts. In Thailand, 46 provinces were targeted by the campaign, following an initial

survey. Surveys were conducted annually or every two years depending on the incidence of yaws initially discovered. Thanks to the declining proportion of active yaws cases, programme activities were able to move into the consolidation phase during the decade.



A village health worker provides information on yaws

WHO reaches out to Indonesian children

The first assistance from WHO to Indonesia was in 1950 to eradicate yaws. At that time Indonesia was one of the poorest countries in the world. We were suffering sorrowfully as a consequence of the fight for independence against colonial rule from 1945 to 1950. Famine was everywhere throughout this country. The total Indonesian population in 1950 was around 72 million, and one out of five children suffered from yaws. WHO introduced penicillin injection for the first time to eradicate yaws in Indonesia. Between 1950 and 1953, about 21 million children were examined and 3.5 million of them were injected with penicillin oil. Because of its efficacy, penicillin was often referred to as 'the magical shot'.

To improve the medical services, WHO sent a team of specialist doctors in 1953. They included well-known European specialists in internal medicine, paediatric care, thoracic surgery, anaesthesia and radiology. These experts helped design the education curriculum for doctors and medical specialists and improved medical services. A number of infectious disease control programmes back in the 1950s also benefited from WHO assistance, such as BCG immunization and malaria eradication in Java and Bali.

Dr Broto Wasisto, one of the leading experts in public health in Indonesia



A traditional Maldivian tapestry. Gifted by Maldives





2

THE SECOND DECADE
1958–1967

Building the
health workforce
and launching
eradication
programmes

MAJOR ACHIEVEMENTS IN THE SECOND DECADE: 1958–1967

1

A system of basic health services with 'basic health units' was developed

2

Training institutions to produce the much needed health workforce were established/enhanced

3

Epidemiological units were created in the health directorates of the ministries of health

4

Malaria eradication programmes were launched across the Region

5

The basics of the tuberculosis control strategy were prepared, and are still in use today

6

Intensified global programme for eradication of smallpox commenced in 1967

7

Country health programming methodologies were formulated and health planners trained

In 1961 the United Nations General Assembly launched the UN Development Decade, reflecting the international socioeconomic climate of that time. This was aimed at sustaining growth and providing for social advancement. This, and the subsequent UN Development Decade, helped countries to recognize the limitation of socioeconomic development per se in improving the health of the people.

In WHO's work, two approaches started to become apparent: the "vertical approach", with a focus on disease control campaigns (with each disease being treated as a single vertical programme), and the "horizontal approach", with a broader emphasis on basic health services. This split resulted in uneven resource mobilization.

In this decade, the urgent need to develop and strengthen basic health services at country level was encouraged by the Regional Office for South-East Asia and continued to be supported. Building the health workforce and controlling the main communicable diseases continued to be the principal areas of WHO's support. Another important focus during the second decade was the introduction of country health programming and health planning.

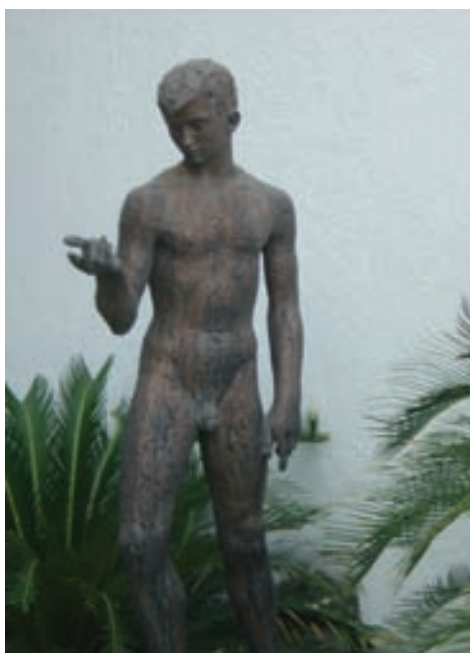
In 1961, the Fourteenth World Health Assembly was held in New Delhi – the first time the Health Assembly was held in Asia. India's Prime Minister Jawaharlal Nehru inaugurated the 18-day conference.

Basic health units and health workers

WHO's work in the Region towards supporting the development of basic health services achieved a milestone in 1958 when it was agreed at an intercountry meeting that health centres could be defined as the "basic health units" of the system. The associated health workforce needed to serve in these units was also defined. In 1964, a WHO study group considered the integration of mass campaigns against specific diseases into the general health services and set up a framework for further priority setting.

In the field of health workforce development, for two decades since the founding of the Regional Office Member States had been endeavouring to establish training institutions to produce the needed health workforce of doctors, nurses, paramedics and technicians. New medical colleges were being opened in the countries, as well as schools for other categories of health workers. In general, these new institutions were advised and assisted by expatriate teachers.

By the end of the second decade, India had more than 150 medical colleges. Despite the growing output of trained national practitioners, there were still many foreign teachers. There were "bridging" schools such as the Baroda–Edinburgh Project in India, in which professors of the University of



Bronze figure.
Gifted by United
Kingdom of
Great Britain
and Northern
Ireland (on
behalf of
Maldives)

Edinburgh undertook six-month assignments in India. Myanmar increased the number of its medical colleges from one to three. The Faculty of Medicine in Yangon (then Rangoon) was reinforced by a medical institute in Mandalay and the Institute of Medicine in Mingaladon. Sri Lanka opened a new medical college in Galle, in addition to its two existing medical institutes. WHO was closely involved in the preparation and opening of a new medical and nursing institute at Songkla, Thailand. In collaboration with UNFPA (then the United Nations Fund for Population Activities), the Regional Office for South-East Asia supported the establishment of the Tribhuvan Medical College in Kathmandu, Nepal.

The Regional Office also assisted in opening and developing more schools for nurses and paramedics as well in many countries of the Region. Many study tours were organized by WHO during the period 1957–1965 for medical college teachers to be trained in pre-clinical and para-clinical subjects. Deans and principals were supported to discuss teaching and research issues with their counterparts in other countries of the Region.

WHO's assistance to the nursing programme in the Region focused on improving basic nurse training, with the emphasis on post-basic nurse training, midwifery education, training of auxiliary nursing personnel and the advancement of nursing administration. There was a growing realization throughout the Region of the need for more and better prepared nursing professionals. Most countries faced the problem of recruiting sufficient numbers with adequate educational qualifications into the nursing profession. At the same time, the demand for nurses in hospitals and rural and urban health centres was growing rapidly. Nursing schools of acceptable quality were needed if young men and women capable of providing leadership and direction in nursing care were to be attracted to the profession. There was also the need to supplement the work of the professional nurse by employing trained auxiliary nurses. Considerable progress was made in the training of auxiliary nurses. The Regional Office also

supported the establishment of the School for Radiographers in Colombo, and the School for Medical Radiography at the Ramathibodi Hospital in Bangkok.

The Third session of the Regional Committee in 1950 tabled a policy to direct WHO's assistance to create a central unit in each country around which future mental health services could be built. WHO provided consultants and long-term Fellowships for specialized training of doctors from Indonesia, Myanmar, Sri Lanka and Thailand. The All-India Institute of Mental Health, Bangalore, was established by the Government of India with WHO's assistance.

Public health dental services were almost non-existent in countries of the Region. The Regional Office focused its efforts on stimulating an interest in public health dentistry and generally to strengthen national efforts to promote training. WHO also provided a large number of Fellowships in dental health.

Since the systematic epidemiological investigation of communicable diseases, and the general collection and analyses of health information, were rarely practised, the Regional Office initiated its assistance in the training of nationals in epidemiology. Assistance was provided to create epidemiological units in the health directorates of Indonesia and Sri Lanka, and later in Afghanistan and Myanmar. Long-term assistance to promote



At a WHO-assisted vaccination project in the Region, circa 1962

the development of statistical organizations in health directorates and to improve peripheral reporting systems in both vital and health statistics was first provided to Indonesia and later extended to Afghanistan, Myanmar, Sri Lanka and Thailand.

Health education increasingly became an important part of control programmes for smallpox, trachoma, malaria and tuberculosis, and for the improvement of nutrition. The

Regional Office assisted health education projects in India, Indonesia, Myanmar, Sri Lanka and Thailand. The emphasis in health education changed from publicity and propaganda to public education as an integral part of general health services, to be carried out by health workers as a part of their regular duties. It was recognized that health education had to play a more prominent role in the implementation of health programmes.

Embarking on malaria eradication programmes

Beginning in 1956, all countries of the Region gradually embarked upon their national malaria eradication programmes. Over the next three years, India, Indonesia, Myanmar, Nepal and Sri Lanka launched malaria eradication programmes, while Bangladesh and Thailand did so in 1961 and Maldives in 1966.

WHO, together with the United States Agency for International Development (USAID) and the United Nations Children's Fund (UNICEF), played a prominent role in carrying out the malaria eradication strategy in the countries. WHO promoted intercountry arrangements by holding a series of regional and interregional



In the years from 1956, all countries of the Region began their national malaria eradication programmes

meetings, coordinated research by arranging regional training courses, periodically organized independent appraisals of the malaria eradication programme, and facilitated re-programming and the implementation of recommendations.

The early years of the malaria eradication campaign witnessed dramatic successes. The task was truly daunting, given the limited tools and difficult environment, but during the decade optimism that the disease would be eradicated was high. Based on indoor residual spraying with DDT as the major tool, the malaria eradication campaign reached its pinnacle in the mid-1960s, and successfully eliminated the risk of malaria infection for about 700 million people living in parts of Asia, Europe and Latin

America. Malaria was reduced to its lowest ebb in 1966, after which the situation began to deteriorate. The programme was officially closed in 1969.

A number of factors were responsible for this ultimate failure, not least the spread of DDT resistance in the mosquito vectors, spread of drug resistance in the parasite, poor health system infrastructure, low levels of economic development, an increase in the price of insecticides, and donor fatigue.

Another factor was that the initial dramatic achievements in reduction of malaria incidence (see Table 1) lulled many decision-makers into a false sense of security, and consequently sustaining the eradication efforts lost priority.

Table 1: The reduction of malaria incidence in the first two decades after 1948 in the SEA Region

Country	Incidence of malaria per 100 000 population	
	Incidence (Year)	Incidence (Year)
Bangladesh	4 400 (1956)	5 (1965)
India	23 000 (1947)	13 (1961)
Indonesia (Java and Bali)	40 000 (1951)	3 (1961)
Maldives	40 000 (1964)	227 (1974)
Myanmar	2 500 (1954)	5 (1961)
Nepal	5 000 (1950)	44 (1968)
Sri Lanka	38 000 (1945)	0.2 (1963)
Thailand	2 600 (1950)	280 (1961)

Reference: World Health Organization. Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992

Exploring drugs in TB treatment

Effective drugs for treating tuberculosis started becoming available from the 1940s (streptomycin in 1944, para-aminosalicylic acid (PAS) in 1946, thioacetazone in 1950, isoniazid in 1952, and rifampicin in 1966). With the availability of these drugs, the British Medical Research Council initiated several randomized controlled clinical trials to assess the effective dosage, combination of drugs and duration of treatment. The trials noted the emergence of resistance while treating patients with a single drug, and found that a combination of drugs could prevent this. This led to the development of multidrug treatment.

During this second decade, the general view was that tuberculosis was being brought under control, and the situation was positive. Studies on tuberculosis conducted in India in the 1950s and 1960s with

support from the Indian Council of Medical Research, the government of the state of Tamil Nadu and WHO indicated that tuberculosis patients did not need to be in hospitals or sanatoria, and could be treated just as effectively at home under supervision without endangering the health of their families or community members. It was also shown in Bangalore that technicians working at the periphery could, with minimal training and regular supervision, carry out sputum smear microscopy for the diagnosis of tuberculosis. The results of these early studies evolved into the basis of today's tools for TB control. Indeed, the DOTS (directly observed treatment, short-course) treatment strategy is one of the most successful and cost-effective interventions in health available today while sputum smear microscopy is still the mainstay of diagnosis.

Planning smallpox eradication

When WHO started its work in the Region, the number of cases and deaths due to smallpox in Member countries was considerable. In India, more than 100 000 deaths were reported annually. In 1958 the Regional Committee for South-East Asia agreed to support the activities recommended by the World Health

Assembly towards the eventual eradication of smallpox.

By 1960, India, Indonesia, Myanmar and Thailand had developed plans for the eradication of smallpox through mass vaccination campaigns. WHO assisted in arranging for the supply of the vaccines for current



This little girl, Rahima Banu, of Bangladesh, was the last recorded case of smallpox in Asia. Seen here with her mother in 1975. The eradication of smallpox from the world was certified by the Global Commission in December 1979 at WHO headquarters in Geneva

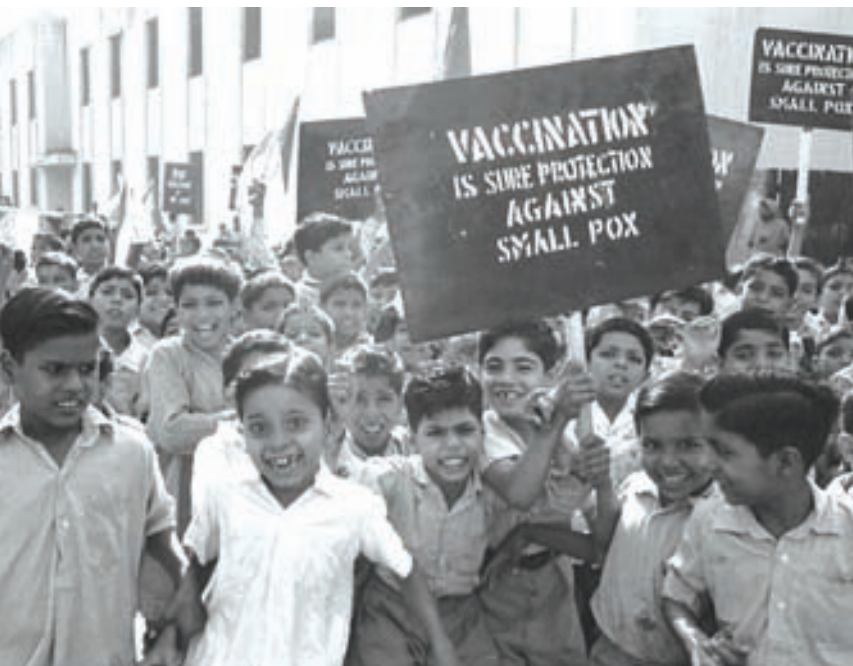
use and at the same time helped national authorities to produce freeze-dried vaccine for use in the mass campaigns.

The smallpox situation in the Region was reviewed at the Sixteenth session of the Regional Committee in 1964. The review revealed that smallpox was no longer endemic in Mongolia and Sri Lanka, while in Thailand it had practically disappeared. In Myanmar, a downward trend had been observed. The situation in Nepal was not clear as reporting was not well established. The largest number of cases reported was from India, reaching 93 423 in 1963. Indonesia reported 17 000 cases in the same year.



Oil painting (0.94 x 0.64 m). Gifted by Myanmar

THE SECOND DECADE: 1958–1967



Perhaps the largest national smallpox vaccination campaign in the world was launched in India

During the preceding five years (1959–1963), 70% to 80% of the world's total number of cases had been reported from Asia. In 1966, the World Health Assembly resolved to embark on an intensified global programme for the eradication of smallpox. This commenced in 1967, and the Health Assembly considered that eradication could be achieved within a decade. Member States requested WHO to initiate all the actions necessary to carry out the worldwide eradication of smallpox, including financing from the Organization's regular Budget, and other bilateral and multilateral assistance.

Controlling trachoma in the community



Volunteers from a WHO-assisted pilot project inspecting the health of village children

WHO helped establish pilot studies to control trachoma in the community. These interventions were initiated in India and Indonesia. A new approach was instituted to encourage people to participate actively in their own treatment, and make antibiotic ophthalmic ointments available where trachoma was hyper-endemic. This single-purpose vertical trachoma programme succeeded in reducing endemicity and preventing blindness from trachoma, but was generally not sustained.

Responding to polio outbreaks

In most countries of the Region, polio virus infection was common in infancy. There had been reports of recurrent epidemics with paralytic results in children under 10 years of age, particularly from India, Indonesia and Sri Lanka. A large number of cases of paralytic polio in young children were reported from Yangon, Myanmar, during 1964–1965. In Sri Lanka, an outbreak of polio occurred in 1962 with about 1800 cases of paralytic polio reported.

Paralytic polio is not curable. However, it is a preventable disease with vaccines that are effective, safe,

inexpensive and (in the case of oral polio vaccine) easy to administer. Since the only hosts of the virus are humans, it was believed that eradication of the disease was possible. Two polio vaccines were already available. The first was the inactivated polio vaccine which came into use in 1955. The oral polio vaccine (attenuated) came into commercial use in 1961. Mass vaccination campaigns against polio were carried out in the latter half of the 1960s. But by 1970 it was evident that as a result of incomplete coverage of all infants with three doses of oral vaccine, epidemic polio was increasing in the Region.

Responding to other major communicable diseases

In 1958, a new haemorrhagic form of dengue was reported in the Region. The first epidemic occurred in Bangkok, and had a case fatality of 10%. The disease affected mainly children. WHO assigned experts to work with national staff in outbreak response activities.

Major outbreaks of cholera had occurred almost every year in Bangladesh and India. There were major epidemics in 1958 in India, Nepal and Thailand, which spread to Afghanistan and Myanmar.

The Regional Office dispatched vaccines and its staff to work with national officials to contain the epidemics. In 1961, the El Tor strain of the *Vibrio cholerae* bacterium spread from Sulawesi, Indonesia, to adjoining countries. Within three years, this strain had made its appearance in Myanmar and Thailand and, in 1964, was also reported in Calcutta, India.

Since zoonoses and foodborne diseases were major public health problems in the Region,

the Regional Office supported the strengthening of veterinary public health programmes, particularly for the control of priority zoonoses (rabies, brucellosis

and echinococcosis) and for food hygiene. WHO also provided assistance in the control of canine rabies and in the production of antirabies vaccine.

Establishing leprosy control programmes

The value of the cheap sulfone DDS, or dapsone, for mass treatment for leprosy had been recognized in the 1950s, and its efficacy demonstrated. Institutional treatment was considered impractical, as the treatment had to be regular and carried out over a long period. Leprosy became one of the principal tropical diseases addressed by the Special Programme for Research and Training in Tropical Diseases (TDR) jointly initiated by the United Nations Development Programme, World Bank and WHO. Since the 1960s, TDR has advocated and coordinated many research studies on leprosy in the Region.

The Region accounted for about 50% of the global leprosy burden at

that time. The estimated number of cases in the 1950s were over a million in India, 110 000 in Myanmar, 100 000 in Thailand, 80 000 in Indonesia and 4000 in Sri Lanka. Most endemic countries started national leprosy control campaigns or specialized vertical disease control programmes, with technical and financial support from WHO and other developmental partners including nongovernmental organizations. Despite intensive efforts carried out in the countries, the prevalence increased from 8.4 cases per 10 000 population in 1966 to 12 cases per 10 000 in 1985. Leprosy remained a major public health problem with millions of people suffering from this disease.

Tackling lymphatic filariasis

Lymphatic filariasis, or elephantiasis, a human disease caused by parasitic worms called filaria, was a common sight in many parts of the Region during the first two decades of WHO. It was mostly prevalent in India, Maldives, Myanmar and Sri Lanka. In some countries, it was known to affect 80% of the population. In Indonesia, Nepal and Thailand, filariasis existed but did not seem to be a serious public health problem. Filariasis due to *Wuchereria bancrofti* worms spread by infected mosquitoes increased every year as a result of

population migration to new towns and rapid urbanization.

In an agreement with the Government of Myanmar, a WHO Filariasis Research Unit, including a Research Unit for the Control of *Aedes aegypti* mosquitoes, was established in Yangon in 1962. Experts in epidemiology, ecology, entomology and parasitology were assigned to the Unit, where they studied the bionomics of the vectors of filariasis, development of the parasite in the mosquito and in carriers other than man, and the epidemiology of the disease.



Painted mural on a wall in the Reception area of the WHO Regional Office, titled 'Transplantation of paddy plants, with Mandalay Hill in the background'. 4.8 x 6.33 m. 1963. Gifted by Myanmar

A future free from kala-azar and yaws

Visceral leishmaniasis (kala-azar) is a disease caused by *Leishmania* parasites which attack the internal organs, while yaws is an infection of the skin, bones and joints caused by the *Treponema pallidum* bacterium.

During this decade, both kala-azar and yaws were on the decline. In kala-azar, this decline was largely a byproduct of malaria eradication activities, as the DDT used in the latter was also effective against the sandflies that spread the disease.

In fact, the sandflies were even more susceptible to DDT than the *Anopheles* mosquitoes. Thanks to the widespread use of DDT for the control of malaria in South-East Asia, transmission of kala-azar was limited and the disease virtually wiped out. However, after the malaria eradication campaign ceased at the end of this decade, there was a resurgence of kala-azar in Bangladesh, Nepal and neighbouring parts of India. This situation persisted for the next few decades.

More than 50 million people were suffering from yaws globally when, in 1949, WHO and UNICEF launched a massive global programme to eliminate it. Since yaws was susceptible to a single dose of long-lasting penicillin, and with humans as the only host, the causative agent was relatively simple and cost-effective to conquer. By 1964, yaws cases had been reduced by 95%, and it had virtually been eradicated. However, owing to unsustainable surveillance and poor integration of the vertical programme with the basic health services, the disease resurged in some countries, particularly in neglected communities in remote areas. It became a priority in the Region for the next decades to eradicate the disease.



Families being examined for yaws

Recalling the eradication of yaws in Indonesia

'I was with a team that visited a remote hill station in central Java. The people were summoned to receive their penicillin shots by the beating of gongs made from hollowed tree trunks. It was a grim sight. Living skeletons were carried in palanquins. Many came crippled and crawling with the claw-foot which occurs when yaws enters the sole and makes the foot contract like the claw of a perching bird.

One little boy who came crawling was Tresno. I made friends with him and held him when he got his injection. Ten days later we reassembled for the check-up and that little boy – who in his life had never had a reason to smile – came running and smiling up the path to greet me.

A year later I heard from a friend in that region. He wrote: "You remember the day Tresno smiled? That was exactly 12 months ago. Today was a feast day to celebrate the disappearance of yaws. Since that day a year ago, children have been born into life without yaws. Youngsters had almost forgotten what it was like but grown-ups remembered and they had a feast. Everybody contributed. Tresno climbed palm trees to collect coconuts. Men brought fish and rice which they had been able to harvest without yaws. The women plucked the chicken. The headman beat the gong and the children came chattering and laughing, skipping and jumping. The band beat out the tunes and old and young joined in the dancing – the dancing they had almost forgotten. People boasted about the size of the ulcers they once had. The local 'comic' put on an act, imitating the walk of the claw-footed yaws' victims and everybody roared with laughter. The men teamed up in a show in which they mimed the painful slow-motion harvesting of the rice when they had yaws and worked up the tempo of the band to the prodigies of speed with which they could now reap. And Tresno's smile had turned to laughter.'

Lord Ritchie Calder

(Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992)

Country health programming

Countries needed not only to have health policies, but also to strengthen the planning and organization of composite health programmes for which available resources were far from adequate. WHO rose to this challenge and a systematic approach was formulated. The methodology formulated was known as “Country health programming”.

The session of the Regional Committee in 1961 urged Member States to use their existing facilities to teach health administrators the techniques of national planning. The countries were also urged to strengthen their health

organizations, and develop an effective mechanism for health planning as a part of national planning. The Regional Office helped to organize health planning units and train national staff through Fellowships, workshops, seminars and short courses. In collaboration with the Economic and Social Council for Asia and the Pacific and with support from the United Nations Development Programme, WHO organized regional training courses in health planning for health workers. By the time the training ended in the late 1970s, more than 50 health planners from countries of the Region had completed the training course.

The World Health Assembly is held in New Delhi

In 1961, the Fourteenth World Health Assembly was held in New Delhi, India. This was the first time a Health Assembly had been held in Asia. Delegates from 105 countries attended the opening session on 7 February, inaugurated by Indian Prime Minister Jawaharlal Nehru. The President of the Health Assembly declared that the Organization’s war against major pestilences was continuing, and

that the progress with smallpox, though slow, was apparent. In the battle against yaws, WHO was about half way through the programme, with 100 million sufferers examined and 40 million given treatment. But in some of the Member States the infant mortality rate was still about 200 in 1000 births, compared with a drop to 20 in industrialized countries. Achieving the higher standard all

over the world would mean that each year some 16 million more children under the age of 1 year would survive.⁴

The first two decades of WHO in South-East Asia thus saw a promising start to the Organization's support to the countries in public health, and constituted a productive period. Important programmes had been launched with Member States in a spirit of cooperation, resulting in some excellent accomplishments. There had been major advances in the control of malaria, tuberculosis and venereal diseases, a marked increase in the development of the health workforce, and the near-eradication of yaws. Of course, by comparison, some of the programmes had not made the same headway – such as the training of auxiliaries and, to a lesser degree, leprosy control. Towards the end of the second decade, outcomes and developments that were quite unanticipated had begun to surface, including the recrudescence of yaws and the development of resistance by the *Anopheles* mosquito to DDT. It was just as well

that some solid gains were made during the first two decades, for the Organization was to face some exacting challenges in the following decade.



A ceramic ceremonial urn. Gifted by the Democratic People's Republic of Korea



Bronze statue mounted on a marble pedestal to commemorate the 40th Anniversary of WHO in 1988. Gifted by Indonesia

⁴ Available at <https://www.britishpathe.com/video/VLVABXFDK3LX25GQ021ZF822X95P-INDIA-14TH-WORLD-HEALTH-ASSEMBLY-OPENS-IN-DELHI/query/Delhi>, accessed on 14 May 2018

The medical system in Sri Lanka in the 1960s: achievements and challenges

In conversation with Dr Palitha Abeykoon

Dr Palitha Abeykoon, one of Sri Lanka's leading public health experts, remembers the 1960s as a time of great achievements and great challenges for the medical system in the country. Globally, the Sixties were a time of change and flux and the country was no different, leading the way with the appointment of the world's first woman Prime Minister Sirimavo Bandaranaike.

By 1960, the groundwork for much of the country's future achievement in health care had already been laid. Of particular relevance was the impact of the country's free education system, and of the generation of doctors and nurses that were beginning to emerge from the national public schools as a result.

Malaria continued to take its toll on the population, but eradication campaigns and more sophisticated surveillance were beginning to have an effect. Coupled with advances in maternal and infant health care, the health of Sri Lanka's growing population continued to improve.

Asked why he decided to enter medicine, Palitha says that the choice was very much made for him. In those days a well-educated Ceylonese had one of three choices: law, engineering or medicine. He chose medicine and, by virtue of the alphabetical order of his surname, became the very first student to enrol in the newly opened Peradeniya Medical Faculty, Kandy, in 1962. It was the beginning of an illustrious medical career, but it was a career that nearly didn't happen.



Dr Palitha Abeykoon

While still a schoolboy, young Palitha cut his foot playing rugby and contracted tetanus. For 11 days he hovered between life and death in Kandy Hospital. The care he was given there, supported by his classmates – and the airlift of antitetanus serum from India – saved his life. As he points out, he was very lucky. And subsequently a life-long advocate for immunization.

It was only in 1961 that DPT – the triple vaccine against diphtheria, whooping cough and tetanus – was introduced. This was followed by OPV, introduced in 1962, and BCG vaccination of neonates in 1963.

For Palitha, the 1960s were characterized by the widespread immunization programme introduced by the Government and WHO, and widely embraced by the population. A well-educated population served by well-trained public health professionals gave Sri Lanka an enormous benefit in countering many of the endemic diseases the country faced.



Immunization campaigns were key public health successes in Sri Lanka during the 1960s

Sri Lanka now has some of the highest rates of immunization in the world. His mentor at Peradeniya was the eminent medical visionary Professor Senaka Bibile. It was from him that Palitha learned the importance of establishing a sound medical education system if a country was to progress. And not just education for doctors but for all tiers of the public health system.

Sri Lanka in the Sixties experienced many of the demographic and social changes that other countries in the Region were to see in subsequent years. The old scourge of malaria still afflicted thousands, particularly since the parasite had started to develop resistance to DDT, but slow and steady progress was being made towards its eventual eradication.

The Sixties were also a period of transition in Sri Lanka. Rapid urbanization, population growth, successful immunization programmes as well as improvements in infant mortality rates characterized the decade. Population growth pressure led to family planning being integrated into the maternal health-care system in 1965. And the lessons learnt were successfully exported to other countries in the Region.

As Palitha points out, Ceylon's success in the Sixties was built on the twin pillars of a good primary health care system and widespread access to free education. He feels this was something that Sri Lanka can be rightly proud of, as it serves as a model for others not just in the Region but also the rest of the world.





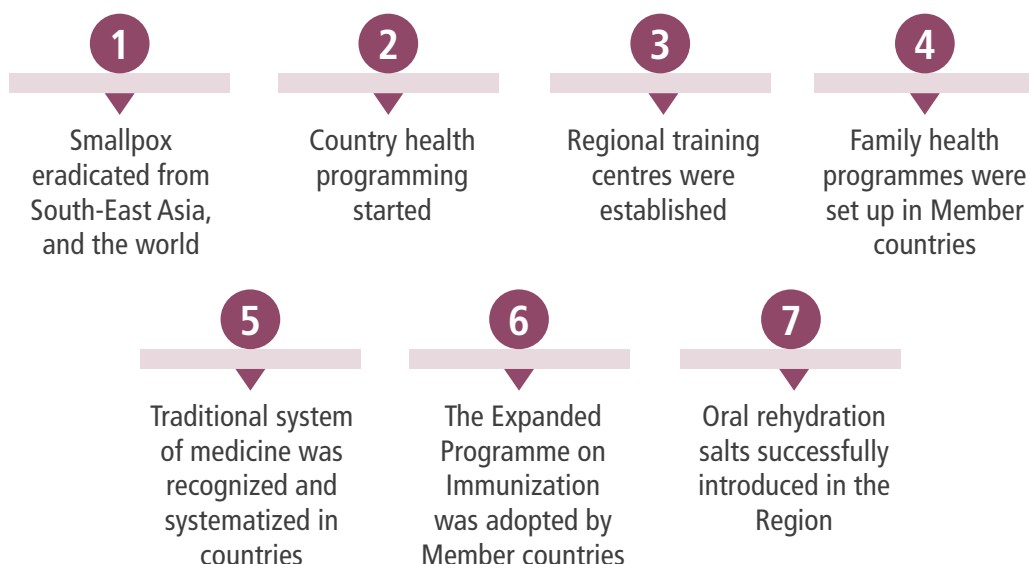
3

THE THIRD DECADE

1968–1977

The eradication
of smallpox

MAJOR ACHIEVEMENTS IN THE THIRD DECADE: 1968–1977



The third decade of WHO in the Region saw many achievements resulting from WHO's collaboration with Member States. An important step was to transform WHO's role and introduce a systematic approach to technical cooperation with Member countries. This decade also witnessed the global eradication of smallpox – one of the greatest achievements in the history of public health. It was also a decade of further strengthening of health planning in countries as a component of the overall socioeconomic development and strengthened health infrastructure.

The global initiatives from this decade, such as the Expanded

Programme of Immunization and the establishment of the goal of "Health for All by the Year 2000", were milestones influencing WHO's work and priority settings in the Region.

Considerable progress had been made in health services development, as evidenced by the significant increase in the number of hospital beds and health centres, subcentres and health posts. There was a definite shift from hospital-based services towards field-oriented health care.

Despite this progress, the health situation in the countries was far from satisfactory. The burden of communicable diseases, the lack

of mother-and-child services, and problems such as malnutrition, population growth, shortages of trained health personnel and inadequate coverage of general health services, persisted. There was the need for greater political commitment to the development of health care, and community participation in health improvement

was yet to take off. In addition to all this, three problematic areas related to globalization and trade in health showed up during this and next decades: i) breast-milk substitutes and infant foods versus breastfeeding; ii) the provision of essential drugs; and iii) the tobacco industry and increasing incidence of tobacco-related diseases.



It is only through social development programmes that human society can drive peace, stability and harmony. It is for this fundamental reason that a significant breakthrough in the field of health has become not only an urgent need but an imperative necessity

Dr VTH Gunaratne
Regional Director, 1968–1981

Implementing country health programming

WHO originally adopted the approach of “funding projects in the country”. But “the projects” often did not fit into the country’s main socioeconomic development scheme, nor were potential socioeconomic capacities seriously considered. It became evident that the fragmented

project-based approach was not effective. Based on policy guidance in WHO’s Fifth General Programme of Work (1973–1977), the Organization’s role in direct country support would become increasingly cooperative in character. To enable this transition, it was essential to

strengthen the health planning and organization in the countries. The Country health programming (CHP) methodology developed during WHO's second decade started being applied throughout the Region in the third decade.

The first application of the methodology was in Bangladesh in 1973, conducted by a national team with technical support from the Regional Office. Country health programming was conducted in Nepal and Thailand in 1974, Myanmar in 1975, Indonesia in 1976 and in Sri Lanka in 1978. It was not carried out in other countries of the Region, notably the Democratic

People's Republic of Korea, India and Mongolia, as the national health planning processes practised in these countries were considered appropriate for their own national administrative systems. The first Long-Term Health Plan (1975–1990) was developed and implemented in Nepal.

Even when the entire UN system was operating with technical assistance as its main *modus operandi*, WHO and its Member countries recognized the importance of resources available internationally, and strived for broader coordination and closer collaboration among donor agencies.

New philosophy of health development

The prevailing view of classical economists was that there should be an economic proof of social benefits. In the late 1970s, this began to be challenged. The opposing view was that social benefits could not and should not be expressed solely in economic terms, but rather, development has to be viewed in terms of social equity and social justice in addition to economic terms, since its principal aim is to improve the quality of life.

In line with these changing ideas on development in general, a new philosophy of health development was debated in WHO. According to this new philosophy, poor

health was not primarily caused by the common diseases; rather, low health status was a product of the prevailing socioeconomic conditions, political structures, nutrition and the environment. Thus, health development had to be seen as an integral part of social and economic development both contributing to and benefiting from it. Viewed in this light, it became obvious that for the solution of the priority health problems mere technical knowledge in isolation from social awareness was no longer sufficient. New approaches were needed. In 1977, the goal of "Health for All by the Year 2000" was formulated. The principles of this goal will be elaborated in the next chapter.

Regional training centres

Countries had been aware of the importance of training and the preparation of teachers. WHO formulated a new and radical approach to overcome the problem of developing an appropriately trained health workforce to run the health services. The concept of “health services manpower development” consisted of the complete process of health workforce development involving the three main interrelated components of planning, production and management. The whole process led to the overall development of health services.

The countries of the Region had been encouraged to consider the importance of training and the preparation of teachers. Two Regional Teacher Training Centres were established in 1972 – one in Peradeniya in Sri Lanka, and the other in Chulalongkorn University in Bangkok, Thailand. India already had the All India Institute of Medical Sciences for training medical teachers, and in 1976

national teachers’ training centres were established at the Jawaharlal Institute of Postgraduate Medical Education and Research (JIMPER) at Pondicherry and, by 1980, at the Postgraduate Institute of Medical Education and Research (PGI) at Chandigarh and the Institute of Medical Sciences in Varanasi.

In consultation with educationists in countries of the Region, and as prompted by them, WHO initiated a change in the medical education curricula to attune it to community needs, under the programme name of “Reorientation of Medical Education (ROME)”. By the next decade this had become a movement in all countries in the Region. Finally, to systematize dental health services in Member countries, the Regional Office supported the establishment of schools for the training of dental hygienists and dental auxiliaries, which were absent in most of the countries. New dental colleges were also established in India, Indonesia, Myanmar, Sri Lanka and Thailand.

Enlarging the concept of maternal and child health

This concept of maternal and child health was expanded by the World Health Assembly in 1968 to embrace

the whole of family health. Family health included the care of mother and child, nutrition, immunization,

THE THIRD DECADE: 1968–1977

health education and family planning. Family planning became an important component of general health services. The maternal and child health (MCH) programmes established demonstration and training projects for professional and auxiliary workers. These projects were aimed at a more comprehensive coverage through a wide network of MCH centres. Furthermore, the integration of MCH services into general health services aimed at forming a basis for more elaborate and effective care. In Bangladesh in 1976, 13 500 women were trained and deployed as family welfare assistants.

Family health programmes in Member countries that had a

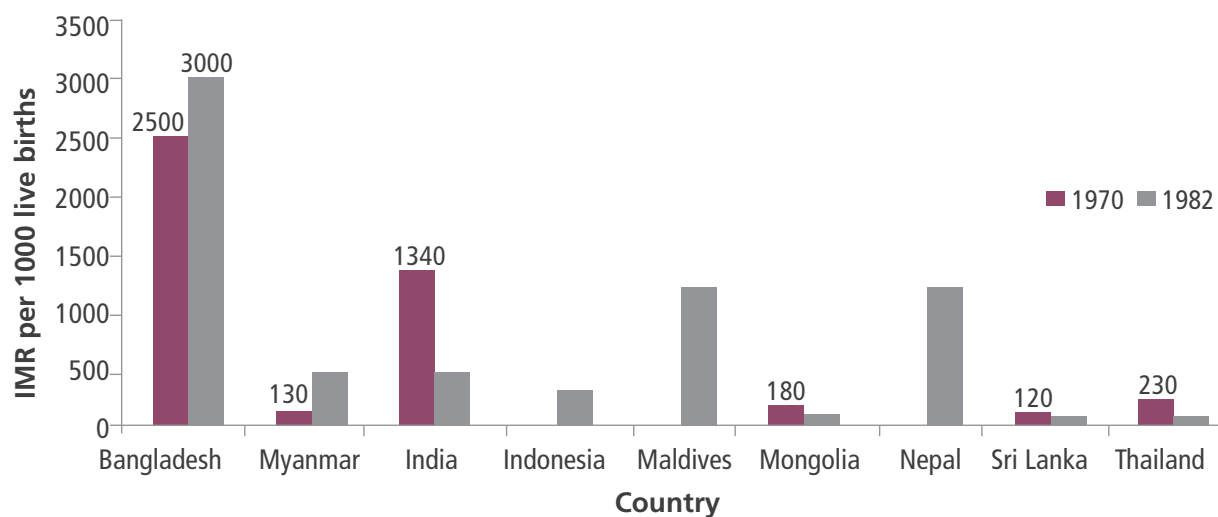
national family planning policy were funded by UNFPA. This programme contributed to the acceptance of family planning as an effective measure to help reduce maternal and infant morbidity and mortality and in upgrading the quality of life. The family health programme was a development of family planning services integrated into MCH services in the context of community health. WHO's assistance to MCH programmes helped to improve the health of mothers and children. By 1970, the infant and maternal mortality rates had fallen in most countries, though they still remained unacceptably high compared with the industrialized countries (Figures 2 and 3).

Figure 2: Infant mortality in SEA Region countries 1970–1975 and 1980



Reference: *Bulletin of Regional Health Information, 1982–1983. WHO SEARO*

Figure 3: Maternal mortality in selected SEA Region countries with available data, 1970 and 1982



Reference: Bulletin of Regional Health Information, 1982–1983. WHO SEARO



WHO's assistance to MCH programmes helped improve the health of mothers and children regionwide

A serious obstacle that has to be overcome in providing health services, including family health to the community, is the shortage of trained health manpower. Therefore, WHO is giving high priority to develop education and training programmes so that the Member States will be in a position to prepare professional and auxiliary personnel in adequate numbers. The long-term objective is to incorporate all aspects of family health activities into the basic training of every category of health personnel. Until this objective is reached, orientation and refresher courses are necessary

Dr VTH Gunaratne

Challenges and Response, Health in the South-East Asia Region, 1977

Establishing model rural health centres

As described in the previous chapters, the countries of the Region recognized early the need to build their health infrastructure by establishing a network of rural health centres. The Regional Committee in 1951 recommended the establishment of model rural health centres, with at least one in each country. This was to provide demonstration and training of required personnel and serve

as a model for the provision of comprehensive health services to rural communities. Model rural health centres were established in India, Indonesia, Myanmar, Sri Lanka and Thailand. By 1968, rural health activities had become an integral part of community development planning. By the end of the decade, encouraging results had been achieved in expanding the coverage through a network of rural health centres.

The Comprehensive Rural Health Project, Jamkhed, India

The Jamkhed Comprehensive Rural Health Project, launched in 1970, was designed to meet the basic health needs of a rural population of about 40 000, in the Indian state of Maharashtra, by mainly using local resources. The key objective of the project was to meet these needs by providing: maternal and child health services, health education in the community, detection, prevention and control of chronic illnesses such as tuberculosis and leprosy, and environmental health through the provision of safe drinking water. The project stressed agricultural support for proper nutrition, the deepening of wells for irrigation and safe drinking water, and the training and use of village health workers and broad-based community participation in the decision-making processes regarding health services.

To achieve basic health-care services at low cost, the project included a number of innovative approaches, such as the use of fees derived from curative services to support promotive and preventive health programmes, and the incorporation into the project of indigenous and Ayurvedic practitioners and dais (traditional midwives).

One of the most important findings of the project was that it was 'based on the recognition particularly by the project leaders, of the priorities determined by the community. To the community, health is not a number one priority; agriculture, water supply, housing are more important... In effect, it appears that in such communities, which have a low economic status and per capita income, doctors and health services will need to identify themselves with the community's priorities in order to fulfil health objectives.'

(Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO)

For more information: <http://jamkhed.org/research/>

Systematizing traditional medicine

Traditional medicine is practised in all countries of South-East Asia. The commonly practised systems in the Region are Ayurveda, Unani, Siddha, Yoga (India), Jamu (Indonesia), Koryo medicine (Democratic People's Republic of Korea), and those originating from other regions such as Chinese medicine, acupuncture and homeopathy. These various systems use herbal medicines, manual and spiritual therapies, and physical exercises. Many are



Silk embroidered wall hanging (0.35 x 0.60 m). Gifted by DPR Korea

THE THIRD DECADE: 1968–1977

formal systems (such as Ayurveda, Siddha, Unani-Tibbi, Chinese and Anchi (Tibet) systems), and some yoga practices, and there are also many non-formal traditional systems (herbalists, bone-setters, healers in the thaad (element system), nature cure and home medications). The use of traditional medicine practices continued to expand, particularly for diseases and conditions that are not effectively managed by modern medicine.



A Bhutanese thangka, a wall-mounted portrait of the Buddha, 1.53 x 2.63 m. Gifted by Bhutan

During this decade, WHO recognized the traditional systems of medicine, emphasizing the important role they were playing in providing health-care services to very large numbers of people, particularly in rural areas. The Regional Committee in 1975 requested WHO to collaborate with Member States to develop well-recognized traditional systems of medicine and enhance research. In 1976 the Regional Committee requested WHO to promote training and research in traditional systems, and requested interested governments to provide facilities for the training of health workers in traditional medicine, and protocols for their role and use in the basic health-care programme.

WHO's Regional Office for South-East Asia has already identified over 110 institutions of traditional medicine in different Member countries for regional networking. Member countries have been strengthening their traditional systems of medicine as part of their national health development. In India there are over 340 recognized training institutions offering degree-level training in the various Indian systems of medicine. A University of Traditional Medicine was established in 2001 in Myanmar. In Thailand, the integration of traditional medicine into the health system by co-location has extended to over 96% of the regional hospitals and 88% of health centres.

Environmental health

A WHO review in 1975 showed that there had been a tangible increase in the population supplied with piped water in urban areas – the proportion served had risen from 50% in 1970 to almost 70% in 1975. A similar increase during the same period was observed in access to safe drinking water in the rural areas – from 9% to 19%.

More than 30% of the urban population in Bangladesh, India, Myanmar, Nepal and Sri Lanka were served by bucket privies. The social aspects of this system were of great concern to the countries. A study by the Regional Office indicated the possibility of replacing bucket privies with water-seal toilets. These

appeared to be the least expensive solution to the social problems.

During the first two decades WHO's environmental health programme had focused mainly on the provision of safe water supply and disposal of excreta for the community, with training of personnel and establishment of demonstration and pilot projects. In the third decade WHO's activities expanded and covered studies on environmental pollution control, waste disposal, environmental planning and information systems. The rapid growth of populations, industrialization and increasing urbanization was a cause for growing concern of the governments and led to the WHO response.

Launching the Expanded Programme on Immunization

At the beginning of this decade, several vaccines were being used in paediatric practice in industrialized countries. It was clear that there were opportunities to bring this up to scale in applications in the Region. In 1974, the World Health Assembly – noting that diphtheria, pertussis, tetanus and measles were still major causes of infant mortality in developing countries, and that polio was widespread and often in

epidemic proportions – called for a public health programme to use the already available vaccines to control several childhood diseases in low-income settings.

The Expanded Programme on Immunization (EPI) was launched in 1974, drawing on the principles of strategic and equitable application in the community. This provided a blueprint for operations, including

THE THIRD DECADE: 1968–1977

training manuals for vaccinators, who were mostly women health workers recruited from the community itself. The diseases targeted for control through EPI were tuberculosis, diphtheria, pertussis, tetanus, polio and measles.

The EPI was a low-cost public health programme. In order to allow capacities to develop, the goal was set to vaccinate 80% of eligible children (with a target of universal child immunization, or UCI, by 1990). The infant vaccinations consisted of BCG (for tuberculosis) as early after birth as possible, DPT (for diphtheria, pertussis/whooping cough and tetanus) and OPV (oral polio vaccine) during early infancy, and measles vaccine at or after 9 months of age.

Between 1974 and 1979, the Expanded Programme on Immunization was adopted by all countries of the South-East Asia Region. The vaccination of pregnant women against tetanus was included in EPI to prevent neonatal tetanus. The historical public health success of smallpox eradication had shown that it was possible to achieve the interruption of transmission, and elimination, of causative agents by immunization, and to reduce morbidity and mortality from vaccine-preventable diseases. This was what the Expanded Programme of Immunization now took forward in the battle against the diseases of children and their mothers.



Intensive immunization programmes have led to many public health successes in Member States

In the early 1970s, international attention on the advantages of breastfeeding and the harmful effects of bottle-feeding increased. Awareness was growing on the links between infant malnutrition and the promotion of breast-milk substitutes in developing countries. The World Health Assembly in 1974 noted that a decline in breastfeeding was one of the factors contributing to infant mortality and malnutrition. It strongly recommended the encouragement of breastfeeding as the ideal feeding method to promote the harmonious physical and mental development of children. The Health Assembly urged

Member States to review sales promotion activities related to baby foods and introduce appropriate remedial measures, including legislation where necessary.

The countries of the South-East Asia Region, with their high infant mortality rates, had a special interest in this and overwhelmingly supported the Health Assembly resolutions on the subject. However, progress was slow and, by 1988, only five of the then 10 countries of the Region had developed some form of regulation, code or ordinance based on the International Code of Marketing of Breast-milk Substitutes.

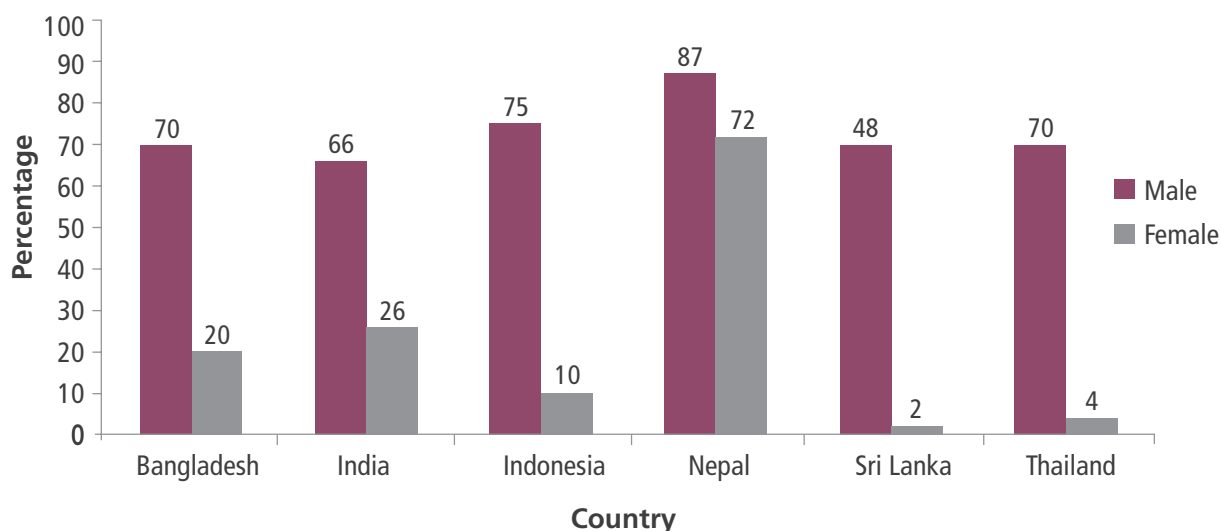
Reacting to emerging public health issues

The lack of a comprehensive national drug policy, as a component of national health planning, created a gap between the demand for drugs and the actual health need for essential drugs. Moreover, the cost of imported drugs and technology for pharmaceutical production was very high. Even though in many countries a high proportion of the health-care budget was spent on pharmaceuticals, 60%–70% of the population did not have ready access to the most essential drugs. This was particularly true in rural areas. The World Health Assembly in 1975 resolved that greater assistance should be made available to Member States in the formulation of national drug policies and in

the selection of essential drugs corresponding to their national health needs. In the Region, WHO collaborated with countries in establishing drug policies and their management. However, because of economic constraints, there was still an inadequate supply of essential drugs of assured quality for the communities in several countries.

There was overwhelming evidence, based on independent publications and studies of all kinds (prospective, retrospective, clinical, case-control, epidemiological and experimental), indicating the link between tobacco consumption and various diseases, including cancers. However, the consumption of cigarettes continued

Figure 4: Prevalence of smoking in adults in some SEA Region countries, late 1970s/early 1980s



Reference: World Health Organization. Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992

to increase (Figure 4). Aggressive advertising by the tobacco industry, and reluctance of the governments to take a strong stand on the issue (since tobacco was a source of revenue and foreign exchange), countered the impact of scientific evidence.

In 1970, the Regional Committee passed a resolution requesting

persons attending all meetings sponsored by the Regional Office to refrain from smoking in future on WHO premises. There were many Health Assembly resolutions and expert committee meetings in the 1970s on tobacco as a major public health problem, but it took many more years to strengthen national strategies for the control of tobacco use.

Smallpox eradication and innovative disease control initiatives

The magnitude of smallpox as a public health problem was enormous. It has been estimated that in the 20th century, smallpox caused 200–500 million deaths.

Around 1967, about 15 million cases occurred throughout the world each year. The fatality rate was about 30%, with a higher rate among babies. Often those who survived

had extensive scarring of their skin and some were left blinded.

The goal of smallpox eradication was first articulated by WHO in 1959–1960. In tackling this disease, there were several intrinsic opportunities. For a start, the smallpox virus had no other carrier – transmission was exclusively human-to-human. This made it vulnerable to the interruption of its transmission locally (elimination) and even globally (eradication) by vaccine-induced immunity.

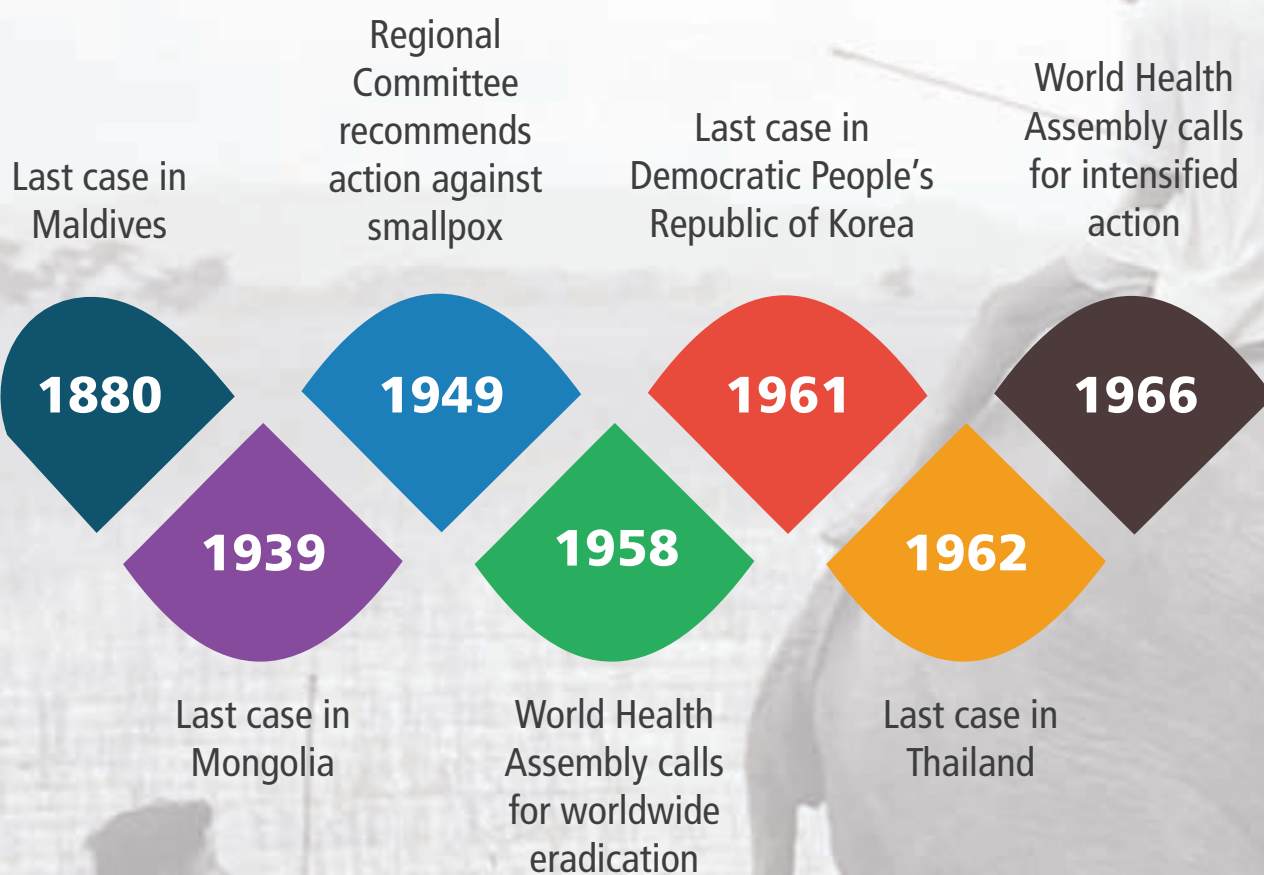
The strategic application of smallpox vaccination under the leadership of WHO through the South-East Asia Regional Office achieved the interruption and elimination of smallpox virus transmission on the Indian subcontinent. In India, the last case of smallpox was reported in Assam on 24 May 1975. No cases had been detected during the preceding 12 months by active surveillance. Eradication was declared in Bangladesh on 14 December 1977 by the International Commission on Eradication. The Commission had earlier (in 1977) certified Bhutan, India, Myanmar and Nepal as free from smallpox. Indonesia had already been declared smallpox-free (the last two known cases detected on 23 January 1972). The strategy used in Myanmar, Sri Lanka and Thailand was based on mass vaccination. In India and its neighbouring countries, the emphasis was on active detection of cases and containment of outbreaks, in addition to mass vaccination.

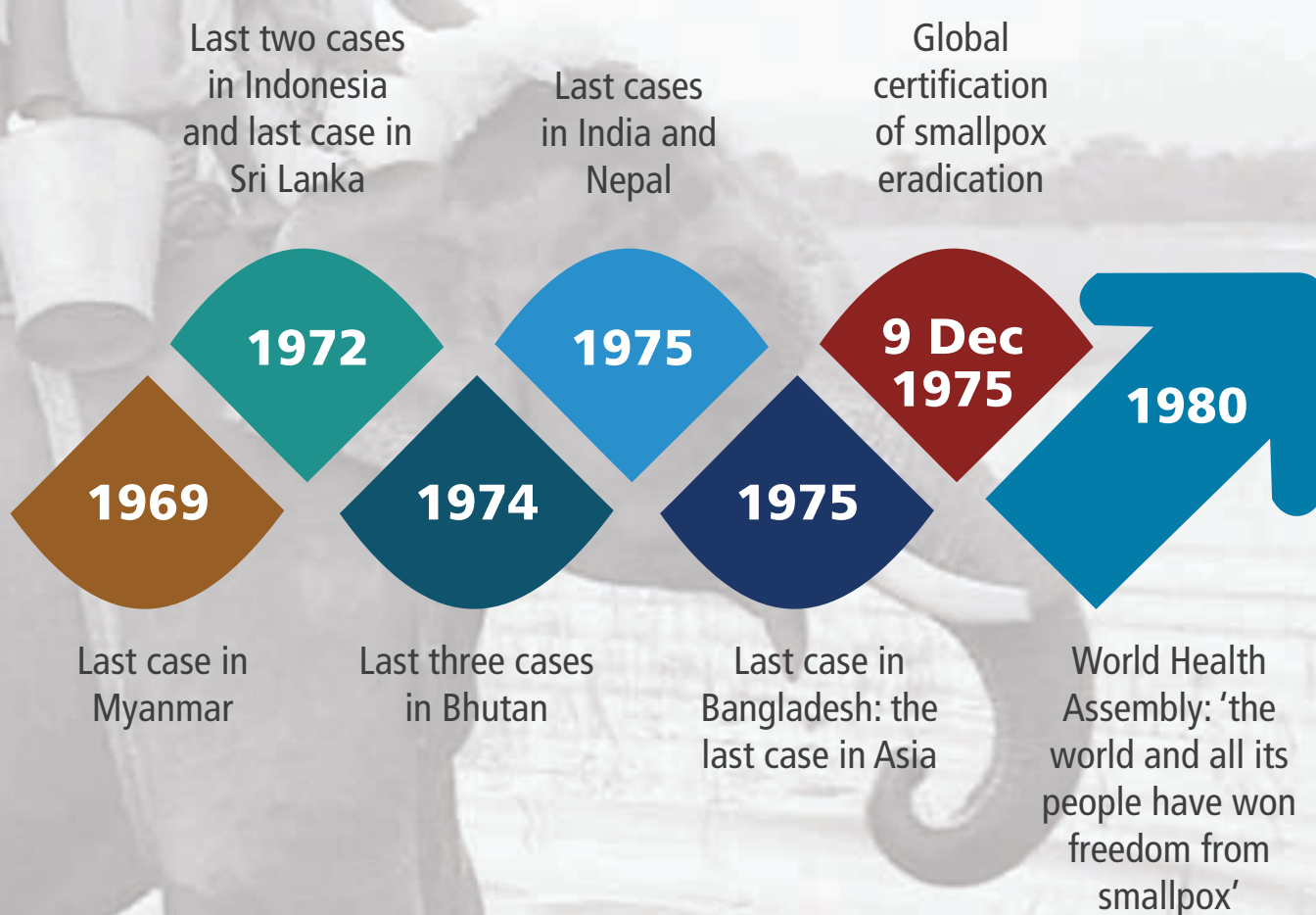


Millions of vaccinations were performed in the 1960s to stop transmission of smallpox

The global eradication of smallpox showed that WHO's visionary leadership in public health was able to bring together, at the global level, both the industrialized and the developing world for a health cause. This was a perfect example of the potential of international cooperation for a significant health benefit.

Milestones in the eradication of smallpox





Strategizing TB control

Tuberculosis is a curable and controllable disease; it is not only a medical but also a social problem, because it affects mainly the poor and makes them even poorer. As indicated in the previous chapter, the sanatorium treatment approach did not give the desired results, mainly because the cost of mass case-finding and management was extremely high and well beyond the resources available in most developing countries.

The National Tuberculosis Institute in Bangalore, India, in collaboration with WHO, developed the concept of passive case-finding (when patients with active tuberculosis experience symptoms serious enough to seek health care), rather than active case-finding (any method for tuberculosis identification that does not rely on patients coming in of their own accord). Passive case-finding was more cost-effective than active case-finding (it should be noted that current evidence suggests it is less effective in case detection).

Sputum smear microscopy was found to be the most cost-effective tool for diagnosis.

These studies in the Region led to the specifics of the strategies for national tuberculosis control programmes in the Member countries. They were developed based on sputum microscopy for diagnosis, passive case-finding and ambulatory chemotherapy. However, tuberculosis programme reviews showed that the programmes suffered from managerial weakness, lack of funding and failure to ensure accessible diagnosis and treatment services. During that period, the interest of the agencies – including WHO – in tuberculosis control deteriorated and the programme lost its visibility to a large extent. Tuberculosis continued to be a major public health problem with serious health consequences, but the international attention and resources devoted to its control were not adequate.

Oral rehydration therapy in cholera treatment

Outbreaks of diarrhoeal diseases including cholera occurred regularly in the South-East Asia Region. This was the case particularly in

Bangladesh and India, but also in other countries in the Region. During this decade, the Regional Office included cholera control as

a priority area in the collaborative programmes with the countries. This helped reduce mortality and morbidity due to cholera. The treatment of diarrhoeal diseases including cholera had dramatically changed because of oral rehydration therapy, which was used for the first time in the Region successfully to prevent dehydration. It worked in almost

all cases, except with those who were severely dehydrated and who needed intravenous therapy instead. The oral rehydration solution (ORS) was developed by Dr Rafiqul Islam in Bangladesh. WHO supplied ORS to countries that reported cholera outbreaks. At the end of this decade, UNICEF also started distributing ORS packets to countries in the Region.



WHO was supplying ORS to countries that reported cholera outbreaks

Cancer control programmes

The first World Health Assembly in 1948 had placed cancer sixth on the list of priority diseases in international work, with a focus primarily on studies and statistics. Until 1970, short-term consultants were employed by WHO to study the magnitude of the problem and provide advice to the countries. A number of international agencies shared a common interest in cancer control and, after 1970, they established a more systematic technical coordination between them.

The strengthening of hospital-based and population-based cancer registries was supported. Information from these helped in the realistic planning of cancer control programmes. Special attention was given to oral and cervical cancers, which were the most common cancers in the Region. The use of clinical screening of cancer of the cervix as a feasible and

optional method at the community level was promoted, and training was conducted in Bangladesh and India.

Practical national cancer control programmes which were well planned with defined strategies were supported and strengthened in India, Maldives and Sri Lanka, always bearing in mind to use the existing infrastructure and health workforce as far as possible. WHO's technical collaboration in this important development was extended to prepare national cancer control plans in Bangladesh, the Democratic People's Republic of Korea, India, Indonesia, Mongolia, Myanmar, Sri Lanka and Thailand.

The important role that tobacco played as a cause of common cancers in the Region (oral, laryngeal and pulmonary) was well known, and WHO conducted regional meetings on controlling the use of tobacco in the late 1970s and early 1980s.

Promoting biomedical research

From 1959, a comprehensive health research programme under the Global Advisory Committee on Medical Research had been developed. WHO headquarters took the sole responsibility in the field of research, mainly in biology standards, microbiology,

immunology, cancer, communicable diseases and nutrition. Initially, the involvement of the regions was minimal.

Following demands from Member countries and intense discussions in the WHO governing bodies, the

World Health Assembly in 1974 and 1975 emphasized the need for involving and encouraging the regions to implement appropriate research programmes. The Regional Committee for South-East Asia discussed the matter in 1973 and 1974, and in 1975 endorsed the proposal for the establishment of the South-East Asia Advisory Committee on Medical Research (SEA-ACMR), authorizing at the same time adequate funding for research programmes. The members of the SEA-ACMR met twice in 1976 and subsequently met annually. The SEA-ACMR identified six priority areas for the health research: i) communicable diseases (covering six diseases), ii) nutrition, iii) control of human fertility, iv) environmental health, v) delivery of health services, and vi) others, based on national priorities.

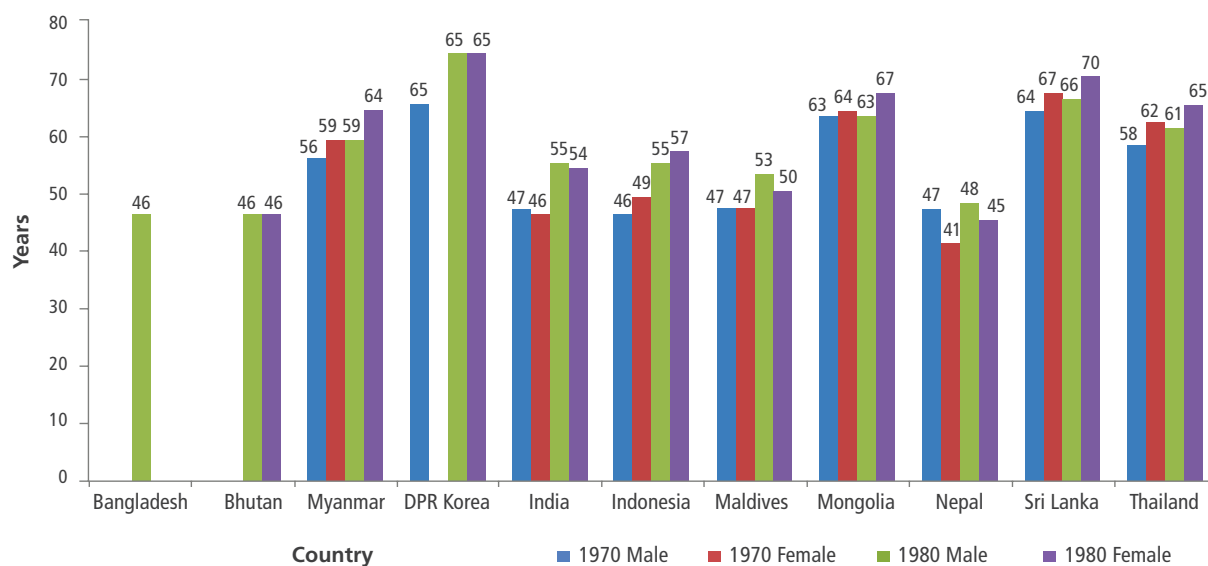
In developing the work of the SEA-ACMR, the Regional Office collaborated closely with the countries. The Regional Office supported the Indian Council of Medical Research in the evaluation of traditional medication in the treatment and management of rheumatoid arthritis, and the

Department of Medical Research in Myanmar in the production of plasma-derived hepatitis B vaccine, and collaborated with Mahidol University on the development of safe and effective individual dengue vaccines. The Regional Office also authorized research funds that were earmarked for countries on an annual basis. At its peak in 1988–1989, the research budget for the Region was US\$ 5.97 million.

Life expectancy at birth in all countries of the Region continued to increase during the decade. Only two countries – the Democratic People's Republic of Korea and Sri Lanka – had reached the level of life expectancy found in industrialized countries, i.e. more than 70 years (see Figure 5). These gains in longevity could be attributed to a number of factors, including improved education, socioeconomic conditions and lifestyle, as well as progress in health care.

Table 2 provides an analysis of the achievements of WHO in the Region made in the first 25 years of its existence.

Figure 5: Life Expectancy at Birth in countries of SEA Region, 1970–1980



Reference: World Health Organization. *Collaboration in Health Development in South-East Asia, 1948–1988*. WHO SEARO, December 1992



60th Anniversary embroidered wall hanging. Gifted by Myanmar

Table 2: Public health achievements during 25 years of WHO's existence in the Region

1947–1948	1973
Malaria was rampant. India alone had 75 million cases and perhaps 800 000 deaths a year. The situation was equally grim in other countries.	Malaria, although attempting to stage a comeback, was considerably reduced. In fact, from a total of 75 million cases in India in 1947 the number dropped to slightly more than 1 million; also, thanks to new antimalarial drugs, the disease is no longer a critical public health problem.
Plague and many other common communicable diseases were an ever-present menace. One of WHO's first activities was to help in the control of an outbreak of plague in Mysore state of India.	Plague no longer represented a health problem in the Region; though some foci still existed, only a few sporadic cases were reported from time to time.
Smallpox reigned unchecked, scarring, blinding and killing thousands.	The disease had been routed from most countries of the Region.
Another problem was yaws, which afflicted millions and millions of people and was particularly serious in Indonesia and Thailand.	Thanks to the vigorous action by governments and WHO, yaws was no longer a public health problem in our Region.
Maternal and child health programmes did not exist in a systematic way and were not integrated into general health services.	The Organization's interest in the health of mothers and children was extended and reinforced through the family health programme.
Unsanitary environment and lack of safe drinking water were persistent problems particularly dominant in rural areas.	The importance of safe community water supply was recognized and continued to be an important activity of the Regional Office.
Many countries were still attempting to deal with their health problems on a day-to-day basis, and there was a dearth of overall planning, often an absence of rational goals, and little attempt at improving training techniques. National health planning was not coherent and not based on health statistics.	WHO and the governments laid particular stress on the need for evolving well-planned national health schemes, which will integrate and improve the delivery of health services. A series of training courses on national health planning had been conducted, and there were national health planning units in various stages of development in every country of the Region.
Doctors and nurses were particularly scarce, and there were extremely limited facilities for training and preparing them.	The number of medical colleges and nursing schools in the Region had risen significantly. In 1972 there were 147 medical colleges as compared with 41 in 1948, and 250 schools and 16 colleges for nurses' training against 175 schools and 2 colleges in 1948. Although the nursing situation remained difficult, great strides were made over the past years. For example, India, Indonesia and Thailand have more than doubled the number of nurses and midwives since 1956, and increased efforts are being made to see that nurses play an important role in the health team.

Reference: World Health Organization. *Collaboration in Health Development in South-East Asia, 1948–1988*. WHO SEARO, December 1992

25 years of WHO in the South-East Asia Region

The 25th anniversary of WHO in the South-East Asia Region was celebrated on 18 September 1973 at World Health House, the Regional Office in New Delhi. Messages received from Heads of States or Heads of Governments of Member countries were read out. Messages were also received from representatives of the United Nations, the specialized agencies and intergovernmental organizations. Extracts from some of the messages are given below:

'I note with sincere appreciation that WHO has been rendering a great service to our war-ravaged country ever since her liberation following catastrophic human sufferings. With its commendable assistance and cooperation we have been able to combat and avert malnutrition, disease and death in epidemic proportions.'

(President of Bangladesh)

'The honourable but difficult task of the World Health Organization of promoting (the) health (of) mankind has been achieved with remarkable success, and the Regional Office's share in this undertaking has been no small contribution.'

(Prime Minister of Burma)

'Allow me to avail myself of this opportunity to extend my fervent greetings to the Regional Director and other staff members of the Regional Committee who have dedicated themselves for many years to the advancement of the work of WHO and especially the South-East Asia Regional Office ... and to the delegates of the Member States present here. Health service, therefore, is a sacred undertaking for everyone who strives for the happiness of the people and for their betterment. We think that, by accomplishing

successfully its noble mission, the World Health Organization should contribute actively to the protection and improvement of the health of the people.'

(The Government Representative of Democratic People's Republic of Korea)

'WHO is one of those international agencies which have rendered substantial help in the eradication of human suffering. It has scored successes in the field of global health in many countries, besides India. Committees like this enable countries which share similar problems to discuss ways and means for promoting common health programmes in the respective countries.'

(President of India)

'We, the people of Indonesia, have enjoyed the benefit of this world organization. In the span of a quarter of century of its existence the Organization has shown remarkable signs of progress. It has grown into an organization covering almost all countries in the world. 137 member countries reflect the true manifestation of the principle of 'universality of membership'. Another significant progress ... important and encouraging achievements in the field of health made possible under the coordination and guidance of this Organization.'

(President of the Republic of Indonesia)

'The invaluable benefits gained by mankind under the worldwide health programmes of the World Health Organization are too obvious to us all. The Administrators of this Specialized Agency of the United Nations, the consultants, experts and staff of this worthy Organization deserve to be congratulated individually and collectively for the tremendous efforts they have made ... in order to impart knowledge and techniques to safeguard mankind from the scourge of disease.'

(President of Maldives)

'I take this opportunity to express my Government's appreciation of the contribution being made by WHO ... to the development of Mongolia's public health services. I am confident that our cooperation and common endeavour will further yield fruitful results in the years to come.'

(Deputy Chairman of the Council of Ministers of the Mongolian People's Republic)

'WHO has been instrumental in strengthening the health services and promoting the health of the people by helping to control various communicable

diseases of the Region. I hope WHO will continue its relentless fight against various diseases to help attain "the highest possible level of health by all people".'

(Prime Minister of Nepal)

'Communicable diseases like malaria, tuberculosis and bowel diseases continue to remain in the forefront but I am happy to note that countries of this region have not suffered major outbreaks of diseases like smallpox or cholera during the last year. I can confidently presume that this situation is largely due to the valuable assistance and guidance given by the South-East Asia Regional Office towards disease control and prevention.'

(Prime Minister of Sri Lanka)

'I recall with happy memory of the remarkable achievements being attained by the WHO Regional Office for South-East Asia since its inception in this region. Through its dynamic actions and unfailing efforts, it has brought ease from suffering and brightened the peoples of South-East Asia with joy, of which I am hopeful that it will continue to progress and achieve by raising the levels of health and standard of living more and more all over the region.'

(Prime Minister of Thailand)

(Reference: 25th Anniversary of the WHO Regional Organization for South-East Asia, 1948–1973. A commemorative volume)





4

THE FOURTH DECADE
1978–1987

Primary health
care and Alma-Ata:
Landmarks of the
'New Vision'

MAJOR ACHIEVEMENTS IN THE FOURTH DECADE: 1978–1987



This decade was dominated by the rise of a new health philosophy and a new focus. The combination was called "Health for All by the Year 2000 through the primary health care approach". The idea was based on social relevance and social justice, and had been discussed, agreed upon and put on the national health tables. Health for All by the Year 2000 and the Alma-Ata Declaration on Primary Health Care were extraordinary milestones in world health, influencing thinking and development both in the health and also non-health sectors. They heralded the start of a new era in health.

"Health for All" provided the first overarching framework of goals

and targets for all aspects of health development. It was the Alma-Ata International Conference on Primary Health Care, held in September 1978 in the former Soviet Union, that broadened the concept of basic health services to encompass a philosophy which went beyond the provision of the first-contact health services. It identified the principles of the primary health care philosophy: equity, community involvement, appropriate technology and a multisectoral approach.

The emphasis of WHO's work in the Region was also put on health services management, e.g. planning, systematic implementation, monitoring and evaluation. The gains in universal immunization, which brought the Region closer

to the eradication of polio, were consolidated. At the same time, other new priorities began to loom large for WHO and the countries. Noncommunicable diseases had become an even bigger concern. The Region had always been particularly exposed to natural disasters, and during this decade, the regional and

national disaster preparedness and response programmes had to be systematized. In the area of disease control important events – such as the appearance in the Region of a new scourge, HIV/AIDS, the resurgence of yaws, and the revision of the malaria strategy – called for increased attention.



The challenge of health development

Today, we are in a very challenging phase of health development. The possibilities of change are open to all people but no standard method or prescription is applicable to them all. Human ingenuity knows no frontiers and thus, if the issues and problems can be analysed in relation to the strengths, it should be possible to assure equitable development within the bounds of a sound ecosystem

Dr U Ko Ko, Regional Director, 1981–1994

The Alma-Ata Declaration: Concept, principles and the role of the Region

Despite the collaborative efforts of countries and the cooperative leadership role that WHO played in the field of health and the two United Nations Development Decades, various limitations and shortcomings had been observed

in meeting the health needs of the people. The United Nations supported the concept of technical cooperation among developing countries, and Member States in the WHO Regions developed Charters for Health Development. These

Charters were conceived on the basic premise that there was an urgent need for mobilizing additional resources in order to accelerate the rate of health development to achieve an acceptable standard of health for all by the year 2000. The South-East Asia Charter for Health Development was endorsed by the Regional Committee in 1978.

Concurrent with these international developments, and recognizing the unsatisfactory health situation in most countries, WHO and UNICEF jointly conceived the idea of holding an International Conference on Primary Health Care. For about a decade, a preparatory commission had been stimulating the countries and begun preparing for the International Primary Health Care Conference. In order to alert their populations and prepare contributions for the international conference, individual countries organized specific activities related to it. These included mass meetings, national seminars, study projects and surveys, all reported to the Regional Committee. The South-East Asia Regional Primary Health Conference was held in November 1977 in New Delhi.

WHO and UNICEF sent joint observation teams on primary health care (PHC) to South-East Asia, and selected Chandigarh, Ludhiana and Varanasi in India and Dhaka and its neighbourhoods in Bangladesh for these visits. Another group visited Kerala and Tamil Nadu in South India to observe PHC activities in the area. The reports of those missions were approved in 1975 by the World Health Assembly and served as basic preliminary documents providing

WHO with a conceptual basis for health development.

The Report of the International Conference on Primary Health Care in 1978 and the ensuing Alma-Ata Declaration on Primary Health Care influenced the world, including the countries of South-East Asia, in their outlook on primary health care. This influence persisted well beyond 1980 and continues to be felt right into the 21st century. Delegations from all Member countries of the WHO South-East Asia Region participated at the Alma-Ata Conference.

The concept of primary health care was at first essentially an expansion of the ideas contained in the concept of basic health services. But it was the Alma-Ata Conference that broadened this concept to encompass a philosophy which went beyond the provision of first-contact health services. The principles of the PHC philosophy are: equity, community involvement, appropriate technology and a multisectoral approach. And the Alma-Ata Declaration had eight components, which were: i) education concerning the prevailing health problems and the methods of preventing and controlling them; ii) promotion of food supply and proper nutrition; iii) an adequate supply of safe water and basic sanitation; iv) maternal and child health care, including family planning; v) immunization against the major infectious diseases; vi) prevention and control of locally endemic diseases; vii) appropriate treatment of common diseases and injuries; and viii) provision of essential drugs.

Primary health care as defined in Alma-Ata Declaration

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral

part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health-care process.



Plenary session of the International Conference on Primary Health Care, 6–12 September 1978, at Alma-Ata (now Almaty) in the former Kazakh Soviet Socialist Republic (now Kazakhstan)

Applying the new concept

In 1981, the World Health Assembly adopted the Global Strategy for Achieving Health for All by the Year 2000, and later in the year, the UN General Assembly endorsed the strategy. It was an ambitious strategy signifying a new model of development, with progress in health promoting overall

socioeconomic development. For the first time, an attempt was made to develop a comprehensive set of goals and targets for health – a precursor of the goals found in the Millennium Development Goals and later the Sustainable Development Goals.

Associated with the overarching goal of Health for All (HFA) in the Region,



To observe the tenth anniversary of the Alma-Ata Conference, a global meeting – From Alma-Ata to the year 2000: A midpoint perspective – was convened at Riga, Latvia, in the former Soviet Union, on 22–25 March 1988. View of delegates at the meeting that was convened by WHO and UNICEF

and with a view to accelerate progress towards it, the Regional Committee urged the countries to initiate and pursue efforts for the development of a new cadre of HFA leadership. Such a group of leaders needed a clear understanding of the value system implicit in the strategy and principles of Health for All. This included an emphasis on, and commitment to, social equity and justice; a comprehension of the intersectoral nature of health development; and the willingness and capability to convert these factors into opportunities. Above all, the leaders needed to develop a capacity to motivate others to embrace the HFA philosophy.

The new concept of health development was firmly rooted in its social context. Health is a universal and fundamental human right, and its attainment is an essential social goal. The guiding principle of the new philosophy was to provide the greatest health benefit to the greatest number of people at the

lowest cost. The main social target of governments and WHO in the coming decades was the attainment by all citizens of the world, by the year 2000, a level of health that will permit them to lead a socially and economically productive life. All countries of the Region committed themselves at the highest levels to the attainment of the goal of HFA by 2000, with primary health care as the key approach. The countries also developed and implemented national strategies and plans of action for attaining the goal. Many of these activities were supported by WHO, both technically and financially. The countries themselves also came up with many innovative approaches.

Community participation as a cornerstone of PHC has a long history in countries of the Region. Even before the Alma-Ata Conference, the countries provided a number of examples of this approach. These included a project in Central Java in 1960,

which involved village committees, village insurance schemes, and the training of volunteers; the Jamkhed health project in India described in the previous chapter; the Sarvodaya Shramadana Movement, which started providing development and conflict resolution programmes to villages in Sri Lanka in 1972; the Lampang health project to expand health coverage among the rural population, particularly to women of childbearing age and preschool children, in Thailand in 1974; and a Ministry of Health scheme for community participation in Sri Lanka in 1975.

Most countries in the Region took to heart the Alma-Ata recommendation that “for many developing countries, the most

realistic solution for attaining total population coverage with essential health care is to employ community health workers who can be trained in a short time to perform a specific task”. They instituted programmes for the training of large numbers of community health workers selected from the community and by the community. There were success stories, as well as failures. However, the use of volunteers for strengthening community action for health in countries of the South-East Asia Region is a reality. It also forms one of the essential strategies in the efforts towards providing primary health care in a number of these countries. Of course, not all countries of the Region were at the same level in the extent of their use of volunteers.

Delivering maternal and child health services in Nepal

Most of the Nepalese population lived in rural and remote areas, far from any health service facility. Despite this, the Government succeeded in bringing maternal and child health services and information to every community in the country. Nepal has used its own resources to deliver services innovatively. The female community health volunteer (FCHV) programme covers all of the country’s 75 districts.

Initially, these 48 000 FCHVs selected from within the community provided health education to mothers, distributed family planning devices, and offered support during campaigns. Their role was then expanded to act as both service providers and health-care promoters. They diagnosed and treated pneumonia in children, diagnosed diarrhoea and provided ORS and zinc, supported immunization campaigns, created awareness about the importance of vitamin A in the community, and referred severe cases.

FCHVs are the key players in the expanded Community-Based Neonatal Care Programme. In addition, they also identified and registered pregnant women, promoted institutional delivery, attended home deliveries, provided services and counselling for immediate newborn care and essential newborn care, managed birth asphyxia, assessed and managed neonatal infections, managed hypothermia and low birth weight, made the four postnatal follow-up visits, and referred severe cases to health facilities. An increasing percentage of pneumonia cases have been treated since 1995. FCHVs were 98% accurate in their assessment of patients. Nationally, 88% of vitamin A and 82% of deworming services was provided by FCHVs.

Promoting district health systems and management

The 1986 evaluation of the national strategies for HFA in the WHO South-East Asia Region indicated that there had been impressive progress in some countries and in many there had also been an expansion of health infrastructure. This resulted in the countries facing formidable managerial and financial problems in trying to ensure the essential elements of primary health care.

The greatest obstacle to achieving HFA was considered to be the weakness in the planning, organization and management of health systems, particularly at the middle managerial level, which was identified as the district level. In 1987, the Regional Office initiated an intensification and targeting of national action programmes for primary health care, focusing on establishing manageable units in the countries. These units were geographical areas small enough to be able to manage health needs effectively and efficiently, yet large enough to make it feasible to include all the ingredients required for self-reliant health care.

These organizational units were called “districts”, but they had various local names in the countries (e.g. *thana* in Bangladesh, block in India, *kabupaten* in Indonesia, atoll

in Maldives, township in Myanmar, division in Sri Lanka, *tambon* in Thailand, and district in Bhutan, Democratic People’s Republic of Korea and Nepal).

The Regional Office worked to strengthen the district health systems in the countries. In the late 1980s, the emphasis shifted to the training of middle-level health managers. This step was relevant as a component of the decentralization of responsibility and authority. It took a longer time for policy changes and formalization of the roles and functions of middle-level managers (District Health Officers) in a decentralized district to happen.

In the late 1980s, responding to the criticism that primary health care was “second-class health care” and mainly for the poor, the Regional Office emphasized the development and organization of referral systems, and organized several regional meetings and funded research projects on various aspects of these systems, in Bangladesh, Bhutan, India, Mongolia and Sri Lanka. The results of the studies showed that the implementation of the referral system faced many difficulties, and that bypassing it was common. From the early 1980s, WHO supported studies on service coverage for urban dwellers and on reform in urban health service delivery. The results

of the studies conducted in India, Indonesia, Myanmar and Thailand were used in facing the challenges of the health consequences of rapid urbanization.

The issue of quality of health care had so far not been addressed by the

primary health care programmes. Since the early 1990s, the Regional Office had played an important role in this through advocacy and by providing technical and financial support to help countries build quality assurance activities into their health-care systems.

The first meeting of health ministers

During a meeting of the health ministers of the Member States of the Region on the sidelines of the World Health Assembly in 1980, it was suggested that a regular ministerial meeting of ministers be held in the Region to provide a forum for the exchange of information, experiences and views on the social, political and economic dimensions of health in the development process. The first Meeting of the Ministers of Health of the countries of the WHO South-East Asia Region was held

in Jakarta in September 1981. At that meeting, the Ministers agreed that steps should be taken to establish technical cooperation and collaboration among the countries of the Region. This was for countries to help each other in their efforts for health development. Since then, the Ministers of Health have been meeting regularly almost every year till 2015. In 2015 the format of this meeting was changed to a roundtable discussion of the ministers during the Regional Committee.

Consultative Committee for Programme Development and Management

Unlike many other multilateral organizations, the health planning and management programmes of WHO were prioritized and coordinated in collaboration with Member countries. To facilitate this, the Consultative Committee for Programme Development and Management was set up in 1981,

with representation of all Member countries. This was an important step, enabling all Member countries to study, analyse and evaluate WHO programmes.

Six countries of the Region had already adopted country health programming or a similar

methodology for health planning. This had led to the rationalization of national medium-term health plans in conformity with the needs of the people. In addition, Nepal and Indonesia developed long-term perspective plans for health. Myanmar developed not only a workable process for monitoring the People's Health Programme but also put in place a built-in

evaluation system. Bangladesh finalized a national health manpower development plan. Maldives attempted to involve island leaders in its efforts to assess the felt needs as an input to PHC planning. Thailand had already decentralized planning to the provincial and district levels. The Regional Office continued to support these national efforts.

The Safe Motherhood Initiative

The Safe Motherhood Initiative was formally launched in 1987 during the International Conference on Better Health for Women and Children through Family Planning. The Conference was organized to effectively address concerns about the continuing high level

of maternal deaths. A global goal had been agreed as a part of HFA to reduce maternal mortality and morbidity by at least 50% by 2000. Following the Conference, Member countries of the Region developed national action plans to promote safe motherhood.

Cross-sector public policies for women and children in Sri Lanka

Sri Lanka had achieved one of the lowest child mortality rates among lower-middle-income countries. The country had made continuous progress as a result of a combination of cross-sector public policies that ensured universal access to education for women, clean water and improved sanitation for the majority, and health system developments that guaranteed universal coverage of essential preventive and curative health interventions to all women and children. The coverage of deliveries by skilled personnel was 98%, and coverage with measles, diphtheria, pertussis and tetanus vaccines was 97%. The country had the highest rates for breastfeeding in the Region.

(A Decade of Public Health Achievements in WHO's South-East Asia Region 2004–2013. World Health Organization Regional Office for South-East Asia 2013)



Bridging the Straits. Depicts composite scenes from the Hindu epic Ramayana. Oil on canvas. 2.27 x 1.56 m. Gifted by Indonesia



The painting portrays the birth of the God Boma. Oil on canvas. 3.08 x 1.93 m. Gifted by Indonesia



Balinese cremation. Oil on canvas. Gifted by Indonesia

Progress in environmental health

At the Alma-Ata Conference on Primary Health Care, environmental health was recognized as an essential element. Another landmark in this area was the endorsement by WHO of the recommendations made by the UN Water Conference held in Mar del Plata, Argentina, in 1977. This conference gave priority to the provision of safe water supply and sanitation for all by the year 1990 and designated the decade 1981–1990 as the International Drinking Water Supply and Sanitation Decade. The main objective of the “Decade” was to stimulate and accelerate national water supply and sanitation programmes so that unserved populations in rural and urban areas had access to these facilities. This was of special relevance to the Region, where a significant proportion of illness was accounted for by waterborne and water-related diseases.

In 1981, the Regional Office for South-East Asia conducted a survey to provide baseline information on the water supply and sanitation sector of each country, which could later be used to monitor progress

at the end of the Decade. WHO identified six priority areas for Decade strategies and accordingly supported the activities of the countries in these areas: i) promotion of the Decade, ii) development of national institutions, iii) development of human resources, iv) information exchange and technology development, v) mobilization of financial resources, and vi) coordination with other agencies.

The mid-Decade review showed that Maldives, Nepal and Thailand were likely to achieve the urban sanitation targets, while Bangladesh and India had a very favourable chance in rural water supply, as did Indonesia and Thailand in rural sanitation. Bhutan, Indonesia and Myanmar were not likely to reach the revised urban water supply targets set for the Decade. The constraints that affected urban and rural water supply and sanitation were limited funds, operation and maintenance difficulties, lack of adequately trained personnel, poor logistic support and, above all, the tremendous and rapid increase in the urban population.

Reaching the community with human resources for health

To address the increasing shortages of trained health-care professionals and in line with the new HFA philosophy based on social relevance and social justice, WHO encouraged the countries to recruit community health workers (CHWs). This part of the health workforce was trained by, and worked in, the community from which the individuals came. Consequently, they were able to respond to local societal and cultural norms and customs.

Many CHW programmes were carried out in the Region in the 1980s as a part of wider health sector reform. The principal aim was to improve the accessibility and affordability of health services for rural and poor communities within the context of primary health care. For example, in Indonesia in 1982, during the restructuring of the health system with a focus on health development, village health volunteers (selected and paid for by the communities) became a part of the health posts in the districts. The dramatic increase in a number of health posts contributed to significant achievements – infant mortality decreased by 30% within seven years, and immunization coverage increased manifold.

In India, while some CHW projects have been successful, the national

CHW scheme in the late 1970s had collapsed in most States within a few years (owing to the community health workers' demand that they should be enrolled as government employees rather than be part-time volunteers supported by a small honorarium). Lessons learnt were that the CHWs must be continuously supported with strategies suitable for utilizing, sustaining and enabling them to work effectively to reduce the disease burden, bridge the gaps in the health workforce, and promote health.

A good example of focusing CHW work were the community activities of the traditional birth attendants (TBAs). In this decade, WHO (together with UNICEF and UNFPA) promoted the training of TBAs because most births took place outside health-care facilities. This was considered to be an important problem, and a major cause of the high infant mortality in the Region. When working under the supervision of and in conjunction with other levels of health care, TBAs were found to have an important role in improving birth services. In reviewing the role of medical doctors in the context of HFA, the Regional Committee in 1976 passed a resolution that doctors should be as close to the community as possible.

In the 1980s there was a movement for the reorientation of medical education to make it more responsive to social and community needs. The movement was promoted by WHO and was taken up by the countries in the Region. The Regional Office organized a series of consultations, with a focus on community orientation

and community-based education, problem-based learning, and responsiveness of medical education to societal needs. By the late 1990s, all Member countries with medical schools had either partially or completely reoriented their programmes. Nursing educators were simultaneously reorienting nursing education programmes.

Reaching out with technical programmes

As mentioned in the previous chapter, between 1974 and 1979 the Expanded Programme on Immunization (EPI) was adopted by all countries of the Region. EPI provided a blueprint of operations including training manuals, and was implemented by the health workers close to the communities. By implementing EPI, countries took a step forward in the battle against the diseases of children and their mothers, and brought other important technical programmes (such as CDD and ARI) within the reach of the communities, in an integrated manner.

A good example of WHO's technical programmes reaching the community was the establishment of a new programme on the control of diarrhoeal diseases (CDD) in 1979. The programme focused on the reduction of mortality and morbidity from diarrhoeal diseases and their effects, including malnutrition, in infants and children. Every effort

was made to ensure that the programme was within the reach of the community. The programme was soon able to report a dramatic fall in mortality thanks to improved management strategies.

Later, in 1984, the acute respiratory infections (ARI) programme was established. In 1990, this was merged with CDD. Innovative approaches such as the Integrated Management of Childhood Illness (IMCI) initiative were introduced in 1998. The focus of IMCI was the complex health needs of the child, including combined treatment for the major disorders such as malaria, pneumonia, measles and malnutrition as well as diarrhoeal diseases. In the 1980s, the Government of Bangladesh provided a one-year basic curative training course covering all these areas to some 16 000 village doctors.

An important step was taken in this decade to share scientific

information between Member States of the Region and also with those from other Regions. The Health Literature, Library and Information Services (HeLLIS) network was

formed in 1979. This helped to make better use of existing library resources in the countries of the Region, by sharing information and carrying out training activities.

Disaster preparedness and response

The countries of the Region cover a vast area with a wide variety of geoclimatic characteristics. As such, they are particularly susceptible to a wide range of different natural calamities. Cyclones, floods, earthquakes, volcanic eruptions, droughts and tidal waves are frequent occurrences in one country or another (Table 3). In addition, the countries faced complex emergencies that were entirely man-made.

During the decade, various types of disasters had hit the countries

of the Region. Cyclones were almost a yearly occurrence in Bangladesh, but unprecedented floods hit Bangladesh and parts of India in September 1988. A severe earthquake occurred in August 1988 in Northern India and Nepal. As for complex emergencies, Bangladesh, India, Myanmar and Sri Lanka had been experiencing conflicts and civil strife in some areas for some years.

The Regional Office established action programmes for disaster preparedness and response as a

Table 3: Disaster profile of selected countries of WHO South-East Asia Region, 1987

Type of emergency	Bangladesh	Bhutan	India	Indonesia	Myanmar	Nepal	Sri Lanka	Thailand
Flood	+	+	+	+	+	+	+	+
Tornado	+			+				
Cyclone	+		+		+	+	+	+
Tidal wave	+		+			+		
Earthquake	+		+	+		+		
Landslide		+	+	+	+	+		
Volcanic eruption				+				
Drought		+	+	+		+	+	
Industrial accidents			+	+		+	+	+
Complex emergencies	+		+	+	+	+	+	+

World Health Organization. Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992

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part of the global programme. The overall objective of the programme was to prevent health hazards, and reduce the adverse effects of disasters on health or health services by strengthening national capacities

for disaster preparedness and response. A survey conducted in 1986 on national disaster preparedness showed that there were formal structures or mechanisms in six countries of the Region.



The Regional Office established action programmes for disaster preparedness and response

Revisiting malaria control

The World Health Assembly (supported by the WHO Expert Committee on Malaria) in 1985 recommended that malaria control should be an integral part of the primary health care systems. Member countries in the Region gradually aligned their health delivery policies along the lines of the primary health care concept, and converted vertical malaria control programmes to horizontal programmes. WHO supported the

development of human resources and helped the countries through consultancies in reprogramming. It introduced malaria stratification for priority and selective interventions, and intensified the monitoring of resistance to insecticides and drugs.

The spread of drug-resistant malaria from the Region started threatening global health. In the renewed attack on malaria in the 1980s, interventions were highly

focused to reduce morbidity and prevent deaths, and protect the achievements gained during the eradication phase. The number of malaria cases annually was first reduced to 3 million. Cases stagnated around the 3 million mark between 1973 and 2001, and then further declined to about 2.5 million by 2005.

Surveillance during the post-resurgence period had either reduced or broken down entirely, leading to gross underreporting of cases. "Man-made malaria", which has been called the "curse of the tropics", was increasing in many places – in urban centres, industrial belts, development projects, irrigated tracts, and the like. Prevention required a health impact assessment as a part of environment impact assessment, which was rather limited in the Region.



WHO supported human resource training in malaria and TB control as an integral part of primary health care

Integrating the tuberculosis programme

Although infants and children were given the BCG vaccine as part of EPI, and national tuberculosis control programmes devoted considerable efforts to case-finding and treatment, their health impact did not match the efforts. Tuberculosis continued to be a serious health issue in

the Region. It was accepted by the countries that interrupting tuberculosis transmission and achieving a substantial reduction of morbidity and mortality would require the integration of the tuberculosis programmes into comprehensive health systems based on primary health care.

Recognizing viral hepatitis as a public health issue

Viral hepatitis infections have frequently been reported from the South-East Asia Region in an epidemic proportion. The high prevalence of hepatitis A is caused by faecal contamination of drinking water and food. The infection was reported from Bangladesh, Bhutan, India, Maldives, Myanmar and Nepal.

Furthermore, an estimated 14–16 million people in the Region were infected with hepatitis B virus, which is acquired from blood and body fluids of an infected person, usually through sex or sharing injection needles. It can also be passed on from a mother to her baby during delivery. It is important

to note that horizontal transmission occurs during close contact with an infected person, particularly in early childhood, and this causes the highest rates of hepatitis infection turning chronic. Besides producing a severe, and sometimes fatal, liver condition, hepatitis B infection is a major cause of liver cancer. The Democratic People's Republic of Korea, Indonesia and Myanmar began producing hepatitis B plasma-derived vaccine, and India and Thailand planned to produce a DNA recombinant hepatitis B vaccine. The vaccines against hepatitis were a powerful prevention tool to address the huge disease burden.

The resurgence of yaws

Yaws is caused by the spirochete bacterium *Treponema pallidum pertenue*, and affects the skin, bones and joints. Before the Second World War, mass campaigns were carried out in India, Indonesia and Sri Lanka for the control of syphilis and yaws, using arsenic and bismuth compounds for treatment. While the results in India and Indonesia were disappointing, the campaign in Sri Lanka was successful and, by 1940, yaws had ceased to exist in the country.

When penicillin was identified as a new, effective tool to control yaws,

WHO and UNICEF launched a global control programme in 1949. In the South-East Asia Region, programmes were launched in India, Indonesia and Thailand. These were successful and yaws was brought under control. In Indonesia, the prevalence decreased in Java and Bali and, by 1976, large areas of the country reported a rate of 0.001% or less. In India, by 1967, transmission of yaws had been almost interrupted in the four major endemic states. The programme was equally successful in Thailand.

Unfortunately, with “victory” in sight the campaigns lost their momentum. In Thailand, yaws control activities were integrated into general health services in 1967. In Indonesia, with the success of the programme, authorities began to consider yaws as a relatively low priority health problem, and there was a loss of interest in maintaining a sustained surveillance.

The results were predictable: by the early 1980s, the resurgence of

yaws had begun. In 1982, Indonesia reported a rise in the prevalence rate of 0.176% with more than 11 000 infectious cases. In India, a few cases were reported from the states of Orissa, Andhra Pradesh and Madhya Pradesh. In Thailand, sporadic cases were reported in 1970. Some cases were also reported from Sri Lanka in 1983. While it was technically feasible to interrupt the transmission of yaws, it was clear that an all-out effort for the eradication of the disease would be necessary.

Dengue research

Epidemiological studies on dengue and research in dengue vaccine development were initiated during the decade. In 1980, a WHO Collaborating Centre for Research in Dengue Vaccine Development was established at Mahidol University, Bangkok. WHO also supported the establishment of Aedes Research Unit in Thailand to study the bionomics of the *Aedes aegypti*

mosquito, the main vector of dengue fever. Support was also given for studies on *A. aegypti* in Indonesia. The WHO Collaborating Centre in Virology, in Pune in India, developed rapid diagnostic techniques. Epidemiological studies on dengue fever, dengue haemorrhagic fever and dengue shock syndrome were supported in Indonesia, Myanmar, Sri Lanka and Thailand.

The new scourge of HIV/AIDS

In 1981 the first case of acquired immune deficiency syndrome (AIDS) in the world was reported by the Centers for Disease Control in the United States of America. Although the disease had been circulating many years before, a man who had sex with men reported with Kaposi's sarcoma in San Francisco in 1980 and

was retroactively identified as the first case.

The causative agent, human immunodeficiency virus (HIV), was detected in 1983, and the first commercially available test to detect HIV antibodies became available in 1985. Other tests,

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such as the viral antigen assay, polymerase chain reaction and viral load measurement, became available later. It became evident from epidemiological studies that there were only three modes of transmission: i) sexual (homosexual and heterosexual), ii) transmission through infected blood and blood products and infected injecting equipment, and iii) mother-to-child transmission.

HIV was first detected in the South-East Asia Region in Thailand in 1984. Early cases in this country were generally confined to men having sex with men until 1987 when an explosive outbreak occurred in Bangkok among injecting drug users (IDUs). HIV prevalence among IDUs dramatically increased from 1% to 40% between November 1987 and August 1988. This was followed by an outbreak among female sex

workers, which subsequently spread to their contacts, and then to the spouses of contacts and finally to their children. HIV prevalence among sex workers in Chiang Rai province increased from 1% to 37% in a short span of time. By 1993, 12% of young military recruits based in northern Thailand were found to be HIV-positive. By 1996, HIV prevalence was 7.1% among pregnant women in Chiang Rai.

Similar patterns and trends were observed in India. The first cases were reported among female sex workers in 1986 in Chennai. The infection spread mostly through heterosexual transmission in the country, the six northern states being the most affected. There were outbreaks of HIV among IDUs as well in some areas. For example, HIV prevalence among IDUs in Manipur increased from 1% in 1988 to 56% in 1995.



Raising awareness about HIV/AIDS has been an important part of the control programme

There had been outbreaks of HIV in other SEA Region countries too, although on a smaller scale. In Myanmar, HIV prevalence among IDUs increased from 17% in 1989 to 59% in 1990. In Indonesia, HIV prevalence among IDUs was nearly 50% in 2001. In Nepal, the first case of HIV was reported in 1988. Since then, the infection spread gradually, mainly among female sex workers and IDUs. HIV prevalence among female sex workers increased from 0.7% in 1992 to 15.7% in 2001 and it was as high as 68% among IDUs in Kathmandu. In Sri Lanka, the first case was reported in a foreigner in 1986 and the first indigenous transmission was recorded in 1989. Despite the presence of vulnerability factors, HIV prevalence remained at a low level in Sri Lanka mainly thanks to a strong health infrastructure and better access to health services, high level of education, the high social status

of women and effective control measures for sexually transmitted infections.

The Special Programme on AIDS, later renamed the Global Programme on AIDS, was officially established in WHO in 1987. An HIV/AIDS unit was also established in the Regional Office. Since HIV is a cross-cutting public health problem, the Regional Office took an integrated approach. Even before the HIV infection reached an epidemic level in the Region, the Regional Office assisted all countries in a quick assessment of the epidemiological situation and in preparing short-term plans covering one year. This was followed by medium-term plans of three to five years and later by strategic plans covering five years. WHO support in the Region focused on interventions aimed at both prevention and care.

The looming threat of NCDs

During this decade, the public health importance of noncommunicable diseases (NCDs) was on rise in most countries. WHO's attention focused on the control of cardiovascular diseases, diabetes mellitus, the prevention of visual impairment and blindness, and accident prevention.

The Regional Office encouraged the countries to develop improved methods and strategies for preventing cardiovascular diseases,

and to assess the extent of the problem in their populations. Community-based, comprehensive cardiovascular disease control programmes were initiated in Member countries, based on primordial prevention – avoiding the development of lifestyle-related risk factors. WHO led educational campaigns on “smoking and health” and advocated physical exercise, balanced nutrition and the avoidance of stress.

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There was a severe paucity of reliable statistical data related to the occurrence of diabetes mellitus in most countries. The Regional Office supported an integrated approach on the prevention and control of NCDs including diabetes. The Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM) was appointed a WHO collaborating centre for the community control of diabetes mellitus. BIRDEM engaged in research and in community-oriented diabetes control activities based on the primary health care approach, and conducted appropriate training courses.

In the early 1970s, there occurred a change in the approach to the problem of blindness. It was recognized that most of the world's blindness was preventable and much of it was curable. In 1972, WHO intensified its technical assistance to national programmes for the prevention of visual impairment and blindness. It provided assistance in organizing manpower training and establishing community-oriented ophthalmic services. The regional strategies for the prevention of blindness included a crash programme to deal with the large backlog of curable blindness cases through eye camps and mobile ophthalmic units, establishing



Member countries were encouraged to develop improved methods and strategies for preventing cardiovascular diseases

or strengthening a permanent infrastructure for eye health care and its extension to rural areas through primary health care, and emergency measures to deal with xerophthalmia with massive doses of vitamin A. These strategies were strengthened during the fourth decade.

Road traffic accidents were on the rise. Rapid urbanization, industrial expansion, and an unprecedented increase in the number of vehicles coupled with high traffic congestion, poor road conditions

and inadequate enforcement of traffic rules led to an increased rate of road accidents. Industrial accidents also increased as a consequence of the lack of proper safety in industrialization and mechanization of labour. WHO's technical collaboration was directed to creating national awareness on the rising morbidity and mortality resulting from road accidents. WHO also promoted the formulation of national policies and encouraged epidemiological and operational research for the prevention and control of accidents.



The Goa Room, gifted by the Government of Portugal, when it was an Associate Member of the Region (representing its holdings in Goa, Daman and Diu in India). Blue ceramic tiles panel two walls of the room. One wall shows the Torre de Belem (Tower of Belem), the first thing Portuguese mariners saw as their ships returned to the homeland from mercantile voyages across the globe. The tiles on the second wall depict Portuguese mariners and missionaries installing the sceptre of Christ at the mouth of the Zaire river as they found another new settlement on the African continent in the late 16th century

The health situation in the South-East Asia Region in 1988

Socioeconomic sector: South-East Asia was the most diverse and populous region, with about a quarter of the world's population. The States played a leading role in regulating development processes and were responsible for supporting key development programmes, including health.

Urban-rural population: The urban population constituted 21.5% of the total population.

Development of the health system: All countries of the Region adopted the goal of Health for All (HFA) by the Year 2000, using primary health care as the key approach, and recognized that health policy should be integrated into the overall national development policy.

Health workforce: Efforts were being made in all Member countries to reorient health workers to primary health care. However, the countries were not able to balance their distribution, especially with regard to professional health personnel. The ineffective utilization and low productivity of health workers caused persistent concern. Professional health

personnel had not yet fully understood primary health care; in some cases, this lack of understanding created resistance to change.

Intercountry cooperation: All countries were committed to the principle and practice of intercountry cooperation. The Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) were important regional mechanisms for such cooperation.

Health status: Only four countries reported infant mortality rates of below 50 per 1000 live births, which was stipulated as the target in the HFA goal. Three countries reported rates between 50 and 100, and four had more than 100 per 1000 live births. Two countries reported life expectancy at birth of between 40 and 50 years, four countries between 50 and 60 years, and another five countries between 60 and 70 years or more. Malnutrition and nutritional deficiency disorders, vector-borne diseases, waterborne parasitic and diarrhoeal diseases, tuberculosis, pertussis, tetanus, diphtheria and

leprosy were all major causes of morbidity in the Region. Cancer, cardiovascular disease and other noncommunicable diseases had more recently become major public health problems, particularly in countries with higher life expectancies. The South-East Asia Region accounted for about half of the total world incidence of positive malaria cases. Decreases in incidence were noted in some areas of Bangladesh, Indonesia and Maldives. In India, the incidence did not record any change, and increasing trends were observed in Bhutan, Nepal, Myanmar, Sri Lanka and Thailand. Leprosy was an important public health problem in eight countries: of the 11 million leprosy patients in the world at the time, 5.3 million (48%) were from South-East Asia. The estimated prevalence rate in the Region was 5.12 per 1000 population. The average incidence of tuberculosis in the Region was estimated at 100 per 1000 population. Acute respiratory infections were major factors contributing to the mortality

of children under the age of 5 years, with case-fatality rates in hospitalized children ranging from 4.2% in Thailand to 17.6% in Bangladesh. In two countries of the Region, all infants were fully immunized against the six EPI target diseases.

In conclusion, with a life expectancy at birth just exceeding 70 in the Democratic People's Republic of Korea, the two major causes of deaths in the country were cardiovascular diseases and cancer. In the remaining countries, excessive mortality and morbidity still prevailed among children and women. The majority of the population was still exposed to high risks of infectious and parasitic diseases, often related to inadequate access to clean water and environmental sanitation. In addition, they were subject to several nutritional deficiency disorders. Indirect health indicators showed inadequate utilization of health services and poor access to safe water supply and sanitation, in particular among the rural populations.

(World Health Organization. Collaboration in Health Development in South-East Asia, 1948–1988. WHO SEARO, December 1992)





5

THE FIFTH DECADE

1988–1997

Targeting disease
elimination,
strengthening
partnerships

MAJOR ACHIEVEMENTS IN THE FIFTH DECADE: 1988–1997



During the 1990s, a number of international conferences were held supporting the goal of Health for All. Many others followed at the beginning of the 21st century. These developments created a strong interest, encouraged commitments and broadened the number of partners in health, both within and outside the United Nations system. This led to a new and complex relationship among traditional and new players and national authorities in international health, and

consequently a changing role for WHO as the leading technical agency in health.

During this decade, there was a recrudescence of certain diseases. These included malaria, tuberculosis, cholera and visceral leishmaniasis. The re-emergence of diseases such as human plague, the genesis of a new HIV/AIDS epidemic, and the rise as a public health problem of noncommunicable diseases with all their risk factors were causes of concern and reasons to prioritize action.



The need for partnerships

If we are serious about meeting the health challenges of our Region, we cannot rely on our own efforts. We need to work together with others, we need to form alliances and partnerships – partnerships for health! Partnerships for health mean bringing together all those involved in improving the health and quality of life of people

Dr Uton Muchtar Rafei,
Regional Director 1994–2004

Emphasizing partnerships and All-for-Health policies

Between 1990 and 1996, nine international conferences were held supporting Health for All. These conferences included the United Nations World Summit for Children (New York, 1990), the International Conference on Nutrition (Rome, 1992), the UN Conference on Environment

and Development (Rio de Janeiro, 1992, also known as the Rio Earth Summit), the International Conference on Population and Development (Cairo, 1994), and the Fourth Conference on Women (Beijing, 1995). Other notable conferences followed, including

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the UN Millennium Summit (2000), the UNGA Special Session on Children (2002) and the Second Earth Summit (2002). These developments created a stronger interest in and commitment to health among the United Nations and other agencies, government aid authorities, professional organizations, international nongovernmental organizations and philanthropists.

WHO was, and remains, the lead technical organization with responsibilities for health, but there were then altogether 13 UN organizations that were involved in health-related work. In addition, many UN agencies including UNDP, the World Bank, and the Asian Development Bank were extending their interest from socioeconomic development to health sector. The UN established UNAIDS, replacing WHO's Global Programme on AIDS, which was terminated in 1995. The UN also supported, with great ambition and massive resource mobilization, the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2002.



Mask with five small skulls on the crown.
Gifted by Bhutan

In addition, there were many powerful, government-backed donor agencies such as the Australian Agency for International Development (AusAID until 2013), the British Department for International Development (DFID), the Canadian International Development Agency (CIDA until 2013), the Finnish International Development Agency (FINNIDA), the Japan International Cooperation Agency (JICA), the Norwegian Agency for Development Cooperation (NORAD), the Swedish International Development Cooperation Agency (SIDA) and the United States Agency for International Development (USAID).

International nongovernmental organizations were also showing a greater interest in the health sector. During this decade, many new partners in health appeared on the horizon every year, in addition to gigantic private philanthropic organizations such as the Bill and Melinda Gates Foundation, the Carter Centre, the Clinton Foundation, and the Hewlett Packard Foundation.

Today, more than 60 international NGOs exist in the health sector, some of the most prominent being Cooperative for Assistance and Relief Everywhere (CARE, before 1993 the Cooperative for American Remittances to Europe), Médecins Sans Frontières (MSF), Population Services International (PSI), Save the Children and World Vision.

The decade witnessed an acceleration in the process of forming partnerships targeting a single disease or groups of diseases such as polio, measles,

tuberculosis and filariasis. Beginning in 1972 with the launch of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), by the end of the decade WHO was engaged in more than 70 global partnerships for health. As time went on, there was hardly an area of work in WHO where global partnerships did not feature, both as fund-raising devices and as mechanisms for the delivery of health programmes. This rise in global partnerships for health was driven by economic factors and the realization that health development is a process based on interdependence among numerous actors.

These factors led to a new and complex relationship among the traditional and new players and national authorities in international health. The planning, management and utilization of resources became increasingly complex, and there was a pressing need for delineation and harmonization of responsibilities. In a way, however, these developments were encouraging, as they came with greater expectations for support and collaboration with national authorities. However, the Member countries were also realizing that each of them was required to improve its planning and managing capability in order to handle these new complex developments effectively and to meet their national needs.

A major initiative was undertaken in 1997 to strengthen WHO's partnership with the Association

of Southeast Asian Nations (ASEAN) with the signing of a memorandum of understanding between ASEAN and the WHO Regional Offices for South-East Asia and the Western Pacific. A similar memorandum of understanding between WHO and the South Asian Association for Regional Cooperation (SAARC) was also signed.

The first International Conference of Medical Parliamentarians was held in 1994 in Bangkok. It was organized by the Asian Forum of Parliamentarians on Population Development in collaboration with WHO and the International Medical Parliamentarians Organization (IMPO). It recommended advocacy to place health development – particularly the health of women, the poor and the disadvantaged groups – very high on the political and developmental agendas of the nations of the Region. The Bangkok Declaration and Call for Action marked a watershed in WHO's efforts towards advocacy for health and in forging new partnerships for health development. In 1997, WHO and IMPO organized another Conference of Parliamentarians on Women, Health and Environment. The conference proposed a series of actions, including strong advocacy to create conditions where women could be empowered to live and work in an environment of equity and social justice.

The historic Declaration on Health Development in the South-East Asia Region in the 21st Century, adopted by Health Ministers of the Region in 1997, affirmed, among others, the countries' commitment to ensure access to health care for all.

Preamble to the Declaration on Health Development, Bangkok, 1997

‘We, the Member States of the South-East Asia Region of WHO, take note of the developments in our Region since the social goal of “Health for All”, with primary health care as the key approach, was first adopted by the Member States of WHO two decades ago. Envisaging the scenarios as we move into the next century, recognizing the challenges that lie ahead, as well as the aspirations of our people, we now state our deepest concerns and unstinting commitment in this Declaration on Health Development in our Region. We affirm our unwavering commitment to ensure access to health care to all. Guided by strong political will, we pledge to take action and responsibility to ensure Health for All by mobilizing All for Health. Through collective leadership, we resolve to strengthen the character of the health sector, and to enhance national capacity and regional solidarity to further this aim. We declare that we will make relentless efforts to realize our peoples’ aspirations.’

Leading health promotion into the 21st century

Another important event related to partnerships and the determinants of health and their role for the 21st century was the Fourth International Conference on Health Promotion: New Players for a New Era – Leading Health Promotion into the 21st century. The Conference was held in Jakarta in July 1997. It was the first such conference held in a developing country, and the first to involve the private sector in supporting health promotion. It provided an opportunity to reflect on what has been learned about effective health promotion, to re-examine the determinants of health, and to identify the directions and strategies

that must be adopted to address the challenges of promoting health in the 21st century. The Conference adopted “the Jakarta Declaration on Leading Health Promotion into the 21st century”. The Declaration included the following priorities for health promotion in the 21st century:

- promote social responsibility for health,
- increase investments for health development,
- consolidate and expand partnerships for health,

- increase community capacity and empower the individual, and
- secure an infrastructure for health promotion.

The participants also endorsed the formation of a global health promotion alliance to advance the priorities for action in health promotion that were set out in the Declaration.

The role of the government health sector in meeting the new situations arising out of enlightenment and conscientiousness will also become more relevant. Health structures as such may not change significantly but strategies and approaches will. This will help to bring health closer to the people through greater decentralization, viable district health system and, most importantly, a willingness and motivation to work with sectors in addition to health to create supportive conditions for health

Dr Uton Muchtar Rafei

Partnerships: A New Health Vision. WHO, New Delhi, 1997

Implementing the DOTS strategy

During this decade DOTS was adopted by all Member countries in the Region for the management of tuberculosis cases. This was an important step forward, because tuberculosis is curable and DOTS was proven to be the most successful and cost-effective treatment strategy. The objectives of the DOTS strategy were to decrease the risk of infection, reduce morbidity and transmission of infection,

and prevent tuberculosis deaths. Achieving these objectives through the DOTS strategy was simple. It envisaged the following:

- Identify tuberculosis cases in communities around the world, particularly those in developing countries.
- Treat tuberculosis cases by directly observing their medication intake for six to

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eight months. This was to ensure that medication was taken in the right combination and appropriate dosage in an effort to prevent the development of multidrug-resistant tuberculosis (MDR-TB).

The tuberculosis patient is almost always cured if the medicines are taken regularly for the entire length of treatment. DOTS was accepted by all countries of the Region, although coverage in some countries needed to be urgently expanded. DOTS required political commitment and adequate resources allocated to tuberculosis control programmes. It was observed that persons who

were infected with both tuberculosis and HIV were at higher risk of developing active tuberculosis. HIV compromised a person's immune system, and accelerated the time between tuberculosis infection and the onset of the illness. An increase of HIV-associated tuberculosis had been observed in some countries. The HIV epidemic and the spread of MDR-TB were threatening to reverse the gains of TB control with DOTS. The revised new Stop TB Strategy addressed these new threats. The need to act with functional integration between the tuberculosis and HIV/AIDS programmes and to address the issue of MDR-TB had been recognized.



DOTS was adopted by all Member countries in the Region during this decade for the management of tuberculosis



Monitoring the coverage of tuberculosis control activities is an important part of successful TB control programmes

A new concept of reproductive health

A new concept of reproductive health emerged from the maternal and child health and family planning programmes. This new concept had been evolving during the decade, and essentially saw reproductive health holistically as a continuum that starts before birth, and progresses through childhood and adolescence to adulthood and old age. WHO's definition of reproductive health was "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive

system and to its functions and processes (1994)".

Over the preceding decade there had been a marked improvement in child survival and a significant reduction in infant mortality in all countries but similar achievements had not been observed in maternal health. Maternal morbidity and mortality was still high in all countries except in Sri Lanka. Since 1994, Member countries started developing strategies and plans of action for promoting reproductive health.

Myanmar's experience with DOTS

Myanmar adopted WHO's DOTS strategy in 1997 to cope with the tuberculosis epidemic. Donation of TB medicine by the Global Drug Facility began in 2001 and contributed to nationwide coverage of DOTS at the township level in November 2003. DOTS strategy was further expanded to the community level since then to increase access to TB treatment very rapidly. From 1998 to 2007, the number of TB cases notified increased from 14 756 to 133 547. Treatment success rate improved gradually from 82% in the late 1990s to achieve the international target of 85% at that time in the 2007 cohort.

Intersectoral collaboration, both public and private, has been piloted since 2004 but needed to be scaled up to make a significant impact on case detection and treatment success at the national level. A few TB patients who received TB treatment by the National Tuberculosis Programme (NTP) around 2005 were interviewed anonymously. Their treatment records were not

preserved and the interviews were based on what they could recall. Most of them recalled the difficulties in travelling to hospital every month for diagnosis and treatment, and the importance of having a good rapport with their doctors.

Three retired doctors who had worked for the NTP since 1980 and were involved in the introduction and expansion of DOTS in the late 1990s shared their experiences. They were Dr Win Maung, who joined the NTP in 1983 and retired as Director of Disease Control in 2013; Dr Tin Mi Mi Khaing, who was posted in Shan and Kayah states in 1998–2008 and retired as Director in 2017; and Dr Myo Zaw, who retired as Regional TB Officer for Yangon in 2008.

More than half of all townships in Myanmar began to provide DOTS in the introduction phase since 1997. Short course chemotherapy (SCC) could be applied only in DOTS townships. TB treatment in other townships relied on the injection of streptomycin and



isoniazid. Patients who lived in non-DOTS townships needed to travel to DOTS townships when they sought quality medicine and had to stay there to finish the full course of treatment. A patient from Mong Tong in a mountainous area of Eastern Shan state was airlifted to the Taunggyi DOTS centre to receive proper TB treatment since there were no means of safe road transport in that area at that time. This patient had to stay in Taunggyi to complete the course, which was financially very difficult for him and his family.

When DOTS was expanded to the whole country, TB patients became treated at their own place of residence. This saved both direct and indirect costs. In addition, it improved adherence to TB medication, with patients receiving continuous support from their families. Monitoring the adverse effects of drugs became easier, and this improved treatment outcomes and reduced the number of those who stopped getting treatment midway. DOTS helped cut the chain of TB transmission in the community and prevented drug-resistant TB. The single oral dose medication also facilitated adherence to treatment regimens. The basic health worker was trained and assigned as DOTS provider. They monitored the side-effects of anti-TB drugs and performed contact tracing that helped locate more cases. Community and family awareness about TB was promoted through peer group education.

Some DOT providers were members of nongovernmental organizations such as the Myanmar Red Cross Society and the Myanmar Maternal and Child Welfare Association. There was greater community participation and mobilization. 'DOT supervisors' were assigned to townships, and they helped ensure the smooth functioning of DOT providers and regular supply of medication. Competent volunteers helped in early case detection. With patients introduced to treatment in the early stages the spread of infection in the community was halted. An international technical mission assessed the DOT activity in the field with great appreciation. A DOT provider was asked if he was afraid of getting infected in the course of his work. The DOT provider replied: 'I knew how TB spread and how it can be prevented ... and I was not afraid of TB.'

Several activities were rapidly implemented by the national programme and partners till the middle of the first decade of the 21st century. However, sustainability of DOTS became an issue when the Global Fund announced termination of funding in 2006. There was a decline in case notification from 2008. The National TB Prevalence Survey 2009–2010 identified a larger TB burden than had been estimated previously. Myanmar had to wait till 2011–2012 to once again strengthen DOTS through community-based TB care, and disseminating essential components of Stop TB strategy that included MDR-TB and TB/HIV care.

The story of the ‘Doctor Mother’:

The work of Tulasi Sharma, female community health volunteer, Surkhet, Nepal

Dr Kiran Banstola, Emergency Programme Field Officer, Nepal Health Emergency Operation Centre, Surkhet, speaks about the work of Tulasi Sharma

Who is ‘Doctor Mother’?

Lovingly referred to as ‘Doctor Mother’ by her community, Tulasi Sharma found life rewarding as a female community health volunteer (FCHV). Tulasi was a permanent resident of Gurdakot municipality in Mehelkuna, and had engaged in volunteer service since 1991. She had been formally serving as an FCHV since 1997.

Learning never stopped for Tulasi. She took the 15-day FCHV training, training on acute respiratory infections/pneumonia, and even on mental health issues. An active participant of various health-related orientation programmes, workshops and review sessions, she also trained herself on reproductive health and implemented her learning in her practice.

Her motivation was her desire to serve other people, and she appreciated being acknowledged for her services by her community. She speaks with pride when she says that it was her example and her profession that encouraged her granddaughter to pursue a medical degree.

During a period when her country suffered from civil strife, Tulasi was at some point abducted by one of the warring parties. But her evident drive to help people, and her motivation to support the marginalized women and children, convinced her captors to release her after just one day of captivity. She went straight back to helping those most in need.



The FCHV for better health

Tulasi considers waterborne disease, jaundice, and cholera as the main health problems in her locality. She remembers the cholera epidemic in 2010 in which 67 people in a single neighbourhood caught the disease as a result of water contamination. Tulasi and her team supported the local health authorities, and together they contained the spread with zero mortality. Later, she imparted health education on the implications of drinking purified water, and raised awareness to ensure that cholera would not return.

She notes the tremendous improvement in health services and in the health status of people in her community in recent years. 'These days, most women deliver in hospital. The result is that very few women lose their babies in childbirth,' she says happily. In recent years people are also more aware and cautious about eating a balanced diet, adopting healthier feeding habits, going for health check-ups, getting their children vaccinated at the right time, delivering babies in hospital, and attending regular follow-up health checks, all of which have made dramatic improvements in the health status of the community.

Tulasi has noted a decrease in immunization coverage in the community, which she thinks is due to short-term labour migration. She also finds that more people are suffering nowadays from high blood pressure, asthma, and cancer. But overall, she credits the improvement in the services provided by the FCHVs as being instrumental in bringing about the many positive changes.



On improving the FCHV workforce

Improving FCHV mobilization is actually improving better health service delivery. FCHVs receive a very small allowance to cover their expenses, but as prices go up, she hopes that the FCHV allowance will soon be increased. Moreover, she asks all stakeholders to work closely together so that the gains that Nepal has made with the help of the FCHVs are not lost. It would help, she says, if the FCHVs are given more recognition, and some rewards, for their contribution to health throughout the country. Most FCHVs, like Tulasi, find their motivation in contributing to the betterment of the community, but suggest some formal recognition would help.

Responding systematically to 'ageing and health'



In 1995, WHO restructured its programme on "Health of the Elderly", renaming it "Ageing and Health". This area of health care is becoming a dominant concern for the near future owing to rapid demographic changes and increased life expectancies in the Member countries. There was a need to have a systematic and concerted response from society to the needs of ageing. The main perspectives that guide programme activities in this area were as follows:

- approaching ageing as a part of the life-cycle rather than compartmentalizing the health care of the elderly;
- promoting long-term health – increasing awareness of the need to focus on the process of healthy ageing;
- observing cultural influences;
- adopting community-oriented approaches;
- recognizing gender differences; and
- strengthening inter-generational links.

There was a need for a systematic and concerted response of society to rapid demographic changes

Reducing the major nutritional disorders

After the Alma-Ata International Conference on Primary Health Care the prevailing vertical approaches in nutrition programmes had changed. The integration of nutrition into community-oriented health services was emphasized. In particular, national nutrition programmes were now aimed at vulnerable groups such as children, and pregnant and lactating mothers.

WHO provided support to health workforce training. The four major nutritional problems of public health importance in the Region were addressed, namely protein-energy malnutrition, iron deficiency anaemia, vitamin A deficiency and iodine-deficiency disorders. There was evidence of a reduction in protein-energy malnutrition in India, Indonesia, Myanmar and Thailand, and there had been an impact on iodine-deficiency disorders with continuing improvement in most countries and Bhutan and Thailand in particular.

There was another positive impact throughout the Region regarding vitamin A-related childhood deficiency blindness. However, there was no documented improvement with iron deficiency. Owing to lack of awareness this had not received the necessary attention. There was also a high prevalence of iodine deficiency disorders in the Member countries. These disorders included enlargement of the thyroid glands, stillbirths,

abortions, congenital anomalies, endemic cretinism characterised by mental deficiency, deaf mutism and spastic diplegia.

In 1989, the Regional Committee called for the intensification of measures to control iodine-deficiency disorders, including goitre, in view of their high incidence. The World Health Assembly, in 1990, declared a target of eliminating iodine deficiency disorders as a major public health problem in all countries by 2000. In addition to the universal iodization of common salt, the iodization of drinking water and oral administration of iodized oil were the measures adopted by the countries.



Measuring growth: the integration of nutrition into community health services was emphasized

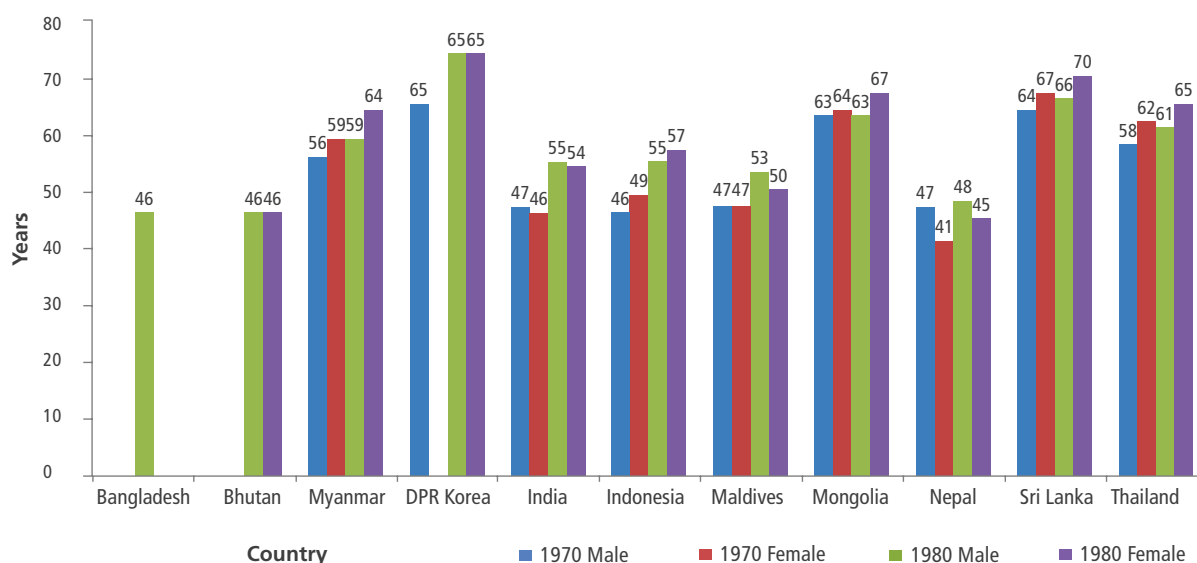
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Cases of vitamin A-related childhood deficiency blindness decreased in the Region

Thus, the nutritional problems that affected millions of people in this Region were controlled and overcome by procedures that were within the economic reach of the countries. The successful control of these nutritional deficiency diseases by the early 1990s must indeed rank as a major achievement. Increased awareness of the nature of these nutritional problems, better health care, and more judicious use of local food resources helped in successfully overcoming these formidable malnutrition challenges. With the control of nutritional deficiency diseases in children, there was a significant reduction in mortality of children aged under 5 years (Figure 6).

Figure 6: Life expectancy at birth in countries of SEA Region, 1970–1980



Reference: World Health Organization. *Collaboration in Health Development in South-East Asia, 1948–1988*. WHO SEARO, December 1992

Universal access to essential drugs

One of the eight elements of primary health care defined in the Alma-Ata Declaration was the provision of essential drugs. WHO published a model list of essential drugs in 1977, as guidance for countries to serve in developing their own lists based on local conditions (such as demographic factors, disease incidence and prevalence, treatment facilities, health personnel, and financial resources). During this decade, countries of the Region established their national essential drug lists and also developed mechanisms for updating them. This was to ensure an adequate supply of essential drugs for PHC, and to strengthen the distribution systems in countries so that these drugs were available at health posts and at the first referral level. Some countries had also set up facilities for the production

of essential drugs and introduced the concept of good manufacturing practices (GMP).

In 1997, the accessibility of essential drugs (of good quality, safety and efficacy), especially at the PHC level, was still a challenge in all countries of the Region. Essential drugs were acquired either from mostly public funding or from private funding – different countries had varying proportions of the two systems working in combination. Based on a newly formed WHO-SEARO Working Group on Drug Financing, universal access to essential drugs at prices people could afford had become a priority in the Region. The Working Group also recommended that national and local drug financing schemes should be strengthened to ensure equity and access to essential drugs, and the situation started to improve.

New challenges in environmental health: Impact of urbanization

The first International Water Supply and Sanitation Decade was observed in 1981–1990. The achievements were reviewed and monitoring of progress continued. The Regional Office supported resource mobilization efforts towards accelerating coverage. Water quality surveillance and improvements in management were given

greater emphasis. Hospital waste management practices in Member countries were strengthened. Action programmes addressing food safety were identified. A framework for controlling environmental health hazards was developed and a regional strategy for health and environment drafted.

A programme on the safety and control of toxic chemicals and hazardous waste was implemented in India, Indonesia, Myanmar, Sri Lanka and Thailand. Poison control centres were established in Bangladesh, India, Indonesia, Sri Lanka and Thailand. “Healthy City” projects were initiated in Bangladesh, Nepal and Thailand.

There had been a substantial increase in urbanization in all countries of the Region. While less than 19% of the population lived in urban areas in 1970, by 1995 this proportion had increased to 27% (and is expected to reach

43% by 2020 when there will be 867 million urban citizens in the Region). This rapid urbanization has been causing many health problems associated with overcrowding, inadequate water and sanitation facilities, proliferation of slums, drug abuse and environmental pollution. Since the early 1980s, the Regional Office for South-East Asia has been addressing this issue by strengthening collaboration within the health sector and among other sectors, reorienting health services and health staff to meet a wide range of urban health problems, and involving the community in the solution of their own health problems.

National immunization days

One of the important milestones of this decade was the initiation of the national immunization day (NID). The NID approach for polio eradication was used for the first time in Brazil in the early 1980s, and it proved to be an effective way to achieve the highest possible coverage in the shortest possible time.

NIDs began to be organized for polio eradication in the Region. They were one of four strategies on which the global initiative to eradicate polio, established in 1988, was based:

- high infant immunization coverage with four doses of oral polio vaccine (OPV)

in developing and endemic countries, and routine immunization with OPV and/or inactivated polio vaccine elsewhere;

- organization of “national immunization days” to provide supplementary doses of oral polio vaccine to all children aged under 5 years;
- active surveillance for wild poliovirus through reporting and laboratory testing of acute flaccid paralysis cases; and
- targeted “mop-up” vaccination campaigns once wild poliovirus transmission is limited to a specific area.

When NIDs for polio eradication were initiated in the Region, the idea arose of holding synchronous NIDs in several countries at the same time. Between December 1996 and January 1997, six countries in the Region conducted synchronous NIDs: about 165 million children below the age of 5 years were immunized in a single day.

At the end of 1997, synchronous NIDs were conducted in Bangladesh, Bhutan, Myanmar, Nepal and Thailand, as well as in other WHO Regions (Pakistan in the Eastern Mediterranean Region and the People's Republic of China in the Western Pacific Region). Over 245 million children under 5 years of age, or nearly 40% of the world's children of this age group, were immunized with oral polio vaccine within a very brief period of time.

Thus, in the decade since 1988, there was considerable progress towards eradicating polio. The conduct of NIDs and other polio eradication strategies were particularly impressive in India, where by 1998 the number of reported polio cases had decreased by 90% compared with 1988.

It should be mentioned here that NIDs were useful for other interventions, too. Vitamin A supplementation was integrated into NIDs, as well as assessment of the nutritional status of children. In the South-East Asia Region, the reported number of polio cases declined from 25 711 in 1988 to 1117 in 1996, representing a reduction of 96%. This set up a good base for polio eradication within the next few decades.



Millions of children were given the polio vaccine on national immunization days

Declaring targets for disease elimination and control

Given the progress in the control of certain diseases, the World Health Assembly began to set target dates for eliminating these diseases or for reducing their prevalence to levels where they no longer posed a public health problem. Accordingly the countries of the South-East Asia Region committed to the following targets:

- **Polio:** the global eradication of polio by the year 2000. This was endorsed by all countries of the Region. The regional polio incidence rate had shown a significant decrease. In Bhutan, the Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand, with high sustained coverage, the trend in incidence indicated that the target of polio eradication could be achieved before the year 2000. At the time, polio-free zones were found in parts of Indonesia, Maldives, Sri Lanka and Thailand.
- **Neonatal tetanus:** in 1989, the World Health Assembly announced the global target of elimination of neonatal tetanus by 1995. Neonatal tetanus was the most common life-threatening consequence of unclean deliveries and umbilical cord care practices; when tetanus develops, mortality rates

are extremely high. The disease can be prevented by hygienic delivery and cord care practices, and by immunizing children and women through the life-course with tetanus-toxoid-containing vaccines, which are inexpensive and very efficacious. All the Member countries of the Region committed to this global elimination target. The countries had taken initiatives to achieve the target through collaboration with the MCH and PHC programmes, by tetanus toxoid (TT) immunization of pregnant women and, indeed, TT immunization of all women of childbearing age.

- **Guinea-worm/dracunculiasis infection:** India was the only country in the South-East Asia Region in which this infection was present. In 1991, the World Health Assembly declared its commitment to the goal of eradicating dracunculiasis by the end of 1995. Supported by the Regional Office, the Government of India launched the Guinea-worm Eradication Programme in 1979. By 1996, the number of cases had fallen from 40 000 in 12 840 villages spread across 89 districts of seven states to only nine cases recorded in three villages in Jodhpur district in Rajasthan.

Since 1996, no case has been reported, and India was certified as free from guinea-worm in March 2000, a major milestone in the disease eradication history in the Region.

- **Leprosy:** In 1991, the World Health Assembly adopted the target of global elimination of leprosy as a public health problem by the year 2000. After years of WHO-supported research, a new treatment regimen consisting of two to three powerful anti-leprosy drugs had been introduced in the early 1980s. This multidrug therapy was found to be very effective and reduced the duration of treatment from five years or more to only 12

months for severe types of leprosy, and to as short a time as six months for the milder types of the disease. Combined with intensified surveillance of new cases, there was a dramatic decline in the number of leprosy cases in the countries.

- **Iodine-deficiency disorder:** The World Summit for Children held in 1990 at the United Nations headquarters in New York adopted the goal of elimination of iodine-deficiency disorders as a public health problem by 2000. The approach taken was to use low-cost and effective remedies based mainly on iodinated salt and iodized oil.

Responding to new, emerging and re-emerging diseases

Several factors can contribute to the emergence of new diseases and the increase in old and previously controlled diseases. These include the migration of people around the world, overcrowding in cities resulting in poor sanitation, poor public health infrastructure, incomplete and lack of timely reporting of disease outbreaks and the emergence of resistance to antibiotics and other medicines linked to their irrational use.

In 1995, the World Health Assembly adopted a resolution urging

Member States to strengthen their surveillance for infectious diseases in order to properly detect re-emerging conditions and identify new infectious diseases. In 1996, a hospital-based sentinel surveillance system, an Early Warning, Alert and Response System (EWARS), was established in Nepal. Associated with this detection and identification requirement was an urgent need by the end of the decade to revise the International Health Regulations (IHR).

The following were some of the new, emerging and re-emerging infectious diseases that were a cause for concern in the Region:

- **Plague:** An outbreak of plague in India started in Beed district of Maharashtra in the mid-1990s. Following a massive rodent die-off or “rat fall” in August 1994, a total of about 600 presumptive bubonic cases were reported from nearby villages and other districts of Maharashtra. The outbreak spread to Surat in the state of Gujarat. About 150 presumptive pneumonic plague cases were reported and over 50 deaths occurred between 19 September and 22 October 1994. An independent international team sent by WHO concluded that clinical, epidemiological and serological findings pointed to *Yersinia pestis* as the likely causative agent of the Surat outbreak. Since this outbreak was of global concern, WHO convened an International Meeting on Prevention and Control of Plague in March 1995 to review the lessons learned from the outbreak, and recommendations were made for the prevention and control of infectious diseases with epidemic potential.
- **Cholera:** In 1991, there was a global resurgence of the El Tor cholera pandemic starting in South America and spreading rapidly in the Americas and in

Africa. The disease also reached the South-East Asia Region and cholera cases were reported from Bhutan, India, Indonesia, Myanmar, Nepal and Sri Lanka.

- **Dengue/dengue haemorrhagic fever (DHF):** This was endemic in Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand. The disease had become a major leading cause of hospitalization and death among children in the Region, after diarrhoeal diseases and acute respiratory infections. DHF incidence was showing an increasing trend and was also spreading to new areas.
- **Kala-azar/visceral leishmaniasis:** The prevalence of visceral leishmaniasis in the Region dropped dramatically as a result of the mass indoor residual spraying of DDT under the malaria eradication programme. It became almost a forgotten disease for about 20 years, before returning with a vengeance in the mid-1970s. By 1987, it had again become a serious public health problem, particularly in Bangladesh, India and Nepal. In 1987, over 110 million people living in the affected areas in these countries were at risk. WHO was supporting multicentric chemotherapy studies and control measures.
- **HIV/AIDS:** WHO estimated that, as of October 1998, there were

more than 92 000 AIDS cases and more than 3.7 million people with HIV infection in the Region. It was projected that by the year 2000 the number of cases of AIDS in the Region would be close to 2 million and HIV infections would range between 8 and 10 million. The Regional Office assisted all Member countries to set up national AIDS programmes. It focused on strengthening the countries' capacity to slow HIV transmission and reduce the adverse effects of AIDS on affected individuals and communities. The Regional Office provided technical guidance on strategies of proven effectiveness, such as condom promotion, treatment of other sexually transmitted diseases, and school education

on HIV/AIDS. The programme also encompassed ensuring the safety of blood and blood products, supporting research into more effective ways of encouraging safer sexual behaviour, and providing care to people with HIV/AIDS. WHO supported national AIDS programmes, in collaboration with UNAIDS, in providing technical support in the health aspects of HIV/AIDS not only to governmental bodies but also to NGOs and the private sector. The Global Programme for AIDS was succeeded by UNAIDS, the first joint programme in the United Nations system of various UN agencies (WHO, UNICEF, UNDP, UNESCO, UNFPA and the World Bank), in January 1996.

Dealing with the double burden of diseases

The process of epidemiological transition brought about by an increased life expectancy had already been observed in Member countries in the previous decades. The pattern of morbidity and mortality in the countries has changed, with noncommunicable diseases gradually superseding the infectious diseases.

In some of the Region's countries, infectious diseases (diarrhoea,

acute respiratory illness) were still the leading causes of illness and death. These were Bangladesh, Bhutan, most of the states in India, Maldives, Myanmar and Nepal. In some other countries, however, demographic transition was taking place together with development. Cardiovascular diseases, cancer, diabetes, congenital anomalies, endocrine disorders and accidents started to be the leading causes of morbidity and mortality. This pattern

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was observed in the Democratic People's Republic of Korea, Sri Lanka and Thailand and, to some extent, in Indonesia and those parts of India that had achieved high levels of life expectancy. Fast changing lifestyles contributed significantly to this situation. In addition, mental disorders and substance abuse, including abuse of tobacco and

alcohol, were posing further public health problems. The Region was thus faced with the double burden of infectious and noncommunicable diseases.

Estimates suggested that about 450 million people suffered from mental, neurological, behavioural and substance abuse disorders in



Noncommunicable diseases became the leading causes of morbidity and mortality in some countries during this decade

the Region during this decade, and their cost in human, social and economic terms was very high. During this decade, WHO launched an intensive effort to raise public and professional awareness of the burden of these diseases. Unfortunately, many patients suffering from these diseases were not getting optimum treatment.

Therefore, WHO had developed programmes to enhance the capacity of community-based workers – both ordinary health workers and physicians – to identify and manage these conditions at the primary health care level. The Regional Office supported Member countries in developing their mental health programmes.

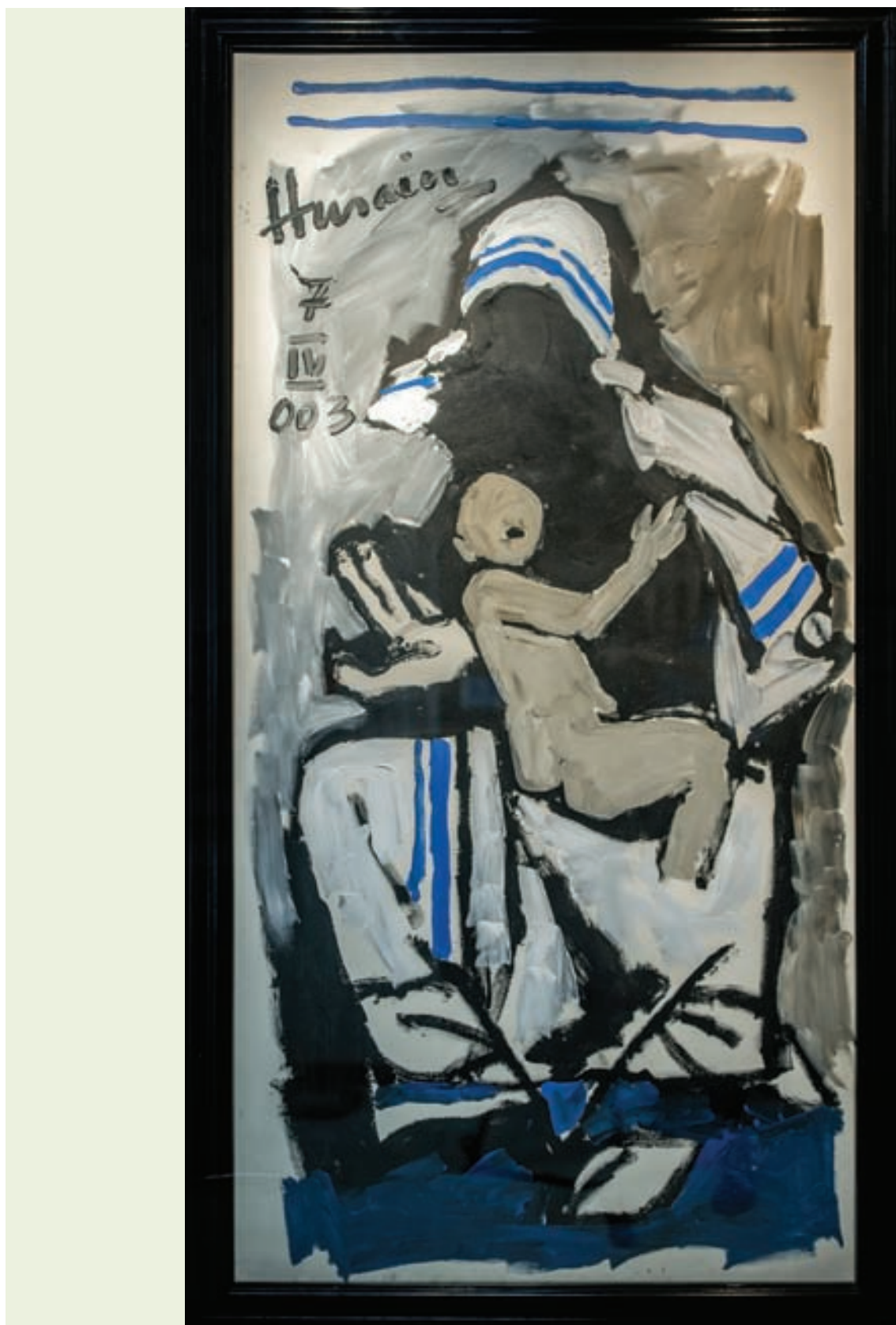
Fighting the tobacco pandemic

The consumption of tobacco in all countries was on the increase. The rise in tobacco consumption was particularly observed among young men and women. Non-smoking campaigns over the previous years had not been successful. This was mainly because of the aggressive advertisements and counter-attacks by the tobacco industry, and the fact that nicotine is addictive. In addition, most governments were reluctant to take a strong stand on this issue, because tobacco was a source of revenue and foreign exchange.

The Regional Office for South-East Asia supported Member countries to establish comprehensive, multisectoral and long-term national strategies for tobacco control. All countries in the Region have now banned cigarette smoking in designated places. Nepal has also mandated the size of the pictorial health warning on tobacco

packets to be 90% – the largest in the world – in one of the most cost-effective ways to increase public awareness on the health risk and reduce consumption. Crop substitution for tobacco was being tried in India and Nepal and community-based tobacco control programmes were operational in Bangladesh, India, Indonesia, Sri Lanka and Thailand in this decade.

The important achievements in this decade related to WHO's growing role in the partnership for health, in prioritizing health promotion, in implementing the DOTS strategy in treating tuberculosis, in initiating the national immunization days and introducing a concept of reproductive health, and in declaring targets for disease elimination and control paved the way to the next decade of unprecedented global initiatives and interest in public health.



M.F. Husain: Mother Teresa, 2003

On 7 May 2003, during the World Health Day celebration at the WHO South-East Asia Regional Office, internationally renowned Indian artist, Mr M.F. Husain painted this canvas in the Conference Hall in front of an audience that included staff, Indian dignitaries, and members of the UN and diplomatic community. Mr Husain completed the work in just 12 minutes, accompanied by the famous song *Maa tujhe salaam* (A salute to you, Mother)

sung by A.R. Rahman, which was playing in the background. Three aspects of the concept of “mother” were represented during the event: 1) the mother and child, 2) Mother Teresa as represented in the painting, and 3) “mother” as in one’s motherland, or native country. Mr Husain generously offered his creative work on behalf of the children of the world, and presented WHO with the canvas painted on the occasion.





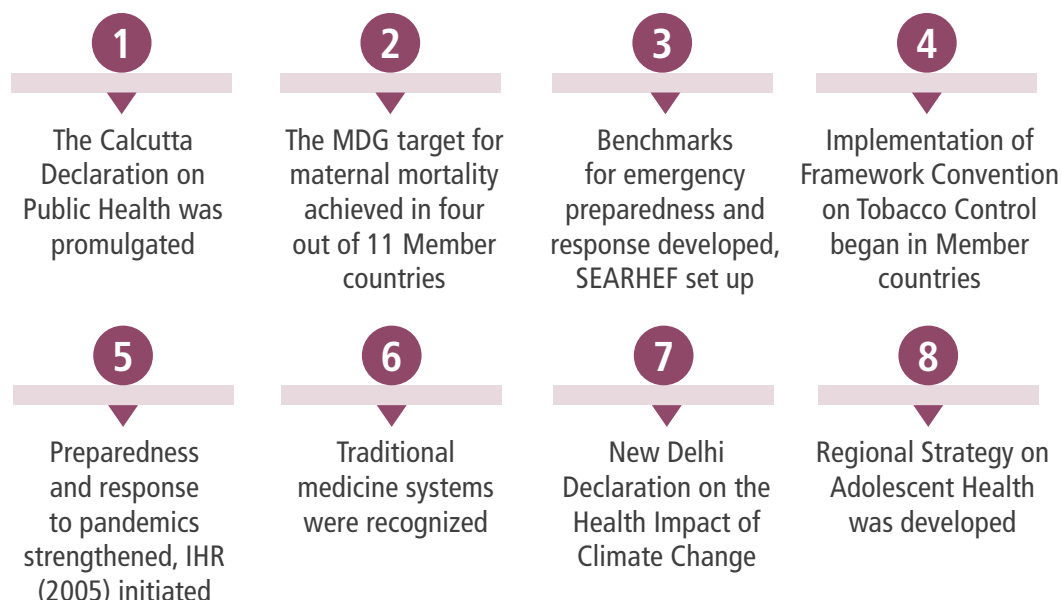
6

THE SIXTH DECADE

1998–2007

Towards meeting
the MDGs

MAJOR ACHIEVEMENTS IN THE SIXTH DECADE: 1998–2007



In September 2000, building on a decade of major United Nations conferences and summits, world leaders came together at the United Nations headquarters in New York to adopt the United Nations Millennium Declaration. In adopting this Declaration, they committed their nations to a new global partnership to reduce extreme poverty and accepted a series of time-bound targets – with a deadline of 2015 – that became known as the Millennium Development Goals (MDGs).

This unprecedented global initiative had influenced the prioritization of public health in the countries, particularly developing countries. It also influenced the style of the Organization's approaches to assisting the countries and forming partnerships. As the first decade of

a new millennium, this decade was marked by unprecedented global interest and action in public health. The Millennium Development Goals provided enormous momentum around global health issues; the Commission on Social Determinants of Health reminded the global public health community about taking multisectoral action on the social determinants of health for health equity; the Commission on Macroeconomics and Health emphasized the primacy of health for national development and called for increased public spending on health; and the Framework Convention on Tobacco Control and the International Health Regulations 2005 were also watershed events in global public health history.

From 1999 on, WHO's work in and with each Member country was

based on a Country Cooperation Strategy that responded to the country's specific priorities and the institutional resources needed to achieve its national health policies.

Two new WHO country offices with their first WHO Representatives were opened in this decade: in Timor-Leste and in the Democratic People's Republic of Korea.



The first decade of the New Millennium

The first decade of the new millennium was marked by unprecedented global interest and action in public health. These included the Millennium Development Goals, the Commission on Social Determinants of Health, the Framework Convention on Tobacco Control and the International Health Regulations 2005

Dr Samlee Plianbangchang,
Regional Director 2004–2014

The Calcutta Declaration on Public Health

The changing epidemiological and demographic patterns, the effects of globalization, socioeconomic changes and other factors posed unprecedented challenges to public health. It was felt that the public health systems in the countries of South-East Asia had not been able to adjust quickly and contribute appropriately to maintain and improve the health of their people. There was a need to revisit and take a close look at the countries' health systems.

The Regional Office for South-East Asia organized a Regional Conference on Public Health in the 21st century in November 1999 in Calcutta (now Kolkata), India. The venue of the conference – the All India Institute of Hygiene and Public Health – was one of the oldest public health institutions in the Region. The general objective of the conference was to advocate the importance of public health in national, socioeconomic and political development, and to promote new

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strategies for developing sound public health systems in the 21st century. The Conference brought together leaders in public health education, research and services from South-East Asian countries, international experts in public health, representatives of UN agencies and bilateral and multilateral agencies. The discussions focused on the quality of schools of public health, professional capacities, societal commitment, dwindling resources for health and the resultant need for greater efficiency of interventions, and the realization of national public health goals. The Calcutta Declaration adopted at the conference provided crucial messages and guidance for future work in the field of public health in the Region and the world (for full text of Declaration, see box).

A strong emphasis was placed on public health education and training in the Region. The Regional Office for South-East Asia launched the

Public Health Initiative, an important component of which was to provide new opportunities for multi- or bilateral training, between and within countries in the Region. It emphasized the recommendations of the Calcutta Declaration, which called on governments to establish a cross-sector collaborative “Platform on Public Health.”

The Public Health Initiative established a web-based Virtual Resource Centre (VRC) to provide users with well-designed distance learning materials, which were made available to faculty and institutions engaged in capacity-building for public health. Initial modules on field epidemiology were available. The Public Health Initiative was linked to an earlier initiative in the area of health systems development. This was the South-East Asia Public Health Initiative, launched in 2005. To support the development of this initiative, a network of South-East Asia



The Sri Lanka Room, gifted by Sri Lanka, with two murals on the wall: one depicting public health scenes and different modes of care from village traditionalists to primary health clinics, and another depicting a ceremonial procession with caparisoned elephants. A collection of Sri Lankan traditional masks was also presented, including a peacock mask, the god Ravana, and others, and a few ‘sesatha’ or Kandyan ceremonial ornamental fans which are used in Buddhist processions at the Temple of the Tooth in Kandy

Public Health Educational Institutes (SEAPHEIN) was formed. The focus of this development was to support countries in strengthening public health education programmes to ensure the availability of a competent public health workforce.

Another programme initiated by WHO contributed directly to building a cadre of young professionals in public health to serve as role models. In 2006,

the programme of enrolling talented and carefully selected young public health professionals to get first-hand experience of working in WHO was initiated. These were the “Junior Public Health Professionals” who worked in the regional offices and WHO headquarters. The programme was intended to emphasize the desirability of a career in public health and give good experience to deserving young professionals.

The Calcutta Declaration on Public Health

‘We, the participants in this Regional Conference on Public Health in South-East Asia in the 21st century, appreciate the substantial achievements made in improving the health status of the people in the countries of the South-East Asia Region during the past decades. However, we enter the 21st century with an unfinished agenda of existing health concerns and new and complex challenges that demand innovative solutions. We uphold the centrality of meeting the health needs of the community and our responsibility to preserve, protect and promote the health of the people. We commit ourselves to the goals of poverty alleviation, equity and social justice, gender equality and universal primary education, which are all essential elements in the pursuit of health for all. We recognize that expertise in public health and capacity-building as well as experience are essential for sustaining partnership in designing, developing and providing health for the community. We emphasize the importance of public health as a multidisciplinary endeavour to meet the health needs of people.

Having noted the progress in public health practice, education and training, and research in the countries of the South-East Asia Region, and having reviewed the lessons from public health-related policies and programmes, we endorse the following strategies and directions for enhancing health development in the South-East Asia Region in the 21st century:

Promote public health as a discipline and as an essential requirement for health development in the Region. In addition to addressing the challenges posed by ill-health and promoting positive health, public health should also address issues related to poverty, equity, ethics, quality, social justice, environment, community development and globalization;

Recognize the leadership role of public health in formulating and implementing evidence-based healthy public policies; creating supportive environments; enhancing social responsibility by involving communities, and increasing the allocation of human and financial resources;

Strengthen public health by creating career structures at national, state, provincial and district levels, and by establishing policies to mandate competent background and relevant expertise for persons responsible for the health of populations, and strengthen and reform public health education and training, and research, as supported by the networking of institutions and the use of information technology, for improving human resources development.

We urge all Member countries as well as WHO to continue to provide leadership and technical cooperation in building partnerships between governments and UN and bilateral development agencies; academia; NGOs; the private sector; the media, and other organs of civil society, and to jointly advocate and actively follow upon all aspects of this Calcutta Declaration on Public Health.’

Strengthening the health workforce

Most countries of the South-East Asia Region were challenged with problems of health workforce shortages, maldistribution, inappropriate skill mix, and limited capacity for the production, management and deployment of human resources for health. The Regional Office had collaborated with Member countries to address their health workforce challenges and advocated for high-level commitment to strengthen health workforce development.

In 2006, the health ministers of the Region adopted a declaration on “Strengthening the health

workforce in countries of the South-East Asia Region”, in which they reaffirmed their commitment to an effective and motivated health workforce. The Regional Office supported countries in developing and carrying out national health workforce strategies and plans. It also gave high priority to balancing the preventive and promotive aspects of health care with the curative and rehabilitative aspects, and took several initiatives to strengthen the public health component of the curricula of medical and nursing courses to better equip medical doctors for service needs.



The Regional Office collaborated with Member States to address their health workforce challenges

Other areas in which countries were supported included programme development, institutional capacity-building, establishing or strengthening teaching-learning resources and libraries, and faculty development. The Regional Office also developed comprehensive strategies and plans to strengthen the community-based health workforce in order to address the changing epidemiological and demographic profile of Member countries in the Region.

Strengthening categories of community-based health workers – such as the community health workers and volunteers who run the community clinics in Bangladesh, the household doctors in the Democratic People’s Republic of Korea, the accredited social health activists (ASHAs) in India, the female community health volunteers in Nepal, and the Health Volunteers in Thailand – are a few examples of the initiatives taken to strengthen the community-based health workforce.

Progress towards universal health coverage

Countries in the Region had made significant progress towards universal health coverage, both in their conceptual thinking as well as in practice. Some Member countries demonstrated that universal health coverage can be achieved at a low cost and in resource-constrained settings. They took a pragmatic, phased approach to universal health coverage by starting with primary health care priorities to eliminate avoidable systems inequities and inefficiencies. The next phase would be to provide more comprehensive coverage as requisite systems and institutional capacities are developed.

The current focus in countries was on equity and efficiency in health systems, with most countries reviewing the health financing

function as a lead area of reforms for universal health coverage. Member countries strengthened both the process and content of national health policies and plans, so as to use the national health policy strategy and plan better for universal health coverage. Countries needed to provide better financing for universal health coverage for social protection and equity in health. They also needed to provide better service delivery by enforcing cost containment and changing the incentives structure in health systems to improve public and private sector performance and partnerships. The focus would be on strengthening capacity and institutions for evidence-based advocacy, development of policies, strategies and plans, and monitoring and evaluation.

WHO begins its work in Timor-Leste

Recollections of Dr Alex Andjaparidze, first WHO Representative to Timor-Leste, 2003–2008

WHO's presence in Timor-Leste began in 1999. Much of the health infrastructure was destroyed at that time and the health system was not able to serve the people. Since 1999, the international community assisted Timor-Leste in re-establishing its health system and developing new health policies for the country. Two public health professionals were placed by the Regional Office for South-East Asia on standby in Darwin, Australia, with the possibility of transferring them to Timor-Leste to manage the initial emergency and humanitarian assistance in health. WHO had to move quickly to deal with malnutrition and prevent an upsurge in communicable diseases. Dr Gro Harlem Brundtland, then Director-General of WHO, made an appeal to the international community to support the efforts of WHO in that country.

Up to January 2000, the WHO Dili Office was technically supervised by the WHO

Regional Office in New Delhi through the WHO Representative's Office in Jakarta, Indonesia, and with full logistic support through the WHO Darwin Office. The Darwin Office was closed on 7 January 2000 and all logistic arrangements and other management issues were handled directly by the WHO Dili Office with a Head of Office appointed by the Regional Office. The WHO Head of Office worked closely with UNTAET, UNICEF, ICRC and many international NGOs to coordinate health activities until the establishment of the Interim Health Authority, the precursor to the national Division of Health Services. In September 2001, the Interim Health Authority was formally transformed into the Ministry of Health.

In September 2002, Timor-Leste became the 192nd Member State of WHO and in May 2003, at the Fifty-sixth World Health Assembly, it was designated the 11th Member State of the South-East Asia



Dr Alex Andjaparidze with the then Regional Director Dr Samlee Plianbangchang during a field visit in Timor-Leste

Region. As such, it received a separate country budget allocation. A WHO Country Office was established and a WHO Representative was appointed.

In the initial stages, the situation in the country compelled WHO to expand its traditional role of providing technical advice, norms and standards, technology and skills. Instead, WHO has been directly involved in the implementation of key health programmes and the coordination of national staff involved in health activities. During the emergency period in the 1970s and 1980s, WHO had played a key role in the coordination of health services that were provided in the country by a large number of donors and NGOs. When the Ministry of Health was established, WHO supported its initial development and training of its staff. At the same time, WHO played an important role in implementing key programmes in the country, most

notably on infectious disease control (malaria, tuberculosis and leprosy), and improved health services for children and mothers, and assisted with clinical nursing care. The successful work of WHO in Timor-Leste was recognized by national and international organizations. The first Country Cooperation Strategy for Timor-Leste was launched in December 2003.

I had the privilege to serve in the country from January 2000 till March 2008. I recall fondly the dedicated work of national health staff and WHO personnel in the country office during that time. I am grateful to the then Regional Directors Dr Uton Muchtar Rafei and Dr Samlee Plianbangchang, and the current Regional Director, Dr Poonam Khetrapal Singh, and the then WHO Representative in Indonesia, Dr Georg Petersen, for their crucial support and advice.

WHO Country Office opens in Pyongyang, Democratic People's Republic of Korea

Recollections of Dr Eigil Sorensen, first WHO Representative to the Democratic People's Republic of Korea

On 19 November 2001, Dr Uton Muchtar Rafei, then Regional Director, officially opened the Country Office in Pyongyang, in the presence of Dr Kim Su Hak, Minister for Public Health, Dr Choe Chang Sik, Vice-Minister, Mr Choe Su Hon, Vice-Minister, Ministry of Foreign Affairs, and Dr Gro Harlem Brundtland, Director-General of WHO. The opening ceremony was attended by senior officials from the Government, the diplomatic corps, UN agencies and international organizations.

The delegation from WHO headquarters also included Dr J.W. Lee, who later became WHO's Director-General.

Dr Uton gave a memorable speech. 'As a response to the difficulties the country had been facing from natural disasters and problems in the economy, WHO had established an office for Emergency and Humanitarian Action in Pyongyang in 1997. This office has been supporting emergency programmes focusing on



Dr Gro Harlem Brundtland, the then Director-General of WHO, during the opening of the Country Office in Pyongyang in the Democratic People's Republic of Korea

control and surveillance of communicable diseases, in particular tuberculosis and malaria, EPI and polio eradication, and on strengthening health care at the community level. This contributed to increased involvement of WHO in the country, and I see the opening of a full country office as a natural development of the strengthened collaboration between the Democratic People's Republic of Korea and WHO in recent years,' he said.

The high-level WHO delegation spent three days in the country meeting with government officials, including Mr Kim Yong Nam, President of the Standing Committee of the Supreme People's Assembly. During a field visit to Hwangju County, the delegation took part in the second round of the National Immunization Day. Dr Brundtland and Dr J.W. Lee, then Director for Tuberculosis at WHO headquarters, visited the Sariwon Provincial Tuberculosis Hospital and handed over the first round of tuberculosis medicines from the Global Drug Facility (GDF). WHO and GDF are continuing to provide support for the

control and treatment of tuberculosis in the country till today.

I served in the country until 2006, and negotiated an office building for WHO close to the other UN agencies. The country office is still in the same premises today. The Pyongyang office was one of the first country offices globally where WHO installed VSAT communications. This enabled global telephone connectivity and provided broadband Internet that vastly improved the effectiveness of the office. WHO successfully mobilized resources in the following years for essential health programmes mainly through the annual UN Consolidated Appeals (UNCAP), provided standardized medical supply and essential medicine kits to Ri-clinics and country hospitals, scaled up support for malaria, tuberculosis and emerging diseases, and provided training in communicable disease control and public health. The first Country Cooperation Strategy for the Democratic People's Republic of Korea 2004–2008 was launched in 2003.

Recognizing traditional medicine systems

As we have observed earlier, countries of the South-East Asia Region have a rich heritage of systems of traditional medicine. Recognizing the key role of these systems in the provision of health care since ancient times, Health Ministers of Member countries in 2003 agreed that the traditional systems of medicine should be included as part of the national health-care system, with patient safety as the overriding consideration for use. The Regional Committee for South-East Asia in 2003 provided strategic directions for the development of traditional medicine in the Region. In 2008, the Regional Office compiled a list of traditional medicine institutions in the Region. These were the core institutions for intercountry

and multicountry collaboration for the development of herbal and traditional medicines and the exchange of information on the subject in the Region. A later revised edition listed 153 institutions.



Traditional medicine plays an important role in the provision of health care in countries of the Region

Towards reaching the MDGs in maternal and neonatal health

The remarkable reduction of the maternal mortality ratio (MMR) in the Region from 270 per 100 000 live births in 2005 to 200 per 100 000 live births in 2010 became possible because of strong political will and commitment to maternal and newborn health in all countries. Millennium Development Goal 5 targeted a reduction in MMR of 5.5% from the 1990 levels. The Region as a whole was just short

of this target, as the reduction in MMR translates into a regional annual reduction of 5.2%. The Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand achieved the target, while Bangladesh, Bhutan, India, Indonesia and Nepal were on track.

Nepal showed what could be done even in a continuing climate of political turmoil and inadequate

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resources. It received two awards for its efforts to contain maternal deaths: in 2010 from the Millennium Development Goals Review Summit, and the Resolve Award in 2012. The fall in maternal mortality was largely due to the increase in the number of deliveries by skilled birth attendants.

However, there were inequities in access to skilled birth attendants between and among the countries. Indonesia and Sri Lanka made progress in narrowing the gaps, while in Bangladesh and Nepal the progress was slower over the years. To address this inequity in access, several countries took the help of the community, as community-

based health workers are an integral part of the health system. The Government of India trained auxiliary nurse midwives to become skilled birth attendants. Bangladesh initiated a six-month training course in midwifery, and planned to launch a three-year midwifery course.

Sociocultural issues have a critical bearing on maternal and neonatal health outcomes, and needed to be urgently addressed to reach the Millennium Development Goals. In 2009, the Regional Office for South-East Asia in collaboration with the Regional Office for the Western-Pacific organized a Consultation on the “Application of Sociocultural Approaches to Accelerate the Achievement of Millennium Development Goals 4 and 5”. The outcome was a “Strategic Framework for Sociocultural Approaches to Accelerate the Reduction of Maternal and Neonatal Mortality”. The South-East Asia Regional Office provided support to countries to develop and implement action plans based on the Framework, including an agenda for research on the sociocultural aspects of maternal and neonatal health.

The Region made tremendous progress in reaching out to millions of children with life-saving vaccines. This received a further boost with the launch of the Global Alliance for Vaccines and Immunization (GAVI), now simply called the Gavi Alliance, in 2000. It was a public-private partnership led by WHO and UNICEF, and supported by the



The remarkable reduction in maternal mortality was possible because of strong political will and commitment

World Bank, leaders of the vaccine industry, bilateral aid agencies and major foundations. The objective of the Alliance was to reach vaccines to the children of the world's poorest countries. Globally 75 countries were listed as GAVI-eligible at the time of the launch of GAVI; in the South-East Asia Region, nine of the 11 countries

were eligible. The Gavi Alliance has made significant contribution to this Region to not only increase routine immunization coverage but also to help countries introduce new vaccines so that today all countries have more than eight vaccines in their routine immunization schedules.

Challenges to adolescent health

The 350 million adolescents in the Region comprised nearly one fifth of its total population. The many health and psychological needs of this population must be taken care of for adolescents to reach healthy adulthood. Some cultural practices in the Region are harmful to adolescent health, such as early marriage and childbearing among girls. Some local norms do not allow discussions between parents, teachers and adolescents on the subject of sex. As a result, adolescents do not have adequate knowledge on how to protect themselves. Onset of sexual activity before they acquire adequate knowledge and skills for protection exposes adolescents to the risks of acquiring sexually transmitted infections and HIV, which have far-reaching consequences. Unintended pregnancy is another likely consequence of unprotected sex, which may be followed by the risks of an unsafe abortion and social censure. Many may have to leave school, which reduces their employability and thus has

long-term economic implications. Undernutrition and anaemia are other health conditions that were prevalent among adolescents in the Region.

The work of the Regional Office in improving adolescent health services was guided by the "4S" framework. This focused on four strategic areas: strategic information, supportive policies, strengthening services, and strengthening collaboration with other sectors.

In the area of strategic information, countries were supported to develop adolescent profiles and country factsheets on adolescent health and adolescent pregnancy. The Regional Office developed a tool to assess relevant laws and policies to determine whether these were conducive to the provision of health services to adolescents. The application of this tool was supported in Bangladesh, India and Sri Lanka. The Regional Office developed a Regional Strategy for Adolescent Health in consultation

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with Member countries and UNFPA, and provided technical assistance to countries to develop their national adolescent health strategies. The Regional office also developed a situation report on adolescent nutrition for the Region, and an evidence base for weekly iron

and folic acid supplementation for the management of anaemia. WHO assisted in tackling the other common public health issues, such as early marriage and early childbearing, through the development of guidelines for the prevention of adolescent pregnancy.



Masks. Gifted by Indonesia

Strengthening emergency preparedness and response

This decade seemed to bring more than its fair share of calamities to the Region, in the occurrence of earthquakes, cyclones and floods. The great tsunami of December 2004 was one of the deadliest in history, and caught the world unawares as it devastated communities along thousands of miles of the Region's coastlines. Of all the people killed in natural disasters in the decade 1996–2005, 58% were from the South-East Asia Region.

Health action in crises has always been part of WHO's activities. WHO is mandated by its Constitution

to give technical assistance upon requests from governments, and to support and enable international agencies working at the frontline of disasters and emergencies. In this role of coordinating the health response to disasters lies one of the Organization's greatest strengths. During the decade, the Regional Office was called to lead the "health cluster" response to disasters in the Region. WHO and Member countries had been preparing for disasters prior to the tsunami and even in the previous decade. WHO had assisted Member countries in strengthening their national

capacities for disaster preparedness and response, and had developed a Global Action Plan for emergency preparedness and response working in conjunction with other regions and organizations.

Nevertheless, the tsunami was a wake-up call to the threat posed by natural disasters, and drew attention to the crucial issues of preparedness and risk mitigation, to the need for capacity at country level, to the need for better and more resilient health systems and for reducing the vulnerability of communities through better preparedness, response and strategic plans.

As the countless human tragedies played out following the tsunami, WHO responded by coordinating health protection and disease prevention (e.g. setting up surveillance and response systems), ensuring access to essential health care (e.g. water and sanitation, immunization, psychosocial support, nursing and midwifery), providing medical and logistic support (e.g. emergency health kits, rehabilitation of laboratories), and mobilizing resources among partners (for formulating and implementing country workplans).

The tsunami brought many partners together and today we are more aware of mutual capacities and perhaps better coordinated as a result of the tsunami response. Many lessons drawn from the tsunami have been applied in containing subsequent disasters. Since then,



Galle in Sri Lanka was one of the places worst affected by the tsunami of December 2004. Here workers repair a hospital damaged by the tsunami

WHO's activities included developing benchmarks for emergency preparedness and response in conjunction with Member countries, strengthening of capacity within WHO and, in response to the suggestion of the Member States, setting up the South-East Asia Regional Health Emergency Fund (SEARHEF).

The last of these was achieved by the Regional Committee in 2007, when it was decided that, in order to streamline the ability of WHO to respond speedily to natural disasters, a special fund would be established for emergency response. The fund was set up by allocating a 1% contribution from the WHO regular Budget in the Region. SEARHEF got an acclaimed opportunity to demonstrate its benefits when Cyclone Nargis hit Myanmar in May 2008 – funds were released within hours of the disaster.

Story of health in Aceh, before, during and after the tsunami

Recollections of Dr Media Yulizar, then Head of Disease Control and Environmental Health, Aceh Provincial Health Office

When the tsunami struck

For a long time, Aceh was in a state of emergency. Armed conflict had started as early as the 1970s, and the intensity increased in the 1990s. In 1998, there were big waves of internally displaced persons (IDPs) as conflict forced the Acehnese to leave their homes and fields. The regular curfew that began around 2000 made it difficult for health workers

to provide the health care people needed. Health-care workers had to wear their white jackets or vests to be able to reach communities safely. Night service was difficult. The work of the health sector was focused on the health of IDPs, and on preventing and managing outbreaks. Preventive services were insufficient as the scope for movement was very limited.



The tsunami on 26 December 2004 devastated Banda Aceh (seen in this picture) and the west coast of Sumatra in Indonesia, along with coastal areas of several Indian Ocean countries. Tens of thousands were left homeless and many thousands were drowned or injured by the killer waves



Millions of survivors were left to pick up the pieces after the devastating tsunami of December 2004

In the immediate aftermath

When the tsunami struck, Dr Media was busy managing a health service to be provided to a patient who was to go for the Hajj pilgrimage. Suddenly, everything was cut off, there was no phone signal or electricity. The sound of sirens came from many directions. Dr Media's husband had been out practising watersports at the coast, and nowhere to be found. There was no means of getting clear information about friends and families affected. This was the situation in the capital, Banda Aceh, where Dr Media lived. It was much worse in other places in Aceh. On Sunday afternoon, officials and staff from the

Ministry of Health in Jakarta reached Aceh, and so did WHO staff.

The next morning, Monday, an official of the Ministry of Health was driven to Dr Media's house on a motorcycle. They combed through Banda Aceh, visiting areas where the health offices and hospitals used to be. The main general hospital was severely damaged. Health services for the residents were taken up by the army hospital which was not affected by the disaster.

In the first week, Dr Media felt alone, as if she had been simply left behind. Of the 35 staff in her unit, 7 were killed. Those who survived the tsunami were

looking for or taking care of their family members. Many of those she knew had lost family members in the catastrophe. Dr Media lost her husband. Like others in the affected areas, health officials and health workers too lost their houses and their belongings. Mobilizing health-care workers was a huge challenge.

Even as she coped with her personal grief, and while her family wanted her to come home to Jakarta, Dr Media started her disaster response work. Her house became the emergency office and she provided meals to those who came to, stayed and worked in her house.

WHO helped to rent a house to set up an emergency provincial health office, and another, around 200 meters away, to be used as the local control office for communicable diseases. One of the first responses was to conduct outbreak prevention. The first worry was that of a cholera outbreak. WHO and the Ministry of Health supported local authorities to conduct cholera immunization. 'Thank God we managed to avoid the outbreak,' she recalls.

A surveillance system was an urgent necessity. Dr Media developed a system to ensure that necessary reports came in from the numerous posts. She had one mobile phone with her receiving reports in English while her staff had another mobile phone to receive reports in Bahasa Indonesia. The communication network had not completely recovered by then.

The Ministry of Health and WHO worked closely together to provide support, both

technical and logistical. Dr Media recalled how WHO played its key roles with the Ministry of Health, leading the health cluster and working side-by-side in every technical area. Cars and motorcycles were procured to help health workers collect reports and provide health services. UNICEF also gave extensive support. Dr Media still remembers the regular meetings that took place in the emergency office, with people sitting and standing everywhere, crowding even the stairs of the building.

Foreigners flooded to Aceh, creating what she calls 'the second disaster'. They brought medicines and supplies. Some of them suddenly sprayed the city of Banda Aceh with disinfectant, some carried out fogging for malaria. One organization went directly to the community and started carrying out immunizations, and then came to Dr Media with a report filled in only with numbers – without any information about the names, ages and location of the immunized people – and requested a certification. Aceh had to redo the entire immunization process.

After the disaster

The support effort left drums of insecticides and piles of medicines everywhere, and the Government of Aceh had to manage them for a long time – even two years after the tsunami. 'There were piles of medicines ... it was a problem. It took years to manage them.' There were plenty of logistics elements that Aceh could not use. From her observation and communications, Dr

Media learned that many of the foreign organizations had very little, if any, information about the situation in Aceh. Keeping in mind diplomatic courtesies, the help was accepted, even though the piles of well-intentioned material could not be used.

After the emergency response, WHO, the Ministry of Health and the Aceh Provincial Health Office developed a small book as a manual for disaster response and management, to guide people to take necessary action when a disaster strikes.

The people of Aceh now are not merely aware of disaster response, they actually live it. To be accredited, a community health centre (Puskesmas) must have an emergency plan. They must be able to explain what they need to do when there is an emergency. Aceh now has an independent unit for disaster management in the provincial and district/city health offices. The Ministry instructed districts/cities to have a '119' emergency response team. The structure for disaster response is now far better. Many agencies and organizations already have a contingency plan. Dr Media certainly sees considerable improvement: 'Our preparedness is much better'.

Dr Media remembered that as late as 2007, WHO was still helping with surveillance and immunization. By 2010, almost all international organizations had left Banda Aceh, the capital of the province, while a few of them continued working in some areas of Aceh.

Learning from her experience, Dr Media went to a regional meeting in Bangkok with a WHO staff member to give a presentation on post-tsunami surveillance. She feels there should be a venue for the continuous sharing of information on disaster management. WHO could review the positive and negative experiences and aspects of disaster response, collecting the lessons from all tsunami affected areas and countries that were supported by WHO. Also, she feels, lessons learnt and best practices, before and after the disaster, must be shared and there should be more communication between countries so that they could learn from each other. Young leaders in the health sector should be well-informed about disaster management. Lessons learned should be shared with them. Capacity-building should be a continuous process, she says.

'There should be a place to access documents/books on disaster response, mitigation and management, so that young health leaders could study them. It was good I went to that refugee health meeting so that I had a bit of information as to what we need to do during emergencies. I could use the knowledge. I would like to see that heads of health offices understand, for example, that when a disaster strikes, immunization is the immediate response to it. Such documents may be available, but they have to be well-disseminated, reaching managers in provinces, districts and cities,' Dr Media explained.

Investing in risk management is investing in future development

The Region has learnt from past experiences and continues to better manage risks. On 11 April 2012, an earthquake of the magnitude of 8.7 on the Richter scale hit the coast of Aceh for over four minutes with tremors being felt in neighbouring countries. It seemed like a repeat of the 2004 earthquake and tsunami. Thankfully, it was not.

But some of our actions on that day clearly demonstrated that we have moved on with better preparedness and response. There was more organized evacuation of people to higher grounds by all coastal communities, not only in Indonesia but also in Sri Lanka, India (in Chennai), Maldives and parts of Thailand. The clear link of communication between tsunami warning systems and the community was seen in many coastal areas. There were only eight deaths, and all those injured were promptly treated and accounted for.

Although some health posts were damaged, the infrastructure in the cities did not suffer major

destruction. Hospitals in Banda Aceh evacuated their patients in an orderly manner, which is a reflection of their preparedness plans and drills. In Sri Lanka, the tourism sector was well organized and moved guests to higher ground.

The 11 April event has proved that in Indonesia, India, Maldives, Sri Lanka and Thailand, the major catastrophe in 2004 was taken as a turning point to integrate lessons into action. This shows how disaster risk management can be improved with proper investments, both technical and financial. Political will and a disaster prevention perspective can bring changes to populations to better live with risks.

With this concrete display of commitment of countries, the Region is well poised to provide inputs to, and adapt and adopt the new global framework and guidance for emergency risk management for health that WHO is developing.

Dr Samlee Plianbangchang

*Regional Meeting on Disaster Risk Management
in the Health Sector, Bangkok, 6–8 June 2012*



Pashupati Nath Temple. Gold leaf replica. 1.07 x 1.45 m. Oil painting (0.54 x 0.65 m) for 40th Anniversary. Gifted by Nepal

Protecting health from climate change

Widespread deforestation, other land-use changes, migration, change in occupation and increased human crowding are likely to influence the patterns and magnitude of occurrence of infectious diseases. The risk of cross-species infection has also increased, as is evident from the spread, emergence and re-emergence of malaria, dengue, scrub typhus, Nipah virus and neoplastic diseases in the Region. Indiscriminate use of chemicals in response to an increase in pests and insects bring additional health problems, such as congenital diseases, poisonings and diarrhoeal deaths.

Climate change is a harbinger of poverty, death and injury through various direct and indirect manifestations. Climate change may in the years ahead cause a serious survival problem for about 1.5 billion South Asians, as it could increase migration, poverty, malnutrition, mental problems and other diseases. Climate change would increase the prevalent endemic diseases, both spatially and in magnitude. This situation would be further complicated by a decline in the quality of the environment and eco-degradation as a result of climate change.

Health threats include the advent of new diseases (e.g. Nipah virus carried by fruit bats, and severe acute respiratory syndrome, or SARS) as well as the emergence of new strains of viruses (e.g. avian influenza), besides changes in the incidence, range,

intensity and seasonality of other diseases.

The World Health Organization has advocated for and supported action to reduce human-induced changes in climate. As a result, in 2007, ministers and high officials of the ministries of environment and health endorsed the Bangkok Declaration on Environment and Health. Further efforts by the Regional Office resulted in the formulation of a Regional Framework for Action to Protect Human Health from the Effects of Climate Change, in 2008. A Regional Working Group on Protecting Health from Climate Change was formed.

In 2008, a meeting of the health ministers in the Region resulted in the New Delhi Declaration on the Impacts of Climate Change on Human Health, at which they committed to a number of specific actions. To garner political support for taking up adaptation measures in Member States, in October 2010 the Regional Office organized a Regional Parliamentarians' Conference on Protecting Human Health from Climate Change. The Regional Office also convened a high-level meeting for the health and environment ministries in October 2010 to prepare their focal points on climate change to take up health concerns from climate change strongly at the Sixteenth Conference of Parties of the United Nations Framework Convention on Climate Change.

Responding to the threat of NCDs

Work in the area of noncommunicable diseases (NCDs) was guided by the Regional Framework for Prevention and Control of Noncommunicable Diseases developed in 2006. The Framework listed key strategies. These include raising awareness of NCDs, conducting surveillance to map the risk factors for NCDs, and promoting primary prevention through health promotion and legislation. Other aspects were early detection and treatment at the primary care level, and conducting research to gather evidence on how best to control NCDs. There were some key achievements, with WHO's technical leadership, related to prevention and control of NCDs in the Region in the decade.

The South-East Asia Network for NCD Prevention and Control, launched in 2004, reviewed progress towards the control of NCDs in Member countries, and provided a forum for sharing best

practices. Five countries in the Region applied the Package of Essential NCD (PEN) interventions, consisting of sets of protocols designed for non-physicians and medical doctors, and a packet of tools to facilitate their application.

NCD units operated within the ministries of health in nine countries, where funding of their programmes was through the government budget. All Member countries provided at least one NCD-related service at the primary health care level in public facilities.

Legislation was adopted as a strategy to limit tobacco and alcohol use in the Region. The Framework Convention on Tobacco Control (2003), the first international treaty negotiated by WHO to reduce the enormous burden of deaths and disease from the use of tobacco, started to be implemented in the Region during this decade.



Physical fitness was a key strategy endorsed by the Regional Framework for NCD Prevention and Control

Progress in disease eradication

As mentioned earlier, in May 1991, the World Health Assembly adopted a resolution declaring its commitment to the goal of eradicating guinea-worm disease (or dracunculiasis) by the end of 1995. Some endemic countries could not achieve this target but, by the year 2000, the South-East Asia Region was finally free of this disease.

India was the only country in the Region where this disease was endemic. A number of factors contributed to its eradication. First, diagnosis did not require any laboratory test. The characteristic symptoms and signs of the disease were easily identified by the victim or his/her relatives. Then, the geographical spread of the disease was limited to areas where people entered water sources and collected drinking water. It followed that infected persons and contaminated water sources could be easily identified and treated. The provision of safe drinking water contributed significantly to the decline of guinea-worm disease. Health education also played a crucial part in empowering rural communities in dealing with the scourge.

The National Guinea-worm Eradication Programme in India, launched in 1983, demonstrated the advantages of partnership and networking between Central and state governments of the country, WHO, UNICEF and NGOs at the national, state and district levels. Various national and international agencies, such as the National Institute of Communicable Diseases (NICD),

Central Health Education Bureau, UNICEF, and the Rajiv Gandhi National Drinking Water Mission, contributed to formal and non-formal education efforts. Community participation was encouraged in the process of eradication. Village leaders, school teachers and children, health workers and women were involved in specific activities. In 2000, WHO certified that India was free of guinea-worm disease.

With the exception of some parts of Asia and Africa, the world has been free from polio since 2000. In the South-East Asian Region, the disease mostly affected the northern states of India. With the implementation of WHO-recommended strategies, polio cases in the Region declined sharply – by over 98%. The last case of type 2 wild poliovirus in the Region was isolated in Aligarh, in the state of Uttar Pradesh, India, in October 1999. With this, the type 2 wild poliovirus has probably been eliminated in India.

Seven of the 11 Member countries successfully interrupted the transmission of wild poliovirus for at least four years, with India being the only endemic country, and Bangladesh, Indonesia and Nepal suffering belated importation of wild poliovirus. Overall, the number of cases of polio in the Region declined by more than 94%, from a reported 25 253 cases (types 1, 2 and 3) in 1988 to 134 laboratory confirmed cases (types 1 and 3) in India in 2004.

India detected only 66 polio cases in 2005, compared with 134 in 2004. However, in 2006, the number of cases increased to 676, the majority being type 1 cases from the state of Bihar. In 2007, there was a similar peak in type 3 cases, with much reduced type 1, and totalling around 850 cases. In 2008 the indicators showed that the marked peak of type 3 cases in 2007 in India had declined and was expected to come down to near baseline level. A number of initiatives were undertaken in India in an intensification of efforts to interrupt transmission of wild poliovirus. In April 2005, the surveillance network in Indonesia detected and reported a wild poliovirus type 1 case in West Java. The WHO laboratory in Mumbai confirmed its relation to polio outbreaks in Yemen and Sudan, and also to viruses detected in Saudi Arabia in late 2004. The number of affected children in Indonesia increased to 287 in October 2005.

Yaws was still a public health problem in Indonesia and Timor-Leste. These countries had accelerated their public health efforts to eliminate this neglected tropical disease before 2020. To do this, the Region adopted the new global strategy of treatment with oral azithromycin. The Regional Strategic Plan to Eliminate Yaws 2012–2020 was revised. The Regional Office took the lead in educating the affected population regarding personal hygiene measures, and advocating with ministries of health and other sectors for resource mobilization and clean water supply.

This Region has traditionally accounted for the highest case load

of leprosy. During this decade it made a remarkable contribution towards reducing the global leprosy burden. Of the more than 15 million cases globally cured with multidrug therapy (MDT), about 12.8 million were from this Region, and more than 11.8 million of them were from India. Nine of the 11 countries in the Region achieved elimination at the national level (with a prevalence of less than 1 case per 10 000 population), leaving only Nepal and Timor-Leste to achieve this goal. In March 2008, in Nepal, there were 3277 cases on MDT with a prevalence of 1.2 per 10 000, and in Timor-Leste, there were 185 cases on MDT with a prevalence of 1.7 per 10 000. Member countries revised and updated their national guidelines in accordance with the WHO Global Strategy and the Operational Guidelines, and were applying these accordingly. Collaboration with various partners was strengthened in the Region during the decade, and there was increased involvement of people affected by leprosy in efforts towards its control.

About 150 million people in the Region were at risk of contracting visceral leishmaniasis (kala-azar). Bangladesh and India were among the most severely affected countries in the world. The disease was endemic in 109 districts (45 in Bangladesh, 52 in India and 12 in Nepal) in the Region. During this decade, cases and deaths had been reduced in Bangladesh and Nepal, and India had strengthened its surveillance, case detection and treatment. A new rapid diagnostic test, along with improved surveillance, enhanced case detection.

The replacement of injectable drugs with an effective oral drug (miltefosine) reduced the number of deaths to less than 100 per year.

As a result of sustained advocacy by the Regional Office at the highest level, in 2005 a memorandum of understanding was signed between Bangladesh, India and Nepal to eliminate kala-azar by 2015, with the aim of reducing the incidence to less than one in 10 000 population. The Regional Office planned to introduce a new drug, liposomal amphotericin B, for treatment, and further scale up elimination in the three endemic countries.

The Region accounted for 65% of the global burden of lymphatic filariasis. The progress made during the decade in mitigating the impact of this disease is likely to culminate in the elimination of this disease by 2020. This is largely a result of mass drug administration (MDA) with diethyl carbamazine and albendazole. Coverage increased from 56 million in 2004 to 365 million in 2011. As a result, the microfilaria rate declined to less than 1%. Maldives and Sri Lanka stopped MDA and focused on surveillance. Thailand soon joined these two countries. Many health units in Bangladesh and Thailand had also discontinued MDA.

The elimination of lymphatic filariasis has the added benefit of controlling soil-transmitted helminthic infections, such as those caused by roundworm, hookworm and whipworm. This helps in reducing morbidity, especially among schoolage children, and in

improving the child's nutritional status and physical and cognitive growth.

WHO continued to supply albendazole to Member countries. Among the plans developed were to provide technical assistance for countries to scale up MDA where required, carry out transmission assessment surveys to stop MDA, and develop disability alleviation services.

During the decade, dengue fever was one of the most important public health threats in the Region. The increasing incidence, severity and frequency of dengue epidemics were linked to trends in human ecology, demography and globalization. The disease had spread to areas where it was historically unknown, such as Bhutan and Nepal. The Democratic People's Republic of Korea was the only country that had not reported any indigenous cases of dengue. Factors responsible for the spread of dengue fever included the lack of availability of antiviral drugs to treat the disease, changing vector dynamics, geographical expansion of the vector due to climate change, community ignorance, and weak public health actions in response to outbreaks. While several of these factors were beyond the control of the health sector, WHO strived to keep mortality caused by this disease to less than 1%. With Regional Office support, countries were able to achieve this. The target was not breached even during the massive outbreaks that hit Indonesia, Maldives, Sri Lanka, Thailand and Timor-Leste. This reflects the increased capacity of the health services to manage clinical cases effectively.

Defeating Kala-azar in Bangladesh

Visceral leishmaniasis, also known as kala-azar, or the 'dark fever', has long been a neglected tropical disease. It claimed hundreds of thousands of victims in South Asia before it was dramatically curbed during the 2005-2015 decade. Endemic in six countries – Bangladesh and India, but also in Brazil, Ethiopia, South Sudan and Sudan – kala-azar is a vector-borne disease transmitted to humans through the bites of infected female sandflies. It usually affects the poorest populations, particularly those living in mud houses. Mud is a construction material that harbours sandflies. As such, kala-azar causes further pain and suffering those already deprived. The disease is fatal if left untreated.

By 2005, according to WHO's estimations, an annual 300 000 people

were carrying the disease, with some 20 000 to 30 000 fatalities. More than 90% of the new cases occurred in the six countries mentioned above. While every country fought its own war against the disease, this was not enough.

'The cross-border issue was a big challenge, as the life patterns of people living in endemic neighbouring areas in Bangladesh, India and Nepal required common and concomitant actions,' says Dr Sanya Tahmina, current director of Centre for Communicable Diseases in Bangladesh, and a long-time fighter against communicable diseases.

And the unprecedented happened: in 2005, during the World Health Assembly in Geneva, Switzerland, the Ministers of Health of



Dr Mannan Bangali



Dr Sanya Tahmina

Bangladesh, India and Nepal signed a memorandum of understanding to eliminate visceral leishmaniasis in the Indian subcontinent. The roadmap was challenging and the goal very bold: decrease the incidence of the disease to below 1 case per 10 000 inhabitants per year in endemic areas at subdistrict level by 2015.

‘The memorandum was, for us, the foundation stone of a National Kala-azar Elimination Programme in Bangladesh. It provided a clear strategy and a pathway ahead. Starting 2006, we strengthened the vector control, while intensive spraying has been conducted with community support for years, both before and after the monsoon season. Tens of thousands of mosquito nets impregnated with insecticide have been distributed. Extensive awareness campaigns have been conducted and hundreds of health staff and volunteers have been involved in case searches. An “early diagnosis and prompt treatment” strategy has also been put in place,’ Dr Tahmena recalls.

Dr Mannan Bangali, retired WHO staff and regional specialist on vector-borne diseases, explains the role of medical developments in fighting kala-azar. ‘The memorandum of understanding gave an enormous boost to the fight against kala-azar, but the later discoveries of faster diagnosis and better treatment methods greatly

helped our efforts. In 1998, a new rapid diagnostic test was developed and introduced in the country and, in 2007, the classic 30-day treatment by painful intramuscular injections was replaced by a revolutionary single oral dose of miltefosine. Furthermore, WHO, working with the Bangladesh Ministry of Health, Family and Welfare and the International Centre for Diarrhoeal Disease Research, Bangladesh, tested the efficiency of new treatments. As a result, the use of a single-dose amphotericin B drug was recommended by WHO in 2012 as a first-line treatment against kala-azar, not only in Bangladesh but in all endemic areas of South Asia.’

Bangladesh reached the goal of having less than one case of kala-azar per 10 000 population in 2016. This was a major victory against a centuries-old disease that brought misery and further impoverished the poorest of the poor.

‘This was a great achievement that made everyone proud. But we should keep in mind that the disease is not eradicated and that continuous efforts need to be made to maintain the high level of monitoring, early diagnosis and treatment, as well as the measures for vector control,’ says Dr Bangali. ‘We know we still have important work ahead of us but the last 13 years of results prove that kala-azar can finally be defeated.’ adds Dr Tahmina.

Tackling new threats

Newly emerging diseases such as Chandipura virus, Nipah virus and Crimean-Congo haemorrhagic fever also posed public health threats to the Region during the decade. These new threats also threw up serious challenges to national public health service capacities.

The beginning of the millennium saw global outbreaks of diseases with pandemic potential. Severe acute respiratory syndrome was the first caused by a hitherto unknown pathogen. A second was a pandemic of influenza, which was similar to the three pandemics experienced in the previous century.

Another emerging threat was caused by outbreaks of highly pathogenic avian influenza (A(H5N1)) among poultry in Thailand and Indonesia (in 2004), India and Myanmar (in 2006), Bangladesh (in 2007), Nepal (in 2009) and Bhutan (in 2010). The disease was deeply entrenched in poultry in Bangladesh and Indonesia, while occasional outbreaks were reported in the other countries. The South-East Asia Region reported a total of 226 human cases of influenza A (H5N1) with 178 deaths since 2004.

Although the number of reported human cases had been decreasing over the previous five years, the fatality rate was very high (>80%). A "stamping out" policy was adapted for containment of poultry avian influenza outbreaks

in all countries. Vaccination of poultry was also done extensively in Indonesia. All countries established functional surveillance and response mechanisms through intersectoral collaboration.

WHO declared the first influenza pandemic of the 21st century in June 2009. All countries of the Region reported outbreaks at different times and a total of 76 302 laboratory confirmed cases with 2054 deaths were recorded. All countries were better able to respond to this pandemic as WHO support had helped them develop institutional and technical capacity by supporting their national avian and pandemic influenza preparedness plans.

A revision of the International Health Regulations (referred to as IHR (2005)) was unanimously adopted on 23 May 2005 by the



Severe acute respiratory syndrome, or SARS, is one of the emerging public health threats in the new century



Specific precaution is needed while taking care of newly emerging diseases

World Health Assembly. The broadened purpose and scope of IHR (2005) were to prevent, protect against, control and provide a public health response to the international spread of disease and avoid unnecessary interference with international traffic and trade. These regulations came into force on 15 June 2007. The Regional Office worked closely with all Member countries to facilitate implementation of IHR (2005).

Substantial progress was made in implementing these Regulations in the Region during 2007 and 2008. The IHR (2005) were responsible in large part for the swift and effective control of epidemics.

A multidisciplinary team was stationed at the Regional Office's Disease Surveillance and Epidemiology unit to provide normative and technical support to countries to strengthen national "Core Capacities" for preparedness, surveillance, risk assessment and outbreak response, as envisaged by the IHR (2005). Member States were expected to develop minimum core capacities to enable them to carry out the IHR (2005) by June 2014. The Regional Office invested its resources to initiate and develop programmes such as the Field Epidemiology Training Programme, and the Early Warning, Alert and Response Systems. In addition, Member States appointed district surveillance officers to improve surveillance capacity.

Universal access to AIDS treatment

Up to quite recently, having an HIV infection meant certain death. Now, with greater awareness, strong policies and increased access to drugs, it is fast becoming a chronic, manageable disease. During this decade, the HIV epidemic was halted and reversed in several countries, notably India, Myanmar, Nepal and Thailand. The

number of people living with HIV in the Region decreased from 6.2 million in 2004 to 3.5 million in 2011, reducing the overall prevalence from 0.7% to 0.3%. The number of new HIV infections fell by 31% during the decade. This achievement would not have been possible without commitment at the highest level.

The number of people receiving antiretroviral therapy (ART) increased substantially during the decade, from 55 000 to more than 814 000 people. The availability of generic, quality and affordable antiretroviral drugs produced in the Region (mainly in India) played a critical role in saving thousands of lives, not only in this Region but also in several other developing countries.

Thailand was the first country to integrate interventions for preventing mother-to-child transmission of HIV into its existing strong antenatal care programme in early 2000. With support from the Regional Office, strong political commitment and an affordable antiretroviral therapy regimen, Thailand successfully reduced mother-to-child transmission of HIV, and prevented more than 20 000 children from acquiring

HIV infection. The Region adopted an ambitious target to eliminate new paediatric infections by 2015. Thailand was also the only country in the Region to have achieved universal coverage of testing and counselling for HIV for all pregnant women. Over 90% of women who test HIV positive receive antiretroviral prophylaxis. Almost all babies born to HIV-positive women receive ART. This resulted in a reduction of the perinatal HIV transmission rate.

The Regional Health Sector Strategy for HIV/AIDS 2011–2015 was endorsed by Member countries. The Strategy calls for “zero new infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives”. ART scaling-up was accelerated by a new approach – the 3x5 Initiative, which aimed at providing ART to



Greater awareness, strong policies and increased access to drugs helped halt and reverse the HIV epidemic

3 million people living with AIDS in developing countries by the end of 2005. In the South-East Asia Region, although remarkable progress was made in scaling up ART since the launch of the 3x5 Initiative, the coverage still remained low compared to requirements (peaking at only 23%). The number of people

who started on treatment increased from 18 000 in 2003 to 320 880 in 2007, an 18-fold increase over four years. Further expansion of access to ART would have to address weaknesses in health systems, including in their human resources, poor strategic information, and low health-care financing.

Reducing the threat from malaria

During this decade the reported (confirmed) number of malaria cases per 1000 population at risk was reduced by more than 30% and the reported mortality rate was reduced by 72%. Malaria, however, remained a major threat to socioeconomic development in South-East Asia. The absolute number of people reported to be receiving antimalarial treatment also dropped. This could be attributed to a significant reduction in incidence in Bhutan, Democratic People's Republic of Korea, Indonesia, Nepal, Sri Lanka and Thailand.

Interventions to control malaria were scaled up considerably. For example, the number of rapid diagnostic tests conducted to diagnose malaria went up from 1.2 million in 2004 to 15.2 million in 2011. The number of insecticide-treated nets distributed increased from 3.35 million in 2004 to 29 million in 2011, and the number of treatment courses administered rose from 4 000 in 2004 to 4 million in 2011. The Regional Office supported

Member countries to reduce malaria cases and deaths by 75% by 2015 (compared with the year 2000) and to contain resistance to the antimalarial drug artemisinin (mainly in Myanmar and Thailand), with the long-term goal of eliminating the disease.

Of the malaria-endemic countries in the South-East Asia Region, five reported decrease in malaria cases and incidence rates of over 75% between 2000 and 2011. Another (Bangladesh) was on track to achieve a decrease in malaria case incidence of 75% by 2015. India, the country with the largest number of cases in the Region, was projected to achieve a decrease of between 50% and 75% in malaria case incidence by 2015. To achieve this ambitious target, the Regional Office was promoting high-level political collaboration, finding mechanisms to bridge the financial gap, expanding access to quality medicines and technologies, ensuring universal coverage of key malaria interventions in priority areas, and accelerating research and development.

Progress in health promotion

Promoting people's health is the most cost-effective measure to reduce their disease burden and consequently reduce costs to the nation. Health promotion is not the purview of the health sector alone, and must be the joint responsibility of all social sectors. To facilitate multisectoral actions for health and development, a Regional Strategy for Health Promotion for the South-East Asia Region was developed in 2006. The Regional Strategy was based on the actions and commitments contained in the Bangkok Charter for Health Promotion 2005, which was articulated at the Global Conference on Health Promotion in August 2005.

The strategy was designed to tackle the broad social, economic,

environmental and political determinants of health that lie outside the health sector. Strategic directions were laid out to promote healthy public policies across all sectors. Evidence-based policy development for health promotion was advocated and implemented in most countries. Specific national health promotion policies, plans or strategies were developed in at least seven Member countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Sri Lanka and Thailand). Some countries, such as Democratic People's Republic of Korea, Myanmar and Timor-Leste, integrated health promotion plans into their national health policies.

Introducing WHO's country cooperation strategies

From 1999 onwards WHO's country work was based on "country cooperation strategies". A Country Cooperation Strategy (CCS) is a medium-term strategic vision to guide the Organization's work in and with a country, responding to that country's specific priorities and institutional resources needed to achieve its national policies, strategies and plans, as well as the actions to achieve its national targets within the Millennium Development Goals (MDGs).

The CCS is the strategic basis for the planning process, and identified a focused and coherent set of priorities that responded to country needs. The CCS informs and reinforces the health dimension of the United Nations Development Assistance Framework (UNDAF) and acts as the main instrument for harmonizing WHO's cooperation in a country in collaboration with other United Nations agencies and development partners towards achieving the MDGs and later the SDGs.

Health in Timor-Leste: Then and now

An interview with Eurico da Costa de Jesus, Village Head (Chefe Suco), Comoro, Dili, Timor-Leste



A 'tai' featuring traditional motifs on cloth. Gifted by Timor-Leste

Eurico da Costa de Jesus, 64, has witnessed the journey of over half a century of the youngest Asian nation. Timor-Leste gained its independence in 1975 after nearly four-and-a-half centuries of colonial rule. 'The country's tumultuous journey to independence and the process of rebuilding itself in the wake of absolute destruction is a story of collective grit and determination, and a quest to rebuild a country literally from the ashes,' says Eurico.

After growing up in the eastern districts of Baucau and Manatuto Eurico, Eurico moved to the capital Dili in 1979 and began to work in the area of health in different roles and capacities.

'To give you a broad idea of where we were during colonial times and where we are now, let me tell you about the immunization programme. As I recall, before 1975 there were only two vaccines in the immunization programme: BCG for tuberculosis and measles. Today we have nine vaccines in the national immunization schedule and we have impressive coverage too,' he says.

Eurico trained as a health volunteer during the colonial era and worked in different areas, including immunization. This was also the time when there were hardly any qualified doctors in the country. The Portuguese ran training programmes under which they trained volunteers to provide

basic treatment and dispense medicines accordingly. 'I remember yaws being widespread in those days, but there was little we could do other than provide basic care, like first aid.'

Religious institutions played a crucial role in catering to the health needs of the people before 1975, although old-timers concede that before the restoration of independence in 2002, health services were thinly spread. 'After 1975 there was marginal improvement in the health services, but that wasn't enough. There was one notable change though: we at least had some doctors compared with nil before 1975. But access to health care was limited.' This was also a time when several disease prevention measures were put in place. Eurico recalls his opportunity to work with the malaria programme where they distributed mosquito nets to the communities in Dili and in nearby districts.

1999 marked the beginning of the World Health Organization in Timor-Leste, when the country started rebuilding infrastructure. 'The process of rebuilding from zero was arduous, long and testing, but not without its rewards. Today, the country boasts of one of the best doctor-to-population ratios in the world. The government is now successfully implementing the second round of its flagship primary health care programme, the Saude na Familia (Health in the Family). Another good measure of our journey

would be to compare the number of doctors we had in the last century to the numbers today. From practically no doctors to now having 1000+ doctors has been a long but rewarding journey for everyone. People now have significantly better access to health care,' says Eurico.

Recalling the years after 1999, Eurico highlighted his experiences in working alongside WHO. 'Health development and WHO in this country have been intertwined since 1999. To give you an example, we are now in the malaria elimination phase. We hope to be certified malaria-free in the next few years. WHO's role in this is widely known. I also recall one major contribution of WHO in the early days: the Organization contributed in a big way to the rehabilitation of the Comoro and Manleuana health facilities. This changed the lives of the local community for better.'

Timor-Leste's journey of rebuilding, however, isn't over yet. The country has committed itself to attaining the dream of universal health coverage leaving no one behind, and has made impressive gains in the area. But there are plenty of challenges. In Eurico's words: 'There always is room for improvement. We now must have doctors who are better qualified and on a par with best in the world. We must also invest more in frontline health workers. We rose from the ashes, so I am sure we can achieve whatever we set our mind to.'

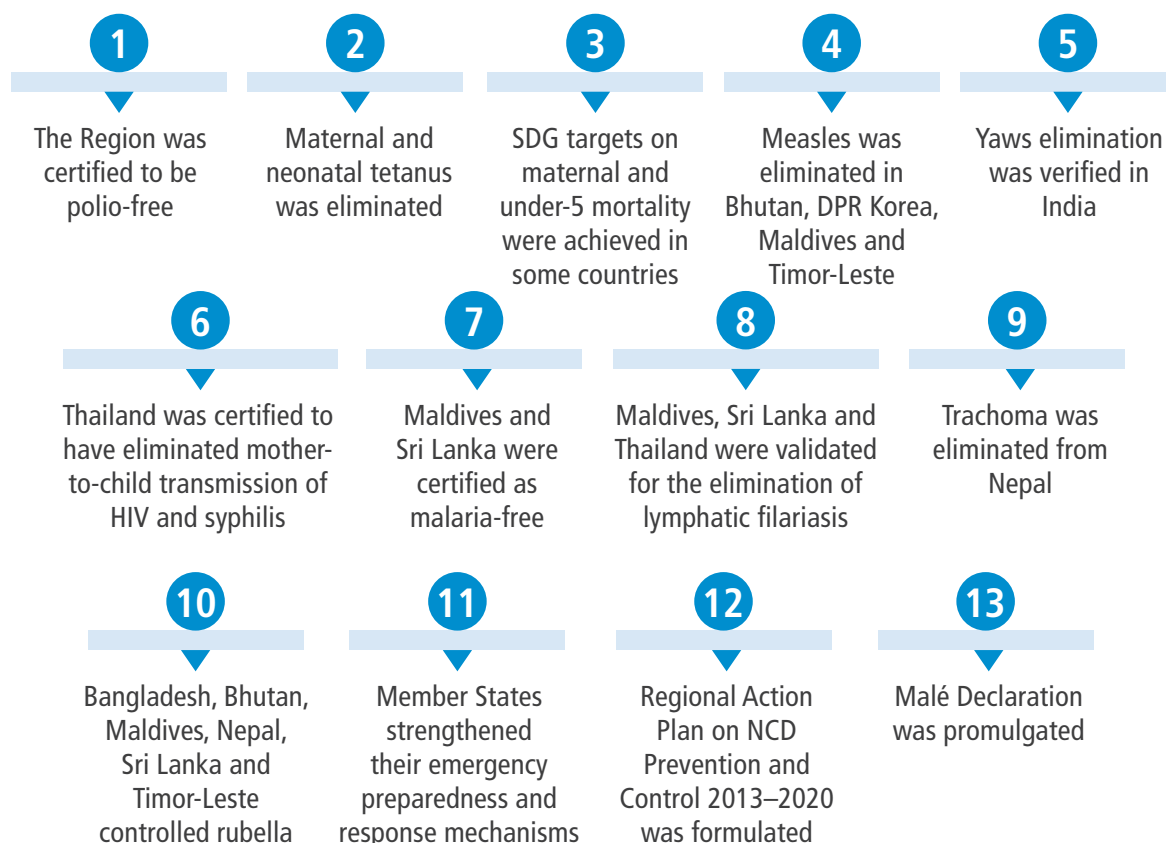




THE SEVENTH DECADE
2008–2018

From MDGs to SDGs
– the dream of
health equity

MAJOR ACHIEVEMENTS IN THE SEVENTH DECADE: 2008–2018



During this last decade WHO and its Member States in the Region recorded substantive and inclusive gains in health and well-being. In line with the Region's guiding framework for action – the eight Flagship Priority Areas⁵ – path-breaking change has been delivered on a series of issues, with

wide-ranging strategic and human impact. The Region was certified polio-free. The Region was credited with halting and reversing the HIV, tuberculosis and malaria epidemics – all key Millennium Development Goals. South-East Asia became the second WHO Region to eliminate maternal and neonatal tetanus. Thailand became the first country

⁵ (1) Measles elimination and rubella control by 2020; (2) the prevention of noncommunicable diseases through multisectoral policies and plans, with focus on "best buys"; (3) the unfinished MDGs agenda: ending preventable maternal, newborn and child deaths, with a focus on neonatal deaths; (4) achieving universal health coverage, with a focus on human resources for health and essential medicines; (5) building national capacity for preventing and combating antimicrobial resistance; (6) scaling up capacity development in emergency risk management in countries; (7) completing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis and yaws); and (8) accelerating efforts to end tuberculosis by 2030.



WHO South-East Asia Region and its Member countries are driving substantive, inclusive gains in health and wellbeing, in line with the Region's Flagship Priority Areas. Overcoming challenges and achieving the dream of health equity is crucial to our collective vision. It is a goal that defines our professional and moral duty.

As we strive to attain our regional vision, the significance of the moment must be fully grasped: We have the opportunity to advance the health of billions and secure wellbeing for all. History can be ours.

**Dr Poonam Khetrpal Singh,
Regional Director since 2014**

in Asia to eliminate mother-to-child transmission of HIV/AIDS and syphilis. Sri Lanka followed Maldives in being certified malaria-free. Both countries and Thailand eliminated lymphatic filariasis as a public health problem. India, meanwhile, became the first country to gain yaws-free status.

In August 2018, two countries of WHO South-East Asia Region, DPR Korea and Timor-Leste, were verified for eliminating measles, and six countries certified for controlling rubella and congenital rubella syndrome, two years ahead of the target year 2020. In May 2018, WHO validated Nepal for having eliminated trachoma as a public health problem – a milestone, as the country becomes the first in WHO's South-East Asia Region to defeat

the world's leading infectious cause of blindness.

The Region became the first to assess health services coverage using an index tool developed by WHO and the World Bank. The South-East Asia Regulatory Framework, aimed at helping the Region's 1.8 billion consumers to access safe, high-quality medical products and thereby enhance health coverage, was launched. National action plans for antimicrobial resistance (AMR) prepared by each country in the Region would help to stymie the rapid and alarming emergence of AMR, thereby fortifying regional and global health security. Efforts to stimulate physical activity and promote healthy eating, as per the regional NCD plan, would also help slash the projected rise in noncommunicable diseases in the coming years.

UHC as a key public health principle

Universal health coverage (UHC) envisages that all people should have access to the services they need, without facing financial hardship. These services should be of high quality and should be oriented to the needs of local populations. They should also be within reach, regardless of a community's location. UHC will be realized progressively, and needs to be an ongoing concern.

At the Sixty-seventh session of the WHO South-East Asia Regional Committee in 2014, Member countries committed themselves to enhancing health workforce education and training as a part of the Decade for Strengthening Human Resources for Health, an initiative launched earlier that year. Key activities included enhancing the retention of rural staff, providing transformative education, and developing information systems that can collect data for action. Aligning education with service needs is another key activity.



Strengthening mother and child health care are among the key components to achieve UHC

A regional consultation on the role of UHC within the Sustainable Development Goals was held in 2016 in the Regional Office. At the consultation, Member countries shared best practices in enhancing service coverage and financial protection for excluded groups, including ethnic minorities, migrants, mobile populations, refugees and the urban poor. Another important technical consultation was held in 2017, in which country representatives discussed enhancing national capacity to monitor progress on the health-related SDGs, including UHC.

The Region carried out an assessment of health service coverage in all Member countries using the service coverage index developed by WHO and the World Bank; it was the first region to do this. Following the Colombo Declaration, endorsed by the Sixty-ninth session of the Regional Committee in 2016, all countries are now working to extend their services for noncommunicable diseases to the primary level. This would help detect NCDs or risk factors on time and prevent possible complications later. It would also help to achieve the SDG target of a one third reduction in premature deaths caused by NCDs by 2030.

The South-East Asia Regulatory Network, launched in 2016, will harmonize regional cooperation on

medical products regulation, ensuring that all drugs and medical devices produced and sold in the Region do exactly what they are supposed to do. The Regional Office for South-

East Asia is dedicated to realizing the promise of universal health coverage, and to continue working with Member countries to identify needs, implement policies and track progress.

Completing the MDG agenda on maternal and child mortality

The health of mothers and mothers-to-be, neonates, children and adolescents is crucial for the Region's future. With WHO support, between 1990 and 2015 countries of the Region reduced maternal mortality by 69%. Child mortality was reduced by 64%, while neonatal mortality was reduced by 54%. Despite all this, MDGs 4 and 5 on maternal and child mortality were not achieved. This is a key regional concern.

Special focus is being given to ensuring that every newborn survives the first 28 days of life, and that the quality and reach of family planning services are enhanced. WHO's work in this important area focuses on enhancing advocacy, strengthening partnership, and delivering sound and effective technical assistance to Member countries.

In 2015, the Regional Office created a regional Technical Advisory Group on Women's and Children's Health, comprising top global and regional experts in these areas. The Group guides national governments, implementing partners and other stakeholders on how best

to accelerate action towards the unfinished MDG targets, and prepares the technical and strategic ground to achieve the broader SDG agenda.

The Region eliminated maternal and neonatal tetanus in 2016. The combined measles and rubella vaccine is now providing life-saving protection to vulnerable groups in 10 of the Region's 11 countries. The Integrated Management of Newborn and Childhood Illness (IMNCI) is being implemented in health facilities across the Region. Maldives, Sri Lanka and Thailand have already achieved the SDG target on maternal mortality as well as on neonatal mortality. The Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand have achieved the SDG target on under-5 mortality. Increasing access to family planning services – including contraception – is a key objective of the 2015 regional reproductive, maternal, neonatal, child and adolescent health strategy. This would drive down maternal and child mortality, empower women to avoid unintended pregnancies, and advance women's social and economic autonomy.

Implementing universal health coverage in Thailand



The Director-General, Dr Tedros Adhanom Ghebreyesus, and the Regional Director for South-East Asia, Dr Poonam Khetrpal Singh, on a field visit in Thailand.

WHO has praised Thailand for providing continuous ambulatory peritoneal dialysis (CAPD) to kidney patients for free. This model could also be adopted by other countries. Speaking after observing the National Health

Security Office's CAPD service at the Phra Jen community, Dr Tedros said: 'I am so inspired by what I have seen that I want to pass the story of Thailand on to other nations so that they can improve the quality of life for kidney patients

around the world. I asked a kidney patient in the community, who pays for his treatment? He replied that the government helped, and that, without support from the government, he may not have survived until this day. I'm very happy to see that the government broke the financial barrier for kidney patients, allowing them to access necessary medicines and health-care services.'

CAPD is a machine-free treatment for kidney failure that patients can perform at home by placing cleansing fluids in their abdomens for draining waste. Previously, all kidney patients who needed to take dialysis had to go to hospital. Since 2008, Thailand has included CAPD treatment in its universal coverage health care scheme to give patients more independence and remove the burden of travelling to hospital for treatment. The Thai National Health Security Office (NHSO) now subsidizes 100% of CAPD treatment, which costs about 15 000 Thai baht (about US\$ 450) per month, across the nation via public hospitals.

The CAPD project, in which doctors and nurses at hospitals and clinics form teams to visit patients with kidney disease at home once a month, has also been created. Patients and their

family members will be taught to perform CAPD safely by themselves. Community health volunteers have been encouraged to participate in the project as well.

There are more than 20 000 kidney disease patients nationwide receiving CAPD treatment. Dr Tedros said another important element that was observed was the involvement of family members and people in the community in taking care of patients. 'Members of a patient's family and community have helped with parts of the job, and do not just rely on doctors and nurses. They are all well trained in primary health care. When you see the involvement of families and communities, you know that the system is very sustainable.'

Piyathida Jungsamarn, a nephrologist at Ban Phaeo Pattanakan Hospital, said normal kidney dialysis is often a physically and emotionally draining process, as patients must go to hospital two to three times per week, with each session taking up to five hours. 'By the time kidney patients recover from each treatment, it is time for the next,' she said. 'However, with CAPD, patients can have a more flexible lifestyle and a sense of self-reliance.'

(Bangkok Post, 2 February 2018)

Freedom from polio and the 'Endgame' plan

In March 2014, the WHO South-East Asia Region was certified polio-free. Mass immunization campaigns were successful in reaching the most vulnerable groups in the remotest of places, and interrupting the transmission of the polio virus. Robust and sensitive surveillance systems helped guide and refine strategies, facilitating the innovations needed to overcome the last challenges. Since January 2011, not a single case of wild poliovirus has been reported in the Region. All countries of the Region are committed to maintaining this polio-free status.

Since the polio-free certification, surveillance has been reinforced and expanded. Immunization systems have been strengthened. Where vaccine-derived strains of the virus have been detected, rapid immunization campaigns have been carried out. The Polio Endgame Plan is being implemented in the Region. The Endgame has four objectives: i) virus detection and interruption, ii) routine immunization strengthening, iii) containment and certification, and iv) mainstream polio functions, infrastructure and learning.



Group photograph of participants at the Seventh Meeting of the South-East Asia Regional Certification Commission for Polio Eradication held in New Delhi, India, on 26–27 March 2014. The Region was certified polio-free in 2014

The Region has had a complete polio vaccine switch, replacing the traditionally used trivalent oral polio vaccine with the bivalent oral polio vaccine. The bivalent vaccine protects against the two remaining wild poliovirus strains (since the wild poliovirus type 2 has already been eradicated globally), and reduces the small risk of paralysis from vaccine-derived polioviruses.

As a part of the Endgame Plan, injectable inactivated polio vaccine is now a standard component of childhood immunization schedules regionwide. Consequently, polio programmes are having wider impact. The polio programme's emphasis on innovation, community

engagement and surveillance has meanwhile been replicated by other public health programmes.

During the Seventy-first World Health Assembly in 2018, Member States adopted a landmark resolution on poliovirus containment, and endorsed the five-year Strategic Action Plan on polio transition. The action plan outlines how essential polio functions, such as surveillance, laboratory networks and core infrastructure, can support the implementation of the Post-Certification Strategy to sustain a polio-free world, and how they can be integrated into the immunization or health emergencies programme, or mainstreamed into national health systems.



The Polio Endgame Plan is being implemented in the Region

Last case of polio in India

The story of Abdul Shah, an unskilled, illiterate, landless and poor villager, is of a spectacular journey from stark hopelessness after learning that his daughter was affected by polio to basking in the reflected glory of the intense spotlight that followed. It spanned the gamut of emotions from sky-high and unrealistic expectations to bleak frustration on realizing the futility of his dreams, and ultimately coming to terms with reality. And the journey lasted seven years.

One wintry afternoon news reached the family that the unthinkable had happened. Their daughter Ruksar, only one-and-a-half years old then, had a confirmed polio infection. The family had never had her immunized. They were averse to immunization, and never expected this attitude could affect them so dearly. Polio was not new to their village of Shahpara, in Howrah district of the state of West Bengal, and so did not appear to be a major catastrophe to the community. But Abdul was shaken. His subsequent interactions with health workers revealed to him the folly of not having immunized his child.

Gradually, as no further polio cases were detected, the spotlight on Ruksar

became more focused and incredibly intense. By that time Abdul was a changed man. He worked hand in hand with social mobilizers engaged specifically in polio immunization activities aimed at breaking the taboo of 'immunization avoidance'. He pleaded with his brethren to not shy away from immunization and face the same fate as his: a child with polio. He withstood mockery and often hostility.

This transformation of Abdul from 'resister' to 'influencer' was neither instantaneous nor easy. In the last phase of the war against polio in the country, every fresh case was a new frontier. As soon as Ruksar was declared a 'confirmed polio' case, urgent action was initiated by the government health authorities, strongly supported by WHO.

The community to which Ruksar belonged was greatly resistant to immunization, even the fact of polio itself failed to soften their stand. They accepted the disease stoically. Relentless efforts and counselling yielded results slowly but surely. All the Polio Eradication Initiative (PEI) partners, led by WHO, pursued their single-minded approach to break this resistance.

Religious leaders were roped in, and so were political personalities.

Abdul, who wasn't even ready to talk to anyone in the beginning, began to listen, and then understand, and finally communicate. To see what it was all about, he was taken along by PEI social mobilizers on their outreach efforts to other resistant families in his own locality. Gradually he started to speak about immunization passionately and positively.

The following years saw a great circus unfolding with Abdul. Uninterrupted visits by a stream of guests coming to meet Ruksar and her family became the norm. Every visit ended cordially with folded hands and nodding heads. The community saw that they now had a true 'VIP' in their midst. The whole show culminated in the year 2014 when Ruksar and her family were invited by none other than the President of India to the capital to commemorate three years of polio-free India. Ruksar had become a truly national icon, and Abdul was overwhelmingly proud of her. Abdul continued to work as an opinion leader, going from door to door to convince the reluctant to immunize their families.

Happily, Ruksar was never crippled, despite being infected by the polio virus. At first, she limped, but very soon was back to normal and running about freely. She joined the local village school. She was too small to harbour any particular expectations other than to be able to keep running and skipping happily. This wasn't the case with the rest of the community, which hoped for some monetary compensation. When this was not forthcoming, frustration grew and the villagers started chasing out visitors, blaming them for 'selling their misery'. 'You benefit from the story of our child and give nothing in return!' was the refrain.

But Abdul, a poor, religious man, now feels enlightened. Come what may, he will help to convince his community not to take the wrong path of avoiding vaccines. 'I will ask everybody not to make the same mistake as I made. I am lucky my child is walking today, but everybody everywhere may not be as lucky as me...'

(WHO Country Office, India)

Maternal and neonatal tetanus eliminated

Maternal and neonatal tetanus has been a major public health problem in 90 countries in the world, including all 11 of the South-East Asia Region. In May 2016, the Region was declared to have eliminated maternal and neonatal tetanus, becoming the second among six WHO regions to achieve the target. Elimination was achieved by concerted efforts in the countries and thanks to several key factors: the courage of the health-care workers, the commitment of policy-makers and donors, and a renewed emphasis on responsive programming that was able to meet local needs and challenges.

By the turn of the millennium, Bhutan, the Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand had eliminated the problem. By 2010, Bangladesh, Myanmar and Nepal had joined this

group. Timor-Leste soon followed, leaving India and Indonesia to chart the final course towards regionwide elimination.

India's health authorities took a state-by-state approach and combined approaches, including the provision of cash incentives, the training of skilled birth attendants, and intensive behavioural change programmes. These interventions led to a strengthening of the health system, particularly as regards maternal and child health, and routine immunization coverage. India was validated as having eliminated maternal and neonatal tetanus in each of the country's districts in April 2015.

Indonesia was also strategic in its approach. To drive progress in affected areas, health authorities targeted tetanus vaccines to all women of childbearing age and held monthly health clinics. They also counselled women on the need for clean delivery and hygienic cord care. This combination proved a success, and Indonesia achieved elimination in May 2016.

Over the years, WHO's Regional Office for South-East Asia supported each country to overcome this major killer disease that affected mothers and neonates. The resurgence of the disease should be avoided by



Maternal and neonatal health services are accorded due priority

strengthening the measures that facilitated elimination in the first place: sustaining and enhancing access to quality maternal and newborn health care, maintaining

and increasing immunization coverage, and upholding robust surveillance systems that can identify lapses and provide the information needed for rapid action.

Last push to eliminate measles

More than 90% of the people in the Region are now benefiting from the life-saving aspect of vaccines. The Regional Office for South-East Asia has identified the elimination of measles and control of rubella and congenital rubella syndrome as priority outcomes by 2020. Both diseases continue to affect the lives of vulnerable groups across the Region, making the efforts of Member countries both bold and necessary. Success demands a combination of robust political commitment, strong partnership and sound technical planning.

In 2014, the Regional Office in consultation with Member countries developed the Strategic Plan for Measles Elimination and Rubella and Congenital Rubella Syndrome Control, 2014–2020. The Region's victories over polio and maternal and neonatal tetanus, as well as the overall increase in routine immunization coverage, mean the foundations for success are already in place. It is now a matter of fine-tuning and using strategies already long familiar to countries. Two doses of measles-containing vaccine have now been introduced in every Member country. A level of 95% of

both doses – the level needed to establish herd immunity – has been achieved in five countries. Rubella vaccine was part of the combination vaccine in the majority of countries. With the goal being regional measles elimination and rubella control, Bhutan and Maldives were verified to have eliminated measles in April 2017, and DPR Korea and Timor-Leste in 2018. More countries are expected to follow. Through technical assistance and planning, data management, advocacy and resource mobilization, WHO is committed to ensuring each country is freed of the burden of measles.



Laboratory examination is an important part of public health

Accelerating efforts to end TB by 2030

The WHO South-East Asia Region bears a disproportionately high burden of tuberculosis: almost 50% of the global burden is to be found in this Region which is home to a quarter of the world's population. Six of the top 30 high-tuberculosis-burden countries are in the Region. It has been estimated that the Region loses nearly US\$ 4 billion as direct and indirect costs to patients for accessing tuberculosis services and in income lost every year.

Many important events in the Region have been conducted since the World Health Assembly adopted the "End TB Strategy" in 2014, which was endorsed by the Sixty-eighth session of the Regional Committee in September 2015. A high-level meeting to discuss ending

TB in the Region was held in March 2016. At the same time, the SEA Regional Strategic Plan to End TB 2016–2020 was launched. During 2016, the concept of "Bending the Curve" was launched; studies on accelerating the end of TB, and an analysis of the associated resource needs were drafted. In March 2017, the Ministerial Meeting towards ending TB in the Region was held in New Delhi and all Member countries signed the "Delhi Call for Action". In March 2018, another high-level End TB Conference was organized also in New Delhi.

The Delhi Call for Action to End TB in the South-East Asia Region was signed by all Member countries. The Call offered six interlinked approaches: i) establish empowered



Tuberculosis is an important public health problem in the South-East Asia Region

national initiatives, ii) ensure full funding, iii) ensure universal access to high-quality TB care in all sectors, iv) provide patient-centred socioeconomic support, v) establish a regional innovation-to-implementation fund, and vi) mobilize global resources. The Regional Office's technical assistance and collaboration would focus on key strategic actions related to the establishment of an empowered national initiative; strengthening technical support for alignment of national strategic plans with the Delhi Call for Action; supporting the countries in identifying innovation needs; following up on implementation of the national



Medicine is available, but an accelerated effort is needed to end tuberculosis by 2030

commitments; and providing support in mobilizing the domestic and international resources needed to end TB.

Ending the HIV, malaria and viral hepatitis epidemics

Epidemics of HIV and malaria have taken millions of lives over the decades. After sustained progress over the years – including meeting the Millennium Development Goal to halt and reverse each epidemic in Member countries – countries are now in a position to end the HIV and malaria epidemics altogether by 2030. Before the SDGs embraced this target, WHO supported Member countries to make cost-effective, high-impact investments, pursue inclusive, community-based policies, and harness cutting-edge, life-saving technologies – strategies that remain central to the Region's focus.

Progress on HIV and malaria has been substantial. From 2001 to 2015 the Region cut new HIV infections by almost a half. Between 2000 and 2015, it reduced reported malaria cases by almost 50% and reported malaria deaths by nearly 90%. In 2016, Thailand was certified to have eliminated mother-to-child transmission of HIV and syphilis. This was the first time a country with a large HIV epidemic had done so. Sri Lanka became the first country in the SGD era and the second in the Region to have eliminated malaria (Maldives was certified malaria-free in 2015). Both achievements will



Countries are now in a position to end the malaria epidemic by 2030

have life-changing consequences for once-affected populations. Strong commitments have been made with regard to HIV and malaria by all Member countries. At a regional consultation on ending

HIV, TB and malaria, in March 2017, countries registered their desire to see associated disease programmes brought under a single, empowered national body that could also tackle viral hepatitis.

Viral hepatitis as a public health threat

Viral hepatitis is the seventh leading cause of mortality worldwide and is the only communicable disease wherein mortality is increasing. Viral hepatitis causes at least as many, if not more, deaths annually than tuberculosis, AIDS or malaria. Around 90% of these deaths are a result of hepatitis B and C infections.

The South-East Asia Region is home to an estimated 39 million people with chronic hepatitis B virus (HBV) infections and an estimated 10 million people with hepatitis C virus (HCV) infections. An estimated 410 000 people in the Region die annually as a result of viral hepatitis, with chronic complications

associated with HBV and HCV accounting for 78% of the total deaths.

Viral hepatitis infections are, to a large extent, amenable to prevention and control. There are effective vaccines to prevent hepatitis A and B, an effective treatment for hepatitis B, and now a cure for hepatitis C in most cases.

The Regional Office developed a regional action plan for 2016–2021 – an actionable framework governed by principles of human rights, equity,

community involvement, universal health coverage, partnership and evidence-led actions – with a goal to eliminate viral hepatitis as a major public health threat in the Region by the year 2030. It has adopted five strategies: i) increase birth dose coverage for hepatitis B; ii) ensure that only reuse prevention syringes are used; iii) assure safe blood supply; iv) improve water and food sanitation; and v) increase access to diagnostic and treatment services for those infected. Increasing awareness among public and health-care providers is also critical.

Eliminating neglected tropical diseases

Neglected tropical diseases (NTDs) share the same biosocial causes of neglect, marginalization, poverty and stigma. In 2014, finishing off the task of eliminating key neglected tropical diseases was made a priority area for action in the Region. Accelerated action is being pursued to achieve the time-bound regional NTD targets set in the previous decade – by 2020, lymphatic filariasis, visceral leishmaniasis, schistosomiasis, trachoma and leprosy should be eliminated as a public health problem and the Region should be free of yaws – and to guarantee the health and well-being of the Region's poor and marginalized.

In 2015, WHO formally acknowledged India to be the first

endemic country in the world to become yaws-free. Maldives, Sri Lanka and Thailand eliminated lymphatic filariasis as a public health problem. Nepal had maintained the elimination target for visceral leishmaniasis of having less than 1 case per 10 000 people at the subnational level for three consecutive years. Every subdistrict in Bangladesh and 90% of the administrative blocks in India have achieved the same. In leprosy, although it has been eliminated as a public health problem at the regional level, active case-finding in affected communities has been enhanced, contact tracing has become routine, and a sentinel system for monitoring drug resistance is being expanded. In Nepal, trachoma has been eliminated



Children taking a mass drug prophylactic: three countries of the Region have already eliminated lymphatic filariasis as a public health problem

as a public health problem and validated by WHO.

At the Sixty-ninth session of the Regional Committee for South-East Asia in 2016, a special session was held on NTDs to help countries overcome the last challenges that persist. The health ministers of all 11 countries reaffirmed their commitments to reaching the NTD targets. A regional consultation on NTDs in April 2017 issued a

high-level “Call for Action” on accelerating progress towards the elimination of NTDs endemic in the Region. Targeting interventions where they are needed most – the grassroots – is fundamental. The Regional Office is working with Member countries to make this happen, and to ensure that the biosocial causes of NTDs and other health issues are identified and removed.

Elimination of trachoma in Nepal

The national trachoma programme (NTP) was launched in 2002 with the single aim of rolling out “SAFE” (surgery, antibiotics, facial cleanliness and environmental improvement) interventions to eliminate trachoma from as many as 20 high-risk districts of Nepal. The NTP and Nepal Netra Jyoti Sangh (NNJS) trained thousands of community health volunteers to tackle the disease at all levels and across all endemic districts. Mass drug administration, counselling, referral of patients and sensitization of the community towards healthier hygiene and sanitation practices ensured that the transmission of trachoma was interrupted in Nepal. In collaboration with WHO, Nepal made concerted efforts to meet the high standards of data collection and disease management that were necessary for this remarkable feat. The result was commendable: the trachoma elimination target in all endemic areas was more than amply met and validated by the World Health Organization. Today, Nepal can stand as tall and proud as its highest mountain, knowing that it has achieved the peak of health stewardship in wiping out trachoma from within its borders. As its people celebrate their bright dreams and visions, I extend my sincerest congratulations to the people and leadership of Nepal on this outstanding success.

Dr Poonam Khetrpal Singh, Regional Director

World Health Organization. Wiping out Trachoma from Nepal, How Nepal eliminated trachoma as a public health problem. WHO SEARO, 2018



Targeting interventions where they are needed most – the grassroots – is fundamental to eliminating neglected tropical diseases

'Filariasis has not stopped me'

In conversation with Ms Aminath Warudha, Maldives



Ms Aminath Warudha was about 10 years old when she was diagnosed with lymphatic filariasis, and this was about 70 years ago. She is a resident of Gaafu Alifu Dhevvadhoo, an island in Maldives with a population of 1000. 'When I was growing up, there were many people in our island who lived with filariasis. I am among the only three to four people who are still alive and fit enough to recall our experience,' she said.

Lymphatic filariasis, commonly known as elephantiasis, is a painful and profoundly disfiguring disease. While the infection may be acquired during childhood, its visible appearances may occur later in life, causing temporary or permanent disability.

For Ms Warudha, it started with very high fever and a lump on her foot. Her fever continued for a week or more, and would often come back every month. 'In the olden days, our island had big water

wells in every home. The water in these wells was visibly unclean. Everyone used to bathe and wash themselves submerged in the same well water. I believe this is where I might have been bitten by mosquitoes. Unfortunately, medicine was not readily available and health centres were not yet established at the time.'

Even when Ms Warudha grew up, got married and had children, she recalls having fever at least once a week. 'The biggest two burdens I faced in life were living with this continuous fever and the thickening and swelling of my feet. This became very challenging during my 12 pregnancies, because my feet used to swell even more during that time. However, I didn't let this disease weigh me down, or diminish my abilities.'

'Despite my condition, I raised 12 children and I went to the forest every day to gather and carry wood, and used it to cook fish to feed my family. Since then, I've been treated and received the appropriate medication to beat the disease. I want to tell people that treatment is available and access to treatment early will stop the suffering. At the age of 80, I am still working hard and am in good shape. Filariasis has NOT stopped me. Of course, the condition of some people was worse than mine. I followed the sanitary practices that were recommended, and

don't even have a scar to show on my feet anymore.'

On 19 July 2016, Dr Poonam Khetrpal Singh, Regional Director for South-East Asia, certified Maldives as having attained the elimination of lymphatic filariasis. She highlighted the fact that this was the result of seven decades of partnership between WHO and Maldives: the first collaboration between WHO and Maldives had been on lymphatic filariasis campaigns in 1951.

'When I learned that Maldives had eliminated lymphatic filariasis, I was elated. Eight of my children are alive today and all of them are, and have been, safe from this disease. Future generations will also be protected from this burden. If a small country like Maldives can eliminate filariasis, I have no doubt that other countries are capable of doing the same,' Ms Warudha said.

Elimination of lymphatic filariasis is among a series of health sector achievements in Maldives in recent years, including the attainment of measles-free status in 2017. Although the elimination target has been reached, efforts will need to be made to sustain the achievement. The people of Maldives can now look forward to a future free from a devastating and stigmatizing neglected tropical disease.

Sustaining momentum to combat AMR

Combating antimicrobial resistance (AMR) is one of the priorities in the South-East Asia Region. The Region is vulnerable to the emergence and spread of resistant bacteria thanks to its large, densely packed populations, inadequate water, sanitation and hygiene, and often suboptimal antibiotic regulation and stewardship across the medical, animal and agricultural sectors.

The consensus is that a concerted approach should be developed to fight AMR. Countries have national multisectoral action plans in place to tackle AMR. The Jaipur Declaration issued by the Region's health ministers in 2011 was the first acknowledgment of the destructive potential of AMR. It recognized the irrational use of antibiotics as the key driver of AMR, and advocated a holistic and multidisciplinary approach for its control.

At the Sixty-eighth session of

the Regional Committee in 2015, a resolution was passed which emphasized the need for political commitment and effective multisectoral coordination to fight the problem. In 2016, a roadmap for the creation of national action plans to combat AMR was developed, and countries pledged to finalize the plans by May 2017.

AMR national action plans are aligned with the target timelines set by the World Health Assembly. In July 2018 an intercountry meeting was held in Bangkok to review implementation of NAPs and the way forward.

AMR requires action at all levels, and with all partners. Ongoing engagement and advocacy will be vital to maintain Regionwide momentum. The Regional Office is committed to support Member countries to counter the growing menace of AMR.

Innovating emergency risk management actions

Across the South-East Asia Region, acute events such as earthquakes, floods and cyclones imperil the health of millions. So do emerging

and re-emerging diseases such as SARS (severe acute respiratory syndrome), MERS-CoV (Middle East respiratory syndrome coronavirus)

and the Zika virus. Managing risk means building health systems that can detect and respond to such events effectively. It also means integrating them into the wider systems of national preparedness and response.

During this decade, emergency risk management has been a regional priority. This includes efforts to achieve compliance with the IHR (2005) – a task vital to health across the Region – as well as global health security. Since 2008, a one-of-a-kind system has helped countries in the Region to respond to several emergencies, providing over US\$ 5 million in emergency funding. The South-East Asia Regional Health Emergency Fund (SEARHEF) has been expanded and now includes

emergency preparedness.

Joint assessments of country capacity have demonstrated how gaps can be found, and where systems can be strengthened. As of now, 10 of the 11 countries have conducted periodic assessments on capacities for emergency risk management, applying 12 SEA regional preparedness benchmarks – a framework devised by Member countries to monitor and evaluate progress. Regional consultations and a ministerial conference on advancing health security and disaster risk reduction, and on scaling up capacities in emergency risk management, have been conducted in recent years to maintain momentum and national commitments.



Member countries are striving to provide health care at all levels

THE SEVENTH DECADE: 2008–2018



The Thai Room, which contains traditional Thai upholstery, curtains, dolls of traditional Thai dancers, and a table and chairs with very oriental designs. Gifted by Thailand



The Indonesia Room, which displays traditional handcrafted furniture and a series of paintings. Gifted by Indonesia

A special fund to manage humanitarian emergencies

The South-East Asia Regional Health Emergency Fund (SEARHEF) is an operational fund that allows for a more rapid response to disasters caused by natural and human-generated hazards. Countries can obtain financial support from the Fund through the country offices within 24 hours of an emergency.

The earthquake and tsunami of December 2004 taught the Region valuable lessons about the need to create a fund that could immediately respond to such emergencies and provide instant support to relief operations. SEARHEF was established in 2008 at the Sixty-first session of the Regional Committee, funded by pooling a budget of US\$ 1 million for each biennium from assessed contributions.

Since then, SEARHEF has supported 36 emergency operations in the Region, with disbursements from the Fund totalling more than US\$ 5.95 million. The types of emergencies supported through the Fund range from Cyclone Nargis in 2008 to various floods and earthquakes to a recent diphtheria outbreak in the Rohingya refugee camps in Cox's Bazar, Bangladesh, in 2017–2018. Although the standard

measure of support of US\$ 175 000 is not huge, the speed of release and the flexibility in its use makes a big difference for the health sector.

Although funding for preparedness is a big challenge, as the health sector's response to the 2015 Nepal Earthquake demonstrates, preparedness and good planning is vital. The Sixty-ninth session of the Regional Committee endorsed a resolution on "Expanding the scope of SEARHEF" to include a preparedness stream that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams.

'Enhancing health security is a critical component of our public health mission, and a core part of WHO's work. The new SEARHEF funding stream will allow Member countries to invest in infrastructure and human resources, thereby strengthening emergency preparedness,' said Dr Poonam Khetrpal Singh.

The SEARHEF mechanism has received wide acclaim across different regions and has been an inspiration to initiate other similar funding mechanisms elsewhere.

Earthquake in Nepal, April 2015

The rapid assessment of the health impact and other actions



The response to the 2015 Nepal earthquake demonstrated the Region's progress in emergency preparedness and response

A rapid assessment of health-care facilities by WHO and Nepal's Ministry of Health and Population in the earthquake-stricken areas found that hospitals in four of the worst affected districts had been completely destroyed or too badly damaged to function. Five other major hospitals, providing important health

care in the districts, were found to be functional but urgently in need of medical supplies. Preliminary findings from the assessment showed that, while there was a shortage of supplies, sufficient health personnel were available to treat patients arriving at the hospitals that were functioning.

'WHO staff have been working round-the-clock to gather a snapshot of the damage inflicted on Nepal's hospitals and clinics by the earthquake. This information will be a vital tool in guiding the short- to medium-term response by national and international health-care providers, determining where to move health teams and supplies in the country,' explained the WHO Representative to Nepal.

Teams visited 21 hospitals in 14 of the districts most severely impacted by the earthquake to gather information. They found that 17 hospitals were still operational. However, many hospitals informed the assessment team that they were experiencing shortages of supplies, including essential medicines, surgery kits, IV fluids, antibiotics and suturing materials, while tents and mattresses were also required. WHO had provided essential medicines and supplies to treat 120 000 people for three months, as well as trauma and surgical kits.

WHO coordinated the deployment of foreign medical teams and humanitarian organizations to priority districts based on the needs of affected populations. Field hospitals were set up on the site of the four non-functioning district hospitals, identified as Ramachhap, Nuwakot, Chautara and Rasuwa. The five hospitals found to be functional but needing urgent support included Gorkha District Hospital, Patan Academy of Health Sciences, Dhading District Hospital, Hetauda District Hospital and Alka hospital in Lalitpur.



After the 2015 earthquake in Nepal

According to the head of WHO SEARO's emergency response team, 'the fact that hospitals do not need additional staff, and that thousands of patients are receiving treatment, shows that the preparedness measures taken by Nepal for emergencies are making a difference – but we must continue replenishing medical supplies, ensuring patients are treated, and that those who require rehabilitation receive it.'

While the rapid assessment provided a snapshot of pressing needs in the aftermath of the quake, additional and ongoing assessments established a better picture to enable the government and health sector to tailor the delivery of medical relief. According to official figures received on 1 May 2015, 6200 deaths had been recorded, while approximately 14 000 people were injured.

From a Regional Office press release dated 2 May 2015

Reducing premature deaths from NCDs



Services that can prevent, control and manage NCDs at the primary health care level are being extended everywhere

The burden of noncommunicable diseases (NCDs) such as diabetes and cardiovascular diseases is rapidly increasing in the South-East Asia Region, and is projected to continue to do so in the foreseeable future. Clearly, this is a key priority in the Region. A Regional Action Plan on NCD Prevention and Control, 2013–2020 – endorsed by the Sixty-sixth session of the Regional Committee – indicates 10 regional targets for NCD prevention and control. This is the first comprehensive NCD action plan in the Region, capturing

for the first time undernutrition, overnutrition, as well as health issues related to micronutrients.

A target of the Sustainable Development Goals is to achieve a one third reduction in premature deaths caused by NCDs by 2030. To achieve this target, it is essential to ensure services that can prevent, control and manage NCDs are available at the primary health care level. In fact, it means nothing less than achieving universal health coverage.

In the Region, NCDs cause more than 60% of all deaths, killing around 8.5 million people every year. Almost 50% from NCDs prematurely, before the age of 60. Member countries are taking steps to address the problem. The Regional Committee in 2016 endorsed the Colombo Declaration, which calls for a focus on strengthening health systems to accelerate delivery of NCD services at the primary level. The WHO Package of Essential Noncommunicable (PEN) Disease Interventions has provided a valuable avenue to the expansion of NCD care across the Region. Recently, WHO PEN has been implemented in Bhutan, Indonesia and Sri Lanka. It is now being piloted in Bangladesh, the Democratic People's Republic of Korea and Myanmar, and further pilot projects are in preparation in Nepal and Timor-Leste.

In addition to strengthening the health system, the Colombo

Declaration calls for exploring innovative financial methods, including taxation of health-damaging commodities such as tobacco, alcohol and unhealthy foods and beverages. Healthy lifestyle promotion is another area which should be promoted, with physical activity as a "best buy" intervention for reducing NCD mortality. The Urban Health Equity Assessment and Response Tool, developed by the SEA Region with Member countries, promotes the creation of healthy public spaces in the cities.

All Member countries have established national NCD targets to be achieved by 2025. These will help them to gauge progress towards the SDG target in 2030. Nine of 11 countries have now developed multisectoral action plans as a whole-of-society approach to reversing NCDs.

Rolling back the tobacco epidemic

Every year, tobacco-related diseases kill 1.3 million people in the South-East Asia Region. However, there are evidence-based policies to reduce this alarming number. The Framework Convention on Tobacco Control was tabled in 2003, and since then 10 countries have passed and implemented tobacco control legislation in line with the Convention provisions. Graphic health warnings have been gradually

implemented in many countries.

Since 2014, some 85% of the cigarette packs in Thailand are displaying the warnings, while in Nepal (as mentioned earlier) it is as much as 90%. In 2016, India increased the size of warnings on tobacco packs from 40% on the front to 85% on both sides, while Myanmar made it mandatory for 75% of the package surface area.

Various initiatives have also been implemented in other countries. In Bangladesh, smokeless tobacco was for the first time included under the definition of tobacco products and brought under the same controls. In Bhutan, anti-tobacco media campaigns accelerated, urging the public to “make every day a no-tobacco day”. In the Democratic People’s Republic of Korea, a comprehensive ban on tobacco advertising was implemented. In Maldives, tobacco import taxes were hiked as a means to diminish demand for tobacco products. Timor-Leste passed some of the most progressive tobacco control laws in the world; and for his outstanding

efforts, Prime Minister Rui Maria de Araújo received the World No Tobacco Day Award in 2016. In Sri Lanka, the country is phasing out tobacco cultivation altogether, while highlighting the benefits that farmers can reap by shifting to alternate crops. This approach was a key agenda item at the Seventh Session of the Global Conference of the Parties (COP7) meeting in New Delhi in November 2016. Sri Lanka’s leadership on the issue is an inspiration to tobacco-producing countries across the world. Effective tobacco control measures are a powerful means to accelerate progress to curb premature deaths from NCDs by a third by 2030.

Resilience to climate change

There is increasing evidence of the direct and indirect adverse impacts of climate change on human health and health systems, which may pose a serious burden to sustainable socioeconomic development. In 2017, the Regional Committee endorsed the Malé Declaration on Building Health System Resilience to Climate Change.

The Malé Declaration suggests that the six building blocks of the health system are important for building overall resilience to climate change and strengthen existing health system capacities. In order to protect the health of the population in

conditions of climate change, the health sector needs to collaborate with sectors that have a direct influence on health, such as water, energy and agriculture. The health sector must engage communities if health systems are to protect health and facilitate community resilience. The Malé Declaration and the Framework for Action in Building Health Systems Resilience to Climate Change in the WHO South-East Asia Region, 2017–2022, provides a roadmap for implementing the Malé Declaration, with the specific objective of providing a conceptual structure to develop specific national action plans.



Oil painting on canvas. 0.86 x 1.5 m. Gifted by Thailand



Mask on frame (0.66 x 0.85 m). Gifted by Thailand

Public health education in Bhutan

The Bachelor of Public Health Programme in Bhutan, launched with WHO support in 2010, has helped to produce a cadre of health workers with a higher level of knowledge and skills in public health. Areas particularly covered are leadership and management; critical thinking and problem solving; planning, monitoring and evaluation of health programmes; engagement in operational research; and evidence-based practice.

More than 80 health workers have graduated since 2010. Most of them are leading the District Health System as district health officers, managing programmes at the Ministry of Health, and supervising the community health units in hospitals and basic health units. Some were also inducted at the Faculty of Nursing and Public Health, Khesar Gyalpo University of Medical

Sciences. Some of the graduates have also completed their Masters degrees in Public Health.

WHO helped initiate the Bachelor of Public Health Programme in 2008, and provided the technical and funding support for:

- A public health specialist to review and revise the curriculum and teach in the programme for two years
- Sending six faculty members to study for their Masters in Public Health
- Sending faculty members for training in pedagogy
- Strengthening library and learning materials

- Building linkages with the Faculty of Public Health, Mahidol University, and the South-East Asia Public Health Education Institutions Network (SEAPHEIN)

WHO has been a vital partner in Bhutan in providing technical support and capacity-building in the health sector. This has brought about significant improvements in the health of the population of Bhutan, as evidenced by the marked improvement in health indicators.

Since the establishment of the Health School in 1974, WHO had provided stipends for trainees in primary health care for a number of years. It supported institutional development, faculty development, and strengthening of the library and teaching-learning facilities.

The institute's library has been designated as a WHO Depository and receives WHO publications regularly. WHO supported the Bachelor in Nursing conversion programme in collaboration with La Trobe University, Australia, in 2001. A total of 52 General Nursing & Midwifery Nurses in three batches were awarded their Bachelor's degree in Nursing from La Trobe University between 2001 and 2008. This paved the way not only for improving the quality of nursing services in the country but also enhancing the quality of the nursing faculty at the Institute. In 2012, WHO provided technical and financial support for the Faculty to launch the two-year Bachelor's degree course in Nursing and Midwifery.

(WHO Country Office, Bhutan)

Vision to Results: Advancing health for billions



in the WHO South-East Asia Region







A HOUSE FOR WORLD HEALTH

A HOUSE FOR WORLD HEALTH

The Regional Office for South-East Asia (SEARO) had very humble beginnings when it started operations on 15 December 1948 in

New Delhi. Its first home was one small room located in the North Block of the Secretariat of the Government of India. At that time, the Regional Office housed only the Regional Director and a messenger (with a part-time clerical assistant on loan from the Government of India). On 27 December 1948, one more clerical staff joined the frugal workforce. Those were the early days of Independent India when Delhi was coping with an acute shortage of official premises and residential accommodation for government functionaries.

The first offer of formal accommodation received by the Regional Office was of 15 small rooms in a rather dilapidated wartime extension of the Old Secretariat Building in Old Delhi.

However, on 1 February 1949 the Regional Office moved into its second premises situated at 12, Hardinge Avenue (now Tilak Marg) in Lutyens' Delhi.

By then, the Deputy Regional Director, Dr S.F. Chellappah, who was from Sri Lanka, had already reported for duty, and started working from the one room that was the first Regional Office. The new accommodation on Hardinge Avenue was on the ground floor of a residential bungalow. Within six months, it was accommodating 24 staff members: the Regional Director, the Deputy Regional Director, a medical officer, an assistant finance officer, an assistant administrative officer, 11 clerical assistants, four messengers, one driver, one *daftary* (office staff), one guard and a janitor.

The Regional Director made several suggestions for a more commodious office, but only one offer of a larger



First home of SEARO: North Block building of the Secretariat of the Government of India, New Delhi, 1948 (file photo)



Second home of SEARO: 12, Hardinge Avenue, New Delhi, from 1949 (file photo)

premises was received in 1949 but without any guaranteed date of availability: in Pattani House on 5, Man Singh Road. This situation was even reflected in the Regional Director's report to the Second session of the Regional Committee:

Difficulty with regard to office and residential accommodation has paralysed the work of the Region from the very start. The office accommodation is wholly inadequate. The present accommodation is not enough for the present staff. On the other hand, additional staff already approved cannot assume duty for want of accommodation. The programme for 1950 is likely to be double that of 1949, but it is not possible to undertake this work unless adequate accommodation for the Regional Office ... can be provided immediately. All efforts of the Regional Director to secure suitable accommodation have met with failure,

*and the position now is so acute that he requests the direction of the Regional Committee in this matter.*⁶

The Regional Committee was due to meet on 26 September 1949. By then, because of the severe paucity of suitable accommodation options, suggestions were even afloat in some quarters that the Regional Office be moved to the capital of some other Member State. Fortuitously, on 17 September 1949, just before the Regional Committee, a letter was received by SEARO from government authorities offering a larger accommodation on the western wing of the ground floor of Patiala House. This was a palace built for the Maharaja of Patiala, who was at that time occupying a part of the building.

But the shift to Patiala House was

⁶ First Annual Report of the Regional Director, 1948, document SEA2/2, p.7

A HOUSE FOR WORLD HEALTH



Third home of SEARO: Patiala House, New Delhi, late 1949 (file photo)

mired in uncertainty. To begin with, vacating the portion that was assigned to WHO, which measured about 6500 square feet of floor space, was delayed. On 31 October 1949 the Regional Director literally walked in with his staff and occupied the allotted rooms in Patiala House. Any objection on the ground that the premises were still not vacant would be overruled by the immunities and privileges enjoyed by an international organization. His action was prompted by rumours that the delay in allotting Patiala House to WHO could mean another imminent change of venue.

The last two of the rooms originally promised by the government were made available only on 31 January 1950. It was not until the end of the following March that the Regional

Director was able to report to WHO headquarters that the furnishing and equipping of the space allotted to the Regional Office in Patiala House had been completed.

Patiala House remained the home of the Regional Office for 13 years. It was originally built as a maharaja's palace with large and lofty rooms and high ceilings, and never ideally suited for office work. It had to be partitioned into cubicles, which officers had to share with their secretaries. There was no room for privacy and quietude.

The magnificent ballroom with its minstrel galleries accommodated the administrative, personnel and finance departments. Once every year, this office was moved into a marquee in order to make room for

the Regional Committee sessions. Working under canvas was not easy during the monsoons, and the acoustic qualities of the ballroom did not facilitate discussions during the Regional Committee. Nevertheless, there were advantages that emanated from such compression of office space: an esprit de corps was fostered, and coordination of operations of technical advisers was facilitated by their enforced proximity.

From 1950 WHO shared the accommodation in Patiala House with UNICEF. The rapid growth of the programmes of both organizations involved a steady augmentation of staff. In September that year, the Regional Committee was informed of the space crunch. As the years went by, the government made available additional space in instalments in consultation with the Maharaja of Patiala himself. Each such occasion involved protracted negotiations. Corridors were occupied, verandas boarded up and every last corner was converted into office space.

In 1958, the Regional Office recruited more staff members to cope with the malaria programme, then the largest regional branch of the global malaria eradication campaign. There were 108 staff members for malaria (with another 230 in the field), and the budget amounted to US\$ 2.7 million. The Government of India then offered five rooms in the "P" Block Hutments (a legacy constructed

during the Second World War) on Raisina Road, a mile and a half from Patiala House. The staff of the administration and finance department moved into this temporary accommodation in June 1958. But this split was found unworkable, and they returned to Patiala House, crowded though it was, after a few weeks.

In January 1959, UNICEF moved to new quarters on Lodi Road, and WHO was able to expand into the space vacated. Work continued efficiently until November 1962, when the new and permanent office on land provided generously by the Government of India – World Health House – was ready for occupation.

The issue of a permanent accommodation for the Regional Office had been raised very early on. In September 1955, the Regional Committee adopted a formal resolution requesting the Regional Director to enter into immediate negotiations with the Government of India regarding accommodation. This resolution was duly forwarded to the Government, and correspondence and reminders continued until September 1956, when the Regional Committee again adopted a strongly worded resolution urging a speedy solution to the problem.

In October 1956, the Government offered Kapurthala House on Man Singh Road, which was expected to be vacated by the end of the year. Though the floor space available

was less than that provided in Patiala House, the Government was prepared to make this venue suitable for the Regional Office's needs. During 1957, both the Executive Board and the World Health Assembly expressed considerable concern over the matter, and references were made to the new buildings offered to WHO for some of its other regional offices – in Brazzaville, Copenhagen and Manila – by the governments concerned. Discussions on proposed alterations that needed to be made to Kapurthala House continued through 1957. In January 1958, the

Regional Director was informed that the proposal for permanent accommodation at Kapurthala House was withdrawn.

Talks continued for a suitable house for world health, with the Executive Board and the Director-General participating, until May 1958. That month, the decision was finally taken to allot some land to build an entirely new office exclusively for WHO. In August 1958, land for WHO's Regional Office was identified in Indraprastha Estate in central New Delhi.

World Health House

Mr H. Rahman, a senior architect empanelled by the Government of India's Central Public Works Department, was chosen to design the new building. WHO owes him, as well as the Government of India, a great debt of gratitude for a fine building.

The Organization was able to arrange for Mr Rahman to travel to Manila to see the new WHO Regional Office for the Western Pacific in that city. His drawings and plans were approved by all concerned. However, it was not easy to get quick approvals for large-scale construction works, and it was only after the personal intervention of the then Prime Minister, Pandit Jawaharlal Nehru, that construction actually started on 4 February 1960.

As could be expected with the erection of a large, six-storey office block, with a separate conference block of two floors, construction did not proceed without the occasional alarm and difficulty. A strike by construction workers held up the work for three days in April 1961. On 2 August 1962, the monsoon caused a breach in a nearby stormwater drain and flooded the site. The water stood three feet deep at the site and reached a height of eight inches on the ground floor for several days. That same year, there was a serious shortage of electricity in Delhi and the local authorities failed to sanction enough power to run the office and meet the needs for air-conditioning and the lifts. The final shock came in October

1962, when a national emergency was proclaimed following hostilities between India and the People's Republic of China on India's north-eastern frontier. It was even suggested that the Government of India use the newly built office for the war effort.

However, the WHO Secretariat at very short notice moved into World Health House before it was completed. The transfer was effected between 4 and 8 November 1962, and Patiala House was released for use by the Government

of India in the war emergency. Prior to the Secretariat's move it became possible to arrange for the Regional Committee to hold its Fifteenth session in the new Conference Hall block of World Health House.

The new permanent Regional Office was a culmination of the promise made by cablegram by the Prime Minister of India to the President of the First World Health Assembly in Geneva 14 years earlier. Now, the World Health Assembly expressed eloquent gratitude to the Government of India that was



World Health House photographed in 2018



Kantha work panel. 2.08 x 0.90 m. Gifted by Bangladesh

echoed widely and sincerely by all associated with the work of the World Health Organization.

On 24 April 1963, Prime Minister Nehru graciously inaugurated World Health House. In his inaugural speech he referred, as at the first session of the Regional Committee in 1948, to WHO as an organization of the United Nations which need not be affected by political influences and which had continued its work over the past decade unaffected by international strife. He expressed hope that this work would continue and pave the way for closer international cooperation between nations in health as well as other fields.

The WHO Regional Director, in his acceptance speech, referred to the personal commitment of the Prime

Minister in making World Health House a reality. "This office," said Dr Mani, "is, in fact, the office of the governments of the South-East Asia Region, where their representatives meet to discuss common health problems and to develop WHO-assisted health programmes for the benefit of their public services."

One realizes that the office is truly regional when one views the many cultural gifts from Member countries and others decorating and illuminating the rooms, halls, walls and corridors. These include: marble tables and carpets from Afghanistan; a large mural painting and framed artwork from Myanmar; furnishings of a meeting room provided by Sri Lanka; an intricate tapestry from France; several paintings, masks, carvings and *batik* curtains gifted by Indonesia; a carpet

from Mongolia; a model of the Pashupati Nath Temple covered in gold leaf from Nepal; two wall tableaux of ornamental tiles from Portugal; Thai silk curtains, tables and chairs and dolls for a meeting room; a bronze statue from the United Kingdom of Great Britain and Northern Ireland; a tapestry and model ships from Maldives; a framed "*kantha*" embroidery and other paintings from Bangladesh; a flower vase from the Democratic People's Republic of Korea; and tapestries and *thangkas* from Bhutan; and a traditional framed "*tai*" from Timor-Leste, among many others. All these were tokens of the goodwill that

has always been a part of the collaboration between WHO and the governments of the Region. India contributed two outstanding murals painted on the walls of the Conference Hall in the 1960s by the well-known artist Maqbool Fida Husain, which together tell the story of the history of medicine and are described elsewhere in the book.

In January 1967, at the 39th session of the Executive Board, the Director-General announced that an offer had been made by the Government of India to WHO for the outright purchase of the Regional Office building for



Oil painting (1.16 x 0.86 m). Gifted by Bangladesh

about US\$ 350 000. As the value of the land and building at the time of its construction had been estimated at about US\$ 1 million, the Government's offer was indeed very generous. It was warmly welcomed by the Board, which had no hesitation in recommending its acceptance by the Twentieth World Health Assembly. This purchase was duly approved by the Health Assembly in May 1967.

The functionally excellent, and by the then standards extremely modern, office and conference hall that was made available to WHO

for its work in the Region bears testimony to the diligent efforts of staff of the Organization to bring tangible change to the lives of the people in this part of the world. This was to be WHO's home for the next 55 years, till 2018. In 2018 it was decided to rebuild and reconstruct the office at the same place. Staff of the Regional Office shifted temporarily to a new location for the reconstruction to happen. This project to build a new iconic Regional Office Building incorporating the latest contemporary technology will run for five years till 2023.

Extract from business case report to the Seventieth Session of the Regional Committee on 16 August 2017

The World Health Organization Regional Office for South-East Asia is located at New Delhi, India on a land parcel admeasuring approximately 7203 sq. metres. The land was leased to WHO by the Government of India on a long-lease basis at a concessional rate. The Main Building and the Conference Hall at the campus was constructed by the Central Public Works Department (CPWD) of Government of India. Since the campus is more than 50 years old, WHO is facing a number of real estate challenges in terms of safety, health, environment, locally applicable regulations, operational costs and future expansion. Most importantly, recent structural surveys carried out by CPWD and other external agencies have revealed that the current buildings within the office campus are highly vulnerable to seismic events, which consequently is a high risk to business continuity and employee safety.

Thus, it was agreed among the key stakeholders, including the Government of India, the Regional Director and the Director-General, to relocate business operations temporarily till such time that the current office is reconstructed in order to avoid any unfortunate incident and mitigate risks that could result in institutional, personal or financial liability and reputational risk for the entire UN system. In this regard, SEARO has identified suitable temporary 'swing space' options in central Delhi, for relocation of its 362 staff members, with the help of an international real estate consultant.

At the Seventieth session of the Regional Committee in Maldives in September 2017, the decision to shift staff to a temporary office space and totally dismantle and reconstruct the Regional Office Building was finally etched in stone through decision SEA/RC70(2). By this covenant, the Regional Committee decided to redevelop the whole campus and construct a new, state-of-the-art and environmentally-friendly building. The estimated budget for this project is US\$ 55.89 million, with WHO covering the

cost of the relocation of the staff to temporary premises for a period of up to five years for about US\$ 20.49 million. The Committee expressed “deep appreciation” to the Government of India for its continued generosity in hosting the Regional Office for South-East Asia, and for agreeing to finance and manage the construction of the new building to the tune of about US\$ 35 million within a time frame of five years. Some Member countries also pledged upfront financial support for the project.



Reception lobby of WHO-SEARO in Indraprastha Estate, New Delhi, with a set of cane furniture. Gifted by Indonesia

History of Medicine, by M.F. Husain, 2 murals. Dimensions: 18.76 x 2.77 m each. Gifted by India

The twin murals on the walls of the Conference Hall were painted by M.F. Husain, titled 'History of Medicine', and were gifted by India. The mural on the southern (left) side of the hall has five panels. They depict the Hindu god Hanuman and the Ramayana legend about the god lifting a mountain to fetch the healing herb 'Sanjivani'; a woman giving birth to twins; an eye surgery in progress; modern laboratory equipment and a scholar engaged in research; and the model of an atom representing nuclear medicine.





On the northern (right) side the mural has eight panels. These portray the sun and herbs that helped heal various diseases in antiquity; the use of fire for curative purposes during an epidemic; an ancient Egyptian scribe writing out a prescription; the pestle and mortar used in the preparation of medicine; the hand of the practitioner and caregiver that plays an important part in healing; the Greek goddess of health Hygeia; and the ancient practice of adjusting a dislocated bone with the help of a ladder.

In 2018, the 13 panels on which the murals had been painted were carefully removed from the walls and have been transferred to a safe storage site. They will be mounted in the new WHO building when construction is complete.





9

LOOKING AHEAD

LOOKING AHEAD

The opening paragraphs of the UN General Assembly Declaration endorsed by 193 Heads of States and Governments in September 2015⁷ set the scene for defining the 17 new Sustainable Development Goals (SDGs) and 169 targets.⁸ These will build on the Millennium Development Goals (MDGs) and complete the “unfinished agenda”, while addressing ongoing and new challenges for a prosperous peaceful world in an inclusive and holistic manner to ensure that “no one is left behind”.

Goal 3 is the main health goal among the Sustainable Development Goals. This is broadly framed as being: to ensure healthy lives and promote well-being for all ages. Goal 3 includes 13 specific targets covering health systems strengthening, prevention and control of diseases and risk factors,

and overall reduction of morbidity and mortality. While several of these follow on from the MDGs, the health agenda in the SDGs is more ambitious, both in its scope as well as its level of ambition. Where the MDGs saw health in isolation, the new agenda frames health as both a contributor to, and outcome of, sustainable development. The intrinsic relationship among the goals are as important as the goals themselves. Hence, this new agenda provides a great opportunity to accelerate progress in health, to make universal health coverage a reality, and to improve the lives of millions.

The most fundamental and positive change in the SDGs is the shift from a limited number of discrete Millennium Development Goals to the much wider range of interdependent Sustainable Development Goals.



UHC increases access to health care to the people and communities

⁷ United Nations General Assembly, 21 October 2015, Seventieth session, Agenda items 15 and 116. Resolution adopted by the General Assembly on 25 September 2015. 70/1. Transforming our world: the 2030 Agenda for Sustainable Development (<https://sustainabledevelopment.un.org/post2015/summit>)

⁸ <https://sustainabledevelopment.un.org/sdgs>

'Transforming Our World': The 2030 Agenda for Sustainable Development

'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 development.

As we embark on this great collective journey, we pledge that no one will be left behind. Recognizing that the dignity of the human person is fundamental, we wish to see the Goals and targets met for all nations and peoples and for all segments of society. And we will endeavour to reach the furthest behind first.

Source: Transforming our world: the 2030 agenda for sustainable development. Finalized text adopted by the United Nations General Assembly, 25 September 2015, New York (NY): United Nations; 2015.



The United Nations has undertaken a process of reform to enable it to address the SDGs within the framework of its four-year work cycle. The resolution covering this reform process⁹ calls for a revitalized, strategic, flexible and results- and action-oriented UN Development Assistance Framework in support of the implementation

of the SDGs in each country. To this end, all UN agencies, including WHO, are required to ensure the best configuration of support on the ground. All UN development activities should have enhanced coordination, transparency, efficiency and impact, in accordance with national development policies, plans, priorities and needs.

⁹ Repositioning of the United Nations development system in the context of the quadrennial comprehensive policy review of operational activities for development of the United Nations system. UN General Assembly Resolution A/72/L.52. Available from: <https://undocs.org/A/72/L.52>

WHO's Thirteenth General Programme of Work 2019–2023, or GPW13,¹⁰ unanimously endorsed by Member States during the Seventy-first World Health Assembly in May 2018, provides the strategic direction for the work of the Organization in the next five years. It is based on the SDGs and is relevant to all countries.

This General Programme of Work is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: i) achieving universal health coverage, ii) addressing health emergencies, and iii) promoting healthier populations.

Founded on WHO's mission (to promote health, keep the world safe, and serve the vulnerable), the GPW13 sets an ambitious agenda with three goals coined as the "triple billion targets". These envisage:

- One billion more people benefiting from universal health coverage,
- One billion more people better protected from health emergencies, and
- One billion more people enjoying better health and well-being.

WHO's Thirteenth General Programme of Work

'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

Health is fundamental to the SDGs and, in an interconnected world, WHO's role in providing global public goods that help to ensure health for all people within and across national boundaries has never been more relevant. WHO's unique status as a science- and evidence-based organization that sets globally applicable norms and standards makes it vital in a rapidly changing world. The Organization's powerful voice for health and human rights is indispensable to ensure that no one is left behind. Broad and sustained efforts are needed to build a community to work for the shared future of humankind, empowering all people to improve their health, address health determinants and respond to health challenges.'

Thirteenth General Programme of Work 2019–2023: Promote health, keep the world safe, serve the vulnerable.

¹⁰ Thirteenth General Programme of Work, 2019–2023: Promote health, keep the world safe, serve the vulnerable. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1

The Thirteenth General Programme of Work sets out three key strategic shifts to facilitate the achievement of the strategic priorities and targets:

- Stepping up WHO's leadership in several key areas, including diplomacy and advocacy, gender equality, health equity and human rights, multisectoral action and finance;
- Driving public health impact in every country, with a differentiated approach based on capacity and vulnerability; and
- Focusing global public goods on impact, including by providing normative guidance, data and research and innovation.

The strategic priorities and goals of GPW13 are aligned with the eight Flagship Priorities of the Region that were promulgated by Dr Poonam Khetrpal Singh, Regional Director. They are also in line with national health priorities as set out in the national health plans and strategies and WHO country cooperation strategies agreed with Member States. Implementation of GPW13 and UN reform provides an opportunity for WHO to continue building on the successes and best practices jointly with Member States and partners to achieve the national and regional targets, while

contributing to the global health and sustainable development agendas.

The face of public health in the South-East Asia Region is changing in unprecedented ways. If we look at some measurable indicators, the Region with more than a quarter of the world's population carries 30% of the global disease burden and accommodates about 40% of the world's poor. Of all the six regions of WHO, South-East Asia is the one with the highest probability of a citizen dying from cardiovascular disease, cancer, diabetes or chronic respiratory disease between the ages of 30 and 70. It has the highest prevalence of stunting and wasting in children under five, the highest reported number of people requiring interventions against NTDs, the second-highest tuberculosis incidence per 100 000 population, the second-lowest amount of general government health expenditure as a proportion of general government expenditure, the second highest suicide mortality rate, and is the second lowest in completeness of cause-of-death data. About 25% of the population of the Region does not have access to essential health protection.¹¹

There are several public health problems of vital importance to the health of the people and to the governments of our Region.

¹¹ World Health Organization. World Health Statistics, 2017: Monitoring Health for SDGs. Available at www.who.int/gho/publications/world_health_statistics/2017/en/, accessed on 13 April 2018

These include the growing threat of non communicable diseases, the health impacts of climate change, environmental pollution and unplanned urbanization, and the new demands that result from changing societal norms, public expectations and ageing populations.

But there is more: the mounting toll of deaths and disability on our roads, the persistent challenge of hunger for some and over nutrition for others, the scandalous neglect of mental health, the blight on communities caused by the traffic in narcotic and other drugs of abuse, the plight of migrants, the victims of human traffickers and others forced to leave their homes by conflict and adversity, and the market and system failures that underpin antimicrobial resistance and the lack of access to safe and affordable medicines and technologies. Public health does not stand still. The list of challenges is

long, but all these health-related issues find their place in the SDGs.

The basic components of a new health agenda are taking shape. There is a need to think about three elements. First, the role of the health sector: what can be achieved through the most effective, equitable and efficient deployment of resources for preventive, curative, promotive and rehabilitative health care? Second, what health outcomes are dependent on policy and action by other sectors and actors, and what can be done to make them happen? Third, how to deal with the set of cross-cutting concerns that underpin both of the other two components: respect for human rights; a concern for equity (no one to be left behind); the primacy of evidence as the basis for decision-making, evaluation and accountability; and the need for investment in research and development?

UHC as a key instrument for change

The importance of the health sector will remain the primary concern of most ministries of health. There is much that remains to be done: completing the elimination of NTDs, further reducing maternal, new born and child mortality, and sustaining the gains made in malaria and HIV/AIDS are just a few examples. We have somehow underestimated the threat posed by tuberculosis.

The future work in the health sector is not just more of the same business-as-usual. There is a need to reconfigure service delivery so that clinics and hospitals can deal with multiple pathologies and continuity of care, particularly for those with chronic diseases and for the elderly. There is a need for mature and carefully managed partnerships with the private sector, which can help

deliver public health outcomes. We need new staffing profiles for the prevention and care of NCDs at the frontline. We need financial incentives that reward prevention, wellness and, increasingly in some countries, cost containment. And – this is the most critical factor – the health sector has to be adequately financed. Governments should make more effort, both to raise revenues (currently only about 15% of GDP) and spend more of this income on promoting better health (only four countries spend more than 10% of their public sector budget on health). Unless we see sustainable change, people will continue to face potentially impoverishing out-of-pocket expenditures when they fall ill.

Universal health coverage is our key instrument of change. Its primary intent is to ensure service access and financial protection, but it has broader implications for the

organization of health programmes in governments and, indeed, in WHO. For UHC to fulfil its potential, all programmes should be managed in ways that support overall national health strategies, rather than pursuing a set of separate and disparate objectives. UHC is about the health sector as a whole, and all its programmes – not just the building blocks of health system strengthening.

While UHC by definition is concerned with equity, the way universality is interpreted in practice matters greatly. This is particularly in countries with refugee or other migrant populations at risk of being excluded from health care, especially if they are not afforded the same rights as full citizens. For health to be a human right, it must be accessible to all. This is the true meaning of universality – a concept that lies at the heart of the Sustainable Development Goals.



Embroidered wall hanging encased in wood and glass cover (1.32 x 1.04 m), for 50th Anniversary, received in 1998. Gifted by Myanmar

Building coalitions for change

Many of the health targets included as a part of the SDGs require action both within the health sector and beyond. Resilience in the face of emergencies requires a strong health sector, but also strong links with many other parts of government. Tackling NCDs requires effective preventive and curative health services. But to reduce the most important risk factors needs action in other domains: taxation, advertising, food and beverage

marketing, promotion of exercise and many others. Similarly, an ageing population will place new demands on health-care providers and require better access to assistive technologies. Equally, a healthy and productive old age will depend on pension, taxation and employment policies, urban planning, transport and connectivity. When it comes to road traffic injuries, the role of the health sector, at best, is just to repair and rehabilitate – literally to

Tobacco control among youth to reduce the risk of NCDs is a significant component of the vision of Regional Director Dr Poonam Khetrpal Singh, seen here at an event in Dili, Timor-Leste



pick up the pieces. The real action to prevent the damage – reducing drink-driving and excess speed, vehicle and road maintenance, driver and passenger safety – takes place elsewhere.

This element of the agenda builds on the familiar themes of “intersectoral action” and “health in all policies”, but if we are to take the SDGs seriously we need to go further. In many areas we already have multisectoral action plans, but too often they are seen as being the primary concern of the ministries of health that organized their preparation. Their impact on the rest of government is limited.

There is a need to build on the solid platform provided by the SDGs and develop a more practical agenda – issue by issue. There are also lessons to be learned from what we have achieved so far. Progress in the fight against tobacco has required an intense focus on a few key outcomes (for example, in the areas of taxation, marketing and packaging). Ministries of health have been powerful advocates for change, but the key decisions are made at different levels of government.

Good health is a product of good political decisions. And good political decisions require a deeper

understanding of the interests of all those involved – in building age-friendly societies, in preventing the further spread of antimicrobial resistance and, indeed, ensuring that the health sector is adequately financed. Advocacy and good intention alone are no longer enough; together, we have to become more effective champions for people’s health.

The responsibility for policy will always rest with governments, but the changing face of public health will require new ways of working in WHO: creating new forms of partnership and building effective coalitions; at the regional level, carrying out and commissioning analysis and research that provides policy-makers with the information they need to make their case; and, at country level, a widening network of relationships across government, civil society and academia.

The combination of a more equitable and effective health sector, more practical and issue-based work across society to promote health, and continuing insistence on equity and rights, backed by good science, evidence and research, represents the way forward. We have a long road to travel, but our agenda in this Region has become increasingly clear.

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For 70 years, the World Health Organization's Regional Office for South-East Asia – which in 1948 was the first WHO region to be established – has been collaborating with its Member States to improve the health of all people in the Region. This collaboration has resulted in many remarkable achievements in improving people's health. This book is an account of the journey of health development in countries of the South-East Asia Region. It describes the main achievements, challenges, and strategies to tackle public health problems specific to this Region in an historical perspective.

Arranged chronologically around work carried out in each decade of collaboration, the various approaches in tackling health issues are outlined, including their successes in disease control, elimination and eradication, and in the improvement of health systems. The book also indicates the chosen path towards achieving the dream of health equity – universal health coverage. This historical document should be of compelling interest to all those who want to learn about health developments in the South-East Asia Region in the last 70 years.

